

**NATIONAL REACH COALITION**  
**FOR THE ELIMINATION OF HEALTH DISPARITIES**

*Testimony Submitted to*  
US Congress Subcommittee on  
Labor, Health and Human Services, Education, and Related Agencies  
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by  
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Thank you Chairman Obey, Ranking Member Tihart and other members of the Subcommittee. My name is Charmaine Ruddock with the Institute for Family Health. I run the Institute's Bronx Health REACH/New York Center of Excellence to Eliminate Disparity, a CDC funded initiative. I am testifying today in the capacity of the National REACH Coalition.

The National REACH Coalition represents a network of more than 40 communities and coalitions in 21 states across the country working to eliminate racial and ethnic health disparities and improve the health of African American, Asian Pacific Islander, Native American and Latino populations and communities. The coalition grew out of the **Racial and Ethnic Approaches to Community Health (REACH) 2010** initiative funded through the Centers for Disease Control and Prevention (CDC) beginning in 1999. REACH 2010, now called REACH US, began as a demonstration project and was one of the first national initiatives to actively engage members of impacted communities in the research, design, development, implementation and evaluation of local strategies for the prevention and management of chronic disease and illnesses. REACH coalitions across the country are working to eliminate the root causes of cardiovascular disease, diabetes, breast and cervical cancer, hepatitis B, adult immunization, tuberculosis, asthma and infant mortality rates.

As many of you know, chronic disease data clearly show disparities in health among racial and ethnic minority populations. While the age-adjusted death rate has declined in recent years nationwide, racial and ethnic differences in mortality have persisted. Minorities are more likely to be diagnosed with late-stage breast cancer and colorectal cancer compared with whites. Vietnamese American women have a higher cervical cancer incidence rate than any ethnic group in the United States—five times that of non-Hispanic white women.<sup>1</sup> Compared to whites, Hispanics are more than twice as likely to have diabetes.<sup>2</sup> The rates of death from heart diseases are 29 percent higher among African-American adults and death rates from stroke are 40 percent higher than among white adults.<sup>3</sup>

Furthermore, health and healthcare inequality exact a huge human and economic toll on the nation. The persistence of health disparities, decade after decade, generation after generation, means that millions of Americans and their families suffer needlessly from a high burden of

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<sup>1</sup> REACH US Finding Solutions to Health Disparities [At A Glance 2008](#).

<sup>2</sup> CDC, [Diabetes Data and Trends](#).

<sup>3</sup> National Center for Health Statistics (NCHS), [Health, United States, 2002, Table 30](#).

illness and mortality. Cardiovascular disease (CVD) costs an estimated \$300 billion annually as measured in healthcare expenditures, medications, and lost productivity due to disability and death.<sup>4</sup> The National Institutes of Health estimated the overall costs of cancer in 2007 at \$219.2 billion.<sup>5</sup> These costs, both to personal income and our national economy, can be reduced significantly through prevention strategies like REACH US. The CDC estimates that if tobacco use, poor diet, and physical inactivity were eliminated, we could reduce heart disease and stroke by 80%, type 2 diabetes by 80% and prevent 40% of the cancer cases in the US. In order to eliminate health disparities, the World Health Organization Commission on Social Determinants of Health concluded we must “improve the conditions of daily life—the circumstances in which people are born, grow, live, work, and age.”<sup>6</sup>

Even with health insurance, access to a quality provider and an ability to pay for medications, our communities need more to combat obesity, eat healthy and stay active. We need key environmental resources, which are often missing in communities of color. Black and Latino neighborhoods have fewer parks, green spaces, gyms, recreational centers, swimming pools and safe places to walk, jog, bike or play than white neighborhoods. One study revealed that black Americans are five times less likely to live in census tracts with supermarkets than white Americans.<sup>7</sup> Nationally, 50% of African American neighborhoods lack access to a full service grocery store or supermarket.<sup>8</sup> It’s more challenging to eat right in neighborhoods where fast-food joints, liquor stores and convenience stores proliferate while supermarkets and other sources of affordable, nutritious food are hard to find. Dozens of empirical studies over the past 40 years have determined that communities of color are more likely to be subjected to environmental degradation and exposed to environmental hazards. For example, 56% of residents in neighborhoods with commercial hazardous waste facilities are people of color even though they comprise less than 30% of our population.<sup>9</sup> These exposures are associated with a variety of ailments including asthma, birth defects, and cancer. Crowded, substandard housing, elevated noise levels, decreased ability to regulate temperature and humidity, and exposure to lead paint and allergens such as mold and dust mites are all more common in poor, segregated communities, as are asthma rates and lead toxicity.<sup>10</sup> Lack of affordable housing often leads to unsafe overcrowding conditions and the diversion of limited financial resources from other basic needs such as food and health.

Through the REACH US model, we aim to increase environmental resources while also fighting chronic disease and health disparities in these highly impacted communities. We do this by:

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<sup>4</sup> [NCCDPHP, 2001.](#)

<sup>5</sup> American Cancer Society (ACS) [Cancer Facts & Figures 2008.](#)

<sup>6</sup> “Closing the Gap in a Generation”: WHO Commission on Social Determinants of Health, 2008.

<sup>7</sup> Morland, K Wing, S; Contextual Effect of the Local Food Environment on Residents’ Diets: The Atherosclerosis Risk in Communities Study Am J Public Health. 2002 November; 92(11): 1761–1768.

<sup>8</sup> Flournoy, R.; "Regional Development and Physical Activity: Issues and Strategies for Promoting Health Equity," PolicyLink, Oakland, CA, November 2002, p.10.

<sup>9</sup> Bullard, Toxic Wastes and Race at Twenty: 1987-2007 (2007).

<sup>10</sup> Williams, D; *Racial Residential Segregation: A Fundamental Cause of Racial Disparities in Health*, 116 Pub. Health Rep. 405, 405-16 (2001).

- Conducting community-based participatory research to assess and document individual, community, societal, cultural, and environmental factors within each community setting as the rationale, evidence and basis for each intervention
- Developing public policy, economic development strategies and planning and land use tools to reduce hazardous environmental conditions and transform the built environment to improve access to healthy food, quality housing, physical activity resources and quality healthcare services
- Providing culturally, linguistically-competent and relevant health education and disease management programs to help prevent and/or manage risk factors and reduce inappropriate use of costly medical treatment
- Generating the tools and building the capacity of both public and private organizations to implement and sustain worksite wellness policies and programs to increase worker productivity
- Funding and providing training and technical assistance to other communities and states to initiate or enhance work towards the elimination of health disparities.

The REACH programs undergo a rigorous evaluation through partnerships with major universities and an independent evaluation by the CDC. The REACH Risk Factor Survey shows that the REACH program is helping people significantly reduce their health risks and manage their chronic diseases. This survey assesses improvements in health-related behaviors and reductions in disparities within the 27 REACH communities that focus on breast and cervical cancer prevention, cardiovascular health, and diabetes management. The data are compelling:

- In 2002, the proportion of African Americans in REACH communities who were screened for cholesterol was below the national average. By 2006, this percentage exceeded the national level.
- Since 2002, the cholesterol screening rate for Hispanics in REACH communities has surpassed the national rates for Hispanics.
- The proportion of American Indians in REACH communities who are taking medication for high blood pressure increased from 67% in 2001 to 74% in 2004, surpassing the national rate for this population.
- The rate of cigarette smoking among Asian American men in REACH communities decreased from 42% in 2002 to 20% in 2006, dipping below the national average for the overall US population.
- In 8 years, the proportion of African American women who received mammography screenings increased from 29% to 61%, surpassing the rate for white women by 13%.

I am here today to urge the subcommittee to fight the high personal and economic cost of chronic disease and illness through an increased investment in community-based prevention programs and interventions such as REACH US. The 2003 GAO report, *Health Care: Approaches to Address Racial and Ethnic Disparities*, identified REACH 2010 as one of the nation's most effective programs in addressing health disparities, underscoring its value. I'd like to take this opportunity to highlight some of the progress across the country from the REACH program.

These changes are taking place in your communities. For example:

### **New York:**

- **The Bronx Health REACH Coalition** works with 22 churches to educate local residents and empower them to adopt healthy lifestyles. Through the nutrition and fitness initiative, Bronx Health REACH works to improve residents' access to healthy foods. As a result, **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.
- **The Northern Manhattan Start Right Coalition** increased the immunization rate to 76% for children of all ages enrolled in the Start Right program during 2002-2006, with 86.5% of children up to date by age 3. The Coalition has 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 immunization rates. In fact, the rate for children aged 19-35 months now exceeds the national average.

### **Alabama**

- **The Breast and Cervical Cancer Coalition** at the University of Alabama at Birmingham works to increase breast and cervical cancer screening rates for African American women throughout the state. A patient navigation system was launched in eight counties to address a significant black/white gap in mammography screening. As a result, the gap has now been eliminated in several counties, and has been reduced by 76% across the 8-county region.

### **California**

- **Community Health Councils' African Americans Building a Legacy of Health** coalition in Los Angeles has improved food and physical activity options in South Los Angeles through zoning and land use policy change. The Los Angeles City Council adopted an ordinance to limit the proliferation of fast-food restaurants and policy to provide incentives to healthy food retailers to encourage them to locate in disadvantaged areas, opening the way for two new stores. The Los Angeles County Board of Supervisors adopted a policy to improve the quality of food offered in county-sponsored programs. The Coalition also worked to preserve a local community fitness center slated for closure and transferred program management to the Los Angeles YMCA in addition to providing seed funding 30 community-based physical fitness programs.
- **The University of California, San Francisco Vietnamese REACH for Health Initiative Coalition** in Santa Clara County reports that 48% of Vietnamese women who had never had a Pap test got one after meeting with lay health workers from REACH. The overall percentage of Vietnamese American women receiving pap tests has increased by 15%.
- **The Los Angeles Biomedical Research Institute at Harbor-UCLA Medical Center Immunize LA Kids Coalition** has implemented culturally appropriate interventions that seek to overcome barriers to immunization by working to improve practices in healthcare

provider settings. In April 2006, 82% of WIC clients in the South Los Angeles service area, most of whom are Latino or African American, were up to date with recommended immunizations at age 2.

### **Illinois**

- **Chicago Department of Health, REACH/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. More than 7,000 assessments for diabetes and heart disease risk have been conducted with community residents. Nine hundred residents were referred to local health agencies for medical care. In addition, 350 residents with diabetes or heart disease received case management services, which sharply increased the use of health screenings.

### **Oklahoma**

- 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. As a result of the Coalition's 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. The Coalition partnered with Colorado State University's Tri-Ethnic Center to create a survey to assess communities' readiness to address the health issues identified in the needs assessment surveys. They also 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 one-third of the time.

The progress and achievements of the REACH US are the building blocks and templates for this country's commitment to prevention and wellness. It is critical that we leverage this experience to create a national blueprint for prevention and to eliminate racial and ethnic health disparities. More than **200 communities** applied for funding under the REACH US program in 2007. REACH US is currently funded at \$33.8 million and is able to fund only 40 local initiatives for the next three years. REACH communities have leveraged and transformed this nominal investment to demonstrate that health disparities that have heretofore been considered expected are not intractable. We can only imagine the progress that could be made in our lifetime with a REACH US program in every state and region of this country.

Thank you for this opportunity to share our story.