

Funding Opportunity Announcement (FOA) Non-research, Domestic

Enhancing Public Health Surveillance of Autism Spectrum Disorder and
Other Developmental Disabilities through the
Autism and Developmental Disabilities Monitoring (ADDM) Network

DD15-1501

National Center on Birth Defects and
Developmental Disabilities (NCBDDD)

Effective date: 08/11/2014

Amendment II (9/26/2014): Has been made to the following Sections of this FOA:

Part II., v. Strategies and Activities: Strategy 3(S3): Site-Initiated Analyses; Activity 9 (A9) has been changed.

Part II., H. Other Information: Additional acceptable attachments were added to the list.

Pages 64-66: Added Questions and Answers obtained from the informational call.



Contents

Part I. Overview Information	3
A. Federal Agency Name.....	3
B. Funding Opportunity Title	3
C. Announcement Type:	3
D. Agency Funding Opportunity Number	3
E. Catalog of Federal Domestic Assistance (CFDA) Number	3
F. Dates:.....	3
G. Executive Summary	4
Part II. Full Text	5
A. Funding Opportunity Description.....	5
B. Award Information	37
C. Eligibility Information	38
D. Application and Submission Information	40
E. Application Review Information.....	50
F. Award Administration Information	53
G. Agency Contacts	58
H. Other Information	59
I. Glossary	60

Part I. Overview Information

Applicants must go to the synopsis page of this announcement at www.grants.gov and click on the “Send Me Change Notifications Emails” link to ensure they receive notifications of any changes to DD15-1501. Applicants also must provide an e-mail address to www.grants.gov to receive notifications of changes.
A. Federal Agency Name:
Centers for Disease Control and Prevention (CDC)
B. Funding Opportunity Title:
Enhancing Public Health Surveillance of Autism Spectrum Disorder and Other Developmental Disabilities through the Autism and Developmental Disabilities Monitoring (ADDM) Network
C. Announcement Type: New—Type 1
This announcement is only for non-research domestic activities supported by CDC. If research is proposed, the application will not be considered. Research for this purpose is defined at http://www.cdc.gov/od/science/integrity/docs/cdc-policy-distinguishing-public-health-research-nonresearch.pdf .
D. Agency Funding Opportunity Number:
CDC-RFA-DD15-1501
E. Catalog of Federal Domestic Assistance (CFDA) Number:
93.998 Autism and Other Developmental Disabilities, Surveillance, Research, and Prevention
F. Dates:
1. Letter of Intent (LOI) Deadline: September 12, 2014
2. Application Deadline: October 10, 2014, 11:59 p.m. U.S. Eastern Standard Time, on www.grants.gov
3. Informational conference call for potential applicants: September 12, 2014 at 12:30 p.m. U.S. Eastern Standard Time, Toll-Free: 855-644-0229 Participant Passcode: 8547938, Participant Webinar Information: 1. Copy this address and paste it into your web browser: https://www.livemeeting.com/cc/cdc/join 2. Copy and paste the required information: Meeting ID: D8W7N9 Entry Code: DD15-1501

G. Executive Summary:

1. Summary Paragraph:

The purpose of this FOA is to enhance the capacity of surveillance programs to implement or enhance a population-based, multiple-source surveillance program for autism spectrum disorder (ASD) and other developmental disabilities (DDs) that co-occur with ASD (cerebral palsy (CP) and intellectual disability (ID)). The project will fund sites to participate in the Autism and Developmental Disabilities Monitoring (ADDM) Network and will enhance surveillance activities at both prior and newly participating sites through two funding components. Component A funds surveillance of autism spectrum disorder (ASD) and other DDs (i.e. CP and ID) among 8-year-olds. Component B funds surveillance of ASD among 4-year-olds. Component A is required for all applicants, while applying for Component B funding is optional. In this FOA, five project period short-term outcomes will be achieved through five strategies and their corresponding activities. The five expected outcomes include: improved understanding of ASD & other DDs, including trends and disparities in ASD prevalence over time; improved understanding of the implications of the change from DSM-IV TR to DSM-5 diagnostic criteria for ASD; stronger relationships with partners and data sources; increased dissemination of ADDM data; improved reliability and efficiency of ADDM surveillance. Strategy 1: [Component A] – 8-year-old ASD + CP or ASD + ID surveillance includes the bulk of ADDM activities for ASD and other DD surveillance, including activities: adhere to standardized ADDM/MADDSP methodology and case definitions; renew or establish agreements for data requests and access to data sources; staff training & continued education; review and abstract records at data sources; clinician review of records based on the ADDM coding scheme; clean data; perform linkages; and report de-identified data to CDC. For Strategy 2: [Component B] – 4-year-old ASD surveillance, the activities are the same as listed above for Strategy 1, but are focused on 4-year-old children. All sites will complete Strategy 3: Site-initiated analyses, which requires sites to conduct at least two site-initiated analyses that focus on topics selected from a list of five options provided in the FOA. Strategy 4: Community education and outreach required activities include initiating and strengthening relationships with data sources and community partners, and disseminating ADDM findings and information about ASD and co-occurring developmental disabilities to stakeholders. Lastly, all sites will participate in Strategy 5: Monitor and evaluate ADDM Surveillance, including activities: create and implement a site strategic plan; complete a site evaluation plan; conduct ongoing quality assurance and control activities; and to identify ways to improve program efficiency.

a. Eligible Applicants: Open Competition

b. FOA Type: Cooperative Agreement

c. Approximate Number of Awards: 6-14

d. Total Project Period Funding: \$25,300,000 / 4 years (This amount is subject to availability of funds. This includes direct and indirect costs. The government reserves the right to adjust award amounts for program areas as agency and public health priorities change.)
e. Average One Year Award Amount: Component A: \$450,000; Component B: \$125,000
f. Number of Years of Award: 4
g. Approximate Date When Awards will be Announced: January 1, 2015
h. Cost Sharing and /or Matching Requirements: N/A

Part II. Full Text

A. Funding Opportunity Description

1. Background

Since the early 1990s, the number of children identified with autism spectrum disorder (ASD) has risen markedly. The uncertainty regarding the cause of this increase and the pressing need for medical and educational services among this growing number of children has created a substantial level of concern among researchers, educators, policy makers, advocacy groups and the general public. Accurate and current prevalence estimates continue to be urgently needed, and CDC and its public health partners are in the best position to provide these prevalence estimates along with other critical information regarding the characteristics, co-occurring conditions, and functional level of children with ASD. Previous data have suggested that current ASD prevalence varies by sex, race/ethnicity, socioeconomic status and geographic location. Therefore, data on ASD prevalence changes among these subgroups provide valuable clues that will meaningfully contribute to the understanding of the prevalence increase.

Because of the need to estimate ASD prevalence using a common methodology with a sufficiently large population to make estimates among subgroups, the use of national surveys or aggregate special education reports is complementary but inadequate. Population-based surveillance data from the ADDM Network allow for stable prevalence estimates and detection of trends over time, including those within subgroups defined by sex, race/ethnicity, socio-economic status and geographical location. Previous surveillance activities indicate that age 8 years is the optimum age for ascertaining the prevalence of ASD. In addition, other developmental disabilities (DDs) such as intellectual disability, an important indicator of functional level among children with ASD, can be reliably assessed at this age. Previous ADDM data suggest that access to children's education records helps to ensure that ascertainment of children with ASD is as complete as possible. Access to education records is also helpful for obtaining information on intellectual ability among

children with ASD. Monitoring ASD among successive birth cohorts in the ADDM Network provides policymakers, service providers, and researchers with critical information on the prevalence and characteristics of children with ASD that is needed to plan services and allocate resources. In particular, assessment of changes in the ages of ASD evaluation and diagnosis over time, particularly in sub-populations among which ASD is thought to be under-ascertained, helps target education and outreach activities, potentially resulting in earlier evaluation and diagnosis of children with ASD.

There is evidence that early treatment of ASD may improve outcomes, therefore, it is important that children with ASD are identified as early as possible. ASD surveillance among 4-year-old children provides information on patterns in the age at ASD evaluation and diagnosis without the time lapse associated with monitoring these data in 8-year-old children. It will provide feedback on progress toward the goal of lowering the age of first evaluation and diagnosis of ASD and other DDs. Data from early intervention records will also contribute to understanding early intervention services, and how referral and eligibility patterns may differ by sex or race/ethnicity, potentially helping to explain variation in ASD prevalence.

Recently, the diagnostic criteria for autism were revised with the publication of the Fifth Edition of the Diagnostic and Statistical Manual of Mental Disorders, or DSM-5 (APA, 2013). The effect of this change in diagnostic criteria is uncertain, including how it may differentially affect certain groups. Because the ADDM Network methodology offers the opportunity to apply ASD surveillance case definitions based on both the older and current diagnostic criteria, the ADDM Network is uniquely poised to evaluate the effect of this change on prevalence and characteristics of children with ASD.

a. Statutory Authorities: Sections 301(a) [42 U.S.C. Section 241(a)] and 317(C) of the Public Health Service Act [42 U.S.C. Sections 243, 247b (k) (2) and 247b-4], as amended

b. Healthy People 2020:

Data from the ADDM Network are used to measure two Healthy People 2020 Maternal, Infant, and Child Health (MICH) objectives (<http://www.healthypeople.gov/2020/topicsobjectives2020/objectiveslist.aspx?topicid=26>), including: MICH Objective 29.2: Increase the proportion of children with an ASD with a first evaluation by 36 months; and MICH 27: Reduce the proportion of children with cerebral palsy born as low birth weight infants (less than 2,500 grams).

c. Other National Public Health Priorities and Strategies:

Data from the ADDM Network are used to inform the strategic planning of the Interagency Autism Coordinating Committee (IACC, <http://iacc.hhs.gov/index.shtml>), a Federal advisory committee charged with coordinating all work within the Department of Health and Human Services (HHS) regarding autism spectrum disorder (ASD).

d. Relevant Work:

CDC currently funds eleven ADDM Network sites through cooperative agreements (current

funding scheduled to end December 2014). Each funded site in the ADDM Network conducts surveillance of ASD and other DDs using a consistent surveillance methodology modeled after the Metropolitan Atlanta Developmental Disabilities Surveillance Program (MADDSP). CDC provides technical support for data collection, case determination, and data analysis without having access to any individually-identifying information. CDC also provides to each site a CDC-designed, standardized web-based database called ARCHEv4. All ADDM sites submit de-identified data to CDC, where they are merged to create a pooled dataset.

Estimates of prevalence and characteristics of children with ASD and other DDs are released every two years for the overall ADDM Network. In addition, dozens of papers have been published using both pooled and site-specific ADDM data, including behavioral descriptions, analyses of risk factors, and frequency of co-occurring conditions, all of which have contributed to the scientific understanding of this complex condition. ADDM pooled datasets (de-identified) are available for public use. Furthermore, ADDM's community education and outreach activities have supported surveillance activities by helping to ensure continuous access to community data sources and fostering community use of ADDM data needed for public health practice and to track progress toward national and community goals. For more information, see <http://www.cdc.gov/ncbddd/autism/addm.html>.

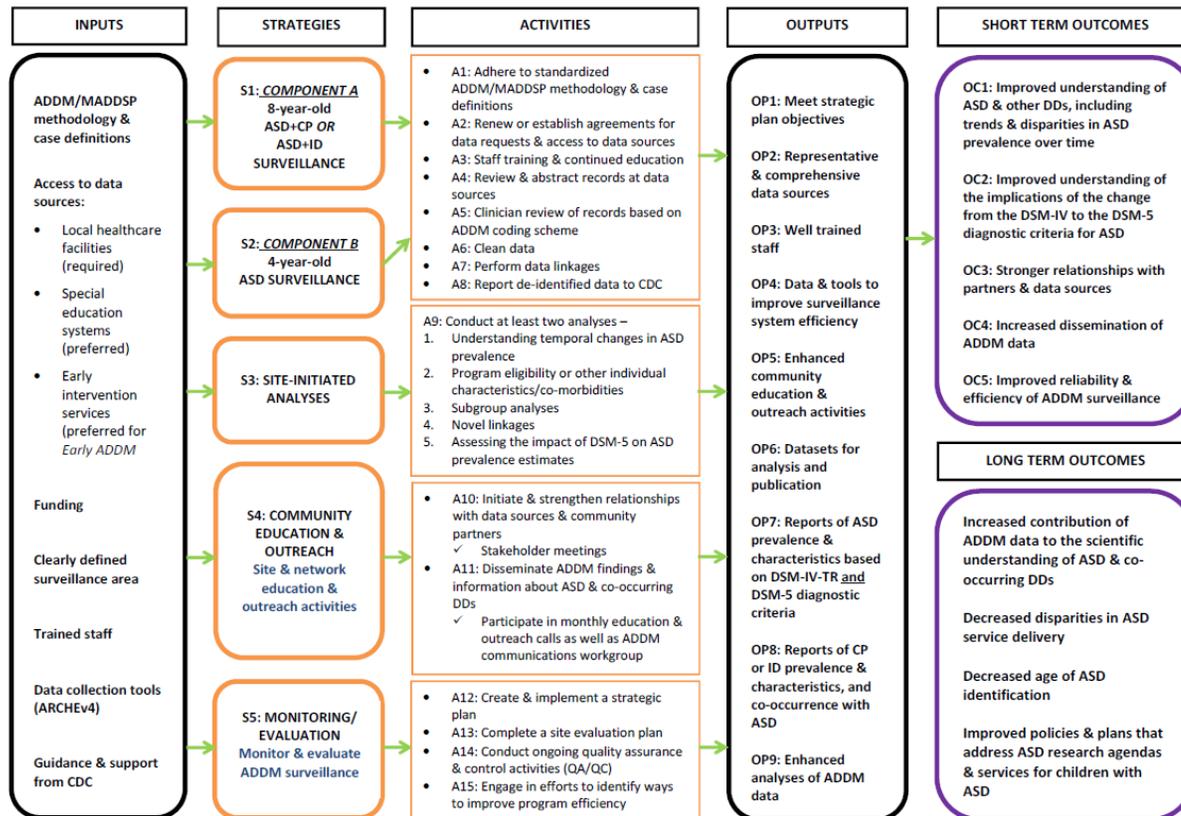
2. CDC Project Description

a. Approach:

This project will fund sites to participate in the Autism and Developmental Disabilities Monitoring (ADDM) Network and will enhance surveillance activities at both prior and newly participating sites through two funding components. Component A funds surveillance of autism spectrum disorder (ASD) and developmental disabilities (DDs) (i.e. cerebral palsy (CP) and intellectual disability (ID)) among 8-year-olds. Component B funds surveillance of ASD among 4-year-olds. Component A is required for all applicants, while applying for Component B funding is optional.

The ADDM Network logic model provides high-level visual depiction of CDC's programmatic approach, including relationships between project strategies, activities, outputs and outcomes for both Components A and B.

Autism and Developmental Disabilities Monitoring (ADDM) Network Logic Model
Project Period 2015-2018 (Surveillance Years 2014 and 2016)



<p>i. Problem Statement:</p>
<p>Autism spectrum disorder (ASD) is a serious developmental disability that generally persists throughout a person’s life and is associated with mild to severe functional impairments in educational and occupational performance, daily living skills, and community participation. Since the early 1990s, the number of children identified with autism spectrum disorder (ASD) has risen markedly. The factors causing this increase are not well-understood and, in general, risk factors for ASD are poorly characterized. Accurate and current prevalence estimates are essential for public health practice, and CDC and its public health partners are in the best position to provide these prevalence estimates along with other critical information regarding the characteristics, co-occurring conditions, age of evaluation and diagnosis, and functional level of children with ASD, including disparities by sex and race/ethnicity. Because there is evidence that early treatment may result in improved long-term outcomes for children with ASD, identifying children as early as possible is important to ensure that children receive appropriate services. These data not only help to target early identification strategies, plan for service use, and allocate resources for children with ASD, but also they help to track progress towards national and community goals on reducing the age of evaluation in the hopes that all children with ASD have the opportunity to thrive.</p>
<p>ii. Purpose:</p>
<p>The purpose of this FOA is to enhance the capacity of currently operational surveillance programs (whether funded by CDC and currently part of the ADDM Network or funded by other sources) to implement or enhance a population-based, multiple-source surveillance program for autism spectrum disorder (ASD) and other developmental disabilities (DDs) that may co-occur with ASD among children.</p> <p>With Component A, de-identified surveillance data collected by the ADDM Network and sent to CDC will be used to calculate population-based estimates of the prevalence and characteristics of 8-year-olds with ASD and other DDs that may co-occur with ASD. These other DDs, including cerebral palsy (CP) and intellectual disability (ID) have been demonstrated to impact the characteristics and diagnosis of ASD. By better describing the population and characteristics of children with ASD and DDs, ADDM data will increase the scientific understanding of ASD, including potential causes of the recent rise in prevalence of ASD and disparities in the prevalence of ASD, and will inform policies and plans for ASD research consortia, scientific agendas, and services. With Component B, de-identified surveillance data collected by the ADDM Network and sent to CDC will be used to calculate population-based estimates of the prevalence and characteristics of 4-year-olds</p>

with ASD. ADDM data from both Components A & B, including information on important measures of disparity, will inform policies and plans to decrease the age of identification of children with ASD. A secondary purpose of this FOA is to help bridge the gap between surveillance and community impact by conducting education and outreach activities that will lead to increased use of ADDM data in public health practice, research, policy development, service planning, and tracking of national/community goals.

iii. Outcomes:

ADDM Network sites are expected to demonstrate measurable progress toward addressing short-term outcomes depicted in the logic model. Long term outcomes are overarching goals of the ADDM network and may not be obtainable or measurable during the project period.

The short term outcomes for Components A and B include:

- Outcome 1 (OC1) Improved understanding of ASD & other DDs, including trends & disparities in ASD prevalence over time;
- Outcome 2 (OC2) Improved understanding of the implications of the change from DSM-IV TR to the DSM-5 diagnostic criteria for ASD;
- Outcome 3 (OC3) Stronger relationships with partners & data sources;
- Outcome 4 (OC4) Increased dissemination of ADDM data to stakeholders (e.g., policy makers, service providers, advocates); and
- Outcome 5 (OC5) Improved quality & efficiency of ADDM surveillance.

iv. Funding Strategy:

This cooperative agreement provides multiple options that applicants can select for development and action. Component A funds surveillance of autism spectrum disorder (ASD) and developmental disabilities (DDs) that frequently co-occur with ASD (i.e. Cerebral Palsy (CP), Intellectual Disability (ID)) among 8-year-olds. Component B funds surveillance of ASD among 4-year-olds. Component A is required for all applicants, while Component B is optional. The annual awards range from \$425,000-\$475,000 for Component A and \$100,000-\$150,000 for Component B. Note: Applicants may apply for both components depending on the special eligibility criteria outlined in Section C. 2. Special Eligibility Requirements. The criteria vary by component.

v. Strategies and Activities:

The outcomes to be achieved during the project period will be the result of the following strategies and activities:

OUTCOME 1 (OC1): Improved understanding of ASD & other DDs, including trends & disparities in ASD prevalence over time

Strategy 1 (S1): [Component A] – 8-year-old ASD and CP or ASD and ID

Surveillance

Applicants must address the following activities in their application:

- Activity 1 (A1): Adhere to standardized ADDM/MADDSP methodology & case definitions

ADDM Network Surveillance Methodology and Case Definitions –

Applicants must describe the surveillance methodology they plan to use for their proposed project site. It is the responsibility of each grantee in the ADDM Network to conduct surveillance of autism spectrum disorder (ASD) and one other developmental disability (either cerebral palsy (CP) or intellectual disability (ID)) using a common methodology modeled after the Metropolitan Atlanta Developmental Disabilities Surveillance Program (MADDSP) (Yeargin-Allsopp M, Rice C, Karapurkar T, Doernberg N, Boyle C, Murphy C. Prevalence of autism in a US metropolitan area. JAMA 2003; 289: 49-55.).

ADDM is an active surveillance system that does not rely on professional or family reporting of an existing diagnosis or classification to ascertain ASD case status. Case determination is completed in two phases. The first phase involves screening and abstraction of records at multiple data sources in the community. All abstracted evaluations then are compiled and reviewed by trained clinicians to determine ASD case status in the second phase of the study. In the first phase, a broad net is cast to screen thousands of records and identify a subset of children with general symptoms of ASD, whereas a much more strict case definition is applied during the second phase of the study.

Because children's records are screened at multiple data sources, developmental assessments completed by a wide range of health and education providers are included. Data sources are categorized as either 1) education source type, including evaluations to determine eligibility for special education services or 2) health source type, including diagnostic and developmental assessments from psychologists, neurologists, developmental pediatricians, physical therapists, occupational therapists, speech/language pathologists, and other providers. When possible, agreements to access records are made at the institutional level in the form of contracts, memoranda, or other formal agreements. In rare cases, permission to access children's records may be based on parent or guardian consent.

In the first phase of the study, ADDM Network sites identify source records to review based on a child's year of birth and either 1) eligibility classifications in

special education or 2) International Classification of Diseases, Ninth Revision (ICD-9) billing codes for select childhood disabilities or psychological conditions. Children's records are screened to confirm year of birth and residency in the surveillance area at some time during the surveillance year. For children meeting age and residency requirements, the source files are screened for certain behavioral or diagnostic descriptions defined by ADDM as "triggers" for abstraction (e.g., child does not initiate interactions with others, prefers to play alone or engage in solitary activities, or has received a documented ASD diagnosis). If abstraction "triggers" are found, evaluation information from birth through the current surveillance year is abstracted into a single composite record for each child.

In the second phase of the ADDM methodology, the abstracted composite evaluation files are de-identified and reviewed systematically by trained clinicians to determine ASD case status using a coding scheme based on the American Psychiatric Association's Diagnostic and Statistical Manual-IV, Text Revision (DSM-IV-TR) criteria for pervasive developmental disorders (presently) and Diagnostic and Statistical Manual-5 (DSM-5) criteria for autism spectrum disorder (henceforth). A child is included as meeting one of the two surveillance case definitions for ASD if he or she displays behaviors at any time from birth through the end of the year when the child reaches age 8 years, as described on a comprehensive evaluation by a qualified professional, that are consistent with 1) the DSM-IV-TR diagnostic criteria for any of the following conditions: Autistic Disorder; Pervasive Developmental Disorder—Not Otherwise Specified (PDD-NOS, including Atypical Autism); or Asperger Disorder or 2) the DSM-5 diagnostic criteria for Autism Spectrum Disorder.

Definitions of qualified professional and ASD clinician (Yeargin-Allsopp M, Rice C, Karapurkar T, Doernberg N, Boyle C, Murphy C. Prevalence of autism in a US metropolitan area. JAMA 2003; 289: 49-55.)

- A qualified professional is defined as a medical, clinical or educational professional in a position to observe children with developmental disabilities. It includes, but is not limited to, psychologist, physician, teacher, learning specialist, speech/language pathologist, occupational therapist, physical therapist, nurse, social worker.
- A qualified diagnostician is defined as a clinician with an advanced degree and specialized training and/or certification in the assessment and diagnosis of children with developmental disabilities (e.g., clinical/developmental psychologist, developmental pediatrician, child psychiatrist, pediatric neurologist).
- An ASD clinician is defined as a qualified diagnostician with specialized training and experience in ASD assessment and diagnosis.

Intellectual Disability Case Criteria -

Intellectual Disability (ID) is defined as a condition marked by an intelligence quotient (IQ) of ≤ 70 on the most recently administered psychometric test (Decouflé P, Boyle CA. The relationship between maternal education and mental retardation in 10-year-old children. *Ann Epidemiol* 1995;5(5):347-53). In the absence of an IQ score, a written statement by a psychometrist that a child's intellectual functioning falls within the range for intellectual disability is acceptable, provided this statement is based on intellectual testing administered or attempted. The severity of intellectual disability is defined according to the following International Classification of Disease, Ninth Edition (add citation), Clinical Modification (ICD-9-CM) categories: mild (IQ of 50-70), moderate (IQ of 35-49), severe (IQ of 20-34), and profound (IQ of < 20). NOTE: a concurrent impairment in adaptive functioning is not required to meet the ID case definition.

Cerebral Palsy Case Criteria -

Cerebral palsy (CP) is defined as a group of permanent disorders of the development of movement and posture that are attributed to non-progressive disturbances that occurred in the developing brain. The motor disorders of cerebral palsy are often accompanied by disturbances of sensation, perception, cognition, communication, and behavior; by epilepsy; and by secondary musculoskeletal problems. Children with post-natally acquired cerebral palsy are included. The impairment of motor function may result in paresis, involuntary movement, or incoordination. It does not include motor disorders that are transient, that result from progressive disease of the brain, or that are due to spinal cord abnormalities/injuries.

A child is included as a confirmed CP case if he or she has a diagnosis of CP or physical findings consistent with CP noted in evaluations at age 2 or older by a qualified professional. Abstracted information is reviewed by a CP clinician reviewer to determine if the diagnostic information and/or physical findings are consistent with cerebral palsy. For CP, a qualified professional is defined as a physician, physical therapist, occupational therapist, nurse practitioner, or physician assistant.

A CP clinician reviewer is defined as a clinician with an advanced degree, direct clinical experience, and specialized training and/or certification in the assessment of and/or diagnosis of children with CP (e.g., developmental pediatrician, OT, PT) (Yeargin-Allsopp M, Rice C, Karapurkar T, Doernberg N, Boyle C, Murphy C. Prevalence of autism in a US metropolitan area. *JAMA* 2003; 289: 49-55)

Data Management:

All sites funded under this cooperative agreement will conduct data collection for

core surveillance activities using the ARCHE system, a web-based SQL Server database application developed at CDC but hosted and maintained locally at each funded site. CDC will provide technical support for installing the base system and upgrades, and CDC will provide tools for data cleaning and closeout. At the conclusion of each surveillance cycle, data for scientific analysis are exported from the ARCHE system using a data extraction module furnished by CDC. The extraction module strips all identifiers from sites data and creates summary tables to be used for analysis. These files are uploaded from all ADDM sites to the CDC ftp site, and CDC appends data from all sites into a pooled analysis dataset for each surveillance cycle. These datasets are used for the combined ADDM Network prevalence report(s) for each surveillance cycle, and they are furnished to all participating sites for further analysis on special topics of interest. A subset of this dataset may be requested by outside investigators in the form of a public-use dataset. ADDM sites may negotiate which data elements to make publicly available, but it is a requirement of all federally-funded programs to furnish data for public use so all funded sites are required to make these data available in an established manner.

Additional Activities for Strategy 1 (S1): [Component A] – 8-year-old ASD and CP or ASD and ID Surveillance

- **Activity 2 (A2):** Renew or establish agreements for data requests and access to data sources:

Applicants must describe what types of data sources they anticipate will be available for surveillance in their proposed project area. Note that all possible sources within the surveillance area should be included, in addition to sources that are outside the surveillance area but may provide evaluations for a significant number of children who reside in the surveillance area. Sources should include a range of facilities that provide evaluation and treatment services for children with developmental disabilities, particularly ASD, Intellectual Disability (ID) and Cerebral Palsy (CP).

- Health Sources (including diagnostic and developmental assessment information) (required)
 - Education Sources (including evaluations to determine eligibility for special education services, e.g., psychological evaluations to determine special education eligibility, physical therapy and occupational therapy evaluations, speech/language pathology assessments) (preferred)
- **Activity 3 (A3):** Staff training and continued education
 - Initial training of staff on ADDM/MADDSP methodology and case definitions per the ADDM training guidebook and ADDM protocols with technical

assistance provided by CDC

- Continued education for staff based on Quality Assurance/Quality Control (QA/QC) results and educational needs of sites and the ADDM Network
 - Each site must appoint a Confidentiality Officer and conduct initial and annual (refresher) training with staff on the ADDM confidentiality guidelines and any additional local requirements.
- Activity 4 (A4): Review and abstract records at data sources
 - As described in methodology section above
 - Activity 5 (A5): Clinician review of records based on ADDM coding scheme
 - As described in methodology section above
 - Coding scheme applies both DSM-IV and DSM-5 case definitions, (including differential diagnostic criteria for Social Communication Disorder)
 - Activity 6 (A6): Clean data
 - Routine data cleaning edit checks per CDC ADDM data cleaning manual in CDC-provided web-based database (ARCHE v4)
 - Run data cleaning programs and conduct final edit checks prior to submitting data to CDC for the ADDM pooled dataset
 - Activity 7 (A7): Perform data linkages to:
 - Birth certificates
 - Community Indicators (e.g., socio-economic status) based on residency geocoding
 - Activity 8 (A8): Report de-identified data to CDC
 - Data to be reported according to the established timeline
 - Pooled de-identified data will be used by CDC to create the ADDM pooled dataset

Note: Any pooled data with other ADDM projects will be grouped as individual, de-identified data. All surveillance reports and results will be disseminated in non-personally identifiable, aggregate form. Applications must include a copy of the applicant's Data Release Plan. CDC recommends data release in the form closest to micro data and one that will preserve confidentiality.

Strategy 2 (S2): [Component B] – 4-year-old ASD Surveillance

Applicants may choose to apply for additional funding for 4-year-old ASD surveillance (referred to as “Early ADDM”).

Because there is substantial overlap in the activities for Component A and Component B, in that the methodology for surveillance is nearly the same, applicants for Component B need only address the following additional activities for Component B when describing activities under this strategy in their application.

- **Activity 2 (A2):** Renew or establish agreements for data requests and access to data sources
 - Local healthcare facilities (**required**)
 - Education sources (**preferred**)- Part B under the Individuals with Disabilities Education Act (IDEA)
 - Early Intervention programs (**preferred**) - Part C under IDEA

Note: Information from early intervention records provides insight into the source and timing of referral and diagnosis, as well as the types of services received among children identified with ASD - including how these may vary by race/ethnicity or geographic location.
- **Activity 3 (A3):** Staff training and continued education
 - Training of staff on “Early ADDM” methodology and case definitions (including meeting QA/QC requirements)

OUTCOME 2 (OC2): Improved understanding of the implications of the change from DSM-IV to the DSM-5 diagnostic criteria for ASD

This outcome is to be achieved through the following strategies:

Strategy 1 (S1): Component A – 8-year-old ASD Surveillance (activities listed previously);

Strategy 2 (S2): Component B – 4-year-old ASD Surveillance (activities listed previously); and

Strategy 3 (S3): Site-Initiated Analyses

For Components A and B, the analysis options differ only for sites that conducted 4-year-old surveillance in Surveillance Years 2010 and 2012. Sites that participated in 4-year-old “Early ADDM” in Surveillance Years 2010 and 2012 will have the capability to explore temporal changes in prevalence among the same birth cohort, and thus have different options available for site initiated analyses. It should be noted that participation in 4-year-old surveillance in SY 2010 and 2012 is not a requirement for this FOA.

Scheme A. For sites who were funded in the Fiscal Years 2010-2014 (Surveillance Years 2010/2012) cooperative agreement for “Early ADDM” 4-year-old surveillance:

Activity 9 (A9): Propose AT LEAST TWO analyses of 4-year-old and/or 8-year-old ADDM surveillance data, one of which addresses option 1 below and the other one of which addresses option 2, 3, 4, ~~or 5~~ or 6:

1. Improve understanding of temporal changes in prevalence among the same birth cohort via follow-up studies of a baseline/prior surveillance year (see table below). Applicants must describe analytic procedures for matching individual identifiers to account for in/out migration between the two time points.

Baseline (SY 2010/2012)		Follow-up (SY 2014/2016)	
<u>Surveillance Year</u>	<u>Age</u>	<u>Surveillance Year</u>	<u>Age</u>
2010	4	2014	8
2012	4	2016	8

2. Improve understanding of program eligibility or other individual characteristics/co-morbidities of children with ASD
3. Conduct subgroup analyses (e.g., differences in prevalence, age at identification or other outcomes of interest among populations with known or suspected disparities, including, for example, disparities among rural vs. urban areas or in-depth evaluations of racial/ethnic differences in prevalence or other characteristics).
4. Conduct analysis of how generalizable the site-specific ASD prevalence estimate is to the state based on distribution of factors such as race/ethnicity, socioeconomic status, and rural/urbanicity.
5. Perform novel linkages for scientific analyses, such as linking ADDM data to newborn screening data, juvenile justice data or longitudinal special education data, or other linkages to follow-up an age cohort previously monitored for ASD.
6. Assess the impact of the DSM-5 diagnostic criteria for ASD (including differential diagnostic criteria for Social Communication Disorder) on ASD prevalence estimates and/or further descriptive analyses of the characteristics of children identified with ASD based on DSM-IV-TR versus DSM-5 case definitions (e.g., diagnostic criteria met, individual characteristics or phenotype).

Scheme B. For all other sites (any site funded for 4-year-old surveillance or 8-year-old surveillance under the current grant cycle but NOT previously funded for Fiscal Years 2010-2014 (Surveillance Years 2010/2012) 4-year-old “Early ADDM” ASD surveillance)

Activity 9 (A9): Propose AT LEAST TWO analyses of 4-year-old and/or 8-year-old ADDM surveillance data that address any two of options 1, 2, 3, 4, ~~or 5~~ or 6:

1. Improve understanding of temporal changes in ASD prevalence (e.g., community identification, socio-economic factors, birth characteristics)
2. Improve understanding of program eligibility or other individual characteristics of children with ASD
3. Conduct subgroup analyses (e.g., differences in prevalence, age at identification or other outcomes of interest among populations with known or suspected disparities, including, for example, disparities among rural vs. urban areas or in-depth evaluations of racial/ethnic differences in prevalence or other characteristics).
4. Conduct analysis of how generalizable the site-specific ASD prevalence estimate is to the state based on the distribution of factors such as race/ethnicity, socioeconomic status, and rural/urbanicity.
5. Perform novel linkages for scientific analyses, such as linking ADDM data to newborn screening data, juvenile justice data or longitudinal special education data, or other linkages to follow-up an age cohort previously monitored for ASD.
6. Assess the impact of the DSM-5 diagnostic criteria for ASD (including differential diagnostic criteria for Social Communication Disorder) on ASD prevalence estimates and/or further descriptive analyses of the characteristics of children identified with ASD based on DSM-IV-TR versus DSM-5 case definitions (e.g., diagnostic criteria met, individual characteristics or phenotype).

OUTCOME 3 (OC3): Stronger relationships with partners & data sources

Strategy 4 (S4): Community education and outreach

Each ADDM site must conduct community education and outreach activities to strengthen relationships with partners and data sources, increase use of ADDM data by community stakeholders, and increase community awareness of ASD and other DDs as well as the importance of population-based surveillance of these conditions. These education and outreach activities directly support surveillance activities by helping to ensure continuous access to community data sources and fostering community use of ADDM data needed for public health practice and to track progress toward community goals.

ADDM sites are strongly encouraged to conduct a brief community needs assessment to inform the education and outreach portion of the overall strategic plan. Education and outreach activities must fall within the following focus areas:

Focus Area 1 & Activity 10 (A10): Initiate and strengthen relationships with data sources and community partners

- Stakeholder Meetings (Required)

A required activity for this focus area is stakeholder meetings. ADDM sites must host and/or participate in either one-on-one or group meetings with data sources (e.g., state/local health departments, pediatric healthcare facilities, and school systems), partner organizations (e.g., local disability service providers, autism advocacy organizations) or/ other local stakeholders (e.g., policymakers). These meetings may involve a presentation of the ADDM methodology and ADDM data.

Focus Area 2 & Activity 11 (A11): Disseminate ADDM findings and information about ASD and co-occurring DDs

- Participation in ADDM education & outreach calls and ADDM communications workgroups (Required)

A required activity for this focus area is participation in the ADDM education and outreach workgroup and in the ADDM communication workgroup. ADDM sites must participate in the ADDM education and outreach workgroup, attend education and outreach conference calls, and host at least one education and outreach call per year. In addition, at least one staff member per ADDM site is required to actively participate in the ADDM communication workgroup during which the ADDM sites will collaborate on the development of community reports, site success stories, and other materials for community stakeholders.

Education and outreach activities should also attempt to address disparities in identification of children with ASD and co-occurring DDs as indicated by ADDM data. For that reason, at least one education and outreach activity MUST be implemented in a way that targets under-identified populations (e.g., racial/ethnic minorities).

In addition to the required activities above, applicants must include in their application at least two additional activities for each focus area. Additional activities that support education and outreach-related outcomes may be chosen from the following or proposed by the applicant.

Additional activities may include:

- Community awareness events
 - ADDM sites may choose to organize community events to raise awareness

about developmental disabilities. These events can be successful in numerous formats and should be tailored to the community audience and needs of the program. These events can also be a platform for increasing visibility and recognition of an ADDM site. Successful events are implemented through collaborations between ADDM sites and community partners. Sites can also participate in existing events (e.g., host information booths at health fairs, give lectures or presentations on ADDM data, or provide information about developmental screening). Applicants should describe the proposed event and potential community partners in their application.

- Trainings/presentations for community stakeholders (e.g., local clinicians or educators)
 - ADDM sites may choose to serve as a local educational and training resource, particularly in the area of ASD and co-occurring DD population-based surveillance. Trainings might include, but are not limited to, workshops for local service providers (e.g., special educators, pediatricians, or early intervention specialists), mentoring and internships.
- Strategic outreach to identify program champions or supporters
 - ADDM sites may choose to reach out to leaders within state/ local governments, universities, or relevant non-profit organizations in their project area to encourage interest and support for the surveillance program. Support from leaders in key positions is critical to program activities such as establishing data access agreements.
- Participation/coordination/leadership in local health community groups (e.g., state autism consortium, medical advisor to local partner organization, board of local children's hospital)
 - ADDM sites may choose to be involved in local community groups. Involvement is beneficial to the surveillance program and the community. Engagement with such groups raises situational awareness and offers information about the context of the surveillance program. Participation can range from presentations of data at local meetings to serving a leadership or facilitative role.
- Development and dissemination of additional site-specific materials
 - Applicants may choose to develop and disseminate materials beyond those created by the ADDM communications workgroup (e.g., community reports, site success stories). Examples of site-specific materials might include a project website; an electronic and/or printed newsletter for data sources and community partners; or a webinar series for data sources, community partners, or other community stakeholders. Applicants must specify in their application which additional materials will be developed and disseminated and the target audience(s) for each.
- Development of data utility examples for community stakeholders

- Applicants may choose to document and present examples of projects or activities to community stakeholders. These projects or activities would be examples of how stakeholders can use ADDM data to inform policies and plans that address services for individuals with ASD, disparities in identification, or decreasing age of identification.
- Engagement in local news and social media
 - Applicants may choose to proactively engage with local news and social media. Examples of engagement include, but are not limited to, conducting project-related interviews for local print, radio, and television and disseminating ADDM materials or messages via project specific or host (e.g., university, health department) social media accounts.
- Collection of structured feedback from community stakeholders on community data needs or uses and/or on ADDM materials and dissemination channels
 - Applicants may choose to collect structured feedback from community stakeholders. The feedback should focus on community data needs and uses as it relates to ASD and co-occurring DD surveillance and evaluating ADDM materials and dissemination channels. Such feedback could be used internally to better understand the data needs and uses of the community and to improve future ADDM materials and dissemination channels. Applicants should specify in their application how and from whom structured feedback will be collected.

OUTCOME 4 (OC4): Increased dissemination of ADDM data
Strategy 4 (S4): Community education and outreach

Note: This outcome and strategy is accomplished by the activities listed directly above

OUTCOME 5 (OC5): Improved reliability & efficiency of ADDM surveillance
Strategy 5 (S5): Monitoring and Evaluation

Activities for both Components A&B:

Applicants must describe their plans to (A12) create and implement a site strategic plan based on the CDC ADDM Logic Model and the strategies/activities described above. The strategic plan must be submitted to CDC within six months of the award. Grantees must plan to have monthly meetings to track efforts toward achieving strategic plans, and send semi-annual reports of strategic plan progress to CDC.

Additionally, applicants must describe the activities they propose to use for monitoring and performance measurement, including plans to (A13) complete a

site-specific, non-research evaluation plan. Details of the CDC Evaluation and Performance Measurement plan (and expectations for applicants/grantees) are provided in the Evaluation and Performance Measures section below.

In order to achieve and maintain reliability of the ADDM Network and methodology, applicants must agree to (A14) conduct ongoing quality assurance and control activities (QA/QC) per the ADDM QA/QC protocols for abstractors, clinician reviewers and project coordinators.

Lastly, to improve efficiency and resource use, applicants must (A15) engage in efforts to identify ways to improve program efficiency. These efforts should include ongoing evaluations to improve efficiency and timeliness of abstraction process (e.g., evaluations of whether abstractors are interpreting triggers efficiently and appropriately) AND ongoing evaluations to improve efficiency and timeliness of clinician review processes (e.g., evaluations of the frequency or percent of clinician reviews requiring secondary review).

1. Collaborations –

a. With CDC funded programs:

(REQUIRED)

Applicants must describe how they plan to work with other CDC-funded ADDM sites in order to achieve the outcomes of the FOA. Examples of anticipated collaborations:

- Collaboration with other ADDM sites and CDC to implement datasharing policies and pooling of data across sites. Pooled datasets will be shared among participating ADDM investigators and ultimately released as restricted access public use datasets. For CDC’s policies on releasing and sharing data see <http://www.cdc.gov/maso/Policy/ReleasingData.pdf>
- Collaboration with other ADDM sites to coordinate methods for data collection, case determination, evaluation, analysis and dissemination for multiple source surveillance.

Participation on ADDM committees (e.g. Project Coordinators/Abstractors, Principal Investigators, Clinician Reviewers, Abstraction Quality Assurance, Education and Outreach, and Scientific Issues), collaborative meetings, and surveillance publications and reports, as appropriate.

b. With organizations external to CDC:

(REQUIRED)

Sites must develop and maintain collaborative relationships with appropriate professionals and organizations that may be sources for data or stakeholders.

Agreements to access evaluation records of potential case children should

be made at the institutional level in the form of a contract, memorandum of understanding (MOU) or other formal agreement allowing access to source records. Each applicant must address relevant issues for their access to records. In some cases passive or active authorization may be required of parents to access their child's records. It is the site's responsibility to ensure any appropriate assurances/ approvals are received prior to accessing children's records, even if parental active or passive authorization is required. Data requests should include a range of diagnoses and special education exceptionalities in order to access records of children that may have one or more of the conditions under surveillance (ASD, CP or ID). Additionally, data requests should include service years from birth (for 8-year-olds, 2006; for 4-year-olds, 2008) through 2014 in order to access records from throughout a child's life that may include relevant information to establishing case status. Previous ADDM reports have indicated that access to education sources is important to ensure as complete a count of children with ASD as possible. Therefore, it is strongly preferred that sites have access to education records for at least half of the surveillance area, defined as access to at least 50% of education sources or access to education sources covering at least 50% of the surveillance population).

2. Target Populations:

Component A:

- Sites will identify a surveillance area with a population of at least 20,000 8-year-old children according to the latest available postcensal estimates.
- The surveillance area should be a contiguous geographic region, preferably contained entirely within one U.S. state, and should be defined by clear state, county or education district boundaries. For sites previously funded as part of the ADDM Network, it is important to maintain consistency in surveillance areas over time, if possible.
- The first surveillance year will include children residing in the surveillance area in 2014 who are 8 years of age (born in 2006) while the second surveillance year will include children residing in the surveillance area in 2016 who are 8 years of age (born in 2008)

Component B:

- Sites will identify a surveillance area with a minimum population size of 8,000 4-year-old children and must be contained entirely within the proposed 8-year-old surveillance area. For sites previously funded as part of the Early ADDM Network, it is important to maintain consistency in surveillance areas over time, if possible.
- The first surveillance year will include children residing in the surveillance area in 2014 who are 4 years of age (born in 2010) while the second surveillance year will include children residing in the surveillance area in

2016 who are 4 years of age (born in 2012).

Inclusion:

Component A:

Inclusion - The applicant must describe how the chosen surveillance area allows for capture of information about children among particularly vulnerable or high-risk groups (e.g. by race/ethnicity, socioeconomic status, rural/urban) whenever possible (and as appropriate to the geographic area), such that data may be used to better understand disparities in ASD prevalence, characteristics and age at identification. In addition, the applicant must describe how this chosen surveillance area compares to the overall state population with respect to these vulnerable or high-risk groups.

Component B:

Inclusion – Criteria are the same as described for Component A above

b. Evaluation and Performance Measurement:

i. CDC Evaluation and Performance Measurement Strategy:

Evaluation and performance measurement will outline the process for effective implementation of ADDM strategies and activities to successfully achieve work plan outputs and outcomes. Evaluation findings will be used by CDC and awardees to: 1) ensure program implementation and continuous system improvement, 2) demonstrate achievement of program outputs and short-term outcomes, 3) provide an evidence base for potential future changes to the ADDM Network surveillance methodology, and 4) assess the usefulness, scalability and effectiveness of community education and outreach strategies, including how well the strategies reach a diverse group of target populations.

CDC's evaluation and performance measurements will include both process and outcome evaluations, and will be consistent with the logic model and approach presented earlier in this FOA. Specifically, CDC's evaluation and measurements will assess: a) strategies and activities related to surveillance, analyses of surveillance data, and community education and outreach, and b) the resulting outputs and short-term outcomes as presented in the logic model. Findings will provide both the awardees and CDC with feedback to improve both current and future public health surveillance activities. Multiple measures address how sub-populations may be reached via ADDM Network activities and outputs. Additionally, measures of the "reach" of ADDM Network data via education and outreach activities will help to demonstrate the value of the FOA. As appropriate, findings will be disseminated to specific sites, the whole ADDM Network or in publications to improve upon or report on the ADDM Network's performance in achieving strategic and scientific objectives.

Evaluation and performance measures must be tracked monthly by sites and reported to CDC on a semi-annual basis (every six months) or biennial basis (every 2 years) as indicated below.

Unless otherwise stated, key questions and performance measures apply only to Component A 8-year-old surveillance. Select questions and measures apply to both Components (as indicated below). Sites applying for Component B should present plans to provide data for performance measures of both their planned Component A 8-year-old and Component B 4-year-old surveillance.

Key Questions and Performance Measures—

QUESTIONS/MEASURES reported EVERY 6 MONTHS:

Output Evaluation Questions/Measures

Evaluation of Output 1 (OP1): “Meet strategic plan objectives”

- Did the site create and implement a strategic plan with support from CDC?

Required Measures:

- Did the site submit a strategic plan to CDC within six months of award?
- Did the site have monthly meetings to track efforts toward achieving strategic plans?
- % of months that meetings were held
- Were semi-annual reports of strategic plan progress sent to CDC according to the established timeline?
- # of semi-annual reports sent to CDC
- Was information required to update the CDC evaluation database that tracks progress toward achieving strategic plans delivered to CDC monthly (on CDC/site calls)?
- % of months that database was updated according to the established timeline

Evaluation of Output2 (OP2): “Representative and comprehensive data sources”

- How comprehensive were data sources as of the reporting period?

Required Measures:

- Briefly discuss progress in acquiring or renewing permission to access records in proposed data sources, including % of education sources that were accessible and % of surveillance population covered by these education sources
- % of data sources from which records have been received, reviewed, and abstracted

Evaluation of Output 3 (OP3): “Well trained staff”

- Were ADDM Network staff appropriately trained per ADDM protocol?

Required Measures:

- # of new abstractors that successfully completed required initial training modules and the corresponding exercises (with a minimum of 80% accuracy) within the agreed upon timeline
- # of new clinician reviewers that successfully completed initial training modules and the corresponding exercises, then met initial Quality Assurance/Quality Checking requirements for the specific developmental disability for which they do clinician review
- # of new project coordinators that successfully completed required initial training modules and the corresponding exercises (with a minimum of 80% accuracy)
- # of new project coordinators that successfully completed additional project coordinator training modules and the corresponding exercises within the agreed upon timeline
- # of abstractors that fell below overall 80% concordance on QA/QC indicators during a QC period (as defined in the ADDM QA/QC protocol)
- # of clinician reviewers that fell below overall 80% concordance on QA/QC indicators during a QC period (as defined in the ADDM QA/QC protocol)
- # of identified key areas (in the ADDM QA/QC protocol) for which concordance on QA/QC indicators fell below 80%

Suggested measure:

- Structured feedback for CDC staff on training quality or effectiveness

Evaluation of Output 4 (OP4): “Data and tools to improve surveillance system efficiency”

- Was the capability of ARCHE v4 maximized?

Required Measures:

- Did the site send a screen shot of the ARCHE database on or before January 1st of the surveillance year (indicating that ARCHE was installed)?
- Did the site send a screen shot to CDC of the ARCHE database within 2 weeks of the release of each ARCHE update (indicating the ARCHE update was appropriately installed)?
- Up to date description of site contingency plans for data sources with limited or interrupted internet connectivity (e.g., internet hot spots)
- Up to date contact information for: 1) the person responsible for any ARCHE system issues, and 2) the IT person responsible for maintaining ARCHE
- Were site data cleaned on a routine basis?

Required Measures:

- Brief description (max: 1 page) of data cleaning activities during the reporting period

QUESTIONS/MEASURES reported EVERY 2 YEARS:

Evaluation of Output 1 (OP1): “Meet strategic plan objectives”

- Were strategic plan objectives (outputs and outcomes) met for both of the surveillance years?

Required Measures:

- What was the % of strategic plan outputs met?
- What was the % of strategic plan short-term outcomes met?

Suggested Measures:

- Written description of any challenges in meeting strategic plan outputs and outcomes

Evaluation of Output 2 (OP2): “Representative and comprehensive data sources”

- How representative and comprehensive were data sources?

Required Measures:

- Source record analysis for each surveillance year, including:

- % of education sources that were accessible and % of surveillance population covered by these education sources
- # of records reviewed per source
- # of records abstracted per source
- # of records abstracted for confirmed surveillance cases (stratified by DD)
- % of total case yield uniquely obtained from each data source (stratified by DD)

Evaluation of Output 4 (OP4): “Data and tools to improve surveillance system reliability and efficiency”

- Was the final surveillance area covered during each surveillance year consistent with requirements for ADDM?

Required Measures:

- Did the population denominators used in reporting prevalence estimates for surveillance year 2014 or 2016 (as applicable) include at least 20,000 8-year-olds?
- For Component B only: Did the population estimates used in reporting prevalence estimates for surveillance year 2014 or 2016 (as applicable) include at least 8,000 4-year-olds?
- Were the geographic boundaries of the final surveillance area contiguous?
- Were the geographic boundaries of the final surveillance area clearly defined according to county or school district boundaries?
- Were the geographic boundaries of the final surveillance area comparable to prior surveillance years (if applicable)?
- Did the site participate in ADDM Network activities?

Required Measures:

- Was a site representative present on at least 85% of monthly All Sites calls?
- Was a site representative present on at least 85% of monthly QA/QC calls?
- Was a site representative present on at least 85% of monthly scientific calls (ADDM SIG)?
- Was a site representative present on at least 85% of monthly PC/Abstractor calls?
- Did the site participate in biennial preparation of prevalence reports?
- Was a site representative present on at least 85% PI prevalence

- report calls?
- COMPONENT B: Was a site representative present on at least 85% of monthly Early ADDM calls?

Evaluation of Output 5 (OP5): “Enhanced community education and outreach activities”

- Did the site attempt to address under-identified groups via education and outreach activities?

Required Measures:

- Did the site implement at least one required or additional community education and outreach activity in a way that targets an under-identified group?

Suggested Measures:

- Written description of which under-identified group was addressed, how this group was addressed and which activities were performed

Evaluation of Output 6 (OP6): “Datasets for analysis and publication”

- Were datasets complete and required linkages performed by the agreed upon deadlines?

Required Measures:

- Were data submitted to CDC according to the established timeline?
- Did data include required variables to evaluate prevalence estimates based on DSM-IV and DSM-5 case definitions?
- Were data linked to birth certificates and submitted to CDC according to the established timeline?
- Were data linked to community indicators based on geocoding and submitted to CDC according to the established timeline?

Suggested Measures:

- Were CDC questions related to site data issues addressed before the agreed upon deadline?

Evaluation of Outputs: (OP7) “Reports of ASD prevalence and characteristics based on DSM-IV and DSM-5 diagnostic criteria” and (OP8) “Reports of CP or ID prevalence and characteristics, and co-occurrence with ASD”

- Did the defined surveillance area include as diverse a population as

possible such that characteristics of children with ASD, CP or ID can be reported?

Required Measures:

- Written description of how well the geographic area chosen for the study includes as diverse a population as possible (in terms of race/ethnicity, socio-economic status, rural/urban areas or other markers of diversity) and a written description of how this chosen geographic area compares to the state overall with respect to the same characteristics.

Evaluation of Output 9 (OP9): “Enhanced analyses of ADDM data”

- Were analyses of site and ADDM data conducted?

Required Measures:

- In 2016: Written description of finalized plans for the two required analyses
- In 2018: Did the site complete the two required analyses?
- Have scientific staff involved in ADDM data analysis and publications read the ADDM data sharing guidelines and the ADDM scientific code of conduct, and agreed to and signed all elements of the guidelines?

Suggested measures:

- Describe plans for additional analyses
- # and type of data sharing proposals
- Were analyses published in peer-reviewed publications?
- # published

Outcome Evaluation Questions/Measures:

Evaluation of Outcome 1 (OC1): “Improved understanding of ASD & other DDs, including trends & disparities in ASD prevalence over time”

This outcome is measured by proxy via all of the measures outlined above and below

Evaluation of Outcome 2 (OC2): “Improved understanding of the implications of the change from the DSM-IV to the DSM-5 diagnostic criteria for ASD”

- Did the site participate in creating methods for determining case

status using the new DSM-5 diagnostic criteria?

Required Measures:

- Did a site representative attend at least 85% of Network DSM-5 workgroup calls?
- Did the site have full (100%) participation in validation exercises for clinician review determination of ASD case status with DSM-5 criteria?

Evaluation of Outcome 3 (OC3): “Stronger relationships with partners & data sources”

- How did the site initiate and strengthen relationships with data sources and community partners?

Required Measures:

- # of stakeholder meetings
- # and type of organizations and individuals that attended stakeholder meetings
- Written summary of meetings and/or events
- Results of meeting and/or event evaluation
- Written summary of follow-up with stakeholders based on feedback from meeting and/or event evaluation

Sites must choose two additional performance measures as appropriate for additional community education and outreach activities, which could include any of the following (but site may propose other measures):

- # of trainings and attendees
- #, type and title of presentations
- # and type of program champions or supporters identified
- # and role of involvement in local health community groups
- # of interviews conducted
- If applicable, # translated into a non-English language
- Written summaries of meetings or events
- Results of training evaluations
- Summary of feedback from community stakeholders

Evaluation of Outcome 4 (OC4): “Increased dissemination of ADDM data”

- Did the site disseminate ADDM findings and information about ASD and co-occurring DDs?

Required Measures:

For collaborative Network activities:

- Was a site representative present on at least 85% of ADDM Education & Outreach calls?
- Was the required annual community education and outreach call presentation given?
- Was a site representative on at least 85% of ADDM Communication workgroup calls?
- How many drafts of collaborative communication materials were reviewed and commented on by a site representative to the ADDM Communication Workgroup?
- # of collaborative communication material drafts (e.g., assigned section of the Community Report) that are reviewed for content, or formatting

For site specific activities:

- Written description of the number of copies distributed of community reports, site success stories or other workgroup materials; including to whom (e.g., data sources, policymakers) and how (e.g., via email, at a community health fair, at a conference) copies were distributed

Sites must choose two additional performance measures as appropriate for additional community education and outreach activities, which could include:

- # of mentions of ADDM and ADDM data reported by the local media
- Pre- and Post- data release assessments
- # tweets/re-tweets or Facebook posts

Evaluation of Outcome 5 (OC5): “Improved reliability and efficiency of ADDM surveillance”

- How efficient were abstraction and clinician review?

Required Measures:

- Is site conducting ongoing evaluations to improve efficiency and timeliness of abstraction processes (e.g., evaluations of whether abstractors are interpreting triggers efficiently and appropriately)?
- Is site conducting ongoing evaluations to improve efficiency and timeliness of clinician review processes (e.g., evaluations of the frequent or percent of clinician reviews requiring secondary review)?
- How many (number) viable options were introduced and implemented as a result of an efficiency evaluation?

- How reliable were ADDM methods and data?

Required Measures:

- Abstraction: Were within-site QA/QC activities implemented with a minimum 80% reliability rate for each abstractor?
- Clinician Review: Did the site achieve a minimum of 90% reliability for determination of case status on the final clinician review reliability sample for each surveillance year (per the ADDM QA/QC protocol)?

ii. Applicant Evaluation and Performance Measurement Plan:

Applicants must provide an initial overall jurisdiction or community-specific evaluation and performance measurement plan that is consistent with the CDC evaluation strategy. Applicants will have already produced a simple logic model and measurable objectives in the work plan referenced above. In this section, they will refine those into performance measures and add details of any additional evaluation to be completed. At a minimum, the applicant plan must:

- Describe key evaluation questions;
- Describe performance measures;
- Describe potentially available data sources and feasibility of collecting appropriate evaluation and performance data; and
- Describe how evaluation findings will be used for continuous program/quality improvement.

c. Organizational Capacity of Awardees to Execute the Approach:

All applicants must demonstrate their existing or forthcoming capacity to successfully execute all proposed strategies and activities to meet the project requirements of each funding component. Applicants should address infrastructure (the applicant organization's physical space and equipment), partnership development, evaluation, performance monitoring, financial reporting, budget management and administration, personnel management (including developing staffing plans, developing and training workforce, managing Direct Assistance), as well as expertise and experience related to all component-specific project focus areas. Furthermore, applicants must be fully capable of managing the required procurement efforts, including the ability to write and award contracts in accordance with 45 or 74 C.F.R.

Key capacity considerations to address in the application:

- Applicants must describe their experience related to the content area, and provide documentation of current operational capacity to conduct multiple source surveillance utilizing a record review methodology.
- Applicants must describe their resources and staffing levels for this project. The exact personnel and percentage of time allotted varies by each ADDM site. However, there are basic project staff requirements, including having actively

involved Principal Investigator(s), a Project Coordinator (at least 75% effort on project), an Epidemiologist (at least 20%), Record Abstractors (at least two full-time equivalent), Clinician Reviewers (at least two part-time), and at least 15% data management/programmer support.

- Each applicant must provide evidence from the state government or governing body that they would have access to health records, if funded.
- Applicants must demonstrate that they have adequate technical and facility resources to meet the project's goals, including informational technology (IT) infrastructure to utilize and maintain CDC-developed database applications. This includes the capacity to maintain a SQL Server database application on a local network server and the capacity to host a web-based SQL Server database application through both a web server and a network data storage server.

d. Work Plan:

Awardees are required to provide a work plan that provides both a high-level overview of the entire four-year project period and a detailed description of the first year of the award for both Components A and B included in the applicant's application. The work plan must demonstrate how the outcomes, strategies, activities, timelines, and staffing/collaborations work together. Information on performance measures should be included in the work plan.

For each component, the First-Year Work Plan should include:

- Program strategies
- Program activities
- Performance Measures
- Timeframe
- Persons responsible
- Activity completion date

For each component, the Four-Year Overview of Project Work Plan should include:

- Intended strategies, activities, outputs, and outcomes for the entire four-year project period

An example work plan is shown below (for Strategy 1):

Expected Outputs for the Project Period					
Strategy	Activity	Performance Measure	Person Responsible	Timeframe	Activity Completion Date
Strategy 1 (S1): Component A – 8-year-old ASD +CP or ASD+ID surveillance	A1: Adhere to standardized ADDM/MADDS P methodology and case definitions				
	A2: Renew or establish agreements for data requests and access to data sources				
	A3: Staff training and continued education				
	A4: Review and abstract records at data sources				
	A5: Clinician review of records based on ADDM coding scheme				
	A6: Clean data				
	A7: Perform data linkages				
	A8: Report de-identified data to CDC				
<p>e. CDC Monitoring and Accountability Approach:</p> <p>Monitoring activities include routine and ongoing communication between CDC and awardees, site visits, and awardee reporting (including work plans, performance, and financial reporting). The HHS Grants Policy and Administration Manual (GPAM) specifies the following HHS expectations for post-award monitoring for grants and</p>					

cooperative agreements:

- Tracking awardee progress in achieving the desired outcomes.
- Insuring the adequacy of awardee systems that underlie and generate data reports.
- Creating an environment that fosters integrity in program performance and results.
- Ensuring that work plans are feasible based on the budget and consistent with the intent of the award.
- Ensuring that awardees are performing at a sufficient level to achieve objectives within stated timeframes.
- Working with awardees on adjusting the work plan based on achievement of objectives and changing budgets.
- Monitoring performance measures (both programmatic and financial) to assure satisfactory performance levels.

Other activities deemed necessary to monitor the award, if applicable.

These may include monitoring and reporting activities as outlined in the HHS Grants Policy Statement.

f. CDC Program Support to Awardees:

In a cooperative agreement, CDC and awardees share responsibility for successfully implementing the award and meeting identified outcomes. In order to ensure the success of the cooperative agreement, CDC will provide technical assistance and facilitate information sharing among awardees.

i. Technical Assistance

CDC provides the following technical assistance to:

- Assist recipients with surveillance activities including the development of a standardized surveillance case definition and operationalization based on the collaborative use of the MADDSP/ADDM model by the ADDM Network.
- Provide technical consultation regarding surveillance methods including data collection and abstraction, quality assurance, evaluation, case review, analyses, and reporting.
- Share with grantees the CDC ADDM web-based data collection systems (ARCHE) used by the ADDM Network for tracking, abstraction, and data management for ASD and other DD surveillance.
- Provide technical support to qualified data management/programmer staff on the standard operation of ARCHE for surveillance.
- Provide tools and guidelines for extracting de-identified data to be submitted by sites contributing to the ADDM pooled datasets.
- Compile datasets and distribute to investigators at participating ADDM sites.
- Provide updated information on relevant CDC, US Department of Health and Human Services (HHS), and other policies and regulations that affect the programs.

- Conduct initial training in surveillance procedures for abstraction, clinician review and data management personnel.
- Facilitate the initial prevalence reports from each surveillance year.
- Develop an ADDM Network strategic plan for education and outreach (at the national level).
- Provide technical assistance for the development, implementation and evaluation of site strategic education and outreach activities.

ii. Information Sharing among Awardees:

CDC provides the following technical assistance to:

- Facilitate the development and update of the ADDM Data Sharing Guidelines.
- Manage the ADDM data sharing proposal system. This system fosters collaboration and information sharing among sites.
- Maintain a SharePoint site which allows documents and other key project materials to be shared among sites.
- Maintain several listservs to facilitate communication among sites (e.g. Project Coordinator listserv, abstraction listserv, Clinician Reviewer listserv).

B. Award Information	
1. Type of Award:	Cooperative Agreement CDC's substantial involvement in this program appears in the CDC Program Support to Awardees section.
2. Award Mechanism:	UR3 Health Investigations and Assessments of Control, Prevention, and Testing Methods - Cooperative Agreements
3. Fiscal Year:	2015
4. Approximate Total Fiscal Year Funding:	\$6,325,000 (This amount is subject to availability of funds. This includes direct and indirect costs. The government reserves the right to adjust award amounts for program areas as agency and public health priorities change.)
5. Approximate Total Project Period Funding:	\$25,300,000 / 4 years
6. Total Project Period Length:	4
	Approximate Number of Awards: 6-14
7. Approximate Average Award:	Component A: \$450,000; Component B (Optional): \$125,000
8. Floor of Individual Award Range:	Component A: \$425,000; Component B (Optional): \$100,000
9. Ceiling of Individual Award Range:	Component A: \$475,000; Component B (Optional): \$150,000

10. Anticipated Award Date: January 1, 2015

11. Budget Period Length: 12

Throughout the project period, CDC will continue the award based on the availability of funds, the evidence of satisfactory progress by the awardee (as documented in required reports), and the determination that continued funding is in the best interest of the federal government. The total number of years for which federal support has been approved (project period) will be shown in the "Notice of Award." This information does not constitute a commitment by the federal government to fund the entire period. The total project period comprises the initial competitive segment and any subsequent non-competitive continuation award(s).

12. Direct Assistance:

Direct Assistance (DA) is available through this FOA. Prior to this FOA, SAS® licenses were available to grantees and paid for using CDC funds. Beginning with the 2014 FOA, the Direct Assistance (DA) mechanism will be used to cover the cost of this software for both the continuation of previously acquired licenses as well as the procurement of new licenses. To take advantage of CDC pricing from the developer, a request to designate DA funds for your SAS® licensing should be included in the application. For planning purposes, SAS® licensing costs were \$1,342.30 per licensed user in 2014. If your request for DA is approved as a part of your award, CDC will reduce the funding amount provided directly to you as a part of your award. The amount by which your award is reduced will be used to provide DA; the funding shall be deemed part of the award and as having been paid to you, the awardee.

C. Eligibility Information

Eligible applicants for this FOA are included in this section.

1. Eligible Applicants:

Government Organizations:

- States or their bona fide agents (includes the District of Columbia)
- Local governments or their bona fide agents
- Territorial governments or their bona fide agents in the Commonwealth of Puerto Rico, the Virgin Islands, the Commonwealth of the Northern Mariana Islands, American Samoa, Guam, the Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau)
- State controlled institutions of higher education

<ul style="list-style-type: none"> American Indian or Alaska Native tribal governments (federally recognized or state-recognized) Public Housing Authorities/Indian Housing Authorities] <p>Non-government Organizations:</p> <ul style="list-style-type: none"> American Indian or Alaska native tribally designated organizations Nonprofit with 501C3 IRS status (other than institution of higher education) Nonprofit without 501C3 IRS status (other than institution of higher education)] <p>Private colleges and universities</p> <p>Community-based organizations</p> <p>Faith-based organizations</p> <p>For-profit organizations (other than small business)</p> <p>Small businesses</p>
<p>2. Special Eligibility Requirements:</p> <p>If the application is incomplete or non-responsive to the requirements listed in this section, it will not be entered into the review process. The applicant will be notified that the application did not meet submission requirements.</p> <ul style="list-style-type: none"> Late applications will be considered non-responsive. See section “D.4. Application and Submission Information” for more information on deadlines. Applicant must provide a letter of support, Memorandum of Understanding (MOU), or other documentation to indicate applicant has access to health records. Place this documentation in Appendix A and attach with “Other Attachment Forms” when submitting via www.grants.gov.
<p>3. Justification for Less than Maximum Competition:</p> <p>N/A</p>
<p>4. Cost Sharing or Matching:</p> <p>Cost sharing or matching funds are not required for this program. Although no statutory matching requirement for this FOA exists, leveraging other resources and related ongoing efforts to promote sustainability is strongly encouraged.</p>
<p>5. Maintenance of Effort:</p> <p>Maintenance of effort is not required for this program.</p>

D. Application and Submission Information

Additional materials that may be helpful to applicants:

<http://www.cdc.gov/od/pgo/funding/docs/FinancialReferenceGuide.pdf> .

The following text is required:

1. Required Registrations: An organization must be registered at the three following locations before it can submit an application for funding at www.grants.gov.

- a. **Data Universal Numbering System:** All applicant organizations must obtain a Data Universal Numbering System (DUNS) number. A DUNS number is a unique nine-digit identification number provided by Dun & Bradstreet (D&B). It will be used as the Universal Identifier when applying for federal awards or cooperative agreements.

The applicant organization may request a DUNS number by telephone at 1-866-705-5711 (toll free) or internet at <http://fedgov.dnb.com/webform/displayHomePage.do>. The DUNS number will be provided at no charge.

If funds are awarded to an applicant organization that includes sub-awardees, those sub-awardees must provide their DUNS numbers before accepting any funds.

- b. **System for Award Management (SAM):** The SAM is the primary registrant database for the federal government and the repository into which an entity must submit information required to conduct business as an awardee. All applicant organizations must register with SAM, and will be assigned a SAM number. All information relevant to the SAM number must be current at all times during which the applicant has an application under consideration for funding by CDC. If an award is made, the SAM information must be maintained until a final financial report is submitted or the final payment is received, whichever is later. The SAM registration process usually requires not more than five business days, and registration must be renewed annually. Additional information about registration procedures may be found at www.SAM.gov.
- c. **Grants.gov:** The first step in submitting an application online is registering your organization at www.grants.gov, the official HHS E-grant Web site. Registration information is located at the "Get Registered" option at www.grants.gov.

All applicant organizations must register at www.grants.gov. The one-time registration process usually takes not more than five days to complete. Applicants must start the registration process as early as possible.

2. Request Application Package: Applicants may access the application package at

www.grants.gov.

3. Application Package: Applicants must download the SF-424, Application for Federal Assistance, package associated with this funding opportunity at www.grants.gov. If Internet access is not available, or if the online forms cannot be accessed, applicants may call the CDC PGO staff at 770-488-2700 or e-mail PGO PGOTIM@cdc.gov for assistance. Persons with hearing loss may access CDC telecommunications at TTY 1-888-232-6348.

4. Submission Dates and Times: If the application is not submitted by the deadline published in the FOA, it will not be processed. PGO personnel will notify the applicant that their application did not meet the deadline. The applicant must receive pre-approval to submit a paper application (see Other Submission Requirements section for additional details). If the applicant is authorized to submit a paper application, it must be received by the deadline provided by PGO.

a. Letter of Intent (LOI) Deadline (must be emailed or postmarked by): September 12, 2014

b. Application Deadline: October 10, 2014, 11:59 p.m. U.S. Eastern Standard Time, at www.grants.gov

5. CDC Assurances and Certifications: All applicants are required to sign and submit "Assurances and Certifications" documents indicated at <http://www.cdc.gov/od/pgo/funding/grants/foamain.shtm>.

Applicants may follow either of the following processes:

- Complete the applicable assurances and certifications, name the file "Assurances and Certifications" and upload it as a PDF file at www.grants.gov
- Complete the applicable assurances and certifications and submit them directly to CDC on an annual basis at [http://wwwn.cdc.gov/grantassurances/\(S\(0pkgmh1imgkwhqeaheiyckd\)\)/GranteeSearch.aspx](http://wwwn.cdc.gov/grantassurances/(S(0pkgmh1imgkwhqeaheiyckd))/GranteeSearch.aspx)

Assurances and certifications submitted directly to CDC will be kept on file for one year and will apply to all applications submitted to CDC within one year of the submission date.

6. Content and Form of Application Submission: Applicants are required to include all of the following documents with their application package at www.grants.gov.

7. Letter of Intent (LOI):

Prospective applicants may choose to submit a LOI. The LOI will not be scored or used to eliminate potential applicants, but it will enable CDC to determine the level of interest and plan the review more efficiently. The LOI should include the following information:

- Descriptive title of proposed project
- Name, address, telephone number, and email address of the Principal Investigator or Project Director, or both

- Name, address, telephone number, and e-mail address of the primary contact for writing and submitting this application
 - Number and title of this FOA
- LOIs may be sent via email, U.S. express mail or delivery service to:
Tineka Yowe-Conley– DD15-1501
 National Center on Birth Defects and Developmental Disabilities
 Division of Birth Defects and Developmental Disabilities
 1825 Century Boulevard, Room 3101
 Atlanta, GA 30345
tay7@cdc.gov

8. Table of Contents: (No page limit and not included in Project Narrative limit)
 Provide a detailed table of contents for the entire submission package that includes all of the documents in the application and headings in the “Project Narrative” section. Name the file “Table of Contents” and upload it as a PDF file under “Other Attachment Forms” at www.grants.gov.

9. Project Abstract Summary: (Maximum 1 page)
 A project abstract is included on the mandatory documents list and must be submitted at www.grants.gov. The project abstract must be a self-contained, brief summary of the proposed project including the purpose and outcomes. This summary must not include any proprietary or confidential information. Applicants must enter the summary in the “Project Abstract Summary” text box at www.grants.gov.

10. Project Narrative:
If applying for Component A only: Maximum of 25 pages, single spaced, Calibri 12 point, 1-inch margins, number all pages. Content beyond 25 pages will not be considered.
If applying for Components A and B: Maximum of 30 pages, single spaced, Calibri 12 point, 1-inch margins, number all pages. Content beyond 30 pages will not be considered.

The Project Narrative must include all of the bolded headings shown in this section. The Project Narrative must be succinct, self-explanatory, and in the order outlined in this section. It must address outcomes and activities to be conducted over the entire project period as identified in the CDC Project Description section.

Applicants must submit a Project Narrative with the application forms. Applicants must name this file “Project Narrative” and upload it at www.grants.gov.

- a. **Background:** Applicants must provide a description of relevant background information that includes the context of the problem. (See CDC Background.)
- b. **Approach**
 - i. **Problem Statement:** Applicants must describe the core information relative to the problem for the jurisdictions or populations they serve. The core information must help reviewers understand how the applicant’s response to the FOA will address the public health problem and support public health

priorities. (See CDC Project Description.)

- ii. **Purpose:** Applicants must describe in 2-3 sentences specifically how their application will address the problem as described in the CDC Project Description.
- iii. **Outcomes:** Applicants must clearly identify the outcomes they expect to achieve by the end of the project period. Outcomes are the results that the program intends to achieve. All outcomes must indicate the intended direction of change (i.e., increase, decrease, maintain). (See the program logic model in the Approach section of the CDC Project Description.)

In addition to the project period outcomes required by CDC, applicants should include any additional outcomes they anticipate.

Note: Applicants will be held responsible for short-term outcomes but not be held responsible for long-term outcomes

- iv. **Strategy and Activities:** Applicants must provide a clear and concise description of the strategies and activities they will use to achieve the project period outcomes. Whenever possible, applicants should use evidence-based program strategies as identified by the Community Guide¹ (or similar reviews) and reference it explicitly as a source. Applicants may propose additional strategies and activities to achieve the outcomes. Applicants must select existing evidence-based strategies that meet their needs, or describe the rationale for developing and evaluating new strategies or practice-based innovations. (See CDC Project Description: Strategies and Activities section.)

- 1. **Collaborations:** Applicants must describe how they will collaborate with programs and organizations either internal or external to CDC.

Applicants must file the MOU or MOA, as appropriate, name the file "MOUs/MOAs", and upload it as a PDF file at www.grants.gov.

Applicants must file letters of support, as appropriate, name the file "Letters of Support", and upload it as a PDF file at www.grants.gov.]

- 2. **Target Populations:** Applicants must describe the specific target population(s) in their jurisdiction. Refer back to the CDC Project Description section – Approach: Target Population.

¹ <http://www.thecommunityguide.org/index.html>

Inclusion: Applicants must address how they will include specific populations who can benefit from being included in the surveillance population and/or education and outreach activities, please refer back to the CDC Project Description section – Approach: Inclusion

- c. Applicant Evaluation and Performance Measurement Plan:** Applicants must provide an overall jurisdiction or community-specific evaluation and performance measurement plan that is consistent with the CDC Evaluation and Performance Measurement Strategy section of the CDC Project Description of this FOA. Data collected must be used for ongoing monitoring of the award to evaluate its effectiveness, and for continuous program improvement.

The plan must:

- Describe how key program partners will be engaged in the evaluation and performance measurement planning processes.
- Describe key evaluation questions to be answered.
- Describe performance measures to be developed by the applicant (as detailed above in the Evaluation section).
- Describe potentially available data sources and feasibility of collecting appropriate evaluation and performance data.
- Describe how evaluation findings will be used for continuous program and quality improvement.
- Describe how evaluation and performance measurement will contribute to development of that evidence base, where program strategies are being employed that lack a strong evidence base of effectiveness.

Awardees will be required to submit a more detailed evaluation and performance measurement plan within the first six months of the project, as outlined in the reporting section of the FOA.

- d. Organizational Capacity of Applicants to Implement the Approach:**

Applicant must address the organizational capacity requirements as described in the CDC Project Description. Applicants must name this file “Organizational Charts” and upload it at www.grants.gov.]

11. Work Plan: *(Included in the Project Narrative’s 25 page limit)*

Applicants must prepare a work plan consistent with the CDC Project Description Work Plan section above. The work plan integrates and delineates more specifically how the awardee plans to carry out achieving the project period outcomes, strategies, and activities, evaluation and performance measurement, including key milestones.

Applicants must name this file "Work Plan" and upload it as a PDF file at www.grants.gov.

12. Budget Narrative:

Applicants must submit an itemized budget narrative, which may be scored as part of the Organizational Capacity of Awardees to Execute the Approach. When developing the budget narrative, applicants must consider whether the proposed budget is reasonable and consistent with the purpose, outcomes, and program strategy outlined in the project narrative. The budget should commensurate with the size of the surveillance area and must include the following:

- Salaries and wages
- Fringe benefits
- Consultant costs
- Equipment
- Supplies
- Travel*
- Other categories
- Total Direct costs
- Total Indirect costs
- Contractual costs

The following meetings/training must be included in the travel budget:

1. For budget year 1 only, two key staff members (Principal Investigator and Project Coordinator) to participate in a post-award meeting in Atlanta, Georgia.
2. Two key staff to participate in ADDM Network collaborative grantee meetings yearly during the 4-year funding cycle.
3. Reverse site visits at the conclusion of each surveillance year, or twice during the 4-year funding cycle to review progress to date, planned activities, and share ideas for future activities.
4. One-time Abstractor training, of three days duration, to be attended by new ADDM Network abstractors (as recommended or provided by CDC).
5. One time Database Management training, of two days duration, to be attended by new ADDM Network database managers.
6. One-time clinician reviewer training, of two days duration, to be attended by new ADDM Network clinician reviewers.

For guidance on completing a detailed budget, see Budget Preparation Guidelines at: <http://www.cdc.gov/od/pgo/funding/grants/foamain.shtm>.

If applicable and consistent with statutory authority, applicant entities may use funds for activities as they relate to the intent of this FOA to meet national standards or seek health department accreditation through the Public Health Accreditation Board (see: <http://phaboard.org>). Applicant entities include state, local, territorial governments (including

the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, the Commonwealth of the Northern Mariana Islands, American Samoa, Guam, the Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau), or their bona fide agents, political subdivisions of states (in consultation with states), federally recognized or state-recognized American Indian or Alaska Native tribal governments, and American Indian or Alaska Native tribally designated organizations. Activities include those that enable a public health organization to deliver public health services such as activities that ensure a capable and qualified workforce, up-to-date information systems, and the capability to assess and respond to public health needs. Use of these funds must focus on achieving a minimum of one national standard that supports the intent of the FOA. Proposed activities must be included in the budget narrative and must indicate which standards will be addressed.

Applicants must name this file “Budget Narrative” and upload it as a PDF file at www.grants.gov. If requesting indirect costs in the budget, a copy of the indirect cost-rate agreement is required. If the indirect cost rate is a provisional rate, the agreement must have been made less than 12 months earlier. Applicants must name this file “Indirect Cost Rate” and upload it at www.grants.gov.

13. Tobacco and Nutrition Policies:

Awardees are encouraged to implement tobacco and nutrition policies.

Unless otherwise explicitly permitted under the terms of a specific CDC award, no funds associated with this FOA may be used to implement the optional policies, and no applicants will be evaluated or scored on whether they choose to implement these optional policies.

CDC supports implementing evidence-based programs and policies to reduce tobacco use and secondhand smoke exposure, and to promote healthy nutrition. CDC encourages all awardees to implement the following optional recommended evidence-based tobacco and nutrition policies within their own organizations. The tobacco policies build upon the current federal commitment to reduce exposure to secondhand smoke, specifically The Pro-Children Act, 20 U.S.C. 7181-7184, that prohibits smoking in certain facilities that receive federal funds in which education, library, day care, health care, or early childhood development services are provided to children.

Tobacco Policies:

1. Tobacco-free indoors: Use of any tobacco products (including smokeless tobacco) or electronic cigarettes is not allowed in any indoor facilities under the control of the awardee.
2. Tobacco-free indoors and in adjacent outdoor areas: Use of any tobacco products or electronic cigarettes is not allowed in any indoor facilities, within 50 feet of doorways and air intake ducts, and in courtyards under the control of the awardee.
3. Tobacco-free campus: Use of any tobacco products or electronic cigarettes is not allowed in any indoor facilities or anywhere on grounds or in outdoor space under

the control of the awardee.

Nutrition Policies:

1. Healthy food-service guidelines must, at a minimum, align with HHS and General Services Administration Health and Sustainability Guidelines for Federal Concessions and Vending Operations. These guidelines apply to cafeterias, snack bars, and vending machines in any facility under the control of the awardee and in accordance with contractual obligations for these services (see: [http://www.gsa.gov/graphics/pbs/Guidelines for Federal Concessions and Vending Operations.pdf](http://www.gsa.gov/graphics/pbs/Guidelines%20for%20Federal%20Concessions%20and%20Vending%20Operations.pdf)).
2. Resources that provide guidance for healthy eating and tobacco-free workplaces are:
<http://www.cdc.gov/nccdphp/dnpao/hwi/toolkits/tobacco/index.htm>
<http://www.thecommunityguide.org/tobacco/index.html>
<http://www.cdc.gov/chronicdisease/resources/guidelines/food-service-guidelines.htm>.

14. Health Insurance Marketplaces:

A healthier country is one in which Americans are able to access the care they need to prevent the onset of disease and manage disease when it is present. The Affordable Care Act, the health care law of 2010, creates new Health Insurance Marketplaces, also known as Exchanges, to offer millions of Americans affordable health insurance coverage. In addition, the law helps make prevention affordable and accessible for Americans by requiring health plans to cover certain recommended preventive services without cost sharing. Outreach efforts will help families and communities understand these new options and provide eligible individuals the assistance they need to secure and retain coverage as smoothly as possible. For more information on the Marketplaces and the health care law, visit: www.HealthCare.gov.

15. Intergovernmental Review:

Executive Order 12372 does not apply to this program.

16. Funding Restrictions:

Restrictions that must be considered while planning the programs and writing the budget are:

- Awardees may not use funds for research.
- Awardees may not use funds for clinical care.
- Awardees may use funds only for reasonable program purposes, including personnel, travel, supplies, and services.
- Generally, awardees may not use funds to purchase furniture or equipment. Any such proposed spending must be clearly identified in the budget.
- Reimbursement of pre-award costs is not allowed.
- Other than for normal and recognized executive-legislative relationships, no funds may be used for:
 - publicity or propaganda purposes, for the preparation, distribution, or use of any material designed to support or defeat the enactment of legislation

- the salary or expenses of any grant or contract recipient, or agent acting for such recipient, related to any activity designed to influence the enactment of legislation, appropriations, regulation, administrative action, or Executive order proposed or pending before any legislative body
- See [Additional Requirement \(AR\) 12](#) for detailed guidance on this prohibition and [additional guidance on lobbying for CDC awardees](#).

The direct and primary recipient in a cooperative agreement program must perform a substantial role in carrying out project outcomes and not merely serve as a conduit for an award to another party or provider who is ineligible.

17. Other Submission Requirements:

- a. Electronic Submission:** Applications must be submitted electronically at www.grants.gov. The application package can be downloaded at www.grants.gov. Applicants can complete the application package off-line and submit the application by uploading it at www.grants.gov. All application attachments must be submitted using a PDF file format. Directions for creating PDF files can be found at www.grants.gov. File formats other than PDF may not be readable by PGO Technical Information Management Section (TIMS) staff.

Applications must be submitted electronically by using the forms and instructions posted for this funding opportunity at www.grants.gov.

If Internet access is not available or if the forms cannot be accessed online, applicants may contact the PGO TIMS staff at 770- 488-2700 or by e-mail at pgotim@cdc.gov, Monday through Friday, 7:30 a.m.–4:30 p.m., except federal holidays. Electronic applications will be considered successful if they are available to PGO TIMS staff for processing from www.grants.gov on the deadline date.

- b. Tracking Number:** Applications submitted through www.grants.gov are time/date stamped electronically and assigned a tracking number. The applicant’s Authorized Organization Representative (AOR) will be sent an e-mail notice of receipt when www.grants.gov receives the application. The tracking number documents that the application has been submitted and initiates the required electronic validation process before the application is made available to CDC.
- c. Validation Process:** Application submission is not concluded until the validation process is completed successfully. After the application package is submitted, the applicant will receive a “submission receipt” e-mail generated by www.grants.gov. A second e-mail message to applicants will then be generated by www.grants.gov that will either validate or reject the submitted application package. This validation process may take as long as two business days.

Applicants are strongly encouraged to check the status of their application to ensure that submission of their package has been completed and no submission errors have occurred. Applicants also are strongly encouraged to allocate ample time for filing to guarantee that their application can be submitted and validated by the deadline published in the FOA. Non-validated applications will not be accepted after the published application deadline date.

If you do not receive a “validation” e-mail within two business days of application submission, please contact www.grants.gov. For instructions on how to track your application, refer to the e-mail message generated at the time of application submission or the Application User Guide, Version 3.0, page 57.

- d. Technical Difficulties:** If technical difficulties are encountered at www.grants.gov, applicants should contact Customer Service at www.grants.gov. The www.grants.gov Contact Center is available 24 hours a day, 7 days a week, except federal holidays. The Contact Center is available by phone at 1-800-518-4726 or by e-mail at support@www.grants.gov. Application submissions sent by e-mail or fax, or on CDs or thumb drives will not be accepted. Please note that www.grants.gov is managed by HHS.
- e. Paper Submission:** If technical difficulties are encountered at www.grants.gov, applicants should call the www.grants.gov Contact Center at 1-800-518-4726 or e-mail them at support@www.grants.gov for assistance. After consulting with the Contact Center, if the technical difficulties remain unresolved and electronic submission is not possible, applicants may e-mail or call CDC GMO/GMS, *before the deadline*, and request permission to submit a paper application. Such requests are handled on a case-by-case basis.

An applicant’s request for permission to submit a paper application must:

1. Include the www.grants.gov case number assigned to the inquiry;
2. Describe the difficulties that prevent electronic submission and the efforts taken with the www.grants.gov Contact Center to submit electronically; and
3. Be postmarked at least three calendar days before the application deadline. Paper applications submitted without prior approval will not be considered. If a paper application is authorized, PGO will advise the applicant of specific instructions for submitting the application (e.g., original and two hard copies of the application by U.S. mail or express delivery service).

E. Application Review Information
1. Review and Selection Process: Applications will be reviewed in three phases.
a. Phase I Review:
All applications will be reviewed initially for completeness by CDC PGO staff and will be reviewed jointly for eligibility by the CDC <i>NCBDDD</i> and PGO. Incomplete applications and applications that do not meet the eligibility criteria will not advance to Phase II review. Applicants will be notified that their applications did not meet eligibility or published submission requirements.
b. Phase II Review:
Approach: (50 points)
<i>Evaluation Criteria:</i>
<ul style="list-style-type: none"> • Does the applicant’s problem statement describe how the applicant’s response to the FOA will address the public health problem and support public health priorities as it relates to the jurisdictions or populations they serve? (4 points) • Does the applicant’s 2-3 sentence purpose describe specifically how their application will address the problem as described in the CDC Project Description? (2 points) • Does the applicant describe the short-term outcomes for the project period? (2 points) • Does the applicant include a logic model that aligns with the CDC ADDM Logic Model and is modified for their site (if applicable)? (2 points) • Does the applicant describe strategies and activities that align with the CDC ADDM logic model, that are achievable, and that will allow for achievement of the outcomes of the project?
<u>Including the following sub-components:</u>
<ul style="list-style-type: none"> ○ Does the applicant propose strategies and activities consistent with the logic model that demonstrate ability and intent to adhere to standardized ADDM/MADDSP methodology? (5 points) ○ Does the applicant propose appropriate strategies and activities for other DD surveillance (i.e. cerebral palsy or intellectual disability) consistent with the logic model that demonstrate ability and intent to adhere to

standardized ADDM/MADDSP methodology? **(5 points)**

- Does the applicant propose appropriate community education and outreach activities consistent with the logic model? **(7 points)**
- Does the applicant propose two site-initiated analyses consistent with the logic model? **(3 points)**
- Does the applicant describe how they will **collaborate** with programs and organizations either internal or external to CDC (including letters of support, MOUs or MOAs) - including evidence of the ability to obtain access to key sources of data? (health, education for Component A; health, education and early intervention for Component B) that are necessary to yield an accurate estimate of prevalence of ASD consistent with other ADDM sites? **(10 points; maximum of 5 points can be awarded if no access to education sources or access to education sources in less than 50% of surveillance area (defined as less than 50% of education sources or education sources covering less than 50% of surveillance population))**
- Does the applicant describe the specific **target populations** in their jurisdiction including:

For Component A, does the applicant: 1) identify a surveillance area that represents a contiguous geographic region clearly defined by county or school-district boundaries, with a population of at least 20,000 8-year-old children (according to latest available postcensal estimates http://www.cdc.gov/nchs/nvss/bridged_race.htm); 2) when applicable, identify a surveillance area maintaining as much consistency with earlier 8-year-old surveillance years as possible; 3) demonstrate how their base geographic area will include a diverse population (including socio-economic, racial/ethnic or other groups (e.g., rural)); and 4) provide a written description of how the chosen geographic area compares to the state overall with respect to the same characteristics?

If applying for Component B does the applicant: 1) identify a surveillance area that represents a contiguous geographic region clearly defined by county or school-district boundaries, with a population of at least 8,000 4-year-old children (according to latest available postcensal estimates http://www.cdc.gov/nchs/nvss/bridged_race.htm), 2) identify a surveillance area that lies entirely within the proposed 8-year-old surveillance area, 3) demonstrate how their base geographic area will include a diverse population (including socio-economic, racial/ethnic or other groups (e.g., rural)); 4) provide a written description of how the chosen geographic area

compares to the state overall with respect to the same characteristics; and 5) if applicable, identify a 4-year-old surveillance area maintaining as much consistency with earlier 4-year-old surveillance years as possible? **(5 points)**

- Does the applicant describe how the chosen surveillance area allows for **inclusion** of information about children among particularly vulnerable or high-risk groups (e.g. by race/ethnicity, socioeconomic status, rural/urban) whenever possible (and as appropriate to the geographic area), such that data may be used to better understand disparities in ASD prevalence, characteristics and age at identification? **(5 points)**

Evaluation and Performance Management: (30 points)

Evaluation Criteria:

- Does applicant describe **key evaluation questions** to be answered? **(5 points)**
- Does applicant describe required and optional/additional **performance measures**? **(10 points)**
- Does applicant describe potentially available **data sources** and feasibility of collecting appropriate evaluation and performance data? **(5 points)**
- Does applicant describe how evaluation findings will be used for continuous **program and quality improvement**? **(10 points)**

Applicant's Organizational Capacity to Implement the Approach: (20 points)

Evaluation Criteria:

- Does applicant demonstrate **relevant experience and capacity** (management, administrative and technical) to achieve the outcomes of project? **(7 points)**
- Does the applicant provide evidence of current operational capacity to conduct multiple source surveillance? If the currently operational system is not based on the MADDSP/ADDM model, does the applicant provide evidence of the system's ability to be comparable to MADDSP/ADDM? Does the applicant provide evidence in the form of actual prevalence results from this surveillance system in the appendices (if applicable)? **(3 points)**
- Does applicant provide a **staffing plan and project management structure** that will be sufficient to meet the outcomes of the project and that clearly defines staff roles (and provides an organizational chart)? **(7 points)**

- Does the applicant demonstrate the capacity to maintain a SQL Server database application on a local network server and the capacity to host a web-based SQL Server database application through both a web server and a network data storage server? **(3 points)**

Not more than thirty days after the Phase II review is completed, applicants will be notified electronically if their application does not meet eligibility or published submission requirements.

c. Phase III Review:

Applications will be funded in order by score and rank determined by the review panel. The following factor will also affect the funding decision: In order to ensure maximum U.S. coverage, no more than one application per State will be funded. If multiple applicants from the same State apply under this FOA only the highest scoring applicant from that particular State will be selected for funding.

2. Announcement and Anticipated Award Dates:

January 1, 2015

F. Award Administration Information

1. Award Notices:

Awardees will receive an electronic copy of the Notice of Award (NoA) from CDC PGO. The NoA shall be the only binding, authorizing document between the awardee and CDC. The NoA will be signed by an authorized GMO and e-mailed to the awardee program director.

Any applicant awarded funds in response to this FOA will be subject to the DUNS, SAM Registration, and Federal Funding Accountability And Transparency Act Of 2006 (FFATA) requirements.

Unsuccessful applicants will receive notification of these results by e-mail with delivery receipt or by U.S. mail.

2. Administrative and National Policy Requirements:

Awardees must comply with the administrative requirements outlined in 45 C.F.R. Part 74 or Part 92, as appropriate. Brief descriptions of relevant provisions are available at http://www.cdc.gov/od/pgo/funding/grants/additional_req.shtm.

The following Administrative Requirements (AR) apply to this project:

Generally applicable ARs:

- AR-9: Paperwork Reduction Act

- AR-10: Smoke-Free Workplace
- AR-11: Healthy People 2020
- AR-12: Lobbying Restrictions
- AR-14: Accounting System Requirements
- AR-16: Security Clearance Requirement
- AR-21: Small, Minority, And Women-owned Business
- AR-24: Health Insurance Portability and Accountability Act
- AR-25: Release and Sharing of Data
- AR-26: National Historic Preservation Act of 1966
- AR-29: Compliance with EO13513, "Federal Leadership on Reducing Text Messaging while Driving," October 1, 2009
- AR-30: Compliance with Section 508 of the Rehabilitation Act of 1973
- AR-33: Plain Writing Act of 2010
- AR-34: Patient Protection and Affordable Care Act (e.g., a tobacco-free campus policy and a lactation policy consistent with S4207)
- AR-35: Nutrition Policies

ARs applicable to awards related to conferences:

- AR-27: Conference Disclaimer and Use of Logos

Organization-specific ARs:

- AR-8: Public Health System Reporting (community-based, nongovernment organizations)
- AR-15: Proof of Non-profit Status (nonprofit organizations)
- AR 23: Compliance with 45 C.F.R. Part 87 (faith-based organizations)]

For more information on the C.F.R., visit the National Archives and Records Administration at <http://www.access.gpo.gov/nara/cfr/cfr-table-search.html>.

3. Reporting

a. CDC Reporting Requirements:

Reporting provides continuous program monitoring and identifies successes and challenges that awardees encounter throughout the project period. Also, reporting is a requirement for awardees who want to apply for yearly continuation of funding. Reporting helps CDC and awardees because it:

- Helps target support to awardees, particularly for cooperative agreements;
- Provides CDC with periodic data to monitor awardee progress towards meeting the FOA outcomes and overall performance;
- Allows CDC to track performance measures and evaluation findings to validate continuous program improvement throughout the project period and to determine applicability of evidence-based approaches to different populations, settings, and contexts; and

- Enables CDC to assess the overall effectiveness and influence of the FOA.

As described in the following text, awardees must submit an annual performance report, ongoing performance measures data, administrative reports, and a final performance and financial report. A detailed explanation of any additional reporting requirements will be provided in the Notice of Award to successful applicants.

b. Specific reporting requirements:

i. Awardee Evaluation and Performance Measurement Plan: Awardees must provide a more detailed evaluation and performance measurement plan within the first six months of the project. This more detailed plan must be developed by awardees as part of first-year project activities, with support from CDC. This more detailed plan must build on the elements stated in the initial plan, and must be no more than 25 pages. At a minimum, and in addition to the elements of the initial plan, this plan must:

- Indicate the frequency that evaluation and performance data are to be collected.
- Describe how data will be reported.
- Describe how evaluation findings will be used to ensure continuous quality and program improvement.
- Describe how evaluation and performance measurement will yield findings that will demonstrate the value of the FOA (e.g., effect on improving public health outcomes, effectiveness of FOA as it pertains to performance measurement, cost-effectiveness, or cost-benefit).
- Describe dissemination channels and audiences (including public dissemination).
- Describe other information requested and as determined by the CDC program.

When developing evaluation and performance measurement plans, applicants are encouraged to use the Introduction to Program Evaluation for Public Health Programs: A Self-Study Guide, available at:

<http://www.cdc.gov/eval/guide/index.htm>

ii. Annual Performance Report: This report must not exceed 45 pages excluding administrative reporting; attachments are not allowed, but Web links are allowed.

The awardee must submit the Annual Performance Report via www.grants.gov 120 days before the end of the budget period. In addition, the awardee must submit an annual Federal Financial Report within 90 days after the end of the calendar quarter in which the budget year ends.

This report must include the following:

- **Performance Measures** (including outcomes)—Awardees must report on performance measures for each budget period and update measures, if needed.
- **Evaluation Results**—Awardees must report evaluation results for the work completed to date (including any data about the effects of the program).
- **Work Plan**—Awardees must update work plan each budget period.
- **Successes**
 - Awardees must report progress on completing activities outlined in the work plan.
 - Awardees must describe any additional successes (e.g., identified through evaluation results or lessons learned) achieved in the past year.
 - Awardees must describe success stories.
- **Challenges**
 - Awardees must describe any challenges that might affect their ability to achieve annual and project-period outcomes, conduct performance measures, or complete the activities in the work plan.
 - Awardees must describe any additional challenges (e.g., identified through evaluation results or lessons learned) encountered in the past year.
- **CDC Program Support to Awardees**
 - Awardees must describe how CDC could help them overcome challenges to achieving annual and project-period outcomes and performance measures, and completing activities outlined in the work plan.
- **Administrative Reporting** (No page limit)
 - SF-424A Budget Information-Non-Construction Programs.
 - Budget Narrative—must use the format outlined in “Content and Form of Application Submission, Budget Narrative” section.
 - Indirect Cost-Rate Agreement.

For year 2 and beyond of the award awardees may request that as much as 75% of their estimated unobligated funds be carried over into the next budget period.

The carryover request must:

- Express a bona fide need for permission to use an unobligated balance;
- Include a signed, dated, and accurate Federal Financial Report (FFR) for the budget period from which funds will be transferred (as much as 75% of unobligated balances); and
- Include a list of proposed activities, an itemized budget, and a narrative

justification for those activities.

The awardee must submit the Annual Performance Report via www.grants.gov 120 days before the end of the budget period.

iii. Performance Measure Reporting: CDC programs must require awardees to submit performance measures annually as a minimum, and may require reporting more frequently. Performance measure reporting must be limited to data collection. When funding is awarded initially, CDC programs must specify required reporting frequency, data fields, and format.

Information on required reporting frequency, data fields, and format is provided in the CDC Evaluation and Performance Measurement Strategy section on pages 23-30.

iv. Federal Financial Reporting (FFR): The annual FFR form (SF-425) is required and must be submitted through eRA Commons² within 90 days after each budget period ends. The report must include only those funds authorized and disbursed during the timeframe covered by the report. The final report must indicate the exact balance of unobligated funds, and may not reflect any unliquidated obligations. The final FFR expenditure data and the Payment Management System's (PMS) cash transaction data must correspond; no discrepancies between the data sets are permitted. Failure to submit the required information by the due date may affect adversely the future funding of the project. If the information cannot be provided by the due date, awardees are required to submit a letter of explanation and include the date by which the information will be provided.

v. Final Performance and Financial Report: At the end of the project period, awardees must submit a final report including a final financial and performance report. This report is due 90 days after the project period ends. (CDC must include a page limit for the report with a maximum of 40 pages).

At a minimum, this report must include:

- Performance Measures (including outcomes)—Awardees must report final performance data for all performance measures for the project period.
- Evaluation Results—Awardees must report final evaluation results for the project period.
- Impact/ Results—Awardees must describe the effects or results of the work completed over the project period, including success stories.
- Additional forms as described in the Notice of Award, including Equipment Inventory Report and Final Invention Statement.

²<https://commons.era.nih.gov/commons/>

Awardees must email the report to the CDC PO and the GMS listed in the "Agency Contacts" section of the FOA.

4. Federal Funding Accountability and Transparency Act of 2006 (FFATA):

The FFATA and Public Law 109-282, which amends the FFATA, require full disclosure of all entities and organizations that receive federal funds including awards, contracts, loans, other assistance, and payments. This information must be submitted through the single, publicly accessible Web site, www.USASpending.gov.

Compliance with these mandates is primarily the responsibility of the federal agency. However, two elements of these mandates require information to be collected and reported by applicants: 1) information on executive compensation when not already reported through SAM; and 2) similar information on all sub-awards, subcontracts, or consortiums for greater than \$25,000.

For the full text of these requirements, see:

<http://www.gpo.gov/fdsys/browse/collection.action?collectionCode=BILLS>.

G. Agency Contacts

CDC encourages inquiries concerning this FOA.

For **programmatic technical assistance**, contact:

Anita Washington
Department of Health and Human Services
Centers for Disease Control and Prevention
1600 Clifton Road, MS E-86
Atlanta, GA 30333
Telephone: 404-498-3861
email: czo9@cdc.gov

For **financial, awards management, or budget assistance**, contact:

Ferrinnia Augustus-High, Grants Management Specialist
Department of Health and Human Services
CDC Procurement and Grants Office
2920 Brandywine Road, MS E-09
Atlanta, GA 30341
Telephone: 770-488-2906
email: wef9@cdc.gov

For assistance with **submission difficulties related to www.grants.gov**, contact the Contact Center by phone at 1-800-518-4726.

Hours of Operation: 24 hours a day, 7 days a week, except on federal holidays.

For all other **submission** questions, contact:

Technical Information Management Section
Department of Health and Human Services
CDC Procurement and Grants Office
2920 Brandywine Road, MS E-14
Atlanta, GA 30341
Telephone: 770-488-2700
E-mail: pgotim@cdc.gov

CDC Telecommunications for persons with hearing loss is available at: TTY 1-888-232-6348.

H. Other Information

Additional information that may be helpful to applicants:

<http://www.cdc.gov/ncbddd/autism/index.html>

Following is a list of acceptable attachments that applicants can upload as PDF files as part of their application at www.grants.gov. Applicants may not attach documents other than those listed; if other documents are attached, applications will not be reviewed.

- Project Abstract
- Project Narrative
- Budget Narrative
- CDC Assurances and Certifications
- Work Plan
- Table of Contents for Entire Submission
- Resumes/CVs
- Letters of Support
- Organizational Charts
- Non-profit organization IRS status forms, if applicable
- Indirect Cost Rate, if applicable
- Memorandum of Agreement (MOA)
- Memorandum of Understanding (MOU)
- Bona Fide Agent status documentation, if applicable
- References
- Reports of Previous Surveillance Programs and Results

I. Glossary

Administrative and National Policy Requirements, Additional Requirements (ARs): Administrative requirements found in 45 CFR Part 74 and Part 92 and other requirements mandated by statute or CDC policy. All ARs are listed in the Template for CDC programs. CDC programs must indicate which ARs are relevant to the FOA; awardees must comply with the ARs listed in the FOA. To view brief descriptions of relevant provisions, see http://www.cdc.gov/od/pgo/funding/grants/additional_req.shtm.

Award: Financial assistance that provides support or stimulation to accomplish a public purpose. Awards include grants and other agreements (e.g., cooperative agreements) in the form of money, or property in lieu of money, by the federal government to an eligible applicant.

Budget Period or Budget Year: The duration of each individual funding period within the project period. Traditionally, budget periods are 12 months or 1 year.

Carryover: Unobligated federal funds remaining at the end of any budget period that, with the approval of the GMO or under an automatic authority, may be carried over to another budget period to cover allowable costs of that budget period either as an offset or additional authorization. Obligated but liquidated funds are not considered carryover.

Catalog of Federal Domestic Assistance (CFDA): A catalog published twice a year that describes domestic assistance programs administered by the federal government. This catalog lists projects, services, and activities that provide assistance or benefits to the American public. This catalog is available at <https://www.cfda.gov/index?s=agency&mode=form&id=0bebbc3b3261e255dc82002b83094717&tab=programs&tabmode=list&subtab=list&subtabmode=list>.

CFDA Number: A unique number assigned to each program and FOA throughout its lifecycle that enables data and funding tracking and transparency.

CDC Assurances and Certifications: Standard government-wide grant application forms.

Competing Continuation Award: A financial assistance mechanism that adds funds to a grant and adds one or more budget periods to the previously established project period (i.e., extends the "life" of the award).

Continuous Quality Improvement: A system that seeks to improve the provision of services with an emphasis on future results.

Contracts: An award instrument that establishes a binding, legal procurement relationship between CDC and a recipient, and obligates the recipient to furnish a product.

Cooperative Agreement: A financial assistance award with the same kind of interagency relationship as a grant except that it provides for substantial involvement by the federal agency funding the award.

Cost Sharing or Matching: Refers to program costs not borne by the federal government but by the awardees. It may include the value of allowable third-party, in-kind contributions, as well as expenditures by the awardee.

Direct Assistance: An assistance support mechanism, which must be specifically authorized by statute, whereby goods or services are provided to recipients in lieu of cash. Direct assistance generally involves the assignment of Federal personnel or the provision of equipment or supplies, such as vaccines.
<http://intranet.cdc.gov/ostlts/directassistance/index.html>.

DUNS: The Dun and Bradstreet (D&B) Data Universal Numbering System (DUNS) number is a nine-digit number assigned by Dun and Bradstreet Information Services. When applying for Federal awards or cooperative agreements all applicant organizations must obtain a DUNS number as the Universal Identifier. DUNS number assignment is free. If requested by telephone, a DUNS number will be provided immediately at no charge. If requested via the internet, obtaining a DUNS number may take one to two days at no charge. If an organization does not know its DUNS number or needs to register for one, visit Dun & Bradstreet at <http://fedgov.dnb.com/webform/displayHomePage.do>.

Federal Funding Accountability and Transparency Act of 2006 (FFATA): Requires that information about federal awards, including awards, contracts, loans, and other assistance and payments, be available to the public on a single Web site at www.USAspending.gov.

Fiscal Year: The year for which budget dollars are allocated annually. The federal fiscal year starts October 1 and ends September 30.

Grant: A legal instrument used by the federal government to transfer anything of value to a recipient for public support or stimulation authorized by statute. Financial assistance may be money or property. The definition does not include a federal procurement subject to the Federal Acquisition Regulation; technical assistance (which provides services instead of money); or assistance in the form of revenue sharing, loans, loan guarantees, interest subsidies, insurance, or direct payments of any kind to a person or persons. The main difference between a grant and a cooperative agreement is that in a grant there is no anticipated substantial programmatic involvement by the federal government under the award.

Grants.gov: A "storefront" Web portal for electronic data collection (forms and reports) for federal grant-making agencies at www.grants.gov.

Health Disparities: Differences in health outcomes and their determinants among segments of the population as defined by social, demographic, environmental, or geographic category.

Healthy People 2020: National health objectives aimed at improving the health of all Americans by encouraging collaboration across sectors, guiding people toward making informed health decisions, and measuring the effects of prevention activities.

Inclusion: Both the meaningful involvement of a community's members in all stages of the program process and the maximum involvement of the target population that the intervention will benefit.

Inclusion ensures that the views, perspectives, and needs of affected communities, care providers, and key partners are considered.

Indirect Costs: Costs that are incurred for common or joint objectives and not readily and specifically identifiable with a particular sponsored project, program, or activity; nevertheless, these costs are necessary to the operations of the organization. For example, the costs of operating and maintaining facilities, depreciation, and administrative salaries generally are considered indirect costs.

Intergovernmental review: Executive Order 12372 governs applications subject to Intergovernmental Review of Federal Programs. This order sets up a system for state and local governmental review of proposed federal assistance applications. Contact the state single point of contact (SPOC) to alert the SPOC to prospective applications and to receive instructions on the State's process. Visit the following Web address to get the current SPOC list: http://www.whitehouse.gov/omb/grants_spoc/.

Letter of Intent (LOI): A preliminary, non-binding indication of an organization's intent to submit an application.

Lobbying: Direct lobbying includes any attempt to influence legislation, appropriations, regulations, administrative actions, executive orders (legislation or other orders), or other similar deliberations at any level of government through communication that directly expresses a view on proposed or pending legislation or other orders, and which is directed to staff members or other employees of a legislative body, government officials, or employees who participate in formulating legislation or other orders. Grass roots lobbying includes efforts directed at inducing or encouraging members of the public to contact their elected representatives at the federal, state, or local levels to urge support of, or opposition to, proposed or pending legislative proposals.

Maintenance of Effort: A requirement contained in authorizing legislation, or applicable regulations that a recipient must agree to contribute and maintain a specified level of financial effort from its own resources or other nongovernment sources to be eligible to receive federal grant funds. This requirement is typically given in terms of meeting a previous base-year dollar amount.

Memorandum of Understanding (MOU) or Memorandum of Agreement (MOA): Document that describes a bilateral or multilateral agreement between parties expressing a convergence of will between the parties, indicating an intended common line of action. It is often used in cases where the parties either do not imply a legal commitment or cannot create a legally enforceable agreement.

New FOA: Any FOA that is not a continuation or supplemental award.

Nongovernment Organization (NGO): Any nonprofit, voluntary citizens' group that is organized on a local, national, or international level.

Notice of Award (NoA): The only binding, authorizing document between the recipient and CDC that confirms issue of award funding. The NoA will be signed by an authorized GMO and provided to the recipient fiscal officer identified in the application.

Performance Measurement: The ongoing monitoring and reporting of program accomplishments, particularly progress toward pre-established goals, typically conducted by program or agency management. Performance measurement may address the type or level of program activities conducted (process), the direct products and services delivered by a program (outputs), or the results of those products and services (outcomes). A “program” may be any activity, project, function, or policy that has an identifiable purpose or set of objectives.

Objective Review: A process that involves the thorough and consistent examination of applications based on an unbiased evaluation of scientific or technical merit or other relevant aspects of the proposal. The review is intended to provide advice to the persons responsible for making award decisions.

Outcome: The observable benefits or changes for populations or public health capabilities that will result from a particular program strategy.

Plain Writing Act of 2010: Requires federal agencies to communicate with the public in plain language to make information more accessible and understandable by intended users, especially people with limited health literacy skills or limited English proficiency. The Plain Writing Act is available at www.plainlanguage.gov.

Program Strategies: Public health interventions or public health capabilities.

Program Official: Person responsible for developing the FOA; can be either a project officer, program manager, branch chief, division leader, policy official, center leader, or similar staff member.

Project Period Outcome: An outcome that will occur by the end of the FOA’s funding period.

Public Health Accreditation Board (PHAB): National, nonprofit organization that improves tribal, state, local, territorial, and U.S. public health departments and strengthens their quality and performance through accreditation.

System for Award Management (SAM): The primary vendor database for the U.S. federal government. SAM validates applicant information and electronically shares secure and encrypted data with federal agencies' finance offices to facilitate paperless payments through Electronic Funds Transfer (EFT). SAM stores organizational information, allowing www.grants.gov to verify identity and pre-fill organizational information on grant applications.

Statute: An act of the legislature; a particular law enacted and established by the will of the legislative department of government, expressed with the requisite formalities. In foreign or civil law any particular municipal law or usage, though resting for its authority on judicial decisions, or the practice of nations. *Black’s Law Dictionary 2 Kent, Comma 450.*

Statutory Authority: Authority provided by legal statute that establishes a federal financial assistance program or award.

Technical Assistance: Advice, assistance, or training pertaining to program development, implementation, maintenance, or evaluation that is provided by the funding agency.

Work Plan: The summary of annual strategies and activities, personnel and/or partners who will complete them, and the timeline for completion. The work plan will outline the details of all necessary activities that will be supported through the approved budget.

QUESTIONS AND ANSWERS:

1. **Question:** Are field staff and clinician review trainings the same for Components A & B?

Response: The trainings are the same with the exception of additional abstractor training modules for Component B. Separate staff for Component B is not required. CDC staff will provide trainings for project coordinators, abstractors, data managers and clinician reviewers.

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2. **Question:** Is a signed MOA required for the application, or will a letter of support suffice indicating they will do a MOA if the project is funded?

Response: A signed MOA is not required but evidence of collaboration can be provided to support your application.

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3. **Question:** Do we need to submit separate budgets for each component or can we combine them?

Response: A separate budget is not required for each component.

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4. **Question:** In the FOA (p. 34) it states that: "Each applicant must provide evidence from the state government or governing body that they would have access to health records." What is considered "evidence"? Would a letter designating the applicant as a bona fide agent of the state health department for this work be sufficient documentation?

Response: A letter of support from the state or local health department or appropriate governing body must be provided to support your application. This letter satisfies the special eligibility requirement of a letter of support, MOU or other documentation to indicate applicant has access to health records. The applicant's activities must be recognized as public health practice by whichever local health agency or agencies serve the population under surveillance. This is typically the state health department but some cities and counties have their own agencies.

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5. Question: For the attachment of CVs/resumes, is there a specific format that these need to be in or are there no requirement re: format?

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Response: There is no required format for CVs/resumes.

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6. Question: What are the job requirements for the data manager/programmer?

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Response: Applicants must demonstrate that they have adequate technical and facility resources to utilize and maintain CDC-developed database applications. This includes the capacity to maintain a SQL Server database application on a local network server and the capacity to host a web-based SQL Server database application through both a web server and a network data storage server. IT support staff must be able to query the data and have experience with the back-end and front-end. CDC will provide the database applications.

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7. Question: The data are de-identified after the abstractors have completed their work, all files on a single child been linked, and they are subsequently presented in de-identified fashion to: a) the clinical panel, and; b) to the portal for upload in the CDC mega file. Can we keep a version of the file with identifiers for our own site usage so that we can later perform linkages with other databases?

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Response: Yes, the data with identifiers are the property of the individual ADDM sites. CDC will only request de-identified data for the pooled dataset.

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8. Question: At which stage do we complete birth certificate linkages?

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Response: Birth certificate linkages are completed at the end of the surveillance year and not during the abstraction process.

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9. Question: Travel: how many days are each meeting in Atlanta? How many hotel nights should we expect to cover in the budget and per diem?

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Response: The following meetings/trainings must be included in the travel budget:

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a. For budget year 1 only, two key staff members (Principal Investigator and Project Coordinator) to participate in a post-award meeting in Atlanta, Georgia. (1 day)

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b. Two key staff to participate in ADDM Network collaborative grantee meetings yearly during the 4-year funding cycle. (2 days)

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c. Reverse site visits (Atlanta, GA) at the conclusion of each surveillance year, or twice during the 4-year funding cycle to review progress to date, planned activities, and share ideas for future activities. (1-2 days)

d. One-time Abstractor training, of three days duration, to be attended by new ADDM Network abstractors (as recommended or provided by CDC). (3 days)

e. One-time Database Management training, of two days duration, to be attended by new ADDM Network database managers. (2 days)

f. One-time clinician reviewer training, of two days duration, to be attended by new ADDM Network clinician reviewers. (2 days)

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10. **Question:** Can you please provide clarification on the page limits for both components and the work plan format?

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Response: Component A: maximum of 25 pages (includes project narrative and work plan). Component B: maximum of 30 pages (additional 5 pages for Component B activities, including project narrative and work plan). The Project Narrative section is described on FOA pages 42 & 43 and MUST include certain sections (e.g., background, approach, purpose, outcomes, strategies/activities, evaluation plan and organizational capacity). The Work Plan is to be completed in table format only. It should support what's written in the project narrative, but delineates specifically how the applicant plans to carry out the required/proposed work. Use the sample work plan on page 35 of the FOA as a guide in creating your work plan (which should look identical in terms of columns). For the first year work plan, all strategies/activities of the first year for Component A or Components A and B should be included. The first year work plan focuses exclusively on the first year. The four year overview work plan encompasses strategies/activities of ALL four years.

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11. **Question:** Where should we include references and evidence of prevalence results?

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Response: Please see updated list of acceptable attachments on page 59 under Other Information.

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