

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention (CDC)

Collaborative Chronic Disease, Health Promotion, and Surveillance Program

Announcement: Healthy Communities, Tobacco Control, Diabetes Prevention and Control, and Behavioral Risk Factor Surveillance System

Announcement Type: 2-Competing Continuation for CDC-RFA-DP09-901

Funding Opportunity Number: CDC-RFA-DP14-1415

Catalog of Federal Domestic Assistance Number: 93.283 and 93.988

Key Dates:

Application Deadline: February 28, 2014, 11:59PM Eastern Standard Time

NOTE: The applicants supported under this one-year funding opportunity announcement will continue to work with the Program Services Branch, Office on Smoking and Health on (1) completing existing activities that could not be finished due to limited time and funds; (2) achieving project period and annual objectives; and (3) preparing applicants for the next competitive 5-year funding opportunity announcement. Please note that three programmatic components (Healthy Communities, diabetes prevention and control, and BRFSS) are no longer funded under this cooperative agreement program. This competing continuation announcement applies only to the tobacco control program component. Further guidance will be provided by the Office on Smoking and Health, Program Services Branch.

I. Funding Opportunity Description

Authority: Public Health Service Act 301, 307, 310, 311, Comprehensive Smoking Education Act of 1984, Comprehensive Smokeless Tobacco Health Education Act of 1986.

Background: Chronic diseases—including heart disease, cancer, stroke, diabetes, arthritis, and related risk factors, such as tobacco use, physical inactivity, poor diet, and obesity—are the leading causes of death and disability in the United States, accounting

for 7 of every 10 deaths and affecting the quality of life of 90 million Americans. Chronic diseases represent 83% of all U.S. health care spending; medical care costs of people with chronic diseases account for more than 75% of the nation's \$2 trillion medical care costs. The direct and indirect costs of diabetes alone are \$174 billion a year. The estimated direct and indirect costs associated with smoking exceed \$193 billion annually. Although chronic diseases are among the most common and costly health problems, they are also among the most preventable.

CDC's National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP) is at the forefront of the nation's efforts to promote people living healthy lives free from the devastation of chronic diseases. The mission of the Center is to lead efforts to promote health and well-being through prevention and control of chronic diseases. The strategic priorities of the Center are as follows: 1) focus on well-being: increase emphasis on promoting health and preventing risk factors, thereby reducing the onset of chronic conditions; 2) health equity: leverage program and policy activities, build partner capacities, and establish tailored interventions to help eliminate health disparities; 3) research translation: accelerate the translation of scientific findings into community practice to protect the health of people where they live, work, learn, and play; 4) policy promotion: promote social, environmental, policy, and systems approaches that support healthy living for individuals, families, and communities; and 5) workforce development: develop a skilled, diverse, and dynamic public health workforce and network of partners to promote health and prevent chronic diseases at the national, state, and local levels. Critical to the success of these efforts are partnerships with state and

territorial health and education agencies, American Indian and Alaska Native tribes and tribal organizations, nongovernmental organizations, local communities, public and private sector organizations, major voluntary associations, federal agencies, and others. Developing and implementing more efficient ways to use resources can provide opportunities for programs to achieve greater health impact by working together. This funding opportunity announcement continues programmatic efforts to reduce chronic disease morbidity and its related risk factors and to reduce premature death associated with chronic diseases. It also continues surveillance, assessment, and evaluation efforts to measure the public health impact of these programs, while placing new emphasis on collaborative work. A recurrent and central guiding principle that is being encouraged by all four programs funded through this program announcement is the increased emphasis on partnerships and collaboration (both internal and external to the state health department) and on program collaboration for the purpose of leveraging CDC and state (federal and non-federal) resources to achieve common goals shared by different programs. It is anticipated that increased partnerships and collaborations will lead to positive and measurable public health impact. For additional guidance and examples of what is meant by collaboration, refer to the **Addendum** of this Funding Opportunity Announcement.

The Centers for Disease Control and Prevention (CDC) announces the availability of fiscal year 2014 funds for a cooperative agreement program for chronic disease prevention and health promotion programs. Specific areas addressed through this announcement are tobacco control, diabetes prevention and control, state-based

surveillance and data analysis for chronic disease prevention and health promotion through the Behavioral Risk Factor Surveillance System (BRFSS), and state-level technical assistance regarding policy and environmental interventions to reduce the burden of chronic diseases and chronic disease risk factors in communities.

Purpose: The purpose of the program is to reduce the morbidity and premature mortality associated with chronic diseases and to eliminate associated health disparities by supporting capacity building, program planning, development, implementation, evaluation, and surveillance for chronic disease conditions and chronic disease-related risk factors. This program addresses the Healthy People 2010 focus areas of Diabetes (focus area 5), Educational and Community-Based Programs (focus area 7), Public Health Infrastructure – Data and Information Systems (focus area 23), and Tobacco Use (focus area 27). This program also addresses the CDC goal of “Healthy People in Every Stage of Life” (“All people, and especially those at greater risk of health disparities, will achieve their optimal lifespan with the best possible quality of health in every stage of life.”) and “Healthy People in Healthy Places” (“The places where people live, work, learn, and play will protect and promote their health and safety, especially those at greater risk of health disparities.”).

Activities and interventions funded under this program announcement should be evidence based and implemented in consultation with CDC. When preparing the application, applicants should avail themselves of technical assistance resources available from the program to ensure that evidence-based capacity building, surveillance and evaluation

activities, intervention strategies, and the infrastructure to implement them are proposed for funding.

Measurable outcomes of the program will be in alignment with one (or more) of the following performance goals for NCCDPHP: 1) reduce death and disability due to tobacco use, 2) prevent diabetes and its complications, 3) establish a focal point at the state level to foster healthy communities, and 4) maintain a national surveillance system to monitor the impact of chronic disease prevention and health promotion programs.

This announcement is only for non-research activities supported by CDC. If research is proposed, the application will not be reviewed. For the definition of research, please see the following CDC Web page:

<http://www.cdc.gov/od/science/regs/hrpp/researchDefinition.htm>

Recipient Activities:

Note: Recipient activities apply to the tobacco control component only.

A) Administration, Management, and Leadership

Effective chronic disease prevention and control programs require substantial leadership to implement them effectively. Staffs that oversee these efforts must be adequately trained in how to manage and implement public health programs in an environment that is placing increased emphasis on collaboration and integration to achieve measurable public health outcomes. Internal capacity within a state health department is essential for program stability, effectiveness, and efficiency. Sufficient capacity enables programs to

plan their strategic efforts, provide strong leadership, and foster collaboration among state, tribal, and local chronic disease programs. An adequate number of skilled staff is necessary to provide or facilitate program oversight, technical assistance, and training. Good fiscal accountability and management are also critical.

1. Strategic Planning

Programs should engage with partners in a data driven and inclusive process to identify state priorities, opportunities, and gaps in chronic disease prevention and health promotion within the state. This process should result in developing, implementing, and evaluating a multi-year statewide strategic plan to address the issues identified with the goal of achieving measurable health impact.

Performance Measures

- Evidence that a multi-year, evidence-based, and data-supported statewide strategic plan has been or will be developed with an inclusive group of partners. The statewide strategic plan can be a chronic disease plan or a disease- and/or risk factor-specific plan.
- If a statewide strategic plan already exists, evidence that the plan has been reviewed and updated as determined by changes in the state's public health or health delivery system environment.
- If state health departments do not have a primary responsibility for developing or implementing the state's overall strategic plan, evidence of participation in the planning process and clear role delineation with other agencies or organizations.

- Evidence that the statewide strategic plan includes interventions that have performance measures focused on the achievement of a measurable health impact.

2. Leadership and Collaboration

Programs should provide leadership for statewide, tribal, and local partnerships that support the goal of reducing or eliminating the health and economic burden of chronic diseases, as identified by state strategic plans. This leadership includes active collaboration and partnership involvement in developing and implementing the plan and developing an effective communication system with partners at the state, tribal, and local levels, based on a culture of shared responsibility among the state program and other partners (internal, external, traditional, or nontraditional).

Performance Measure

- Evidence of active involvement of partners in developing and implementing the strategic priorities outlined in the state's strategic plan.

3. Training, Technical Assistance, and Consultation

Programs should increase skills and capacity at the state, tribal, and local levels by supporting the provision of ongoing consultation, training, and technical assistance that is aligned with the priorities identified in the state strategic plan. Programs should conduct culturally competent technical assistance and training for contractors, grantees, and partners. Collaboration with other chronic disease prevention and health promotion programs on the provision of training, such as jointly conducted training

on common skills needed, should be considered to ensure synergistic reach and desired outcomes.

Performance Measures

- Evidence describing the strategic purpose of the training, the skills development that was provided, the collaboration that occurred in conducting the training, and the outcome that resulted.
- Evidence of the approach (e.g., needs assessment, environmental scan) used to provide technical assistance, consultation, and training aligned with the priorities identified in the state strategic plan.
- Evidence describing the technical assistance, consultation, and training that have been provided and the impact they have had at the state, tribal, and local levels.

4. Coordination of Efforts Among Chronic Disease Prevention and Health

Promotion Programs

Programs should identify and leverage opportunities to enhance the recipient's work with other state health programs that address related chronic diseases or risk factors to maximize the public health impact of CDC funding. This activity may include cost sharing to support activities such as shared positions and joint planning, implementation and evaluation of activities, joint training, funding of complementary evidence-based interventions, coalition alliances, and joint efforts around health communication strategies. This activity may also include implementing categorical and cross-cutting interventions and other cost-sharing activities that cut across state

health department programs, as well as other appropriate state agencies, and that are aligned with state strategic plans, such as the following:

- Coordinate and collaborate with other state health programs that address core chronic disease areas such as injury, asthma, environmental health, substance abuse, and maternal and child health that would contribute to overall chronic disease prevention and health promotion efforts to translate science into public health practice and policy.
- Enhance inclusion of common language and key messages in the work of related programs.
- Coordinate work within health department programs that work with similar partners.
- Coordinate work within specific settings, such as worksites, schools, health care systems, and community organizations, to achieve local changes necessary to prevent chronic diseases and their risk factors.
- Use consistent formats for documents such as state plans and descriptions of burden.

Performance Measure

- Evidence of coordination and collaboration among health promotion and chronic disease programs in implementing evidence-based public health practice and policy interventions.

5. Information Exchange

Programs should develop and implement mechanisms to facilitate exchange of information regarding program accomplishments and lessons learned among the state program, CDC, program staff in other states, and national partners. Information exchange may include presentations at national and regional meetings and conferences, postings to the state Web site or other accessible sites, participation in CDC task forces and workgroups, and publications in peer-reviewed journals and CDC's *Morbidity and Mortality Weekly Report* and *Preventing Chronic Disease*.

Performance Measures

- Evidence of the publication of best practices, abstracts, posters, and other documents at the local, tribal, state, and national levels, as appropriate.
- Evidence of other means of sharing ideas and methods of disseminating reports, findings, conclusions, or other strategies to advance program achievement and impact.

6. Sustainability

Programs should develop a plan with partners for ensuring statewide program sustainability and for acquiring funding from non-federal sources. Programs should educate the public and decision makers on the morbidity and mortality of chronic diseases addressed by this announcement, and on evidence-based public health practice and policy interventions.

Performance Measures

- Evidence that a sustainability plan has been developed separately or as part of the overall state strategic plan.
- Evidence that efforts are under way to educate the program's grantees, the public, and decision makers about the importance of sustained funding for evidence-based public health practice and policy interventions.

7. Program Management

a. Staffing

A full-time program manager is required to administer each of the following programs: tobacco control, diabetes and BRFSS. All staff should have or develop knowledge and skills in areas as appropriate to support the Project Work Plan and should possess the appropriate competencies to lead and manage chronic disease prevention and health promotion programmatic efforts. Staff should possess knowledge of culturally competent public health practice for the populations being served. A part-time staff program manager or 1-3 staff members should be identified to administer the Healthy Communities initiative to provide technical assistance to entities working with local communities in implementing policy, systems, and environmental change strategies to prevent chronic diseases.

Performance Measures

- Evidence that the state health department has dedicated human resources with appropriate knowledge and skills to administer and manage the program effectively.

- Evidence of the provision of ongoing training for staff, as demonstrated through staff participation in CDC-sponsored training, meetings, conferences and other continuing education opportunities, as identified by program management in the state health department.

b. Fiscal Management

Programs must use funding to support state, tribal, and local programs that focus on population-based strategies that are science-based, that reach diverse population groups, and that focus on social determinants of health. Specifically, programs must

- Develop and maintain systems for sound fiscal management, including
 - Monitoring the cooperative agreement award and program contracts and grants, ensuring that funds are expended in support of approved activities.
 - Tracking expenditures and sources of match support accurately and in a timely manner.
 - Projecting categorical balances accurately.
 - Preventing excessive unobligated balances.
- Establish an effective communication system with appropriate state fiscal management staff and develop a process for regularly assessing status of funds.
- Define and describe the program manager's role in fiscal management.

Performance Measures

Evidence of:

- timely submission and accuracy of financial status reports,
- the budget being aligned with the Project Work Plan,
- minimal percentage of budget that is unobligated at end of fiscal year,
- timely redirection of program funds to avoid unobligated balances,
- timely requests for prior approvals items, and
- documentation of the required 1:4 match.

c. Attendance at Training Sessions/Conferences

Program staff must attend required CDC conferences, meetings, and training sessions. See the **Addendum** for specific information regarding attendance at required training sessions by program.

Performance Measure

- Evidence of attendance at required CDC conferences, meetings, and training.

B) Surveillance, Analyses, and Evaluation

The framework used by CDC and NCCDPHP for preventing and controlling diseases is supported by public health surveillance. Public health surveillance is the ongoing, systematic collection, analysis, interpretation, and dissemination of data regarding a health-related event for use in public health action to reduce the morbidity and premature mortality associated with chronic diseases and to eliminate associated health disparities.

Data disseminated by a public health surveillance system are used by national, state, tribal, and local public health professionals and decision makers to

- Measure and monitor trends in the burden of a disease (or other health-related event), including detection of epidemics and pandemics, as well as changes in related factors.
- Identify new or emerging health concerns.
- Identify high-risk populations.
- Guide the planning, implementation, and evaluation of public health programs and policies to prevent and control disease, injury, or adverse exposure.
- Detect changes in health practices and the effects of these changes.
- Prioritize the allocation of limited health resources.
- Describe the clinical course of disease.
- Provide a basis for public health research.

NCCDPHP supports a number of surveillance systems that are essential to national, state, tribal, and local health promotion goals. These systems include, but are not limited to, BRFSS, the Youth Risk Behavior Surveillance System, the Youth Tobacco Survey, the Adult Tobacco Survey, the Pregnancy Risk Assessment Monitoring System, and the National Program of Cancer Registries. Use of other surveillance systems that generate data to support chronic disease prevention and health promotion programs is encouraged.

The purpose of this activity is to establish, maintain, use, and expand surveillance and data systems for chronic disease prevention and health promotion at the state level. To the extent possible, surveillance data should be used to evaluate programs and policies as described in Project Work Plans. To achieve this goal, collaboration among chronic disease prevention programs and surveillance system administrators is essential.

Programs should lead the establishment and maintenance of surveillance systems and methodologies to collect program-specific data about the general or defined population that contribute to the occurrence or prevention of chronic diseases and injuries.

Specifically, programs must

- Collaborate with CDC programs and partners to develop key indicators and program evaluation plans, collect and analyze data about the key indicators, and disseminate findings.
- Analyze data collected within the specified surveillance system to address programmatic goals and objectives.
- Interpret and disseminate findings from specified surveillance systems to address programmatic goals and objectives. Findings should be disseminated to state, tribal, and local categorical programs.
- Use data from the surveillance system to evaluate progress toward reaching programmatic goals and objectives, in accordance with the overall program plans.
- Provide technical assistance, training, and consultation to state and local staff to facilitate understanding, analyses, interpretation, and use of the surveillance data.

- Participate in CDC-sponsored training opportunities that foster understanding, analyses, interpretation, and use of the surveillance data and underlying methodologies.

Performance Measures

- Evidence that the state health department has dedicated appropriate leadership to administer and manage the surveillance systems.
- Evidence of collaboration with chronic disease prevention and health promotion programs to provide and use surveillance data in support of planning, implementing, and evaluating programs and policies.
- Evidence of adherence to recommended methodologies for conducting surveillance activities, analyzing surveillance data, and disseminating findings.
- Evidence of provision of technical assistance, training, and consultation to state and local health department staff.
- Evidence of participation in training opportunities offered by CDC, as demonstrated by participation in CDC-sponsored training opportunities, conferences, and workshops.

C) Promoting Social, Environmental, Policy, and Systems Approaches at the State and Community Levels

Policies, partnerships, and intervention activities that occur at the state, tribal, and local levels ultimately help change social norms and make healthy choices easier, safer, more accessible, and more affordable. To ensure social, environmental, policy, and system

changes that will promote and sustain these behavior changes, gaining an understanding of the role of social determinants of health is important. Work on social determinants goes beyond standard approaches of public health for enhancing policy and environmental supports to make healthful behaviors (such as physical activity) safer, easier, more accessible, and more affordable. Intervening on social determinants of health and equity refers to efforts that expand beyond the scope of traditional public health practice, requiring the public health community to work collaboratively with partners in education, housing, transportation, justice, labor, and other sectors to achieve improved outcomes to create healthier communities.

1. Develop and support program capacity to implement effective social, environmental, policy, and system approaches to help reduce the social inequalities in health by creating healthier communities.

Develop the capacity within the state health department that promotes collaboration among and with local agencies, tribes, partner organizations, and public health programs to implement social, environmental, policy, and system approaches to achieve the priorities identified to reduce the burden of chronic diseases and their related risk factors. This activity includes supporting the overall program goals and intervention strategies for accomplishing this work, including identifying and eliminating health disparities. Statewide, tribal, and local efforts should reflect objectives determined through an inclusive strategic planning process, should be planned for long-term sustainability, and should be coordinated through

communication to coalitions and networks. The level of commitment for partner organizations should be defined, and role definitions for partners should be clear.

Performance Measures

- Evidence of support for local and statewide program capacity to implement effective social, environmental, policy, and system approaches to help reduce social inequalities in health by creating healthier communities that make healthy choices easier, more accessible, and more affordable.
- Letters of support that define the level of commitment from partner organizations.
- Evidence of the role that partners played to ensure that social, environmental, and system approaches have been effectively implemented.

2. Consider social determinants of health when developing programs to eliminate chronic disease-related health disparities

Disparities in health in communities, defined by CDC as “preventable differences in the burden of disease, injury, violence, or opportunities to achieve optimal health experienced by socially disadvantaged racial, ethnic, and other population groups and communities,” are starkly revealed by chronic diseases. Programs should use data to identify communities within the state that are disproportionately affected by chronic diseases and their related risk factors. In collaboration with a diverse group of partners and various sectors, programs should consider social determinants of health in the development, implementation, and evaluation of program specific efforts and

use culturally appropriate interventions that are tailored for the communities for which they are intended.

Performance Measures

- Evidence that a data-driven and inclusive process has been used to assess health disparities related to chronic diseases within the state.
- Evidence that culturally appropriate interventions tailored for specific communities have been developed, implemented, and evaluated in collaboration with a diverse group of partners.
- Evidence of the development of relationships with other sectors that can influence the outcomes related to social determinants of health.

D) Health Communication Interventions

An effective health communication intervention should deliver strategic, culturally appropriate, and high-impact messages in sustained and adequately funded campaigns that support the priorities of the state's chronic disease prevention and health promotion program efforts.

Programs should develop and maintain an effective communication system and communication plan to share information on a regular basis and, as needed, with funded and unfunded partners, communities, the media, and the public, which may be part of the state strategic plan. Communication interventions can include paid advertising, media advocacy, public relations efforts, health promotion activities at the state and community levels, and targeting specific audiences through innovative channels.

Performance Measures:

- Evidence of a communication system and plan, as part of the state strategic plan.
- Evidence of communication interventions and how they are integrated and directly supportive of the primary program goals.

E) Interventions to Improve Health Care Systems

Improving the health of people with chronic conditions, such as diabetes, heart disease, arthritis, asthma, and cancer, will require transforming a health care system that is primarily reactive—that responds to episodes of illness—to one that is more proactive—that is focused on keeping individuals as healthy as possible. This transformation will require the support of policy and environmental changes and community interventions. The Planned Care Model (formerly known as the Chronic Care Model), which can be applied to a variety of chronic conditions, health care settings, and target populations, identifies specific areas of a health care system necessary to promote high-quality chronic disease preventive care and services. With the participation of appropriate partners and stakeholders, applicants will work in one or more of the following areas, based largely on the Planned Care Model and on documents such as CDC’s *Best Practices for Comprehensive Tobacco Control Programs*, to promote effective improvement strategies aimed at comprehensive health system change. To maximize population-level reach and impact, interventions within systems should occur at the highest level possible.

- Health care organization—Create a culture, an organization, and mechanisms that promote high-quality care (e.g., support development of agreements and systems changes to facilitate care coordination within and across organizations, promote processes for open and systematic handling of quality problems to improve care).
- Community resources and policies—Mobilize community services and resources to meet the needs of individuals with chronic diseases (e.g., form partnerships with community services and organizations to address identified gaps in care, advocate for policies to improve care).
- Self-management support—Support development of strategies that empower individuals to manage their health and health care (e.g., increase or strengthen community resources to support self-management, promote use of culturally competent standardized education materials).
- Decision support—Promote care that is consistent with scientific evidence and patient preferences (e.g., promote consistent use of treatment guidelines and care standards, provide appropriate tools and training for providers).
- Delivery system design—Ensure delivery of effective, efficient clinical care and self-management support (e.g., promote use of clinical case management practices, use registry information to provide feedback to improve care, implement practices to better coordinate care and follow-up).
- Clinical information systems—Organize patient and population-level data to facilitate efficient and effective care (e.g., provide technical support to assist in effective use of data, computerized systems, and other tools to improve

coordination and delivery of quality care and to identify relevant populations for proactive care).

- State-based tobacco cessation quit line—Maintain a state-based cessation quit line linked to 1-800-QUIT-NOW.

Performance Measure

- Evidence of use of one or more of the seven intervention areas to impact systems change, as described above.

CDC activities: In a cooperative agreement, CDC staff is substantially involved in the program activities, above and beyond routine grant monitoring.

CDC activities for this program are as follows and represent a combined description of support activities for chronic disease prevention and health promotion programs:

- Provide ongoing guidance, consultation, technical assistance, and training as related to the recipient activities.
- Provide up-to-date information that includes development and dissemination of evidence-based interventions for chronic disease prevention and health promotion programs.
- Provide resources, training, technical assistance, and consultation to develop, maintain, and enhance monitoring and surveillance systems.
- Provide guidance to states to identify performance indicators that can be used to monitor and evaluate state-level chronic disease prevention and health promotion programs.

- Provide resources, training, technical assistance, and consultation to support and facilitate collection and analyses of data that can be used to monitor and evaluate these programs.
- Facilitate adoption of practice-based evidence and policy efforts among grantees and other partners through workshops, conferences, training, consultation, and electronic communications.
- Identify, develop, and disseminate media campaign materials for use by programs; facilitate coordination of counter-marketing materials among programs; provide technical assistance on design, implementation, and evaluation of media.
- Develop, disseminate, and evaluate culturally and linguistically appropriate health communication materials, resources, and tools to support specific program efforts for chronic disease prevention and health promotion.
- Maintain electronic mechanisms for information sharing, program planning, and progress reporting.
- Develop and maintain partnerships with other federal and non-federal organizations to foster and support the state infrastructure for chronic disease prevention and health promotion programs.
- Serve as a resource to states in identifying and eliminating disparities among population groups.
- Maintain Web sites that provide links to databases (such as the State Activities Tracking and Evaluation System and BRFSS) that contain state-specific

information and comparable measures that are critical to chronic disease prevention and health promotion activities.

- Help identify gaps in the chronic disease prevention and health promotion evidence base and prioritize efforts to fill those gaps.
- Provide training and technical assistance on publications and opportunities for diffusion of program evaluation findings.
- Serve as a convener and resource for the continued expansion of the science base of chronic disease prevention and health promotion programs.
- Promote and actively engage in collaboration among CDC chronic disease prevention and health promotion programs, other appropriate CDC programs, and related public health programs across state health agencies.

II. Award Information

Note: Award information applies to the tobacco control program component only.

Type of Award: Cooperative Agreement.

CDC's involvement in this program is listed in the Activities Section above.

Award Mechanism: U58 Chronic Disease Prevention and Control

Fiscal Year Funds: 2014

Approximate Current Fiscal Year Funding: \$63,000,000 (This amount is an estimate and is subject to availability of funds.)

Tobacco Control: \$63,000,000

Diabetes Prevention and Control: \$28,000,000

BRFSS: \$12,000,000

Healthy Communities: \$2,000,000

Approximate Total One-Year Funding: \$63,000,000 (March 29, 2013 – March 28, 2014)

(This amount is an estimate, and is subject to availability of funds and includes both direct and indirect costs.)

Approximate Number of Awards: 51

Approximate Average Award:

Tobacco Control: \$1,200,000

Diabetes Prevention and Control: \$500,000

Behavioral Risk Factor Surveillance System: \$200,000

Healthy Communities: \$40,000

See the **Addendum** for specific guidance on funding ranges by program.

The average award is for the first 12-month budget period and is the total cost, which includes direct and indirect costs.

Anticipated Award Date: March 29, 2014

Budget Period Length: March 29, 2014 – March 28, 2015

Project Period Length: March 29, 2014 – March 28, 2015

Throughout the project period, CDC's commitment to continuation of awards will be conditioned on the availability of funds, evidence of satisfactory progress by the recipient (as documented in required reports, in documented technical assistance, and in other relevant documented activities), and the determination that continued funding is in the best interest of the federal government.

III. Eligibility Information

III.1. Eligible Applicants

This Funding Opportunity Announcement (FOA) is a Competing Continuation.

The following organizations are eligible to apply:

- a) Currently funded DP09-901 state department of health tobacco control program grantees or their designated bona fide agent.

Limiting eligibility to currently funded state-based tobacco control grantees will allow CDC the ability to gain critically important information from grantees experiences in 2014 to better inform the structure of future tobacco prevention and control programming.

The following recipients are eligible to apply and may submit an application:

State Health Departments
Alabama
Alaska
Arizona
Arkansas
California
Colorado
Connecticut
Delaware
District of Columbia
Florida
Georgia
Hawaii
Idaho
Illinois
Indiana

Iowa
Kansas
Kentucky
Louisiana
Maine
Maryland
Massachusetts
Michigan
Minnesota
Mississippi
Missouri
Montana
Nebraska
Nevada
New Hampshire
New Jersey
New Mexico
New York
North Carolina
North Dakota
Ohio
Oklahoma
Oregon
Pennsylvania
Rhode Island
South Carolina
South Dakota
Tennessee
Texas
Utah
Vermont
Virginia
Washington
West Virginia
Wisconsin
Wyoming

III.2. Cost Sharing or Matching

Matching funds are required from non-federal sources in the amount of not less than \$1 for each \$4 federal funds awarded for Tobacco Control, Diabetes Prevention and Control, Behavioral Risk Factor Surveillance System, and Healthy Communities activities. The match must be from non-federal sources and can be all cash, in-kind, or a combination thereof. The match must be for the total dollar amount requested (for each activity) and cannot be “counted” more than once. The amount and source of the match is required in the budget narrative and justification section of the application. Responsiveness to match requirements will be a criterion used in evaluating the application. Cost sharing is encouraged if it helps to leverage federal and state resources, is responsive to stated CDC recipient activities, is advantageous to the programs, and does not compromise the integrity or the ability of the programs to accomplish proposed activities. Examples of cost sharing may include, but are not limited to, sharing 1) the cost of an FTE that can support the work of several projects across program content areas, 2) costs associated with data collection and analysis, 3) costs associated with various communication campaigns that can benefit multiple program areas, and 4) costs associated with working with diverse populations to modify risk factors or eliminate chronic disease-related disparities.

CDC funds cannot be used to supplant existing state funding. Applicants may not use these funds to supplant funds from federal or state sources, the Preventive Health and Health Services Block Grant, or Center for Substance Abuse Prevention funding for youth access enforcement.

Funds may not be used to conduct research. Surveillance and evaluation activities are for the purposes of monitoring program performance and are not considered research.

III.3. Other

Special Requirements:

If the application is incomplete or non-responsive to the special requirements listed in this section, it will not be entered into the review process. The applicant will be notified the application did not meet submission requirements.

- Late applications will be considered non-responsive. See section “IV.3. Submission Dates and Times” for more information on deadlines.
- The application’s five year Project Work Plan narrative (see pages 30-32) and Annual Action Plan must include evidence of coordination and collaboration among chronic disease prevention and health promotion programs related to chronic diseases and their risk factors.
- See the **Addendum** for a list of required attachments and appendices and instructions on how to upload them using Grants.gov.
- Note: Title 2 of the United States Code Section 1611 states that an organization described in Section 501(c)(4) of the Internal Revenue Code that engages in lobbying activities is not eligible to receive federal funds constituting a grant, loan, or an award.

IV. Application and Submission Information

IV.1. Address to Request Application Package

To apply for this funding opportunity, use the application forms package posted in Grants.gov.

Electronic Submission:

CDC strongly encourages the applicant to submit the application electronically by utilizing the forms and instructions posted for this announcement on www.Grants.gov, the official federal agency wide E-grant Web site. Only applicants who apply on-line are permitted to forego paper copy submission of all application forms.

Registering your organization through www.Grants.gov is the first step in submitting applications online. Registration information is located in the “Get Registered” screen of www.Grants.gov. While application submission through www.Grants.gov is optional, we strongly encourage you to use this online tool.

Please visit www.Grants.gov at least 30 days prior to filing your application to familiarize yourself with the registration and submission processes. Under “Get Registered,” the one-time registration process will take three to five days to complete; however, as part of the Grants.gov registration process, registering your organization with the Central Contractor Registry (CCR) annually, could take an additional one to two days to complete. We suggest submitting electronic applications prior to the closing date so if difficulties are encountered, you can submit a hard copy of the application prior to the deadline.

Paper Submission:

Application forms and instructions are available on the CDC Web site, at the following

Internet address: http://www.cdc.gov/od/pgo/funding/grants/app_and_forms.shtm

If access to the Internet is not available, or if there is difficulty accessing the forms on-line, contact the CDC Procurement and Grants Office Technical Information Management Section (PGO-TIMS) staff at 770-488-2700 and the application forms can be mailed.

IV.2. Content and Form of Submission Application:

States participating in the CDC/NCCDPHP Negotiated Agreement Demonstration Project may submit their completed integrated workplan as the response to this FOA. The integrated workplan must be submitted with the appropriate budget forms and certification documents by the due date listed in this funding opportunity announcement. For all other applicants, a Project Abstract must be submitted with the application forms. All electronic project abstracts must be uploaded in a PDF file format when submitting via Grants.gov. The abstract must be submitted in the following format, if submitting a paper application:

- Maximum of 2-3 paragraphs
- Font size: 12 point unreduced, Times New Roman
- Single spaced
- Paper size: 8.5 by 11 inches
- Page margin size: One inch

The Project Abstract must contain a summary of the proposed activity suitable for dissemination to the public. It should be a self-contained description of the project and should contain a statement of objectives and methods to be employed. It should be

informative to other persons working in the same or related fields and insofar as possible understandable to a technically literate lay reader. This Abstract must not include any proprietary/confidential information.

A five year Project Work Plan narrative must be submitted with the application forms. All electronic narratives must be uploaded in a PDF file format when submitting via Grants.gov. The narrative must be submitted in the following format, if submitting a paper application:

- Maximum number of pages: 75. If your narrative exceeds the page limit, only the first pages which are within the page limit will be reviewed.
- Font size: 12 point unreduced, Times New Roman
- Double spaced
- Paper size: 8.5 by 11 inches
- Page margin size: One inch
- Printed only on one side of page.
- Number all narrative pages; not to exceed the maximum number of pages.
- Paper application should be held together only by rubber bands or metal clips; not bound in any other way.

The narrative should address activities to be conducted over the one-year project period and must include the following items *in the order listed*:

- Project Abstract: 2-3 paragraphs (includes all four programs)
- Background and Need: 3-5 pages (includes all four programs)

- Project Work Plan: 59-61 pages (includes all four programs). The Project Work Plan contains both the narrative supporting the five-year Project Objectives and the Annual Action Plan for the first year of the project period. The Project Work Plan includes descriptions of how the applicant will address the recipient activities. Programs should use the guidance provided in the **Addendum** to develop their first year's Annual Action Plans. Program-specific Annual Action Plans (four in total) will not be counted as part of the 59-61 page limit mentioned above, but each should be no more than 20 pages and should be included as appendixes.
- Accomplishments and Proven Capacity: 10-12 pages (includes all four programs).
- Budget: One 424S should be submitted with the complete application.
- Along with the application, a 424A should be submitted that identifies Budget Categories in Section B, with a column for Diabetes, Tobacco Control, BRFSS, and Healthy Communities. Total Object Class Categories (e.g., Personnel, Fringe, Travel) should be summarized for each of the four programs in this section. A separate budget justification and narrative should be included for each of the four programs as separate appendixes and will not to be counted as part of the page limit. Refer to the **Addendum** for how to name these attachments. Please use the budget template provided on the PGO Web site when preparing the budget:

<http://www.cdc.gov/od/pgo/funding/budgetguide.htm>

Additional information may be included in the application appendixes. The appendixes will not be counted toward the narrative page limit. This additional information should be

submitted as a PDF file. See the **Addendum** for instructions on how to name files.

Additional appendixes should be limited to no more than 16 electronic files for the entire application and should include the following documents: 1) organizational charts (scanned into one document and labeled according to program), 2) current statewide strategic plan, if available (one per program for a total of up to four), 3) brief biographical sketches for program directors and coordinators (limited to 20 pages total and collated into one document that is separated and labeled according to program), 4) letters of collaboration (collated into one document that is separated and labeled according to program), 5) budget justification and narrative using the template provided on the PGO Web site (one per program for a total of four), 6) Annual Action Plan using the guidance provided in the **Addendum** (one set of completed Annual Action Plan not to exceed 20 pages per program for a total of four), and indirect cost rate agreement.

The agency or organization is required to have a Dun and Bradstreet Data Universal Numbering System (DUNS) number to apply for a grant or cooperative agreement from the federal government. The DUNS number is a nine-digit identification number, which uniquely identifies business entities. Obtaining a DUNS number is easy and there is no charge. To obtain a DUNS number, access the [Dun and Bradstreet Web site](#) or call 1-866-705-5711.

Additional requirements that may request submission of additional documentation with the application are listed in section “VI.2. Administrative and National Policy Requirements.”

IV.3. Submission Dates and Times

Application Deadline Date: February 28, 2014

Explanation of Deadlines: Applications must be received in the CDC Procurement and Grants Office by 11:59 p.m. Eastern Time on the deadline date.

Applications may be submitted electronically at www.Grants.gov. Applications completed on-line through Grants.gov are considered formally submitted when the applicant organization's Authorizing Organization Representative (AOR) electronically submits the application to www.Grants.gov. Electronic applications will be considered as having met the deadline if the application has been successfully submitted electronically by the applicant organization's AOR to Grants.gov on or before the deadline date and time.

When submission of the application is done electronically through Grants.gov (<http://www.grants.gov>), the application will be electronically time/date stamped and a tracking number will be assigned, which will serve as receipt of submission. The AOR will receive an e-mail notice of receipt when HHS/CDC receives the application.

If submittal of the application is by the United States Postal Service or commercial delivery service, the applicant must ensure that the carrier will be able to guarantee delivery by the closing date and time. The applicant will be given the opportunity to submit documentation of the carrier's guarantee, if HHS/CDC receives the submission after the closing date due to: (1) carrier error, when the carrier accepted the package with a guarantee for delivery by the closing date and time; or (2) significant weather delays or

natural disasters. If the documentation verifies a carrier problem, HHS/CDC will consider the submission as having been received by the deadline.

If a hard copy application is submitted, HHS/CDC will not notify the applicant upon receipt of the submission. If questions arise on the receipt of the application, the applicant should first contact the carrier. If the applicant still has questions, contact the PGOTIMS staff at (770) 488-2700. The applicant should wait two to three days after the submission deadline before calling. This will allow time for submissions to be processed and logged.

This announcement is the definitive guide on application content, submission address, and deadline. It supersedes information provided in the application instructions. If the application submission does not meet the deadline above, it will not be eligible for review. The application face page will be returned by HHS/CDC with a written explanation of the reason for non-acceptance. The applicant will be notified the application did not meet the submission requirements.

IV.4. Intergovernmental Review of Applications

Executive Order 12372 does not apply to this program.

IV.5. Funding Restrictions

Restrictions, which must be taken into account while writing the budget, are as follows:

- Recipients may not use funds for research.
- Recipients may not use funds for clinical care and pharmaceutical products.

- Recipients may only expend funds for reasonable program purposes, including personnel, travel, supplies, and services, such as contractual and grants.
- Awardees may not generally use HHS/CDC/ATSDR funding for the purchase of furniture or equipment. Any such proposed spending must be identified in the budget.
- The direct and primary recipient in a cooperative agreement program must perform a substantial role in carrying out project objectives and not merely serve as a conduit for an award to another party or provider who is ineligible.
- Reimbursement of pre-award costs is not allowed.

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 should be less than 12 months of age. The indirect cost rate agreement should be uploaded as a PDF file with “Other Attachment Forms” when submitting via Grants.gov.

The recommended guidance for completing a detailed justified budget can be found on the CDC Web site, at the following Internet address:

<http://www.cdc.gov/od/pgo/funding/budgetguide.htm>.

IV.6. Other Submission Requirements

Application Submission Address:

Electronic Submission:

HHS/CDC strongly encourages applicants to submit applications electronically at

www.Grants.gov. The application package can be downloaded from www.Grants.gov.

Applicants are able to complete it off-line, and then upload and submit the application via the Grants.gov Web site. E-mail submissions will not be accepted. If the applicant has technical difficulties in Grants.gov, customer service can be reached by E-mail at support@grants.gov or by phone at 1-800-518-4726 (1-800-518-GRANTS). The Customer Support Center is open from 7:00a.m. to 9:00p.m. Eastern Time, Monday through Friday.

HHS/CDC recommends that submittal of the application to Grants.gov should be prior to the closing date to resolve any unanticipated difficulties prior to the deadline. Applicants may also submit a back-up paper submission of the application. Any such paper submission must be received in accordance with the requirements for timely submission detailed in Section IV.3. of the grant announcement. The paper submission must be clearly marked: "BACK-UP FOR ELECTRONIC SUBMISSION." The paper submission must conform to all requirements for non-electronic submissions. If both electronic and back-up paper submissions are received by the deadline, the electronic version will be considered the official submission.

The applicant must submit all application attachments using a PDF file format when submitting via Grants.gov. Directions for creating PDF files can be found on the Grants.gov Web site. Use of file formats other than PDF may result in the file being unreadable by staff.

AND/OR

Paper Submission:

Applicants should submit the original and two hard copies of the application by mail or express delivery service to:

Technical Information Management – DP14-1415

Department of Health and Human Services

CDC Procurement and Grants Office

2920 Brandywine Road, MS E-14

Atlanta, GA 30341

V. Application Review Information

NOTE: Technical Reviews will be conducted by program staff of the Program Services Branch, Office on Smoking and Health, CDC. Application review information applies to the tobacco control component only.

V.1. Criteria

Applicants are required to provide measures of effectiveness that will demonstrate the accomplishment of the various identified objectives of the cooperative agreement.

Measures of effectiveness must relate to the performance goals stated in the “Purpose” section of this announcement. Measures must be objective and quantitative and must measure the intended outcome. The measures of effectiveness must be submitted with the application and will be an element of evaluation. **Each of the four programs will be individually scored.**

The application will be evaluated against the following criteria:

Project Abstract (reviewed and not scored)

Background and Need (10 points)

This section will be scored on the extent to which the applicant includes a description of chronic disease and/or risk factor-specific burden for the state and includes references to relevant data and burden documents.

Project Work Plan (75 points)

The applicant will be scored on the extent to which the one-year Project Work Plan includes objectives and activities to accomplish the project. The project objectives are to be specific, measurable, achievable, relevant, and time-phased, and the method proposed for accomplishing them should be feasible and evidence based. The one-year Project Work Plan should also include a more detailed Annual Action Plan for the first year of the five year project period that addresses the following activity areas, as appropriate, for each of the four programs:

- A. Administration, Management, and Leadership—the extent to which the applicant describes the following:
 1. Strategic planning—how the state strategic plan will be developed or revised.
 2. Leadership and collaboration with partners—what the applicant’s leadership role will be in developing partnerships and how these partnerships will contribute to the accomplishment of program goals and objectives.

3. Training, technical assistance, and consultation—what training and technical assistance will be provided and how the applicant will consult and collaborate with others to accomplish this activity.
4. Coordination of efforts among chronic disease prevention and health promotion programs—what specific steps will be taken to better coordinate efforts among programs
5. Information exchange—how information exchange activities will be conducted, what opportunities exist for their conduct, and who will participate in the information exchange.
6. Sustainability—what efforts will be undertaken to identify and acquire non-federal resources to sustain or enhance program activities.
7. Program management
 - a. Staffing—what staff will be hired to carry out the project activities, including a description of tasks or roles, required experience, and time commitment for each of the project staff. As appropriate, the applicant should indicate whether the position is shared with another chronic disease prevention and health promotion program and how much time is dedicated to each one. This information should also be reflected in the budget narrative and justification section.
 - b. Fiscal management—what capacity the applicant has to manage funds effectively.

c. Attendance at CDC meetings—what plans and commitments exist for attending CDC-required meetings.

B. Surveillance, Analyses, and Evaluation—the extent to which the applicant describes the following:

- Data collection—what data will be collected and which survey instruments will be used.
- Data analyses—how the data will be analyzed and how they will be used to evaluate program impact and promote policy changes.
- Interpretation and dissemination—what types of reports will be developed using the data collected and how these data will be disseminated and to what audiences.
- Identification of disparities—how the data collected will be used to identify trends in specific populations, including disparities that exist within these populations.
- Program evaluation—how the data collected can be used to evaluate program effectiveness and impact.

C. Promoting Social, Environmental, Policy, and System Approaches at the State and Community Levels—the extent to which the applicant describes the following:

- What infrastructure exists to support the oversight of proposed programs and activities.
- What state- and community-level interventions exist to impact change and how community-level interventions will be supported and administered through partners (e.g., local health departments, voluntary organizations, tribes).
- What policy interventions will be conducted to impact change.
- What environmental interventions will be conducted to impact change.

D. Health Communication Interventions—the extent to which the applicant describes the following:

- What communication system or plan will be, or has been, developed to support health communication intervention efforts. This plan should be well thought-out and linked to objectives contained in the Annual Action Plan and may be incorporated into the overall state strategic plan.
- How communication efforts will be developed in collaboration with partners and how these efforts will be coordinated to accomplish the objectives outlined in the Annual Action Plan.
- What materials will be used to accomplish the communication objectives outlined in the Annual Action Plan and how their impact will be measured and evaluated.

E. Health Care Systems Interventions—the extent to which the applicant describes the following:

- Use of the Planned Care Model—how the six elements of the Planned Care Model will be used to promote and achieve improvements within health systems.
- Tobacco cessation quitlines—how the availability of the state’s tobacco cessation quit line and the 1-800-QUIT-NOW portal number will be maintained and promoted to increase its use by providers and consumers of intervention services for health care systems.

Accomplishments and Proven Capacity

- What past accomplishments have taken place and what proven capacity exists to accomplish the work that is proposed in the application.
- What successes have been accomplished for activities that are outlined in areas A through E of the Project Work Plan.
- What unique qualifications staff and partners have to support the accomplishment of the work that is proposed in the application and in the Annual Action Plan.
- What capacity the applicant has to accomplish the activities that are outlined in areas A through E of the Project Work Plan.

Budget and Justification (reviewed but not scored)

Note: Budget narrative and justification applies to tobacco control program only.

A budget narrative and justification should be included for each of the four programs, using the template provided by PGO and including the match requirement. The budget justification should be sufficiently detailed and should clearly indicate instances where

there is cost sharing of staff positions, contracts, or projects among programs. In addition to the 424S, one 424A should be submitted that shows funding request by Object Class Categories for each of the four programs.

V.2. Review and Selection Process

Note: Review and selection process applies to tobacco control program only.

Applications will be reviewed for completeness by the Procurement and Grants Office (PGO) staff and for responsiveness jointly by NCCDPHP and PGO. Incomplete applications and applications that are non-responsive to the eligibility criteria will not advance through the review process. Applicants will be notified the application did not meet submission requirements.

Applications will be reviewed by each of the four programs, using a systematic technical acceptability review process. The review will consist of the applicants' previous accomplishments of funded objectives for the past 5 years that are reflected in required reports, technical assistance documents (i.e. site visit reports, conference call notes, financial status reports, and other relevant documents) that are maintained by Project Officers and the Program. The quality and technical merits of the application will be scored using an objective set of criteria established by each of the four programs.

Funding preference may be given to states participating in the CDC/NCCDPHP negotiated agreement demonstration project.

V.3. Anticipated Announcement Award Dates

Awards will be announced on or before March 15, 2013.

VI. Award Administration Information

VI.1. Award Notices

Successful applicants will receive a Notice of Award (NoA) from the CDC Procurement and Grants Office. The NoA shall be the only binding, authorizing document between the recipient and CDC. The NoA will be signed by an authorized Grants Management Officer and emailed to the program director and a hard copy mailed to the recipient fiscal officer identified in the application.

Unsuccessful applicants will receive notification of the results of the application review by mail.

VI.2. Administrative and National Policy Requirements

Successful applicants must comply with the administrative requirements outlined in 45 CFR Part 74 and Part 92, as appropriate. The following additional requirements apply to this project:

- AR-7 Executive Order 12372
- AR-8 Public Health System Reporting Requirements
- AR-9 Paperwork Reduction Act Requirements
- AR-10 Smoke-Free Workplace Requirements

- AR-11 Healthy People 2010
- AR-12 Lobbying Restrictions

Additional information on the requirements can be found on the CDC Web site at the following Internet address: http://www.cdc.gov/od/pgo/funding/Addtl_Reqmnts.htm.

CDC Assurances and Certifications can be found on the CDC Web site at the following Internet address: <http://www.cdc.gov/od/pgo/funding/grants/foamain.shtm>

For more information on the Code of Federal Regulations, see the National Archives and Records Administration at the following Internet address:

<http://www.access.gpo.gov/nara/cfr/cfr-table-search.html>

VI.3. Reporting Requirements

The applicant must provide CDC with an annual interim progress report via www.grants.gov:

1. The interim progress report is due no less than 90 days before the end of the budget period. The progress report will serve as the non-competing continuation application, and must contain the following elements:
 - a. Standard Form (“SF”) 424S Form.
 - b. SF-424A Budget Information-Non-Construction Programs.
 - c. Budget Narrative.
 - d. Indirect Cost Rate Agreement.

- e. Project Narrative and Annual Action Plan per guidance.

Additionally, the applicant must provide CDC with an original, plus two hard copies of the following reports:

2. Annual progress report, due 90 days after the end of the budget period.
3. Financial status report, due no more than 90 days after the end of the budget period. Please attach to the FSR a separate sheet outlining expenditures for each component.
4. Final performance and financial status reports, no more than 90 days after the end of the project period.

These reports must be submitted to the attention of the Grants Management Specialist listed in the “VII. Agency Contacts” section of this announcement.

VII. Agency Contacts

CDC encourages inquiries concerning this announcement.

For general 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

For program technical assistance, contact:

Christopher J. Kissler, Project Officer,
Department of Health and Human Services
Centers for Disease Control and Prevention
National Center for Chronic Disease Prevention
and Health Promotion
4770 Buford Hwy, MS-E44
Telephone: 770-488-5374
E-mail: cpk2@cdc.gov

For financial, grants management, or budget assistance, contact:

Patricia French, Grants Management Specialist
Department of Health and Human Services
CDC Procurement and Grants Office
2920 Brandywine Road, MS E09
Atlanta, GA 30341
Telephone: 770-488-2849
E-mail: pff6@cdc.gov

CDC Telecommunications for the hearing impaired or disabled is available at: TTY 1-888-232-6348.

VIII. Other Information

Other CDC funding opportunity announcements can be found on the CDC Web site,
[Internet address: http://www.cdc.gov/od/pgo/funding/FOAs.htm](http://www.cdc.gov/od/pgo/funding/FOAs.htm).

Applicants may access the application process and other awarding documents using the Electronic Research Administration System (eRA Commons). A one-time registration is required for interested institutions/organizations at
<http://era.nih.gov/ElectronicReceipt/preparing.htm>

Program Directors/Principal Investigators (PD/PIs) should work with their institutions/organizations to make sure they are registered in the eRA Commons.

1. Organizational/Institutional Registration in the eRA Commons

- To find out if an organization is already eRA Commons-registered, see the "List of Grantee Organizations Registered in eRA Commons."

- Direct questions regarding the eRA Commons registration to:

eRA Commons Help Desk

Phone: 301-402-7469 or 866-504-9552 (Toll Free)

TTY: 301-451-5939

Business hours M-F 7:00 a.m. – 8:00 p.m. Eastern Time

Email commons@od.nih.gov

2. Project Director/Principal Investigator (PD/PI) Registration in the eRA Commons:

Refer to the NIH eRA Commons System (COM) Users Guide.

- The individual designated as the PD/PI on the application must also be registered in the eRA Commons. It is not necessary for PDs/PIs to register with Grants.gov.
- The PD/PI must hold a PD/PI account in the eRA Commons and must be affiliated with the applicant organization. This account cannot have any other role attached to it other than the PD/PI.
- This registration/affiliation must be done by the Authorized Organization Representative/Signing Official (AOR/SO) or their designee who is already registered in the eRA Commons.
- Both the PD/PI and AOR/SO need separate accounts in the eRA Commons since both hold different roles for authorization and to view the application process.

Note that if a PD/PI is also an HHS peer-reviewer with an Individual DUNS and CCR registration, that particular DUNS number and CCR registration are for the individual reviewer only. These are different than any DUNS number and CCR registration used by an applicant organization. Individual DUNS and CCR registration should be used only for the purposes of personal reimbursement and should not be used on any grant applications submitted to the federal government.

Several of the steps of the registration process could take four weeks or more. Therefore, applicants should check with their business official to determine whether their organization/institution is already registered in the eRA Commons. HHS/CDC strongly encourages applicants to register to use these helpful on-line tools when applying for funding opportunities.

ADDENDUM

I. General Guidance Document—Funding Opportunity Announcement DP-09-901, Collaborative Chronic Disease, Health Promotion, and Surveillance Program Announcement: Healthy Communities, Tobacco Control, Diabetes Prevention and Control, and Behavioral Risk Factor Surveillance System.

This guidance document for applicants for this funding opportunity was developed jointly by the National Center for Chronic Disease Prevention and Health Promotion's (NCCDPHP's) Office on Smoking and Health (OSH), Division of Diabetes Translation (DDT), and Division of Adult and Community Health (DACH) to clarify the following elements or requirements that have been included in the announcement: 1) evidence-based activities, 2) examples of partnerships and collaboration among chronic disease prevention and health promotion programs, 3) funding information, 4) required attendance at trainings and conferences, 5) application information, and 6) recommended format for the Annual Action Plan.

II. Collaboration on Joint Projects, Activities, Shared Positions and Cost Sharing

NCCDPHP supports the development and implementation of collaborative program components and more efficient ways of using resources to create opportunities for

chronic disease prevention and health promotion programs to achieve greater impact by working together.

The following are examples of collaborative activities that may be considered and, if appropriate to the program(s), included in the proposed recipient activities and the Annual Action Plan.

Data gathering, community mapping and environmental scans.

- Data collection on access to and provision of care.
- Activities to support the state-based tobacco cessation quit line through the 1-800-QUIT-NOW portal number.
- Dissemination of educational materials developed by the National Diabetes Education Program to a variety of consumer and professional audiences. These materials could be tailored as appropriate to increase reach and serve multiple purposes (e.g., promote smoking cessation to people with diabetes and promote the state-based tobacco cessation quit line through 1-800-QUIT-NOW).
- Changes within health care systems to
 - Educate providers.
 - Increase coverage for tobacco cessation treatment coverage.
 - Encourage referrals to the state-based tobacco cessation quit line.
 - Encourage provision of diabetes preventive care services (e.g., A1C tests, eye and foot exams, flu vaccine, blood pressure tests, and cholesterol screenings).

- Policy initiatives to eliminate exposure to secondhand smoke, including implementation of laws and regulations.
- Policies to improve access to prevention and health care services for all persons, but particularly the uninsured, underinsured, and people living in communities with a high burden of chronic diseases.
- Data-gathering efforts in the state to identify risk factors, disease burden, and smoking prevalence.
- Participation in the development of state strategic plans to
 - Prevent and reduce the complications associated with diabetes.
 - Reduce heart disease and stroke.
 - Prevent and reduce obesity.
 - Provide comprehensive cancer control.
 - Reduce tobacco use.
 - Reduce the burden of other chronic diseases.
- Training for chronic disease prevention and health promotion competencies, including coalition building, policy development and implementation, program management, and leadership in public health.
- Dissemination of findings and evidence-based practices.
- Projects focused on the elimination of disparities.
- Participate in the development and implementation of school health policies.

- Sharing or allocation of resources to achieve common goals and objectives (e.g., epidemiologist, support staff, outreach coordinator, communication specialist, evaluator, grant writer).

Additional examples of collaboration are posted on the National Association of Chronic Disease Directors' Web site www.nacdd.org www.chronicdisease.org and the Directors of Health Education and Promotion Web site www.dhpe.org.

III. Integrating Epidemiology Capacity Across Chronic Disease Programs

Because some categorical programs are not adequately funded to hire a full-time epidemiologist, programs are encouraged to share the costs of hiring epidemiology staff. Chronic disease epidemiology activities should be coordinated and integrated across categorical programs. States with current chronic disease epidemiology work force below the level recommended by the Council of State and Territorial Epidemiologists should attempt to increase their work force according to the council's guidelines (<http://www.cste.org/PS/2007ps/2007psfinal/cd/07-CD-01.pdf>).

IV. Funding Information

Each of the four programs has developed a funding formula and funding range using criteria that have been applied to all states equally. Each program will be competing for funding within a designated funding range. Therefore, each program should submit a technically acceptable application. Funding recommendations for each program will be made separately, and will be based on the merit and quality of the applications received.

Although PGO will send out the Notice of Grant Award as one award, individual budget narratives and budget justifications are being requested by each program to accompany the program's Annual Action Plan. Funding in subsequent years (level/increases and/or decreases in funds) will be dependent on how well applicants implement the activities proposed in their Project Work Plans to achieve specific performance measures, as well as on what funds are available from CDC.

Annual Action Plan

Each program is required to submit an Annual Action Plan which must include the following:

- Program goal area(s).
- SMART long-term objective(s).
- Annual objective(s).
- Rationale.
- Activities.

Each program activity (up to four) must include a target date for completion, funding source(s), lead person, and partner(s) involved.

The following are requirements for all objectives:

- Program(s) involved.
- Data source used.
- Indicator or rationale if there is no indicator.

For additional guidance on the Annual Action Plan, please see the Guidance and Definition of Terms.

Tobacco Control

Approximately \$63 million is available for fiscal year (FY) 2014 to fund 51 awards for comprehensive tobacco control programs. States and eligible territories will be able to apply for funding in the ranges listed below, with an average award of \$1.2 million. The final award amount will be based on the funding range according to population, technical merit and quality of the application (using evaluation criteria scores), and previous spending history for the cooperative agreement recipients for the National Tobacco Prevention and Control Program.

- States and territories with a population of less than 3 million (Range A) can apply for funding in the range of \$150,000 to \$1.4 million. These include AK, AR, DE, DC, HI, IA, ID, KS, ME, MS, MT, ND, NE, NH, NM, NV, RI, SD, UT, VI, VT, WV, and WY.
- States and territories with a population between 3 million and 8 million (Range B) can apply for funding in the range of \$1 million to \$1.7 million. These states include AL, AZ, CO, CT, IN, KY, LA, MA, MD, MO, MN, OK, OR, PR, SC, TN, VA, WA, and WI.
- States with a population from 8 million to 13 million (Range C) can apply for funding in the range of \$1.1 million to \$1.8 million. These states include GA, IL, MI, OH, PA, NC, and NJ.

- States with a population above 13 million (Range D) can apply for funding in the range of \$1.8 million to \$2 million. These states include CA, FL, NY, and TX.

V. Attendance at Trainings and Conferences

Attending required trainings and conferences is critical for building and maintaining the skills of the staff with responsibility for carrying out the program requirements of this Funding Opportunity Announcement. Awardees are required to attend specific trainings and conferences as a term and condition of this award.

Specific travel requirements for each program are listed below:

Tobacco Meetings:	# of Staff	# of Days	Dates
Location			
National Tobacco Control Program Meeting Atlanta	3-5	3	TBD
A Tobacco Control Meeting of your choice: (Awardees are encouraged to discuss this meeting with Program Consultant.) TBD	1-2	2-4	TBD

Additional General Application Packet Tips:

- Use the Chronic Disease MIS to prepare the Project Narrative which includes a) Year 4 progress report and b) Year 5 annual action plan.
- Completing your work plan in the MIS will include all of the information needed for the Project Narrative section. However, if you elect to attach a separate and optional Project Narrative, do not exceed 20 pages excluding appendices, Chronic Disease MIS-generated Progress Reports, Annual

Action Plans, and Budget with detailed justification.

States can request that CDC cover the travel costs of out-of-state trainings and meetings for up to two staff person per required meeting or conference. If a state program elects to have CDC cover travel costs, clearly state that the program is electing this option and provide an estimated expense for travel in the budget justification and narrative. Under this arrangement, the state award will be reduced by the amount estimated for travel plus an additional administrative cost (approximately 20%).

VI. Application Information

Application page limit is 75 pages; budget, Annual Action Plan, and appendixes do not count toward the page limit. Each program will be reviewing the applicants' five year Project Work Plans and budget justifications to ensure that specific programmatic content areas are addressed. Applicants should collaborate on the Project Abstract, Background and Need; Past Accomplishments and Proven Capacity; and 5 Year Project Work Plan and Budget (Forms 424S and 424A) sections, while keeping their Annual Action Plans and budget justification sections separate. PGO requires that Form 424S and 424A be submitted. Applicants are also required to submit an individual budget narrative and justification for each program.

VII. Submission of Appendixes in Grants.gov

Additional information may be submitted with the application via grants.gov as appendixes. The appendixes will not be counted toward the narrative page limit.

Appendixes should include no more than 16 files and should include the following documents:

- Organizational Chart—all charts scanned into one document.
- Strategic Plan—up to four plans submitted individually.
- Brief Biographical Sketches—limited to the program manager and program director for each program (2 page limit per program) and scanned into one document.
- Letters of Collaboration—collated for all programs and scanned into one document.
- Budget Justification and Narrative, using the budget template provided on the PGO Web site and submitted individually for each program.
<http://www.cdc.gov/od/pgo/funding/budgetguide.htm>
- Annual Action Plan for the first year—four plans submitted individually.
- Indirect Cost Rate Agreement—scanned into one document.

VIII. File Names for Parts of Application

Application content sections should be saved as PDFs and named as follows: two-letter abbreviations for the applicant's state or territory, year (e.g., 09), name of the file or section title, and the file extension .pdf.

Examples: AZ 09 Project Narrative.pdf—includes Project Abstract and
Background and Need
AZ 09 Work Plan.pdf
AZ 09 Accomplishments and Proven Capacity.pdf

AZ 09 Budget.pdf—including 424S and 424A

Appendixes should be saved as PDFs and named as follows: two-letter abbreviations for the applicant's state or territory, year (e.g., 09), name of the file as described above in 1-7 (e.g., Organizational Chart), the program area for which it applies (i.e., Tobacco, Diabetes, BRFSS, or Healthy Communities if the appendix is specific to just one program), and the file extension .pdf.

Examples: CA 09 Organizational Chart.pdf
CA 09 Strategic Plan Diabetes.pdf
CA 09 Bio Sketches.pdf
CA 09 Annual Action Plan Tobacco.pdf

Guidance and Definitions of Terms

Program Goal Area: The purpose toward which a series of coordinated objectives is directed.

- Required for all programs.
- Program goal areas are defined by program-specific guidance. They may be unique to each program, or they may overlap to direct collaborative work towards a specific health outcome.
- More than one goal may be listed if they are related and being addressed by the same set of objectives and activities.
- If more than one goal is listed, number each goal.

Long-Term Outcome Objective: A SMART* objective that describes a lasting change in behavior regarding unhealthy practices or exposure to unhealthy environments or reductions in morbidity and mortality.

- Required for all programs.
- More than one objective may be listed if they are related and address the same program goals areas.
- If more than one objective is listed, number each objective.
- The objective should cover the 5-year funding period.

Annual Objective: A measurable objective that quantifies the results of one or more program activities that will be completed within a 12-month funding period.

- Required for all programs.
- More than one objective may be listed if they are related and address the same short-term outcome objective.
- If more than one objective is listed, number each objective.
- The objective should cover one budget year and be updated annually.

Program Involved: The program(s) involved with the objective.

- Required for all required objectives.
- Identify all programs involved.
- Select from Tobacco, Diabetes, BRFSS, Healthy Communities, or Other (specify).

Indicator: A specific, observable, and measurable characteristic or change that represents achievement of an outcome.

- Identify all indicators, if available or appropriate.
- If no indicator is used, enter “Not applicable.”

Data Source: A designated source of information, such as a survey, which is used for tracking progress towards a long-term, intermediate-term, short-term, or annual objective.

- Required for all objectives.
- Identify all data sources.

Rationale: A description of how an annual objective was selected and how it will lead to the accomplishment of the long-term outcome objective.

- Required for all objectives for which no indicator is identified.
- Include the following three components:
 - What is the problem being addressed?
 - What is the evidence (including data) indicating that this is a problem worth addressing?
 - What is the evidence (including data) that this objective will address the problem?

Activities: An event or action that a program implements in order to achieve an objective. Activities support the accomplishment of annual objectives.

- Required for all programs.
- Up to four high-level activities should be identified to describe the most significant activities that the funded program will conduct and not simply the day-to-day activities of the program.

Target Date: The date an activity is expected to be completed.

- Required for all programs and all activities.

Funding Sources: Identify which CDC- or state-funded programs are contributing resources (monetary or in-kind) to the accomplishment of an activity.

- Required for all programs and all activities.

Lead Person: The individual with primary responsibility for an activity.

- Required for all programs and all activities.

Partners: Identify up to five key partners involved in the activity.

- Required for all programs and all activities.

*SMART objectives are **S**pecific, **M**easurable, **A**chievable and ambitious, **R**elevant and realistic, and **T**ime-bound. When writing a SMART objective, identify the following:

- Target date for completion.
- Baseline measure.
- Target measure.
- Population specifics, including race, ethnicity, sex, and age.
- Setting, such as community, health care, faith-based, school, worksite, and government.