

## AMENDMENT I

Cover page:

- addition of “*Heart Disease & Stroke Prevention Program and Diabetes prevention-*”
- addition of “PPHF14”

## AMENDMENT II

Page 3:

### 1. Background

**Statutory authority.**

**Addition of:**

“Additional authorities also apply to certain diabetes-related activities concerning behavioral interventions; these are Sections 399V-3 and 1703(a) of the Public Health Service Act, 42 U.S.C. 280g-14 and 300u-2.”

Page 57. Addition of: “CDC encourages questions concerning this FOA. Please submit your questions to <http://www.cdc.gov/chronicdisease/about/statelocalpubhealthactions-prevcd/faq/index.htm>. All questions must be submitted by July 14, 2014. CDC is unable to respond to any questions submitted after that date.”

# ***PPHF 2014: Heart Disease & Stroke Prevention Program and Diabetes prevention - State and Local Public Health Actions to Prevent Obesity, Diabetes, and Heart Disease and Stroke – financed solely by 2014 Prevention and Public Health Funds***

**DP14-1422PPHF14 National Center for Chronic Disease Prevention and Health Promotion**

## Table of Contents

Part I. Overview Information .....	1
A.    Federal Agency Name: .....	1
B.    Funding Opportunity Title:.....	1
C.    Announcement Type: New—Type 1 .....	1
D.    Agency Funding Opportunity Number:.....	1
E.    Catalog of Federal Domestic Assistance (CFDA) Number:.....	1
F.    Dates .....	1
G.    Executive Summary.....	1
Part II. Full Text .....	3
A.    Funding Opportunity Description .....	3
B.    Award Information.....	34
C.    Eligibility Information.....	35
D.    Application and Submission Information.....	36
E.    Application Review Information .....	45
F.    Award Administration Information.....	49
G.    Agency Contacts.....	57
H.    Other Information.....	58
I.    Glossary.....	59

## Part I. Overview Information

<p>Applicants must go to the synopsis page of this announcement at <a href="http://www.grants.gov">www.grants.gov</a> and click on the “Send Me Change Notifications Emails” link to ensure they receive notifications of any changes to DP14-1422. Applicants also must provide an e-mail address to <a href="http://www.grants.gov">www.grants.gov</a> to receive notifications of changes.</p>
<b>A. Federal Agency Name:</b>
Centers for Disease Control and Prevention (CDC)
<b>B. Funding Opportunity Title:</b>
PPHF 2014: Heart Disease & Stroke Prevention Program and Diabetes prevention - State and Local Public Health Actions to Prevent Obesity, Diabetes, and Heart Disease and Stroke – financed solely by 2014 Prevention and Public Health Funds
<b>C. Announcement Type:</b> 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 <a href="http://www.cdc.gov/od/science/integrity/docs/cdc-policy-distinguishing-public-health-research-nonresearch.pdf">http://www.cdc.gov/od/science/integrity/docs/cdc-policy-distinguishing-public-health-research-nonresearch.pdf</a> .
<b>D. Agency Funding Opportunity Number:</b>
DP14-1422PPHF14
<b>E. Catalog of Federal Domestic Assistance (CFDA) Number:</b>
CFDA number 93.757 PPHF 2014: State and Local Public Health Actions to Prevent Obesity, Diabetes, Heart Disease and Stroke – financed solely by Prevention and Public Health Funds
<b>F. Dates</b>
<b>1. Letter of Intent (LOI) Deadline:</b> Not required.
<b>2. Application Deadline:</b> July 22, 2014, 11:59 p.m. U.S. Eastern Daylight Time, on <a href="http://www.grants.gov">www.grants.gov</a>
<b>3. Informational conference call for potential applicants:</b> May 29, 2014, 4:00 pm–5:30 pm Eastern Daylight Time, Call-in number: 1-877-784-3233 (toll free), Participant passcode: 9833862
<b>G. Executive Summary</b>

## 1. Summary Paragraph:

The Centers for Disease Control and Prevention (CDC) announces the availability of Fiscal Year (FY) 2014 funds to implement FOA DP14-1422, PPHF 2014: State and Local Public Health Actions to Prevent Obesity, Diabetes, and Heart Disease and Stroke – financed solely by Prevention and Public Health Funds. The purpose of the funding is to support implementation of population-wide and priority population approaches to prevent obesity, diabetes, and heart disease and stroke and reduce health disparities in these areas among adults. There are two components to this competitive funding opportunity announcement (FOA) – Component 1 and Component 2. State and large city health departments or their bona fide agents are eligible to apply for this funding. A large city is defined as a city with a population of 900,000 or more.

Component 1 is to support environmental and system approaches to promote health, support and reinforce healthful behaviors, and build support for lifestyle improvements for the general population and particularly for those with uncontrolled high blood pressure and those at high risk for developing type 2 diabetes. Populations at high risk for type 2 diabetes include those with prediabetes or those who have a sufficient number of risk factors on evidence-based risk tests that put them in a high risk category.

Component 2 will support health system interventions and community-clinical linkages that focus on the general population and priority populations. Priority populations are those population subgroups with uncontrolled high blood pressure or at high risk for type 2 diabetes who experience racial/ethnic or socioeconomic disparities, including inadequate access to care, poor quality of care, or low income.

Component 1 environmental strategies will be implemented in the same communities and jurisdictions as Component 2 health system and community-clinical linkage strategies, with local improvements supported by statewide efforts funded by this FOA as well as those supported by DP13-1305 State Public Health Actions. Through DP13-1305, all 50 states and the District of Columbia receive funds to help prevent chronic diseases. Thirty-two states received extra funds to enhance their program and to reach more people. This program focuses on healthy environments in workplaces, schools, early childhood education facilities, and in the community. This program also focuses on working through health systems and communities to reduce complications from multiple chronic diseases such as diabetes, heart disease, and stroke. More information on DP13-1305 is available at <http://www.cdc.gov/chronicdisease/about/state-public-health-actions.htm>.

Components 1 and 2 both focus on the adult population. Applicants must address both components and all strategies listed in the chart on pages 21-29. Applicants must propose a cohesive work plan, aligned with but not duplicative of DP13-1305 activities. The strategies in both components should be mutually reinforcing. Applicants will

<p>propose criteria to select 4-8 communities in which to focus the prevention efforts of both components. A community in this FOA is defined as a county, Metropolitan Statistical Area (MSA), or a group of contiguous counties. These communities must have significant disease burden and sufficient combined populations to allow the strategies supported by this FOA to reach significant numbers of people. State awardees must subaward 50% of funds to 4-8 communities to contribute to the work and are encouraged to fully consider the capabilities of their local health departments for fulfilling the scope of work. Large city awardees are strongly encouraged to sub-award a portion of award funds to local entities to contribute to the work. The primary recipient of this funding will have major responsibility for providing leadership and technical assistance to selected communities and will ensure overall coordination.</p>
<p><b>a. Eligible Applicants:</b> Competition is limited to all 50 States or their bona fide agents and the District of Columbia, and Large Cities with populations over 900,000 (using July 2012 U.S. Census Estimates). The two groups will be competed separately.</p>
<p><b>b. FOA Type:</b> Cooperative agreement</p>
<p><b>c. Approximate Number of Awards:</b> 15-19 states and the District of Columbia, and 3-5 large cities, for a total of 18-22 awards</p>
<p><b>d. Total Project Period Funding:</b> \$280,000,000</p>
<p><b>e. Average One Year Award Amount:</b> \$3,000,000</p>
<p><b>f. Number of Years of Award:</b> 4 years</p>
<p><b>g. Approximate Date When Awards will be Announced:</b> September 30, 2014</p>
<p><b>h. Cost Sharing and /or Matching Requirements:</b></p>
<p>N/A</p>

## Part II. Full Text

<p><b>A. Funding Opportunity Description</b></p>
<p><b>1. Background</b></p>
<p><b>Statutory Authorities:</b> This program is authorized under Sections 301(a) and 317 (k)(2) of the Public Health Service Act, 42 U.S.C. section 241 and 247b(k)(2), and Title IV Section 4002 of the Affordable Care Act, Prevention and Public Health Fund. <b>Additional authorities also apply to certain diabetes-related activities concerning behavioral interventions; these are Sections 399V-3 and 1703(a) of the Public Health Service Act, 42 U.S.C. 280g-14 and 300u-2.</b></p>
<p><b>a. Healthy People 2020:</b></p>
<p>This program addresses the Healthy People 2020 focus areas of:  Heart Disease and Stroke available at:  <a href="http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=21">http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=21</a>),  Diabetes available at:  <a href="http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=8">http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=8</a></p>

Nutrition and Weight Status available at:  
<http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=29>  
Physical Activity available at:  
(<http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=33>)  
available at <http://www.healthypeople.gov>

**b. Other National Public Health Priorities and Strategies:**

This program supports strategies to prevent obesity, diabetes, heart disease and stroke, and increase physical activity and healthy eating as outlined in the following national plans and guidance:

**The Guide to Community Preventive Services:**

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

**Dietary Guidelines for Americans, 2010:**

<http://www.cnpp.usda.gov/DGAs2010-PolicyDocument.htm>

**National Physical Activity Plan:** <http://www.physicalactivityplan.org>

**2008 Physical Activity Guidelines for Americans:** <http://www.health.gov/PAGuidelines/>

**Accelerating Progress in Obesity Prevention: Solving the Weight of the Nation:**

<http://www.iom.edu/Reports/2012/Accelerating-Progress-in-Obesity-Prevention.aspx>

**Million Hearts®:** [www.millionhearts.hhs.gov](http://www.millionhearts.hhs.gov)

**CDC-led National Diabetes Prevention Program:**

<http://www.cdc.gov/diabetes/prevention/index.htm>

**National Partnership for Action to End Health Disparities:**

<http://minorityhealth.hhs.gov/npa/>

**The National Prevention Strategy:**

<http://www.healthcare.gov/prevention/nphpphc/strategy/report.pdf>

**c. Relevant Work:**

For over 20 years, the National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP) has provided scientific leadership and technical expertise to state, tribal, local and territorial departments of health to assist them in building capacity to develop, deliver, and implement chronic disease prevention and health promotion programs that have measureable impact. The Division for Heart Disease and Stroke Prevention, Division of Diabetes Translation, and Division of Nutrition, Physical Activity, and Obesity have a rich history of working collaboratively with state and local departments of health to increase their ability to carry out public health functions and implement evidence-based strategies to reduce risk factors associated with a variety of chronic diseases. More recently, NCCDPHP has focused efforts on four key strategies common to multiple disease and risk factor prevention programs: epidemiology and surveillance, environmental approaches, health system improvements and community-clinical linkages. More information about the four key strategies is available at <http://www.cdc.gov/chronicdisease/about/>. The resulting enhanced coordination across program activities offers the potential to more efficiently achieve greater public health impact. The approach outlined in this FOA builds on the lessons learned implementing coordinated models intended to maximize CDC's investment in the work

of state and local departments of health, including the complementary work of DP 13-1305 State Public Health Actions.

**2. CDC Project Description**

**a. Approach:**

The DP14-1422 logic model illustrates how environmental, health systems, and community-clinical linkage strategies will be implemented simultaneously and synergistically to address multiple risk factors and chronic diseases. These community efforts represent a dual approach that improves health for the whole population and for specific, selected population subgroups at high risk or experiencing disproportionate disease burden. Adults are the focus of these strategies. The strategies in Component 1 are environmental approaches to promote health, support and reinforce healthful behaviors, and build support for lifestyle improvements. Strategies in Component 2 are health system interventions and community-clinical linkages that more directly focus on populations experiencing higher risk or disproportionate disease burden within the same geographic community as Component 1. Both components must be included and be mutually reinforcing. The strategies in Component 1 are environmental and system approaches to promote health, support and reinforce healthful behaviors, and build support for lifestyle improvements for the general population and particularly for those with uncontrolled hypertension and those at high risk for developing type 2 diabetes. Populations at high risk for type 2 diabetes include those with prediabetes or those who have a sufficient number of risk factors on evidence-based risk tests that put them in a high risk category. Strategies in component 2 are health system interventions and community-clinical linkages that focus on the general population and priority populations. Priority populations are those population subgroups with uncontrolled hypertension or at high risk for type 2 diabetes with a disproportionate risk of chronic diseases or conditions who experience racial/ethnic or socioeconomic disparities, including inadequate access to care, poor quality of care, low income, or other disparities that contribute to health status.

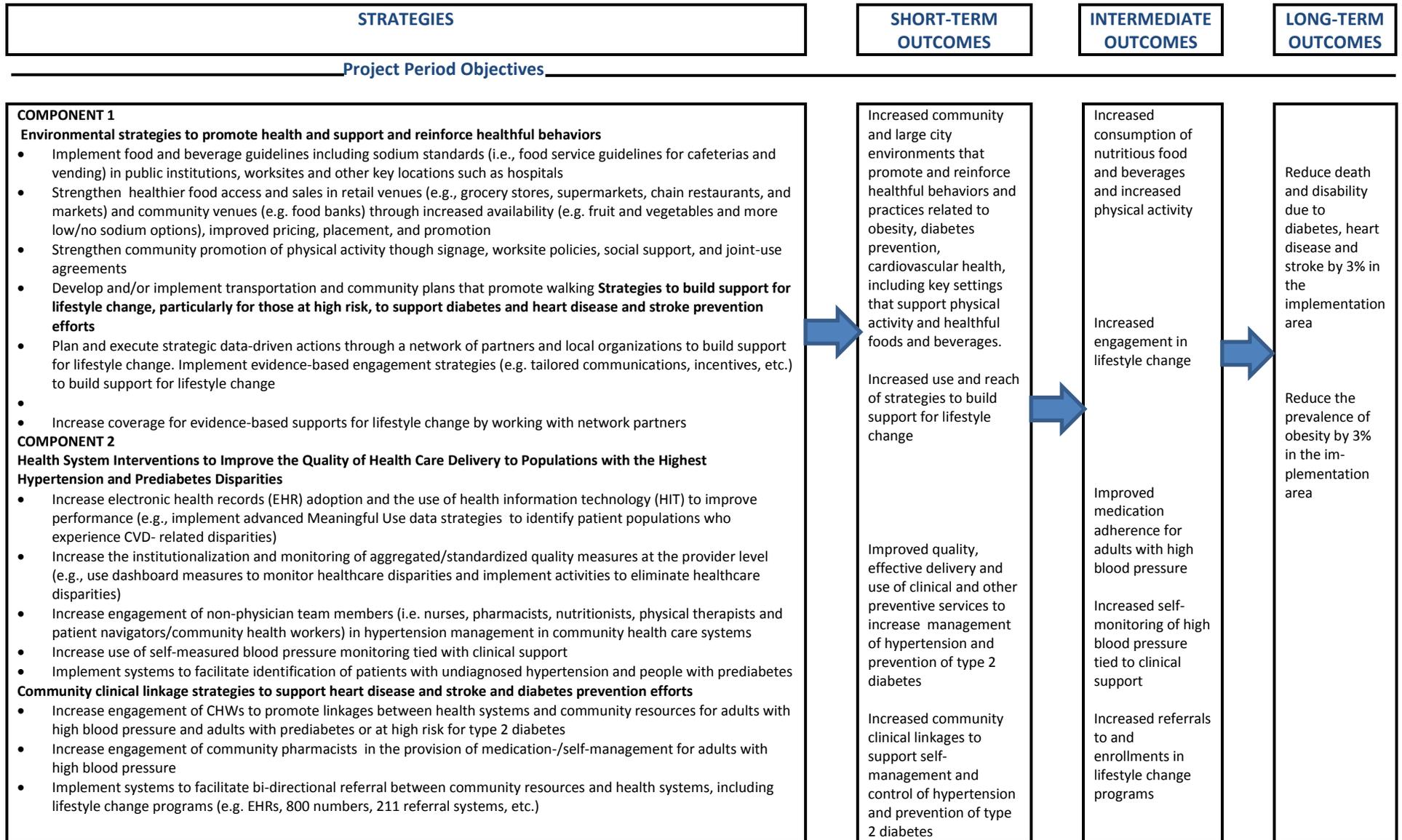
All Americans should have equal opportunities to make healthy choices that allow them to live long, healthy lives, regardless of their income, education, race/ethnic background, sexual orientation, gender identity, or other factors. Health disparities represent preventable differences in the burden of disease, disability, injury or violence, or in opportunities to achieve optimal health. Recipients will describe the population selected, including relevant health disparities, and how the selected interventions will improve health and reduce or eliminate one or more identified health disparities.

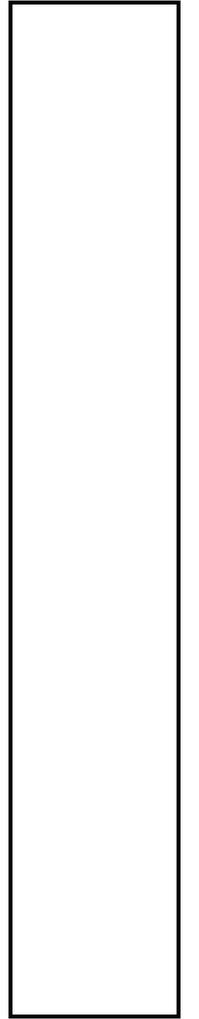
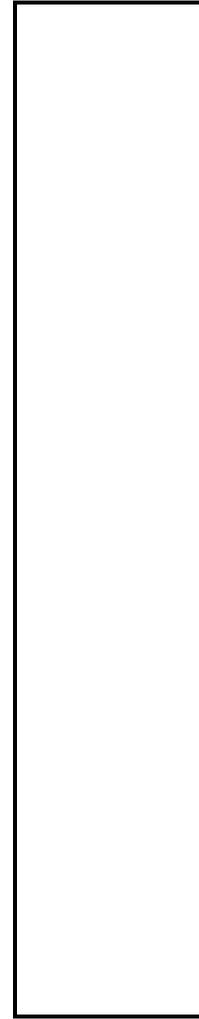
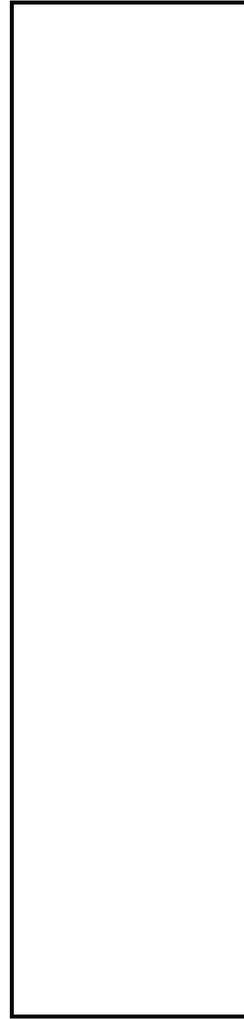
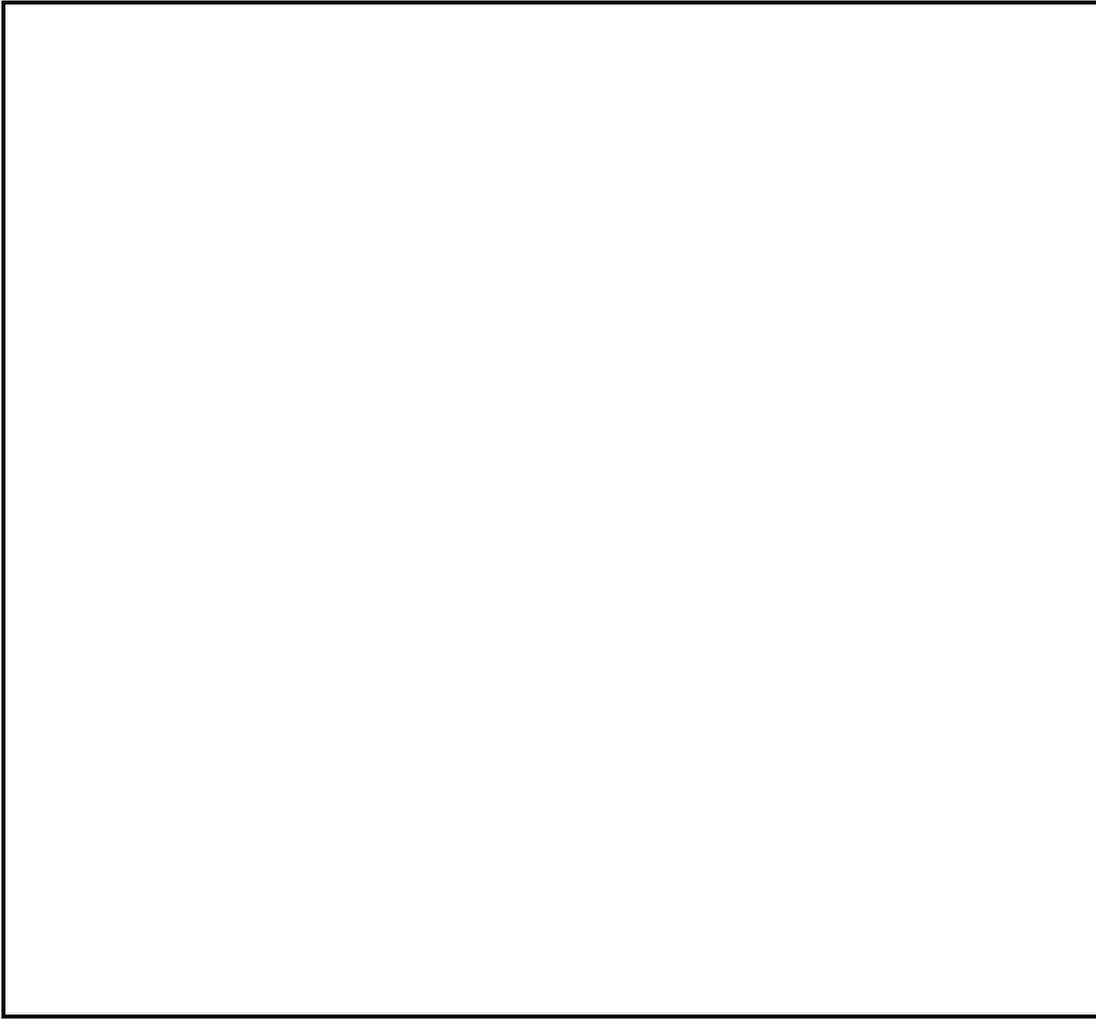
All activities supported through this FOA must contribute to area-wide health improvements and reductions in health disparities and should be based on a robust analysis of area health burden overall and across population subgroups (population subgroups may be defined by factors such as race or ethnicity, gender, age [e.g., youth

and elderly], education or income, disability, geographic location, or sexual orientation, among others)

State and Local Public Health Actions to Prevent Obesity, Diabetes, and Heart Disease and Stroke

Inputs: Funding, guidance and support from DDT, DHDSP, DNPAO





**i. Problem Statement:**

1. Chronic diseases—including heart disease, cancer, stroke, diabetes, obesity—and related risk factors, such as tobacco use, physical inactivity, and poor diet, are the leading causes of death and disability in the United States, accounting for 7 of every 10 deaths. About one-fourth of people with chronic conditions have one or more daily activity limitations.<sup>i</sup> In 2005, 133 million Americans – almost half of adults – had at least one chronic illness.<sup>ii</sup> Heart disease, cancer and stroke account for more than 50% of deaths each year. Diabetes continues to be the leading cause of kidney failure, non-traumatic lower-extremity amputations, and blindness among adults aged 20-74, and is a major cause of heart disease and stroke. According to CDC research, 79 million Americans – 35% of adults aged 20 years and older – have prediabetes and half of all Americans aged 65 years and older have prediabetes.<sup>iii</sup> Gestational diabetes is also a serious concern among women of childbearing age and affects from 2% to 10% of pregnancies. Women who have had gestational diabetes have a 35% to 60% chance of developing diabetes in the next 10-20 years.<sup>iv</sup>
2. Less than half of people with hypertension have their blood pressure adequately controlled and only one-third of people with high cholesterol have adequately controlled hyperlipidemia.<sup>v</sup> <sup>vi</sup> Among those with uncontrolled hypertension, many people (40% or 14 million people) don't know they have it, and millions more (45% or 16 million people) are taking blood pressure medicines, but still are not under control. Nearly 90% of U.S. adults with uncontrolled hypertension have a usual source of health care and insurance, representing a missed opportunity for hypertension control.<sup>vii</sup> Improved hypertension control will require an expanded effort and an increased focus on blood pressure from health care systems, clinicians, and individuals.<sup>viii</sup> Eating too much sodium, which most people do<sup>ix</sup>, is a major contributor to high blood pressure.
3. Obesity is a significant public health problem. Currently, in the U.S., 38% of adults are obese.<sup>x</sup> Adult obesity is associated with an increased risk for many serious health conditions, including coronary heart disease, hypertension, stroke, type 2 diabetes, certain types of cancer, and premature death.<sup>xi, xii</sup> Data from 2001-2004 indicate that the majority of the population did not meet federal dietary recommendations.<sup>xiii</sup> Fewer than 15 percent of adults eat recommended amounts of fruits and vegetables each day.<sup>xiv</sup> Consuming too much solid fats, saturated and *trans* fatty acids, and added sugars increases the risk of some of the most common chronic diseases in the United States. Added sugars contribute an average of 16 percent of the total calories in American diets and reducing added sugars will lower the calorie content of the diet, without compromising its nutrient adequacy (Dietary Guidelines for Americans 2010).  
Medical care costs for people with chronic diseases account for more than 75% of

<p>the nation’s \$2.6 trillion medical care costs. In 2010, the total costs of cardiovascular diseases in the United States were estimated to be \$444 billion and treatment costs for heart diseases account for about \$1 of every \$6 spent on health care.<sup>xv</sup> In 2013 the direct and indirect costs of diabetes are \$245 billion a year<sup>1</sup>. Medical expenses for people with diabetes are more than two times higher than for people without diabetes.<sup>xvi</sup> In 2006, the annual medical cost of obesity to the U.S. health-care system was estimated at as much as \$147 billion (2008 dollars), almost half of which was financed by the Centers for Medicare &amp; Medicaid Services (CMS) (23% by Medicare and 19% by Medicaid).<sup>xvii</sup></p>
<p><b>ii. Purpose:</b></p>
<p>The purpose of this funding is to support implementation of population-wide and priority (high burden/risk) population approaches to prevent obesity, diabetes, and heart disease and stroke (through control of high blood pressure) and reduce health disparities in these areas among adults. These efforts are supported by state/jurisdiction level leadership, coordination and technical assistance to selected communities. Activities funded under this FOA align with, are complementary to, and do not duplicate DP13-1305 activities.</p>
<p><b>iii. Outcomes:</b></p>
<p>The project period outcomes of this program are illustrated in the logic model on page 6.</p>
<p><b>iv. Funding Strategy:</b></p>
<p>Expected number of awards: 15-19 states and the District of Columbia, and 3-5 large cities, for a total of 18-22 awards  Average award size: \$3,000,000  Applicants will be expected to evenly divide their proposed budget between Components 1 and 2.  State applicants must subaward 50% of funds to 4-8 communities; large city applicants are strongly encouraged to subaward a portion to local entities to contribute to the work.  In order to maximize reach of federal funding, awardees should ensure that efforts are complementary and not duplicative of other efforts in a particular geographic area.</p>
<p><b>v. Strategies and Activities:</b></p>
<p>State awardees will work within 4-8 communities in their states to implement evidence-based whole population and priority (high burden/risk) population strategies to prevent obesity, diabetes, and heart disease and stroke (through control of high blood pressure) among adults, and reduce disparities, using the program strategies in this FOA. Large city awardees will define the geographic area</p>

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<sup>1</sup> American Diabetes Association. Economic costs of diabetes in the U.S. in 2012. Diabetes Care. 2013;36:1033-1046.

of focus within their jurisdiction (this may be the entire area). Applicants will propose criteria for community selection. These criteria must be based on disease and risk factor burden data and combined potential to reach and effect outcomes for in large numbers of adults.

The table on pages 21-29 provides greater detail regarding the overall program strategies that awardees will work on during the 4-year project period for both components. These strategies are framed in terms of the environmental systems, or community-clinical linkage changes that will result from the awardee activities undertaken for each strategy. Applicants must address both components and all strategies. The two components are intended to be mutually reinforcing and create seamless, coordinated support to improve health and healthful behaviors.

**1. Collaborations –**

**a. With CDC funded programs:**

Applicants are expected to collaborate with other related CDC funded programs that have a role in achieving the FOA outcomes. Potential areas of collaboration include partners, stakeholder groups, data, location of interventions, common public messages, etc. Related programs include State Public Health Actions (1305), WISEWOMAN, national organizations funded under CDC-DP12-1212PPHF12 - Preventing Type 2 Diabetes Among People at High Risk, and other CDC-funded community chronic disease prevention programs. Applicants should describe how selected strategies align with state priorities identified in the CDC-approved Chronic Disease State Plan and the Four Domains of Chronic Disease (Epidemiology and Surveillance; Environmental Approaches; Health System Strategies; and Community-Clinical Links) and how each will specifically or collectively contribute to improvements in health status and reduce health disparities in disproportionately affected populations as evidenced by state and local data (if available). Applicants should refer to the CDC-approved State Chronic Disease Plan, as appropriate.

Letters of support are encouraged, though not required for state applicants. However, large city health department applicants need to provide a letter of support from the state department of health or its bona fide agent documenting activities proposed in DP14-1422 are being coordinated with the state's DP13-1305 activities.

**b. With organizations external to CDC:**

Applicants are expected to collaborate with organizations external to CDC that have a role in achieving FOA outcomes. This should help maximize resources and increase public health impact. The collaboration may include data sharing with appropriate privacy protections, program implementation, reaching priority populations, communication, etc. Examples of these groups

include local health departments, employer groups, health systems, Medicaid, other insurers, non-governmental organizations, transportation and community planning authorities, etc. Letters of support from Medicaid and others are encouraged, though not required.

For example, an applicant may wish to promote increased fruit and vegetable intake. The applicant could contact local Farmers Markets to assess whether vendors accept USDA Electronic Benefit Transfer (EBT) payment and provide assistance to vendors on various food assistance incentives, such as “Health Bucks”.

**2. Target Populations:**

Applicants must identify criteria for selecting their communities based on disease and risk factor burden data and combined potential to impact large numbers of adults. Further, they must identify specific priority populations of focus for Component 2. Priority populations are those that are affected disproportionately by uncontrolled high blood pressure or at risk for type 2 diabetes due to racial/ethnic, socioeconomic or other characteristics, including inadequate access to care, poor quality of care, or low income.

**Inclusion:**

The program will include populations that can benefit from programmatic strategies (e.g., people with disabilities, non-English speaking populations, lesbian, gay, bisexual and transgender (LGBT) populations, people with limited health literacy), or other targeted populations.

**b. Evaluation and Performance Measurement:**

**i. CDC Evaluation and Performance Measurement Strategy:**

Awardees are required to (1) report on CDC performance measures as specified in this FOA, (2) develop and implement an evaluation plan that addresses progress on the performance measures, and 3) participate in national evaluation efforts. This evaluation approach will provide data on the progress and achievements that awardees are making toward reducing obesity and addressing high blood pressure and prediabetes within states, communities and jurisdictions.

CDC will work with awardees to operationalize the required outcome performance measures and assist with the identification of sound data collection approaches and/or the availability of existing data collection instruments. CDC will manage and synthesize the required outcome performance measure data submitted by awardees. Throughout the 4 years of the project period, CDC will work individually and collectively with each of the awardees to answer the following evaluation questions based on the program logic model.

1. To what extent have the environmental strategies implemented by states, communities and large cities improved the prevention of obesity, diabetes and heart disease and stroke?
2. To what extent have the strategies to build support for healthy lifestyles improved the prevention of obesity, diabetes, and heart disease and stroke?
3. To what extent have improvements in quality, use and delivery of clinical and prevention services improved hypertension management?
4. To what extent have increased community-clinical linkages improved the prevention of diabetes, heart disease and stroke (through control of high blood pressure)?

**Process measures:** CDC will work with awardees to identify, develop and report on state/large city-specific process measures that demonstrate progress in strategy implementation. The measures will be developed based on the populations that are being targeted, the partners participating in the strategies, and the specific activities that are being adopted/implemented to achieve impact on the outcomes. Measures will be developed based on strategy setting and proposed activities and will be reported as part of the state evaluation plan. Awardees will need to manage and synthesize the process measure data submitted by the communities receiving sub-awards or, for large cities, communities that are the focus of the intervention, for submission to CDC as part of the state evaluation plan.

**Outcome performance measures:** Applicants must report on measures for all strategies in each of the two components (see table below). These measures reflect the short-term, intermediate, and long-term outcomes included in the FOA logic model. State awardees will need to manage and synthesize the required outcome performance measure data submitted by the communities receiving sub-awards for submission to CDC as part of the Annual Performance Report. Large cities will need to report the required outcome performance measures for their geographic area of focus.

**ii. Applicant Evaluation and Performance Measurement Plan:**

Evaluation and performance measurement are a critical component of this work. Applicants must provide an overall evaluation and outcome performance measurement plan that is consistent with the CDC evaluation and performance measurement strategy. The evaluation plan and the performance measures are integrally related. The plan should address facilitators and barriers to achieving progress on the measures. In addition, the plan should include information relevant to the applicant's strategy-specific approach and context not addressed by the performance measures. Applicants are encouraged to work with professional evaluators (either internal or external) to meet the evaluation requirements of this FOA. Applicants should allocate between 5% - 10% of their

total funding award to evaluation and performance monitoring. Applicants should consider both developmental and implementation costs for evaluation. The fixed costs of developing an evaluation plan will likely consume a higher percentage of the resources for states receiving awards at the lower end of the funding range. Evaluation implementation costs will likely decrease proportionately with the size of the award.

This plan should be no more than 25 pages. At a minimum, the evaluation and performance measurement plan must:

- Describe how key program partners will be engaged in the evaluation and performance measurement planning processes
- Describe the type of evaluations to be conducted (i.e. process and/or outcome)
- Describe key evaluation questions to be answered
- Describe process and outcome performance measures (see table below) that will be used to track progress toward the outcomes on the logic model
- Describe how reach of the proposed strategies will be measured
- Describe potentially available data sources and feasibility of collecting appropriate evaluation and performance data
- Describe how evaluation findings will be used for continuous program improvement and quality improvement
- Include a logic model that illustrates seamless connection between component 1 and component 2
- Describe how evaluation and performance measurement results will be disseminated both within and beyond CDC

## Performance Measures

*The strategies and performance measures outlined in this table should be implemented to the extent applicable law allows.*

Strategy	Short-term Performance Measures	Intermediate Performance Measures	Long-term Performance Measures
<b>COMPONENT 1: Environmental Strategies to Promote Health and Support and Reinforce Healthful Behaviors</b>			
<ul style="list-style-type: none"> <li>Implement nutrition and beverage standards including sodium standards (i.e., food service guidelines for cafeterias and vending) in public institutions, worksites and other key locations such as hospitals</li> </ul>	<ul style="list-style-type: none"> <li>Number of key community locations (e.g., number of separate public institutions, worksites, and hospitals, etc.) that implement nutrition and beverage standards</li> <li>Number of adults who have access to key community locations that implement nutrition and beverage standards</li> </ul>	Consumption of fruits, vegetables, and healthy drinks. Data source is purchase data from participating venues	<ul style="list-style-type: none"> <li>Reduce the prevalence of obesity by 3% in the implementation area.</li> <li>Reduce death and disability due to diabetes, heart disease and stroke by 3% in the implementation area.</li> </ul>
<ul style="list-style-type: none"> <li>Strengthen healthier food access and sales in retail venues (e.g., grocery stores, supermarkets, chain restaurants, and</li> </ul>	<ul style="list-style-type: none"> <li>Number of retail venues in the community or jurisdiction (e.g., grocery stores, supermarkets, chain restaurants,</li> </ul>	<ul style="list-style-type: none"> <li>Consumption of fruits, vegetables, and healthy drinks. Data source is purchase data</li> </ul>	<ul style="list-style-type: none"> <li>Reduce the prevalence of obesity by 3% in the implementation area.</li> <li>Reduce death</li> </ul>

<p>markets) and community venues (e.g. food banks) through increased availability (e.g. fruit and vegetables and more low/no sodium options), improved pricing, placement, and promotion</p>	<p>and markets) and community venues (e.g. food banks) that promote healthier food access through increased availability, and improved pricing, placement and promotion</p> <ul style="list-style-type: none"> <li>• Number of adults, who have access to retail venues and community venues that promote healthier food access</li> </ul>	<p>from participating venues (note: food bank measure more likely to be inventory data)</p>	<p>and disability due to diabetes, heart disease and stroke by 3% in the implementation area.</p>
<ul style="list-style-type: none"> <li>• Strengthen community promotion of physical activity through signage, worksite policies, social support, and joint use agreements in communities and jurisdictions</li> </ul>	<ul style="list-style-type: none"> <li>• Number and type of community venues that promote physical activity through signage, worksite policies and shared-use/joint use agreements</li> <li>• Number of adults who have access to community venues that promote physical activity</li> </ul>	<ul style="list-style-type: none"> <li>• Number of adults who meet physical activity guidelines. Data source: SMART BRFSS data, where available.</li> </ul>	<ul style="list-style-type: none"> <li>• Reduce the prevalence of obesity by 3% in the implementation area.</li> <li>• Reduce death and disability due to diabetes, heart disease and stroke by 3% in the implementation area.</li> </ul>
<ul style="list-style-type: none"> <li>• Develop and/or implement transportation and community plans that promote walking</li> </ul>	<ul style="list-style-type: none"> <li>• Number of communities that develop and/or implement a transportation plan that</li> </ul>	<ul style="list-style-type: none"> <li>• Number of adults who meet physical activity guidelines. Data source: SMART</li> </ul>	

	<p>promotes walking</p> <ul style="list-style-type: none"> <li>Number of adults who have access to communities that develop and/or implement plans to promote walking</li> </ul>	BRFSS data, where available.	
<b>COMPONENT 1: Strategies to build support for healthy lifestyles, particularly for those at high risk, to support diabetes and heart disease and stroke prevention efforts</b>			
<ul style="list-style-type: none"> <li>Plan and execute strategic data-driven actions through a network of partners and local organizations to build support for lifestyle change (e.g., create and implement a comprehensive plan to build support for evidence-based lifestyle change in the state, coordinate with existing organizations and programs supporting evidence-based lifestyle change)</li> </ul>	<ul style="list-style-type: none"> <li>Number of unique sectors represented in the network (e.g. employers, insurers, health systems, representatives of community organizations, food banks, and others)</li> <li>Annual participation/response rate of network partners in network self-assessments</li> </ul>	<ul style="list-style-type: none"> <li>Number of persons with prediabetes or at high risk for type 2 diabetes who enroll in a CDC-recognized lifestyle change program (as reported by the CDC Diabetes Prevention Recognition Program “DPRP”)</li> </ul>	<ul style="list-style-type: none"> <li>Percent of participants in CDC-recognized lifestyle change programs achieving 5-7% weight loss (as reported by the CDC DPRP)</li> <li>Reduce death and disability due to diabetes, heart disease and stroke by 3% in the implementation area.</li> <li>Reduce the prevalence of obesity by 3% in the implementation area.</li> </ul>
<ul style="list-style-type: none"> <li>Implement evidence-based engagement strategies (e.g. tailored communications,</li> </ul>	<ul style="list-style-type: none"> <li>Number of people reached through evidence-based engagement strategies</li> </ul>	<ul style="list-style-type: none"> <li>Number of persons with prediabetes or at high risk for type 2 diabetes</li> </ul>	<ul style="list-style-type: none"> <li>Percent of participants in CDC-recognized lifestyle change programs</li> </ul>

<p>incentives, etc.) to build support for lifestyle change.</p>		<p>who enroll in a CDC-recognized lifestyle change program (as reported by the CDC DPRP)</p>	<p>achieving 5-7% weight loss (as reported by the CDC DPRP)</p> <ul style="list-style-type: none"> <li>• Reduce the prevalence of obesity by 3% in the implementation area.</li> <li>• Reduce death and disability due to diabetes, heart disease and stroke by 3% in the implementation area.</li> </ul>
<ul style="list-style-type: none"> <li>• Increase coverage for evidence-based supports for lifestyle change by working with network partners (e.g., educate employers about the benefits and cost-savings of evidence-based lifestyle change programs as a covered health benefit)</li> </ul>	<ul style="list-style-type: none"> <li>• Number of employees with prediabetes or at high risk for type 2 diabetes who have access to evidence-based lifestyle change programs as a covered benefit</li> </ul>	<ul style="list-style-type: none"> <li>• Number of persons with prediabetes or at high risk for type 2 diabetes who enroll in a CDC-recognized lifestyle change program (as reported by the CDC DPRP)</li> </ul>	<ul style="list-style-type: none"> <li>• Percent of participants in CDC-recognized lifestyle change programs achieving 5-7% weight loss (as reported by the CDC DPRP)</li> <li>• Reduce the prevalence of obesity by 3% in the implementation area.</li> <li>• Reduce death and disability due to diabetes, heart disease and stroke by 3% in the</li> </ul>

			implementation area.
<b>COMPONENT 2: Health System Interventions to Improve the Quality of Health Care Delivery to Populations with the Highest Hypertension and Prediabetes Disparities</b>			
<ul style="list-style-type: none"> <li>Increase electronic health records (EHR) adoption and the use of health information technology (HIT) to improve performance (e.g., work with health system partners to implement advanced Meaningful Use data strategies to identify patient populations who experience CVD-related health disparities)</li> </ul>	<ul style="list-style-type: none"> <li>Percentage of patients within health care systems with electronic health records appropriate for treating patients with high blood pressure</li> </ul>	<ul style="list-style-type: none"> <li>Proportion of adults with high blood pressure in adherence to medication regimens</li> </ul>	<ul style="list-style-type: none"> <li>Proportion of adults with known high blood pressure who have achieved blood pressure control</li> <li>Reduce death and disability due to diabetes, heart disease and stroke by 3% in the implementation area.</li> </ul>
<ul style="list-style-type: none"> <li>Increase the institutionalization and monitoring of aggregated/standardized quality measures at the provider level (e.g., use dashboard measures to monitor healthcare disparities and implement activities to eliminate healthcare disparities)</li> </ul>	<ul style="list-style-type: none"> <li>Percentage of persons within health care systems with systems to report standardized clinical quality measures for the management and treatment of patients with high blood pressure</li> </ul>	<ul style="list-style-type: none"> <li>Proportion of adults with high blood pressure in adherence to medication regimens</li> </ul>	<ul style="list-style-type: none"> <li>Proportion of adults with known high blood pressure who have achieved blood pressure control</li> <li>Reduce death and disability due to diabetes, heart disease and stroke by 3% in the implementation area.</li> </ul>
<ul style="list-style-type: none"> <li>Increase engagement</li> </ul>	<ul style="list-style-type: none"> <li>Percentage of</li> </ul>	<ul style="list-style-type: none"> <li>Proportion of</li> </ul>	<ul style="list-style-type: none"> <li>Proportion of</li> </ul>

<p>of non-physician team members (i.e. nurses, pharmacists, and nutritionists, physical therapists, and patient navigators/community health workers) in hypertension management in community health care systems</p>	<p>patients within health care systems with policies or systems to encourage a multi-disciplinary team approach to blood pressure control</p>	<p>adults with high blood pressure in adherence to medication regimens</p>	<p>adults with known high blood pressure who have achieved blood pressure control</p> <ul style="list-style-type: none"> <li>• Reduce death and disability due to diabetes, heart disease and stroke by 3% in the implementation area.</li> </ul>
<ul style="list-style-type: none"> <li>• Increase use of self-measured blood pressure monitoring tied with clinical support</li> </ul>	<ul style="list-style-type: none"> <li>• Percentage of patients within health care systems with policies or systems to encourage self-monitoring of high blood pressure</li> </ul>	<ul style="list-style-type: none"> <li>• Proportion of patients with high blood pressure that have a self-management plan (may include medication adherence, self-monitoring of blood pressure levels, increased consumption of nutritious food and beverages, increased physical activity, maintaining medical appointments)</li> </ul>	<ul style="list-style-type: none"> <li>• Proportion of adults with known high blood pressure who have achieved blood pressure control</li> <li>• Reduce death and disability due to diabetes, heart disease and stroke by 3% in the implementation area.</li> <li>• Reduce the prevalence of obesity by 3% in the implementation area.</li> </ul>

<ul style="list-style-type: none"> <li>• Implement systems to facilitate identification of patients with undiagnosed hypertension and people with prediabetes</li> </ul>	<ul style="list-style-type: none"> <li>• Percentage of patients within health care systems with policies or systems to facilitate identification of patients with undiagnosed hypertension and people with prediabetes</li> </ul>	<ul style="list-style-type: none"> <li>• Proportion of adults with high blood pressure in adherence to medication regimens</li> <li>• Number of persons with prediabetes or at high risk for type 2 diabetes who enroll in a CDC-recognized lifestyle change program (as reported by the CDC DPRP)</li> </ul>	<ul style="list-style-type: none"> <li>• Proportion of adults with known high blood pressure who have achieved blood pressure control</li> <li>• Percent of participants in CDC-recognized lifestyle change programs achieving 5-7% weight loss (as reported by the CDC DPRP)</li> <li>• Reduce death and disability due to diabetes, heart disease and stroke by 3% in the implementation area.</li> </ul>

**COMPONENT 2: Community Clinical Linkage Strategies to Support Heart Disease and Stroke and Diabetes Prevention Efforts**

<ul style="list-style-type: none"> <li>• Increase engagement of CHWs to promote linkages between health systems and community resources for adults with high</li> </ul>	<ul style="list-style-type: none"> <li>• Number of health systems that engage CHWs to link patients to community resources that</li> </ul>	<ul style="list-style-type: none"> <li>• Proportion of adults with high blood pressure in adherence to medication regimens</li> </ul>	<ul style="list-style-type: none"> <li>• Proportion of adults with known high blood pressure who have achieved blood</li> </ul>
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<p>blood pressure and adults with prediabetes or at high risk for type 2 diabetes</p>	<p>promote self-management of high blood pressure and prevention of type 2 diabetes</p>	<ul style="list-style-type: none"> <li>• Proportion of patients with high blood pressure that have a self-management plan (including medication adherence, self-monitoring of blood pressure levels, increased consumption of nutritious food and beverages, increased physical activity, maintaining medical appointments)</li> <li>• Number of persons with prediabetes or at high risk for type 2 diabetes who enroll in a CDC-recognized lifestyle change program (as reported by the CDC DPRP)</li> </ul>	<p>pressure control</p> <ul style="list-style-type: none"> <li>• Percent of participants in CDC-recognized lifestyle change programs achieving 5-7% weight loss (as reported by the CDC DPRP)</li> <li>• Reduce death and disability due to diabetes, heart disease and stroke by 3% in the implementation area.</li> <li>• Reduce the prevalence of obesity by 3% in the implementation area.</li> <li>•</li> </ul>
<ul style="list-style-type: none"> <li>• Increase engagement of community pharmacists in the provision of medication-/self-management for adults with high blood pressure</li> </ul>	<ul style="list-style-type: none"> <li>• Number of community pharmacists that promote medication-/self-management</li> </ul>	<ul style="list-style-type: none"> <li>• Proportion of adults with high blood pressure in adherence to medication regimens</li> <li>• Proportion of patients with high blood</li> </ul>	<ul style="list-style-type: none"> <li>• Proportion of adults with known high blood pressure who have achieved blood pressure control</li> <li>• Reduce death</li> </ul>

		<p>pressure that have a self-management plan (including medication adherence, self-monitoring of blood pressure levels, increased consumption of nutritious food and beverages, increased physical activity, maintaining medical appointments)</p>	<p>and disability due to diabetes, heart disease and stroke by 3% in the implementation area.</p> <ul style="list-style-type: none"> <li>• Reduce the prevalence of obesity by 3% in the implementation area.</li> </ul>
<ul style="list-style-type: none"> <li>• Implement systems and increase partnerships to facilitate bi-directional referral between community resources and health systems, including lifestyle change programs (e.g. EHRs, 800 numbers, 211 referral systems, etc.)</li> </ul>	<ul style="list-style-type: none"> <li>• Number of health care systems with an implemented community referral system for evidence-based lifestyle change programs</li> </ul>	<ul style="list-style-type: none"> <li>• Number of persons with high blood pressure who enroll in an evidence-based lifestyle change program</li> <li>• Number of persons with prediabetes or at high risk for type 2 diabetes who enroll in a CDC-recognized lifestyle change program</li> </ul>	<ul style="list-style-type: none"> <li>• Proportion of adults with known high blood pressure who have achieved blood pressure control</li> <li>• Percent of participants in CDC-recognized lifestyle change programs achieving 5-7% weight loss (as reported by the CDC DPRP)</li> <li>• Reduce death and disability due to diabetes, heart disease and stroke by 3% in</li> </ul>

			<p>the implementation area.</p> <ul style="list-style-type: none"> <li>• Reduce the prevalence of obesity by 3% in the implementation area.</li> <li>•</li> </ul>
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<p><b>c. Organizational Capacity of Awardees to Execute the Approach:</b></p> <p>Applicants must describe their organizational capacity to carry out the strategies outlined in both Component 1 and Component 2. CDC anticipates that all applicants will be able to demonstrate sufficient capacity and readiness to implement the required strategies and demonstrate impact on the project period performance measures over the 4-year project period.</p> <p>For work being conducted under Component 1, environmental approaches for whole adult populations and support for healthy lifestyles, particularly in high risk populations, should be addressed in order to reach the maximum number of people through the strategies being implemented. For work being conducted under Component 2, priority populations --those population subgroups with pre-diabetes or uncontrolled high blood pressure who experience health disparities due to race, ethnicity, socioeconomic or other characteristics, including inadequate access to care, poor quality of care, low income--must be identified. Component 2 strategies should be specifically tailored to the unique needs of these populations. When applicants are describing organizational capacity, they must:</p> <ul style="list-style-type: none"> <li>• Minimize duplication of effort, and particularly, build on complementary efforts being funded by CDC under DP13-1305 and other relevant CDC funding.</li> <li>• Include a focus on reducing health disparities associated with prediabetes and uncontrolled high blood pressure within the communities/jurisdiction.</li> <li>• Coordinate efforts with other federally and privately funded programs within the state/large city in an effort to leverage resources and maximize reach and impact.</li> </ul> <p>Demonstrated general readiness to implement the evidence-based strategies in both components includes the ability of applicants to describe the following:</p> <ul style="list-style-type: none"> <li>• Established partnerships with groups/organizations relevant to the strategies selected</li> <li>• Prior experience working and providing technical assistance on and</li> </ul>
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demonstrating outcomes for priority populations at the highest level possible (e.g., community-wide or at a systems level) for the FOA strategies

- Ability to conduct program evaluation and monitor performance, including the ability to collect and use population-level data to demonstrate impact on priority populations
- Committed leadership within the state or large city department of health for program planning and development including the identification, hiring, or reassignment and supervision of staff, contractors, and/or consultants sufficient in number and subject matter expertise to plan and implement strategies across the components.

Demonstrated readiness to work on component-specific strategies includes the ability of applicants to describe the following:

Component 1

- Demonstrated experience in policy/environmental change leading to health improvements.
- Demonstrated success building support for lifestyle change for those at high risk for diabetes.
- Established partnerships with key stakeholders for nutrition and physical activity, policy/environmental improvement initiatives (e.g., state/local department of transportation, employers, retailers, food banks, parks and recreation departments, and others).
- Established partnerships with key stakeholders for building support for lifestyle change (e.g. employers, insurers, state Medicaid agencies, health systems, representatives of CDC recognized lifestyle change programs, and others).

Component 2

- Access to health systems data, including, for example, payer data (e.g., Medicaid), hospital discharge data, and health plan performance data.
- Demonstrated experience in health systems quality improvement processes.
- Demonstrated experience engaging health care extenders to promote linkages between health systems and community resources.
- Established partnerships with key stakeholders for health system interventions to improve the quality of health care delivery to populations with the highest hypertension and prediabetes disparities (e.g., Quality Improvement Organization, Regional Extension Center, state Medicaid, other insurers, Primary Care Organization, state chapters of National Medical or Nurses Associations, faith-based and community-based organizations, Historically Black Colleges).
- Demonstrated experience in developing systems to facilitate bi-directional referral between health systems and community resources.
- Established partnerships with key stakeholders for promoting community-clinical linkages (e.g., CHW Associations, Community Pharmacists, community organizations offering the CDC recognized lifestyle change program, Department

of Housing and Urban/Community Development).

Demonstrated Readiness to Implement Project Management includes the ability of applicants to describe the following:

- Core project management to execute strategies in both components including the roles and responsibilities of project staff.
- Who will have day-to-day responsibility for key tasks such as: leadership of the project; monitoring of the project’s on-going progress; preparation of reports; program evaluation; and communication with partners.
- Any contractual organization(s), consultants, and/or partner organizations that will have a significant role(s) in implementing program strategies and achieving project outcomes.
- An efficient and effective mechanism for making sub-awards to communities, jurisdictions, and other local organizations and for ensuring accountability of sub-awardees for demonstrating impact on the project period outcomes.

**d. Work Plan:**

Applicants must provide a detailed work plan for the first year of the project period and a high level plan in narrative form for subsequent years in support of FOA outcomes. At a minimum, the work plan must include:

- Activities that are in alignment with the strategies on the FOA logic model and include appropriate milestones for accomplishing tasks.
- The required outcome performance measures associated with each strategy and associated data sources.
- Staff and administrative roles and functions to support implementation of the award.
- Administration and assessment processes to ensure successful implementation and quality assurance.

A sample work plan template is provided below. Applicants are required to include all of the elements listed within the sample work plan. CDC will provide feedback and technical assistance to awardees to finalize the work plan activities post-award.

<b>Expected Outcome(s) for the Project Period</b>				
•				
•				
<b>Program Strategies</b>	<b>Performance Measures</b>	<b>Data Source</b>	<b>Target</b>	<b>Timeframe</b>
•				
•				
<b>Activities</b>			<b>Person Responsible</b>	<b>Activity Completion Date</b>
•				
•				
•				

**e. CDC Monitoring and Accountability Approach:**

Monitoring activities include routine and ongoing communication between CDC and awardees, site visits, and awardee reporting (including work plans, performance, and financial reporting). HHS specifies the following HHS expectations for post-award monitoring for grants and 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.

Monitoring may also include the following activities:

- 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 that assists grants management staff (e.g., grants management officers and specialists, and project officers) in the identification, notification, and management of high-risk grantees.

**f. CDC Program Support to Awardees:**

The CDC programs that are involved with this FOA will provide substantial involvement beyond site visits and regular performance and financial monitoring during the project period. Substantial involvement means that the awardee can expect federal programmatic partnership in carrying out the effort and the award. CDC will work in partnership with the awardee to ensure the success of the cooperative agreement by:

- Supporting awardees in implementing cooperative agreement requirements and meeting program outcomes.
- Providing technical assistance to revise annual work plans.
- Assisting awardees in advancing program activities to achieve project outcomes.
- Providing scientific subject matter expertise and resources.
- Collaborating with awardees to develop and implement evaluation plans that align with CDC evaluation activities.
- Providing technical assistance on awardees' evaluation and performance measurement plan.
- Providing technical assistance to define and operationalize performance

measures.

- Using webinars and other social media (e.g., PH Connects) for awardees and CDC to communicate and share tools and resources.
- Establishing learning communities to facilitate the sharing of information among grantees.
- Providing professional development and training opportunities, either in-person or through virtual web-based training formats, for the purpose of sharing the latest science, best practices, success stories, and program models.
- Participating in relevant meetings, committees, conference calls, and working groups related to the cooperative agreement requirements to achieve outcomes.
- Coordinating communication and program linkages with other CDC programs and Federal agencies, such as Centers for Medicare and Medicaid Services (CMS), Health Resources and Services Administration (HRSA), Food and Drug Administration (FDA), United States Department of Agriculture (USDA), and the National Institutes of Health (NIH).
- Providing surveillance technical assistance and state-specific data collected by CDC.
- Providing technical expertise to other CDC programs and Federal agencies on how to interface with grantees.
- Translating and disseminating lesson learned through publications, meetings and other means on promising and best practices to expand the evidence base.

## B. Award Information

*Insert narrative for each header below based on content outlined in the Guidance.*

**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:** U58 Chronic Disease Control Cooperative Agreement

**3. Fiscal Year:** 2014

**4. Approximate Total Fiscal Year Funding:** \$70,000,000

**5. Approximate Total Project Period Funding:** \$280,000,000 for four years, subject to availability of funding, including both direct and indirect costs

**6. Total Project Period Length:** Four years

**7. Approximate Number of Awards:** 15-19 states and the District of Columbia, and 3-5 large cities, for a total of 18-22 awards

**8. Approximate Average Award:** \$3,000,000

**9. Floor of Individual Award Range:** \$2,000,000

<b>10. Ceiling of Individual Award Range:</b> \$4,000,000
<b>11. Anticipated Award Date:</b> September 30, 2014
<p><b>12. Budget Period Length:</b> 12 months</p> <p>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).</p>
<p><b>13. Direct Assistance:</b></p> <p>Direct Assistance (DA) is not available through this FOA.</p>

<b>C. Eligibility Information</b>
<p><b>1. Eligible Applicants:</b></p> <p>Government Organizations:</p> <ul style="list-style-type: none"> <li>• State health departments or their bona fide agents (includes the District of Columbia)</li> <li>• Large city health departments or their bona fide agents, with populations of at least 900,000 (using July 2012 U.S. Census Estimates<sup>xviii</sup>)</li> </ul>
<p><b>2. Special Eligibility Requirements:</b></p> <p>Large city applicants must work in partnership with and provide a letter of support from the state department of health or its bona fide agent documenting activities proposed in this FOA are being coordinated with the state’s DP13-1305 activities.</p>
<p><b>3. Justification for Less than Maximum Competition:</b></p> <p>State and large city departments of health are uniquely positioned to carry out the activities outlined in this FOA. State departments of health serve as the lead for chronic disease prevention programs in every state and large city departments of health lead this work in their jurisdictions, in collaboration with state departments of health. State departments of health provide leadership for coordinating and providing chronic disease prevention technical assistance to communities throughout the state through a strong network of partnerships that are in place to expand access, availability to and use of evidence-based strategies. Also, state departments of health have existing personnel who are able to provide technical assistance based on their area of expertise (e.g., policy and systems development, communications, epidemiology, partnership development,</p>

and evaluation) which conserves valuable resources. All these capacities and strategies can be integrated and employed by state departments of health to: implement policy and programmatic strategies that cut across multiple chronic conditions and that leverage individual categorical efforts and create synergies and efficiencies across multiple state programmatic efforts also funded by CDC, given the high level of co-morbidities among people with chronic diseases and conditions (e.g., obesity, diabetes, hypertension); develop models that integrate with other state health department chronic disease programs affecting similar populations; collect statewide surveillance data on chronic diseases and key risk factors through data sources that are uniquely available to state health departments. Large city departments of health provides access to jurisdiction-wide health data, leadership in convening partners that are key to implementing population-wide strategies, and the ability to work with state departments of health and influence the health of large populations.

**4. Cost Sharing or Matching:**

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.

**5. Maintenance of Effort:**

Maintenance of effort is not required for this program.

**D. Application and Submission Information**

Additional materials that may be helpful to applicants:

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

**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](http://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](http://www.SAM.gov).

- c. **Grants.gov:** The first step in submitting an application online is registering your organization at [www.grants.gov](http://www.grants.gov), the official HHS E-grant Web site. Registration information is located at the “Get Registered” option at [www.grants.gov](http://www.grants.gov).

All applicant organizations must register at [www.grants.gov](http://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](http://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](http://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](mailto: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. If Grants.gov is inoperable and cannot receive applications due to an emergency or other unanticipated event (and circumstances preclude advance notification of an extension), then applications must be submitted by the first business day on which government operations resume.

a. **Letter of Intent (LOI) Deadline:** Not applicable

b. **Application Deadline:** July 22, 2014 11:59 p.m. U.S. Eastern Daylight Time, at [www.grants.gov](http://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](http://www.grants.gov)
- Complete the applicable assurances and certifications and submit them directly to CDC on an annual basis at <http://wwwn.cdc.gov/grantsassurances/Homepage.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](http://www.grants.gov).

**7. Letter of Intent (LOI):** Not applicable

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

**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.name of state” and upload it as a PDF file under “Other Attachment Forms” at [www.grants.gov](http://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](http://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.name of state” text box at [www.grants.gov](http://www.grants.gov).

**10. Project Narrative:** (Maximum of 30 pages, single spaced, Calibri 12 point, 1-inch margins, number all pages. Content beyond 30 pages will not be considered. Thirty page limit includes the work plan.

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 that clearly addresses Components 1 and 2 with the application forms. Applicants must name this file “Project Narrative.state/large city name” and upload it at [www.grants.gov](http://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.)
  - iv. **Strategy and Activities:** Applicants must provide a clear and concise description of the strategies and activities they will to use to achieve the project period outcomes. Whenever possible, applicants should use evidence-based program strategies as identified by the Community Guide<sup>2</sup> (or similar reviews) and reference it explicitly as a source (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. Letters of support, including from Medicaid, are encouraged, though not required. However, large city applicants are required to include a letter of support from the state health department or its bona fide agent documenting activities proposed in DP14-1422 are being coordinated with the state’s DP13-1305 activities.
    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. Applicants must include proposed criteria for selecting their 4-8 communities. These

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<sup>2</sup> <http://www.thecommunityguide.org/index.html>

criteria must be based on disease and risk factor burden data and combined potential to impact large numbers of adults. Applicants must also identify specific priority populations of focus for Component 2. These priority populations are affected disproportionately by heart disease and stroke and prediabetes. Supporting data should demonstrate increased health risk, using data, including non-health data on factors that influence health (e.g., poverty, education, or housing).

**Inclusion:** Applicants must address how they will include specific populations who can benefit from the program, refer back to the CDC Project Description section – Approach: Inclusion, if applicable.

- 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 the type of evaluations to be conducted (i.e., process and/or outcome).
- Describe key evaluation questions to be answered.
- 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 are to name the supporting documentation file “CVs/Resumes.state/large city name” or “Organizational

Charts.state/large city name” and upload it at [www.grants.gov](http://www.grants.gov). Applicants are to name documentation of collaboration “Letters of support.state/large city name” and upload it at [www.grants.gov](http://www.grants.gov).

**11. Work Plan:** *(Included in the Project Narrative’s 30 page limit)*

Applicants must prepare a work plan consistent with the CDC Project Description Work Plan section that clearly addresses Components 1 and 2. The work plan integrates and delineates more specifically how the awardee plans to achieve the project period outcomes, strategies, and activities, evaluation and performance measurement, including key milestones.

Applicants must name this file “Work Plan.state/large city name” and upload it as a PDF file at [www.grants.gov](http://www.grants.gov).

**12. Budget Narrative:**

Applicants must submit an itemized budget narrative which clearly addresses Components 1 and 2. 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 must include:

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

*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 governments (including the District of Columbia), or their bona fide agents) and large cities with populations over 900,000 (using July 2012 U.S. Census Estimates<sup>xviii</sup>). 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](http://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](http://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](http://www.HealthCare.gov).

#### **15. Intergovernmental Review:**

The application is subject to Intergovernmental Review of Federal Programs, as governed by Executive Order 12372, which established a system for state and local intergovernmental review of proposed federal assistance applications. Applicants should inform their state single point of contact (SPOC) as early as possible that they are applying prospectively for federal assistance and request instructions on the state's process. The current SPOC list is available at: [http://www.whitehouse.gov/omb/grants\\_s poc/](http://www.whitehouse.gov/omb/grants_s poc/).

#### **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 before any legislative body
  - 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](http://www.grants.gov). The application package can be downloaded at [www.grants.gov](http://www.grants.gov). Applicants can complete the application package off-line and submit the application by uploading it at [www.grants.gov](http://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](http://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](http://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](mailto: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](http://www.grants.gov) on the deadline date.

- b. Tracking Number:** Applications submitted through [www.grants.gov](http://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](http://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](http://www.grants.gov). A second e-mail message to applicants will then be generated by [www.grants.gov](http://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](http://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](http://www.grants.gov), applicants should contact Customer Service at [www.grants.gov](http://www.grants.gov). The [www.grants.gov](http://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](mailto: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](http://www.grants.gov) is managed by HHS.
- e. Paper Submission:** If technical difficulties are encountered at [www.grants.gov](http://www.grants.gov), applicants should call the [www.grants.gov](http://www.grants.gov) Contact Center at 1-800-518-4726 or e-mail them at [support@www.grants.gov](mailto: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](http://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](http://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 National Center for Chronic Disease Prevention and Health Promotion 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:**

An objective review panel will evaluate complete and responsive applications according to the criteria listed in the criteria section of the FOA. Applicants will be notified electronically if the application did not meet eligibility and/or published submission requirements thirty (30) days after the completion of Phase II review.

**Review Criteria**

**i. Approach (40)**

- Purpose and Outcomes (10) - The extent to which the applicant:
  - Describes how it will address the problem statement and work with partners to implement whole population and targeted evidence-based strategies to address the prevention of obesity, diabetes, and heart disease and stroke among adults.
- Workplan (30) – The extent to which the applicant describes a detailed one-year work plan that:
  - Aligns with the program logic model on page 6.
  - Specifies the component 1 and 2 strategies and performance measures from the table on pages 21-29.
  - Specifies the scope and setting for work under each strategy selected.
  - Lists appropriate activities that will be done to accomplish the work and achieve the performance measures for each strategy selected.
  - Provides a general summary of activities for Years 2-5. Includes plans for identifying and accessing data for any short-term performance measures where data is currently unavailable (i.e., those measures on the work plan template that are missing information on data source, baseline, and target).

**ii. Evaluation and Performance Management (25)**

- Includes a state-specific logic model that describes how Component 1 and 2 strategies will be implemented simultaneously and synergistically to address multiple chronic diseases and risk factors. (5)
- Evaluation and Performance Management Plan (20) – The extent to which the applicant describes how it will:
  - Establish baselines and targets for all required project period performance measures
  - Identify data sources for setting baselines and targets and for measuring performance
  - Engage key program partners in the development and implementation of the evaluation plan, including the identification of key evaluation questions.
  - Use evaluation findings for continuous program and quality improvement.
  - Ensure full participation in and compliance with any national evaluations.

**iii. Applicant’s Organizational Capacity to Implement the Approach (35)**

- Organizational Capacity Statement (5) – The extent to which the applicant:

- Describes its capacity to carry out the required strategies, including coordination with other federally and privately funded programs within the state in order to minimize duplication, leverage resources, address health equity, and maximize reach and impact.
- Demonstrates general readiness to work on strategies (10), as evidenced by:
  - Established partnerships with groups/organizations relevant to the strategy selected.
  - Prior experience working and providing technical assistance on and demonstrating outcomes for priority populations at the highest level possible for the FOA strategies.
  - Ability to conduct program evaluation and monitor performance, including ability to collect and use population-level data to demonstrate impact on priority populations.
  - Committed leadership within the state or large city department of health for program planning and development including the identification, hiring, or reassignment and supervision of staff, contractors, and/or consultants sufficient in number and subject matter expertise to plan and implement strategies across the components.
- Demonstrates readiness to work on component-specific strategies (15), as evidenced by:
  - Component 1
    - Demonstrated experience in policy/environmental change.
    - Demonstrated experience in building support for lifestyle change for those at high risk for diabetes
    - Established partnerships with key stakeholders for nutrition and physical activity, policy/environmental change initiatives (e.g., state/large city department of transportation, employers, retailers, food banks, parks and recreation departments, transportation and community planning agencies)
    - Established partnerships with key stakeholders for building support for lifestyle change (e.g. employers, insurers, state Medicaid agencies, health systems, representatives of CDC recognized lifestyle change programs, etc.)
  - Component 2
    - Access to health systems data, including, for example, payer data (e.g., Medicaid), hospital discharge data, and health plan performance data.
    - Demonstrated experience in health systems quality improvement processes.
    - Demonstrated experience in engaging health care extenders to promote linkages between health systems and community resources.
    - Established partnerships with key stakeholders for health system interventions to improve the quality of health care delivery to populations with the highest hypertension and prediabetes disparities (e.g., Quality Improvement Organization, Regional Extension Center, state Medicaid, other insurers, Primary Care Organization, state chapters of National Medical or

Nurses Associations, faith-based and community-based organizations, Historically Black Colleges)

- Demonstrated experience in developing systems to facilitate bi-directional referral between health systems and community resources
- Established partnerships with key stakeholders for promoting community-clinical linkages (e.g. CHW Associations, Community Pharmacists, community organizations offering the CDC recognized lifestyle change program, Department of Housing and Urban/Community Development)
- Project Management (5) – The extent to which the applicant:
  - Describes core project management to execute Component 1 including the roles and responsibilities of project staff.
  - Describes who will have day-to-day responsibility for key tasks such as: leadership of the project; monitoring of the project’s on-going progress; preparation of reports; program evaluation; and communication with partners and CDC.
  - Describes any contractual organization(s), consultants, and/or partner organizations that will have a significant role(s) in implementing program strategies and achieving project outcomes.
  - Describes an efficient and effective mechanism for making sub-awards to communities, jurisdictions, and other local organizations and for ensuring accountability of sub-awardees for demonstrating impact on the project period outcomes.
  - Aligns with the program logic model on page7.
  - Specifies the component 2 strategies and performance measures from the table on pages 24-29.
  - Specifies the scope and setting for work under each strategy selected.
  - Lists appropriate activities that will be done to accomplish the work and achieve the performance measures for each strategy selected.
  - Provides a general summary of activities for Years 2-5. Includes plans for identifying and accessing data for any short-term performance measures where data is currently unavailable (i.e., those measures on the work plan template that are missing information on data source, baseline, and target).

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 Selecting Official shall rely on the rank order established by the objective review as the primary factor in making awards. However, in order to maximize the reach and impact of federal funding, the Selecting Official may depart from the rank order to achieve a balance of awards representing different 1) geographic areas of the United States, or 2) specific project foci

within Component 2.

**2. Announcement and Anticipated Award Dates:**

Successful applicants can anticipate notice of funding by September 30, 2014 with a start date of September 30, 2014.

**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 Principal Investigator and business official.

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](http://www.cdc.gov/od/pgo/funding/grants/additional_req.shtm).

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

- AR-7: Executive Order 12372
- AR-9: Paperwork Reduction Act
- AR-10: Smoke-Free Workplace
- AR-11: Healthy People 2010
- AR-12: Lobbying Restrictions
- AR-14: Accounting System Requirements
- 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

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>

Other Provisions that Apply

**General Provisions Title II, Division H, Consolidated Appropriations Act (2014).**

**Section 203 - Cap on Researcher Salaries**

*None of the funds appropriated in this title shall be used to pay the salary of an individual, through a grant or other extramural mechanism, at a rate in excess of Executive Level II; reduced from \$199,700 to \$179,700 effective December 23, 2011.*

**Section 217 - Gun Control Prohibition**

*None of the funds made available in this title may be used, in whole or in part, to advocate or promote gun control.*

**Section 218 - Prevention and Public Health Fund Reporting Requirements**

*(a) The Secretary shall establish a publicly accessible website to provide information regarding the uses of funds made available under section 4002 of Public Law 111-148.*

*(b) With respect to funds provided for fiscal year 2012, the Secretary shall include on the website established under subsection (a) at a minimum the following information:*

*(1) In the case of each transfer of funds under section 4002(c), a statement indicating the program or activity receiving funds, the operating division or office that will administer the funds, the planned uses of the funds, to be posted not later than the day after the transfer is made.*

*(2) Identification (along with a link to the full text) of each funding opportunity announcement, request for proposals for grants, cooperative agreements, or*

*contracts intended to be awarded using such funds, to be posted not later than the day after the announcement or solicitation is issued.*

*(3) Identification of each grant, cooperative agreement, or contract with a value of \$25,000 or more awarded using such funds, including the purpose of the award and the identity of the recipient, to be posted not later than 5 days after the award is made.*

*(4) A report detailing the uses of all funds transferred under section 4002(c) during the fiscal year, to be posted not later than 90 days after the end of the fiscal year.*

*(5) Semi-annual reports from each entity awarded a grant, cooperative agreement, or contract from such funds with a value of \$25,000 or more, summarizing the activities undertaken and identifying any sub-grants or subcontracts awarded (including the purpose of the award and the identity of the recipient), to be posted not later than 30 days after the end of each 6-month period.*

*Recipients are responsible for contacting their HHS grant/program managers for any needed clarifications.*

*Responsibilities for Informing Sub-recipients:*

*(a) Recipients agree to separately identify to each sub-recipient, and document at the time of sub-award and at the time of disbursement of funds, the Federal award number, any special CFDA number assigned for 2014 PPHF fund purposes, and amount of PPHF funds.*

*(b) Recipients agree to separately identify to each sub-recipient, and document at the time of sub-award and at the time of disbursement of funds, the Federal award number, CFDA number, and amount of 2014 PPHF funds. When a recipient awards 2014 PPHF funds for an existing program, the information furnished to sub-recipients shall distinguish the sub-awards of incremental 2014 PPHF funds from regular sub-awards under the existing program.*

**Reporting Requirements:**

*This award requires the recipient to complete projects or activities which are funded under the 2014 Prevention and Public Health Fund (PPHF) and to report on use of PPHF funds provided through this award. Information from these reports will be made available to the public.*

*Recipients awarded a grant, cooperative agreement, or contract from such funds with a value of \$25,000 or more shall produce reports on a semi-annual basis with a reporting cycle of January 1 - June 30 and July 1 - December 31; and email*

such reports (in 508 compliant format) to the CDC website (template and point of contact to be provided after award) **no later than 20 calendar days** after the end of each reporting period (i.e. July 20 and January 20, respectively). Recipient reports shall reference the notice of award number and title of the grant or cooperative agreement, and include a summary of the activities undertaken and identify any sub-grants or sub-contracts awarded (including the purpose of the award and the identity of the sub-recipient).

**General Provisions, Title V, Division H, Consolidated Appropriations Act, 2014.**

**Section 503 - Proper Use of Appropriations - Publicity and Propaganda**

(a) No part of any appropriation contained in this Act or transferred pursuant to section 4002 of Public Law 111-148 shall be used, other than for normal and recognized executive-legislative relationships, for publicity or propaganda purposes, for the preparation, distribution, or use of any kit, pamphlet, booklet, publication, electronic communication, radio, television, or video presentation designed to support or defeat the enactment of legislation before the Congress or any State or local legislature or legislative body, except in presentation of the Congress or any State or local legislature itself, or designed to support or defeat any proposed or pending regulation, administrative action, or order issued by the executive branch of any State or local government itself.

(b) No part of any appropriation contained in this Act or transferred pursuant to section 4002 of Public Law 111-148 shall be used to pay 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 the Congress or any State government, State legislature or local legislature or legislative body, other than normal and recognized executive legislative relationships or participation by an agency or officer of an State, local or tribal government in policymaking and administrative processes within the executive branch of that government.

(c) The prohibitions in subsections (a) and (b) shall include any activity to advocate or promote any proposed, pending, or future Federal, State or local tax increase, or any proposed, pending, or future requirement or restriction on any legal consumer product, including its sale or marketing, including but not limited to the advocacy or promotion of gun control.

**Section 522 - Needle Exchange**

Notwithstanding any other provision of this Act, no funds appropriated in this Act shall be used to carry out any program of distributing sterile needles or syringes for the hypodermic injection of any illegal drug.

**General Provisions, Title IV, Division G, Consolidated Appropriations Act, 2014**

**Section 422 - Funding Prohibition - Restricts dealings with corporations with**

**recent felonies**

*None of the funds made available by this Act may be used to enter into a contract, memorandum of understanding, or cooperative agreement with, make a grant to, or provide a loan or loan guarantee to, any corporation that was convicted (or had an officer or agent of such corporation acting on behalf of the corporation convicted) of a felony criminal violation under any Federal law within the preceding 24 months, where the awarding agency is aware of the conviction, unless the agency has considered suspension or debarment of the corporation, or such officer or agent and made a determination that this further action is not necessary to protect the interests of the Government.*

**Section 423 - Limitation Re: Delinquent Tax Debts - Restricts dealings with corporations with unpaid federal tax liability**

*None of the funds made available by this Act may be used to enter into a contract, memorandum of understanding, or cooperative agreement with, make a grant to, or provide a loan or loan guarantee to, any corporation with respect to which any unpaid Federal tax liability that has been assessed, for which all judicial and administrative remedies have been exhausted or have lapsed, and that is not being paid in a timely manner pursuant to an agreement with the authority responsible for collecting the tax liability, unless the agency has considered suspension or debarment of the corporation and made a determination that this further action is not necessary to protect the interests of the Government.*

**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](http://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](http://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.

Awardees must report annually on all measures for the strategies in the table

(see p. X) as part of the Annual Performance Report (APR). Baselines, one and four year targets, and actual performance must be reported for all measures. Awardees will need to manage and synthesize the required outcome performance measure data submitted by the communities receiving subawards for submission to CDC as part of the APR.

**iv. Federal Financial Reporting (FFR):** The annual FFR form (SF-425) is required and must be submitted through eRA Commons<sup>3</sup> within 90 days after the calendar quarter. 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.

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

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<sup>3</sup> <https://commons.era.nih.gov/commons/>

assistance, and payments. This information must be submitted through the single, publicly accessible Web site, [www.USASpending.gov](http://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 questions concerning this FOA. Please submit your question to <http://www.cdc.gov/chronicdisease/about/statelocalpubhealthactions-prevcd/fag/index.htm>. All questions must be submitted by July 14, 2014. CDC is unable to respond to any questions submitted after that date.

For **programmatic technical assistance**, contact:

Patricia Shea, Evaluation Team Lead  
Department of Health and Human Services  
Centers for Disease Control and Prevention  
4770 Buford H'wy NE  
Chamblee, GA 30341  
Email: [gzt0@cdc.gov](mailto:gzt0@cdc.gov)  
Telephone: 770-488-1208

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

Stephanie Latham, Grants Management Specialist  
Department of Health and Human Services  
CDC Procurement and Grants Office  
2920 Brandywine Rd., MS E09  
Atlanta, GA 30341-4146  
Email: [fzv6@cdc.gov](mailto:fzv6@cdc.gov)  
Telephone: 770-488-2917

For assistance with **submission difficulties related to [www.grants.gov](http://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](mailto:pgotim@cdc.gov)

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

## H. Other Information

National Center for Chronic Disease Prevention and Health Promotion

<http://www.cdc.gov/chronicdisease/index.htm>

Following is a list of acceptable attachments that applicants can upload as PDF files as part of their application at [www.grants.gov](http://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
- Memorandum of Agreement (MOA)
- Memorandum of Understanding (MOU)
- Organizational Charts
- Indirect Cost Rate , if applicable
- Bona Fide Agent status documentation, if applicable

## 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](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.

**Community Health Worker (CHW):** CHWs are frontline public health workers who are trusted members of and/or have an unusually close understanding of the community/population being served.

**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](http://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](http://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.

**Health Equity:** Health equity is attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and healthcare disparities. (source: Healthy People 2020, <http://minorityhealth.hhs.gov/npa/templates/browse.aspx?lvl=1&lvlid=34> ).

**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.

**Health Systems:** The health systems referenced in the FOA are health care delivery organizations and may include health maintenance organizations (HMOs), Federally Qualified Health Centers (FQHCs), Rural Health Centers (RHCs) and other clinical groups operating within the state.

**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/](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.

**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.

**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.

**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](http://www.plainlanguage.gov).

**Policy:** For purposes of this FOA, policy refers to programs and guidelines adopted and implemented by institutions, organizations and others to inform and establish practices and decisions and to achieve organizational goals. Policy efforts do not include activities designed to influence the enactment of legislation, appropriations, regulations, administrative actions, or Executive Orders (“legislation and other orders”) proposed or pending before the Congress or any State government, State legislature or local legislature or legislative body, and awardees may not use federal funds for such activities. This restriction extends to both grass-roots lobbying efforts and direct lobbying. However, for state, local, and other governmental grantees, certain activities falling within the normal and recognized executive-legislative relationships or participation by an agency or officer of a state, local, or tribal government in policymaking and administrative processes within the executive branch of that government are not considered impermissible lobbying activities and may be supported by federal funds. Please refer to Additional Requirement (AR) 12 referenced in the FOA for further guidance on this prohibition.

**Priority Populations:** High risk, high burden populations are referred to as “priority populations” and are those population subgroups with pre-diabetes or uncontrolled high blood pressure who experience racial/ethnic or socioeconomic health disparities including inadequate access to care, poor quality of care, or low income.

**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](http://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.

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- <sup>i</sup> Anderson G. Chronic conditions: Making the case for ongoing care. Baltimore, MD: Johns Hopkins University; 2004.
- <sup>ii</sup> Kung HC, Hoyert DL, Xu JQ, Murphy SL. Deaths: final data for 2005. National Vital Statistics Reports 2008;56(10). Available from; [http://www.cdc.gov/nchs/data/nvsr/nvsr56\\_10.pdf](http://www.cdc.gov/nchs/data/nvsr/nvsr56_10.pdf)
- <sup>iii</sup> Centers for Disease Control and Prevention. Diabetes Facts. National Diabetes Prevention Program available from <http://www.cdc.gov/diabetes/prevention/factsheet.htm>
- <sup>iv</sup> Centers for Disease Control and Prevention. National diabetes fact sheet, 2011. Atlanta, GA: U.S. Department of Health and Human Services; 2011. Available from: <http://www.cdc.gov/diabetes/pubs/factsheet11.htm>
- <sup>v</sup> CDC. Vital Signs: Awareness and Treatment of Uncontrolled Hypertension Among Adults-United States, 2003-2010. MMWR September 4, 2012;61(35);703-709.
- <sup>vi</sup> Vital Signs: Prevalence, Treatment and control of High Levels of Low-Density Lipoprotein Cholesterol-United States, 1999-2002 and 2005-2008. MMWR February 2, 2011;60(4); 109-112.
- <sup>vii</sup> Centers for Disease Control and Prevention. Vital Signs: Awareness and Treatment of Uncontrolled Hypertension Among Adults-United States, 2003-2010.
- <sup>viii</sup> MMWR; September 4, 2012;61(35); 703-709
- <sup>ix</sup> Centers for Disease Control and Prevention. Usual Sodium Intakes Compared with Current Dietary Guidelines – United States. 2005-2008. MMWR (2011);60(941):1413-1417.
- <sup>x</sup> Flegal, K., et al. (2012). Prevalence of obesity and trends in the distribution of body mass index among US adults, 1999-2010. *JAMA*, 307(5):doi:10.1001/jama.2012.39.
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- <sup>xi</sup> National Heart, Lung, and Blood Institute. (1998). *Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults: The Evidence Report*. Bethesda, MD: US Department of Health and Human Services, National Institutes of Health, National Heart, Lung, and Blood Institute. Available at [http://www.nhlbi.nih.gov/guidelines/obesity/ob\\_gdlns.htm](http://www.nhlbi.nih.gov/guidelines/obesity/ob_gdlns.htm). Accessed October 26, 2012.
- <sup>xii</sup> US Department of Health and Human Services. (2001). *The Surgeon General's Call to Action to Prevent and Decrease Overweight and Obesity 2001*. Rockville, MD: US Department of Health and Human Services, US Public Health Service, Office of the Surgeon General. Available at <http://www.surgeongeneral.gov/topics/obesity/calltoaction/CalltoAction.pdf>. Accessed October 26, 2012.
- <sup>xiii</sup> Krebs-Smith. Et al. (201). Americans do not meet federal dietary recommendations. *J of Nutrition*, 140:1832-1838. Doi:10.3945/jn.110.128426.
- <sup>xiv</sup> Kimmons J, Gillespie C, Seymour J, Serdula M, Blanck HM. (2009). Fruit and vegetable intake among adolescents and adults in the United States: percentage meeting individualized recommendations. *Medscape J Med*. 2009;11(1):26.
- <sup>xv</sup> Centers for Disease Control and Prevention. Heart Disease and Stroke Prevention At-a-Glance. <http://www.cdc.gov/chronicdisease/resources/publications/AAG/dhdsp.htm>
- <sup>xvi</sup> Centers for Disease Control and Prevention. National diabetes fact sheet, 2011. Atlanta, GA: U.S. Department of Health and Human Services; 2011. Available from: <http://www.cdc.gov/diabetes/pubs/factsheet11.htm>
- <sup>xvii</sup> Finkelstein, E., et al. (2009). Annual medical spending attributable to obesity: payer- and service-specific estimates. *Health Affairs*, 28, w822—831.
- <sup>xviii</sup> Annual Estimates of the Resident Population for Incorporated Places Over 50,000, Ranked by July 1, 2012 Population: April 1, 2010 to July 1, 2012 Source: U.S. Census Bureau, Population Division Release Date: May 2013