Community Health Interventions

Prevention’s Role in Reducing Racial and Ethnic Health Disparities

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“Of all the forms of inequality, injustice in health is the most shocking and the most inhumane.”
Dr. Martin Luther King, Jr.
Executive Summary

Despite the overall improved health of Americans collectively, racial and ethnic disparities continue to exist. This health burden is most evident among minorities suffering from preventable diseases. African Americans, American Indians and Alaska Natives, Hispanics, and Native Hawaiians and Pacific Islanders have higher rates of modifiable risk factors—such as hypertension, high blood cholesterol levels, diabetes, tobacco use, physical inactivity, and obesity—than their white counterparts.

Health policy leaders increasingly recognize the importance of controlling these risk factors through interventions that alter behaviors or one’s lifestyle. Former Surgeon General David M. Satcher argues that “while access to and quality of health care are paramount to eliminating racial and ethnic health disparities, their roles are not as significant as lifestyle and environment.” However, behavioral changes are difficult to make—inertia is strong, and changing behaviors requires major changes in thinking, action, and lifestyle.

One solution is community programs that work directly to modify risky health behaviors. For example, the Center for Disease Control and Prevention’s Racial and Ethnic Approaches to Community Health (REACH 2010) and the Department of Health and Human Services’ Office of Minority Health’s two grant programs—Community Programs to Improve Minority Health and the State Partnership Grant Program to Improve Minority Health—have effectively reduced racial and ethnic disparities in targeted subpopulations. The idea is to change the actions of people rather than to act on individuals passively.

Empirical evidence of community-level interventions shows that efforts to organize communities, educate them through mass and direct education, provide screenings for risk factors, and change their environment through local programs and policies can alter risky health behaviors. Yet, the success of many of these interventions is dependent on the Congressional appropriations process.

Specific policy suggestions include:

- **Increase and Leverage Funding for Community Programs:**
  - Increase funding for the REACH 2010 program and the Community Programs to Improve Minority Health Grant Program at a level that would allow current programs to continue to operate and additional programs to be developed.
  - Leverage funding for community organizations to work together to tailor health programs to meet the specific cultural needs of the targeted racial or ethnic subpopulation.

- **Increase Infrastructure Capacity:**
  - Restore funding to the Department of Health and Human Services’ Office of Minority Health to previous years’ allotments, with an inflationary increase.
  - Allocate necessary funding for each state, territory, and district to have an Office of Minority Health.
Introduction

For too many racial and ethnic minorities in the U.S., good health and health care is elusive. Life expectancy and overall health have improved for Americans collectively, yet the prevalence of preventable diseases among racial and ethnic minorities persists. Calculations, for example, show that there would have been 85,000 fewer black deaths overall in the year 2000 alone if health disparities had been eliminated in the last century. This includes 24,000 fewer black deaths from cardiovascular disease and 22,000 fewer black deaths from diabetes, which are diseases that, for the most part, can be prevented with healthy lifestyles.

Community interventions focused on altering risky health behaviors that lead to chronic illness are instrumental in reducing health disparities experienced by African-Americans, American Indians and Alaska Natives, Hispanics, and Native Hawaiians and Other Pacific Islanders. These interventions have the potential to address three access-related barriers: poor understanding of needed healthcare services; structural barriers associated with living in underserved communities; and lack of cultural competency related to a lack of racial and ethnic diversity in the health care workforce.

These interventions, however, cannot address the number one access barrier—lack of health care coverage for clinical services. This access barrier is better addressed through national policy solutions rather than local and state level fixes. Still, community interventions have their niche. They have the unique ability to focus on individuals by providing them with the needed tools to alter lifestyle choices that may lead down a path of unhealthy living.

Racial and Ethnic Health Disparities

The National Institute of Health defines health disparities as “differences in the incidence, prevalence, mortality, and burden of diseases and other adverse health conditions that exist among specific population groups in the United States.” Health disparities include disparities in health care such as differences in access to medical care and disparities in health such as differences in health outcomes and prevalence of modifiable risk factors.

Racial and ethnic health disparities are closely linked to the high rate of preventable chronic disease that many minority subgroups experience. Targeting modifiable risk factors—or those factors that are not connected to family history or genetic abnormalities—effectively reduces preventable chronic disease, and therefore disparities. These risk factors include hypertension, high blood cholesterol levels, diabetes, tobacco use, physical inactivity, and obesity.

Below are some examples of disparities in health experienced by various racial and ethnic subgroups. These statistics highlight the prevalence of modifiable risk factors in these communities.
African Americans: Roughly 13 percent of African Americans over 20 years of age suffer from either Type 1 or Type 2 diabetes, one-third of whom are undiagnosed. On average, African Americans are two times more likely to have diabetes than whites of similar age. Blacks have the highest rate of hypertension in the world; more than one in every three blacks are plagued by this risk factor. Also, African American women are more likely to be obese or overweight than any other racial or ethnic group—almost 80 percent of African-American women 20 years of age and older are overweight and over 50 percent are obese.

American Indians and Alaska Natives: Tobacco use is most prevalent in American Indian communities. Median cigarette smoking rates in these communities is 42.2 percent for men and 36.7 percent for women. Physical inactivity is also a risk factor associated with this subpopulation. Nearly 50 percent of American Indian and Alaska Native adults never engaged in leisure-time physical activity from 1999 to 2003, which is 37 percent higher than the rate for whites during the same period. Additionally, only one in three American Indians or Alaska Natives have been told they have hypertension, and only one in eight of them have been told they have diabetes.

Mexican Americans: Mexican Americans have high rates of physical inactivity, overweight and obesity, and tobacco use. They have a 1.5 times higher rate of physical inactivity than whites. Nearly 70 percent of the population is overweight, with roughly 40 percent of the population classified as obese. And nearly one-quarter of Mexican-Americans smoked during the 2000-2003 time frame.

Native Hawaiians and Other Pacific Islanders: Pacific Islander Americans have a high rate of obesity—nearly half of all Native Hawaiians are obese. Besides obesity, Pacific Islander Americans have high rates of diabetes, hypertension, cardiovascular disease, and stroke. Data collected from 1996 to 2000 suggests that Native Hawaiians are 2.5 times more likely to be diagnosed with diabetes than white residents of Hawaii of similar age.

Because the risk factors identified here can largely be modified, finding effective ways to change behaviors can improve health and reduce health disparities.

Reducing Racial and Ethnic Health Disparities through Community Interventions

Researchers and practitioners acknowledge that many complex issues lead to the health disparities of people living in marginalized communities. Barriers to health care access—such as a lack of health coverage and a regular source of care, poor health education, living in underserved communities, and a lack of cultural competency in health care—is one accepted causal category of health disparities.

Recent research has found that the single biggest access factor affecting the health and health care of racial and ethnic minorities is insurance. In fact, data shows that providing health insurance to racial and ethnic minorities would decrease one-third of the reason for disparity in a measure of access for improving the opportunity for quality health care. And while creating a health care system that
guarantees affordable coverage to everyone is fundamental to reducing health disparities, the prevention of negative health behaviors that inhibit or delay the onset of chronic conditions is also effective since nearly 50 percent of morbidity and mortality is caused by an unhealthy lifestyle.  

One proven method of modifying negative health behaviors is through community programs. The logic behind these interventions is straightforward. Community interventions influence individual behaviors on a large scale throughout a population and shift the distribution of risk. In the process, norms regarding socially acceptable behaviors and practices are changed.

Indeed, by their very nature, community interventions may have a comparative advantage over other methods of altering risky health behaviors in communities of racial and ethnic minorities. Recognizing the cultural and linguistic diversity of their own population, local organizations, often through the aid of Lay Health Advisors, are better equipped to effectively administer behavioral interventions, and are more likely to be able to transcend cultural and discriminatory barriers. Additionally, these interventions are often administered by community organizations and agencies that have an existing relationship with the population it is trying to serve.

Behavioral changes are not mutually exclusive of medical care; in fact, in many cases appropriate medical care requires behavioral changes. But the idea of community interventions is to change the actions of people rather than to act on individuals passively. Empirical evidence of community-level interventions shows that efforts to organize communities, educate populations through mass and direct education, provide individuals with screenings for risk factors, and change community environments by developing and implementing local programs and policies are effectively altering risky health behaviors.

The Center for Disease Control and Prevention’s *Guide to Community Preventive Services* recommends a set of evidence- and population-based approaches to change health behaviors and health outcomes. Table 1 lists and describes some of these interventions aimed at decreasing physical inactivity, tobacco use, and the prevalence of Type 2 Diabetes.

Many of the recommendations in Table 1 are applicable to any community or sub-population in the United States. Yet any intervention that is directed at making individuals change behaviors must adjust to the individual’s readiness for change and cultural norms of the individuals and communities. That is why tailoring community interventions to the individual, or in this case, subpopulation is effective as well.

Tailoring requires a departure from a one-size-fits-all intervention strategy in order to enhance the effectiveness of community interventions. This process requires that a target audience be divided into subgroups with similar demographic, psychological, geographic, and problem-relevant characteristics. This allows for interventions to be tailored to the unique needs and cultures of communities. As highlighted in the next section, tailoring community interventions to specific racial and ethnic groups have been effective in altering risky health behaviors.
Tailored Community Interventions at Work

Through federal funding, many local organizations and government agencies have successfully implemented community interventions that alter behaviors that decrease risk factors in racial and ethnic populations. For example in 1999, the Center for Disease Control and Prevention launched the Racial and Ethnic Approaches to Community Health 2010, or REACH 2010 program. The program supports community coalitions that devise, implement, and evaluate community-driven strategies to reduce health disparities by targeting risk factors associated with prevalent chronic conditions.

REACH 2010 sites are tasked with creating community coalitions composed of a community-based organization and three other entities, at least one of which is a local or state health department, a university, or a research organization. The focus of these interventions is to target adverse health behaviors. Furthermore, data collection is an integral part of the REACH 2010 program. These initiatives are one of the only sources for racial and ethnic data regarding health risk behaviors.
The Office of Minority Health of the Department of Health and Human Services also runs two grant programs focused on reducing racial and ethnic health disparities. One is the Community Programs to Improve Minority Health Grant Program, launched in 1986. The purpose of this program is “to improve the health status of targeted minority populations through health promotion and disease risk reduction intervention programs.”

The program aims to grant funding to private, non-profit, community-based, and minority-serving organizations. Funds are to be used to conduct collaborative efforts to modify behavioral conditions that are often implicated in the health problems of minority groups such as cardiovascular disease.

The second Office of Minority Health program is the State Partnership Grant Program to Improve Minority Health. This initiative works to strengthen the relationship between state and territorial offices of minority health and public and private organizations that specifically address minority health and health disparities. According to an assessment of state minority health infrastructure capacity, state and territorial offices of minority health have a visible presence at the state policymaking level and provide opportunities for “shaping and creating initiatives that could affect the health state of minority populations and serve as pivotal points for local efforts to improve the health status of minority populations.”

Although the reduction of racial and ethnic health disparities challenges the entire nation, individual states are on the frontline of many initiatives and are often the focus of important policy efforts. These efforts include initiatives proposed by the National Governors’ Association, National Association of State Legislators, and various state and territorial governments.

Additionally, policy statements and funding initiatives by a number of private foundations have sprung up to address the problem. These include, but are not limited to, the W.K. Kellogg Foundation’s Community Based Public Health Initiative, the Henry J. Kaiser Family Foundation’s Community Health Promotion Grant Program of the 1990s, and more recent programs of the Robert Wood Johnson Foundation, such as the Policy Advocacy on Tobacco and Health Program and its effort to build community partnerships for diabetes prevention.

**Highlights of Community Interventions**

Below are highlights of some of the community interventions that are federally funded. These programs have effectively utilized the behavioral interventions identified in Table 1 and address access barriers through the provision of health information and education, peer advisors who relate culturally, and needed community resources. These interventions have been tailored to different racial and ethnic subpopulations, and have been successful in reducing health disparities.

**Community Interventions in the African-American Population**

The *Charlotte REACH 2010* initiative focuses on the reduction and control of cardiovascular disease and diabetes among African Americans in the northwest region of Charlotte, North Carolina. This initiative uses a five-pronged ecological approach, under the guidance of a community coalition, to reach participants at all levels of influence: intrapersonal, interpersonal, organizational, institutional, and community levels.
The intrapersonal component emphasizes education and skill-learning to increase positive health behaviors. Quarterly newsletters are distributed with specific information regarding smoking cessation, diabetes management, and nutrition. At the interpersonal level, the community coalition trains individuals within the community to be lay health advisors, and once trained, the individual can promote healthy behaviors with other members of the community.

At the organizational level, the community coalition garners participation from the YMCA and diabetes support groups. Primary care disease management and quality-assurance projects for diabetes care comprise the institutional commitment. And finally, the coalition implemented a neighborhood farmers’ market.

Participants in the program reported an increase in knowledge of preventive health behaviors, the development of health-related skills, and diffusion of knowledge to family. In fact, a survey of participants found a 10 percent increase in adults who were physically active at least five times a week and a 14 percent increase in adults who reported eating five or more fruits and vegetables a day from 2002 to 2004. Fellowship was identified as the primary motivator to continue positive health behaviors. This program is one of the 40 programs funded in fiscal year 2006 by the Center for Disease Control and Prevention through the REACH 2010 initiative.

Community Interventions in the American Indian and Alaska Natives Population

The American Indian Families Medical, Nutritional, and Fitness Program to Prevent and Treat Diabetes is a comprehensive strategy to provide medical, nutrition, and fitness intervention to American Indian families living in Hennepin County, Minnesota. The program provides these interventions for the entire family when a family member has been either diagnosed with diabetes, or has been identified as having one of the major risk factors for the disease.

The family program coordinator refers the family to the Indian Health Board for screening of all members. The family program coordinator then works with the family to develop a health management plan and coordinates a meeting with personal trainers at the YWCA. The personal trainer conducts an initial fitness assessment with each family member and creates an individually-tailored fitness plan. The family, individually and as a whole, is monitored on an on-going basis by the program coordinator and the personal trainer to ensure that nutrition, medical, and fitness plans are being followed.

Participants are informed about and encouraged to participate in other program components, among them: monthly diabetic education classes; the nutrition/cooking classes conducted in eight-week sessions; group fitness sessions; and monthly family gatherings which serve a healthy, shared meal. The YWCA is the lead agency for the project in a coalition that includes Indian Health Board of Minneapolis and the Division of Indian Work. The program's funding from the Community Programs to Improve Minority Health Grant Program will end in September 2007.

Community Interventions in the Hispanic Population

The REACH 2010 Latino Health Project's Community Action Plan works to address the prevalence of diabetes among Hispanic residents of Lawrence, Massachusetts. Interventions include community
strategies that teach individuals how to prevent and control the disease. Culturally-tailored prevention strategies include: intergenerational exercise through the YWCA; media outreach; church involvement; nutrition education and modeling through the Lawrence Senior Center; and empowerment groups. Data from 2001 to 2003 show dramatic improvements in control of blood glucose and high blood pressure for these two ethnic groups. This program continues to receive funding through the REACH 2010 initiative of the Center of Disease Control and Prevention.\textsuperscript{35}

**Community Interventions in the Native Hawaiians and Other Pacific Islanders Population**

The *Kauai’s Great Weigh Out*, or KGWO program, promotes healthy behaviors in order to reduce complications of diabetes, obesity, and related risk factors for chronic diseases among Native Hawaiians and Filipinos living in Kauai County, Hawaii. The project promotes physical activity, balanced nutrition, health screenings, and access to medical care for at-risk target populations.

KGWO has two phases. The first phase is a healthy lifestyle challenge designed to help participants shed weight and become more physically active. Participants enroll in teams of ten, and agree to participate in eight weeks of exercise, healthy eating and education, and maintain a weekly exercise and nutrition log. Teams stay in communication throughout the program to offer support and encouragement. A cultural component involves such activities as Makahiki, Hele Mai Ai classes, Kauai Diabetes Ball, cultural hikes, and fishing excursions.

Phase two is a healthy lifestyle maintenance program for those who have completed phase one. It involves a continuation of physical and nutritional activities and maintenance of health promoting behaviors through use of healthcare services and support groups. An island-wide educational campaign involves the media, including commercials, radio interviews, and printed media (ads, articles), and the use of a website to promote activities. A video/DVD is also shown to encourage participation in events. Staff work with community agencies, civic groups, churches, businesses, councils, and other stakeholders in outreach and recruitment activities, as well as with primary care providers to promote prevention, health screenings, and regular medical visits.

Coalition members involved in the project include IO Vision, the American Heart Association, Kauai District Health Office, Kauai County Parks and Recreation, Wilcox Women’s Health Program, Mahelona Nutrition Program, and the University of Hawaii Extension. Community Programs to Improve Minority Health funding ends in September 2007.\textsuperscript{36}

**Budget Implications**

Future funding for the REACH 2010 program and the grant programs—Community Programs to Improve Minority Health and the State Partnership to Improve Minority Health—is dependent upon the Congressional appropriations process. But with continuing pressure on domestic discretionary funding within the Federal budget suggests that these programs are unlikely to experience the funding increases necessary to expand their reach and impact.
In the President’s proposed Federal budget for fiscal year 2008, for example, the REACH 2010 program would (for the fourth consecutive year) receive an allocation of $34 million. In FY 2005, this funding supported 44 REACH programs across the country, but in FY 2006 it could support only 40 programs. These effective projects, which boast successes including increased rates of cholesterol monitoring among African Americans and decreases in cigarette smoking among Asian men in targeted communities, will be unable to realize their potential without a significant change in budgetary priorities.

The Office of Minority Health allocates moneys to the Community Programs to Improve Minority Health Grant Program and the State Partnership Grant Program to Improve Minority Health. The Community Programs grant funds projects for up to three years with 12-month budget periods. In fiscal year 2004, 24 projects in 17 states were funded for the period from September 30, 2004 through September 29, 2007. In 2005 and 2006 these programs received $6.5 million. The Office of Minority Health awarded nearly $5 million of State Partnership grants to state and territorial offices of minority health. At that time (since only 39 states and territories had offices of minority health) only 39 grants were available.37 The President’s allocation of program moneys to the Office of Minority Health for fiscal year 2008 is unknown at the time this report went to press.

**Policy Recommendations**

The case studies above illustrate that effective community interventions can alter risky health behaviors and increase personal health promotion. These programs allow for racial and ethnic minorities to assume a more active role in their health. In turn, many interventions have been able to reduce racial and ethnic health disparities. Yet there has been a lack of focus on the effective use of community intervention to reduce racial and ethnic disparities at the federal policy level that needs to be addressed. Our recommendations are to:

**Increase and Leverage Funding for Community Interventions**

Both the Center for Disease Control’s REACH 2010 initiative and the Office of Minority Health’s Community Programs to Improve Minority Health Grant Program are demonstrably effective in altering risky health behaviors. Both programs have implemented funding stipulations designed to increase collaboration between community organizations, local or state health departments, and/or academia. Furthermore, the programs demonstrate that tailoring interventions to a specific subpopulation is an effective way of reaching a cultural, race, and/or ethnic subpopulation. To bolster their effectiveness, we offer three specific policy recommendations:

1) For fiscal year 2008, fund the REACH 2010 Program at a level of $60 million. This amount would restore the program’s fiscal year 2005 allocation of $34.5 million, replace the $5 million no longer provided to CDC through the National Institutes of Health, and potentially allow for the funding for an additional 20 programs (a 50 percent increase in the number of programs).38

2) For fiscal year 2008, allocate the Community Programs to Improve Minority Health Grant Program to the funding level of $9 million. This will allow for the continuation of the 24 programs already in existence and the funding of additional programs.39
3) Leverage funding for collaboration and planning of community organizations devoted to altering risk behaviors in order to reduce racial and ethnic health disparities. These programs must meet two stipulations. First, the community organization’s action plan must include coalition building at the community, local and/or state government levels, and public and/or private sector levels. One of these organizations must also specialize in the health delivery sector. Secondly, the community organization must demonstrate how it will tailor its program to the specified racial or ethnic subpopulation. This enables the organization to meet the unique needs and culture of its community.

**Increase State Infrastructure**

Policy studies demonstrate that the Offices of Minority Health serve as the federal and state hub for the development of health policies and programs that work to eliminate health disparities. This fact is illustrated by the many effective grant programs in existence at the department. Funding for the office, however, has decreased in past years and not all states, territories, and districts have offices of minority health to direct state policy. Therefore, we offer two more specific policy recommendations:

4) Restore funding to the Department of Health and Human Services’ Office of Minority Health at the fiscal year 2005 level of $50 million, and include funding for an inflationary increase. The fiscal year 2008 proposed budget allotment is a $4 million decrease from the 2005 level. The fiscal year 2006 level of $56 million included a $10 million earmark for Hurricane Katrina sufferers, which will not be renewed.40

5) Provide the appropriate amount of funding for each state, territory, and district to develop a functioning Office of Minority Health. As of 2005, only 39 states and territories had offices, leaving states, the District of Columbia, some territories, and Indian Health Service Areas without resources devoted to decreasing racial and ethnic health disparities.

**Conclusion**

As cited, African Americans, American Indians, Hispanics (specifically Mexican-Americans), and Native Hawaiians and Pacific Islanders experience higher rates of preventable disease. Various factors contribute to this inequity. However, individuals can be proactive in regards to their health. As this paper illustrates, community interventions that focus on preventing disease through altering behaviors are effective in reducing health disparities. These interventions empower individuals to take charge of modifiable aspects of their health.

Community interventions tailored to meet specific cultural, racial, or ethnic needs are particularly successful. Examples of interventions in various parts of the country targeted to different racial and ethnic groups illustrate this point. The continuation of the programs highlighted in this paper and the potential for further community, government, and private sector collaboration will go a long way in reducing health disparities. Ultimately, these programs will ensure that race and ethnicity do not play definitive roles in individuals’ health.
Endnotes


21. Through a systematic synthesis of research and case studies, the *Guide to Community Preventive Services* developed matrices to assess the average effectiveness of various population-based interventions. The numbers in the chart reflect this.


Office of Minority Health, Department of Health and Human Services, *Community Programs to Improve Minority Health Grant Program*.


Federal Register, Vol. 70, No. 119, June 22, 2005.


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In fiscal year 2006, the mean program allocation was $200,000. With the $2 million increase from the 2006 allocation, 10 additional programs could be funded in fiscal year 2007.

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