Racial and Ethnic Approaches to Community Health (REACH)
Good Health and Wellness in Indian Country (GHWIC)

Centers for Disease Control and Prevention (CDC)
Division of Nutrition, Physical Activity, and Obesity & Division of Population Health
FY2022 Labor HHS Appropriations Bill

FY 2020	FY 2021	FY 2022 President's Request	FY 2022 TFAH Request
$59,950,000 • REACH: $38,950,000 • GHWIC: $21,000,000	$63,950,000 • REACH: $41,950,000 • GHWIC: $22,000,000	N/A	$102,500,000 • REACH: $75,500,000 • GHWIC: $27,000,000

Racial and Ethnic Approaches to Community Health (REACH) Background:
The REACH program explicitly focuses on improving chronic diseases for specific racial and ethnic groups in communities with high rates of chronic disease. REACH grantees (which include community organizations, universities, local health departments, tribal organizations, and states) develop and implement evidence-based practices, and help communities identify and effectively use their own power to reduce health disparities. REACH grantees plan and carry out local, culturally appropriate programs to address the root causes of chronic disease and reduce health disparities among African Americans/Blacks, Hispanic Americans, Asian Americans, Native Hawaiian/Other Pacific Islanders, American Indians, and Alaska Natives. For many racial and ethnic minority groups the health gaps are wide, for example:

- In 2019, Diabetes prevalence was higher among American Indians/Alaska Natives (14.7%), people of Hispanic ethnicity (12.5%), and non-Hispanic Blacks (11.7%) than among Asians (9.2%) or non-Hispanic whites (7.5%).[1]
- In 2017-2018, Hispanic (44.8%) and non-Hispanic Black (49.6%) adults had a higher prevalence of obesity than non-Hispanic white adults (42.2 %).[2]
- In 2017, the rate of new cases of cervical cancer was highest among Hispanic women (8.9 per 100,00) and second highest among Black women (8.3 per 100,000). [3]

Further, racial and ethnic minority groups have historically not had broad opportunities for economic, physical, and emotional health, and these inequities have increased the risk of getting sick and dying from COVID-19 for some groups. Many of these same factors are contributing to the higher level of obesity in some racial and ethnic minority groups.[4]

Good Health and Wellness in Indian Country (GHWIC) Background:
American Indian and Alaskan Native (AI/AN) populations bear a disproportionate burden of the leading causes of death and disability compared to other racial and ethnic groups.[5] CDC's largest investment to improve AI/AN tribal health, the Good Health and Wellness in Indian Country (GHWIC) program promotes evidence-based and culturally adapted strategies to improve health, prevent disease, reduce chronic disease health disparities, and strengthen community-clinical links. Since FY 2017, Congress has set aside a portion of

REACH funding to support tribal cooperative agreements that improve health outcomes for AI/AN communities, including the Tribal Practices for Wellness in Indian Country (TPWIC) and Tribal Epidemiology Centers for Public Health Infrastructure (TECPHI).

Impact:

While the Division of Nutrition, Physical Activity, and Obesity received 300 applications for the REACH program in 2018, CDC can only currently fund 36 recipients (and potentially up to 40 with the FY21 increase) to reduce health disparities among racial and ethnic populations with the highest burden of chronic disease. Key REACH outcomes during 2014-2018 (the latest completed program cycle) include:

- Over 2.9 million people have better access to healthy foods and beverages.
- About 1.4 million people have more opportunities to be physically active.
- About 830,000 people have access to local chronic disease programs that are linked to clinics.
- Over 322,000 people have benefited from smoke-free and tobacco-free interventions.

REACH recipients have proven that they can continue effective chronic disease program efforts while also addressing COVID-19 pandemic challenges. Given the demonstrated ability of REACH recipients to be trusted community messengers, CDC's National Center for Immunization and Respiratory Diseases provided supplemental funding to REACH recipients to improve COVID-19 and flu vaccination confidence in racial and/or ethnic populations experiencing disparities in vaccination rates.

While there are 574 federally recognized tribes, funds from REACH that support GHWIC can only fund 21 tribes directly and support other tribes by funding 15 Urban Indian Health Centers and 12 Tribal Epidemiology Centers (TECs). GHWIC, administered by CDC's Division of Population Health, continues to support healthy behaviors in Native communities by supporting coordinated and holistic approaches to chronic disease prevention; continuing to support culturally appropriate, effective public health approaches; and expanding the program's reach and impact by working with more tribes and tribal organizations, including Urban Indian Organizations. In addition, these GHWIC funds support the Tribal Epidemiology Centers for Public Health Infrastructure (TECPHI), as the main source of funding for TECs.

FY 22 Appropriations Recommendation:

TFAH recommends that REACH be funded in FY 2022 at $102,500,000: $75,000,000 for the REACH grant program and $27,000,000 for Good Health and Wellness in Indian Country to ensure that CDC can continue to reduce chronic disease for multiple racial and ethnic groups that bear the highest burden of disease.

FY 22 Report Language Recommendation:

The Committee includes $102,500,000 for REACH: $75,000,000 for the REACH program to continue scaling to all states and U.S. territories and support grantees in building capacity for collaboration and disseminating evidence-based strategies in communities, and $27,000,000 for Good Health and Wellness in Indian Country to expand Tribal Epidemiology Centers for Public Health Infrastructure and continue the program's important work.

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[1] Centers for Disease Control and Prevention. Diabetes Report Card 2019. Atlanta, GA: Centers for Disease Control and Prevention, US Dept of Health and Human Services; 2020.
[2] https://www.cdc.gov/nchs/data/hestat/obesity-adult-17-18/obesity-adult.htm
[3] U.S. Cancer Statistics Working Group. U.S. Cancer Statistics Data Visualizations Tool, based on 2019 submission data (1999-2017): U.S. Department of Health and Human Services, Centers for Disease Control and Prevention and National Cancer Institute; www.cdc.gov/cancer/dataviz, released in June 2020.
[4] https://www.cdc.gov/obesity/data/obesity-and-covid-19.html
[5] https://www.cdc.gov/nchs/fastats/american-indian-health.htm