

REACH

RACIAL AND ETHNIC APPROACHES TO COMMUNITY HEALTH

THE POWER TO REDUCE HEALTH DISPARITIES VOICES FROM REACH COMMUNITIES



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



**For more information about the REACH program
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THE POWER TO REDUCE HEALTH DISPARITIES

Voices from REACH Communities

From the Director

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

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 *The Power to Reduce Health Disparities: Voices from REACH Communities*, 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 publication 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 community profiles in this publication 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

Contents

Introduction 1

Community Profiles

Alabama

University of Alabama at Birmingham: Alabama REACH 2010 Breast and Cervical Cancer Coalition 3

Alaska

Chugachmiut Native Organization: Alaska Native Cardiovascular Disease Prevention/
Core Capacity Building Project..... 5

California

Community Health Councils of Los Angeles: African Americans Building a Legacy of Health 7
Los Angeles Biomedical Research Institute at Harbor-UCLA Medical Center: Immunize LA Kids Coalition 9
San Francisco Department of Public Health: SevenPrinciples Project 11
Special Services for Groups, Inc.: REACH 2010/Health Access for Pacific Asian Seniors..... 13
University of California, San Francisco: Vietnamese REACH for Health Initiative Coalition 15

Florida

Florida International University: Coalition to Reduce HIV in Broward’s Minority Communities 17

Georgia

Fulton County Department of Health and Wellness: REACH for Wellness 19

Illinois

Access Community Health Network and University of Illinois at Chicago: REACH Out..... 21
Chicago Department of Health: REACH 2010/Lawndale Health Promotion Project 23
University of Illinois at Chicago: Chicago Southeast Diabetes Community Action Coalition 25

Louisiana

Black Women’s Health Imperative: REACH 2010: At the Heart of New Orleans Coalition 27

Massachusetts

Boston Public Health Commission: Boston REACH 2010 Breast and Cervical Cancer Coalition 29
Boston Public Health Commission: REACH Boston Elders 2010..... 31
Center for Community Health, Education & Research, Inc.: Metropolitan Boston Haitian REACH 2010 HIV Coalition..... 33
Greater Lawrence Family Health Center: REACH 2010 Latino Health Project 35
Lowell Community Health Center: Cambodian Community Health 2010 Program 37

Michigan

Community Health & Social Services Center, Inc.: REACH Detroit Partnership 39
Genesee County Health Department: Genesee County REACH 2010 Team 41

Missouri

Missouri Coalition for Primary Care: Kansas City - Chronic Disease Coalition 43

Nevada

University of Nevada, Reno: Healthy Hearts Project 45

New Hampshire

New Hampshire Minority Health Coalition: New Hampshire REACH 2010 Initiative 47

New Mexico

Albuquerque Area Indian Health Board, Inc.: Partners in Tribal Community Capacity Building (REACH 2010) Project 49

Hidalgo Medical Services: La Vida Program 51

National Indian Council on Aging: Diabetes Educational Outreach Strategies Project 53

New York

Institute for Urban Family Health: Bronx Health REACH Coalition 55

Mailman School of Public Health of Columbia University: Northern Manhattan Start Right Coalition 57

North Carolina

Carolinas HealthCare System: Charlotte REACH 2010 Coalition 59

Eastern Band of Cherokee Indians: Cherokee Choices/REACH 2010 Diabetes Prevention Program 61

Oklahoma

Association of American Indian Physicians: Oklahoma REACH HIV/AIDS American Indian Capacity Building 63

Choctaw Nation of Oklahoma: Choctaw Nation Core Capacity Building Program 65

Oklahoma State Department of Health: Oklahoma Native American REACH 2010 Project 67

Oregon

African American Health Coalition, Inc.: REACH African American Health Coalition 69

South Carolina

Medical University of South Carolina: REACH 2010 Charleston and Georgetown Diabetes Coalition 71

Tennessee

Matthew Walker Comprehensive Health Center: Nashville Health Disparities Coalition REACH 2010 Project 73

United South and Eastern Tribes, Inc.: REACH 2010 Immunization and Infant Mortality Project 75

Texas

Latino Education Project: REACH Latino Education Project 77

Migrant Health Promotion: REACH Promotora Community Coalition 79

Washington

Public Health - Seattle & King County: Seattle & King County REACH 2010 Coalition 81

Index

REACH Communities by Racial and Ethnic Group 83

REACH Communities by Health Priority Area 84

Introduction

As racial and ethnic minority groups continue to make up an increasingly larger percentage of the U.S. population, the reality of health disparities continues to severely impact our nation's health. Although life expectancy and overall health have improved in recent years for most Americans, not everyone is benefiting equally. Many racial and ethnic minority groups have persistently higher rates of illness and death than the U.S. population as a whole.

The well-documented link between race/ethnicity and health disparities motivates programs such as the Racial and Ethnic Approaches to Community Health (REACH) program to ensure that all U.S. residents have an equal chance to live a healthy life.

REACH is an important cornerstone of CDC's efforts to eliminate health disparities in the United States. During 2000–2007, CDC funded 40 communities that focused on innovative strategies to eliminate health disparities in key health areas, including cardiovascular disease, diabetes, breast and cervical cancer, immunizations, infant mortality, and HIV/AIDS. These programs target several racial and ethnic groups, including African Americans, Alaska Natives, American Indians, Asian Americans, Hispanics/Latinos, and Pacific Islanders.

REACH communities have produced impressive results and proven that health disparities are not inevitable and can be overcome. We are learning from the REACH experience that community-driven strategies that fully engage community members and address social, economic, and cultural circumstances can improve health outcomes and reduce health disparities. The successes reported in these communities provide a strong foundation for the future, as the REACH program continues to expand and share its lessons learned and best practices.

Community engagement and partnerships are key to the success of the REACH program. Each local program is built around a community coalition that includes at least one community-based organization, research institution, and state or local health department. These coalitions also bring together participants and resources from other government agencies, faith-based groups, community centers, and civic organizations.

CDC provides training, technical assistance, and support to REACH communities to help them address the multiple factors that influence health and health disparities. With this support, communities develop and implement effective interventions, evaluate their programs, and disseminate their findings through the media and the scientific literature.

By developing, implementing, and evaluating a broad range of innovative strategies, REACH communities have been able to

- Build and sustain effective long-term partnerships.
- Provide individuals and communities with the tools to seek and demand better health and local resources.
- Make sustainable improvements to community systems and infrastructures.
- Share lessons learned and best practices that can be used in other communities.

This publication celebrates the successes of REACH communities throughout the United States. Each community profile presents community-driven strategies and solutions, as well as specific examples of how the communities are reducing health disparities and improving people's health.

These profiles demonstrate the REACH program's unique contribution to addressing health disparities in multiple settings, including communities, schools, work sites, and health care settings. By sharing their strategies, lessons learned, and best practices, the REACH communities give other communities and public health programs across the country valuable tools to eliminate health disparities among racial and ethnic minority populations.

“Before the Alabama REACH 2010 project came to my community, I was afraid to even say the word “cancer.” Perhaps I was afraid because, as a child, I had seen so many relatives die of cancer. When I was asked to attend the REACH training program, I saw a chance to learn more about the “C” word. Now that I’ve been a community health advisor for the past 4 years, I can boldly say that cancer is not a death sentence because there are resources and help available. Now, I’m telling everyone I know about the program that changed my life!”

—Community health advisor

REACHing African American Women in Rural Alabama

Who We Are

The University of Alabama at Birmingham coordinates the Alabama REACH 2010 Breast and Cervical Cancer Coalition (ABCCC).

- The ABCCC includes an array of partners, such as community groups, state and national organizations, health care providers, and researchers.
- The ABCCC is working to eliminate disparities in breast and cervical cancer among African American women by promoting awareness of and access to prevention and screening services.
- The coalition serves women in two urban and six rural counties in Alabama, in an area known as the Black Belt.

The Problem

- Breast cancer is diagnosed less often in African American women than white women, but more African American women die of this disease each year.
- Cervical cancer is diagnosed more often in African American women than white women, and more African American women die of this disease each year.

The Solution

- The ABCCC created a community action plan to address the barriers that prevent African American women aged 40 or older from receiving breast and cervical cancer screening services.
- Action plan activities include
 - 1) creating a core working group of lay volunteers, church representatives, and health professionals in each targeted county;
 - 2) awarding mini-grants to nonprofit groups that target breast and cervical cancer screening;
 - 3) conducting outreach activities to assess screening status and promote future screenings; and
 - 4) distributing educational materials.
- Other action plan activities include promoting the Breast and Cervical Cancer Early Detection Program

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(a free screening program funded by CDC) and helping women get to their screening appointments by visiting, calling, and sending reminders.

Our Achievements

- During 2001–2003, the ABCCC launched an intervention to increase breast and cervical cancer screening among African American women in the target counties.
- In 2002, self-reported baseline data showed that only 48% of women participating in this intervention had received a mammogram. Within 2 years, 62% reported having a mammogram.
- Also in 2002, 55% of participating women said they had previously received a Pap test. Within 2 years of the intervention, 66% had received a Pap test.
- Before the ABCCC intervention, a 17% disparity in mammography screening existed between African American and white women in the target counties. During 2001–2003, this disparity decreased to 11%.





Mobilizing Community Resources

University of Alabama at Birmingham (UAB); University of Alabama; Western Kentucky University; Markey Cancer Center; Tuskegee University, National Center for Bioethics; Alabama Cooperative Extension System; Alabama Department of Public Health, Office of Minority Health; Community Care Network; American Cancer Society; National Black Church Family Council; SISTAs Can Survive; Mineral District Medical Society; Tuskegee Area Health Education Center; B & D Cancer Care Center; Alabama Quality Assurance Foundation; Alabama Breast and Cervical Cancer Early Detection Program; Maude L. Whatley Health Services; UAB Comprehensive Cancer Center; UAB Minority Health and Research Center.

Our Future

The ABCCC will continue to 1) increase women's awareness and use of breast and cervical cancer screening services in Alabama, 2) work with existing partners and project supporters and add new coalition members, 3) refer eligible women to the Breast and Cervical Cancer Early Detection Program, 4) share our research findings with the community, and 5) educate stakeholders about the REACH program and its efforts to eliminate health disparities in breast and cervical cancer.

Getting the Word Out Locally

- "Alabama REACH 2010," 30-minute documentary video.
- "Governor's Black Belt Action Commission," health committee press release, June 21, 2005.
- "Promoting Cancer Awareness in the African American Community," WIAT Channel 42 News, April 20, 2002.
- "Development of a Community Action Plan to Combat Breast and Cervical Cancer: An Overview of the Alabama

REACH 2010 Project," WAKA Channel 8 News, April 18, 2001.

Generating New and Exciting Science

- "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.
- "A Community-Driven Action Plan to Eliminate Breast and Cervical Cancer Disparity: Successes and Limitations." *Journal of Cancer Education* 2006; 21(suppl):S91–S100.
- "The Development of a Community Action Plan to Reduce Breast and Cervical Cancer Disparities Between African American and White Women." *Ethnicity & Disease* 2004;14 (3, suppl 1):54–62.
- "REACH 2010: A Unique Opportunity to Create Strategies to Eliminate Health Disparities Among Women of Color." *American Journal of Health Studies* 2001;17(2):93–106.

Keys to Lasting Change in the African American Community

To make the Alabama REACH 2010 project a success, we worked to empower residents to be their own health advocates and to build community capacity by training residents to serve as community health advisors.

We also were able to create a sense of ownership for the project by drawing on community groups and a core working group of volunteers to create and implement the community action plan. In addition, we adopted the principles of community-based participatory research, which is designed to involve researchers, organizations, and community members as equal partners in all aspects of the research process.

These activities led to the creation of a unified and motivated coalition. We were able to see results above and beyond our expectations because of mutual collaboration and trust between our coalition and community volunteers.

REACH FOR MORE INFORMATION



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"I walked a lot of steps this month, ran 10 miles, exercised for 120 hours, lost 5 pounds, and went from 20 cigarettes a day to 5. I feel great!"

—Alaska Native woman, aged 22

REACHing Alaska Natives in Chugach Region, Alaska

Who We Are

The Chugachmiut Native Organization coordinates the Alaska Native Cardiovascular Disease Prevention/Core Capacity Building Project.

- This project serves seven rural and remote Alaska Native communities that are spread across more than 15,000 square miles in the Prince William Sound, Resurrection Bay, and Lower Cook Inlet areas of Alaska. All villages except two are accessible only by plane.
- The project is working to help Chugach region communities reduce the high rates of death and disability from heart disease among their residents.

The Problem

- Heart disease is the leading cause of death for American Indians and Alaska Natives.
- American Indians and Alaska Natives have higher rates of heart disease and premature death than any other racial or ethnic group in the United States.

- Alaska Natives also have higher rates of risk factors for heart disease than other population groups. For example, they are more likely to be smokers and to be physically inactive and obese, and they are less likely to be screened for high cholesterol.

The Solution

- To address these problems, the Alaska Native Cardiovascular Disease Prevention/Core Capacity Building Project has trained community wellness advocates in each of its REACH communities. This training was provided through a 1-year distance-learning program offered by the University of Alaska in Sitka in conjunction with the SouthEast Alaska Regional Health Consortium.

- We partner with local tribal councils, community health aides, community health representatives, and traveling health care providers to increase support for this project.
- We work to develop and implement programs and activities that will increase community members' awareness of heart disease and promote healthy lifestyle changes. These programs and activities reflect the native cultures and languages of the communities we serve.
- We also conduct community health assessments and provide technical assistance and training to guide local interventions in all Chugach region communities.

Our Achievements

- Community wellness advocates are working in all Chugach region communities.
- We have implemented a variety of programs and activities that reflect local cultures and are helping to promote healthy behaviors among local residents.

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Mobilizing Community Resources

Our partners include tribal chiefs, tribal councils, community health aides, community health representatives, community school representatives, and traveling health care providers in the seven villages of the Chugach region—Nanwalek, Port Graham, Seward, Chenega Bay, Tatitlek, Valdez, and Cordova.

Our Achievements, cont.

- We developed an interactive calendar called Take the Idita-Heart Challenge. Residents can use the calendar to set goals and track their progress toward eating a healthy diet, being more physically active, not smoking, losing weight, and lowering their blood pressure and cholesterol levels. They also can register for monthly prize drawings.
- We implemented 312 events in local communities, making 3,959 contacts with community members. These events included exercise classes, nutrition and healthy cooking classes, heart disease prevention classes, a smoking cessation program, and local health fairs.
- We completed 1,106 heart disease awareness tests. Results showed that residents who participated in our activities were knowledgeable about heart disease and how to manage and prevent it.

Our Future

The Alaska Native Cardiovascular Disease Prevention/Core Capacity Building Project will continue to educate Alaska Natives

in the Chugach region about heart disease and other chronic diseases and their risk factors. We also will continue to share information and lessons learned from this project with local, regional, and national audiences.

Getting the Word Out Locally

- *Nupuat*, the Chugachmiut quarterly newsletter, features articles about this project in every issue.
- Monthly articles are written by community wellness advocates in local tribal newsletters.

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- "Community Wellness Advocates: Creating Behavioral Health Changes to Build Healthy Hearts in Alaska Native Communities." Presented at the Annual Meeting of the American Public Health Association, Boston, Massachusetts, November 2006.
- "Community Wellness Advocates: Creating Healthy Changes in Chugach Region Communities." Presented at the Alaska Tribal Health System Showcase in Anchorage, Alaska, September 2006.

- "Community Wellness Advocates: Building Healthy Hearts Through Health Education in Chugach Region Tribal Communities." Presented at the Alaska Health Education Consortium Spring Meeting in Anchorage, Alaska, May 2006.
- "Community Wellness Advocates: Creating Behavioral Changes Through Health Education in Native Villages." Presented at the CDC Diabetes and Obesity Prevention and Control Conference, Denver, Colorado, May 2006.

Keys to Lasting Change in Alaska Native Communities

Death and disability from heart disease can be prevented or controlled by reducing several known risk factors, including high blood pressure, high blood cholesterol, smoking, physical inactivity, diabetes, obesity, and poor diet.

Control of these risk factors at individual and community levels is key to preventing heart disease and its complications. Community support and involvement also are vital to the success of prevention programs.

REACH FOR MORE INFORMATION



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“The wellness program created enough buzz around the office—people interested in walking more, drinking more water, avoiding processed foods—that a second 8-week set of classes was set up for people who missed the opportunity the first time around. The program is a great way to improve health and quality of life, and it pays dividends to participants and the community as a whole.”

—Emile Gardner, assistant general manager, First Transit, Los Angeles

REACHing African Americans in Los Angeles, California

Who We Are

Community Health Councils (CHC) of Los Angeles coordinates the African Americans Building a Legacy of Health coalition.

- CHC is a nonprofit group based in Los Angeles that is committed to building coalitions, conducting community-based participatory research, and developing policies to increase public awareness and improve health care services in communities with limited resources.
- CHC brought together a cross section of groups and key stakeholders to form the African Americans Building a Legacy of Health coalition.
- This coalition works to promote healthy communities and reduce disparities in the rates of diabetes, heart disease, and stroke for African Americans living and working in South Los Angeles.

The Problem

- African Americans in Los Angeles County have higher rates of death from coronary heart disease, stroke,

and diabetes than any other racial or ethnic group in the United States.

- South Los Angeles has the country’s highest incidence of obesity (30%).
- Compared with residents of similar cities, South Los Angeles residents have little or no access to resources such as healthy food options and safe places to be physically active that could help to improve their health.

The Solution

- The African Americans Building a Legacy of Health coalition found ways to improve food and physical activity options in South Los Angeles through community development, awareness, and advocacy.
- The coalition worked to improve access to and quality of health care resources

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by promoting activities proven to improve health and by funding disease-management services at local hospitals and clinics.

- The coalition also worked to integrate wellness policies and practices into local workplaces.

Our Achievements

- The Los Angeles City Council adopted a policy to provide incentives to retailers that sell healthy foods to encourage them to locate in disadvantaged areas. The Los Angeles County Board of Supervisors adopted a policy to improve the quality of food offered in county-sponsored programs.
- The coalition trained nearly 75 health care professionals on new and better ways to manage and treat heart disease and diabetes in African Americans.
- The coalition created a network of more than 35 physical activity programs through seed funding to community and faith-based groups, reaching more than 1,500 people in nontraditional settings.



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Mobilizing Community Resources

University of Southern California; University of California, LA; American Cancer Society; American Heart Association; Apostolic Faith Home Assembly; California Department of Health Services; Cedars-Sinai Medical Center; Central Baptist Church; Centinela/Freeman Hospital-ULAAC Project; Drew Medical Society; Los Angeles County Department of Public Health; Los Angeles Urban League; Mount Moriah Baptist Church; Office of Assemblyman Mark Ridley Thomas, Assembly District 48 Empowerment Congress; Office of Assemblyman Jerome Horton, Assembly District 51; T.H.E. (To Help Everyone) Clinic; Watts Healthcare Corporation; Willowbrook Senior Center; Worksite Wellness LA.

Our Achievements, cont.

- The coalition helped develop wellness programs and policies in nearly 50 local workplaces, reaching more than 650 people.
- The coalition preserved a local community fitness center and transferred program management to the Los Angeles YMCA. It also helped increase membership from 300 to more than 1,000.

Our Future

CHC's future plans include promoting and adopting community standards for healthy food options in local stores and calling for the establishment of one or more local health food suppliers.

CHC also will provide training and program development to help improve the quality of health care offered by local health care providers and will expand the existing network of physical activity and workplace wellness programs by 20%.

Getting the Word Out Locally

- "Hungry for a Supermarket," *Los Angeles Times*, August 2006.
- "Culture of Healthy Eating Urged at Workplace," *Daily Breeze*, July 2006.
- "Road to Health" segment on the lack of healthy food options in predominantly poor and minority communities, *The Tavis Smiley Show*, November 17, 2005.
- "Limited Healthy Food Choices in South L.A. Restaurants, Study Says," *Los Angeles Business Journal*, March 2005.
- "Eating Good in the 'Hood,'" *VIBE*, February 2004.

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- "Assessing Resource Environments to Target Prevention Interventions in Community Chronic Disease Control." *Journal of Health Care for the Poor and Underserved* 2006;17(2, suppl): 146–158.

- "Putting Promotion into Practice: The African Americans Building a Legacy of Health Organizational Wellness Program." *Health Promotion Practice* 2006;7(3, suppl 1):233S–246S.
- "African Americans' Access to Healthy Food Options in South Los Angeles Restaurants." *American Journal of Public Health* 2005;95(4):668–673.
- "Improving the Nutritional Resource Environment for Healthy Living Through Community-Based Participatory Research." *Journal of General Internal Medicine* 2003;18:568–575.

Keys to Lasting Change in the African American Community

Each of the following is equally important and crucial to creating and sustaining community change: identifying and getting the support of key stakeholders, engaging community partners in planning and implementation activities, making sure all partners are treated equally, and identifying appropriate at-risk populations and interventions to target.

REACH FOR MORE INFORMATION



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"A parent of a 2-year-old who had received only one series of shots at 2 months came to us asking for information on immunizations. Neither parent nor child had medical insurance. Immunize LA Kids staff discussed the importance of immunizations and being up to date, and provided the mother with supportive educational materials. As a result of this interaction, the mother made an appointment to begin getting her child up to date on her immunizations."

—Immunize LA Kids Coalition community health promoter

REACHing Latino and African American Children in South Los Angeles, California

Who We Are

The Los Angeles Biomedical Research Institute at Harbor-UCLA Medical Center coordinates the Immunize LA Kids Coalition.

- The coalition is administered by South Los Angeles Health Projects, a community-based unit of the Los Angeles Biomedical Research Institute.
- The coalition links public and private agencies, health care providers, and the community to help Latino and African American children in South Los Angeles get the immunizations they need.

The Problem

- Although Los Angeles County has met the *Healthy People 2010* objective of 80% of children receiving all recommended vaccines by age 2, nearly 1 in 5 infants and young children are not up to date on their immunizations.
- In California, only 53% of African American and 72% of Hispanic children entering kindergarten during

the 2004–2005 school year were up to date on their immunizations at age 2, compared with 75% of white children.

The Solution

- The Immunize LA Kids Coalition developed a multifaceted community action plan that reflects recent recommendations by the Task Force on Community Preventive Services and the Advisory Committee on Immunization Practices.
- The coalition has implemented culturally appropriate interventions that seek to overcome barriers to immunization by working to improve practices in health care provider settings.

- The coalition's interventions also are designed to increase community demand for immunizations by providing reminders for parents, including those whose children receive WIC services, and conducting outreach to families of at-risk children.

Our Achievements

- In April 2006, 82% of WIC clients in our service area, most of whom are Latino or African American, were up to date with recommended immunizations at age 2.
- In 2005, we provided immunization information to nearly 10,000 parents through outreach activities at health fairs, schools, faith-based events, and door-to-door visits.
- Nearly 4,000 children in our service area have received an immunization assessment and information from a community health promoter.
- We also provided technical assistance, consultation, and follow-up services to 75 medical offices.

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Mobilizing Community Resources

California Coalition on Childhood Immunization; California Department of Health Services, Immunization Branch; California Distance Learning Health Network; Child Health and Disability Prevention Program; Los Angeles County Department of Children and Family Services; Clinica Monseñor Oscar A. Romero; Esperanza Community Housing Corporation; GlaxoSmithKline; Grace Elliott Center; Healthy African American Families; Immunization Coalition of Los Angeles County; L.A. Care Health Plan; Los Angeles County Department of Public Health, Immunization Program; MedImmune, Inc.; Merck Vaccine Division; MotherNet LA; Sanofi Pasteur; SHIELDS for Families, Inc.; South Los Angeles Health Projects; St. Francis Medical Center; St. John's Well Child Center; T.H.E. (To Help Everyone) Clinic; Watts Healthcare Corporation; Wyeth; community representatives.

Our Future

Our coalition will disseminate findings from the immunization program at conferences and in professional journals and publish a technical brief.

We also plan to enter WIC client records into a countywide immunization registry, encourage physicians to use this registry, and focus on immunization follow-up strategies in African American communities.

Getting the Word Out Locally

- "It's a Family Affair! Immunization Health Fair," *Our Weekly*, August 2006.
- "Culturally Appropriate Outreach Boosts South LA Immunization Rates," *First 5 LA Monday Morning Report*, June 26, 2006.
- "Proteja a Sus Niños, Vacunelos a Tiempo," *El Ahorro*, August 2005.

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- "Programs Aim to Improve Immunization Coverage in Practices." *Infectious Diseases in Children* April 2006: 24–26.
- "Evaluation of Immunize LA Kids' Enhanced-AFIX Intervention in South Los Angeles: What Worked?" Presented at the 2006 National Immunization Conference, Atlanta, Georgia, March 6, 2006.
- "Closing the Immunization Gap." *Minority Nurse Magazine* 2004; Winter:28–33.

Keys to Lasting Change in the Latino and African American Communities

The Immunize LA Kids Coalition includes a diverse group of individuals and organizations. We value the contributions

of all coalition members, including parents, community members, and health care providers. This attitude ensures that our strategies and materials are culturally appropriate and meet community and family needs. Coalition partners work together and with other regional and state groups, and these partnerships promote sharing of resources, lessons learned, and coordinated approaches to improving immunization rates.

We use evidence-based approaches that have been proven to work and that address the broad array of barriers to improving immunization rates. By promoting these strategies and integrating system changes into health care provider and community settings, we ensure that our interventions are effective and have a lasting effect on the community.

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“Since attending an anti-racism workshop, I serve as a resource at work and in the community.”

—Participant in a SevenPrinciples Undoing Racism™ workshop

REACHing African American Infants and Families in San Francisco, California

Who We Are

The San Francisco Department of Public Health coordinates the SevenPrinciples Project.

- This project includes a diverse coalition of people who are working to improve the health of African American families and the survival rate of African American infants in San Francisco.

The Problem

- Infant death rates for African Americans are higher than rates for all other racial and ethnic groups in San Francisco, both separately and combined. Twice as many African American infants die each year as white infants.
- African American women also are more likely not to receive prenatal care until late in their pregnancy and to deliver an infant that is preterm or has a low birth weight.
- African Americans often have less access to health care and receive lower quality care. They are more likely to be affected by social, economic, and environmental factors that have been linked to high infant death rates and other poor health outcomes.

The Solution

- The SevenPrinciples Project has implemented three interventions that have shown promise in reducing disparities and improving infant survival rates among African Americans in San Francisco.
- The first intervention is community awareness campaigns that address the lack of knowledge among African Americans about their community’s health and the disparities in infant death rates.
- The second is activities designed to improve community health by addressing social factors that have been linked to high infant death rates. These include violence, substance abuse, crime, poor nutrition, food insecurity, and lack of community unity and leadership.

- The third is skills training and workshops for health care providers to improve patient-provider interactions, promote mutual respect, and examine the impact of race and racism on health disparities and health outcomes.

Our Achievements

- The community awareness campaigns were seen by 62% of African Americans in the REACH community. People who had seen the campaigns were more aware of the racial disparity in infant death rates in their community. They also knew about correct sleep positions for infants, which help reduce deaths.
- Community action teams assessed the levels of violence, crime, poor nutrition, food insecurity, and community unity and leadership in their neighborhoods. They proposed and implemented actions to correct the problems they found.
- We developed a cultural competency training class for health care providers to help them communicate better with their patients and understand the influence of racism on patient-physician interactions.

Racial and Ethnic Approaches to Community Health (REACH) is a community-based public health program funded by CDC to eliminate racial and ethnic health disparities.

www.cdc.gov/reach





Mobilizing Community Resources

Blue Cross Wellpoint; Black Coalition on AIDS; Booker T. Washington Community Service Center; I.T. Bookman Community Center; Jelani House; Homeless Prenatal Program; Parents Who Care; Goodwill Industries; University of California, San Francisco, Family Health Outcomes Project.

Our Achievements, cont.

- After the training, 78% of participants said they were more confident using the recommended communication tools, 65% were more confident accessing resources for cultural competency, and 63% were more confident in their ability to describe social conditions linked to high infant death rates among African Americans.
- We also provided anti-racism workshops that examined the role of racism in poor health outcomes. After the workshops, participants said they intended to be a resource within their organizations.
- More than 200 health care providers participated in the trainings and workshops.

Our Future

The SevenPrinciples Project has identified partner agencies that will offer the cultural competency training classes to health care providers and other employees within their agencies. These partners also will conduct awareness campaigns to educate

community members about 1) the high infant death rates and other health disparities among African Americans; 2) the correct sleep position for infants, which can help to prevent sudden infant death syndrome (SIDS); and 3) the need to take action to prevent poor health outcomes for African American infants. In addition, the San Francisco Department of Public Health has made the anti-racism workshop a standard offering for its staff and community partners.

Getting the Word Out Locally

- *Habari Gani*, a quarterly newsletter published by the SevenPrinciples Project.

Generating New and Exciting Science

- "Lessons Learned From an Evaluation of Community Action Teams: Methods and Recommendations for Similar Community Action Evaluations." Presented at the 134th Annual Meeting of the American Public Health Association, Boston, Massachusetts, November 7, 2006.

Keys to Lasting Change in the African American Community

The African American community has endured inequalities and has struggled with the burden of violence, crime, substance abuse, limited access to healthy food, and a lack of community unity and leadership. To eliminate the longstanding disparity in infant death rates between African Americans and all other U.S. racial and ethnic groups, the entire African American community must be aware of the social, economic, and environmental factors that have been linked to high infant death rates.

In addition, health care agencies must commit to improving the relationships between health care providers and their African American patients and to ensuring equal health care for all Americans. Community and health care agencies also must adopt and enforce anti-racism policies and principles that will help to improve health behaviors and health outcomes at local levels.

REACH FOR MORE INFORMATION



The SevenPrinciples Project for African American Infant Survival & Community Unity
Project Partners: San Francisco Department of Public Health; Black Coalition on AIDS; Booker T. Washington Community Service Center; CAHEED, Inc.; Jelani House; I.T. Bookman Community Center; Homeless Prenatal Project; UCSF Family Health Outcomes Project; and others.
Funded by: Federal Centers for Disease Control & Prevention, REACH 2010 Initiative

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"I believe that without the HAPAS project in the community, I would still be an uninformed person living with diabetes, without a clue how to successfully manage and control diabetes. I also attribute my interest in health advocacy and community involvement to the HAPAS project. I became a volunteer for the project and was trained as a lay health worker for the Chamorro community diabetes education program."

—Frank G., HAPAS project lay health worker

REACHing Asian American and Pacific Islander Older Adults in California

Who We Are

Special Service for Groups, Inc., coordinates the REACH 2010/Health Access for Pacific Asian Seniors (HAPAS) project.

- This project is part of the Older Adults Program of Special Service for Groups, a nonprofit community group based in Los Angeles.
- The project created a coalition of health care providers, community groups, grassroots groups, faith-based groups, universities, and local health departments to work together to reduce health disparities among Asian American and Pacific Islander older adults living in Los Angeles County and Orange County, California.
- The coalition focuses on disparities in adult immunization, type 2 diabetes, and heart disease in the Cambodian, Chamorro (Guamanian), Filipino, Laotian, Samoan, Thai, Tongan, and Vietnamese communities.

The Problem

- The leading causes of death among Asian Americans and Pacific Islanders

aged 60 or older are cancer, heart disease, diabetes, pneumonia, and influenza.

- Data on immunization, diabetes, and heart disease rates among older adults in Southeast Asian, Pacific Islander, and Filipino communities are limited.
- Many people believe that Asian Americans and Pacific Islanders are "generally healthy," but health disparities are a problem among some subpopulations in this diverse group.
- Southeast Asians are among the most disadvantaged within this group. Problems include poverty, poor education, and social isolation because of language barriers. Many Southeast Asians also lack health insurance, which limits their access to health care services.

- When the HAPAS project surveyed older adults in Los Angeles County and Orange County, nearly all respondents said that immunizations were only for children.
- Older adults are at increased risk for many vaccine-preventable diseases. In 1999, about 90% of all deaths related to influenza and pneumonia occurred among people aged 65 or older.

The Solution

- To address these health disparities, the HAPAS coalition developed health education and media materials that reflect the cultures and languages of the target populations.
- The coalition provided training to local health care providers to increase their awareness of and sensitivity to the cultural traditions of Asian Americans and Pacific Islanders.
- The coalition also conducted community-based research and evaluation activities in these under-represented communities, and it coordinated community health fairs.

Racial and Ethnic Approaches to Community Health (REACH) is a community-based public health program funded by CDC to eliminate racial and ethnic health disparities.

www.cdc.gov/reach





Mobilizing Community Resources

Special Service for Groups, Inc.; Little Tokyo Service Center, Asian and Pacific Islander Older Adult Task Force; Cambodian Association of America; St. Mary Medical Center, Families in Good Health; Federation of Filipino America Association; Guam Communications Network; Samoan National Nurses Association; Special Service for Groups, Tongan Community Service Center; Orange County Asian Pacific Islander Community Alliance; University of California, Los Angeles, School of Public Affairs, Department of Social Welfare.

Our Achievements

- The HAPAS coalition produced a resource tool kit for health care providers and community leaders. The tool kit was created to address health disparities identified by a community focus group in eight Asian American and Pacific Islander communities.
- The coalition produced educational brochures on adult immunization, diabetes, and heart disease in eight languages and distributed these brochures to more than 40,000 people.
- We reached more than 100,000 older adults, health care providers, and caregivers through various venues, including ethnic media, health fairs, and community outreach activities.
- We developed eight multilingual evaluation tools on immunization, diabetes, and heart disease in collaboration with the Department of Social Welfare at the University of California, Los Angeles. These tools assess the effectiveness of one-on-one outreach

education and help us identify health disparities among Asian American and Pacific Islander subgroups.

Our Future

The REACH 2010 HAPAS project will continue to educate older adults and caregivers about adult immunization, diabetes, and heart disease. We also will continue to teach health care providers how to provide culturally sensitive services to Asian Americans and Pacific Islanders.

Getting the Word Out Locally

- "Medical System Gap: Underestimation of the Need, Language, and Cultural Barriers Creates Blind Spots in Health Care Needs of Asian and Pacific Islander Health Care," *Sing Tao Daily*, May 18, 2006.
- "Health Prevention Information for Seniors: REACH 2010 HAPAS (Health Access for Pacific Asian Seniors)," *Sereechai Newspaper*, April 22–26, 2006.

- "REACH 2010, UCLA, Thai Nurses Association, and the Asian Pacific Health Care Venture Provide Hepatitis B and Health Screenings in North Hollywood," *Thai Town USA*, December 5, 2004.

Keys to Lasting Change in Asian American and Pacific Islander Communities

Policy makers, researchers, and members of the private and public sector need data specific to Asian American and Pacific Islander communities to understand and reduce health disparities among these populations. More programs and research projects need to target these populations to collect these data.

We also need a stronger commitment to recruit and train bilingual and bicultural members of underrepresented communities to work in health and social service fields.

REACH FOR MORE INFORMATION



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REACH

RACIAL AND ETHNIC APPROACHES TO COMMUNITY HEALTH

"If I had known about this earlier, maybe I would not have 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 then she died last year. I now know as a result of the VRHI Coalition that we can prevent and treat this 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."

—Lay health worker

REACHing Vietnamese-American Women in Santa Clara County, California

Who We Are

The University of California, San Francisco, coordinates the Vietnamese REACH for Health Initiative (VRHI) Coalition.

- The VRHI Coalition is a partnership of 16 community groups, county health providers, and researchers at the University of California, San Francisco.
- The coalition works to promote awareness and use of breast and cervical cancer screenings among the more than 105,000 Vietnamese-Americans living in Santa Clara County.

The Problem

- Vietnamese-American women have the highest age-adjusted incidence rate of cervical cancer in the United States: 43 per 100,000 people. This rate is 5 times higher than the rate for white women, which is 8.7.
- Cervical cancer can be detected and prevented with regular Pap tests, but more than 25% of Vietnamese-American women have never had a Pap test, compared with less than 5% of all U.S. women.

- Breast cancer can be detected early with regular mammograms, but 25% of Vietnamese-American women aged 40 or older have not had a mammogram within the past 2 years.

The Solution

- During 2000–2004, the VRHI Coalition planned and implemented a cervical cancer action plan that included a multimedia campaign, outreach activities by lay health workers, a Pap test clinic that provides patient navigation assistance, a Pap test registry and reminder system, continuing medical education for Vietnamese health care professionals, and return of the Breast and Cervical Cancer Control Program in Santa Clara County.

- During 2004–2007, the coalition planned and implemented a breast cancer action plan that included a multimedia campaign, outreach activities by lay health workers, patient navigation assistance, continuing medical education for Vietnamese health care professionals, and collaboration with Every Woman Counts, the state's breast and cervical cancer program.

Our Achievements

- An evaluation of coalition programs showed that 47.7% of participants who had never had a Pap test received one after meeting with a lay health worker.
- The evaluation also showed that 17.9% of participants received a mammogram and 27.9% received a clinical breast exam after meeting with a lay health worker, compared with 3.9% and 5.1%, respectively, of women who did not meet with a lay health worker.
- In addition, 52.1% of participants had a repeat Pap test within 18 months, and 4,187 women enrolled in a reminder system.

Racial and Ethnic Approaches to Community Health (REACH) is a community-based public health program funded by CDC to eliminate racial and ethnic health disparities.

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Mobilizing Community Resources

Asian Americans for Community Involvement; American Cancer Society; Blue Cross of California; Catholic Charities of Santa Clara County, John XXIII Multiservice Center; Community Health Partnership; Immigrant Resettlement and Culture Center; Kaiser Permanente; Northern California Cancer Center; Premier Care of Northern California Medical Group; Santa Clara County Public Health Department; Santa Clara County Ambulatory and Community Health Services; Santa Clara Family Health Plan; Southeast Asian Community Center; Vietnamese Physician Association of Northern California; Vietnamese Voluntary Foundation, Inc.; Vietnamese Community Health Promotion Project.

Our Achievements, cont.

- More than 50 Vietnamese-American physicians attended each of 6 continuing education seminars to learn more about breast and cervical cancer screening.
- The VRHI Coalition led a petition drive to reinstate the Breast and Cervical Cancer Control Program in Santa Clara County. The program returned in 2003 as the Every Woman Counts program, offering breast and cervical cancer screening to all low-income women in the county.
- The percentage of women who received a Pap test increased from 77.5% in 2000 to 84.2% in 2004, according to a study that compared Santa Clara County with a control community where residents received no intervention.

Our Future

The VRHI Coalition will continue to refer women to Every Women Counts clinics and to recruit health care providers for these clinics. We also will continue to educate stakeholders about health disparities in California.

Getting the Word Out Locally

- "Cervical Cancer Deaths Frustrate Doctors," *The Associated Press*, July 25, 2005.
- "UCSF Community Program Wins U.S. 'Closing the Health Gap' Award," *UCSF Today*, November 24, 2004.
- "Community Forum on Cervical Cancer Among Vietnamese Women," *Thoi Bao and California Today*, September 18, 2003.
- "Culture Puts Vietnamese Women at Increased Cancer Risk," *Los Angeles Times*, October 20, 2000.

Generating New and Exciting Science

- "Community-Based Participatory Research Increases Cervical Cancer Screening Among Vietnamese-Americans." *Journal of Health Care for the Poor and Underserved* 2006;17(2, suppl):31–54.
- "Papanicolaou Testing Among Vietnamese Americans: Results of a Multifaceted Intervention." *American Journal of Preventive Medicine* 2006;31(1):1–9.
- "Processes and Capacity-Building Benefits of Lay Health Worker Outreach

Focused on Preventing Cervical Cancer Among Vietnamese." *Health Promotion Practice* 2006;7(3, suppl):223S–232S.

- "Increasing Vietnamese-American Physicians' Knowledge of Cervical Cancer and Pap Testing: Impact of Continuing Medical Education Programs." *Ethnicity & Disease* 2004;14(3, suppl 1):S122–S127.

Keys to Lasting Change in the Vietnamese-American Community

Researchers who work at the community level must reach out to residents to generate trust and to help community members become effective researchers themselves. Research projects should be flexible enough to adjust to community input.

Projects will succeed if organizers are committed to building a broad coalition of people who share a common goal, decision-making power, and resources. Coalition members also should be equal partners in designing, developing, conducting, and interpreting the results of research projects.

REACH FOR MORE INFORMATION



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REACH

RACIAL AND ETHNIC APPROACHES TO COMMUNITY HEALTH

"I didn't know how huge the HIV problem was in Broward, especially in my community. I think it's great to have people like the REACH 2010 staff giving out information and other stuff to help us protect ourselves. I also didn't know that female condoms existed and how to use them. Those are very helpful when the guy doesn't want to use them himself. I haven't taken an HIV test yet, but now I'm pretty worried and want to know if I am positive, so I will take the test."

—African American woman, aged 23

REACHing African Americans and Hispanics in Broward County, Florida

Who We Are

Florida International University coordinates the Coalition to Reduce HIV in Broward's Minority Communities.

- The coalition is a group of partners working together to reduce the burden of disease and death due to infection with HIV and AIDS among young adults aged 18–39 years who live in Broward County, Florida.
- The coalition's mission is to promote the primary prevention of HIV/AIDS and to facilitate social change by helping communities respond more effectively to this health crisis.

The Problem

- The Florida Department of Health estimates that nearly 1% of Broward County residents are infected with HIV, about three times the estimated national average.
- African American and Hispanic young adults in Broward are at increased risk for HIV infection.
- Research indicates that 73% of the 1994–1999 AIDS cases reported

among racial and ethnic minorities in Broward County occurred among residents in just 12 of 53 ZIP codes.

The Solution

- The coalition is working to reduce the high disease rates among young adults in the African American, Caribbean, and Hispanic communities in the 12 ZIP codes identified as having the highest numbers of HIV/AIDS cases.
- Based on input from community members, the coalition designed a comprehensive, multilevel, multisector, and multiphased intervention to interrupt the transmission of HIV.
- The coalition used culturally sensitive community-level strategies to enhance services already provided by the Broward County Health Department.

Racial and Ethnic Approaches to Community Health (REACH) is a community-based public health program funded by CDC to eliminate racial and ethnic health disparities.

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These strategies included 1) a continuing presence and persistent outreach to area residents; 2) outreach to local businesses, organizations, and community leaders; 3) efforts to educate individuals and mobilize communities for collective action; and 4) efforts to build capacity for community groups and enhance the public health infrastructure.

Our Achievements

- Telephone interviews conducted with more than 2,000 residents indicate that we are reaching the target audience, increasing AIDS awareness, and stimulating change.
- Personal interviews with more than 150 residents and noninvasive urine testing for sexually transmitted diseases helped to identify previously undiagnosed and untreated infections.
- Thousands of HIV prevention supplies (e.g., condoms, latex sheets, lubricant tubes) have been discussed, demonstrated, and offered free to adult community members.



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





Mobilizing Community Resources

Past and present coalition members: Hispanic Unity of Florida; Urban League of Broward County; Minority Development and Empowerment Inc.; Florida International University, Robert Stempel School of Public Health.

Our Achievements, cont.

- The percentage of self-reported sex without a condom declined from 26.3% in 2001 to 21.5% in 2005 among the project's target population.
- Self-reported condom use at least once in the past year increased steadily among the Caribbean population, from 51.8% in 2001 to 65.8% in 2005.

Our Future

The coalition will continue to provide outreach services to the targeted communities. We will continue to improve our communication strategies to make sure we increase people's awareness of the HIV problem in their own communities.

We also hope to prevent future HIV infections by reducing the prevalence of risky sexual practices, increasing healthy behaviors, and transforming community conditions and systems to create a supportive environment for change.

Getting the Word Out Locally

- "The Protection Racket: And the Band Plays On," *Broward-Palm Beach New Times*, February 2, 2006.
- "Broward Works to Keep the Promise," *Miami Herald*, December 1, 2005.
- "Push on to End Stigma of AIDS Among Latinos," *Miami Herald*, October 13, 2005.
- "SIDA: 25 Años Después," *El Sentinel*, June 3, 2006.
- "Taking It to the Streets: An FIU Team Is Leading Grass-Roots Efforts to Empower Communities in the Fight Against HIV/AIDS," *FIU Magazine*, Summer 2004.

Generating New and Exciting Science

- "HIV Risk Reduction Among Young Minority Adults in Broward County." *Journal of Health Care for the Poor and Underserved* 2006;17:159-173.
- "Eliminating Disparities in HIV Disease: Community Mobilization to Prevent HIV Transmission Among Black and Hispanic Young Adults in Broward County, Florida." *Ethnicity & Disease* 2004; 14(3, suppl 1):108-116.

- "Should HIV-Prevention Programs Promote Abstinence and Mutual Monogamy or Condom Use?" *Sexologies* 2006;15:S35.
- "Impact of a Comprehensive Community-Level HIV Prevention Program on the Behaviors of Racial and Ethnic Minority Young Adults in Broward County, Florida." Presented at the 2006 National STD Prevention Conference in Jacksonville, Florida, May 9, 2006.

Keys to Lasting Change in the African American, Caribbean, and Hispanic Communities

To reach highly mobile immigrant communities, such as those in Broward County, Florida, sustained and culturally appropriate educational messages and outreach interventions are crucial. Such efforts can help residents learn what they need to know about HIV/AIDS and how to change their behaviors and prevent infection.

Key stakeholders and community leaders, including those in the faith communities, should be actively involved in helping to deliver these types of interventions.

REACH FOR MORE INFORMATION



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REACH

RACIAL AND ETHNIC APPROACHES TO COMMUNITY HEALTH

"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

REACHing African Americans in Atlanta, Georgia

Who We Are

The Fulton County Department of Health and Wellness coordinates the REACH for Wellness program.

- REACH for Wellness works to improve nutrition, increase physical activity, create a smoke-free community, and manage stress for residents in the Atlanta Renewal Community.
- The Atlanta Renewal Community, located in Fulton County, Georgia, receives special tax incentives to spur economic development and help eliminate high poverty, unemployment, and crime rates.
- The Atlanta Renewal Community's population is 90% African American, and 76% of the population is made up of female-headed households living below the poverty level, with a median household income of \$8,953.

The Problem

- In 2002, age-adjusted death rates for diseases of the heart were 30% higher for African Americans than for whites in the United States; death rates for stroke were 41% higher.

- Heart disease is the leading cause of death in Georgia. African American men living in Fulton County can expect to live to age 61, compared with white men, who can expect to live to age 71. African American women can expect to live to age 72, compared with white women, who can expect to live to age 79.

The Solution

- REACH for Wellness is helping to improve cardiovascular health for Atlanta Renewal Community residents through collaborative planning, advocacy, empowerment, community action, and systems change. The program also works to improve overall health for this population and to eliminate health disparities among minority groups.

Racial and Ethnic Approaches to Community Health (REACH) is a community-based public health program funded by CDC to eliminate racial and ethnic health disparities.

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- The program offers free, community-based services such as nutrition education classes, physical activity programs, empowerment groups for men and women, cardiovascular wellness centers in churches, and cardiovascular resource centers in barbershops and beauty salons.

Our Achievements

- REACH for Wellness has served more than 24,000 people in the Atlanta Renewal Community, and improvements have been reported since the program began.
- The percentage of African American adults who currently smoke decreased from 25.8% in 2002 to 20.8% in 2004.
- Adults who reported having their blood cholesterol level checked increased from 69.1% in 2002 to 79.7% in 2004.
- Medication adherence among adults with high blood pressure increased from 79.1% in 2002 to 80.5% in 2004.



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





Mobilizing Community Resources

Association of Black Cardiologists; Association of Black Psychologists; Morehouse School of Medicine; Divine Universal Sisterhood; Sisters Action Team; Fulton County Library System; Georgia Office of Women's Health; Dunbar Neighborhood Center; Fulton County Board of Health; Center for Black Women's Wellness; Ariel Bowen Church; Mechanicsville Civic Association; Concerned Black Clergy; Reynoldstown Civic Improvement Association; West End Medical Centers; Phyllis Wheatley YWCA; Dunbar Recreation Center; New Hope Baptist Church; Eddie's Barbershop; Emmaus House; Diabetes Association of Atlanta; The Villages at Carver; Hunger Coalition; Kool Smiles; Butler St. Baptist Church; Chapel of Christian Love; Cosmopolitan AME; Faith AME Zion; Greater Deliverance Baptist; Greater Vine City; Liberty Baptist; Mt. Gilead Missionary; Mt. Olive Baptist Church; Martin Street Church of God; New Hope Baptist; St. Mark Baptist; True Light Baptist; West Oakland Baptist; Wheat Street Baptist.

Our Achievements, cont.

- The percentage of adults who participate in moderate activity at least 30 minutes a day 5 days a week or in vigorous physical activity at least 20 minutes a day 3 days a week increased from 25.4% in 2002 to 28.7% in 2004.
- The percentage of adults who are not physically active decreased from 32.6% in 2002 to 30.6% in 2004.

Our Future

The REACH for Wellness program will continue to teach Atlanta Renewal Community residents about heart disease and stroke through its coalition partners, cardiovascular wellness centers in churches, and cardiovascular resource centers in barbershops and beauty salons.

We also will continue to train community volunteers as health promotion specialists

to monitor residents' blood pressure and provide health education through the cardiovascular resource centers.

Getting the Word Out Locally

- "Black Barbers Join Fight to Cut Heart Diseases," *The Atlanta Journal-Constitution*, March 14, 2006.
- "Take Good Care of Your Heart," *The Atlanta Voice*, February 23–March 1, 2006.
- "REACHing Out to Bring Health to Community," *Atlanta Business Chronicle*, May 13–19, 2005.

Generating New and Exciting Science

- "REACH 2010 Coalitions: Reaching for Ways to Prevent Cardiovascular Disease and Diabetes." *Journal of Women's Health & Gender-Based Medicine* 2002;11(10):829–839.

Keys to Lasting Change in the African American Community

REACH for Wellness is working effectively with African Americans in the Atlanta Renewal Community by using several key strategies. We recruit community volunteers from within the community to be lay health educators.

We take our interventions to places that are comfortable and easy for people to get to, such as churches, local recreation centers, libraries, and barbershops.

We provide activities and resources—such as child care, primary medical care, and substance abuse treatment—that can make it easier for people to participate in these wellness programs.

REACH FOR MORE INFORMATION



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REACH

RACIAL AND ETHNIC APPROACHES TO COMMUNITY HEALTH

"I discovered something beautiful through the REACH program. I discovered that I can help other women and make a difference in someone's life. I share my story with other women when I give workshops. I tell them that because my Pap test showed abnormal cells, I need to go every 6 months to make sure I don't get cervical cancer. I encourage them to get their Pap test and to use the REACH program to get their Pap tests and mammograms. I tell women that cervical cancer can be prevented if detected early."

—REACH Out lay health worker

REACHing African American and Hispanic Women in Chicago, Illinois

Who We Are

The Access Community Health Network (ACCESS) and the University of Illinois at Chicago coordinate the REACH Out program.

- REACH Out is a collaborative program that works with local faith leaders to help low-income women of color get tested for breast and cervical cancer.
- REACH Out targets women in the Chicago metro area and is currently working with 17 churches in Chicago, Cicero, and Berwyn.

The Problem

- Breast cancer is the second leading cause of cancer deaths among African American women and the leading cause of cancer deaths among Hispanic women in the United States.
- African American women are more than twice as likely to die of cervical cancer than white women, partly because the disease is often diagnosed at later stages.
- Hispanic women are about 1.5 times more likely to die of cervical cancer than white women.

- Women with no insurance are 28% less likely to get routine mammograms and 12% less likely to get routine Pap tests than women with insurance. Uninsured women also are 2–3 times more likely to have breast cancer diagnosed at a later stage.

The Solution

- REACH Out encourages low-income African American and Hispanic women to get early breast and cervical cancer screenings.
- The program reaches women by getting support from local faith leaders, recruiting lay health workers from participating churches, adding health information and reminders into Sunday

- sermons, holding focus groups, setting up support groups, and sponsoring health fairs.
- The program also reaches more women by working with ACCESS, which offers primary care services in 47 health centers in medically underserved areas around Chicago.

Our Achievements

- Since the program began more than 5 years ago, 9,089 African American and Hispanic women have attended REACH Out educational sessions on breast and cervical cancer.
- In addition, 5,188 African American and Hispanic women have been referred for a Pap test or mammogram.
- African American women aged 40 or older who received one piece of information about mammograms or breast cancer were 80% more likely to get a mammogram during or right after a REACH Out intervention at their church. Those who received information four or more times were 15 times more likely to get a mammogram.

Racial and Ethnic Approaches to Community Health (REACH) is a community-based public health program funded by CDC to eliminate racial and ethnic health disparities.

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CENTERS FOR DISEASE CONTROL AND PREVENTION





Mobilizing Community Resources

Access Community Health Network (ACCESS); nine African American churches; eight Latino churches; The Resurrection Project; Interfaith Leadership Project; University of Illinois at Chicago; Y-Me National Breast Cancer Organization.

Our Future

REACH Out will continue to work with community partners to meet the health needs of low-income women in the Chicago metro area.

Getting the Word Out Locally

- REACH Out staff appeared on a CAN-TV show to promote the program, January 17, 2006, and October 25, 2005.
- "REACH Sponsored Breast Cancer Survivor's Celebration," *Austin Weekly News*, October 19, 2005.
- Staff appeared on Univision Radio's "Una Nueva Dia" show with Javier Salas to discuss the REACH Out program, May 17, 2005.

Generating New and Exciting Science

- "A Qualitative Evaluation of a Faith-Based Breast and Cervical Cancer Screening Intervention for African American Women." *Health Education and Behavior* 2006;33(5):643–663.
- "Knowledge About Breast Cancer and Participation in a Faith-Based Breast Cancer Program and Other Predictors of Mammography Screening Among African American Women and Latinas." *Health Promotion Practice* 2006; 7(3, suppl):201S–212S.
- "Sustaining a Safety Net Breast and Cervical Cancer Detection Program." *Journal of Health Care for the Poor and Underserved* 2006;17(2):20–30.

Keys to Lasting Change Among African American Women and Latinas

The REACH Out program is unique because it draws on the support of local faith leaders and the faith community to encourage women to seek early breast and cervical cancer screenings. The program uses lay health workers recruited from participating churches to teach women about breast and cervical cancer. The lay health workers hold workshops in the churches, attend health fairs, and go out into nearby neighborhoods to reach more women.

This approach can extend life-saving prevention programs and screening services across cultural divides to communities that would not likely be reached by traditional programs.

REACH FOR MORE INFORMATION



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REACH

RACIAL AND ETHNIC APPROACHES TO COMMUNITY HEALTH

"From the beginning, they teach you how to shop, what to shop for, and how to read food labels. I used to read labels very little, but now I read them in detail and know what I'm looking for. My blood sugar is down 40 points, my cholesterol is down, my blood pressure is down, and the doctor has taken me off some of my medications. REACH 2010 has been a turning point in my health."

—Health education class participant

REACHing Hispanics and African Americans in Chicago, Illinois

Who We Are

The Chicago Department of Health coordinates the REACH 2010/Lawndale Health Promotion Project.

- This project seeks to eliminate health disparities in type 2 diabetes and heart disease among Hispanics and African Americans living in Lawndale.
- It includes a coalition of community residents, local hospitals, community groups, area universities, and government agencies.
- Lawndale includes two communities on Chicago's West side and is home to about 66,700 Hispanics and 54,500 African Americans.

The Problem

- African Americans are 1.8 times more likely to develop diabetes than whites, and Hispanics are 1.7 times more likely to develop diabetes than whites.
- In Lawndale, 71% of residents are at risk for diabetes, and 85% are at risk for heart disease.

- During 1996–1998, African Americans made up 63.4% of all deaths from heart disease in Lawndale, compared with the national average of 40%.
- In Lawndale, 28% of residents are overweight and 29% are obese.

The Solution

- The Lawndale Health Promotion Project offers health education classes to increase residents' awareness about risk factors for diabetes and heart disease, such as high blood pressure, high blood cholesterol, obesity, smoking, unhealthy eating habits, and lack of regular physical activity. These classes are designed to reflect the culture and language of local residents.
- To help residents overcome these risk factors, the project offers health

screenings, information and referral services, smoking cessation programs, nutrition and cooking classes, and walking groups.

- The project increases residents' access to local health care providers through physician referrals. It also offers education and services to help people with diabetes and heart disease manage these diseases better.
- In addition, this project includes African American and Hispanic case managers and community health workers who assess residents' risk for diabetes and heart disease.

Our Achievements

- More than 7,000 assessments for diabetes and heart disease risk have been conducted with community residents. These assessments increased residents' awareness of risk factors for these diseases.
- Nine hundred residents were referred to local health agencies for medical care.

Racial and Ethnic Approaches to Community Health (REACH) is a community-based public health program funded by CDC to eliminate racial and ethnic health disparities.

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Mobilizing Community Resources

American Diabetes Association; American Heart Association; Chicago Department of Public Health, Office of Substance Abuse; Chalmers Elementary School; Chicago Hispanic Health Coalition; Dominicks; Family Focus Lawndale; Jorge Prieto Family Health Center; Joseph E. Gary Elementary School; Lawndale Christian Health Center; Loyola University Chicago, Stitch School of Medicine; Matthew Henson Elementary School; North Lawndale Symphony of Services; U.S. Department of Health and Human Services, Office of Minority Health, Public Health Service Region V; Osco Pharmacy/Lawndale; Our Lady of Tepeyac Parish Church and School; Programa CIELO; Saint Anthony Hospital; Sinai Health Systems; University of Chicago, Diabetes Education Center; University of Illinois, School of Public Health; University of Illinois Extension; University of Illinois at Chicago Neighborhoods Initiative, Division of Community Health.

Our Achievements, cont.

- In addition, 350 residents with diabetes or heart disease received case management services, which sharply increased their use of health screenings. For example, the percentage of this group who received annual blood sugar tests increased from 21% to 96%, the percentage who received annual eye exams increased from 22% to 72%, the percentage who received annual foot exams increased from 42% to 72%, and the percentage who received annual cholesterol tests increased from 47% to 77%.

Our Future

The Lawndale Health Promotion Project will continue to provide diabetes and heart disease awareness training to the Lawndale community. We also will continue to partner with community groups and faith institutions to increase health education opportunities.

In addition, we will work to educate local and state stakeholders about health disparities in Chicago.

Getting the Word Out Locally

- *Community Partners*, CAN TV program on diabetes awareness, November 9, 2006.

Generating New and Exciting Science

- "Using Multilevel, Multisource Needs Assessment Data for Planning Community Interventions." *Health Promotion Practice* 2004;5(1):59–68.
- "Evaluating Community Based Public Health Projects—REACH 2010: The Chicago Lawndale Health Promotion Project (LHPP)." Presented at the 132nd Annual Meeting of the American Public Health Association, Washington, DC, November 10, 2004.

Keys to Lasting Change in Hispanic and African American Communities

To effectively reach people with health messages, educational materials should reflect the culture and language of local populations. Health professionals also should work closely with community members who are strongly committed to improving their community. For example, a community health worker with the Lawndale Health Promotion Project recruited a local group to provide free, on-site fitness classes. We also have collaborated with local health agencies to improve access to health care services for people without insurance and to expand the ability of community health workers to refer residents to other community services. In addition, we are using a community mapping tool to identify resources that can help residents improve their health.

REACH FOR MORE INFORMATION



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REACH

RACIAL AND ETHNIC APPROACHES TO COMMUNITY HEALTH

"I have been a diabetic for over 14 years. It has been a constant battle to try to stay focused. I enjoy cooking and eating, and this combination can be a problem. I know how to eat healthy, but other factors interfere, like when I work late hours and can't eat on time. Too little exercise is one of my biggest downfalls. But the DEEP class is a big help. With them teaching us all they know and what can happen, I think twice and try to make a better choice. Keep up the good work!"

—Nancy Chico, community resident and director of YMCA South Chicago

REACHing African Americans and Hispanics in Chicago, Illinois

Who We Are

The University of Illinois at Chicago coordinates the Chicago Southeast Diabetes Community Action Coalition.

- The coalition includes community, health care, and business groups, as well as academic institutions.
- Coalition partners work together to reduce the high rates of diabetes in the African American and Hispanic communities in Southeast Chicago by educating people about the disease.

The Problem

- In Southeast Chicago, 16.6% of African American adults and 10.8% of Hispanic adults reported having diabetes in 2000.
- Also in 2000, 63.6% of whites in Southeast Chicago received diabetes education from their health care providers, compared with 47.5% of African Americans and 57.1% of Hispanics. Twenty-nine percent of African Americans and 25% of Hispanics with diabetes received an annual flu shot, compared with 44% of whites.

- Hispanics often do not receive quality health care because of lack of insurance related to high unemployment (42.6%).

The Solution

- The coalition is working to address disparities in diabetes education and quality of care by building community capacity, identifying people at high risk for diabetes, offering training and education, supporting health promotion activities, and creating diabetes self-care centers.
- Coalition partners provide information to increase people's knowledge about diabetes and to promote health at health fairs and screening events.
- Business and health groups work together to influence changes in food

distribution and to increase demand for fruits and vegetables.

- The coalition supported the implementation and testing of the Diabetes Empowerment Education Program (DEEP), a diabetes self-management class for community residents. Local health care providers and lay health workers are trained to teach the class, and they receive regular updates on diabetes care and prevention.
- Two diabetes self-care centers were set up in target communities to offer outreach, health promotion, and education activities.

Our Achievements

- Coalition members have sponsored or participated in more than 200 health fairs and community awareness events, reaching over 37,000 people.
- Thirty-five DEEP classes, which last 10 weeks, have been offered in targeted communities, and more than 350 people have completed these classes.

Racial and Ethnic Approaches to Community Health (REACH) is a community-based public health program funded by CDC to eliminate racial and ethnic health disparities.

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Mobilizing Community Resources

University of Illinois at Chicago; Healthcare Consortium of Illinois; Centro Comunitario Juan Diego; Chicago Family Health Center; Hispanic Center for Wellbeing and Health Promotion; Hegewisch Community Committee; South Chicago Chamber of Commerce; Healthy South Chicago; Villa Guadalupe Senior Center.

Our Achievements, cont.

- When DEEP participants were evaluated after the class, they showed improvements in their eating habits and physical activity levels.
- Participants also showed lower blood sugar levels after taking the class.

Our Future

Our DEEP class is being implemented in a local health clinic, and we are expanding and strengthening the “train the trainer” part of the program. We have completed a community survey to evaluate changes in diabetes prevalence, risk factors, and quality of care. This information will help us to plan future activities

Getting the Word Out Locally

- “Center’s Goal: Confronting and Conquering Diabetes,” *Southeast Chicago Observer*, September 28, 2005.
- “DEEP Diplomas Awarded at St. Kevin’s,” *Southeast Chicago Observer*, July 20, 2005.

- “Diabetes Class: Glucose Levels and Pounds Drop,” *Southeast Chicago Observer*, May 15, 2005.
- “Diabetes Update: A Quarterly Bilingual Newsletter,” coalition publication for Southeast Chicago.

Generating New and Exciting Science

- “Reducing Diabetes Health Disparities Through Community-Based Participatory Action Research: The Chicago Southeast Diabetes Community Action Coalition.” *Public Health Reports* 2003;118: 309–323.
- “Trends in Diabetes Prevalence and Risk Factors Among Minority Residents in Southeast Chicago.” Presented at the CDC Diabetes and Obesity Conference, Denver, Colorado, May 17, 2006.
- “A Participatory Training Program for Community Health Workers.” Presented at the CDC Diabetes and Obesity Conference, Denver, Colorado, May 17, 2006.
- “Use of Empowerment Theory and Adult Education in Affecting Clinical

and Behavioral Outcomes in Patients with Diabetes.” Presented at the 134th Annual Meeting of the American Public Health Association, Boston, Massachusetts, November 6, 2006.

- “Promoting Healthy Eating in the Latino South Chicago Neighborhood: An Ecological Approach.” Presented at the 134th Annual Meeting of the American Public Health Association, Boston, Massachusetts, November 6, 2006.

Keys to Lasting Change in the Hispanic and African American Communities

Empowering communities through education at individual, group, and community levels is essential for success. This strategy includes addressing individual needs by providing knowledge, peer support, and information; teaching people to help others while helping themselves; involving business groups and providing a win-win strategy for change; and spreading the word and inviting support from advocates and legislators.

REACH FOR MORE INFORMATION



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REACH

RACIAL AND ETHNIC APPROACHES TO COMMUNITY HEALTH

“REACH helped us to understand that if we don’t take care of ourselves, we can’t take care of our husbands, our children, and our people. REACH 2010 is the best thing that could have happened to New Orleans. It helped us to see what our needs are and determine better ways of meeting our health needs.”

—Delores Aaron, REACH 2010 participant and New Orleans community leader

REACHing African American Women in New Orleans, Louisiana

Who We Are

The Black Women’s Health Imperative coordinates the REACH 2010: At the Heart of New Orleans Coalition.

- The coalition is a community-based participatory research project that is working with local churches to reduce risk factors for heart disease among African American women.
- The coalition includes community groups, city and state health departments, a historically black university, the local public library, and 40 African American churches in New Orleans.
- The Black Women’s Health Imperative is a national nonprofit educational, advocacy, and leadership development group committed to the health and well-being of black women, their families, and their communities.

The Problem

- Heart disease is the leading cause of death for men and women in Louisiana. In 2002, heart disease killed more women than men in Louisiana.
- In 2000, 32% of African Americans who died of heart disease in Louisiana were younger than 65, compared with 16% of whites.

- Nationally, African Americans have a disproportionate burden of heart disease and stroke compared with other U.S. racial and ethnic groups.

The Solution

- REACH 2010 interventions are guided by community-based participatory research methods that emphasize community collaboration and control. We are working with 40 African American churches across 10 denominations in New Orleans to tailor our interventions to local communities.
- Our interventions are designed to reduce risk factors for heart disease and prediabetes among African Americans in New Orleans. Activities include health screenings, workshops on how to navigate the health care system, health education classes, self-help group sessions, and a walking program.

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- We evaluate our interventions to make sure they are effectively promoting positive community changes over time.

Our Achievements

- We organized African American health professionals to provide free screenings and health counseling on risk factors for heart disease and prediabetes for more than 10,000 African Americans at church and community sites.
- We conducted 500 health education classes focused on heart disease. We also worked with local communities and churches to implement the Black Women’s Health Imperative’s signature fitness program, Walking for Wellness.
- We planned and facilitated more than 150 Sister Circle self-help group sessions for women at local church, community, and work sites. We also trained 35 REACH volunteers as self-help facilitators for these sessions.
- We trained more than 300 volunteers to support our interventions.
- We promoted community-wide physical activity and healthy eating programs, reaching more than 30,000 African Americans through multiple media outlets.



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Mobilizing Community Resources

Black Women's Health Imperative; Southern University and A&M College in Baton Rouge, School of Nursing; Drexel University School of Public Health, Healthy Heart Community Prevention Project; City of New Orleans Health Department; Louisiana Office of Public Health, Cardiovascular Health Program; Black Women's Health Project of Louisiana; New Orleans Public Library; Shiloh Missionary Baptist Church, Baton Rouge; and 40 area churches.

Our Future

The REACH 2010: At the Heart of New Orleans Coalition will continue to help African American churches reduce heart disease and associated risk factors among its members. We will continue to make people more aware of the need to prevent heart disease in all African American communities.

The Black Women's Health Imperative will continue to provide leadership to achieve these goals. In addition, one of our coalition partners, Southern University, has applied to become a Center of Excellence to eliminate heart disease disparities among African American women in the Gulf region.

Getting the Word Out Locally

- "Diet is a Dirty Word and a Dreadful Thought," *Louisiana Weekly*, February 28–March 5, 2005.
- "Women Get the Word Out on Heart Disease," *The Times Picayune*, February 17, 2005.
- "Program Focuses on Women's Health," *The Times Picayune*, February 3, 2005.

- "Health Issues 2010," local TV show addressing heart disease and other health issues. Co-produced with the Healthy Heart Community Prevention Project.

- *The Healing Voice*, the coalition's quarterly newsletter.

Generating New and Exciting Science

- "Mentoring for Leadership to Eliminate Health Disparities." Presented at the 19th National Conference on Chronic Disease Prevention and Control, Atlanta, Georgia, March 1, 2005.
- "Keep the Faith: Lessons Learned in Working with Health Ministries in Faith Communities." Presented at the 133rd Annual Meeting of the American Public Health Association, Philadelphia, Pennsylvania, December 13, 2005.
- "Community Lifeguards of Black Women's Health." *The Women's Health Activist* Nov/Dec 2004;29(6):3.
- "At the Heart of New Orleans: Nurses and Community Health Workers Find Innovative Ways to Reduce Health Disparities." *Texas/Louisiana: Advance for Nurses* 2003;1(4):25.

Keys to Lasting Change in the African American Community

The REACH 2010 project has built collaborative relationships with 40 churches across 10 denominations to reduce risk factors for heart disease among African Americans in Louisiana.

We have found that certain components are essential to making positive and sustainable changes at the community level. These components include sharing power and decision-making across groups, establishing clear roles for all partners, and respecting people's differences. We also must communicate and coordinate our activities across all groups, emphasize a principle of personal caring, and anticipate challenges and barriers.

In addition, we must understand that African American women can be agents of change for their own health as well as for the health of their families and communities. To do so, women need safe spaces to tell their stories, connect with other women, and receive emotional support.

REACH FOR MORE INFORMATION



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REACH

RACIAL AND ETHNIC APPROACHES TO COMMUNITY HEALTH

“The input I received from the group reflected our motto: ‘Strong women growing stronger.’ Women came into the meeting already strong advocates for themselves, and they went away further equipped with specific tools and strategies for maximizing their health care experiences.”

—REACH 2010 Women’s Health Ambassador

REACHing Black and African Descendent Women in Boston, Massachusetts

Who We Are

The Boston Public Health Commission coordinates the Boston REACH 2010 Breast and Cervical Cancer Coalition.

- The coalition includes community members, community groups, health care providers, business and faith leaders, and academic partners.
- The mission of the coalition is to eliminate racial and ethnic disparities in breast and cervical cancer by promoting screening, education, prevention, treatment, and access to care for black women and women of African descent in Boston.
- By working directly with the community, we make sure our programs reflect the culture of local populations.

The Problem

- Black Bostonians have a 12% higher death rate for all cancers than white Bostonians.
- Death rates are particularly high for breast, prostate, and cervical cancers, even when screening rates are higher among black residents. This finding suggests that access to health care

services is not the reason for the higher death rates.

- Black women in the United States die of breast cancer at a higher rate (33.6 deaths per 100,000) than white women (29.6 per 100,000).
- Black women in Boston die of cervical cancer at a significantly higher rate (6.1 per 100,000) than white women (2.5 per 100,000).

The Solution

- To address these problems, the coalition implemented the Women’s Health Demonstration Project. This project ensures that black women and women of African descent in Boston get primary care and follow-up services when they receive an abnormal result from breast and cervical cancer screenings. The

project also offers cultural competency training for primary care providers.

- Community outreach workers, called Women’s Health Ambassadors, provide education on breast and cervical health and racial disparities at health fairs, hair and nail salons, and faith-based institutions. They also provide support and resources to community members through workshops in people’s homes and at community locations.
- The coalition has earned a reputation in the local and public health communities for raising awareness of health disparities, educating residents about health issues that affect Boston’s black community, and building partnerships with key community stakeholders.

Our Achievements

- The coalition’s community interventions have reached more than 3,500 women in Boston.
- Nearly 1,600 women are enrolled in the Women’s Health Demonstration Project, where case managers at four area health centers connect women with resources and information.

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Mobilizing Community Resources

Boston Public Health Commission; REACH Boston Elders 2010; Boston STEPS; YWCA; Boston Black Women's Health Institute; Cherishing Our Hearts and Souls Coalition; Project Right; Hyde Square Task Force; faith-based organizations; schools; community centers; other city programs; Boston Mayor Thomas M. Menino.

Our Achievements, cont.

- Our Women's Health Ambassadors have reached thousands of women in hundreds of workshops since 2000.
- After participating in a public policy training session, 50 coalition members came together to lead a community campaign to support breast and cervical cancer programs across the state.

Our Future

The coalition will expand its scope to address public health issues related to men's health, adolescent wellness, community advocacy, public policy, and environmental health. A strategic plan will ensure that community efforts to eliminate racial and ethnic health disparities can be sustained.

Our demonstration project is encouraging community health centers to adopt a case management model that will help them continue to improve communication between patients and health care providers.

Getting the Word Out Locally

- "Breast Cancer: Two Women Struggle for Survival," *The Boston Banner*, October 12, 2006.
- "The Boston Disparities Project: Closing the Gap," Boston Neighborhood Network, June 2005. Episode no. 2 featured the director of the REACH coalition.
- "REACH 2010: Spreading the Word About Racial and Ethnic Health Disparities and the Work of the REACH 2010 Breast and Cervical Cancer Coalition," WILD FM radio, 2003.

Generating New and Exciting Science

- "Evaluation of Health Disparities Outcomes: Process and Policy." Presented at the Moffit Cancer Center's 5th Biennial Conference, titled Cancer, Culture and Literacy: Solutions for Addressing Health Disparities Through Community Partnerships, Clearwater Beach, Florida, May 19, 2006.

- "Boston's REACH 2010 Coalitions: Creating Change and Collaborating for the Future." Presented at the Office of Minority Health National Leadership Summit on Eliminating Racial and Ethnic Disparities in Health, Washington, DC, January 10, 2006.

Keys to Lasting Change for Black Women and Women of African Descent

The coalition has brought together community residents and public health partners to eliminate racial and ethnic health disparities in Boston. REACH staff and partners have coined the phrase "REACH: Each one, teach one," to reflect their belief that information provided in a way that takes into account the culture of the target population can spread through the community and have a positive impact.

Our efforts have been successful because they draw on systemic change and community empowerment models that use education, case management, and cultural competency training to address health disparities at personal, community, and public policy levels.

REACH FOR MORE INFORMATION



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“The REACH Boston Elders 2010 project had a great impact on my life, especially being a diabetic who had been noncompliant. Regarding racial disparities in the black community, I have seen the facts come to life before my eyes. I have been more observant of my health care providers and how patients have been treated, including myself.”

—REACH program participant

REACHing Black Older Adults in Boston, Massachusetts

Who We Are

The Boston Public Health Commission coordinates the REACH Boston Elders 2010 project.

- This project works to eliminate health disparities in diabetes and heart disease among black older adults in Boston.
- This project provides opportunities for black older adults to actively lead, plan, and develop a citywide model to improve health outcomes and raise awareness of the problems faced by the black older adult population.
- As part of a community approach, a coalition was formed to develop a community action plan. This coalition includes community elders, health care providers, educators, researchers, and representatives of local government agencies.

The Problem

- In Massachusetts, the estimated prevalence of diabetes among non-Hispanic blacks is 9.9%, compared with 6.0% among non-Hispanic whites.

- Massachusetts adults aged 75 years or older are more than twice as likely to have diabetes as those aged 45–64.
- Heart disease is the leading cause of death in Massachusetts. Blacks are at the greatest risk for health problems related to overweight and obesity, which are major risk factors for heart disease.

The Solution

- To address these problems, the REACH Boston Elders 2010 project uses an approach that includes community mobilization, education, and training to eliminate the unequal burden of disease and social inequities in the health care system.
- An education and training model teaches health care providers and

community members how to properly care for older adults, especially those with diabetes and heart disease.

- The REACH Boston Elders 2010 project uses seminars, health fairs, walk-a-thons, and intensive health training sessions to reinforce and support the adoption of healthy lifestyles and to help connect older adults with needed services.
- The coalition also offers classes and workshops on topics important to older adults, such as nutrition, self-management of chronic diseases, and safe exercises such as tai chi.

Our Achievements

- In 2006, the REACH Boston Elders 2010 project reached more than 2,000 black older adults through 49 health education workshops, presentations, and events. These activities focused on issues such as physical activity, nutrition, heart disease, diabetes, health disparities, advocacy, medications, and Medicare/Medicaid.
- When surveyed, 86% of respondents said they had learned something new at these events, and 60% said they would change their behavior.

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Mobilizing Community Resources

Boston Public Health Commission; Action for Boston Community Development; Commission on Affairs of the Elderly; Center for Community Health Education Research and Service; Jubilee Christian Church; American Diabetes Association, Boston Chapter; American Heart Association, Boston Chapter; Central Boston Elder Services; 60 Plus Veterans; The Goldenaires of Freedom House.

Our Achievements, cont.

- When surveyed, 90% of people who attended the coalition's monthly meeting said they had made changes in their lifestyle as a result of attending these meetings.
- In 2007, our coalition received the Community Leaders Award from Health Care for All, a nationally recognized health care, policy, and advocacy group.

Our Future

The REACH Boston Elders 2010 project will continue to highlight the concerns of black older adults in Boston, and we will incorporate an intergenerational approach to reducing health disparities in Boston.

Our coalition will continue to address topics and activities related to diabetes and heart disease prevention, the need for equal access to care, and other social determinants of health. Coalition members and partners will continue to support black older adults in Boston and lead the way

in developing a solid community-based model to improve health and health care access for blacks in Boston and beyond.

Getting the Word Out Locally

- "Health Care Disparities Among the Races: REACH Boston Elders 2010," *National Public Radio/WBUR Boston*, September 28, 2005.
- "Pair Keep Eye on Health of Hub's Minority Elders," *Boston Herald*, December 3, 2004.

Generating New and Exciting Science

- "REACHing Beyond Expectations: Black, Elderly, and Fighting for Health, Justice and Equality." Presented at the 10th Anniversary Conference of the Community-Campus Partnerships for Health, Toronto, Canada, April 11–14, 2007.
- "REACH Boston Elders 2010: Moving a Community and Changing the Business as Usual." Presented at the 5th New England Regional Minority Health

Conference, Mashantucket, Connecticut, April 3, 2007.

Keys to Lasting Change in the Black Older Adult Community

Community commitment and active participation by black older adults, along with various stakeholders and key state and local policy makers, have increased the visibility and knowledge of public health problems affecting black older adults in Boston. Our coalition's ability to effectively address the high rates of diabetes, heart disease, and their related risk factors and complications among local residents has demonstrated the strength of community organizing.

We have found that health disparities can be addressed through ongoing education, long-term partnerships, and a commitment to change. We have made significant strides in improving the health of black older adults in Boston.

REACH FOR MORE INFORMATION



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REACH

RACIAL AND ETHNIC APPROACHES TO COMMUNITY HEALTH

"I used to say that HIV/AIDS is all about politics. Now I know it's real. I would like all folks to take this class because there are so many people like me who think SIDA [AIDS] is 'politics.' I have learned a lot, not only about HIV/AIDS, but about other diseases and about domestic violence. Thanks to the facilitators."

—Participant in an HIV education workshop

REACHing the Haitian Community in Boston, Massachusetts

Who We Are

The Center for Community Health, Education & Research, Inc. (CCHER) coordinates the Metropolitan Boston Haitian REACH 2010 HIV Coalition.

- The coalition includes community groups, community health centers, and one faith-based group.
- Coalition members work to reduce the high HIV/AIDS rates among Haitian immigrants in the Boston metropolitan area.

The Problem

- As of February 1, 2005, there were 1,074 cases of HIV/AIDS reported among Haitian-born people living in Massachusetts.
- The rate of heterosexual transmission of HIV within the Massachusetts Haitian community is more than three times the rate among non-Haitians.
- Haitian women represent 41% of all Haitian-born people with HIV/AIDS in Massachusetts, compared with

the state's general population, where women represent 24% of HIV/AIDS cases.

The Solution

- The coalition provides HIV prevention education through a community-wide media campaign and culturally appropriate workshops for Haitian immigrants. It also provides access to HIV testing.
- The project targets six groups of people: women, men, youth, couples, Haitians living with HIV, and new immigrants.
- The coalition works to educate and involve community leaders, including faith and media leaders, in HIV prevention efforts.

Racial and Ethnic Approaches to Community Health (REACH) is a community-based public health program funded by CDC to eliminate racial and ethnic health disparities.

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Our Achievements

- The coalition completed the first comprehensive survey of the adult Haitian population in Boston, documenting the health attitudes, beliefs, and behaviors of more than 2,700 men and women.
- The coalition provided six HIV/AIDS educational programs, reaching more than 500 women, 200 men, 250 youth, 60 couples, 60 Haitians living with HIV, and 130 new immigrants.
- The coalition also launched an HIV prevention media campaign in Creole on billboards, buses, trains, and Haitian radio stations, reaching more than 12,000 Haitians in the Boston metropolitan area.
- More than 80 Haitian faith and media leaders received training in HIV prevention strategies.
- Forty non-Haitian health care and social service providers received cultural competency training.
- The coalition also set up a statewide network of groups to address health disparities related to HIV/AIDS rates in communities of color.



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Mobilizing Community Resources

The Center for Community Health, Education & Research, Inc.; Association of Haitian Women in Boston; Boston Medical Center, Supporting Parents and Resilient Kids Program; Cambridge Health Alliance, Haitian Health Outreach Project; Caribbean U-Turn; Dorchester Nazarene Compassionate Center; Haitian American Public Health Initiative; Haitian Multi-Service Center; Massachusetts Coalition for Health Services, Brockton CHASE AIDS.

Our Future

Working with other groups that serve immigrants, the Metropolitan Boston Haitian REACH 2010 HIV Coalition will continue to provide educational programs tailored to specific groups of people. In the future, we plan to expand the program to include advanced behavioral-change training. The coalition structure also will be used to address other health needs, such as improving women's access to mammograms.

Getting the Word Out Locally

■ "SIDA Se Zafé Nou Tout. Ann Potekole Nan Yon Konbit Kominote Pou N Bare Wout Li" ("HIV/AIDS: We Are All Concerned. Let's Work Together to Stop the Virus"), ongoing media campaign that includes weekly radio shows, posters, billboards, brochures, and flyers.

Generating New and Exciting Science

- "Cultural Barriers to HIV-Preventive Behaviors Among Haitian Immigrants in Metro Boston." Oral presentation at the American Public Health Association Annual Meeting, Philadelphia, Pennsylvania, December 12, 2005.
- "Role and Importance of Media in Health Promotion: The Case of the Haitian Population in HIV Prevention in the Greater Boston Area." Presented at the New England Conference on Health Disparities, Portland, Maine, April 2005.
- "The Boston Haitian HIV Prevention Coalition Formative Evaluation: A Participatory Approach to Community Self-Assessment." *Ethnicity & Disease* 2004;14(3, suppl 1):20–26.
- "Overcoming Historical and Institutional Distrust: Key Elements in Developing and Sustaining the Community Mobilization Against HIV in the Boston Haitian Community." *Ethnicity & Disease* 2004;14(3, suppl 1):46–52.

Keys to Lasting Change in the Haitian Community

Our program has succeeded because we created a solid infrastructure within the community that is supported by health care providers, faith leaders, and media leaders. The unique network of Haitian groups and health care providers sets an example for collaborative action, makes more health care services available to the community, and creates a way to address other community needs.

Because health care providers, community partners, residents, faith leaders, and local and state officials are willing to work together to reduce health disparities in the Haitian community, we can tackle major challenges related to sex education, the stigma of HIV/AIDS, and disclosure of HIV status.

REACH FOR MORE INFORMATION



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REACH

RACIAL AND ETHNIC APPROACHES TO COMMUNITY HEALTH

"I am grateful for all you have done for me and my health. Before I began this course, my diabetes was really bad, and I was really depressed, disillusioned, and sad. With this program, I learned to be more conscientious. I feel different, better."

—REACH project participant

REACHing Latinos in Lawrence, Massachusetts

Who We Are

The Greater Lawrence Family Health Center coordinates the REACH 2010 Latino Health Project.

- This project works to eliminate health disparities among Latinos living in Lawrence, Massachusetts, who have diabetes and associated heart disease.
- Lawrence is the poorest city in Massachusetts. About 68.7% of its population is Latino, primarily from the Dominican Republic and Puerto Rico.

The Problem

- The prevalence of diabetes among Puerto Rican and Dominican adults in Lawrence is 11.8%, nearly twice the rate among whites in Massachusetts.
- Diabetes prevalence is 7.4% among Latinos statewide, compared with only 6.4% among non-Hispanic whites.
- One in three children born in 2000 in the United States will develop diabetes. The incidence among Hispanic females born in 2000 is closer to 1 in 2.

The Solution

- The REACH 2010 Latino Health Project works to raise people's awareness about diabetes, teach them how to eat a healthy diet and be more physically active, and help them to understand that diabetes can be prevented and controlled.
- The project provides information on how to prevent and manage diabetes that reflects the local culture.
- The project also provides outreach activities through a local health education center, works with community groups, partners with local health care providers, and promotes health messages through a media campaign.

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Our Achievements

- More than 10,000 Latinos in Lawrence who had little access to information about diabetes or heart disease before now know where to go for help.
- In 2006, blood sugar levels improved from an average of 8.21 to 7.67 among participants in Winning with Diabetes, a 10-week educational program at the Lawrence Senior Center.
- Also in 2006, the percentage of participants with total cholesterol levels <200 mg/dL increased from 75% to 80%.
- The percentage of Latinos receiving services at the Greater Lawrence Family Health Center (GLFHC) who had their blood sugar level measured at least twice a year as recommended increased from 50.6% in 2002 to 61.6% in 2006 after the center took specific steps to improve the health of its Latino clients with diabetes.
- The percentage of Latinos receiving services at the GLFHC who reached their blood sugar goal (A1C level <7) increased from 20.7% in 2002 to 43.4% in 2006.



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CENTERS FOR DISEASE CONTROL AND PREVENTION





Mobilizing Community Resources

Greater Lawrence Family Health Center; Lawrence Council on Aging; Home Health VNA; Merrimack Valley Nutrition Project; Lawrence General Hospital; Greater Lawrence YWCA; more than 30 other community groups.

Our Achievements, cont.

- The percentage of Latinos receiving services at the GLFHC who had an annual flu shot increased from 44.2% in 2005 to 55% in 2006.
- The Diabetes Self Management Education program at the GLFHC received the American Diabetes Association's Education Recognition award.
- A wellness group that began with one physician teaching 25 groups has expanded to include several physicians.

Our Future

We plan to expand a community-based intervention called Alcanzando el Bienestar/REACHing for Wellness that is designed to reflect the culture and traditions of Latino adults and youth in Lawrence. We will continue to improve health care for Latinos with diabetes. We also will continue to publish our research findings to improve the quality of information available to patients, researchers, and health care professionals dealing with the burden of diabetes.

Getting the Word Out Locally

- "La Coalición Contra la Diabetes de Lawrence Celebra su 3rd Feria Anual 'Fiesta de Salud,'" *RUMBO*, April 22, 2006.
- "La Feria de Salud Latina," *RUMBO*, April 15, 2004.
- Regular appearances on *Para tu Salud*, a program produced by the Greater Lawrence Family Health Center on Lawrence Community Access Television (LCAT).
- Ad campaign promoting awareness of type 2 diabetes and public service announcements on area radio stations WCCM, WCEC, and WEZE.
- "Who's at Risk for Diabetes?" ad campaign on Univision-Noticiero TV.

Generating New and Exciting Science

- "Changing Lives of Latinos Who Have Diabetes: Three Case Studies." Presented at the Office of Minority Health National Leadership Summit on Eliminating Racial and Ethnic Disparities in Health, Washington, DC, January 9, 2006.

- "Integrating Health Education and Health Promotion to Reduce Health Disparities Related to Diabetes in a Latino Population." Presented at the 23rd National Conference on Health Promotion and Education, Minneapolis, Minnesota, May 25, 2005.
- "Practice-Based Interventions to Improve Health Care for Latinos With Diabetes." *Ethnicity & Disease* 2004;14(3, suppl 1):117-121.

Keys to Lasting Change in the Latino Community

The keys to lasting change in the Latino community are education, social support, and community collaboration. The REACH 2010 Latino Health Project aims to use the relationships that already exist among Latino populations and community groups in Lawrence to promote community wellness. These relationships can provide the foundation to create the health care support needed to improve health outcomes and to encourage more people to use diabetes prevention services.

REACH FOR MORE INFORMATION



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REACH

RACIAL AND ETHNIC APPROACHES TO COMMUNITY HEALTH

"Before, my cholesterol level was close to 400. But after I exercised regularly and ate healthier, my cholesterol level right now is at 160. I am extremely happy with this improvement."

—Cambodian senior in the Lowell Senior Center exercise program

REACHing Cambodian Adults in Lowell, Massachusetts

Who We Are

The Lowell Community Health Center coordinates the Cambodian Community Health 2010 Program (CCH 2010).

- CCH 2010 is a coalition of health care providers, community groups, and representatives from the University of Massachusetts Lowell.
- Our goal is to reduce health disparities in the rates of heart disease and diabetes among Cambodians living in Lowell, Massachusetts.
- Lowell has the second largest Cambodian community in the United States.

The Problem

- In Lowell, Cambodian adults aged 45 years or older have higher death rates from stroke (15.9%) and diabetes (13.4%) compared with all Massachusetts adults in this age group (6.5% for stroke, 2.5% for diabetes).
- In 2002, 65% of Cambodian adults aged 50 years or older reported that their health was fair or poor in a survey conducted by CCH 2010.

- Also in 2002, 77% of Cambodian men said they had smoked 100 cigarettes or more in their lifetime, and 37% were current smokers.
- The survey also found that 99% of Cambodian adults in Lowell were born in Cambodia, and 85% had spent time in a refugee camp. Among adults aged 50 years or older, men received an average 7.2 years of schooling in Cambodia, and women received an average 3.1 years. When they talk with a doctor who does not speak Khmer, their main language, 89% said they wanted an interpreter.

The Solution

- CCH 2010 increases access to the health care system for Cambodians. It also increases participation in

Racial and Ethnic Approaches to Community Health (REACH) is a community-based public health program funded by CDC to eliminate racial and ethnic health disparities.

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wellness programs such as peer support groups, exercise classes, and stress management sessions.

- CCH 2010 increases awareness among health care providers and researchers about Cambodian culture, health care beliefs, and health care needs.
- The program also offers educational sessions to teach Cambodians about heart disease and diabetes and to teach those who have these diseases how to manage them better.

Our Achievements

- The number of Cambodian patients accessing health care at Lowell Community Health Center's Metta Health Center increased from 0 in 2000 to more than 4,000 in 2005.
- During September 2003–2006, 901 health and human service professionals attended classes to help them understand Cambodian culture, and 424 people attended presentations on Cambodian culture and health care beliefs and practices.
- Seven local pharmacies agreed to help improve communications with Cambodians about their medications.



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Mobilizing Community Resources

Lowell Community Health Center; Cambodian Mutual Assistance Association of Greater Lowell; University of Massachusetts Lowell, Center for Family, Work and Community and School of Health and Environment; Visiting Nurse Association of Greater Lowell; City of Lowell Council on Aging; Saint Julie Asian Center; Saints Memorial Medical Center; Lowell General Hospital; Greater Lawrence Family Health Center, Merrimack Valley Area Health Education Center; Massachusetts Department of Public Health, Division of Community Health Promotion; Khmer Health Advocates; Lowell Police Department; Trinity EMS; Lowell Telecommunications; City of Lowell Health Department.

Our Achievements, cont.

- During September 2003–2006, 82 Cambodian health professionals completed a Khmer medical terminology course to improve their ability to recognize and understand definitions and analysis of medical terms, as well as anatomic, diagnostic, operative, and symptomatic terms.
- CCH 2010 helped to change policies related to language accessibility services at the Lowell Community Health Center and local hospitals by developing and implementing an interpreter competency and training program.
- CCH 2010 provided content for 75 one-hour shows for Jivit Thmey, a Khmer-language cable television program.

Our Future

In addition to providing culturally appropriate community wellness and educational programs, CCH 2010 will continue to educate and work with local stakeholders to implement solutions to eliminate health disparities in Lowell's Cambodian community.

Getting the Word Out Locally

- "Deep Wounds Fester From Horror Inflicted by the Khmer Rouge," *The Boston Globe*, April 18, 2006.
- "Conference Touches Upon Cambodian Health Issues," *The Lowell Sun*, September 29, 2005.
- "Seminar Promotes an Understanding of Health Literacy," *The Shuttle*, April 20, 2005.

Generating New and Exciting Science

- "Self-Reported Health Among Cambodians in Lowell, Massachusetts." *Journal of Health Care for the Poor and Underserved* 2006;17(2, suppl): 133–145.
- "Smoking Among Cambodian Adults in Lowell, Massachusetts, and Ideas for Promoting Cessation." Presented at the American Public Health Association Annual Meeting, Philadelphia, Pennsylvania, December 12, 2005.
- "Bringing Equal Health Outcomes Within REACH." *Minority Nurse* 2003; Fall:27–32.

- "Building on the Strengths of a Cambodian Refugee Community Through Community-Based Outreach." *Health Promotion Practice* 2007 (in press).

Keys to Lasting Change in the Cambodian Community

CCH 2010 interventions are succeeding because we have implemented lasting change in the social service and health care community. We also are continuing to develop and invest in a strong infrastructure that represents the community, is capable of mobilizing prevention efforts, and encourages the development of individuals and groups who can make change.

Other important factors for success are innovative community outreach practices that promote health, help people advocate for their own health, and can sustain communitywide behavior change. By making sure that community members are involved in planning outreach activities, we are helping to improve the health of Cambodians in Lowell.

REACH FOR MORE INFORMATION



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REACH

RACIAL AND ETHNIC APPROACHES TO COMMUNITY HEALTH

"Whenever I look in the refrigerator to get something to eat, I see my family health advocate's face, and I know that I better not get anything unhealthy to eat or eat too much."

—An intervention participant

REACHing African Americans and Latinos in Detroit, Michigan

Who We Are

The Community Health & Social Services Center, Inc., coordinates the REACH Detroit Partnership.

- This partnership works to inform, educate, and involve families, communities, and health care systems to prevent and manage diabetes among Detroit residents.
- The partnership targets African Americans and Latinos living in the east side and southwest communities of Detroit.

The Problem

- Nationally, African Americans and Latinos are more likely to be obese and to have diabetes than whites. In the area of Detroit targeted by the REACH Detroit Partnership, 68.8% of African Americans and 73.8% of Latinos are overweight or obese.
- According to state data, diabetes prevalence is 7.3% among whites, 8.5% among Latinos, and 11.0% among African Americans in Michigan. Disparities between racial and ethnic groups are even higher when reported by age

group. For example, 13.4% of whites and 26.2% of African Americans aged 55–64 years have diabetes.

- More than 25% of African Americans and more than 30% of Latinos in the target area reported a sedentary lifestyle, and less than 35% of both groups met minimum recommendations for regular physical activity.

The Solution

- The REACH Detroit Partnership conducts interrelated family, health system, social network, and community interventions to help residents prevent and manage diabetes.
- Program services include interventions led by family health advocates, continuing medical education for health

care providers, and opportunities for healthy eating and physical activity.

- The program also offers health education classes and bilingual health information for residents.

Our Achievements

- The Family Intervention targeted two groups, and participants in both groups showed improvements as a result of this program.
- In the first group, 70.8% of participants had blood sugar levels ≥ 7 , which put them at higher risk for diabetes complications. After 1 year, this percentage had dropped to 57.3%, and participants reported improvements in self care, diabetes knowledge, and healthy eating.
- In the second group, participants were divided into two subgroups, with some receiving interventions right away and others receiving interventions 6 months later. Participants in subgroup 1 showed a mean decrease of 1.2 in their blood sugar levels, compared with 0.02 for subgroup 2. Participants in subgroup 1 also showed improvements in diabetes-related depression and consumption of high-fat foods.

Racial and Ethnic Approaches to Community Health (REACH) is a community-based public health program funded by CDC to eliminate racial and ethnic health disparities.

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Mobilizing Community Resources

Community Health & Social Services Center, Inc.; Friends of Parkside; Alkebu-lan Village; Detroit Department of Health and Wellness Promotion; Michigan Department of Community Health; Henry Ford Health System; University of Michigan, School of Social Work, School of Public Health, and Medical School; Southeast Michigan Diabetes Outreach Network; Detroit Community-Academic Urban Research Center.

Our Achievements, cont.

- To promote healthy eating, we conducted 166 mini-markets at 16 locations, 139 food demonstrations at 33 locations, 125 community education events, and 250 support group sessions.

Our Future

The REACH Detroit Partnership will continue to evaluate the effectiveness of the family health advocate model. We also plan to evaluate and distribute the tool kits used by our staff. We will expand the healthy eating component of the Family Intervention to find new ways to help residents have greater access to healthy foods and to help communities grow and sell fresh produce. In addition, we will evaluate our physical activity interventions more rigorously to assess health outcomes among participants and the effectiveness of our train-the-trainer program.

Getting the Word Out Locally

- "Fighting Back: Group Aims to Help Hispanics, African Americans Beat Diabetes Odds," *Detroit Free Press*, November 12, 2006.

- "Books Donated to Bowen, Conely, and Gray Branch Libraries," *El Central*, January 22, 2004.
- "REACH Helps Fight Diabetes Spread," *The Michigan Chronicle*, March 31–April 6, 2004.
- "Arabs Join Other Minorities in Diabetes Risk," *Detroit Free Press*, October 23, 2003.
- "REACH Pamper Day Picnic," *El Central*, July 10, 2003.

Generating New and Exciting Science

- "Chronic Disease-Related Behaviors and Health Among African Americans and Hispanics in the REACH Detroit 2010 Communities, Michigan, and the United States." *Health Promotion Practice* 2006;7(3, suppl):256S–264S.
- "Diabetes-Specific Emotional Distress Among African Americans and Hispanics with Type 2 Diabetes." *Journal of Health Care for the Poor and Underserved* 2006;17(2, suppl):88–105.
- "The Relationship Between Knowledge of Recent HbA1c Values and Diabetes Care Understanding and Self-Management." *Diabetes Care* 2005;28(4):816–822.

- "Racial and Ethnic Approaches to Community Health (REACH) Detroit Partnership: Improving Diabetes-Related Outcomes Among African American and Latino Adults." *American Journal of Public Health* 2005;95(9):1552–1560.

Keys to Lasting Change in African American and Latino Communities

Family health advocates understand and share the challenges that residents face in making healthy lifestyle changes. By bringing together public health professionals with community members and other partners, we can find new ways to address diabetes and its complications and eliminate health disparities. These partnerships also will help community members plan, implement, and evaluate intervention activities; develop and disseminate tool kits, educational resources, and lessons learned; and take a more active role in conducting community-based participatory research in their communities. In addition, building relationships between health care providers, their patients, and REACH family health advocates helps providers communicate better with their patients.

REACH FOR MORE INFORMATION



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REACH

RACIAL AND ETHNIC APPROACHES TO COMMUNITY HEALTH

"It takes so much more than being open-minded. It takes work. There are so many levels and layers to this problem. However, I have hope that because universities and organizations are training their people through REACH 2010, there will be changes."

—Genesee County REACH 2010 participant

REACHing African Americans in Flint, Michigan

Who We Are

The Genesee County Health Department coordinates the Genesee County REACH 2010 Team.

- The team is a coalition of 12 groups working with people at the community level to reduce health disparities in infant death rates among African Americans living in Flint, Michigan.
- Genesee County has the fifth largest population of any county in Michigan, with 436,141 residents. Flint is the largest city in Genesee County, with a population of 124,943, of whom 53.27% are African American.

The Problem

- Despite more than 20 years of efforts, the racial disparity in infant death rates among African Americans persists in Flint and Genesee County.
- The infant death rate among African Americans living in Genesee County is nearly 3 times higher than the rate for white infants. This disparity is highest in the areas targeted by the REACH 2010 Team (ZIP codes 48503, 48504, 48505, and 48458).

The Solution

- The Genesee County REACH 2010 Team has implemented a community action plan designed to mobilize people at the community level; improve health care services for infants; and reduce racism at individual, institutional, and systems levels.
- Activities include community dialogue sessions, workshops that address racism, a media campaign, educational sessions at a local African Cultural Education Development Center, educational classes for parents, and cultural competency classes for health care providers and local university students.

- Other activities include assigning maternal and infant health advocates (MIHAs) to help pregnant women and teaching healthy eating through community dinners called Harambee (Swahili for "pulling together") dinners.

Our Achievements

- Our team conducted 20 Undoing Racism™ workshops that were attended by 764 people, including 48 doctors, from more than 100 groups.
- MIHAs have provided support and mentoring to 691 African American women and helped them to navigate the medical system. This support is provided during the women's pregnancies and for 1 year after the birth of their children.
- More than 1,079 African American women and 105 African American men have attended "One Stop Village" classes, which teach parenting skills and car seat safety and provide information about breast-feeding.

Racial and Ethnic Approaches to Community Health (REACH) is a community-based public health program funded by CDC to eliminate racial and ethnic health disparities.

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Mobilizing Community Resources

Genesee County Health Department; Faith Access to Community Economic Development; Flint Family Road; Flint Odyssey House Inc. Health Awareness Center; Genesee County Community Action Resource Department; Greater Flint Health Coalition; Hurley Medical Center; Genesys Regional Medical Center; Mott Children's Health Center; PRIDE (Programs to Reduce Infant Deaths Effectively) Medical Services Committee; University of Michigan-Flint; University of Michigan, School of Public Health.

Our Achievements, cont.

- The African Cultural Education Development Center has given hundreds of educational tours and hosted seven sessions called Middle Passage Experiences, reaching more than 270 African Americans and 45 whites. The center also sponsored Racism 101 classes, reaching more than 200 people.
- We developed a standard prenatal screening tool that is now being used in 11 local medical offices.
- Our Cultural Competence in Health Care class has trained more than 160 students at the local university.

Our Future

The coalition will continue its efforts to reduce racial disparities in infant death rates in Genesee County. We will conduct research to evaluate the impact of the REACH community action plan.

We also will develop training manuals and provide technical help for duplicating REACH activities in other communities of color.

Getting the Word Out Locally

- "Flint's Black Infant Deaths Drop in Wake of Local Efforts," *The Flint Journal*, August 18, 2006.
- "Doctors Learn to Have Patience With Patients," *The Flint Journal*, February 7, 2005.
- "Black Men Focus on Infant Mortality," *The Flint Journal*, January 30, 2005.

Generating New and Exciting Science

- "Teaching Cultural Competence to Reduce Health Disparities." *Health Promotion Practice* 2006;7(3, suppl):247S–255S.
- "A Birth Records Analysis of the Maternal Infant Health Advocate Service Program:

A Paraprofessional Intervention Aimed at Addressing Infant Mortality in African Americans." *Ethnicity & Disease* 2004;14 (3, suppl 1):102–107.

Keys to Lasting Change in the African American Community

No single intervention is likely to eliminate the high infant death rates among African Americans, in part because the 9-month period of pregnancy is simply too short to address effectively the many risk factors important to infant health.

Many different types of solutions are needed, and our coalition is working to be a part of this process. In addition, to eliminate health disparities among African Americans completely, communities must address underlying social inequalities and racism.

REACH FOR MORE INFORMATION

Genesee County
REACH 2010
...together to save our precious black babies!



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“The Healthy Habits program has freed me to take better charge of my health. The availability and variety of information offered have allowed me to share with friends and family. And best of all, my overall health has improved through making positive changes in my life.”

—Community member

REACHing African Americans and Latinos in Kansas City

Who We Are

The Missouri Coalition for Primary Care created the Kansas City - Chronic Disease Coalition (KC-CDC) to coordinate the REACH 2010 initiative.

- KC-CDC is a community-based network of groups working together to reduce risk factors for diabetes and heart disease among African Americans and Hispanics/Latinos living in the urban core of Kansas City, Missouri, and Kansas City, Kansas.
- The groups involved in this initiative come from nine sectors, including faith, cultural, neighborhood, government, media, health and human services, law enforcement, private, and education.

The Problem

- In Kansas City, the average life expectancy for people of color is 11 years shorter than the life expectancy for whites.
- African Americans in Kansas City are 2.5 times more likely to die of diabetes and 1.5 times more likely to die of heart disease compared with whites.
- Hispanics/Latinos in Kansas City are slightly more than 1.5 times more likely to die of diabetes compared with whites.

The Solution

- To address these problems, the KC-CDC launched a community campaign called We Practice Healthy Habits, or Nosotros Practicamos Habitos Saludables in Spanish. This campaign promotes ways that individuals and communities can help people with diabetes and heart disease improve their health.
- The campaign includes a community action plan that offers a wide range of changes that can be made at a variety of levels. For example, individuals can create a personal plan to adopt healthy habits to reduce their risk for chronic diseases, and they can request materials to support their efforts. Neighborhood and faith groups can become resource partners to help people adopt healthy habits.

- In addition, various organizations, including community groups, government agencies, and health care centers, can enter into “Pick 6” service agreements that promote changes in programs, policies, and procedures to support healthy habits. “Pick 6” activities come from a list of 86 options developed by community members.
- Examples of community activities that partners can choose to promote include encouraging people to walk as a natural way to get from place to place, offering community cooking classes with tips on healthy meals, and developing campaigns that promote healthy lifestyles.
- Other activities include assessing grocery store chains and their weekly ads to see how well they promote healthy food options to cost-conscious consumers, working with schools to promote healthy school meals and snacks, developing best practices for treating diabetes and heart disease, and promoting these best practices with local health care providers.

Racial and Ethnic Approaches to Community Health (REACH) is a community-based public health program funded by CDC to eliminate racial and ethnic health disparities.

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Our Achievements

- We have documented more than 500 community changes made or promoted by coalition partners, and 55% of these changes are ongoing.





Mobilizing Community Resources

Al-Haqq Islamic Center; American Diabetes Association; American Heart Association; American Indian Council; Battleflood Heights Neighborhood Association; Black Health Care Coalition; Blue Valley Neighborhood Association; Cabot Westside Health Center; Camino Verdad y Vida/Way, Truth and Life Church; Centennial United Methodist; Christ Temple; Corinthian Missionary Baptist Church; The Diabetes Center; El Centro; Foxtown East Neighborhood Association; Harvesters; Housing Authority of Kansas City; Ivanhoe Neighborhood Council; Jesucristo el Buen Pastor; Kansas City Free Health Clinic; Maternal and Child Health Coalition; Metropolitan Spiritual Church; N.O.B.L.E. Neighborhood Association; Phi Delta Kappa; Samuel Rodgers Health Services; Somali Foundation Inc.; Swope Health Services; Sisters Let's Talk; Swope Parkway UCC; Tony Aguirre Center; Troost Corridor; Troost Plateau; University of Missouri Extension; Victoria Arms Senior Center; Victorious Life; Vineyard Neighborhood Association; The Wellness Journey; Women of Excellence; Donnelly College Student Association; American Postal Workers Union.

Our Achievements, cont.

- In addition, 46% of all changes target African Americans, while 16% target Hispanics/Latinos.
- Early results indicate that older African American women have benefited the most from our community change model.

Our Future

KC-CDC will continue to refine its network approach to best serve the needs of our community. This concept is supported by a strong community coalition that continually reevaluates and capitalizes on its strengths. Our coalition also will continue to create new activities and programs in areas of need to improve the health of Kansas City residents.

Getting the Word Out Locally

- Maria Boudreaux, licensed nutritionist and KC-CDC board member, appeared on Fox 4 Morning Show's "Healthy Eating" segment, January 28, 2007.
- Maria Boudreaux appeared on KSHB 41 Morning Show's "Gluten-free Diet Tied to Healthy Habits" segment, January 25, 2007.

- Maria Boudreaux appeared on KPRT 1180 AM radio's "Diabetes and Nutrition" segment, January 17, 2007.
- A local campaign aimed at faith networks and focusing on Hispanic/Latino churches and residents included a bilingual flyer and ads in *The Kansas City Star*, December 2006.
- "Group Promotes KC's Healthy, Scenic Walks," *The Kansas City Star*, April 16, 2003.

Generating New and Exciting Science

- "Analyzing a Community-Based Coalition's Contributions to Reducing Risk for Chronic Disease and Health Disparities in Kansas City, Missouri." *Preventing Chronic Disease* [serial online] 2007;4(3). Available at http://www.cdc.gov/pcd/issues/2007/jul/06_0101.htm.

Keys to Lasting Change in African American and Hispanic/Latino Communities

KC-CDC has used several strategies to improve the health of African Americans and Hispanics/Latinos living in Kansas

City. These strategies include training a wide range of partners from community and faith groups on primary prevention techniques and making sure that our program goals take into account the cultures of our REACH communities. We also make sure that our educational programs and materials reflect the cultures and languages of these communities and that local leaders and groups receive the funds they need to make changes in their communities.

We promote health education and disease prevention in Hispanic/Latino communities through Hispanic/Latino media and faith networks. The We Practice Healthy Habits/Nosotros Practicamos Hábitos program has been effective at the community level because of its strong primary prevention messages: eat better, exercise more, quit tobacco use, see a health care professional on a regular basis, and reduce stress. Our coalition partners work hard to teach people that these risk-reducing behaviors can be achieved and that they are a practical way to avoid or manage diabetes and heart disease.

REACH FOR MORE INFORMATION



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REACH

RACIAL AND ETHNIC APPROACHES TO COMMUNITY HEALTH

“Excellent introduction to the pool, as I was extremely frightened. The workout gave me confidence and interest to continue. The exercises are useful for muscles not generally used. Recommended! Thank you for the opportunity. Great instructors!”

—Healthy Hearts Project participant

REACHing African Americans in Clark County, Nevada

Who We Are

The University of Nevada, Reno coordinates the Healthy Hearts Project.

- This project works with the university's College of Cooperative Extension and the local faith community to deliver educational and awareness programs on heart disease to Nevada residents.
- The target population is African Americans living in Clark County, Nevada, mainly in two ZIP codes (89030 and 89106).

The Problem

- Heart disease is the leading cause of death for women and men in Nevada and the United States.
- African Americans have a higher death rate for heart disease than any other racial or ethnic group in Clark County, Nevada.

The Solution

- We began the Healthy Hearts Project by assessing the target community to identify residents' health needs and the types of programs that could be used to address these needs.

- As part of this project, we implemented educational and awareness programs to address the lack of knowledge about heart disease and its risk factors among African Americans living in Clark County.
- We hired and trained community members from local churches to implement our interventions.
- We also helped plan and develop educational programs as part of health ministries in three local churches and one mosque. These programs increase members' awareness of health disparities among African Americans in Nevada.

Our Achievements

- Our project provided support and resources to help strengthen the

Community Partners for Better Health Coalition, a faith-based group that works to address health disparities among people of color.

- We worked with local health care providers to improve primary and secondary preventive care for African Americans at risk for heart disease.
- We increased community members' awareness of how some risk factors for heart disease can be controlled, and we increased their awareness of the disparity in disease rates among African Americans.
- We also have given community members the information and skills they need to change their behaviors and lower their risk for heart disease.
- Sixty-one churches and four senior and recreation centers are participating in this project.
- Our project has reached more than 6,000 people through 127 workshops, 3 women's conferences, 2 physical activity festivals, and 35 physician seminars.

Racial and Ethnic Approaches to Community Health (REACH) is a community-based public health program funded by CDC to eliminate racial and ethnic health disparities.

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CENTERS FOR DISEASE CONTROL AND PREVENTION





Mobilizing Community Resources

American Diabetes Association; American Heart Association; American Stroke Association; 100 Black Men of America, LV Chapter; Clark County Health District, Health Education Division; Clark County Library District; Community Baptist Church; Courage Unlimited; CSM Consultants; Ebenezer COGIC; First African Methodist Episcopal Church (FAME); Holy Trinity AME Church; National Black Leadership Initiative on Cancer; Nevada Cancer Institute; Miracle Hands Foundation; Powerhouse COGIC; Reach One Teach One; Second Baptist Church; Sisters Network; Southern Nevada Black Nurses; Southern Nevada Cancer Research Foundation; University of Nevada, Reno, College of Cooperative Extension; Victory Baptist Church; Zion United Methodist Church.

Our Future

The Healthy Hearts Project will continue to help its community partners improve their ability to reduce disparities in heart disease among African Americans in Clark County, Nevada. We also will continue to develop and strengthen health ministries in the faith community. In addition, we plan to use physician seminars and community workshops to help health care providers improve their interactions with patients.

Getting the Word Out Locally

- "Healthy Hearts Project Promotes Fitness," *Las Vegas Sentinel Voice*, September 15, 2005.
- "Variety May Be the Key: Cooperative Extension Offers a Number of Programs," *Las Vegas Review Journal*, January 11, 2005.

- "Fair Shows Benefits of Diet, Exercise," *Las Vegas Sentinel Voice*, September 23, 2004.
- "Doolittle Festival Focuses on Health," *Las Vegas Sentinel Voice*, September 16, 2004.
- "Workshop Focuses on Female Health," *Las Vegas Sentinel Voice*, July 8, 2004.

Generating New and Exciting Science

- "Techniques for Establishing Educational Programs Through the African American Faith Community." *Journal of Extension* [serial online] 2006;44(1). Article no. 1T0T3, published at <http://www.joe.org/joe/2006february/tt3.shtml>.
- "Food for Health and Soul: A Curriculum Designed to Facilitate Healthful Recipe Modifications to Family Favorites." *Journal of Nutrition Education and Behavior* 2005;37(6):323-324.

Keys to Lasting Change in the African American Community

The Healthy Hearts Project developed from the community it serves. Members of predominantly African American churches and a coalition of community groups helped make decisions and create an action plan to address disparities in heart disease rates among African Americans in Clark County.

Church members were recruited to help implement activities and programs, most of which grew out of input from the community. Over the life of this project, we have used community feedback to make changes to ensure that our efforts are effective. Local churches also have created health ministries to help them meet the health education needs of their members.

REACH FOR MORE INFORMATION



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REACH

RACIAL AND ETHNIC APPROACHES TO COMMUNITY HEALTH

"Now I can tell that the program is not just a diet or exercise program. It's more like my choice to choose and replace my unhealthy habit for a healthy habit."

—Cambia tu Vida program participant

REACHing African Descendents and Latinos in Hillsborough County, New Hampshire

Who We Are

The New Hampshire Minority Health Coalition coordinates the New Hampshire REACH 2010 Initiative.

- This initiative works to improve the health of African descendents and Latinos living in Hillsborough County by conducting outreach, educational, and research activities that focus on diabetes and high blood pressure.
- The county's population is very culturally diverse. We use the phrase "African descendents" to refer to African Americans and recent immigrants from Africa and the Caribbean. Our Latino population also includes U.S. citizens and recent immigrants.
- In Manchester and Nashua, the two largest cities in Hillsborough County, the Latino populations grew more than 133% and 124%, respectively, during 1990–2000.

The Problem

- Compared with white adults in the United States, African Americans are 1.6 times more likely to have diabetes. Latinos are 1.5 times more likely to have diabetes than whites.

- Nationally, African Americans are 30% more likely to die of heart disease than whites.
- African Americans and Latinos also have higher rates of overweight and obesity, which are two of the leading risk factors for diabetes and heart disease.

The Solution

- One of the main goals of the New Hampshire REACH 2010 Initiative is to implement programs that will reduce health disparities in diabetes and high blood pressure.
- Our programs are designed by the target communities to reflect their cultures and languages. One such program is Change for Life, or Cambia tu Vida in Spanish. This community-based

program helps African descendents and Latinos adopt healthy habits to reduce their risk for diabetes and high blood pressure.

- Another program is Let's Talk Diabetes, or Hablemos de Diabetes in Spanish. This community-based program provides education and support to people with diabetes and their families.
- Other activities include a community walking program, educational and nutritional counseling for people with diabetes, and a Community Health Advisory Board made up of local leaders.
- We also collect data on the health status, health care access, and health behaviors of African descendents and Latinos in Hillsborough County. These data can be used to educate state officials about the need for equal health care services for all residents.

Our Achievements

- We are the first group in New Hampshire to collect significant data about health disparities among African descendent and Latino populations in Hillsborough County.

Racial and Ethnic Approaches to Community Health (REACH) is a community-based public health program funded by CDC to eliminate racial and ethnic health disparities.

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Mobilizing Community Resources

New Hampshire Minority Health Coalition; Dartmouth Medical School, New Hampshire Area Health Education Center; Dartmouth-Hitchcock Nashua; Manchester Community Health Center; Manchester Public Health Department; Nashua Area Health Center (a center of Lamprey Health Care); New Fellowship Baptist Church; Southern New Hampshire Area Health Education Center; Ujima Collective; University of New Hampshire.

Our Achievements, cont.

- We contributed these data to *New Hampshire Diabetes Data, 2003*, a report by the New Hampshire Department of Health and Human Services.
- More than 1,300 African descendents and Latinos in Hillsborough County have participated in our education and prevention programs.
- We created the Community Health Advisory Board to advise our initiative on how best to serve African descendent and Latino populations.

Our Future

Our initiative will provide training and assistance to community leaders and residents who want to use the Change for Life/Cambia tu Vida and Let's Talk Diabetes/Hablemos de Diabetes programs in their communities. We also will work with state policy leaders to ensure that appropriate data are collected and analyzed to identify and address health disparities.

Getting the Word Out Locally

- "Discrimination Stops Immigrants From Seeking Care," *The Nashua Telegraph*, October 5, 2006.

- "Discrimination May Discourage Immigrants From Getting Health Care," *The Boston Globe*, October 4, 2006.
- "Study: Racism Affects Health of Minorities," *The Union Leader*, September 29, 2006.

Generating New and Exciting Science

- "Self-Reported Discrimination and Mental Health Status Among African Descendents, Mexican Americans, and Other Latinos in the New Hampshire REACH 2010 Initiative: The Added Dimension of Immigration." *American Journal of Public Health* 2006;96(10):1821–1828.
- "Change For Life/Cambia Tu Vida: A Health Promotion Program Based on the Stages of Change Model for African Descendent and Latino adults in New Hampshire." *Preventing Chronic Disease* [serial online] 2006;3(3). Available at http://www.cdc.gov/pcd/issues/2006/jul/05_0218.htm.
- "The Association Between Self-Reported Discrimination, Physical Health, and Blood Pressure: Findings from African Americans, Black Immigrants, and Latino Immigrants in New

Hampshire." *Journal of Health Care for the Poor and Underserved* 2006;17(2, suppl):116–132.

- "Change for Life! ¡Cambia Tu Vida! A Community-Based Intervention Addressing Behavioral Risk Factors for Diabetes and Hypertension." Presented at the Office of Minority Health National Leadership Summit on Eliminating Racial and Ethnic Disparities in Health, Washington, DC, January 2006.

Keys to Lasting Change in African Descendent and Latino Communities

The New Hampshire REACH 2010 Initiative helps African descendents and Latinos adopt healthy habits to reduce their risk for diabetes and high blood pressure. To achieve this goal, we use tailored home-based interventions for Latinos and faith-based interventions for African descendents.

Our programs and materials reflect the cultures and languages of the target communities, which is key to their effectiveness. We also have found that offering follow-up services, such as ongoing support groups, to program participants helps them sustain healthy habits over time.

REACH FOR MORE INFORMATION



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REACH

RACIAL AND ETHNIC APPROACHES TO COMMUNITY HEALTH

“When we had the workshop down at the Chapter House, mostly women attended. There were only about two men, but the women were going over to the stomach and prostate cancer awareness booth to get information. We need to try and get everyone in.”

—Tribal health care provider

REACHing American Indians in New Mexico and Colorado

Who We Are

The Albuquerque Area Indian Health Board, Inc., coordinates the Partners in Tribal Community Capacity Building (REACH 2010) Project.

- This project targets seven American Indian tribes whose members live on ancestral lands in New Mexico and southern Colorado. Together, these tribes include about 19,000 members.
- The project works to build community and scientific capacity to address the rising incidence of breast and cervical cancer among American Indian women.

The Problem

- Breast cancer is the second leading cause of death for American Indian women, with rates that equal those of all racial and ethnic groups in the United States combined.
- Rates of cervical cancer and cervical dysplasia are consistently high among American Indian women, but screening rates are very low.
- In 2003, only 5.5% of American Indian women aged 40 or older who are part

of the Ramah Band of Navajo Indians had received a mammogram, compared with 47% of all American Indian women in this age group.

- Overcoming these health disparities can be hard because of cultural beliefs about the causes of cancer and the belief that cancer cannot be cured. In the Navajo language, cancer is translated as “the sore that will not heal.”
- Other barriers include an overall lack of awareness of cancer risks and symptoms and a lack of access to transportation and screening services.

The Solution

- To address these problems, our project worked with a pilot community, the Ramah Band of Navajo Indians, to create partnerships between local tribal health

programs, tribal leaders, and nontribal groups. We also conducted focus groups to gather more information about community members’ knowledge and awareness of cancer and about their screening behaviors.

- To encourage more tribal women aged 40 or older living in the pilot community to get screened for breast cancer, we used a socioecological framework and community-based participatory research principles to design and implement an intervention called Mammography Days.
- For this intervention, project staff scheduled mammograms for tribal women at the nearest hospital, about 45 miles away. The project transported the women to the hospital in groups to create social support for the screenings. Staff also provided health information that reflected the women’s tribal culture and language.
- Tribal health care providers received training in public health topics, cancer-screening techniques, and surveillance methods to improve their patient care.

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Mobilizing Community Resources

Ramah Band of Navajo Indians; Alamo Band of Navajo Indians; Cañoncito (Tóhajiilee) Band of Navajo Indians; Jicarilla Apache Nation; Mescalero Apache Tribe; Southern Ute Indian Tribe; Ute Mountain Ute Tribe.

Our Achievements

- Project staff implemented a model called Community Involvement to Renew Commitment, Leadership, and Effectiveness (CIRCLE) to help develop public health capacity among the targeted tribes.
- Breast cancer awareness has increased significantly among tribal women since a case manager who specializes in breast health was hired in 2004.
- As part of the Mammography Days intervention, 130 women aged 40 or older have received a mammogram, some for the first time in their lives.
- In addition, the Albuquerque Area Indian Health Board produced a video called "Healthy Navajo Women: Walk in Beauty" that features health care providers and community members discussing breast and cervical cancer in English and Navajo. The video is shown as part of Mammography Days educational activities.

Our Future

REACH project staff are working to duplicate the successful Mammography Days intervention in other tribal communities. We also will continue to build the capacity of tribal and non-tribal health care providers to educate community members about cancer in a way that takes their native cultures and languages into account.

Generating New and Exciting Science

- "A Socioecological Approach to Improving Mammography Rates in a Tribal Community." *Health Education & Behavior* 2006. Published online November 17, 2006, at <http://heb.sagepub.com/pap.dtl>.
- "Building True Capacity: Indigenous Models for Indigenous Communities." *American Journal of Public Health* 2006;96(4):596–599.
- "Healthy Navajo Women: Walk in Beauty" [video]. *Preventing Chronic*

Disease [serial online] 2006;3(3).

Available at http://www.cdc.gov/pcd/issues/2006/jul/06_0052.htm.

- "Intermediate Outcomes of Tribal Community Public Health Infrastructure Assessment." *Ethnicity and Disease* 2004;14(3, suppl 1):61–69.

Keys to Lasting Change in the American Indian Community

The Partners in Tribal Community Capacity Building (REACH 2010) Project has shown that a community-driven intervention that is based on a capacity-building model and reflects the culture of the target population can improve mammography screening in a tribal community. We also found that this type of intervention will succeed if it includes a range of partners, such as tribal leaders, community members, the scientific community, and other relevant programs and community groups. In addition, the intervention should serve as a model for similar health initiatives in other tribal communities.

REACH FOR MORE INFORMATION



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REACH

RACIAL AND ETHNIC APPROACHES TO COMMUNITY HEALTH

“The promotora [lay health worker] did all the work for me. I was just lost. I didn’t know where I was going to get medical attention—help that I needed. She enrolled me in everything right away. I looked through the phone book myself, [but] if you don’t have insurance, you’re kind of lost. There was all the help I needed in one little building.”

—La Vida Program participant

REACHing Hispanics in Hidalgo and Grant Counties, New Mexico

Who We Are

Hidalgo Medical Services coordinates the La Vida Program.

- The La Vida (Lifestyles and Values Impact Diabetes Awareness) Program is a collaboration of community partners working in southwestern New Mexico.
- The program works to raise awareness about diabetes and lessen its negative effect on Hispanics living in Hidalgo and Grant counties in New Mexico.

The Problem

- Hidalgo Medical Services serves a geographically large and remote rural area that has a high percentage of Hispanics among its 35,000 residents. Many of these residents are poor, elderly, and have major health problems.
- In our service area, 1 in 5 people does not have health insurance, and 1 in 11 has diabetes.
- Diabetes is a serious health problem for Hispanics because of its growing prevalence and the high number of risk factors and complications among this population. The problem must be addressed as the number of Hispanics in the United States continues to grow.

The Solution

- The La Vida Program offers services aimed at Hispanics with or at risk for diabetes. These services include diabetes education classes, support groups, community outreach, and grocery store tours that include instructions on how to read food labels.
- The program also offers a restaurant intervention that teaches people how to make healthy eating choices and identify healthy options on menus.
- The program includes a physical fitness program called Active and Alive that is available at several local health clubs; it also offers classes, home visits, and one-on-one sessions with certified diabetes educators.
- Our holistic approach addresses the following nine dimensions of health:

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physical, emotional, spiritual, intellectual, social, cultural, occupational, material and financial, and environmental.

- Lay health workers, called promotoras in Spanish, provide support for program participants. Promotoras are members of the local culture and community, and most are bilingual.

Our Achievements

- The La Vida Program has been well-received in the Hispanic community, serving more than 13,000 clients during 2005–2006.
- After initial involvement in the La Vida Program, Hidalgo Medical Services patients had an average hemoglobin A1c level of 8.2, compared with the national average of 9.0 for Hispanics. (Levels ≥ 7 increase a person’s risk for diabetes complications.) After 9–12 months of involvement in the program, patients’ average A1c levels dropped to 7.6.
- Patients’ median A1c levels dropped significantly within 1 year of a promotora visit or education class.
- In a recent survey, nearly 74% of residents had heard of the La Vida education classes.



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CENTERS FOR DISEASE CONTROL AND PREVENTION





Mobilizing Community Resources

Hidalgo Medical Services
Gila Regional Medical Center
New Mexico Department of Health

Our Achievements, cont.

- The La Vida Program has been designated a best practice model by the federal Health Resources and Services Administration.
- Over the past several years, Hidalgo Medical Services has used funds from other sources to expand the La Vida Program into a more integrated program that provides family support services (including case management and referrals), a medication assistance program, smoking cessation classes, and nutrition programs.

Our Future

The La Vida Program will continue to provide services and develop new ones as needed. Because this program is considered a best practice model, we would like to introduce it to other federal health centers that serve low-income residents who are members of minority populations at higher risk for health disparities. Sharing our program will require seminars to teach others how to replicate our model and fund their own family support programs.

Getting the Word Out Locally

- "HMS to Celebrate National Health Center Week," *Hidalgo Herald*, August 4, 2006.
- "Hidalgo Medical Services Receives Award of Excellence from the New Mexico Primary Care Association," *Lordsburg Liberal*, June 30, 2006.
- "La Vida Approves 23 Menu Items for Diabetics at Bayard Restaurant," *Silver City Daily Press*, June 29, 2006.
- "Diabetes Seminar for Hispanic Women Scheduled on Saturday," *Silver City Daily Press*, February 1, 2006.

Generating New and Exciting Science

- "Model Clinical and Family Support Program in Southwestern New Mexico." Presented at the Annual Conference of the National Rural Health Association, Anchorage, Alaska, May 2007.
- "A Holistic, Integrated Diabetes Intervention Model in Hispanic, Rural Communities." Presented at the American Association of Diabetes Educators Annual Meeting, Los Angeles, California, August 11, 2006.

- "Developing a Holistic Family Support Program in a Rural Area." Presented at the National Conference of the Family Support of America, Chicago, Illinois, April 29, 2006.
- "Providing Holistic Family Support: Creating Systems Change." Presented at the Annual Conference of the New Mexico Public Health Association, Albuquerque, New Mexico, October 2005.

Keys to Lasting Change in Rural Hispanic Communities

We have learned that the best approach to helping people with diabetes is to view them first as people, not just "people with a disease," and to provide a holistic program that meets all their needs in an integrated way.

Our use of promotoras helped our clients relate to and learn from their peers. This approach was more successful—and got more people involved—than our previous efforts because it reflected the culture of local residents. We also attribute our success to our partnerships with other diabetes groups working in New Mexico.

REACH FOR MORE INFORMATION



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“People who attended our diabetes prevention support group say they look forward to the planned activities in the prevention program. I have seen a big difference in the people who are actively involved. They look healthier, and most have lost weight.”

—Diabetes prevention coordinator and registered nurse

REACHing American Indian Elders in New Mexico

Who We Are

The National Indian Council on Aging coordinates the Diabetes Educational Outreach Strategies (DEOS) Project.

- This project serves American Indian elders who live in New Mexico’s two American Indian reservations and four pueblos and are members of the following tribes: Pueblo of Cochiti, Ramah Navajo Band of Indians, Pueblo of Laguna, Mescalero Apache, To’ha-jilee Navajo Band of Indians, Pueblo of Isleta, and Pueblo of Santa Ana.
- The DEOS Project works to make American Indian elders aware of the importance of making healthy lifestyle choices to prevent or control diabetes. It also offers technical assistance to help mobilize communities to achieve this goal.

The Problem

- The prevalence of diabetes is 2–4 times higher among American Indians and Alaska Natives of all ages than it is among non-Hispanic whites. American Indians and Alaska Natives also have higher rates of diabetes complications

than all other racial or ethnic groups in the United States.

- The risk of developing diabetes increases with age. For example, in 2002, the prevalence of diagnosed diabetes among American Indian and Alaska Native adults aged 20–34 years was 3.1%, compared with 28.3% for those aged 65 or older.
- American Indians and Alaska Natives also report significantly higher rates of health risk factors, such as obesity, smoking, and lack of physical exercise, than other racial and ethnic groups in the United States.

The Solution

- A major research study conducted by the Diabetes Prevention Program found that healthy lifestyle changes

can reduce the risk of developing diabetes by 58% across all U.S. racial and ethnic groups.

- The DEOS Project offers technical assistance to build capacity for grass-roots educational programs to help American Indian and Alaska Native elders with diabetes better manage the disease.
- The DEOS Project provides training and guidance on how to assess community needs through focus groups, community surveys, and personal interviews.
- The project also helps communities build coalitions to address local health disparities and establish diabetes self-management support groups.

Our Achievements

- The DEOS Project trained community members at 10 reservations to begin and maintain diabetes support groups. Training materials were modified to fit the needs of each community.
- More than 66% of participants said the support groups helped them maintain their healthy eating and physical fitness goals.

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Mobilizing Community Resources

Bemidji Area: Mille Lacs Band of Chippewa Indians (Onamia, MN); St. Croix Band of Lake Superior Chippewa Indians (Webster, WI); Fond du Lac Band of Lake Superior Chippewa (Cloquet, MN).

Albuquerque Area: Pueblo of Cochiti (Cochiti Pueblo, NM); Ramah Navajo Band of Indians (Ramah-Pine Hill, NM); Pueblo of Laguna (Laguna, NM); Mescalero Apache (Mescalero, NM); Tohajiilee Navajo Band of Indians (To'hajiilee, NM); Pueblo of Isleta (Isleta, NM); Pueblo of Santa Ana (Santa Ana, NM).

Our Achievements, cont.

- The project also supported capacity building for outreach and fostered partnerships with community groups that share common goals.

Our Future

The National Indian Council on Aging (NICOA) will develop a road map to help project partners assess each community's level of readiness to address diabetes prevention. The stage of readiness will indicate to local leaders what approach they should take before they plan for capacity building. This road map can be used along with a community needs assessment tool to provide guidelines on how to evaluate diabetes interventions and ensure that they are improving the health of the target population. The DEOS Project also will create marketing materials that can be used by community groups to promote their activities and make residents aware of what services are available in their communities.

Getting the Word Out Locally

- "Eating Healthy on the Road," *Elder Visions*, the NICOA quarterly newsletter, Fall 2006.

- "Make the Link! Diabetes, Heart Disease and Stroke" (adapted from an American Diabetes Association initiative), *Elder Visions*, Fall 2006.
- "Confetti Salmon Cakes" (recipe), *Elder Visions*, Fall 2006.
- "What DEOS Can Do for You . . ." NICOA/DEOS Brochure, September 5, 2006.
- "Attitudes Weigh Heavy in Reducing Pounds," *Elder Visions*, Spring/Summer 2006.
- "Orange Almond Chicken" (recipe), *Elder Visions*, Spring/Summer 2006.
- "Planting Gardens at Elderly Centers to Address Diabetes," *Elder Visions*, Spring/Summer 2006.
- "What's in What We Eat?" *Elder Visions*, Winter 2005.
- "Support for a Healthy Change," *Elder Visions*, March 2005.

Generating New and Exciting Science

- "Creating the Vision for Change: A Two Front Approach to Diabetes Prevention for Our Native American Elders." Presented at the 23rd Annual Consumer Conference of the National Indian

Health Board, Denver, Colorado, October 10–13, 2006.

- "Community Gardening & Diabetes Prevention." Presented at the American Society on Aging Conference, Anaheim, California, March 2006.
- "Community Support for Diabetes Prevention and Treatment." Presented at the American Heart Association/American Stroke Association/Indian Health Service Conference, Denver, Colorado, May 2005.

Keys to Lasting Change for Native American Elders

We developed educational standards and used social marketing practices to create community support for healthy lifestyles among American Indian and Alaska Native elders. To improve diabetes education for this population, we must develop materials that appeal to elders and work with local diabetes educators to provide programs in their communities. Communication and cooperation with community service providers that represent and advocate for American Indian and Alaska Native elders also must be enhanced. In addition, we are working with appropriate agencies to maximize resources and increase the efficiency and effectiveness of service delivery systems.

REACH FOR MORE INFORMATION



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REACH

RACIAL AND ETHNIC APPROACHES TO COMMUNITY HEALTH

"The church is strategically situated to communicate health messages of importance and also to heighten the awareness of our friends and neighbors and constituents regarding the absence of fair and equitable delivery of health services to our communities. We must be foot soldiers for medical justice."

—Rev. Robert L. Foley, Sr., pastor, Cosmopolitan Church of the Lord Jesus

REACHing Blacks and Latinos in Bronx, New York

Who We Are

The Institute for Urban Family Health coordinates the Bronx Health REACH Coalition.

- This coalition develops and implements community-based health promotion programs focused on preventing diabetes and related conditions. It also mobilizes community leaders to make health equality a reality by addressing local and state health policies.
- We focus on black and Latino communities in the southwestern area of the Bronx, which include 280,000 people living in the following ZIP codes: 10452, 10453, 10456, and 10457.

The Problem

- In the South Bronx, where more than 95% of the population is black or Latino, 18% of residents have diabetes, 64% are overweight, and 24% are obese.
- The death rate for heart disease is 17% higher for people living in the Bronx compared with people living in New York state.

- Women in the South Bronx are 20 times more likely to die of diabetes than women living on the Upper East Side of Manhattan, a 10-minute subway ride away.

The Solution

- Research shows that improving nutrition, increasing physical activity, losing 5%–7% of body weight, and having better access to preventive care can prevent or delay the onset of diabetes or decrease the rate of poor outcomes.
- In response to these findings, the Bronx Health REACH Coalition has implemented several programs, including a faith-based outreach initiative, a nutrition and fitness initiative,

public health education programs, and community health advocacy programs.

- We also conducted a survey to identify community members living with or at risk for diabetes. This information helped us develop and tailor our programs.

Our Achievements

- The faith-based outreach initiative works with 22 churches to educate local residents and empower them to adopt healthy lifestyles. This initiative includes a program called Fine, Fit and Fabulous that helps people make positive and sustainable changes to their eating habits and activity levels.
- Local pastors include health messages in their weekly sermons, and many churches include health-related information in their weekly church bulletins.
- The nutrition and fitness initiative works to improve residents' access to healthy foods. New York City schools have switched from whole milk to low-fat milk, neighborhood grocers carry low-fat milk and healthier snacks, and local restaurants highlight their healthy menu options.

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Mobilizing Community Resources

Bronx District Public Health Office; New York City Department of Health and Mental Hygiene; 22 churches in the Faith-Based Outreach Network; Bronx Westchester Area Health Education Center; Center for Health and Public Service Research, New York University; Center for Medicare and Medicaid Services, New York Regional Office, Commission on the Public's Health System; Correction Community Linkage Program; New York City Department of Education, Region 1; City University of New York, Lehman College, Department of Health Services; Health People; Highbridge Community Life Center; Joyce Davis Associates; Leukemia & Lymphoma Society; Math Arts Recreation Center After School Program; Mid-Bronx Senior Citizens Council; Montefiore School Health Program; Mount Hope Housing Company; Neighborhood Self-Help for Older Persons; New York State Department of Health, Diabetes Prevention and Control Program; Healthy Hearts Program; Cornell University Cooperative Extension; New York Lawyers for the Public Interest; Partners in Health; U.S. Department of Justice, Office of Civil Rights, Region II; Women's Housing and Economic Development Corporation.

Our Achievements, cont.

- Our coalition produced a video called "Voices for Health Equality," and we developed a cultural competency training program for health care providers.
- We published *Separate and Unequal: Medical Apartheid in NYC*, a report that examines the policies and practices that contribute to differences in access to and quality of health care for members of different racial and ethnic groups.

Our Future

The Bronx Health REACH Coalition will expand its faith-based outreach initiative, continue to develop and support a public policy agenda to address obesity, and conduct a community food assessment. We also will promote a new medical reimbursement policy designed to offset some of the underlying causes for the separate and unequal health care system in New York City.

Getting the Word Out Locally

- "Eateries Go on a Trim Fling," *Daily News*, October 23, 2006.

- "In New York Schools, Whole Milk Is Cast from the Menu," *The New York Times*, February 2, 2006.
- "New York Pushing Better Diet in Poorer Neighborhoods," *The New York Times*, January 20, 2006.
- "Apartheid at Apple Hospitals," *New York Post*, October 16, 2005.
- "El Bronx en plan de comer saludable," *Hoy Nueva York*, October 24, 2006.

Generating New and Exciting Science

- "Fostering Organizational Change Through a Community-Based Initiative." *Health Promotion Practice* 2006;7(3, suppl):181S–190S.
- "Racial and Ethnic Disparities in Health: A View from the South Bronx." *Journal of Health Care for the Poor and Underserved* 2006;17(1):116–127.
- "The Role of Faith-Based Institutions in Addressing Health Disparities: A Case Study of an Initiative in the Southwest Bronx." *Journal of Health Care for the Poor and Underserved* 2006;17(2, suppl):9–19.

- "Separate and Unequal Care in New York City." *Journal of Health Care Law and Policy* 2006;9(1):105–120.
- "Making Health Equality a Reality: The Bronx Takes Action." *Health Affairs* 2005;24(2):491–498.

Keys to Lasting Change in Black and Latino Communities

To develop and implement model community programs in black and Latino communities, the Bronx Health REACH Coalition has designed, developed, and implemented interventions that reflect local cultures and have become part of the targeted communities.

We also have promoted policy changes that help to sustain improvements in community health. We developed a health policy agenda and mobilized community leaders to educate government officials about this agenda. Our coalition also has conducted research to identify the barriers to quality health care; disseminated our findings to public policy makers, regulators, legislators, and health care officials; and developed recommendations for improvement.

REACH FOR MORE INFORMATION



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REACH

RACIAL AND ETHNIC APPROACHES TO COMMUNITY HEALTH

"I learned how to inquire about the immunizations my baby should get. Now I know what shots the baby needs. This program helped me by giving me information on places to go for immunizations and also by 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."

—Parent enrolled in the Start Right program

REACHing Children and Families in Harlem and Washington Heights, New York

Who We Are

The Mailman School of Public Health of Columbia University coordinates the Northern Manhattan Start Right Coalition.

- This coalition serves the predominantly low-income communities of Harlem and Washington Heights/Inwood of Northern Manhattan in New York City. Of the nearly 462,000 residents in this area, 32% are African American and 52% are Latino.
- The coalition includes 17 community groups or agencies, two health care networks, the New York City health department, and Columbia University's Mailman School of Public Health.
- The coalition is working to improve low immunization rates among children living in Northern Manhattan. Our goal is to bring 10,000 children younger than age 3 up to date on all recommended childhood immunizations.

The Problem

- In 2000, childhood immunization rates in Northern Manhattan were 11% below the rates in other parts of New York City and 19% below national rates.

- Before the Start Right program began, fewer than half of children in the target communities were immunized on time.

The Solution

- Our coalition's strategy is to promote immunization through existing community programs that serve the needs of parents of young children. Examples include programs that offer parenting education or support, early childhood education, WIC services, and facilitated enrollment in the State Children's Health Insurance Program.
- We developed a five-part training program for community health workers that integrates community health worker materials, immunization

materials, health education strategies, evaluation activities, and record-keeping activities.

- Of the 902 community health workers we trained through the Start Right program, 577 completed the entire series and 261 are actively promoting immunizations as part of their regular program activities.

Our Achievements

- Start Right community health workers have talked with more than 10,000 families about the importance of children being up to date on all immunizations. By September 2006, we had enrolled 9,560 children.
- We increased the immunization rate to 76% for children of all ages enrolled in our program during 2002–2006, with 86.5% of children up to date by age 3.
- We have closed the immunization disparity gap in Northern Manhattan. Latino and African American children enrolled in the Start Right program no longer lag behind the city and nation in their immunization rates. In fact, the rate for children aged 19–35 months now exceeds the national average.

Racial and Ethnic Approaches to Community Health (REACH) is a community-based public health program funded by CDC to eliminate racial and ethnic health disparities.

www.cdc.gov/reach



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CENTERS FOR DISEASE CONTROL AND PREVENTION





Mobilizing Community Resources

Arthur Eugene & Thelma Adair Community Life Centers; Alianza Dominicana, Inc.; CHILD Head Start, Inc., Riverside Center; Dominican Women's Development Center; Ecumenical Community Development Organization; Ft. George Community Enrichment Center; Harlem Children's Zone (The Baby College); Harlem Congregations for Community Improvement; Harlem Hospital WIC Program; Mailman School of Public Health, Columbia University; Northern Manhattan Improvement Corp.; Northern Manhattan Perinatal Partnership, Inc.; Puerto Rican Family Institute/Vacunas Para la Familia; Washington Heights/Inwood Early Childhood Education Coalition; New York Presbyterian Hospital Department of Pediatrics; Northern Manhattan Community Voices Collaborative; New York City Department of Health and Mental Hygiene, Bureau of Immunizations.

Our Future

The Northern Manhattan Start Right Coalition will continue to expand its efforts and to work with other groups throughout our communities. To make our training program available nationwide, we are working with community health worker networks to put our materials on the Internet.

Getting the Word Out Locally

- "Bank of America Supports Local Community Organization," *El Diario*, February 14, 2006.
- "The Start Right Coalition Increases Childhood Immunization in Northern Manhattan," *Manhattan Times*, December 9, 2004.
- Starting Right: A Community-Based Community Health Worker Training Program. Developed by the Northern Manhattan Start Right Coalition, the Mailman School of Public Health of Columbia University,

and the Community Health Worker Institute of Alianza Dominicana, Inc.

Generating New and Exciting Science

- "Community-Based Strategies to Reduce Childhood Immunization Disparities." *Health Promotion Practice* 2006;7(3, suppl):191S–200S.
- "The Impact of Community Health Worker Training and Programs in New York City." *Journal of Health Care for the Poor and Underserved* 2006;17(1): S24–S43.
- "Community Empowerment to Reduce Childhood Immunization Disparities in New York City." *Ethnicity & Disease* 2004;14(3, suppl 1):134–141.
- "Community-Provider Partnerships to Reduce Immunization Disparities: Field Report from Northern Manhattan." *American Journal of Public Health* 2003;93(7):1041–1044.

Keys to Lasting Change in African American and Latino Communities

To sustain lasting change in the immunization rates of children in Northern Manhattan, our coalition has learned that a program must have community leaders, peer health educators, integration with community social service programs, and linkage with community health care providers. Our program has relied on proven strategies, including setting up reminder and tracking systems and providing positive feedback to community groups and parents.

We also learned that parents must be empowered as active partners so they will help promote the importance of immunizations beyond the doctor's office and into the community. In addition, we found that integrating immunization promotion activities into ongoing programs (e.g., WIC, Head Start) is an effective approach.

REACH FOR MORE INFORMATION



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REACH

RACIAL AND ETHNIC APPROACHES TO COMMUNITY HEALTH

"Since I took the nutrition class, I've changed my eating habits. The nutritionist showed us what a portion looked like. It was hard at first. I also learned that eating in the morning is important, even if it's nothing but a little bit. I stopped eating all fried foods, and I've gotten away from eating fast food. I've lost 77 pounds."

—Neighborhood resident

REACHing African Americans in Charlotte, North Carolina

Who We Are

The Carolinas HealthCare System coordinates the Charlotte REACH 2010 Coalition.

- The coalition is made up of several community and health care groups who are working together to reduce the incidence of heart disease and diabetes among African Americans living in the Northwest Area of Charlotte, North Carolina (ZIP codes 28208 and 28216).
- According to the 2000 U.S. Census, 89% of residents in the Northwest Area are African American.

The Problem

- The average death rate for heart disease among residents of Charlotte's Northwest Area is nearly 40% higher than the rate for the rest of Mecklenburg County.
- The average death rate for stroke in the Northwest Area is nearly twice the rate for the rest of Mecklenburg County.
- In 2000, 10% of Northwest Area residents had diabetes, compared with

7% of all North Carolinians and 9% of African Americans in North Carolina.

- Also in 2000, 35% of Northwest Area residents had high blood pressure, compared with 23% of all North Carolinians and 26% of African Americans in North Carolina.

The Solution

- The Charlotte REACH 2010 Coalition has implemented interventions that focus on the primary prevention of heart disease and diabetes. These interventions focus on physical activity, nutrition, smoking cessation, tobacco use prevention, and systems and environmental changes. We also evaluate our interventions to ensure their effectiveness.
- The foundation of our efforts is the use of trained lay health advisors who

are recruited from local communities affected by health disparities.

- Our outreach and education programs help community members change unhealthy behaviors and increase activities that can reduce disease risk, such as being more physically active, eating a healthy diet, and quitting smoking.

Our Achievements

- In 2001, a neighborhood farmers' market was opened to provide Northwest Area residents with greater access to fresh fruits and vegetables. The market is open every Saturday (except during winter) and averages about 350 customers a week. It is managed by a neighborhood group and provides space for local vendors to sell their produce.
- Since the market opened, 73% of residents said they are eating more fresh fruits and vegetables each day. In addition, 72% said they are being more physically active, and 67% said they have reduced the amount of fat in their diet.

Racial and Ethnic Approaches to Community Health (REACH) is a community-based public health program funded by CDC to eliminate racial and ethnic health disparities.

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





Mobilizing Community Resources

Carolinas HealthCare System; University Park Neighborhood Association; North Carolina Department of Health and Human Services; Mecklenburg County Health Department; McCrorey Family YMCA; Substance Abuse Prevention Services, Inc.; University of North Carolina at Charlotte.

Our Achievements, cont.

- Through a partnership with the Greater Charlotte YMCA (McCrorey Branch), exercise classes are provided free at community recreational centers and the local YMCA branch.

Our Future

The Charlotte REACH 2010 Coalition will continue to bring together more community partners to help reduce racial and ethnic health disparities among North Carolina residents. Our current efforts, including the lay health advisors, the neighborhood farmers' market, and the YMCA partnership, have all been well-received by the community. These interventions will continue to be a part of our efforts to promote healthy lifestyles in North Carolina.

Getting the Word Out Locally

- "No Butts About It," *Pride Magazine*, Summer 2004.

- "A Fighting Chance," *Pride Magazine*, Summer 2003.
- "Making a Difference in Diabetes: Working to Control Your Diabetes for Life," *The Charlotte Observer*, May 29, 2003.
- "Seasonal Solution Gathers Momentum," *The Charlotte Observer*, February 10, 2003.

Generating New and Exciting Science

- "A Lay Health Advisor Program to Promote Community Capacity and Change Among Change Agents." *Health Promotion Practice*. Published online November 14, 2006, at <http://heb.sagepub.com/pap.dtl>.
- "A Qualitative Assessment of Charlotte REACH: An Ecological Perspective for Decreasing CVD and Diabetes Among African Americans." *Ethnicity & Disease* 2004;14(3, suppl 1):77-82.

- "A Community-Oriented Primary Care Demonstration Project: Refining Intervention for Cardiovascular Disease and Diabetes." *Annals of Family Medicine* 2004;2(2):103-109.

Keys to Lasting Change in the African American Community

The success and effectiveness in promoting primary prevention of heart disease and diabetes in this African American community is directly related to the commitment and dedication of the members of the Charlotte REACH 2010 Coalition. The purpose of the coalition is to provide direction and to monitor our progress. Members include grassroots groups and representatives from health and human service agencies. Without these collaborations, the work of each group would be less effective.

REACH FOR MORE INFORMATION



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REACH

RACIAL AND ETHNIC APPROACHES TO COMMUNITY HEALTH

"At Cherokee Elementary, I've noticed that since we've had Cherokee Choices in our school, the students are much more aware of the necessity of physical exercise and eating healthy foods. When they come to the library, they're looking for materials on cooking and about their bodies and maturing. We see them out walking on our track, and they're trying to be healthier overall."

—Cherokee Elementary School teacher

REACHing Eastern Band of Cherokee Indians in Cherokee, North Carolina

Who We Are

The Eastern Band of Cherokee Indians coordinates the Cherokee Choices/REACH 2010 Diabetes Prevention Program.

- Cherokee Choices includes three components: mentoring for elementary school students, work site wellness programs for adults, and health promotion activities at local churches. It is administered by the Health and Medical Division of the Eastern Band of Cherokee Indians.
- The cornerstones of this program are listening to the community and providing social support to increase physical activity and promote well-being and healthy choices, which can reduce the risk for obesity and diabetes.

The Problem

- Cherokee men and women are twice as likely to be obese as members of other racial and ethnic groups in North Carolina.
- The prevalence rate of type 2 diabetes among Cherokee men and women

combined is 23.8%. This rate is more than three times the combined rate for men and women from all other racial and ethnic groups in North Carolina.

The Solution

- Cherokee Choices works to mobilize the community to confront environmental and biological factors that put Cherokee people at higher risk for diabetes. Our efforts include addressing issues related to racism and mental health; creating a supportive environment for community participation; and developing policies for schools, work sites, and churches that promote positive health changes.
- Mentors work with elementary school children and staff to develop lesson plans on self-esteem, cultural pride, conflict resolution, emotional well-being,

and health knowledge. These mentors also developed a weekly after-school program to enhance teamwork, cultural awareness, and physical health.

- Nutritionists, dietitians, and fitness workers help tribal members participate in activities at their churches and work sites that are designed to help them reduce stress, eat healthier foods, and increase their physical activity levels.

Our Achievements

- Cherokee Choices has changed the culture of local schools, allowing policy changes that support physical activity programs for students and staff.
- To promote healthy eating, the Cherokee Central School System Board reduced the amount of saturated fat allowed in school meals.
- A significant increase in healthy eating and physical activity has been reported in Cherokee schools and at participating work sites; 96% of school participants said they know how to make healthier food choices.

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Mobilizing Community Resources

Cherokee Central School System; Cherokee Hospital; Cherokee Diabetes Clinic; Community Club Council; Cherokee Human Resources; Healthy Cherokee; Cherokee Central School System Board; United Methodist Church; Latter Day Saints; Cherokee Tribal Planning Office; multiple Cherokee work sites.

Our Achievements, cont.

- Some program participants have been able to decrease or eliminate their use of medications for diabetes and high blood pressure.
- We produced a documentary called "Generations of Wellness," which provides positive stories and role models for the community.
- Five area churches and 170 church members are involved in the Walk to Jerusalem project, where participants try to walk the equivalent distance between Cherokee and Jerusalem. Participants have collectively walked more than 31,600 miles in 6 months. Progress is tracked on a map at each church, and celebrations are held periodically to keep people motivated.

Our Future

The Cherokee Choices/REACH 2010 Diabetes Prevention Program hopes to expand to incorporate more schools, work sites, and churches. We will share our knowledge and promote development of similar programs in surrounding counties.

We will seek funding to create a more walkable community with greenways and sidewalks. As our program grows, we will try to show the link between our program and health care costs paid by the tribe, to illustrate the value of investing in prevention.

Getting the Word Out Locally

- "Students Lend a Leg to Fight Diabetes Among Cherokee," *Asheville Citizens-Times*, February 26, 2004.
- "Living With Diabetes," published monthly in *Cherokee One Feather*, the weekly newspaper of the Tribal Council of Eastern Band of Cherokee Indians.
- Three 30-second television ads shown throughout western North Carolina, 2005–2006.

Generating New and Exciting Science

- "Cherokee Choices: A Diabetes Prevention Program for American Indians." *Preventing Chronic Disease* [serial online] 2006;3(3). Available at http://www.cdc.gov/pcd/issues/2006/jul/05_0221.htm.

Keys to Lasting Change in the Cherokee Community

Our program's community-based participatory approach has prompted strong community involvement and earned respect from community members. This approach makes Cherokee Choices different from the top-down programs typically provided by social service agencies in Cherokee communities. As a result, community members have expressed interest in using the same techniques to deal with other local health issues.

Now that community members have seen positive changes in their children and their co-workers, they are learning that a diabetes diagnosis is not inevitable. The philosophy that underlies the Cherokee Choices program is that conducting multiple activities at the same time can bring about community and system changes.

REACH FOR MORE INFORMATION



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REACH

RACIAL AND ETHNIC APPROACHES TO COMMUNITY HEALTH

"If it was not for my involvement with the coalition, I would have never been able to talk about HIV. Now I can talk with my family about the risk factors associated with HIV and prevention. As a result of the knowledge of HIV that I gained through the coalition, I am now in a leadership program for the prevention of hepatitis C."

—OKRAICB coalition member

REACHing American Indians in Oklahoma

Who We Are

The Association of American Indian Physicians coordinates the Oklahoma REACH HIV/AIDS American Indian Capacity Building (OKRAICB) program.

- The OKRAICB program has established community coalitions in three Oklahoma regions. Partners in these coalitions include community groups that serve American Indians, county health care providers, federal health care providers, and tribal health care systems.
- The OKRAICB program promotes awareness about HIV and AIDS among American Indians.
- The program also helps tribes address issues related to HIV and AIDS by helping them develop interventions that reflect the culture of tribal communities.

The Problem

- American Indians are infected with HIV and AIDS at a rate of 11.7 per 100,000 people, which is nearly 1.5 times the rate for whites (7.9).
- HIV infection often goes unnoticed in American Indian communities that

already face other severe and more visible health and social problems, such as alcoholism, diabetes, and high unemployment.

- As a group, American Indians often have high levels of risk factors that allow the easy spread of HIV, including high rates of sexually transmitted infections and illegal drug use.

The Solution

- By working with and supporting other community groups and by targeting young people, the OKRAICB coalitions have been able to raise awareness about and interest in dealing with the problem of HIV infection in American Indian communities. These efforts have helped overcome the stigma of the disease.

Racial and Ethnic Approaches to Community Health (REACH) is a community-based public health program funded by CDC to eliminate racial and ethnic health disparities.

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- By developing interventions that reflect the culture of tribal communities, coalition members have helped change attitudes and beliefs about HIV and AIDS among community leaders.
- Coalitions have hosted several community events to raise awareness about HIV and AIDS, including a concert and powwow called BUH: Battling Stigma to Unite Indian Youth Against HIV/AIDS.
- The OKRAICB program also teaches coalition members about behavioral theories and how to create community interventions; holds monthly planning meetings in each community; and provides quarterly training sessions to teach coalition members how to conduct Internet research, write grants, and create PowerPoint presentations.

Our Achievements

- In 2006, more than 1,000 community members attended community-based activities sponsored by the coalitions.
- Coalitions have gained the support of tribal members within the communities.



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CENTERS FOR DISEASE CONTROL AND PREVENTION





Mobilizing Community Resources

The OKRAICB program includes three coalitions—the Oklahoma Native Nations United Against AIDS Coalition, the Pani HOPE Coalition, and the HEART Coalition. The partners in each coalition are listed below.

Our Achievements, cont.

- In 2006, 100 American Indian mothers brought their daughters to a community training session that addressed basic facts about HIV and AIDS.
- Coalitions have gained the support of the public school systems and tribal boarding schools in their regions.

Our Future

The OKRAICB program will continue to support the efforts of the community coalitions. We also will continue to develop the skills of community leaders to help them prevent HIV and AIDS in their communities.

Mobilizing Community Resources

Oklahoma Native Nations United Against AIDS Coalition: Comanche Nation Substance Abuse Program; Ft. Sill Apache Emergency Youth Shelter; Anadarko Public Schools Indian Education Program; Riverside Indian School; Caddo County Department of Human Health Services; Wichita & Affiliated Tribes Juvenile Services Program; Wichita Tribal Youth Program; Apache Tribe Caregiver Program; Apache Tribe Title VI AOA Program;

Kiowa Tribe Substance Abuse Program; Anadarko Indian Health Center; Consortium Against Substance Abuse; Comanche Nation New Pathways; Lawton Indian Hospital; Kiowa Tribe Injury and Prevention Program; Kiowa Workforce Investment Act Program.

Pani HOPE Coalition: Kaw Nation of Oklahoma/Kanza Health Center; Pawnee Nation Tax Commission; Pawnee Indian Health Center; Pawnee Gaming Commission; Hunter Health Clinic; Pawnee Nation Tribal Council; Pawnee Nation Diabetes Program; Pawnee Public Schools Indian Education Program; Pawnee Nation Health Education Program; Pawnee Nation Title VI Elderly Meals Program; White Eagle Indian Health Center; Pawnee County CASA; Pawnee Nation Housing Authority; Pawnee Nation Fire Department.

HEART Coalition: Cherokee Nation Behavioral Health Services; Northeastern Tribal Health Center; Cherokee Nation Community Health Nursing; Claremore Indian Hospital; Planned Parenthood of Arkansas and Eastern Oklahoma; Sam

Hider Jay Community Clinic; Tulsa Indian Health Care Resource Center; Inter-Tribal Substance Abuse & Treatment Center; Freeman Health System.

Getting the Word Out Locally

- "Group Tells Indians About AIDS," *Tulsa World*, May 22, 2006.

Keys to Lasting Change in the American Indian Community

Partners in the OKRAICB program have learned many important lessons that have helped to sustain real change in the American Indian community. For example, we learned that it takes at least 12 months to develop a community-driven prevention program. We also learned that, for community-based and community-driven interventions to work, staff members must gain the respect of the community and create interventions that reflect local cultures. In addition, community interventions must meet the specific needs of each community to be successful.

REACH FOR MORE INFORMATION



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“Outstanding program. Thank you for making such a wonderful program available for our students. Programs like this are greatly needed. Thank you for caring about the future of our youth.”

—Sixth-grade teacher in Talihina, Oklahoma

REACHing American Indians in the Choctaw Nation of Oklahoma

Who We Are

The Choctaw Nation of Oklahoma coordinates the Choctaw Nation Core Capacity Building Program.

- This program works to identify the burden of heart disease among American Indians living within the Choctaw Nation of Oklahoma boundaries. It also assesses current prevention efforts and works to implement better strategies to prevent and control disease among this population.
- More than 80,000 American Indians live inside the Choctaw Nation of Oklahoma boundaries. More than 395,000 American Indians live in the state of Oklahoma.

The Problem

- Prevalence rates for heart disease and many of its risk factors are high among American Indians/Alaska Natives in the United States. For example, the rate for heart disease is 5.2%, the rate for high blood pressure is 24.4%, and the rate for high cholesterol is 31.6%.
- Heart disease is the leading cause of death for American Indians living in Oklahoma.

- Substance abuse, especially of methamphetamines, is affecting more and more Choctaw Nation of Oklahoma communities. Research has shown that substance abuse can have a devastating effect on heart health.

The Solution

- The Choctaw Nation Core Capacity Building Program has successfully worked with its partners to create 12 community coalitions within the 11 counties of the Choctaw Nation of Oklahoma. These coalitions are raising awareness about heart disease prevention, improving access to care, and assessing the health needs of each community.
- This program also has developed an innovative educational program that works to increase awareness about heart

disease prevention and to address the identified needs of each community.

- When several Choctaw communities said they needed educational programs on substance abuse, we created a slide presentation that describes the effects of certain drugs on a person’s heart. We have shown this presentation at a variety of community events, and we put it on our Web site. We also provide copies to anyone who wants to share this presentation with other groups.
- We found that children, particularly those in kindergarten and Head Start programs, were the most receptive to our presentation. Many students said they wanted to keep their hearts healthy, and that they would never use drugs because they did not want their hearts to stop beating.

Our Achievements

- We have presented our educational program at 17 national conferences and 116 state events.
- We have made 92 presentations at 45 schools, educating students and staff about heart disease prevention and the devastating effects of substance abuse on heart health.

Racial and Ethnic Approaches to Community Health (REACH) is a community-based public health program funded by CDC to eliminate racial and ethnic health disparities.

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Mobilizing Community Resources

Choctaw County Coalition; Atoka/Coal County Partnership for Change; Community Chest; Pushmataha County Turning Point; A Better Clayton Coalition; McCurtain County Coalition for Change; Haskell County Coalition; Inter-Service Agency Organization; Local Service Coalition; Bryan County Community Services Council; Living in Latimer Coalition; Parents Against Substance Abuse.

Our Achievements, cont.

- As a result of our partnerships with local community and public health groups, the Choctaw Nation Recovery Center added questions about heart health to its patient intake forms and follow-up interviews.
- We also partnered with Colorado State University's Tri-Ethnic Center to create a survey to assess communities' readiness to address the health issues identified in needs assessment surveys.
- We partnered with the Oklahoma State Department of Health to link the state's death certificate database with the Indian Health Service Patient Registration database. This linkage will help to correct the problem of American Indians being misclassified as members of other races on their death certificates (which happens about one-third of the time).

Our Future

The Choctaw Nation Core Capacity Building Program will continue to raise awareness about heart disease prevention by sharing our community capacity plan locally and nationally

with other tribes, school systems, and coalitions, as well as at public events. We also plan to work with partners such as Colorado State University's Center for Applied Studies in American Ethnicity to integrate heart disease prevention into college curriculums.

Getting the Word Out Locally

- "Choctaw Nation Shares Link Between Substance Abuse and Heart Disease," *American Indian Horizons*, Fall 2006.
- "The Choctaw Nation Preventive Health Core Capacity Program," *Bishinik*, the official publication of the Choctaw Nation of Oklahoma, July 2006.
- "Choctaw Nation and Pekin Woman Partner to Show Effects of Substance Abuse," *Bishinik*, September 2005.
- "Choctaws Get Help from Pekin Woman," *Pekin Daily Times*, June 3, 2005.

Generating New and Exciting Science

- "Cardiovascular Risk Factors and Use of Medical Advice in Native Americans." *Journal of Health Care for the Poor and Underserved* 2007 (in press).

Keys to Lasting Change in the American Indian Community

We have found that programs are more effective if they first assess the needs of individual communities, and then respond to those needs with tailored interventions. This approach works better than using a preconceived curriculum, and it has greatly increased community participation in our program.

For example, we have been able to reach many more people with our message about the effects of substance abuse on heart health because substance abuse was identified as a major concern in Choctaw communities. In addition, many school administrators have asked us to bring our educational program to their schools to address the health of young children, teach them about heart disease prevention, and deter them from drug use. These children might not have been as receptive to learning about heart health in a traditional way, but they are very interested in our program when we make these connections.

REACH FOR MORE INFORMATION



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REACH

RACIAL AND ETHNIC APPROACHES TO COMMUNITY HEALTH

"This program has been instrumental in causing a major lifestyle change for me. I use the fitness centers 3–5 days a week, and I teach fitness classes. I walk my dog and do yoga every day. Before, in addition to being overweight, I was sedentary, had high blood pressure and high cholesterol, and I smoked. I had all the risk factors for diabetes and heart disease. I have lost 86 pounds and 24 inches since I started working with the REACH project."

—Assistant program manager, Wichita and Affiliated Tribes' REACH 2010 program

REACHing Native Americans in Oklahoma

Who We Are

The Oklahoma State Department of Health coordinates the Oklahoma Native American REACH 2010 Project.

- This project includes a coalition of representatives from eight Native American tribes or nations, one urban Indian health center, and the Chronic Disease Service of the Oklahoma State Department of Health.
- The main goal of this project is to reduce disparities in heart disease and diabetes among Native Americans in nine communities through primary and secondary prevention efforts.

The Problem

- The age-adjusted death rate for diabetes among Native Americans in Oklahoma is nearly 200% higher than the rate for whites.
- The prevalence rate for diabetes among Oklahoma adults is 13.1% for Native Americans, compared with 7.0% for whites. The prevalence rate for obesity is 31.6%, compared with 22.2% for whites.

The Solution

- To help reduce racial disparities in diabetes, heart disease, and their risk factors in Oklahoma, our coalition is working to promote physical activity and make it more available at the community level.
- Our project has implemented physical fitness and wellness interventions, trained physical fitness specialists (or equivalents), and supported policy and environmental changes in our nine REACH communities.
- For our interventions, we collected baseline and follow-up measurements, such as body mass index, waist-to-hip ratios, and body fat percentages, from participants to help track their progress.

Racial and Ethnic Approaches to Community Health (REACH) is a community-based public health program funded by CDC to eliminate racial and ethnic health disparities.

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- We also educated participants about the importance of physical activity and good nutrition to their health.

Our Achievements

- More than 5,000 participants are enrolled in the Oklahoma Native American REACH 2010 Project.
- Trained and certified staff members in the nine REACH communities have collectively implemented more than 75 physical activities each week.
- More than 75 tribal staff and community members have been trained in fitness and health promotion.
- Partners in all nine communities have developed employee fitness/wellness programs and implemented secondary prevention programs related to good nutrition, smoking cessation, and obesity.
- All partners have made environmental changes such as policies that control or prevent tobacco use, promote employee fitness, and encourage healthy eating.
- We have developed new partnerships with community health representatives, tribal fitness facilities, schools, local colleges and universities, and Indian Health Service/ Tribal Health Service diabetes prevention and heart disease programs.



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CENTERS FOR DISEASE CONTROL AND PREVENTION





Mobilizing Community Resources

Absentee Shawnee Tribe of Oklahoma; Cherokee Nation; Cheyenne-Arapaho Tribes of Oklahoma; Chickasaw Nation; Choctaw Nation of Oklahoma; Indian Health Care Resource Center of Tulsa; Oklahoma State Department of Health; Pawnee Nation of Oklahoma; Seminole Nation of Oklahoma; Wichita and Affiliated Tribes.

Our Achievements, cont.

- Our community partners have received more than \$2 million in funding from other sources to expand and enhance their programs.
- We have shared information about our project through 34 national presentations, two international presentations, three peer-reviewed articles, one book chapter, and two reports.

Our Future

The Oklahoma Native American REACH 2010 Project will continue to work to sustain its programs, institutionalize its activities, and share information and lessons learned with other Native American communities.

Getting the Word Out Locally

- "REACH 2010 Leading the Way," *Bishinik*, the official publication of the Choctaw Nation of Oklahoma, January 2006.
- "Absentee Shawnee Basketball Challenge," *The Absentee Shawnee News*, January 2006.
- "Healthy Choices Available in Vending Machines," *Cherokee Phoenix*, September 2005.

- "REACH 2010 5-K Run at Bigfoot Festival," *Talihina American*, 2005.
- "REACH Activities," *Watonga Republican*, December 2004.
- "REACH Success Stories from Our Communities," a DVD that highlights projects in Oklahoma and other states.

Generating New and Exciting Science

- "Behavioral Risk Factors, Chronic Diseases, Health Care Access and Health Status of Rural American Indian Women in Oklahoma." In: *Rural Women's Health: Linking Mental, Behavioral, and Physical Health*. New York: Springer Publishing; 2006.
- "From Risky Behaviors to Chronic Outcomes: Current Status and *Healthy People 2010* Goals for American Indians in Oklahoma." *Journal of the Oklahoma State Medical Association* 2003;96(12): 569-574.
- "Prevalence of Current Smoking Among American Indians in Oklahoma: A Comparison." *Journal of the Oklahoma State Medical Association* 2002;95(3):155-158.

Keys to Lasting Change in the Native American Community

State, federal, and tribal governments can work together to accomplish a common goal. Respect and trust are key components to working successfully with Native American tribes to build a foundation that ensures long-term partnerships and collaboration. For our project, collaboration with other programs, departments, and professionals within tribes has been essential.

Personal relationships with intervention participants also are important. Monthly logs are an effective way to motivate participants because they show improvements over time. Parents must be taught good nutrition concepts while their children are infants. Parents also should be educated about the importance of increasing physical activity and limiting the amount of time their children spend in front of the TV or computer. To make our project even more successful, we need more resources for collecting data and conducting evaluations.

REACH FOR MORE INFORMATION



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REACH

RACIAL AND ETHNIC APPROACHES TO COMMUNITY HEALTH

"The coalition's work and dedication over the past 10 years have brought exercise and health consciousness to the African American community. This is no doubt helping families to reclaim their health, prolong their lives, strengthen their social networks, and increase their quality of life."

—Tricia Tillman, REACH participant

REACHing African Americans in Portland, Oregon

Who We Are

The African American Health Coalition, Inc., coordinates the REACH program in Portland, Oregon.

- The coalition's mission is to promote and improve the health of African Americans living in Oregon through education, advocacy, and research, with a focus on heart disease.
- The African American population in Oregon is less than 2% of the total population, making us an isolated community within an isolated population.
- Our vision is to make the African American community in Portland the healthiest in the nation.

The Problem

- Heart disease is the leading cause of death in Oregon, accounting for 34.8% of all deaths in 2002.
- In 2001, the death rate for heart disease among African Americans in Oregon was 254 per 100,000, compared with 194 for whites,

97.3 for Asians and Pacific Islanders, and 63.5 for Hispanics.

- The death rate for stroke among African Americans living in Oregon was 88% higher than the rate for whites in 2001.

The Solution

- To address these health disparities, our coalition has designed and implemented four major programs and three annual events to increase knowledge and change attitudes and behaviors related to heart disease and its risk factors, including diabetes, poor nutrition, obesity, and inactivity.
- We are working to build capacity at the community level by developing programs that reflect the culture of

local populations. These programs train community health workers to help African Americans in Oregon make and sustain healthy lifestyle choices.

- Our holistic approach includes a hands-on nutrition program called Spice It Up, which teaches people how to cook healthy foods on a budget. Nutrition seminars are held in partnership with the Oregon Food Bank and a local health food store.

Our Achievements

- The Lookin' Tight, Livin' Right intervention trained 11 beauty and barber shop operators as lay health educators to talk with their clients about heart disease and its risk factors. Participants have enrolled more than 480 clients each year and conducted more than 3,500 "health chats."
- In 2005, 47 African American high school students participated in the Healthy Options Living Longer Actively (HOLLA) program. Through this program, students gave 164 presentations on heart disease and its risk factors to 1,086 of their peers and family members.

Racial and Ethnic Approaches to Community Health (REACH) is a community-based public health program funded by CDC to eliminate racial and ethnic health disparities.

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Mobilizing Community Resources

AmeriCorps*VISTA; Eli Lilly; Northwest Health Foundation; City of Portland Parks and Recreation; Oregon Health Division; New Seasons Market; Multnomah County Health Department; American Heart Association; Oregon Food Bank; Portland State Regional Research Institute; Center for Health Disparities Research; Urban League of Portland; Albina Community Bank; Black United Fund; Trimet; four major health care systems; Office of Mayor Tom Potter; many other organizations.

Our Achievements, cont.

- During 2002–2006, more than 4,700 community members participated in a free physical activity program called the Wellness Within REACH, which provides access to a variety of culturally appropriate exercise classes. As a result, 58% of participants say they are exercising more.
- Our coalition holds an annual health fair, called the Wellness Village, that offers free health screenings and information to residents in a way that reflects their local culture. When we evaluated these events, 50% of respondents said the Wellness Village is the only place they get health screenings.
- In 2006, more than 4,200 people participated in our programs.
- Our coalition received the 2006 Spirit of Portland Award for Non-Profit Organization of the Year. This award recognizes outstanding contributions to the community.

Our Future

The African American Health Coalition will continue to build community capacity and sustain our current efforts to reduce health disparities among African Americans in Oregon. We will continue to educate our policy makers, expand our existing key partnerships, and implement a strategic development plan to sustain our programs into the future.

Getting the Word Out Locally

- "Take It Off, Keep It Off," *The Oregonian*, February 26, 2006.
- "Leaders Fight Racial Health Disparities," *The Portland Observer*, October 26, 2005.
- "'Blessed' Patient Bolstered by Black Sisterhood," *The Oregonian*, September 11, 2005.
- "Teaming Up for Healthy Hearts," *The Oregonian*, September 7, 2005.
- "Coalition Shines Light on Community Health," *The Portland Observer*, September 10, 2003.
- "The Way to a Healthy Heart? Through the Hairdo," *The Oregonian*, April 10, 2002.

Generating New and Exciting Science

- "The African American Wellness Village in Portland, Oregon." *Preventing Chronic Disease* [serial online] 2006;3(3). Available at http://www.cdc.gov/pcd/issues/2006/jul/05_0211.htm.
- "Wellness Within REACH: Mind, Body, and Soul: A No-Cost Physical Activity Program for African Americans in Portland, Oregon, to Combat Cardiovascular Disease." *Ethnicity & Disease* 2004;14 (3, suppl 1):93–101.

Keys to Lasting Change in the African American Community

According to community members, REACH is a "movement" that has changed the African American community's behaviors related to health, physical activity, and nutrition. Our REACH participants are active in all areas of our coalition, and they educate local policy makers about the effect this program has had on their lives.

Our programs have been so successful that the City of Portland has partnered with us to ensure affordable access to physical activity for all REACH participants.

REACH FOR MORE INFORMATION



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“Many of the participants have invited others to come to the [diabetes self-management] class. They are taking their [patient report cards] with them to see the doctor, and they are asking questions. The doctors are listening to them.”

—REACH 2010 community health advisor

REACHing African Americans in Charleston and Georgetown Counties, South Carolina

Who We Are

The Medical University of South Carolina coordinates the REACH 2010 Charleston and Georgetown Diabetes Coalition.

- This urban-rural, community-university coalition works to eliminate racial and ethnic disparities in diabetes in South Carolina.
- The coalition reaches more than 13,000 African Americans with diabetes living in Charleston and Georgetown counties, South Carolina.

The Problem

- African Americans are almost twice as likely to have diabetes as the majority of Americans.
- In 1999, African Americans living in Charleston and Georgetown counties were less physically active, ate a less healthy diet, and had higher rates of obesity compared with whites and members of other racial and ethnic groups.
- In addition, African Americans with diabetes living in Charleston and Georgetown counties reported a lower quality of diabetes care, as well as

higher rates of heart disease, amputations, and kidney disease compared with whites and members of other racial and ethnic groups.

The Solution

- To overcome these health disparities, our coalition works to 1) help people better manage their diabetes, 2) help health care providers give better diabetes care, and 3) build community advocacy and support to sustain these efforts.
- To make our efforts more effective, we use approaches that reflect the culture of local populations.
- We developed a comprehensive community action plan that includes walk-talk groups, home and telephone visits, educational sessions, health

care visits, health and information fairs, support groups, grocery store tours, and Internet access at local public libraries.

Our Achievements

- During 1999–2004, chart audits of African Americans who visited partner health centers showed sharp increases in the use of annual testing for diabetes and its complications. The percentage who had their blood sugar level checked annually increased from 77% to 97%, while the percentage who had their blood cholesterol level checked increased from 47% to 81%. Kidney testing increased from 13% to 53%, and foot exams increased from 64% to 97%.
- Health care providers documented better adherence to American Diabetes Association guidelines for self-management, from 41% to 94% of patients.
- Emergency room visits decreased by about 50% for people who have diabetes but do not have health insurance.
- Fewer lower extremity amputations were reported among African American men in Charleston and Georgetown counties, from 80 per 1,000 hospitalizations in 1999 to 33 per 1,000 in 2004.

Racial and Ethnic Approaches to Community Health (REACH) is a community-based public health program funded by CDC to eliminate racial and ethnic health disparities.

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Mobilizing Community Resources

Alpha Kappa Alpha, Omicron Rho Omega Chapter; Carolinas Center for Medical Excellence; Charleston Diabetes Coalition; Commu-I-Care; Diabetes Initiative of South Carolina; East Cooper Community Outreach; Franklin C. Fetter Family Health Center; Georgetown County Diabetes CORE Group; Medical University of South Carolina, College of Nursing; South Carolina State Budget and Control Board; South Carolina Department of Environmental Control, Diabetes Prevention and Control Program, Region 7 (Charleston) and Region 5 (Georgetown); South-Santee St. James Community Center; Tri-County Black Nurses Association; Trident United Way; St. James Santee Family Health Center; area churches, community centers, work sites, and libraries.

Our Achievements, cont.

- We established a faith-based diabetes program that matches patients treated at a local hospital with volunteers from a local church. These volunteers provide social support for patients and help them get information from diabetes educators. Several volunteers expanded the program to include fellow church members who were treated at other hospitals.
- Our coalition partners received two national awards in 2006: the Community-Campus Partnerships for Health Award and the U.S. National Commission on Libraries and Information Science's Health Information Award for Libraries.

Our Future

The REACH Charleston and Georgetown Diabetes Coalition will continue to work to link people with resources to reduce disparities in diabetes, its risk factors, and its complications, especially heart disease and amputations.

Getting the Word Out Locally

- "Rural Health Fair Tackles Diabetes," *Coastal Observer*, July 6, 2006.
- "Area Program to Combat Diabetes Recognized as a National Model," *Charleston Post and Courier*, June 20, 2006.
- "Classes Help Diabetics Improve Health," *Georgetown Times*, April 7, 2006.
- "Diabetes CORE Group Program to Focus on the Loss of Eyesight," *Georgetown Times*, February 15, 2006.

Generating New and Exciting Science

- "Equal Care, Unequal Outcomes: Experiences of a REACH 2010 Community," *Journal of Health Disparities Research and Practice* 2006;1(1):47-62.
- "A Community-Based Participatory Health Information Needs Assessment to Help Eliminate Diabetes Information Disparities," *Health Promotion Practice* 2006;7(3, suppl):213S-222S.
- "Racial Disparity in the Diagnosis of Obesity Among People with Diabetes," *Journal of Health Care for the Poor and Underserved* 2006;17(2, suppl):106-115.

- "Reducing Disparities for African Americans with Diabetes: Progress Made by the REACH 2010 Charleston and Georgetown Diabetes Coalition." *Public Health Reports* 2004;119(3):322-330.

Keys to Lasting Change in the African American Community

Our coalition found that identifying principles and goals early will help to resolve problems that may arise. All viewpoints are important, and involving all partners equally in solving community issues will help you to move beyond power struggles.

We also found that the combined resources of all partners create power far beyond that of individuals. Providing opportunities to learn about each partner's culture benefits the coalition as a whole. Health care professionals provide the "science of diabetes," while the community determines how to translate this science into practice. By working as equal partners, we can eliminate health disparities in diabetes in South Carolina.

REACH FOR MORE INFORMATION



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REACH

RACIAL AND ETHNIC APPROACHES TO COMMUNITY HEALTH

"Until I enrolled in a smoking cessation class, I was unaware of the effects smoking had on my body. I have high blood pressure and diabetes, and smoking increased my chances for life-threatening complications. I'm glad I found REACH."

—REACH Quit and Win campaign participant

REACHing African Americans in Nashville, Tennessee

Who We Are

The Matthew Walker Comprehensive Health Center coordinates the Nashville Health Disparities Coalition REACH 2010 Project.

- This project is working to reduce and eliminate health disparities in diabetes and heart disease rates among African Americans living in North Nashville, Tennessee.
- In 2000, 88% of North Nashville residents were African American.

The Problem

- In 2003, 15.7% of African American residents living in North Nashville had diabetes, and 33.6% had high blood pressure.
- African Americans in North Nashville are three times more likely to die of complications of diabetes and heart disease than white residents.
- Although 52% of African American women living in North Nashville are obese, many residents are unaware that obesity is a major risk factor for diabetes, and many residents may have undiagnosed diabetes.

The Solution

- The Nashville Health Disparities Coalition developed a community action plan to address health disparities among African Americans who have or are at risk of developing diabetes, heart disease, or high blood pressure.
- We created teams to develop strategies to address the following key health issues: tobacco use, access to health care, health screenings, and overall health and wellness.
- We formed partnerships with several groups and institutions to increase residents' access to health care services and reduce their risk of developing chronic diseases such as diabetes.

Racial and Ethnic Approaches to Community Health (REACH) is a community-based public health program funded by CDC to eliminate racial and ethnic health disparities.

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Our Achievements

- Our coalition expanded the hours of operation at six community clinics to improve residents' access to care.
- We developed and disseminated 500 screening manuals and trained local groups to conduct health screenings. Since 2000, more than 4,000 people have been screened for diabetes, heart disease, and associated risk factors.
- We developed the *Nashville REACH 2010 Resource Manual* to link people who have diabetes and heart disease with the health services they need. This booklet was distributed to more than 15,000 local residents.
- We provided diabetes self-management classes to local community groups and to 720 clients at the Matthew Walker Comprehensive Health Center.
- We worked with local nutrition groups to start community gardens and produce stands. We also changed local school menus, reduced the amount of junk food sold in vending machines, and provided nutrition education to residents.
- We worked with other local groups to convince the governor to sign into law a no-smoking policy in state office buildings.



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Mobilizing Community Resources

Metro Public Health Department; Tennessee Department of Health; Vanderbilt University; Matthew Walker Comprehensive Health Center; Meharry Medical College; Tennessee State University; Fisk University; Interdenominational Ministers' Fellowship; Nashville Branch of the NAACP; Metro General Hospital; American Baptist College.

Our Future

The Nashville REACH 2010 Project will continue to implement and evaluate interventions designed to promote health and prevent disease, particularly those that address diabetes and heart disease.

Getting the Word Out Locally

- "Nashville REACH 2010 at Matthew Walker Comprehensive Health Center Announces its 2nd Annual 'Quit and Win' Campaign to Help Smokers," *The Tennessee Tribune*, August 10, 2006.
- "Program Teaches Children Songs, Words to Persuade Family to Quit," *Tennessean*, July 25, 2006.
- "Smoking Ban Leaves Lasting Effects on Legislative Plaza," *The City Paper*, June 21, 2006.

Generating New and Exciting Science

- "REACH-Meharry Community-Campus Partnership: Developing Culturally Competent Health Care Providers." *Journal of Health Care for the Poor and Underserved* 2006;17(2, suppl):78–87.
- "Diabetes Management Among Low-Income African Americans: A Description of a Pilot Strategy for Empowerment." *Journal of Ambulatory Care Management* 2006;29(2):162–166.
- "An Evaluation of the Nashville REACH 2010 Community Health Screening Strategy." *Journal of Ambulatory Care Management* 2006;29(2):151–161.
- "Development and Evaluation of a Bible College-Based Course on Faith and Health." *Journal of Ambulatory Care Management* 2006;29(2):141–150.

Keys to Lasting Change in the African American Community

People working at the community level must keep in mind that social and environmental factors such as poverty, racism, violence, crime, lack of opportunity, education, and housing can have negative effects on community health. When people have stressful lives, they often do not make their health a priority.

To make and sustain positive changes in people's lifestyles and health, we must address society's problems head-on, and all sectors of the community, including churches, must participate. These efforts also require sustainable resources, and communities must address this issue to continue their work.

REACH FOR MORE INFORMATION



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REACH

RACIAL AND ETHNIC APPROACHES TO COMMUNITY HEALTH

“The REACH 2010 program has allowed tribes affiliated with United South and Eastern Tribes to increase—and in some cases establish for the first time—immunization surveillance for their children. With so many health disparities affecting American Indians in the eastern United States, REACH has allowed us to address a fundamental aspect of bettering the health of our tribal children.”

—Jim Marshall, epidemiologist at the USET Tribal Epidemiology Center

REACHing American Indians in the United South and Eastern Tribes

Who We Are

United South and Eastern Tribes, Inc. (USET) coordinates the REACH 2010 Immunization and Infant Mortality Project.

- USET is a nonprofit intertribal group that collectively represents 24 federally recognized American Indian tribes at regional and national levels. USET serves about 60,000 American Indians in 12 states.
- USET’s REACH project is working to promote healthy lifestyles and to reduce health disparities, particularly in immunization and infant mortality rates, among American Indians.
- USET’s Tribal Epidemiology Center helps tribes implement and enhance disease surveillance systems for their communities. The resulting data can be used to guide public health policy and activities, prioritize health objectives, and monitor progress toward meeting these objectives. The data also help tribes develop, implement, and evaluate disease prevention and control programs.

The Problem

- In general, American Indians have higher rates of death and disease than members of other racial and ethnic groups in the United States.
- In 2003, the infant mortality rate for American Indians was 8.7 per 1,000 live births, compared with 6.8 for all races and 5.7 for white infants.
- Childhood immunization coverage for USET tribes is well below *Healthy People 2010* goals. For example, 74% of children aged 19–35 months received all recommended immunizations in 2005. The *Healthy People 2010* goal is 90%.
- The incidence of vaccine-preventable disease among American Indians is not

known because of racial misclassification of this population in state data systems and incomplete reporting in tribal systems.

The Solution

- Twenty USET tribes are working with the Infant Mortality Project to collect prenatal data and identify what factors may influence infant death. In addition, 23 tribes are collecting mortality data that will be linked with birth records.
- USET helps tribes conduct local surveillance for immunization coverage and vaccine-preventable disease incidence and then link the data collected with state immunization registries. We also help tribes develop community-specific interventions.
- USET provides training, technical support, information sharing, and coordination of activities between tribal, local, state, and federal public health groups.
- USET also assesses tribal-level data to identify and address gaps in the data and improve data quality.

Racial and Ethnic Approaches to Community Health (REACH) is a community-based public health program funded by CDC to eliminate racial and ethnic health disparities.

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CENTERS FOR DISEASE CONTROL AND PREVENTION





Mobilizing Community Resources

Eastern Band of Cherokee; Mississippi Band of Choctaw; Miccosukee Tribe; Seminole Tribe of Florida; Chitimacha Tribe of Louisiana; Seneca Nation of Indians; Coushatta Tribe of Louisiana; St. Regis Band of Mohawk Indians; Penobscot Indian Nation and the Passamaquoddy Tribes; Houlton Band of Maliseet Indians; Tunica-Biloxi Indians of Louisiana; Poarch Band of Creek Indians; Narragansett Indian Tribe; Mashantucket Pequot Tribe; Wampanoag Tribe of Gay Head (Aquinnah); Alabama-Coushatta Tribe of Texas; Oneida Indian Nation; Aroostook Band of Micmac Indians; Catawba Indian Nation; Jena Band of Choctaw Indians; Mohegan Tribe of Connecticut; Cayuga Nation.

Our Achievements

- Of the 24 USET tribes, 83% are participating in the Infant Mortality Project.
- The number of tribes using immunization registries has increased from 9 to 21. The number of American Indian children whose immunization coverage is now being tracked has increased threefold.
- USET has provided training to tribes on how to use immunization registries, and we have helped tribes gain access to registries in their respective states.
- USET produces and distributes annual reports on tribal-specific data, immunization coverage, and infant death rates. These reports provide an overview of tribal programs and help the tribes monitor their progress.

Our Future

USET will continue to provide technical assistance and training for our tribal immunization programs. We also will continue to focus on improving immunization rates at the community level. We will assess data quality for each tribe to ensure that the tribal health data system

is as complete as possible, and we will continue to provide mortality reports to tribal programs. USET will work to establish data-sharing agreements with state agencies and to improve relationships between states and tribes. We will provide prenatal care, assessment reports, and recommendations to tribal programs to help reduce infant deaths.

Getting the Word Out Locally

- USET produces and distributes annual reports on tribal-specific, aggregated data on immunization coverage and infant death rates.

Generating New and Exciting Science

- "Building Immunization Surveillance Capacity in Tribal Health Programs." Presented at the Office of Minority Health National Leadership Summit on Eliminating Racial and Ethnic Disparities in Health, Washington, DC, January 9–11, 2006.
- "Building Immunization Surveillance Capacity in Tribal Health Programs." Presented at the 2006 National Immunization Conference, Atlanta, Georgia, March 6–9, 2006.

Keys to Lasting Change in American Indian Communities

For projects to succeed in American Indian communities, we must build relationships with community members. Because community support is key, leaders of projects such as REACH must show how these projects will serve and benefit local residents. Consistent communication between project leaders and communities also is important.

In the past, the relationship between researchers and communities was often one-sided. The researchers dictated the process, even when community members knew from experience that a different approach would be more effective. In contrast, USET projects promote community participation and empowerment, which are important factors in achieving lasting change. Our projects are also flexible enough to allow for changes that help to ensure sustainability. In addition, we have found that sharing the results of these projects in annual reports to the affected communities is key to maintaining community support and making progress toward meeting our health goals.

REACH FOR MORE INFORMATION



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REACH

RACIAL AND ETHNIC APPROACHES TO COMMUNITY HEALTH

"As a promotora de salud [lay health worker], I feel that we best help our community when we promote 'una vida sana y buena' [a healthy and good life]!"

—A promotora de salud working with the REACH project

REACHing Hispanic Older Adults in the Texas Coastal Bend Area

Who We Are

The Latino Education Project (LEP) coordinates the REACH Project in the Texas Coastal Bend.

- This project promotes awareness of the need for early screening and diagnosis to prevent diabetes and its complications among Hispanic older adults and their families living in the Texas Coastal Bend.
- The Coastal Bend is a 12-county area located along the south-central Gulf Coast shore of Texas. It includes the city of Corpus Christi.
- LEP is a community-based, nonprofit group that uses innovative approaches to help people improve their health. These approaches take into account the age and diverse experiences of the target population.

The Problem

- Nearly 34% of the Hispanic older adults living in the Texas Coastal Bend have diabetes or complications from diabetes, including heart disease, renal disease, blindness, and amputations.
- The City of Corpus Christi averages 4.4 lower-extremity amputations per 1,000

Medicare patients each year, which is nearly three times the national average of 1.6 per 1,000.

- Lack of access to timely and affordable health care, lack of transportation, and high levels of poverty are typical of many rural communities in the Coastal Bend. These problems contribute to the high incidence of diabetes and its complications among residents.

The Solution

- LEP has implemented interventions to prevent and control diabetes at individual, family, and community levels.
- We partner with more than 25 community groups, as well as local health care providers, educators, business people, and older adults. These community members provide input to our programs,

giving us insight into the unique experiences and diverse backgrounds of our target population.

- We have found that people can make healthy lifestyle changes, such as eating a healthy diet and being more physically active, if interventions are accessible and appropriate for their culture and age.
- We also have found that increasing community capacity for self-help and empowerment will build community ownership for health problems.

Our Achievements

- Lay health workers, called promotores de salud in Spanish, are expected to be leaders in creating social and economic conditions that help people control and manage their health. They are certified by the state and considered valuable members of the health care workforce.
- For its interventions, LEP first identifies the desired health outcome, and then identifies the knowledge and skills needed to achieve this outcome. Then, we find promotores de salud who have the necessary knowledge and skills.

Racial and Ethnic Approaches to Community Health (REACH) is a community-based public health program funded by CDC to eliminate racial and ethnic health disparities.

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Mobilizing Community Resources

Child Protective Services; Coordinator Congregational Health Ministry; Regional Cancer Center; American Cancer Society; Texas Cooperative Extension Service; CHRISTUS Spohn South Health Systems; City of Corpus Christi Senior Community Services; Community Service Aide, Nueces County Health Department.

Our Achievements, cont.

- Promotores de salud conduct free 12-week discussion groups for older adults called Study Circles. Discussions include a wide variety of health topics, including diabetes, nutrition, exercise, and medication management.
- We hold biannual, community-wide health forums that bring together approximately 400 community stakeholders who support the goals and objectives of the REACH project.
- LEP's diabetes prevention and control efforts are enhanced by health literacy programs, educational programs that teach people how to manage their medications, and wide media coverage of our health forums.
- We built on the REACH project to provide other services to isolated, rural, and low-income older adults and their families. These services include affordable housing, a low-income tax clinic, and a Senior Medicare Patrol program.

Our Future

LEP will continue to identify best practices in the early prevention and treatment of diabetes that can be used to help older

adults living in the Coastal Bend. We will refine our data management system to increase our ability to evaluate our interventions. We will increase the scope and range of our media programs to reach more residents and to find new partners to expand the reach of the REACH project.

Getting the Word Out Locally

- *Nuestra Salud*, LEP quarterly newsletter.
- "Perks of Getting Older: Recognizing Benefits of Exercise, Insurance Firms, Community Centers Offer Free Classes to Seniors," *Corpus Christi Caller-Times: Mi Vida*, January 2005.

Generating New and Exciting Science

- "Building Community Capacity for Health Promotion in a Hispanic Community." *Preventing Chronic Disease* [serial online] 2007;4(1). Available at http://www.cdc.gov/pcd/issues/2007/jan/06_0086.htm.
- "Reaching for the Stars: Innovative Tools for the Trade." Presented at the Annual Conference of the Texas Society for Public Health Education, Houston, Texas, September 22–23, 2006.

- "Looking Back, Moving Forward—REACH 2010: Promotores de Salud in Community Building Strategy." Presented at the California REACH 2010 Conference, Los Angeles, California, May 17, 2006.
- "Betting on Health Education: Increasing the Odds for Collaboration." Presented at the Society for Public Health Education (SOPHE) 2006 Midyear Scientific Conference, Las Vegas, Nevada, May 4–7, 2006.

Keys to Lasting Change in the Hispanic Older Adult Community

The Hispanic older adult community must take ownership of the diabetes problem, its complications, and the obesity crisis that is devastating Hispanic communities in South Texas and the Coastal Bend. Residents, health care providers, and local stakeholders can bring their unique experiences and diverse backgrounds together to support and expand activities that promote health. Interventions designed to promote healthy lifestyles and well-being must take into account the cultures, languages, and traditions of local residents. In addition, the traditional medical establishment must accept community-based, nonprofit groups as legitimate partners in these efforts.

REACH FOR MORE INFORMATION



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REACH

RACIAL AND ETHNIC APPROACHES TO COMMUNITY HEALTH

"I am very happy with this aerobics class. I am a mother of six children, I'm 30 years old, and I almost hit 290 on the scale. This class has really helped me on different levels. My weight dropped to 270 in 3 weeks. My self-esteem picked up, and my health has improved. This program does a lot for people like me who don't have time and resources to exercise."

—Marilu Sifuentes, REACH program participant

REACHing Mexican Americans on the Texas-Mexico Border

Who We Are

Migrant Health Promotion coordinates the REACH Promotora Community Coalition.

- Migrant Health Promotion is a community organization that serves counties with predominantly Mexican-American populations along the Texas-Mexico border.
- The group develops, implements, and evaluates programs that use peer health educators, called promotores and promotoras in Spanish, to bring information, resources, and improved access to health services to their communities.
- The REACH Promotora Community Coalition developed and initiated a community action plan to reduce diabetes and its complications for residents in three communities in Cameron and Hidalgo counties.
- Hispanics make up 86% of the population in Cameron County and 89% of the population in Hidalgo County, compared with 35% overall for the state of Texas.

The Problem

- In 1997, the estimated prevalence of diabetes for residents in Cameron and Hidalgo counties was 23% and 18%, respectively, compared with 5.9% for all Texas residents.
- The diabetes death rate for residents in the Rio Grande Valley of Cameron and Hidalgo counties is nearly twice the rate for the rest of the state.
- Rates of poverty, unemployment, and underemployment are high among border residents. Many residents also lack transportation and live in sub-standard housing or neighborhoods without municipal services.

The Solution

- More than 600 residents participated in 46 community work groups and

chose diabetes as the leading health problem in the Rio Grande Valley.

- Residents offered several solutions to address this problem. These solutions included improving access to clinics, hospitals, specialists, medications, and other medical services for low-income residents; providing health education and information in residents' homes, schools, churches, and supermarkets; and creating a community environment that encourages healthy behaviors.
- The REACH Promotora Community Coalition developed a community action plan that includes school-based, clinic-based, and colonia-based interventions. Colonias are rural, unregulated, low-income neighborhoods.
- Promotores and promotoras share the same socioeconomic background, language, and culture as the community members they serve.

Racial and Ethnic Approaches to Community Health (REACH) is a community-based public health program funded by CDC to eliminate racial and ethnic health disparities.

www.cdc.gov/reach

Our Achievements

- Our coalition enrolled more than 2,800 community residents in walking and nutrition classes.
- We provided diabetes self-management classes to more than 800 health clinic patients with diabetes.



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





Mobilizing Community Resources

Nuestra Clinica del Valle; University of Texas Pan American, Border Health Office; Su Clinica Familiar; Brownsville Community Health Center; University of Arizona, Mel and Enid Zuckerman School of Rural Public Health; Weslaco Independent School District; City of Weslaco, Parks and Recreation; Santa Rosa Independent School District; Progreso Community Center; City of Weslaco; Rio Hondo Independent School District; Los Fresnos Housing Authority; Texas A & M University, Center for Housing and Urban Development; Texas Department of State and Health Services; U.S.-Mexico Border Health Commission.

Our Achievements, cont.

- More than 500 parents participated in diabetes education sessions at local schools.
- Our coalition received the Border Models of Excellence Award from the U.S.-Mexico Border Health Commission.
- Before our clinic intervention, baseline data showed that 24.5% of patients with diabetes drank whole milk. After our intervention, patients reported a 14% decrease in their consumption of whole milk.
- Moderate walking increased by 25% among community residents.

Our Future

The REACH Promotora Community Coalition is duplicating its intervention in two other communities in Texas. We plan to disseminate our data in journals and at state and national conferences. We also will continue to work with local and state policy makers to improve the health of residents in the lower Rio Grande Valley.

Getting the Word Out Locally

- "Support Groups Hope to Prevent Diabetes," *The Monitor*, June 5, 2006.
- "Una Lucha Diaria Contra Diabetes," *El Valle*, January 18, 2005.
- "Students Join to Fight Diabetes," *Valley Morning Star*, January 1, 2005.
- "Healthy Choices," *The Monitor*, November 28, 2004.
- "Santa Rosa Warriors Walk for Diabetes," *La Feria News*, November 24, 2004.

Generating New and Exciting Science

- "Promotora-Led Changes in Nutrition and Physical Activity Among Hispanic Residents of the Texas Rio Grande Valley." Presented at the 134th Annual Meeting of the American Public Health Association, Boston, Massachusetts, November 7, 2006.
- "REACH 2010 Community Health Workers Use Community Forums to Promote Strategic Action and Policy Change in Their Communities." Presented at the 134th Annual Meeting of the American Public Health Association, Boston, Massachusetts, November 6, 2006.

Keys to Lasting Change in the Mexican-American Community

The REACH Promotora Community Coalition is led by promotores/promotoras and includes agencies and community members committed to ending health disparities in the Rio Grande Valley. The promotores/promotoras are the heart of this project because they share the same cultural, linguistic, educational, and economic characteristics as the community members they serve. They advocate for diabetes awareness, education, and self-management programs in their communities, and they promote systems and policy changes to encourage healthy behaviors.

Our community action plan's integrated strategies are supported by ongoing capacity building, training, program development, and evaluation activities. Our coalition combines health education with advocacy for community and systems changes that support healthy lifestyles.

REACH FOR MORE INFORMATION



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“Well, I have learned a lot since I have been coming to the diabetes classes, and I try to keep up with everything I hear. I have learned a lot about taking care of myself and what to eat.”

—African American participant in a REACH diabetes class

REACHing African Americans, Asian Americans, and Latinos in Seattle and King County, Washington

Who We Are

Public Health - Seattle & King County coordinates the Seattle & King County REACH 2010 Coalition.

- Coalition partners include community members, community groups, and community health centers; local health care providers; public health professionals; and researchers at the University of Washington.
- The coalition’s goal is to reduce health disparities related to diabetes among African Americans, Asian Americans and Pacific Islanders, and Latinos living in Seattle and King County, Washington.

The Problem

- In general, minority populations in the United States have higher rates of diabetes-related deaths, complications, and risk factors. In addition, they often have limited access to health care services and health insurance.
- The diabetes death rate for African Americans in King County is 3.5 times higher than the rate for whites.

- The diabetes death rate for Latinos in King County is 62% higher than the rate for whites.
- Members of several Asian American and Pacific Islander groups have higher rates of undiagnosed diabetes than whites. The diabetes death rate for this population in King County is slightly higher than the rate for whites.

The Solution

- To address these health disparities, our coalition first assessed the status of diabetes prevention and control efforts in minority communities in Seattle and King County. Then, we developed and implemented an intervention plan that reflected the cultures and languages of the target populations.

- We provided support groups, peer education, self-management classes, faith-based education, and case management services.
- We also provided interpreter services and translated educational materials into Cambodian, Chinese (Cantonese and Mandarin), Filipino, Korean, Spanish, Samoan, and Vietnamese.

Our Achievements

- In 2002, we collaborated with the Washington State Department of Health to train 21 peer and health educators at local community health centers in the Spanish version of the Chronic Disease Self-Management Program. Previously, only two people nationwide had been trained to teach this program in Spanish.
- The percentage of people participating in our interventions who were able to keep their blood sugar level under control increased from 48% to 56%.
- The percentage of participants who said they were confident they could stick to their diet increased from 56% to 69%.

Racial and Ethnic Approaches to Community Health (REACH) is a community-based public health program funded by CDC to eliminate racial and ethnic health disparities.

www.cdc.gov/reach





Mobilizing Community Resources

Aging and Disability Services; American Diabetes Association; American Heart Association; American Lung Association; Center for MultiCultural Health; Harborview Medical Center; International Community Health Services; Kin On Health Centers; National Asian Pacific Center on Aging; Urban Impact, Rainer Health and Fitness; Pacific Northwest Research Institute; Public Health - Seattle & King County; Qualis Health; Sea Mar Community Health Centers; Seattle Indian Health Board; Senior Services of Seattle/King County; University of Washington, School of Nursing, School of Nutritional Sciences, Health Promotion Research Center, School of Public Health and Community Medicine; Washington State Department of Health; Center for Health Training; Eli Lilly; Northwest Kidney Center; Urban Indian Health Institute; Washington Health Foundation; Washington State University Extension.

Our Achievements, cont.

- The percentage of participants who said their health was good, very good, or excellent increased from 34% to 39%.
- The percentage of participants who reported being more physically active increased from 75% to 86%.

Our Future

The Seattle & King County REACH 2010 Coalition will explore the possibility of expanding its focus to include other diabetes-related diseases, such as heart disease and obesity.

Getting the Word Out Locally

- "Diabetes Not Equal Opportunity Disease," *Seattle Post Intelligencer*, February 7, 2006.
- "Community Clinic Encourages Patients to Learn About Their Risks for Diabetes," *International Examiner*, December 6, 2005.
- "Diabetes: Una Epidemia en Auge—Es La Séptima Causa de Muerta en el Condado de King," *Sea Latino*, November 18, 2005.

Generating New and Exciting Science

- "A Community-Based Participatory Theater Project to Educate Latinos About Diabetes." Presented at the 134th Annual Meeting of the American Public Health Association, Boston, Massachusetts, November 6, 2006.
- "Building and Sustaining a Multicultural Partnership." Presented at the Midyear Scientific Conference of the Society for Public Health Education (SOPHE), Las Vegas, Nevada, May 4–7, 2006.
- "A Community-Based Approach to Diabetes Control in Multiple Cultural Groups." *Ethnicity & Disease* 2004; 14(3, suppl 1):83–93.
- "Learning from the Community: The Challenges and Rewards of Diabetes Interventions Among Culturally Diverse Populations." Presented at the 132nd Annual Meeting of the American Public Health Association, Washington, DC, November 9, 2004.

Keys to Lasting Change in Minority Communities

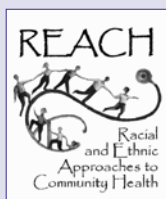
Our coalition found that the most successful strategy is to tailor interventions

and educational materials to reflect the cultures and languages of the target populations. We also found that hiring bilingual and bicultural staff members and serving culturally appropriate foods at events is important.

In addition, we learned the value of identifying key community members and groups to work with and making time to develop relationships and trust. This approach will open many doors for recruitment, service delivery, and research. For the African American community, successful outreach strategies include working with beauty salons and the faith community.

For Asian Americans and Pacific Islanders, outreach strategies varied. We partnered with community groups and associations to reach Chinese, Filipino, and Vietnamese residents. We partnered with churches and the faith community to reach Korean and Samoan residents. For the Latino community, churches were critical for outreach activities and service delivery. We also used promotoras (Spanish for "lay health workers") to reach Latino residents.

REACH FOR MORE INFORMATION



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Index

REACH Communities by Racial and Ethnic Group

African American

African American Health Coalition, Inc.: REACH African American Health Coalition	69
Black Women’s Health Imperative: REACH 2010: At the Heart of New Orleans Coalition	27
Boston Public Health Commission: Boston REACH 2010 Breast and Cervical Cancer Coalition	29
Boston Public Health Commission: REACH Boston Elders 2010.....	31
Carolinas HealthCare System: Charlotte REACH 2010 Coalition.....	59
Center for Community Health, Education & Research, Inc.: Metropolitan Boston Haitian REACH 2010 HIV Coalition.....	33
Community Health Councils of Los Angeles: African Americans Building a Legacy of Health	7
Fulton County Department of Health and Wellness: REACH for Wellness	19
Genesee County Health Department: Genesee County REACH 2010 Team	41
Matthew Walker Comprehensive Health Center: Nashville Health Disparities Coalition REACH 2010 Project.....	73
Medical University of South Carolina: REACH 2010 Charleston and Georgetown Diabetes Coalition	71
San Francisco Department of Public Health: SevenPrinciples Project	11
University of Alabama at Birmingham: Alabama REACH 2010 Breast and Cervical Cancer Coalition	3
University of Nevada, Reno: Healthy Hearts Project	45

African American, Asian American, Pacific Islander, and Hispanic/Latino

Public Health - Seattle & King County: Seattle & King County REACH 2010 Coalition.....	81
--	----

African American and Hispanic/Latino

Access Community Health Network and University of Illinois at Chicago: REACH Out.....	21
Chicago Department of Health: REACH 2010/Lawndale Health Promotion Project	23
Community Health & Social Services Center, Inc.: REACH Detroit Partnership	39
Florida International University: Coalition to Reduce HIV in Broward’s Minority Communities	17
Institute for Urban Family Health: Bronx Health REACH Coalition.....	55
Los Angeles Biomedical Research Institute at Harbor-UCLA Medical Center: Immunize LA Kids Coalition	9
Mailman School of Public Health of Columbia University: Northern Manhattan Start Right Coalition	57
Missouri Coalition for Primary Care: Kansas City - Chronic Disease Coalition	43
New Hampshire Minority Health Coalition: New Hampshire REACH 2010 Initiative.....	47
University of Illinois at Chicago: Chicago Southeast Diabetes Community Action Coalition	25

American Indian

Eastern Band of Cherokee Indians: Cherokee Choices/REACH 2010 Diabetes Prevention Program.....	61
Oklahoma State Department of Health: Oklahoma Native American REACH 2010 Project	67

American Indian/Alaska Native

Albuquerque Area Indian Health Board, Inc.: Partners in Tribal Community Capacity Building (REACH 2010) Project	49
Association of American Indian Physicians: Oklahoma REACH HIV/AIDS American Indian Capacity Building.....	63
Choctaw Nation of Oklahoma: Choctaw Nation Core Capacity Building Program.....	65
Chugachmiut Native Organization: Alaska Native Cardiovascular Disease Prevention/Core Capacity Building Project	5
National Indian Council on Aging: Diabetes Educational Outreach Strategies Project.....	53
United South and Eastern Tribes, Inc.: REACH 2010 Immunization and Infant Mortality Project.....	75

Asian American

Lowell Community Health Center: Cambodian Community Health 2010 Program	37
Special Services for Groups, Inc.: REACH 2010/Health Access for Pacific Asian Seniors.....	13
University of California, San Francisco: Vietnamese REACH for Health Initiative Coalition	15

Hispanic/Latino

Greater Lawrence Family Health Center: REACH 2010 Latino Health Project	35
Hidalgo Medical Services: La Vida Program	51
Latino Education Project: REACH Latino Education Project.....	77
Migrant Health Promotion: REACH Promotora Community Coalition.....	79

REACH Communities by Health Priority Area

Breast and Cervical Cancer

Access Community Health Network and University of Illinois at Chicago: REACH Out.....	21
Albuquerque Area Indian Health Board, Inc.: Partners in Tribal Community Capacity Building (REACH 2010) Project.....	49
Boston Public Health Commission: Boston REACH 2010 Breast and Cervical Cancer Coalition	29
University of Alabama at Birmingham: Alabama REACH 2010 Breast and Cervical Cancer Coalition	3
University of California, San Francisco: Vietnamese REACH for Health Initiative Coalition	15

Cardiovascular Disease

African American Health Coalition, Inc.: REACH African American Health Coalition	69
Black Women’s Health Imperative: REACH 2010: At the Heart of New Orleans Coalition	27
Choctaw Nation of Oklahoma: Choctaw Nation Core Capacity Building Program.....	65
Chugachmiut Native Organization: Alaska Native Cardiovascular Disease Prevention/Core Capacity Building Project	5
Fulton County Department of Health and Wellness: REACH for Wellness.....	19
University of Nevada, Reno: Healthy Hearts Project	45

Diabetes

Community Health & Social Services Center, Inc.: REACH Detroit Partnership	39
Eastern Band of Cherokee Indians: Cherokee Choices/REACH 2010 Diabetes Prevention Program.....	61
Hidalgo Medical Services: La Vida Program	51
Medical University of South Carolina: REACH 2010 Charleston and Georgetown Diabetes Coalition	71
Migrant Health Promotion: REACH Promotora Community Coalition.....	79
National Indian Council on Aging: Diabetes Educational Outreach Strategies Project.....	53
New Hampshire Minority Health Coalition: New Hampshire REACH 2010 Initiative.....	47
Public Health - Seattle & King County: Seattle & King County REACH 2010 Coalition.....	81
University of Illinois at Chicago: Chicago Southeast Diabetes Community Action Coalition	25

Diabetes and Cardiovascular Disease

Boston Public Health Commission: REACH Boston Elders 2010.....	31
Carolinas HealthCare System: Charlotte REACH 2010 Coalition.....	59
Chicago Department of Health: REACH 2010/Lawndale Health Promotion Project	23
Community Health Councils of Los Angeles: African Americans Building a Legacy of Health	7
Greater Lawrence Family Health Center: REACH 2010 Latino Health Project	35
Institute for Urban Family Health: Bronx Health REACH Coalition.....	55
Latino Education Project: REACH Latino Education Project.....	77
Lowell Community Health Center: Cambodian Community Health 2010 Program	37
Matthew Walker Comprehensive Health Center: Nashville Health Disparities Coalition REACH 2010 Project.....	73
Missouri Coalition for Primary Care: Kansas City - Chronic Disease Coalition	43
Oklahoma State Department of Health: Oklahoma Native American REACH 2010 Project	67

HIV/AIDS

Association of American Indian Physicians: Oklahoma REACH HIV/AIDS American Indian Capacity Building.....63
Center for Community Health, Education & Research, Inc.: Metropolitan Boston Haitian REACH 2010 HIV Coalition.....33
Florida International University: Coalition to Reduce HIV in Broward’s Minority Communities 17

Immunization

Los Angeles Biomedical Research Institute at Harbor-UCLA Medical Center: Immunize LA Kids Coalition9
Mailman School of Public Health of Columbia University: Northern Manhattan Start Right Coalition57

Immunization, Diabetes, and Cardiovascular Disease

Special Services for Groups, Inc.: REACH 2010/Health Access for Pacific Asian Seniors..... 13

Immunization and Infant Mortality

United South and Eastern Tribes, Inc.: REACH 2010 Immunization and Infant Mortality Project..... 75

Infant Mortality

Genesee County Health Department: Genesee County REACH 2010 Team41
San Francisco Department of Public Health: SevenPrinciples Project 11

