

An amendment was made to this Funding Opportunity Announcement DP15-1509. All amendments to the following sections are noted in red type:

F. Dates, 3. Informational Conference Call for Potential Applicants

D. Application and Submission Information, 9. Project Abstract Summary

D. Application and Submission Information, 10. Project Narrative

H. Other Information, Acceptable Attachments

Delete text under Anticipated Funding Range for the Core Component that states ‘and previous spending history” page 10

National State-Based Tobacco Control Programs
CDC-RFA-DP15-1509
National Center for Chronic Disease Prevention
and Health Promotion



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Part I. Overview Information

At www.grants.gov, applicants will find “Send Me Change Notifications Emails” link on the announcement’s synopsis page. To ensure applicants receive notifications of any changes to DP15-1509, National State-Based Tobacco Control Programs, they must provide an e-mail address to www.grants.gov to receive notifications of changes

A. Federal Agency Name:

Centers for Disease Control and Prevention (CDC)

B. Funding Opportunity Title:

National State-Based Tobacco Control Programs

C. Announcement Type: New—Type 1

This announcement is only for non-research domestic activities supported by CDC. If research is proposed, the application will not be considered. Research for this purpose is defined at <http://www.cdc.gov/od/science/integrity/docs/cdc-policy-distinguishing-public-health-research-nonresearch.pdf>.

D. Agency Funding Opportunity Number:

CDC-RFA-DP15-1509

E. Catalog of Federal Domestic Assistance (CFDA) Number:

93.305 - National State-Based Tobacco Control Programs

F. Dates:

1. Letter of Intent Deadline: A Letter of Intent is not required, but is encouraged for those applying for the **Competitive Component**.

- Monday, September 29, 2014, 11:59 p.m. U.S. Eastern Standard Time

2. Application Deadline:

- Monday, December 1, 2014, 11:59 p.m. U.S. Eastern Standard Time, on www.grants.gov

3. Informational **conference call/webinar** for potential applicants:

CDC will conduct **three conference calls/webinars** for all interested applicants to provide technical assistance and respond to any questions regarding this Funding Opportunity Announcement.

Conference Call/Webinar Number 1: Tuesday, September 16, 2014, 10:00AM – 11:00AM, U.S. Eastern Daylight Time.

Conference Call/Webinar Number 2: Wednesday, September 17, 2014, 3:30PM-4:30PM, U.S. Eastern Daylight Time.

Conference Call/Webinar Number 3: Thursday, September 25, 2014, 2:00PM-3:00PM U.S. Eastern Daylight Time

The conference call number and link for all three webinars is below:

Toll-free: +1 (877) 907-9887

Participant code: 31703877

[Join the meeting](#)

In addition, a list of Frequently Asked Questions will be available at http://www.cdc.gov/tobacco/osh/foa/state_based/. Please submit questions related to this FOA to mailbox dp151509@cdc.gov.

G. Executive Summary:

1. Summary Paragraph:

The CDC, Office on Smoking and Health (OSH) announces the availability of Fiscal Year 2015 funds to implement DP15-1509, National State-Based Tobacco Control Programs. This FOA supports the implementation of evidence-based environmental, policy, and systems interventions, strategies, and activities to reduce tobacco use, secondhand smoke (SHS) exposure, tobacco-related disparities and associated disease, disability, and death.

There are **two** components to this FOA:

Core Component – State-Based Tobacco Control Programs will be awarded to state health departments in all 50 states and the District of Columbia if a technically acceptable application proposing to implement a state-based tobacco control program using an evidence-based, comprehensive approach is submitted. Approximately \$58 million per year is available.

Competitive Component - Advancing Evidence-Based Tobacco Control is **competitive** and will be awarded to four to seven applicants for 2-year project periods. State health departments in all 50 states and the District of Columbia are eligible to apply if they meet specific criteria outlined in this FOA. The **Competitive Component** seeks to advance evidence-based tobacco control through developing, implementing, and evaluating innovative and/or promising practices. Approximately \$3 million per year is available.

a. Eligible Applicants: Limited – State and District of Columbia health departments or their Bona Fide Agents¹. (NOTE: The Commonwealth of Puerto Rico, Virgin Islands, Commonwealth of the Northern Mariana Islands, American Samoa, Guam, Federated States of Micronesia, Republic of the Marshall Islands, and Republic of Palau are funded through another FOA, CDC-RFA-DP14-1406, thus are ineligible).

b. FOA Type: Cooperative agreement

c. Approximate Number of Awards:

¹ A Bona Fide Agent is an agency/organization identified by the state as eligible to submit an application under the state eligibility in lieu of a state application. If applying as a bona fide agent of a state or local government, a legal, binding agreement from the state or local government as documentation of the status is required.

<p><u>Core Component:</u> 51 <u>Competitive Component:</u> 4 to 7</p>
<p>d. Total Project Period Funding: \$305 million for 5 years, subject to availability of funding, including direct and/or indirect costs.</p>
<p>e. Average One Year Award Amount: <u>Core Component:</u> \$1 million <u>Competitive Component:</u> \$500,000</p>
<p>f. Number of Years of Award: <u>Core Component:</u> 5-year project period <u>Competitive Component:</u> Two, 2-year project periods</p>
<p>g. Approximate Date When Awards will be Announced: March 30, 2015</p>
<p>h. Cost Sharing and /or Matching Requirements:</p> <p>Cost sharing is encouraged if it helps to leverage federal and state resources, is responsive to stated CDC recipient activities, is advantageous to chronic disease prevention and health promotion programs, supports the four National Tobacco Control Program goals, focuses on evidence-based interventions, strategies, and activities outlined in CDC's Best Practices for Comprehensive Tobacco Control Programs - 2014 and the Community Preventive Services Task Force's <i>Guide for Community Preventive Services</i>, does not compromise the integrity or the ability of the tobacco control program to accomplish proposed activities. Matching funds are not required under this cooperative agreement, but are encouraged.</p>

Part II. Full Text

<p>A. Funding Opportunity Description</p>
<p>1. Background</p> <p>This FOA supports the implementation of evidence-based environmental, policy, and systems interventions, strategies, and activities to reduce tobacco use, secondhand smoke (SHS) exposure, tobacco-related disparities and associated disease, disability, and death. This FOA aligns with CDC's Best Practices for Comprehensive Tobacco Control Programs - 2014 (Best Practices - 2014), the Community Preventive Services Task Force's Guide for Community Preventive Services (Community Guide), the <i>2014 Surgeon General's Report: The Health Consequences of Smoking-50 Years of Progress (SGR – 2014)</i> and the National Center for Chronic Disease Prevention and Health Promotion's (NCCDPHP) four domains to prevent and reduce chronic diseases and promote health. The NTCP aims to achieve four national goals (1) prevent initiation of tobacco use among youth and young adults; (2) promote quitting among adults and youth; (3) eliminate exposure to secondhand smoke, and (4) identify and eliminate tobacco-related disparities among population groups. These goals can be achieved through implementation of a state-based tobacco control program that supports state and community interventions, mass-reach health communication interventions, cessation interventions, surveillance and evaluation, and infrastructure, administration, and management. The goals of the NTCP complement the NCCDPHP four domains to reduce chronic diseases and promote health (Epidemiology and Surveillance; Environmental Approaches that Promote Health and Support and Reinforce Healthful Behaviors; Health System Interventions; and Community-</p>

[Clinical Links](#)). State department of health chronic disease prevention and health promotion programs are stakeholders and partners in tobacco control. This award may be used to support interventions, strategies, and activities to address state tobacco control priorities as described in the state chronic disease prevention and health promotion plan provided that interventions, strategies, and activities are consistent with the evidence-base defined in CDC’s [Best Practices - 2014](#) and the [Community Guide](#) and support achieving the four NTCP goals.

Based on current science, the most effective interventions for tobacco control are population-based environmental, policy and systems approaches that contribute to changes in social norms and behaviors related to tobacco use and SHS exposure. In order to have the greatest population impact, these evidence-based interventions must be sustained for a sufficient amount of time at the appropriate intensity and have the greatest span (economic, regulatory, and comprehensive) and reach. Research has demonstrated that the more states spend on comprehensive tobacco control programs, the greater the reductions in smoking, and that the longer states invest in such programs, the greater and faster the impact.

CDC recommended evidence-based interventions, strategies, recommendations, and guidance for comprehensive state based tobacco control programs are located in the following publications:

- [CDC’s Best Practices for Comprehensive Tobacco Control Programs – 2014](#)
- [The Community Preventive Services Task Force’s Guide for Community Preventive Services](#)
- [The 2014 Surgeon General’s Report: The Health Consequences of Smoking-50 Years of Progress](#)
- [The 2012 Surgeon General’s Report: Preventing Tobacco Use Among Youth and Young Adults](#)
- [The Institute of Medicines’ Ending the Tobacco Problem – A Blueprint for the Nation](#)
- [CDC’s Key Outcome Indicators for Evaluating Comprehensive Tobacco Control Programs](#)

a. Statutory Authorities: This program is authorized under section 317(k)(2) of the *Public Health Service Act*, 42 U.S.C. 247b(k)(2), *Comprehensive Smoking Education Act of 1984*, and *Comprehensive Smokeless Tobacco Health Education Act of 1986*.

b. Healthy People 2020:

This program relates to the Tobacco Use focus area objectives of [Healthy People 2020](#).

c. Other National Public Health Priorities and Strategies:

This program supports the Government Performance Results Modernization Act long term objective to reduce death and disability due to tobacco and [CDC’s Winnable Battles](#).

d. Relevant Work:

This FOA continues to support efforts since 1999 to build state health department infrastructure and capacity to implement comprehensive tobacco control programs. This FOA replaces the tobacco control component of cooperative agreements *DP09-901 and DP14-1415, Collaborative Chronic Disease, Health Promotion, and Surveillance Program Announcement: Healthy Communities, Tobacco Control, Diabetes Prevention and Control, and Behavioral Risk*

Factor Surveillance System.

2. CDC Project Description

a. Approach: See Logic Model below.

National State-Based Tobacco Control Programs Logic Model

Inputs: CDC funding, training, technical assistance, and consultation on evidence-based strategies and activities, surveillance and epidemiology, and program evaluation

Evidence-Based Strategies and Activities	Short-Term Outcomes (Years 1 – 2)	Intermediate Outcomes (Years 2 – 4)	Long Term Outcomes (Year 5)
<p>State and Community Interventions</p> <ul style="list-style-type: none"> - Engage partners, mobilize communities, and develop coalitions - Coordinate and collaborate across programs, agencies, and stakeholder groups - Inform and educate leaders, decision makers and the public - Strengthen community-based organization capacity - Implement/support evidence based, culturally appropriate state/local interventions <p>Mass-Reach Health Communication Interventions</p> <ul style="list-style-type: none"> - Plan, implement, and evaluate health communication and counter-marketing campaigns - Support media engagement efforts - Expand, leverage and localize CDC media campaigns, <i>Surgeon General Reports</i>, and other science/evidence-based publications <p>Cessation Interventions</p> <ul style="list-style-type: none"> - Promote health systems change - Educate decision makers about the benefits of comprehensive insurance coverage and evidence-based cessation treatments - Maintain a state quitline/support state quitline capacity <p>Surveillance and Evaluation</p> <ul style="list-style-type: none"> - Develop an evaluation plan - Collect, analyze and disseminate state and community-specific data - Use data to identify disparate populations and inform public health action - Monitor pro-tobacco influences and inform and educate leaders, decision makers and the public - Develop/submit success stories and evaluation reports <p>Infrastructure, Administration and Management</p> <ul style="list-style-type: none"> - Develop and maintain infrastructure aligned with the five core components of the Component Model of Infrastructure (networked partnerships, multilevel leadership, engaged data, managed resources, responsive planning) - Provide ongoing training and technical assistance - Award and monitor subrecipient contracts and grants - Develop and maintain a fiscal management system 	<p>Increased public-private partnerships addressing tobacco control, tobacco-related disparities and health equity</p> <p>Increased public and decision-maker knowledge about the dangers of tobacco use, exposure to SHS, and tobacco-related disparities</p> <p>Increased public and decision-maker awareness of effective tobacco control interventions, strategies and social norm change</p> <p>Increased implementation and enforcement of interventions and strategies to support quitting, reduce exposure to SHS, and decrease access and availability of tobacco products</p> <p>Increased health communication interventions and messages to reach populations disproportionately affected by tobacco use, exposure to SHS, and tobacco-related disparities</p> <p>Increased health care system changes to promote and support cessation</p> <p>Increased public awareness/support/awareness of actions to increase access to and utilization of evidence-based cessation treatments</p> <p>Increased capacity to collect, analyze, and disseminate data related to tobacco-related disparities and health equity</p> <p>Increased or maintained state health department infrastructure and capacity to support a state-based tobacco control program</p>	<p>Decreased exposure to pro-tobacco messages and availability of tobacco products</p> <p>Increased awareness of pro-tobacco influence</p> <p>Decreased susceptibility to experimentation with tobacco products</p> <p>Increased public compliance with tobacco control policies</p> <p>Increased coverage by and utilization of comprehensive insurance coverage for evidence-based tobacco cessation treatments</p> <p>Increased quit attempts among current tobacco users</p> <p>Increased successful cessation among current tobacco users</p> <p>Increased development of innovative and/or promising practices that contribute to the tobacco control evidence-base</p> <p>Increased implementation of evidence-based interventions and strategies that address vulnerable and underserved populations</p>	<p>NTCP Goal 1: Decreased initiation of tobacco use among youth and young adults</p> <p>NTCP Goal 2: Decreased exposure to SHS</p> <p>NTCP Goal 3: Decreased tobacco use among adults and youth</p> <p>NTCP Goal 4: Decreased tobacco-related disparities</p>

*Bolted text indicate outcomes awardees will be held accountable for.

<p>i. Problem Statement:</p>
<p>Tobacco use remains the leading preventable cause of death and disease in the United States resulting in more deaths annually than HIV/AIDS, alcohol use, cocaine use, heroin use, homicides, suicides, motor vehicle crashes, and fires combined. Each year, approximately 480,000 people die from smoking or exposure to SHS and another 16 million suffer from serious smoking-related illnesses. For every person who dies from smoking or exposure to SHS, 30 more people suffer with at least one serious smoking-related illness. Moreover, annual costs associated with tobacco-related illness amount to nearly \$280 billion in medical expenses and lost productivity. Cigarette smoking causes numerous types of cancer, respiratory and cardiovascular diseases, diabetes, eye disease, complications to pregnancy and reproduction, and comprises the immune system. The burden of death and disease from tobacco use in the United States is overwhelmingly caused by cigarettes and other combusted tobacco products; rapid elimination of their use will dramatically reduce this burden. If current trends continue, the national Healthy People 2020 objective to reduce cigarette smoking prevalence to 12% will not be met.</p>
<p>ii. Purpose:</p>
<p>The purpose of the FOA is to provide funding support, technical assistance, and guidance in collaboration with state health departments and their state and community partners to establish and maintain sufficient tobacco control program capacity to achieve the four NTCP goals using population-based environmental, policy, and systems interventions and strategies demonstrated to effectively impact the tobacco epidemic.</p>
<p>iii. Outcomes:</p>
<p><u>Short Term Outcomes</u></p> <ul style="list-style-type: none"> • Increased public-private partnerships addressing tobacco control, tobacco-related disparities and health equity • Increased public and decision-maker knowledge about the dangers of tobacco use, exposure to SHS, and tobacco-related disparities • Increased public and decision-maker awareness of effective tobacco control interventions, strategies and social norm change • Increased implementation and enforcement of interventions and strategies to support quitting, reduce exposure to SHS, and decrease access and availability of tobacco products • Increased health communication interventions and messages to reach populations disproportionately affected by tobacco use, exposure to SHS, and tobacco-related disparities • Increased health care system changes to promote and support cessation • Increased public awareness/support/awareness of actions to increase access to and utilization of evidence-based cessation treatments • Increased capacity to collect, analyze, and disseminate data related to tobacco-related disparities and health equity

- Increased or maintained state health department infrastructure and capacity to support a state-based tobacco control program

Intermediate Outcomes

- Decreased exposure to pro-tobacco messages and availability of tobacco products
- Increased awareness of pro-tobacco influence
- Decreased susceptibility to experimentation with tobacco products
- Increased public compliance with tobacco control policies
- Increased coverage by and utilization of comprehensive insurance coverage for evidence-based tobacco cessation treatments
- Increased quit attempts among current tobacco users
- Increased successful cessation among current tobacco users
- Increased development of innovative and/or promising practices that contribute to the tobacco control evidence-base
- Increased implementation of evidence-based interventions and strategies that address vulnerable and underserved populations

Long-Term Outcomes

- Decreased initiation of tobacco use among youth and young adults
- Decreased exposure to SHS
- Decreased tobacco use among adults and youth
- Decreased tobacco-related disparities

iv. Funding Strategy:

There are two components to this FOA:

The **Core Component** will be awarded to state health departments in all 50 states and the District of Columbia if a technically acceptable application proposing to implement an evidence-based state tobacco control program is submitted. The **Core Component** supports CDC’s [Best Practices – 2014](#) recommendations that states establish and sustain comprehensive tobacco control programs that contain the following overarching components to reduce tobacco use, exposure to SHS, tobacco related disparities, and associated disease, disability, and death: (1) State and community interventions, (2) Mass-reach health communication interventions, (3) Cessation interventions, (4) Surveillance and evaluation, and (5) Infrastructure, administration and management. These elements will be supported by core public health activities such as partner engagement, coordination and collaboration, strategic planning, workforce development, training and technical assistance, and promoting health equity. Approximately \$58 million per year is available. **Core Component** applications will be objectively reviewed and scored. The project period for the **Core Component** is 5 years, with a 12-month budget period and an anticipated start date of March 30, 2015.

The **Competitive Component** seeks to advance evidence-based tobacco control through

designing, implementing and evaluating innovative and/or promising practices and will be awarded to four to seven applicants. Applicants can apply for the **Competitive Component** if they meet the following criteria:

- Had a state smoking prevalence rate <19% in calendar year 2012
- Have a full-time tobacco control program manager
- Have dedicated state funding for the state tobacco control program
- Proof of published program evaluation results for cooperative agreements DP09-901 or DP14-1415
- Have an active statewide coalition, advisory board, or other tobacco control entity that brings external partners together with the state department of health in addressing tobacco control issues
- Capacity to conduct tobacco control program evaluation
- Capacity to conduct tobacco control surveillance

Awardees of the **Competitive Component** are expected to collaborate with each other and CDC to maximize opportunities for coordination and leveraging resources to avoid duplication. State health departments awarded the **Competitive Component** will implement and rigorously evaluate innovative and/or promising practices in partnership with organizations that may or may not have worked with state health departments in the past (e.g. not-for-profit organizations, law enforcement, economists, business sector, governmental fiscal management offices, researchers, CDC funded National Networks, and other key organizations necessary to change the dynamic for reducing tobacco use). Examples of innovative and/or promising practices include those aimed at the retail environment, point-of-sale, dual use of tobacco products, new tobacco products, and other relevant emerging areas of tobacco control consistent with applicable federal laws. Approximately \$3 million per year is available. **Competitive Component** applications will be objectively reviewed and scored. There will be a second opportunity for all **Core Component** awardees to compete for the **Competitive Component** during the Year 3 application period. The project period for the **Competitive Component** is two-years (First Round FY 2015 – FY 2017) (Second Round FY2018 – FY 2020) with a 12-month budget period and an anticipated start date of March 30, 2015.

Anticipated Funding Range for the Core Component

Approximately \$58 million is available for fiscal year 2015 to fund 51 awards to state-based tobacco control programs. State and District of Columbia departments of health will be able to apply for funding in the ranges listed below, with an average award of \$1 million.

These funding ranges were derived from the following funding formula - [Base (\$500,000 + Weighted Proportion of Metrics)] of two factors (number of smokers and level of poverty) from CDC's [Best Practices - 2014](#). The final award amount will be based on the technical merit and quality of the application (using evaluation criteria scores).

The table below provides guidance related to the minimum and maximum amount of funding

available for the **Core Component**.

State	Floor of Award	Ceiling of Award
Alabama	\$933,284	\$1,366,605
Alaska	\$658,418	\$987,628
Arizona	\$931,452	\$1,364,315
Arkansas	\$887,842	\$1,309,803
California	\$1,748,060	\$2,385,075
Colorado	\$826,415	\$1,233,019
Connecticut	\$715,961	\$1,073,941
Delaware	\$684,184	\$1,026,276
District of Columbia	\$699,280	\$1,048,920
Florida	\$1,461,746	\$2,027,182
Georgia	\$1,139,101	\$1,623,876
Hawaii	\$686,073	\$1,029,109
Idaho	\$763,286	\$1,144,928
Illinois	\$1,193,934	\$1,692,417
Indiana	\$1,020,612	\$1,475,765
Iowa	\$749,824	\$1,124,736
Kansas	\$776,486	\$1,164,730
Kentucky	\$990,042	\$1,437,553
Louisiana	\$967,501	\$1,409,376
Maine	\$703,104	\$1,054,656
Maryland	\$790,332	\$1,185,498
Massachusetts	\$851,081	\$1,263,851
Michigan	\$1,177,875	\$1,672,344
Minnesota	\$821,118	\$1,226,397
Mississippi	\$871,815	\$1,289,769
Missouri	\$992,680	\$1,440,850
Montana	\$751,206	\$1,126,808
Nebraska	\$686,744	\$1,030,116
Nevada	\$803,558	\$1,204,448
New Hampshire	\$605,921	\$908,881
New Jersey	\$948,186	\$1,385,233
New Mexico	\$813,119	\$1,216,399
New York	\$1,380,531	\$1,925,664
North Carolina	\$1,138,846	\$1,623,558
North Dakota	\$611,072	\$916,608
Ohio	\$1,274,118	\$1,792,648
Oklahoma	\$872,258	\$1,290,323
Oregon	\$815,634	\$1,219,543

Pennsylvania	\$1,261,458	\$1,776,823
Rhode Island	\$693,362	\$1,040,042
South Carolina	\$947,603	\$1,384,504
South Dakota	\$696,734	\$1,045,100
Tennessee	\$1,052,654	\$1,515,817
Texas	\$1,710,171	\$2,337,714
Utah	\$716,064	\$1,074,096
Vermont	\$640,585	\$960,877
Virginia	\$946,289	\$1,382,861
Washington	\$918,846	\$1,348,558
West Virginia	\$825,367	\$1,231,709
Wisconsin	\$892,397	\$1,315,496
Wyoming	\$661,393	\$992,089

v. Strategies and Activities:

Core Component

Awarded applicants are required to implement the five overarching areas of tobacco control outlined in CDC's [Best Practices - 2014](#), but have flexibility in selecting evidence-based strategies and activities as long as they aren't linked to specific outcomes required under this cooperative agreement (e.g., strategic plan, communication plan, and sustainability plan, success stories, etc.)

State and Community Interventions

- Establish statewide programs that support and/or facilitate tobacco prevention and control partnership and coalition development, as well as links to other related partnerships and coalitions (e.g., cancer control, cardiovascular disease, diabetes, asthma)
- Establish a strategic plan for comprehensive tobacco control with appropriate partners at the state and community levels
- Educate state leaders, decision-makers, and the public about the burden of tobacco use and evidence-based policy and other strategies to reduce this burden
- Engage stakeholders and partners on approaches, such as message development and messengers, to reach populations with the greatest disparities in tobacco use
- Collect, disseminate, and analyze state and community-specific data
- Develop and implement culturally appropriate interventions with appropriate multicultural involvement
- Sponsor community, regional, and statewide trainings, conferences, and technical assistance on best practices for effective tobacco use prevention and cessation programs
- Monitor pro-tobacco influences to facilitate public discussion and debate among partners, decision makers, and other stakeholders at the state and community level

- Support new ways of implementing evidence-based interventions and strategies to address unique characteristics of the communities where the interventions are being implemented
- Provide support to community-based organizations in order to strengthen the capacity of these groups to positively inform social norms regarding tobacco use
- Build relationships among multiple sectors of the community, such as housing, education, business, planning, and transport
- Empower local agencies to build community coalitions and partnerships that facilitate collaboration among programs in local governments, voluntary and civic organizations, and diverse community-based organizations
- Collaborate with partners and other programs to implement evidence-based interventions and build and sustain capacity through technical assistance and training;
- Support community strategies or efforts to educate the public and media, not only about the health effects of tobacco use and exposure to SHS, but also about available cessation services
- Promote public discussion among partners, decision makers, and other stakeholders about tobacco-related health issues and pro-tobacco influences
- Establish community strategic plans of action that are consistent with the comprehensive state tobacco control plan
- Ensure that community grantees measure and evaluate social norm change outcomes (e.g., policy adoption, increased compliance) resulting from their interventions
- Ensure that partners receiving funding for tobacco control from various entities work collaboratively

Mass-Reach Health Communication Interventions

- Deliver evidence-based, strategic, culturally appropriate, high-impact messages through sustained and adequately funded health communication campaigns and counter-marketing strategies
- Raise awareness, educate the public and decision-makers, promote cessation, increase prevention, increase protection from SHS and address the impact of tobacco use on others using hard-hitting, emotionally evocative messaging
- Use a broad range of channels to effectively reach target audiences, such as paid television, radio, billboard, print, Web, digital, and social media, as appropriate
- Ensure counter-marketing and other media has sufficient reach, frequency and duration
- Conduct formative, process, and outcome evaluation of health communication interventions
- Support and leverage CDC's national tobacco education campaigns and *Surgeon General Reports* about tobacco at the state and community level

- Review and consider effective campaigns housed in the CDC’s Media Campaign Resource Center (MCRC) previously created by other states and partners

Cessation Interventions

- Sustain or improve existing evidence-based state quitline services that increase quit attempts and successful cessation among adults and young people
- Expand efforts to promote the use of the quitline and expand its reach, including among populations with especially high tobacco use rates
- Inform and educate the private and public healthcare systems , health insurers, and employers about how quitting smoking reduces tobacco-related disease and death, and health care costs
- Address and/or reduce barriers in order to provide seamless language services and promotion of existing culturally and linguistically appropriate federal resources such as the Spanish Quitline Portal 1-855-DEJELLO-YA (1-855-335-3569) and the [Asian Quitline](#) .
- Increase collaborations with healthcare systems and providers
- Maintain active membership in the North American Quitline Consortium
- Collect the Minimum Data Set, as defined by the North American Quitline Consortium
- Participate in the CDC, OSH, National Quitline Data Warehouse (NQDW) (i.e., quarterly reporting of intake data on quitline callers and information on services provided through the NQDW Online Services Survey
- Participate in continuing education activities related to quitline operations and evaluation
- Evaluate the state quitline

Surveillance and Evaluation

- Establish a surveillance and evaluation system designed to monitor and document key short-term, intermediate, and long-term outcomes within populations
- Collect data on tobacco use behaviors and other key risk factors and health outcomes using Behavioral Risk Factor Surveillance System (BRFSS), Youth Risk Behavior Surveillance System (YRBSS), Pregnancy Risk Assessment Monitoring System (PRAMS), and the Adult or Youth Tobacco Surveys (ATS/YTS)
- Work in partnership with universities, Prevention Research Centers (PRCs), and other research institutions as appropriate to tap into existing expertise in surveillance and evaluation
- Develop and implement a written evaluation plan for the tobacco control program
- Conduct evaluations designed to inform and engage stakeholders, including members of the target population, at each step, including planning, implementation, interpretation, dissemination, and use of results

- Develop key questions to be answered by the evaluation of the program
- Conduct evaluation activities consistent with [CDC's Framework for Evaluation](#)
- Identify credible evidence and verify its accuracy and appropriateness with stakeholders
- Use surveillance data to monitor programmatic state and local progress toward program objectives
- Communicate evaluation findings and lessons learned to stakeholders

Infrastructure, Administration and Management

Networked Partnerships

- Maintain active strategic partnerships and established communication systems at the state and community level that support the achievement of the four NTCP goals. Partnerships may include state and local organizations, tribes, tribal organizations, and Tribal Support Centers, National Networks for Tobacco Control and Prevention, organizational members of the Funders Alliance for State-Based Tobacco Prevention and Control Programs, organizations serving populations disproportionately affected by tobacco use, exposure to SHS, and tobacco-related diseases, organizations that represent diverse communities, voluntary health organizations, educational institutions, housing and education authorities, private and business sector, local health departments, community-based organizations, the private and business sector, state and local coalitions, commissions, and advisory groups.

Multilevel Leadership

- Identify and nurture leaders and champions at all levels. This includes leadership above the tobacco control program in the state health department or other organizational units where the tobacco control program is located; leadership within the tobacco control program beyond the program manager; leadership in local health departments and boards of health; leadership among partners and other chronic disease areas; leadership in local programs, and leadership in groups outside of public health.

Engaged Data

- Collect, analyze, and use data from a variety of viewpoints and multiple stakeholders for the purposes of program planning, implementing and evaluating
- Use data in a manner that engages staff, leadership, partners, decision makers, and local programs to act
- Use data to promote public health goal
- Share data and experiences to facilitate dissemination of new promising practices

Managed Resources

- Ensure an adequate number of diverse and qualified staff and partners are available to effectively implement the tobacco control program. A full-time program manager to

administer the program is required. In addition to a full-time program manager, ideal staffing levels include a policy coordinator, communication specialist, cessation coordinator, surveillance and evaluation staff, fiscal management systems staff, and administrative staff.

- Implement a training and technical assistance process to address the needs of state and local health department staff, coalitions, and partners involved in tobacco prevention and control activities.

Responsive Plans/Planning

Develop plans in collaboration with partners that are dynamic and evolve in response to contextual influences, such as changes in scientific evidence, priorities, funding levels, and external support. Awarded applicants will develop the following plans:

a. **Comprehensive State Tobacco Control Plans:** Awarded applicants will develop a five-year comprehensive state tobacco control plan or update an existing multi-year plan that aligns with or builds upon the state chronic disease and health promotion plan and spans the proposed funding cycle with active participation of a diverse group of stakeholders. The plan should outline the overall goals, objectives, activities, and evidence-based interventions and strategies for tobacco control in the state. The comprehensive state tobacco control plan should be based on data from state health department surveillance systems and other data gathering efforts, including an environmental scan; outline, and provide justification for all major tobacco control outcome objectives to be addressed over the term of the plan; serve as a framework for decisions on annual programmatic direction; provide a foundation for the development of annual work plans that include appropriate evidence-based interventions and strategies that support the outcome objectives identified in the plan; identify and provide support for addressing areas of tobacco-related disparities and health equity; incorporate sustainability measures from the state sustainability plan, if applicable; assist in benchmarking and performance monitoring; complement other state chronic disease prevention and health promotion plans to reduce tobacco-related diseases; stimulate change; and include a schedule for annual review of the plan to revise programmatic direction as appropriate.

b. **Sustainability Plan:** Awarded applicants will develop a plan to ensure funding sustainability and maintaining a state based tobacco control program. This plan is to be developed with partners from multiple sectors, including the private sector with a goal of maintaining or increasing funding for the comprehensive state tobacco control program and sustaining programmatic accomplishments. State tobacco control programs and their partners should increase leadership and other decision-makers' knowledge, awareness, and support of tobacco control; build and maintain relationships with the media to increase public support for tobacco control; identify strategies to increase public knowledge of the health and economic burden of tobacco use and exposure to SHS based on state data, evaluation reports, personal stories and testimonials; demonstrate the return on investment and the importance of a well-funded tobacco control program; convene partners on a regular basis to identify new relationships and

outlets for informing the public and decision-makers about tobacco use, exposure to SHS, tobacco-related disparities, and to pro-tobacco practices that disproportionately affect vulnerable and underserved populations.

C. Health Communication Plan: Awarded applicants will develop a health communication plan to educate leaders, decision-makers and the public about the dangers of tobacco use, the dangers of exposure to SHS, and available cessation support and resources.

Benchmarks

The following list of benchmarks are key milestones for maintaining a functioning program infrastructure. Awardees will work with CDC annually to provide evidence of infrastructure components and context for tobacco control using the CDC defined reporting system.

Benchmarks for Core Component	Frequency of Reporting to CDC
Evidence state health officer and other senior state health department management involvement in the tobacco control program	Annually
Evidence of written success story	Annually
Evidence of an annual work plan that addresses 5-year outcome measures	Annually
Evidence of executed sustainability plan and activities	Annually
Evidence of an approved mass-reach health communications plan to educate leaders, decision-makers, and the public about the dangers of tobacco use, the dangers of exposure to SHS, and available cessation support and resources	Annually
Evidence that the state health department has dedicated human resources to administer and manage the tobacco control program effectively	Annually
Evidence of the provision of ongoing training for staff through participation in CDC sponsored training, meetings, conferences and other continuing education opportunities as identified by state health department program staff	Annually
Evidence that training and technical assistance needs have been assessed and provided by the program to state and local health department staff, coalition members, and partners statewide	Annually
Evidence of use of funding to support	Annually

environmental, policy, and systems interventions and strategies that are evidence-based and reach populations disproportionately affected by tobacco use, exposure to SHS and tobacco-related diseases	
Evidence of on-time submission of Federal Financial Reports	Annually
Evidence of increased community networks and community-based organizations and individuals who have been affected by tobacco use to educate the community's decision makers and leaders	Annually
Evidence of identifying and training tobacco control spokespersons for each Designated Market Area (DMA)	Annually
Evidence of participating in the CDC, OSH, NQDW (i.e., quarterly reporting of intake data on quitline callers and information on services provided through the NQDW Online Services Survey)	Annually
Evidence of monitoring the percentage of population covered by state and local comprehensive smoke-free indoor air laws covering worksites, bars and restaurants	Annually
Evidence of monitoring the percentage of public housing authorities with 100% smoke-free indoor air policies	Annually
Evidence of monitoring the percentage of public mental health and substance abuse facilities with tobacco-free policies for their campuses	Annually
Evidence of participation with CDC defined evaluation technical advisor and CDC evaluation team to conduct evaluation activities (i.e. awardee-level evaluation and national-level evaluation)	Annually
Evidence of a five-year, evidence-based and data-supported comprehensive state tobacco control plan	Year 1
Evidence of an evaluation report reflecting program infrastructure (as defined by the CMI), process measures, outputs, outcomes, and impacts	Year 3 and Year 5

The **Competitive Component** seeks to advance evidence-based tobacco control.

Awarded applicants will:

- Design, implement and rigorously evaluate innovative and/or promising practices in tobacco control.
- Collaborate with each other and CDC to maximize opportunities for coordination and leveraging resources to avoid duplication.
- Partner with organizations such as not-for-profit organizations, economists, business sector, governmental fiscal management offices, researchers, CDC funded National Networks for Tobacco Control and Prevention, other key organizations and law enforcement.

1. Collaborations

a. With CDC funded programs:

Required Collaborations: Awarded applicants are required to collaborate with CDC and relevant CDC funded programs. Partnerships include CDC funded programs within state health department chronic disease prevention and health promotion programs, CDC funded programs conducting tobacco control activities at the community level, and CDC funded surveillance programs responsible for collecting, analyzing, and disseminating risk factor and tobacco-related disease, death, and disability data. Working with partners includes building capacity through training, technical assistance and consultation, as well as collaboration on implementing evidence-based interventions and strategies. Collaborative activities under this FOA should align with state tobacco control priorities as described in the comprehensive state tobacco control plan and state chronic disease and health promotion plan, be consistent with CDC's [Best Practice - 2014](#) and the [Community Guide](#), and support the four NTCP goal areas.

Optional Collaborations: Awarded applicants may partner with other public health programs such as asthma, environmental health, HIV, TB, maternal and child health, and other related programs.

b. With organizations external to CDC:

Required Collaborations: Awarded applicants are required to collaborate with local health departments, organizations representing specific subgroups experiencing tobacco-related disparities within their respective populations, tribes and organizations that represent tribes, Tribal Support Centers, and members of the Funders Alliance for State-Based Tobacco Prevention and Control Programs within their state. Applicants must submit Letters of Support from specific tribes they plan on collaborating with.

Optional Collaborations: Awarded applicants may partner with state and local organizations, voluntary health organizations, educational institutions, multi-sector partners such as housing, business, and education, community-based organizations, other state agencies, statewide and local coalitions, and boards, commissions, and advisory groups who have a stake in tobacco control.

2. Target Populations:

Awarded applicants of the **Core Component** and the **Competitive Component** will address

populations disproportionately affected by tobacco use, exposure to SHS, and associated disease, disability, and death through the implementation of (1) State and community interventions, (2) Mass reach health communications, (3) Cessation interventions, (4) Surveillance and evaluation, and (5) Infrastructure, administration, and management. Additional guidance addressing tobacco-related disparities and health equity can be found in CDC's [Best Practices – 2014](#) and [A Practitioner's Guide for Advancing Health Equity – Community Strategies for Preventing Chronic Disease](#).

Inclusion:

Awarded applicants must be inclusive of specific populations that are disproportionately affected by tobacco use, exposure to SHS, and associated disease, disability, and death. Awarded applicants should be inclusive of populations experiencing tobacco-related disparities by age, disability/limitation, educational attainment, geographic location (e.g., rural/urban), income, mental health status, occupation, race/ethnicity, sex, sexual orientation and gender identity, substance abuse conditions, veteran and military status and other relevant dimensions (e.g., tribal communities) in all aspects of tobacco control.

b. Evaluation and Performance Measurement:

i. CDC Evaluation and Performance Measurement Strategy:

CDC will work with awarded applicants to accomplish two levels of evaluation, (1) awardee-level evaluation, and (2) national-level evaluation. Awardee-level evaluation will answer questions most important to each individual state health department tobacco control program, their context and need for information to inform program improvement and decision making. The national-level evaluation will serve to synthesize information across awardees, facilitate informing improvements, render judgments as well as generate knowledge depending on which purpose(s) are chosen to guide the evaluation plan development. CDC will include the evaluation professional networking group and feedback groups as appropriate when developing evaluation plans, tools, and technical assistance. CDC will provide technical assistance if requested for the development of required evaluation reports.

In addition, CDC will:

- Provide ongoing training, technical assistance and consultation on implementing evidence-based environmental, policy, and systems interventions and strategies for tobacco control
- Collaborate with selected sites, such as the National Networks for Tobacco Control and Prevention, on the evaluation of innovative strategies addressing populations disproportionately affected by tobacco use and SHS exposure
- Provide surveillance and evaluation technical assistance through a variety of mediums including phone, site visits, guidance tools, and webinar trainings
- Provide technical assistance if requested for the development of success stories and publish selected stories on the CDC/OSH website as appropriate
- Provide technical assistance if requested on the implementation of the YTS and ATS
- Provide technical assistance if requested with the submission of data to NQDW

- Use evaluation to inform technical assistance, best practices development, future FOAs, and peer reviewed publications
- Provide resources and technical assistance to develop and enhance monitoring and surveillance systems
- Provide guidance to states to identify indicators that can be used to monitor and evaluate state level tobacco control programs
- Collect and analyze data that can be used to monitor and evaluate tobacco control programs

Data collected by CDC will include but is not limited to documentation from regular phone consultations, technical assistance and site visits, as well as evidence provided by awardees in their annual and final performance reports, and 3rd year and final evaluation reports. Awarded applicants must provide the required information outlined in the CDC defined reporting system. Information collected will include progress related to outputs, outcomes, possible environmental impacts appropriate to grantee defined activities, and infrastructure necessary to a comprehensive tobacco control and prevention program as described in CDC's [Best Practices - 2014](#). Population outcomes should be reported in aggregate, for specific population groups, and include reach indicators (e.g., number of people who receive a program message or intervention). Additionally, the awardee must participate in the CDC, OSH, NQDW (i.e., quarterly reporting of intake data on quitline callers and information on services provided through the NQDW Online Services Survey). Participation may include the collection of data on new and emerging products such as electronic nicotine delivery systems such as e-cigarettes (e.g. current use, type of product used, frequency of use, and reasons for use) collaboratively developed with CDC. Awardees must participate with CDC defined evaluation technical advisor and CDC evaluation subject matter experts to conduct evaluation activities (e.g. awardee-level evaluation and national-level evaluation).

ii. Applicant Evaluation and Performance Measurement Strategy:

Awarded applicants of the **Core Component** and the **Competitive Component** should conduct evaluation activities consistent with [CDC's Framework for Evaluation](#). Awarded applicants will be expected to attend required CDC surveillance and evaluation meetings and participate on CDC technical assistance webinars, conference calls, and regional evaluation networks. Evaluation and performance measures will be coordinated with other awardees and CDC to ensure resources are leveraged across programs and common and consistent measures are used.

Core Component

Evaluation and Performance Measurement Plan: Applicants must submit an evaluation and performance measurement plan with their application. Data collected must be used for ongoing monitoring of the award to evaluate its effectiveness, and for continuous program improvement. Awarded applicants will work with CDC on developing a more detailed evaluation and performance measurement plan within the first year of the project. For additional assistance on developing the plan, please refer to [OSH's Developing an Effective](#)

Evaluation Plan.

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 other information, as determined by the CDC program (e.g., performance measures to be developed by the applicant) that must be included
- 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 findings will be disseminated to stakeholders

The performance measures (process and outcome) listed below relate to specific outcomes in the National State-Based Tobacco Control Program logic model (bolded text in logic model). Awardees will be required to collect and report performance measures annually for the **Core Component**. Awardees will collect and report: 1) performance measures identified below, 2) state-specific performance measures related to their own logic model outcomes and based on OSH's *Key Outcome Indicators*, and 3) reach indicators (e.g., number of people who receive a program message or intervention). Additionally, performance measures collected and monitored by CDC for the national-level evaluation and awardee-level evaluation are identified.

Performance Measures: Awardees will be required to collect and report annually on the following performance measures for the **Core Component** indicated as "Awardee" in the "Reporting Responsibility" column. The performance measures labeled as "CDC" in the "Reporting Responsibility" column will be collected and monitored by CDC using national data sources throughout the funding period. Indicators reported to CDC's State Tobacco Activities Tracking and Evaluation (STATE) System are indicated with "STATE" following the responsible party's name.

Best Practice Area	Relevant Logic Model Outcomes	Performance Measures (Data Source)	Reporting Responsibility
State and Community Interventions	<ul style="list-style-type: none"> • Increased implementation of evidence-based interventions and strategies that address vulnerable and underserved populations • Increased implementation & enforcement of interventions & strategies to support quitting, reduce exposures to SHS & decrease access & availability of tobacco products • Increased public compliance with tobacco control policies • Decreased susceptibility to experimentation with tobacco products • Decreased exposure to SHS • Decreased initiation of tobacco use among youth and young adults 	<ul style="list-style-type: none"> • Process: Proportion of interventions and strategies implemented by awardees to address disparate populations (Annual Progress Report) • Outcome: Proportion of public housing tenets that report exposure to secondhand smoke at home-(Annual Progress Report) • Outcome: Proportion of the population reporting exposure to secondhand smoke at workplace (TUS-CPS) • Outcome: Average age at which young people first smoked a whole cigarette (YRBSS) • Outcome: Proportion of young people who report never having tried a cigarette (YRBSS) 	<ul style="list-style-type: none"> • Awardee • Awardee • CDC: STATE • CDC • CDC
Mass-Reach Health Communication Interventions	<ul style="list-style-type: none"> • Increased public & decision-maker knowledge about the dangers of tobacco use, exposure to SHS, & tobacco-related disparities • Increased public & decision-maker awareness of effective tobacco control interventions, strategies, & social norm change • Increased health communication interventions & messages to reach 	<ul style="list-style-type: none"> • Process: Number of monthly speaking opportunities by trained tobacco control spokespersons to educate decision-makers, stakeholders, and public (Annual Progress Report) • Process: Number of paid and earned media efforts targeting populations or areas with high concentrations of smoking prevalence, secondhand smoke exposure, and chronic disease (Annual Progress 	<ul style="list-style-type: none"> • Awardee • Awardee

	populations disproportionately affected by tobacco use, exposure to SHS, & tobacco-related disparities	Report) <ul style="list-style-type: none"> • Process: Types of social media activities used to complement traditional paid and earned media efforts (e.g., social media campaign, posting content) and the reach of social media activities by social media site used (e.g., Facebook, Twitter, YouTube) (Annual Progress Report) 	<ul style="list-style-type: none"> • Awardee
Cessation Interventions	<ul style="list-style-type: none"> • Increased implementation & enforcement of interventions & strategies to support quitting, reduce exposures to SHS & decrease access & availability of tobacco products • Increased quit attempts among current tobacco users Decreased tobacco use among adults and youth 	<ul style="list-style-type: none"> • Outcome: Total quitline call volume by quarter (NQDW) • Outcome: Total number of quitline tobacco users who receive a service (NQDW) • Outcome: Quitline reach to persons with low education levels (NQDW) • Outcome: Proportion of adult smokers who have made a quit attempt (BRFSS) • Outcome: Proportion of young smokers who have made a quit attempt (YRBSS) 	<ul style="list-style-type: none"> • Awardee: STATE • Awardee: STATE • CDC: STATE • CDC: STATE • CDC: STATE
Surveillance and Evaluation	<ul style="list-style-type: none"> • Increased capacity to collect, analyze, and disseminate data related to tobacco-related disparities & health equity 	<ul style="list-style-type: none"> • Process: Number and type of tobacco-related surveys implemented during the funding year (e.g., ATS, YTS), and type of tobacco-related modules implemented (e.g., BRFSS, YRBSS) (Annual Progress Report) • Process: Number and type of tobacco-related indicators developed and implemented in state surveillance systems 	<ul style="list-style-type: none"> • Awardee • Awardee

		during the funding year (e.g., ATS, YTS, BRFSS, YRBSS) (Annual Progress Report)	
Infrastructure, Administration, and Management	<ul style="list-style-type: none"> Increased or maintained state health department infrastructure & capacity to support a state-based tobacco control program 	<ul style="list-style-type: none"> Process: Percentage of funding (state, CDC, and other) used to meet CDC-recommended funding levels outlined in Best Practices - 2014 (Annual Progress Report) Process: Number and type of staff positions maintained throughout the entire funding year to support the tobacco control program (e.g., program director, policy coordinator, communications specialist, cessation coordinator, surveillance and evaluation staff, fiscal management systems staff, and administrative staff) (Annual Progress Report) Process: Levels of infrastructure increased or maintained as defined by the Component Model of Infrastructure included in Best Practices - 2014 (Annual Progress Report) 	<ul style="list-style-type: none"> Awardee Awardee Awardee
<p>ANRF=American Nonsmokers' Rights Foundation policy tracking system BRFSS=Behavioral Risk Factor Surveillance System NHIS=National Health Interview Survey TUS-CPS=Tobacco Use Supplement to the Current Population Survey YRBSS=Youth Risk Behavior Surveillance System</p>			

Competitive Component

During the 2-year project period, awarded applicants are expected to demonstrate progress toward the outcomes depicted on the logic model. **Competitive Component** awardees must include a detailed evaluation and performance measurement plan for the complete 2-year project period. In addition to the requirements described in the CDC Evaluation and Performance Measurement Strategy, **Competitive Component** awardees will:

- Collaborate with CDC on in-depth evaluation of implemented strategies including process and outcome evaluation.
- Collaborate with CDC to evaluate infrastructure in relation to progress on outcomes.
- Collaborate with CDC to contribute to building the evidence-base through publication of findings via success stories, peer-reviewed publications, conference proceedings, webinars and other key activities.
- Collaborate with CDC to evaluate the innovative and/or promising practices for national impact in addition to state impact.
- Participate in all national evaluation activities, including participation in case study evaluation if selected or collaborative evaluation projects leading to publication of findings.
- Submit description of progress on performance measures in annual progress reports as outlined in the performance measure requirements section.
- Attend CDC surveillance and evaluation meetings and participate in CDC technical assistance webinars, conference calls, and regional evaluation networks.

The following key elements should be addressed in the **Competitive Component** evaluation plans:

- Description of the type of evaluations to be conducted during the project period (i.e., process and/or outcome).
- Description of the key evaluation questions to be answered, potential available data sources, and feasibility of collecting available data.
- Description of how evaluation and performance measures are linked to the FOA program strategy and project period outcomes.
- Description of how evaluation and performance measurement will track how subpopulations are impacted by program strategies and the effectiveness of evidence-based interventions and strategies when implemented in different settings and contexts.
- Description of how evaluation findings and performance measures will be used for continuous program/quality improvement.
- Description of how evaluation and performance measures will yield findings to demonstrate the value of the FOA (e.g., impact on improving public health outcomes,

effectiveness of FOA, cost-effectiveness or cost benefit).

- Description of dissemination channels and audiences for evaluation results and performance measures (including public dissemination).

c. Organizational Capacity of Awardees to Execute the Approach:

Organizational capacity is required to execute each component of the FOA and ensures applicants have the ability to execute CDC program strategies and meet periodic outcomes.

Core Component: Applicants must have sufficient organizational capacity to carry out the evidence-based strategies and activities outlined in this FOA. Specifically, applicants should have:

- Adequate program management and staffing with sufficient workforce capacity and competence to ensure program success
- Capacity to implement evidence-based strategies and activities related to tobacco prevention and control including capacity to address populations disproportionately affected by tobacco use and SHS exposure
- Capacity to conduct surveillance, epidemiology, and evaluation activities
- Capacity to develop diverse partnerships, engage and mobilize communities, and build coalitions
- Capacity to identify populations disproportionately affected by tobacco, SHS exposure, and associated disease, disability, and death using data and implementing evidence-based interventions and strategies in conjunction with key partners to reduce health disparities and improve health equity at the state and community level
- Capacity to convene diverse groups of partners and stakeholders to promote use and implementation of evidence-based environmental, policy, and systems approaches to address tobacco use, SHS exposure, and tobacco-related disparities
- Capacity to engage the public and decision-makers about the dangers of tobacco use, SHS exposure, tobacco-related disparities and associated disease, disability, and death and the most effective evidence-based interventions and strategies to address the tobacco problem
- Ability to coordinate and collaborate with state health department chronic disease prevention and health promotion programs and external partners to leverage limited resources and maximize reach and impact
- Adequate travel and financial management procedures and full capacity to manage contracting and procurements efforts
- Ability to attend CDC sponsored trainings, meetings and events and other training opportunities recommended by CDC

Competitive Component: In addition to the organizational capacity described in the **Core Component**, **Competitive Component** applicants must have state health department capacity for implementing its proposal and for conducting evaluation for the 2-year project period and

meet the criteria on page 11.

d. Work Plan:

Applicants will develop a detailed work plan for Year 1 of the award that also encompasses a high level plan for Years 2 - 5 and submit this with the application. CDC will provide feedback and technical assistance to awarded applicants to finalize the work plan post-award. A sample work plan template is available for use at http://www.cdc.gov/tobacco/osh/foa/state_based/. Applicants are not required to use the work plan template, but are required to include all of the elements listed within the template.

Core Component: Applicants must submit a detailed work plan for Year 1 that at a minimum includes: (1) evidence-based strategies and activities to support achievement of FOA outcomes (strategies and activities must be in alignment with the FOA logic model and should have appropriate performance measures); (2) staff roles and responsibilities to support implementation of recipient activities, and (3) project monitoring and evaluation processes to ensure successful implementation.

Competitive Component: Applicants must submit a detailed workplan for the two-year project period that includes (1) innovative and/or promising practices to support achievement of FOA outcomes; (2) staff roles and responsibilities to support implementation of recipient activities, and (3) project monitoring and rigorous evaluation processes to ensure successful implementation.

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). Consistent with applicable grants regulations and policies, CDC expects the following to be included in post-award monitoring for grants and cooperative agreements:

- Tracking awardee progress in achieving the desired outcomes.
- Ensuring 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 outcomes within stated timeframes.
- Working with awardees on adjusting the work plan based on achievement of outcomes, evaluation results, 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 activities may include monitoring and reporting activities that assist 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:

CDC will also provide the following program support:

- Provide ongoing training, technical assistance and consultation on environmental, policy, and systems interventions and strategies for tobacco control.
- Provide up-to-date information that includes dissemination of best practices for tobacco prevention and control.
- Inform and educate grantees and other partners about evidence-based environmental, policy, and systems interventions and strategies for tobacco control through workshops, conferences, training, electronic and verbal communication.
- Identify, develop, and disseminate media campaign materials for use by programs; facilitate coordination of counter advertising materials between programs; provide technical assistance on design, implementation, and evaluation of media.
- Maintain electronic mechanisms for information sharing, program planning, and progress reporting.
- Develop and maintain partnerships with Federal and non-Federal organizations to assist in tobacco control and maintain a national infrastructure to complement state infrastructure.
- Serve as a resource to states with regard to identifying and eliminating tobacco-related disparities among population groups.
- Maintain a Web site with access to a data warehouse that contains comparable measures of tobacco use prevention and control from different data sources.
- Help identify gaps in the evidence-base of tobacco control and prioritize efforts to fill those gaps; provide training and technical assistance on publications and opportunities for dissemination of program evaluation findings.
- Serve as a convener and resource for the continued expansion of the evidence - base of tobacco control.

B. Award Information
<p>1. Type of Award: Cooperative Agreement CDC's substantial involvement in this program appears in the CDC Program Support to Awardees section.</p>
<p>2. Award Mechanism: Activity Code U58 NCCDPHP</p>
<p>3. Fiscal Year: 2015</p>
<p>4. Approximate Total Fiscal Year Funding: <u>Core Component:</u> \$58 million <u>Competitive Component:</u> \$3 million</p>
<p>Approximate Total Project Period Funding: \$305 million for 5 years, subject to availability of funding, including direct and/or indirect costs.</p>
<p>5. Total Project Period Length: <u>Core Component:</u> 5 year project period <u>Competitive Component:</u> Two, 2-year project periods</p> <p>Throughout the project period, CDC's commitment to continuation of awards will be conditioned on the availability of funds, evidence of satisfactory progress by awardees (as documented in required reports, site visits, ongoing communication with the Project Officer, and spending patterns), and the determination that continued funding is in the best interest of the Federal government. This does not constitute a commitment by the Federal government to fund the entire project period.</p>
<p>6. Approximate Number of Awards: <u>Core Component:</u> 51 <u>Competitive Component:</u> 4 - 7</p>
<p>7. Approximate Average Award: <u>Core Component:</u> \$1 million <u>Competitive Component:</u> \$500,000</p>
<p>8. Floor of Individual Award Range: <u>Core Component:</u> \$500,000 <u>Competitive Component:</u> \$250,000</p>
<p>9. Ceiling of Individual Award Range: <u>Core Component:</u> \$2.3 million <u>Competitive Component:</u> \$750,000</p>
<p>10. Anticipated Award Date: March 30, 2015</p>
<p>11. Budget Period Length: 12-months. 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</p>

competitive segment and any subsequent non-competitive continuation award(s).

12. Direct Assistance: Direct Assistance is available through this FOA. An official state, tribal nation, local or territorial government applicant may request that CDC provide Direct Assistance in the form of federal personnel as a part of the grant awarded through this FOA. If your request for Direct Assistance is approved as a part of your award, CDC will reduce the funding amount provided directly to you as a part of your award. The amount by which your award is reduced will be used to provide Direct Assistance; the funding shall be deemed part of the award and as having been paid to you, the awardee.

C. Eligibility Information

1. Eligible Applicants: State and District of Columbia health departments or their Bona Fide Agents². Bona Fide Agents must submit documentation of their status with their application via grants.gov (NOTE: The Commonwealth of Puerto Rico, Virgin Islands, Commonwealth of the Northern Mariana Islands, American Samoa, Guam, Federated States of Micronesia, Republic of the Marshall Islands, and Republic of Palau are funded under another FOA, CDC-RFA-DP14-1406).

2. Special Eligibility Requirements: Not applicable.

3. Justification for Less than Maximum Competition:

State health departments are uniquely positioned to carry out the activities outlined in this FOA. State health departments serve as the governmental lead for tobacco control in every state. State health departments are essential for coordinating the public health response to prevent tobacco use, protect the public from SHS exposure, and reduce tobacco-related disparities and associated disease, disability, and death. They have experience with implementing evidence-based environmental, policy, and systems interventions and strategies that have the potential to reach large numbers of people in the state. State health departments also have experience working with an array of state and local governmental and non-governmental organizations to leverage resources that can support tobacco control efforts across a number of categorical programs and sectors. State health departments have existing personnel who are able to provide training and technical assistance based on their area of expertise (e.g., evidence-based interventions and strategies, public health program planning, implementation, and evaluation, health communication, surveillance, epidemiology, and partnership development) which conserves valuable resources. This infrastructure and capacity can be integrated and employed by state health departments to: (1) leverage partnerships to support the implementation of evidence-based environmental, policy, and systems interventions and strategies to prevent and control tobacco use, SHS exposure and tobacco-related disparities at the state and community level; (2) implement program and policy

² A Bona Fide Agent is an agency/organization identified by the state as eligible to submit an application under the state eligibility in lieu of a state application. If applying as a bona fide agent of a state or local government, a legal, binding agreement from the state or local government as documentation of the status is required.

strategies across multiple chronic diseases and conditions 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, heart disease and stroke); (3) utilize the public health resources and capacity unique to state health departments to achieve a comprehensive state based tobacco control program; (4) develop models to effectively coordinate and collaborate with other state health department chronic disease programs affecting similar populations; (5) collect state-wide data related to tobacco use, SHS exposure, and tobacco-related disparities and associated disease, disability, and death, and the populations most affected through surveillance systems that are uniquely available to state health departments.

4. Cost Sharing or Matching:

Cost sharing is encouraged if it helps to leverage federal and state resources, is responsive to stated CDC recipient activities, is advantageous to chronic disease prevention and health promotion programs, supports the four NTCP goals, focuses on evidence-based interventions outlined in CDC's [Best Practices - 2014](#) and the [Community Guide](#), and does not compromise the integrity or the ability of the tobacco control program to accomplish proposed activities. Matching funds are not required under this cooperative agreement, but is 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.

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

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

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

- b. System for Award Management (SAM):** The SAM is the primary registrant database for the federal government and the repository into which an entity must submit information required to conduct business as an awardee. All applicant organizations must register with SAM, and will be assigned a SAM number. All information relevant to the SAM number must be current at all times during which the applicant

has an application under consideration for funding by CDC. If an award is made, the SAM information must be maintained until a final financial report is submitted or the final payment is received, whichever is later. The SAM registration process usually requires not more than five business days, and registration must be renewed annually. Additional information about registration procedures may be found at www.SAM.gov.

- c. **Grants.gov:** The first step in submitting an application online is registering your organization at www.grants.gov, the official HHS E-grant Web site. Registration information is located at the “Get Registered” option at www.grants.gov. All applicant organizations must register at www.grants.gov. The one-time registration process usually takes not more than five days to complete. Applicants must start the registration process as early as possible.

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

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

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

a. **Letter of Intent Deadline:** A letter of Intent is encouraged, but not required for those applying for the **Competitive Component**. If a Letter of Intent is submitted, it must be emailed or postmarked by: **Monday, September 29, 2014, 11:59 p.m. U.S. Eastern Standard Time**

b. **Application Deadline: Monday, December 1, 2014, 11:59 p.m. U.S. Eastern Standard Time**, at www.grants.gov

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

Applicants may follow either of the following processes:

- Complete the applicable assurances and certifications, name the file “Assurances and Certifications” and upload it as a PDF file at www.grants.gov
- Complete the applicable assurances and certifications and submit them directly

to CDC on an annual basis at
<http://wwwn.cdc.gov/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.

7. Letter of Intent (LOI):

A LOI is not required, but encouraged for **Competitive Component** applications only.

The Letter of Intent should include the following:

- 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

If a Letter of Intent is submitted, it must be emailed or postmarked by **Monday, September 29, 2014, 11:59 p.m. U.S. Eastern Standard Time**

LOIs may be sent via email, U.S. express mail or delivery service to:

Christopher J. Kissler, MPH, Project Officer, DP15-1509
Department of Health and Human Services
Centers for Disease Control and Prevention
4770 Buford Highway, MS F79
Atlanta, Georgia 30341
Telephone: 770-488-5374
Email: cpk2@cdc.gov

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

9. Project Abstract Summary: One page maximum

A project abstract is included on the mandatory documents list and must be submitted at www.grants.gov. The project abstract must be a self-contained, brief summary of the proposed project including the purpose and outcomes. **Those applying for both Components should clearly indicate the summary for the Core Component and the summary for the Competitive Component.** This summary must not include any proprietary or confidential information. Applicants must enter the summary in the “Project Abstract Summary” text box at

www.grants.gov.

10. Project Narrative: The maximum number of pages for the Project Narrative is 30 (25 pages for the **Core Component** and 5 pages for the **Competitive Component**).

In addition:

- Text should be single spaced
- Font should be Calibri 12 point
- Use 1-inch margins
- Number all pages

The Project Narrative must include all the following headings:

- Background
- Approach (includes Problem Statement, Purpose, Outcomes, Strategies and Activities)
- Collaborations
- Target Populations (includes Inclusion)
- Applicant Evaluation and Performance Measurement Plan
- Organizational Capacity of Applicants to Implement the Approach (includes Fiscal Capacity)

The Project Narrative must be succinct, self-explanatory, and in the order outlined in this section. It must address outcomes and activities to be conducted over the entire project period as identified in the CDC Project Description section. Applicants must submit a Project Narrative with the application forms. Applicants must name this file “Project Narrative” and upload it at www.grants.gov.

Project Narrative Outline for Core Component

A. Background-Core Component

Applicants must provide a description of relevant background information that includes the context of the problem. Describe how the FOA will address the tobacco control problem, support tobacco control priorities, and the context in which your program operates.

Information and data requested below to support the Background section can be submitted as an additional attachment so that it doesn't count against the maximum 25 page limit for the **Core Component** Project Narrative. Name the file “Background Information/Data for Core Component” and upload it as a PDF file under “Other Attachment Forms” at www.grants.gov.

A table format is suggested for this information, but is not required:

- Provide the current percentage of the population of adults and young people who smoke.
- Provide the percentage of the population (and calculated number of individuals) below the Federal poverty level. Include the percentage of the adult population (and calculated number of individuals) without a high school diploma or GED.
- Provide data for any racial, ethnic or other sub-population groups with higher rates of smoking, tobacco use, or SHS exposure.

Include the following information when describing state context:

- Number of local smokefree air laws that include workplaces, bars and restaurants
- Provide the total population reach for all ages
(<http://factfinder2.census.gov/faces/nav/jsf/pages/index.xhtml>).
- Number of state and local smokefree/tobacco free primary/secondary public school policies. Provide the total population reach for students enrolled in state public schools grades K-12 for students enrolled in state public schools grades K-12
- Number and name of smokefree/tobacco free public colleges, universities and post-secondary technical schools. Provide the total enrolled students and total number of faculty/staff/employees for each institution.
- Number and name of Public Housing Authorities with smoke/tobacco free policies. Provide the total population reach
(http://portal.hud.gov/hudportal/HUD?src=/program_offices/public_indian_housing/sytems/pic/50058/rcr)
- Number of state or local smoke/tobacco-free policies that include electronic nicotine delivery systems such as e-cigarettes.
- Number of state or local laws increasing the age of sale to minors above age 18

Provide information related to total population, smoking prevalence, and number of individuals who smoke. A table format is encouraged, but is not required.

	Total Population	Smoking Prevalence	Calculated Number of Individuals who Smoke
Adults 18+ Years or Older			
Young Adults 18 – 24 Years			
Adults with Income Below Federal Poverty Level			
Adults who are Medicaid Enrollees			
Adults with Less than a High School Education			
Add rows (as needed) to describe additional populations targeted in the workplan			

B. Approach - Core Component

i. Purpose: Applicants must describe in 2-3 sentences specifically how their application will address the problem as described on page 9.

ii. 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.

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 on page 7.)

iv. Strategy and Activities: Applicants must provide a clear and concise description of the strategies and activities they will use to achieve the project period outcomes. Applicants should use evidence-based program strategies as identified by the CDC's [Best Practices – 2014](#) or [Community Guide](#) and reference it explicitly as a source. Applicants may propose additional strategies and activities to achieve the outcomes. Applicants must select existing evidence-based strategies that meet their needs.

Collaborations: Applicants must describe how they will collaborate with programs and organizations either internal or external to CDC. Applicants are expected to collaborate with state and local coalitions and internal and external partners in order to implement evidence-based interventions and strategies to reduce tobacco use, SHS exposure, tobacco-related disparities, and associated disease, disability, and death. Applicants must describe how they will collaborate with:

- CDC funded chronic disease prevention and health promotion programs at the state and local level
- State tobacco coalition
- Local communities and/or local coalitions
- Partners and organizations representative of low socioeconomic populations or with a mission to serve low socioeconomic populations
- Partners and organizations representative of target populations identified for this project period
- State or local organizations with dedicated tobacco control funding that is not federal funding
- Local housing authorities
- Local education authorities
- Private/business, economic sectors (Chambers of Commerce), economic development boards and other business organizations
- Media partners
- Community-based organizations serving individuals disproportionately affected by tobacco use, SHS exposure, and associated disease, disability and death

Applicants must describe how they will collaborate with CDC funded programs as well as with

organizations external of CDC. At a minimum, applicants are encouraged to provide Letters of Support (LOS) from:

- Chronic disease prevention and health promotion program director in state health department
- State tobacco control coalition (or other representative body)
- One local tobacco control coalition
- One low socioeconomic partner organization
- One partner organization addressing tobacco-related disparities and health equity
- If applicable, tobacco control partner member of the Funders' Alliance

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

Target Populations: Applicants must describe the specific target population(s) in their jurisdiction. Applicants should summarize their top three accomplishments since 2009 to reduce tobacco-related disparities and promote health equity. Applicants should describe how they will use data to identify populations disproportionately affected by tobacco use, SHS exposure, and associated disease, disability, and death at the state and local level. Applicants must identify populations that they plan to work with to address tobacco related disparities. For each population, provide background on the disparity and the approach for working with this population over the next 5 years. Tobacco-related disparities by race, ethnicity, sex, age, sexual orientation, gender identity, education level, occupation, income, geographic location, mental health status, substance use, and other relevant dimensions (e.g., tribal communities) should be considered. States with American Indian/Alaska Native populations above the US average (2.0%) should list the major federally recognized tribes in the state. States with more than two-percent of American Indian/Alaskan Native populations must include a description of past efforts since 2009 working with these populations. Applicants must describe how they are working with any CDC funded Tribal Support Centers located in the state. Applicants must submit Letters of Support from specific tribes they plan on collaborating with. Applicants must describe how they will address low socioeconomic populations in addition to other target populations selected. Applicants must list current partners and organizations they are working with that are representative of low socioeconomic populations. This should include providing documentation of current partners to reach low socioeconomic populations, current and planned work with Medicaid, Federally Qualified Health Centers and other state-funded and not-for-profit health centers to reach low socioeconomic populations and additional organizations and partners planned for recruitment. Applicants must indicate how they will address tobacco-related disparities among mentally ill and substance abusing populations.

Inclusion: Applicants must address how they will include target populations who can benefit from the program. Applicants should describe how they will be inclusive of populations disproportionately affected by tobacco use, SHS exposure, and associated disease, death, and

disability through (1) representation on state and local coalitions, (2) fostering specific partnerships, (3) inclusion of evidence-based interventions and strategies addressing tobacco-related disparities and health equity in long-range plans as well as annual work plans, and (4) other relevant work plan activities and actions.

Applicant Evaluation and Performance Measurement Plan – Core Component

Evaluation and Performance Measurement Plan: Applicants must provide an overall 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. Awarded applicants will be required to submit a more detailed evaluation and performance measurement plan within the first year of the project, as outlined in the reporting section of the FOA. This more detailed evaluation and performance measurement plan should be developed by awarded applicants with support from CDC as part of first year project activities. This more detailed evaluation and performance measurement plan will build on the elements stated in the initial plan.

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 how they will answer key performance measures as outlined in the evaluation and performance measurement strategy section
- Describe other information, as determined by the CDC program (e.g., performance measures to be developed by the applicant) that must be included
- 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

Organizational Capacity of Applicants to Implement the Approach – Core Component

Organizational Capacity Statement: The applicants' organizational capacity statement should describe how the state health department is organized, the nature and scope of its work and/or the capabilities it possesses. Applicants should include a detailed description of their experience, program management components, readiness to establish contracts in a timely manner, and a plan for long-term sustainability of the project. Applicants should describe how contractors/consultants/coalitions/partners will contribute to achieving the project's outcomes. Information should be included about any organizations(s) that will have a significant role(s) in implementing specific strategies and achieving specific project outcomes

for this project period. This section should describe the day-to-day management plan for the tobacco control program and explain roles and responsibilities for key tasks such as program leadership, monitoring the program's progress, report preparation, program evaluation, training and technical assistance for both staff and internal and external partners, media and communication. Applicants must describe how the state health department is organized to accomplish tobacco control work. In this section please describe state health department internal programs that currently partner with the tobacco control program and their role. In addition, describe state health department internal programs that will be targeted for partnership during the project period. Applicants should include (1) an organizational chart(s) showing where the tobacco control program is located in the state health department, (2) an organizational chart for the state tobacco control coalition. Name this file "Organizational Charts" and upload to www.grants.gov. Applicants should explain the following: (1) process for communicating tobacco control issues with the state health official and senior leadership; (2) process for collaborating with the chronic disease prevention and health promotion program; (3) how the state tobacco control program works with the state comprehensive cancer coalition; and (4) how the state tobacco control program is collaborating with other CDC funded chronic disease prevention and health promotion awardees (if appropriate) including a brief description of tobacco control activities being implemented. Applicant should include CVs/Resumes for staff and name the file "CVs/Resumes" and upload to www.grants.gov.

Fiscal Capacity: Applicants must describe how the fiscal management system works in conjunction with the tobacco control program. This should include fiscal management to accomplish timely and accurate Federal Financial Reports and contracting. Applicants must provide a description of and timelines for the state's contracting processes. Describe the tobacco control program's mechanism for meeting with the fiscal department to obtain updates on federal funding expenditures. Applicants must provide a history of funding for tobacco control for the past 5 years including the following: (1) Federal Funding: DP09-901 amount awarded annually and amount drawn down for years 1-5; (2) State Funding: State funding appropriated and received for the tobacco control program for the past 5 years. If the state experienced a trend of unobligated federal dollars, please provide an analysis and the corrective steps that were taken by the applicant.

Project Narrative Outline for Competitive Component

A. Background - Competitive Component

The applicants must describe the emerging area of tobacco control to be addressed, the innovative and/or promising practice to be implemented and evaluated, and how the award would complement the **Core Component**.

B. Approach – Competitive Component

i. Purpose: Applicants must describe in 2-3 sentences specifically how their application to implement and evaluate promising and innovative strategies will address the problem as described on page 9.

ii. Problem Statement: Applicants must describe how they will address the problem statement through implementation and rigorous evaluation of innovative and/or promising practices to further the advancement of the tobacco control evidence-base. Include a statement on how this advancement would benefit the entire NTCP.

iii. Outcomes: Applicants must clearly identify the outcomes they expect to achieve by the end of the 2-year 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).

iv. Strategy and activities: Applicants must clearly describe the program strategy with detailed information on their ability to conduct a rigorous evaluation for the 2-year project period. Applicants should describe the rationale for developing and evaluating innovative and/or promising practices in tobacco control.

Collaborations: Applicants must describe how they will collaborate with internal and external partners on implementing innovative and/or promising practices and evaluation methods.

Target Populations: Applicants must describe the specific population their innovative and/or promising practice is addressing.

Inclusion: Applicants should describe how they will be inclusive of populations disproportionately affected by tobacco use, SHS exposure, and associated disease, death, and disability.

Applicant Evaluation and Performance Measurement Plan – Competitive Component: The applicant must describe their published program evaluation results during the past cooperative agreement period; describe capacity to conduct tobacco control surveillance and program evaluation; describe how they plan to work with key organizations to implement and rigorously evaluate innovative and promising practices and collaborate with CDC to contribute to building the evidence-base through publication of findings via success stories, peer-reviewed publications, conference proceedings, and webinars. 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.

Organizational Capacity of Applicants to Implement the Approach – Competitive Component

Organizational Capacity Statement: Applicants must explain state health department capacity for conducting rigorous evaluation over the 2-year project period.

11. Work Plan:

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

available at http://www.cdc.gov/tobacco/osh/foa/state_based/.

Competitive Component: Applicants are required to provide a workplan consisting of 2-year project period outcomes, strategies, and activities, evaluation and performance measurement, including key milestones.

Applicants must name this file “Work Plan(s)” and upload it as a PDF file at www.grants.gov.

12. Budget Narrative:

Core Component: Applicants must submit an itemized budget narrative. 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

Attending required trainings and conferences is critical for building and maintaining the skills of the staff with responsibility for carrying out the program requirements of this FOA. OSH requires attendance at specific trainings and conferences as a term and condition of this award.

Applicants should budget to attend the following meetings:

- Three persons to attend 3-day DP15-1509 Awardee Meeting in Atlanta, GA
- Three persons to attend 3-day National Tobacco Control meeting in Atlanta, GA

Specific meeting dates and guidance related to travel will be provided at a later date.

Competitive Component: Applicants applying for the **Competitive Component** must submit a separate itemized budget narrative.

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

Applicants must name this file “Budget Narrative” and upload it as a PDF file at www.grants.gov. If requesting indirect costs in the budget, a copy of the indirect cost-rate agreement is required. If the indirect cost rate is a provisional rate, the agreement must have

been made less than 12 months earlier. Applicants must name this file “Indirect Cost Rate” and upload it at www.grants.gov.

13. Tobacco and Nutrition Policies:

Awardees are encouraged to implement tobacco and nutrition policies.

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

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

Tobacco Policies:

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

Nutrition Policies:

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

14. Health Insurance Marketplaces:

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

15. Intergovernmental Review:

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_spoc/.

16. Funding Restrictions:

Restrictions that must be considered while planning programs and developing budgets under cooperative agreement DP15-1509 are:

- Awardees may not use funds for research
- Awardees may not use funds for clinical care
- Awardees may not use funds to supplant existing state funding or to supplant funds from federal or state sources
- Awardees may use funds only for reasonable program purposes, including personnel, travel, supplies, and services
- Awardees are the direct and primary recipients in a cooperative agreement program and 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
- Awardees are generally not allowed to use funds to purchase furniture or equipment. Any such proposed spending must be clearly identified in the budget
- Awardees may not be reimbursed pre-award costs
- Awardees may only use funds for evidence-based tobacco control interventions, strategies, and activities
- Awardees may not use funds to provide direct cessation services or other direct services other than those through evidence-based quitline services
- Awardees may not use funds to purchase nicotine replacement therapy or other products used for cessation
- Awardees may not use funds to purchase K-12 school curriculum
- Awardees 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

In addition, other than for normal and recognized executive-legislative relationships, no funds may be used for: (1) 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; (2) 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. NOTE: See [Additional Requirement \(AR\) 12](#) for detailed guidance on this prohibition and [additional guidance on lobbying for CDC awardees](#).

17. Other Submission Requirements:

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

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

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

- b. Tracking Number:** Applications submitted through www.grants.gov are time/date stamped electronically and assigned a tracking number. The applicant’s Authorized Organization Representative (AOR) will be sent an e-mail notice of receipt when www.grants.gov receives the application. The tracking number documents that the application has been submitted and initiates the required electronic validation process before the application is made available to CDC.
- c. Validation Process:** Application submission is not concluded until the validation process is completed successfully. After the application package is submitted, the applicant will receive a “submission receipt” e-mail generated by www.grants.gov. A second e-mail message to applicants will then be generated by www.grants.gov that will either validate or reject the submitted application package. This validation process may take as long as two business days. Applicants are strongly encouraged to check the status of their application to ensure that submission of their package has been completed and no submission

errors have occurred. Applicants also are strongly encouraged to allocate ample time for filing to guarantee that their application can be submitted and validated by the deadline published in the FOA. Non-validated applications will not be accepted after the published application deadline date. If you do not receive a “validation” e-mail within two business days of application submission, please contact www.grants.gov. For instructions on how to track your application, refer to the e-mail message generated at the time of application submission or the Application User Guide, Version 3.0, page 57.

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

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

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

E. Application Review Information

1. Review and Selection Process: Applications will be reviewed in three phases.

a. Phase I Review:

All applications will be reviewed initially for completeness by CDC PGO staff and will be reviewed jointly for eligibility by the CDC NCCDPHP 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, eligible applications in accordance with the “Criteria” section of the FOA. 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.

Core Component – Comprehensive State-Based Tobacco Control Programs = 100 Total Points

Approach: [50 points]

Applicants will be scored on the extent to which the problem of tobacco use, SHS exposure, and tobacco related diseases within the state by population group is described, the evidence-based interventions and strategies that will be implemented to address the problem, how equity will be achieved to reduce tobacco-related disparities, active partner collaboration, coordination and involvement in tobacco control. Applicants will be scored on the following elements of their project narrative and workplan:

I. State and Community Interventions

- **Statewide Programs:** The extent to which the applicant describes what efforts will be undertaken to develop and maintain statewide and local active partnerships for the purpose of achieving the four NTCP goals. **[5 points]**
- **Community Programs:** The extent to which the applicant describes how they will administer, monitor, and evaluate organizations and activities funded through contracts or grants and how the applicant will ensure that CDC recommended evidence-base interventions and strategies are implemented. **[5 points]**

II. Mass-Reach Health Communication Interventions: The extent to which the applicant describes how they will implement and evaluate health communication interventions; how they plan to leverage CDC National Educational Campaigns, SGR, and other scientific reports and use counter-marketing. **[5 points]**

III. Cessation Interventions: The extent to which the applicant describes how they will maintain a tobacco quitline and work with partners to increase access to evidence-based tobacco cessation treatments; how they will increase public support/awareness of tobacco cessation modalities and medications; and how they will increase health care system changes to promote and support cessation. **[5 points]**

IV. Surveillance and Evaluation: The extent to which the applicant describes the data collected and which survey instruments will be used; how the data will be analyzed and how they will be used to evaluate program impact and promote policy changes; what types of reports will be developed using the data collected and how these data will be disseminated and to what audiences; how the data collected will be used to identify trends in specific populations, including disparities that exist within these populations. **[5 points]**

V. Infrastructure, Administration, and Management

- **Networked Partnerships** - the extent to which the applicant describes how they will collaborate with CDC, relevant CDC funded programs, and external organizations necessary to execute the proposed work plan. **[5 points]**
- **Multi-level Leadership** – the extent to which the applicant describes how they will identify and nurture leaders and champions at all levels. **[5 points]**
- **Engaged Data** – the extent to which the applicant describes how they will use data to engage staff, partners, decision makers, and local programs to act and to promote public health goals. **[5 points]**
- **Managed Resources** – the extent to which the applicant describes what staff will be hired to carry out the project activities, including a description of tasks or roles, required experience, and time commitment for each of the project staff and the capacity to manage funds effectively. **[5 points]**
- **Responsive Plan/Planning** – the extent to which the applicant describes how the comprehensive state tobacco control plan, sustainability plan, and health communication plan will be developed or revised in partnership with a diverse group of stakeholders. **[5 points]**

Evaluation and Performance Measurement [30 Points]

Applicants will be scored on the extent to which the applicants evaluation and performance measurement plan addresses:

- Description of how key program partners are engaged in the evaluation and performance measurement planning processes and how the program engages partners and stakeholder using evaluation information. **[5 points]**
- Description of key evaluation questions. **[5 points]**
- Description of the type of evaluations conducted (i.e. process and/or outcome) and how performance measures are addressed, evaluated, and reported. **[5 points]**
- Description of available data sources and feasibility of collecting appropriate evaluation and performance data. **[5 points]**
- Description of how evaluation findings are used for continuous program and quality improvement. **[5 points]**
- Description of how the program plans to provide evidence for progress on the performance measures outlined in the evaluation and performance measurement strategy section. **[5 points]**

Organizational Capacity to Execute the Approach [20 points]

Applicants will be scored on the extent to which the applicant demonstrates adequate infrastructure and capacity to implement a comprehensive state based tobacco control program to achieve the outcomes of the FOA:

- The extent to which the applicant describes existing, active, multi-sector partnerships

with demonstrated success implementing evidence-based tobacco control interventions and strategies. **[5 points]**

- The extent to which the applicant indicates they have the appropriate and trained staff; describes clearly defined roles for staff; demonstrates sufficient programmatic capacity to accomplish program goals. **[5 points]**
- The extent to which the applicant describes their communication system and how internal and external information exchange activities are conducted and who participates in the information exchange. **[5 points]**
- The extent to which the applicant describes their plan to manage the program fiscally including timely spending, contract management of awards with state and local partners, and successful history in using federal dollars. **[5 points]**
- Budget and Budget Narrative Justification (reviewed but not scored) - The extent to which the budget is reasonable and consistent with the stated objectives and planned program activities, including adequate staff infrastructure.

Competitive Component – Advancing Evidence-Based Tobacco Control Total Points = 100 total points

Approach [40 points]

The extent to which the applicant describes how they will address the tobacco epidemic in their state through implementation of innovative and/or promising practices; describes how implementing and evaluating innovative and/or promising practice will further the advancement of the tobacco control evidence-base and how this would benefit the entire NTCP; describes the outcomes they expect to achieve; describes their program strategy and ability to conduct rigorous evaluation; describes the rationale for implementing and evaluating innovative and/or promising practices in tobacco control; describes how they will collaborate with internal and external partners on implementing innovative and/or promising practices and evaluation methods, and describes the specific population their innovative and/or promising practice is addressing.

Evaluation and Performance Management [40 Points]

The extent to which the applicant provides evidence of published program evaluation results during the past cooperative agreement period; demonstrates capacity to conduct tobacco control surveillance; demonstrates capacity to conduct tobacco control program evaluation; describes how they plan to work with key organizations to implement and rigorously evaluate innovative and promising practices and collaborate with CDC to contribute to building the evidence-base through publication of findings via success stories, peer-reviewed publications, conference proceedings, and webinars.

Organizational Capacity to Execute the Approach [20 points]

The extent to which the applicant describes having a state smoking prevalence rate <19%

(2012); provides proof having a full-time tobacco control program manager; dedicated state funding to the state tobacco control program; demonstrated existence of an active statewide coalition, advisory board, or other tobacco control entity that brings external partners together with the state department of health in addressing tobacco control issues; capacity to implement and evaluate innovative and/or promising practices over the 2-year project period.

Budget and Budget Narrative Justification (reviewed but not scored) - The extent to which the budget is reasonable and consistent with the stated objectives and planned program activities, including adequate staff infrastructure.

a. Phase III Review:

Competitive Component: The following factors also may affect the funding decision:

- Duplicative projects
- Geographic diversity
- Target populations

NOTE: CDC reserves the right to fund applications out of rank order.

2. Announcement and Anticipated Award Dates:

Successful applicants will anticipate notice of funding by March 30, 2015 with a start date of March 30, 2015.

F. Award Administration Information

1. Award Notices:

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

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

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

2. Administrative and National Policy Requirements:

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

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

- AR-7: Executive Order 12372
- AR-9: Paperwork Reduction Act
- AR-10: Smoke-Free Workplace

- AR-11: Healthy People 2020
- AR-12: Lobbying Restrictions
- AR-13: Prohibition on Use of CDC Funds for Certain Gun Control Activities
- AR-14: Accounting System Requirements
- AR-16: Security Clearance Requirement
- AR-21: Small, Minority, And Women-owned Business
- AR-24: Health Insurance Portability and Accountability Act
- AR-25: Release and Sharing of Data
- AR-26: National Historic Preservation Act of 1966
- AR-29: Compliance with EO13513, "Federal Leadership on Reducing Text Messaging while Driving," October 1, 2009
- AR-30: Compliance with Section 508 of the Rehabilitation Act of 1973
- AR-33: Plain Writing Act of 2010
- AR-34: Patient Protection and Affordable Care Act (e.g., a tobacco-free campus policy and a lactation policy consistent with S4207)
- AR-35: Nutrition Policies

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. In addition, as outlined above, awardees must submit a Year-3 and Final (Year-5) evaluation 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 year 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 10 pages. At a minimum, and in addition to the elements of the initial plan, this plan must:

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

When developing evaluation and performance measurement plans, applicants are encouraged to use the Introduction to Program Evaluation for Public Health Programs: A Self-Study Guide, available at: <http://www.cdc.gov/eval/guide/index.htm>.

ii. Annual Performance Report: This report must not exceed 45 pages excluding administrative reporting; attachments are not allowed, but Web links are allowed. The awardee must submit the Annual Performance Report via www.grants.gov 120 days before the end of the budget period. In addition, the awardee must submit an annual Federal Financial Report within 90 days after the end of the calendar quarter in which the budget year ends.

This report must include the following:

- **Performance Measures** (including outcomes)—Awardees must report on performance measures for each budget period and update measures, if needed.
- **Evaluation Results**—Awardees must report evaluation results for the work completed to date (including any data about the effects of the program).
- **Work Plan**—Awardees must update work plan each budget period.
- **Successes**
 - Awardees must report progress on completing activities outlined in the work plan.
 - Awardees must describe any additional successes (e.g., identified

through evaluation results or lessons learned) achieved in the past year.

- Awardees must describe success stories.
- **Challenges**
 - Awardees must describe any challenges that might affect their ability to achieve annual and project-period outcomes, conduct performance measures, or complete the activities in the work plan.
 - Awardees must describe any additional challenges (e.g., identified through evaluation results or lessons learned) encountered in the past year.
- **CDC Program Support to Awardees**
 - Awardees must describe how CDC could help them overcome challenges to achieving annual and project-period outcomes and performance measures, and completing activities outlined in the work plan.
- **Administrative Reporting** (No page limit)
 - SF-424A Budget Information-Non-Construction Programs.
 - Budget Narrative—must use the format outlined in “Content and Form of Application Submission, Budget Narrative” section.
 - Indirect Cost-Rate Agreement.

iii. Performance Measure Reporting: CDC programs must require awardees to submit performance measures annually at 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.

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

v. Final Performance and Financial Report: At the end of the project period, awardees must submit a final report including a final financial and performance report. This report is due 90 days after the project period ends

and be no more than a maximum of 40 pages long.

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 impact/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.
- Final Financial Report (SF-425)

Awardees must email the report to the CDC Project Officer and the Grants Management Section listed in the “Agency Contacts” section of the FOA.

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

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

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

For the full text of these requirements, see:

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

G. Agency Contacts

CDC encourages inquiries concerning this FOA.

For **programmatic technical assistance**, contact:

Christopher J. Kissler, MPH, Project Officer
Department of Health and Human Services
Centers for Disease Control and Prevention
4770 Buford Highway, MS F79
Atlanta, Georgia 30341
Telephone: 770-488-5374
Email: cpk2@cdc.gov

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

Patricia French, Grants Management Specialist
Department of Health and Human Services
CDC Procurement and Grants Office
2920 Brandywine Road, MS E09
Atlanta, Georgia 30341
Telephone: 770-488-2849
Email: ppf6@cdc.gov

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

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

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

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

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

H. Other Information

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

- Project Abstract
- Project Narrative
- Budget Narrative
- CDC Assurances and Certifications
- Work Plan
- Table of Contents for Entire Submission
- Resumes/CVs
- Letters of Support
- Organizational Charts
- Non-profit organization IRS status forms, if applicable
- Indirect Cost Rate , if applicable
- Memorandum of Agreement (MOA)

- Memorandum of Understanding (MOU)
- Bona Fide Agent status documentation, if applicable
- **Background Information/Data for Core Component**

I. Glossary

Activities: The events or actions that are part of a tobacco control program.

Attitudes: Biases, inclinations, or tendencies that influence a person's response to situations, activities, other people, or program goals.

Awareness: The extent to which people in the target population know about an event, activity, or campaign.

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

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

Best Practice: A best practice results from a rigorous process of peer review and evaluation that indicates effectiveness in improving public health outcomes for a target population. A best practice 1) has been reviewed and substantiated by experts in the public health field according to predetermined standards of empirical research, 2) is replicable and produces desirable results in various settings, and 3) clearly links positive effects to the program or practice being evaluated and not to other external factors.

Bonafide Agent: A Bona Fide Agent is an agency/organization identified by the state as eligible to submit an application under the state eligibility in lieu of a state application. If applying as a bona fide agent of a state or local government, a legal, binding agreement from the state or local government as documentation of the status is required.

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.

Capacity: The resources (e.g., staff, data-collection systems, funds) needed to conduct a tobacco control program or to evaluate such a program.

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

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

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

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

Community-based Intervention An intervention conducted within and by members of a particular community (e.g., grassroots efforts, efforts by a local civic group). Can be done in conjunction with an outside group (e.g., nonprofit organization, research group).

Community Mobilization: A process through which action is stimulated by a community itself, or by others, that is planned, carried out, and evaluated by a community’s individuals, groups, and organizations on a participatory and sustained basis to improve the health, hygiene and education levels so as to enhance the overall standard of living in the community.

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.

Consortium of National Networks to Impact Populations Experiencing Tobacco-Related and Cancer Health Disparities (National Networks): A CDC funded, national network model of extended groups of organizations, individuals and other entities serving a specific population to provide mutual assistance, collaboration, learning and support to each other and the NTCP and the National Comprehensive Cancer Control Program to impact tobacco-related and cancer health disparities in special populations.

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

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

Direct Assistance: An assistance support mechanism, which must be specifically authorized by statute, whereby goods or services are provided to recipients in lieu of cash. Direct Assistance generally involves the assignment of Federal personnel or the provision of equipment or supplies, such as vaccines.

<http://intranet.cdc.gov/ostlts/directassistance/index.html>.

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

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

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

Funders Alliance for State-Based Tobacco Prevention and Control Programs: A network of eight states (Hawaii, Kansas, Louisiana, Missouri, Minnesota, North Dakota, Oklahoma, and Virginia) that have resources dedicated to comprehensive tobacco prevention and control independent of state health departments.

[Guide to Community Preventive Services](#) (Community Guide): The body of evidence and recommendations approved by the Community Preventive Services Task Force.

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

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

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

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

Inclusion: Both the meaningful involvement of a community's members in all stages of the program process and the maximum involvement of the target population that the intervention will benefit. Inclusion ensures that the views, perspectives, and needs of affected communities, care providers, and key partners are considered.

Indirect Costs: Costs that are incurred for common or joint objectives and not readily and specifically

identifiable with a particular sponsored project, program, or activity; nevertheless, these costs are necessary to the operations of the organization. For example, the costs of operating and maintaining facilities, depreciation, and administrative salaries generally are considered indirect costs.

Innovations: Cutting-edge approaches that reflect new, possibly untested thinking. They are sometimes variations on an old theme. Innovations come in the form of pilot programs or experimental projects. Little, if any, objective evidence exists that the practice will have the desired impact.

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/.

Intervention: The method, device, or process used to prevent an undesirable outcome or create a desirable outcome. Interventions are specific public health actions within a strategy. These changes can improve health at the population level. They can be specific to a single disease or risk factor, or can be based in a sector or other cross-cutting area. In many cases, states and CDC track progress and achievements at this specific intervention level.

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.

Logic model: A graphic depiction of the presumed causal pathways that connect program inputs, activities, outputs, and outcomes.

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.

National Center for Chronic Disease Prevention and Health Promotion Domains: Four key domains for transforming the nation's health and providing individuals with equitable opportunities to take charge of

their health. These domains are (1) epidemiology and surveillance to gather, analyze, and disseminate data and information and conduct evaluation to inform, prioritize, deliver, and monitor programs and population health; (2) environmental approaches that promote health and support and reinforce healthful behaviors statewide and in communities; (3) health system interventions to improve the effective delivery and use of clinical and other preventive services in order to prevent disease, detect diseases early, and reduce or eliminate risk factors and mitigate or manage complications; (4) strategies to improve community-clinical linkages ensuring that communities support and clinics refer patients to programs that improve management of chronic conditions.

Earned Media: Coverage of a story without paying for media placements. Examples include letters to the editor, op-eds, coverage of press conferences, appearances on talk shows or local news programs, and on-air or print interviews. Such coverage is called “earned media” because you have to develop materials (e.g., news releases, press kits), work with reporters (e.g., by holding press conferences, proactively contacting reporters), and expend resources to get it; however, you do not pay for the placement of the messages in the stories.

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

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

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

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

Policy: A set of organizational rules (including but not limited to laws) intended to promote health or prevent disease.

Pro Bono Media: Media placements that are free, obtained either as bonus placements as part of a larger buy or provided based on requests made to stations/networks.

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

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

Plain Writing Act of 2010: Requires federal agencies to communicate with the public in plain language

to make information more accessible and understandable by intended users, especially people with limited health literacy skills or limited English proficiency. The Plain Writing Act is available at www.plainlanguage.gov.

Program Strategies: Public health interventions or public health capabilities.

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

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

Promising Practice: A program, activity, or strategy that has worked within one organization and shows promise during its early stages for becoming a best practice with long-term, sustainable impact. A promising practice must have some objective basis for claiming effectiveness and must have the potential for replication among other organizations.

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.

Reach: The number of people or households that receive a programs message or intervention.

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

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

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

Strategies: Changes that health departments are working to achieve within each of the four domains (e.g. epidemiology and surveillance, environmental approaches, health systems, or community-clinical linkages). These changes can improve health at the population level. They can be specific to a single disease or risk factor, or can be based in a sector or other cross-cutting area.

Target Population: The population or community to which a given intervention is directed.

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

U.S. Preventive Services Task Force: A non-federal panel, commissioned by the U.S. Public Health

Service in 1984 and 1990, charged with developing recommendations for clinicians on the appropriate use of preventive interventions, based on systematic reviews of evidence of clinical effectiveness.

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.