REACH FY 2018-2023 NOFO

To provide communities the opportunity to improve health, prevent chronic diseases, and reduce health disparities among racial and ethnic populations with the highest risk, or burden, of chronic disease (e.g., hypertension, heart disease, Type 2 diabetes, and obesity).

Strategies	Outcomes in Communities with Health Disparities		
	Short (1-*3 years)*	*Intermediate* *(4-5 years)*	*Long* *(Beyond Project Period)*
Tobacco Collaborate with partners to promote tobacco free living in priority population(s) to: • Support implementation of tobacco free policies within workplaces and multi-unit housing. • Support and leverage CDC's national tobacco education campaigns • Promote community-based, culturally-appropriate tobacco-free living messages • Work with health care providers to include tobacco-free living screening and counseling • Train community-level spokespersons to communicate on tobacco-free living • Inform and educate leaders, decision makers and the public about the evidence-based solutions to protect workers and multi-unit housing residents from exposure to secondhand smoke • Engage and leverage community stakeholders and assets to address healthier retail options	Demonstrated progress on activities to increase tobacco free living	Increased number of workplaces and multi-unit housing complexes that implement tobacco free policies Increased number of persons in workplaces and multi-unit housing complexes with tobacco free policies	Increased tobacco free living, increased purchasing of healthier foods, and increased physical activity in racial and ethnic populations Improved health outcomes Reduced health disparities in chronic conditions (i.e., hypertension, heart disease, type 2 diabetes, and obesity)
Nutrition Collaborate with partners to improve nutrition in priority population(s) to: • Establish healthy nutrition standards in key institutions such as hospitals, afterschool and recreation programs, community health centers, faith-based organizations, food banks/pantries, and early care and education • Work with food vendors, distributors and producers to enhance healthier food procurement and sales • Make improvements to local programs/systems (e.g., voucher incentive programs, increased electronic benefit transfer acceptance where food is purchased, improved public transportation routes to food stores, access to healthier foods at community venues • Implement continuity of care/community support for breastfeeding by incorporating services into existing community support services	Demonstrated progress on activities to improve nutrition and increase access to healthier foods	Increased number of places offering healthier foods Increased number of persons with access to healthier foods Increased number of continuity of care/community support actions implemented for breastfeeding	
Physical Activity Collaborate with partners to improve physical activity in priority population(s) to connect sidewalks, paths, bicycle routes, public transit with homes, early care and education, schools, worksites, parks, or recreation centers through implementing master plans and land use interventions to: • Establish new or improved pedestrian, bicycle, or transit transportation systems (i.e., activity-friendly routes) that are combined with new or improved land use or environmental design (i.e., connecting everyday destinations).	Demonstrated progress on activities to connect safe and accessible places for physical activity	Increased number of places that improve community design by connecting safe and accessible places for physical activity Increased number of persons with safe and accessible places for physical activity	
Community-Clinical Linkages Collaborate with partners to increase referral and access to community-based health programs for the priority population(s) to: • Promote the use of appropriate and locally available programs for individuals in the priority population(s) • Expand the use of health professionals such as Community Health Workers, patient navigators, and, pharmacists, to increase referral of individuals in the priority population(s) to appropriate and locally available health and preventive care programs	Demonstrated progress on activities to increase access to relevant health or community programs for the priority population.	Increased use of appropriate and locally available health or community programs	