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NATIONAL CENTER FOR CHRONIC DISEASE PREVENTION AND HEALTH
PROMOTION

The National Cardiovascular Health Program

CDC-RFA-DP-23-0004

04/25/2023

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Part I. Overview

Applicants must go to the synopsis page of this announcement at www.grants.gov and click on the "Subscribe" button link to ensure they receive notifications of any changes to CDC-RFA-DP-23-0004. Applicants also must provide an e-mail address to www.grants.gov to receive notifications of changes.

A. Federal Agency Name:

Centers for Disease Control and Prevention (CDC) / Agency for Toxic Substances and Disease Registry (ATSDR)

B. Notice of Funding Opportunity (NOFO) Title:

The National Cardiovascular Health Program

C. Announcement Type: New - Type 1:

This announcement is only for non-research activities supported by CDC. If research is proposed, the application will not be considered. For this purpose, research is defined at <https://www.gpo.gov/fdsys/pkg/CFR-2007-title42-vol1/pdf/CFR-2007-title42-vol1-sec52-2.pdf>. Guidance on how CDC interprets the definition of research in the context of public health can be found at <https://www.hhs.gov/ohrp/regulations-and-policy/regulations/45-cfr-46/index.html> (See section 45 CFR 46.102(d)).

D. Agency Notice of Funding Opportunity Number:

CDC-RFA-DP-23-0004

E. Assistance Listings Number:

93.426

F. Dates:

1. Due Date for Letter of Intent (LOI):

The LOI date will generate once the Synopsis is published if Days or a Date are entered.

2. Due Date for Applications:

04/25/2023

11:59 p.m. U.S. Eastern Standard Time, at www.grants.gov.

3. Due Date for Informational Conference Call:

The National Cardiovascular Health Program

Applicant Informational Webinar

Thursday, March 9, 2023

2:00pm - 3:00pm ET

Click the link below to join the webinar:

<https://cdc.zoomgov.com/j/1604944328?pwd=VXJNUmZ6TFE4VE0wcVRUVVVV3b21HUT09>

Or join by phone:

US: +1 669 254 5252 or +1 646 828 7666 or +1 646 964 1167 or +1 551 285 1373 or +1 669 216 1590 or +1 415 449 4000

Webinar ID: 160 494 4328

Passcode: 51291371

Additional information about this and other DHDSP funding opportunities may be found at:

<https://www.cdc.gov/dhdsp/funding-ops/index.htm>

Questions about this NOFO may be submitted via email: NationalCVH@cdc.gov

Responses will be posted to the NOFO informational website.

G. Executive Summary:

1. Summary Paragraph

This NOFO supports state investments in implementing and evaluating evidence-based and evidence-informed strategies to prevent and manage cardiovascular disease (CVD) in each state and the District of Columbia.

The populations of focus are those impacted by the high prevalence of CVD, exacerbated by health inequities and disparities, social determinants, such as low incomes, poor health care, and unfair opportunity structures. Specific emphasis is placed on the prevention and control of hypertension and high cholesterol.

An applicant must demonstrate the capacity to achieve outcomes that reduce hypertension and high blood cholesterol in alignment with the broad strategies indicated. The applicant must accomplish these outcomes by aligning with and joining an existing, or creating a new, learning collaborative (LC). LCs will support health agencies in various jurisdictions to facilitate communication and the exchange of ideas and leverage technical and financial resources to support programs to improve cardiovascular health outcomes for all persons but specifically focus on those with or at highest risk of poor cardiovascular health outcomes. The LCs should directly intervene on a clinical or community basis to address the social determinants of health.

This new funding opportunity builds on the outcomes achieved via CDC-RFA-DP18-1815 and CDC-RFA-DP18-1817 and provides a structured environment for states to work more deliberately for the advancement of health equity.

a. Eligible Applicants:

Open Competition

b. Funding Instrument Type:

CA (Cooperative Agreement)

c. Approximate Number of Awards

51

d. Total Period of Performance Funding:

\$275,000,000

e. Average One Year Award Amount:

\$1,000,000

f. Total Period of Performance Length:

5 year(s)

g. Estimated Award Date:

May 30, 2023

h. Cost Sharing and / or Matching Requirements:

No

Part II. Full Text

A. Funding Opportunity Description

1. Background

a. Overview

Extensive scientific evidence links nonmedical factors, including systemic racism and the lack of economic opportunities, with poor health outcomes and increased mortality rates, all of which are preventable. Factors such as poverty, inadequate housing, poor health care, and other debilitating social conditions, commonly referred to as social determinants of health, contribute to long-standing disparities and health inequities.

These social conditions contribute to the increased prevalence of cardiovascular disease (CVD) in the US population. CVD is the leading cause of death in the US; stroke is the 5th leading cause. In 2020, about 1 in 5 adults who died from CVD were younger than 65 years old. It is estimated that 1 in 9 health care dollars are spent on CVD.

CVD mortality rates declined for several decades due to both clinical and public health interventions, but recently declining death rates from both heart disease and stroke have stalled. One reason is that hypertension, the primary risk factor for CVD, is very common (1 in 2 US adults has hypertension) but control is not. Only 1 in 4 adults with hypertension (26.1%) has it under control.

Gains have been made in treating high cholesterol, another primary risk factor for CVD. Overall, the age-adjusted prevalence of high cholesterol decreased from 21% to 10% from 1988–1994 to 2017–2018. This improvement is due in part to individuals’ healthy behaviors such as eating a healthy diet, losing weight, being physically active, and medication adherence, along with clinical contributions from appropriate prescribing and intensification of medication. Additional public health and health system interventions aimed at preventing, detecting, and controlling elevated cholesterol and blood pressure can help to further decrease CVD mortality.

This NOFO aims to implement and evaluate evidence-based strategies contributing to the prevention and management of CVD in populations disproportionately at risk. Given the importance of health equity, this new NOFO also addresses social and economic factors to help communities and health systems respond to social determinants present in their communities to offer those at risk of or burdened with CVD the best health outcomes possible.

b. Statutory Authorities

Sec 317(a) of the Public Health Service Act [42 USC 247b]

Title IV Section 4002 of the Affordable Care Act, Prevention and Public Health Fund [42 USC 300u-11]

c. Healthy People 2030

Healthy People 2030 objectives related to Heart Disease and Stroke:

<https://health.gov/healthypeople/objectives-and-data/browse-objectives/heart-disease-and-stroke>

HDS-01: Improve cardiovascular health in adults

HDS-02: Reduce coronary heart disease deaths

HDS-03: Reduce stroke deaths

HDS-04: Reduce the proportion of adults with high blood pressure

HDS-05: Increase control of high blood pressure in adults

HDS-06: Reduce cholesterol in adults

HDS-07: Increase cholesterol treatment in adults

HDS-D07: Increase the proportion of adults whose risk for atherosclerotic cardiovascular disease was assessed

d. Other National Public Health Priorities and Strategies

- CMS Framework for Health Equity 2022-2032: <https://www.cms.gov/files/document/cms-framework-health-equity.pdf>
- HHS Equity Action Plan: <https://www.hhs.gov/sites/default/files/hhs-equity-action-plan.pdf>
- HRSA Strategic Plan FY23: <https://www.hrsa.gov/about/strategic-plan>
- Million Hearts® 2027: <https://millionhearts.hhs.gov/index.html>
- The Guide to Community Preventive Services: <https://www.thecommunityguide.org/topics/heart-disease-stroke-prevention.html>
- The Surgeon General’s Call to Action to Control Hypertension: <https://www.hhs.gov/sites/default/files/call-to-action-to-control-hypertension.pdf>

e. Relevant Work

This NOFO builds on the accomplishments and outcomes achieved via Improving the Health of Americans Through Prevention and Management of Diabetes and Heart Disease and Stroke (CDC-RFA-DP18-1815) (<https://www.cdc.gov/chronicdisease/about/foa/1815/index.htm>) and Diabetes and Heart Disease & Stroke Prevent Programs-Innovative State and Local Public Health Strategies to Prevent and Manage Diabetes and Heart Disease and Stroke (CDC-RFA-DP18-1817) (<https://www.cdc.gov/chronicdisease/programs-impact/supported/index.htm>).

2. CDC Project Description

a. Approach

Bold indicates period of performance outcome.

Required Strategies	Short-Term Outcomes	Intermediate Term Outcomes	Long-Term Outcomes
<i>Strategy 1. Track and Monitor Clinical and Social Services and Support Needs Measures Shown to Improve Health and Wellness, Health Care Quality, and Identify Patients at Highest Risk of Cardiovascular Disease (CVD) with a Focus on Hypertension and High Cholesterol.</i>		Improved blood pressure control among populations within partner health care and community settings.	Improved cardiovascular health
1A. Advance the adoption and use of electronic health records (EHR) or health information technology (HIT), to identify, track, and monitor measures for clinical and social services	Increased use of EHRs or HIT to report, monitor, and track clinical and social services and support needs data to improve detection of health care disparities	Reduced disparities in blood pressure control among populations within partner health care and community settings. Increased utilization of social services and support	Reduced disparities in cardiovascular health

<p>and support needs to address health care disparities and health outcomes for patients at highest risk of cardiovascular disease (CVD) with a focus on hypertension and high cholesterol.</p>	<p>and the identification, management, and treatment of patients at highest risk of CVD, with a focus on hypertension and high cholesterol.</p>	<p>among populations at highest risk of CVD, with a focus on hypertension and high cholesterol.</p>	
<p>1B. Promote the use of standardized processes or tools to identify the social services and support needs of patient populations at highest risk of CVD, with a focus on hypertension and high cholesterol, and monitor and assess the referral and utilization of those services, such as food assistance, transportation, housing, childcare, etc.</p>	<p>Increased use of standardized processes or tools to identify, assess, track, and address the social services and support needs of patient populations at highest risk of CVD.</p>		
<p><i>Strategy 2: Implement Team-Based Care to Prevent and Reduce CVD Risk with a Focus on Hypertension and High Cholesterol Prevention, Detection, Control, and Management through the Mitigation of Social Support Barriers to Improve Outcomes.</i></p>			
<p>2A. Advance the use of health information systems that support team-based care to monitor population health with a focus on health disparities, hypertension, and high cholesterol.</p>	<p>Increased use of EHRs or HIT to support communication and coordination among care team members to monitor and address patients' hypertension and high cholesterol.</p>		
<p>2B. Assemble or create multidisciplinary teams (e.g., nurses, nurse practitioners, pharmacists, nutritionists, physical therapists, social workers, and community-based</p>	<p>Increased use of multidisciplinary care teams adhering to evidence-based guidelines to address patients' social services and support</p>		

workers) to identify patients' social services and support needs and to improve the management and treatment of hypertension and high cholesterol.	needs and improve the management and treatment of hypertension and high cholesterol.		
2C. Build and manage a coordinated network of multidisciplinary partnerships that address identified barriers to social services and support needs (e.g., childcare, transportation, language translation, food assistance, and housing) within populations at highest risk of CVD.	Increased multidisciplinary partnerships that address identified barriers to social services and support needs within populations at highest risk of CVD.		
<i>Strategy 3: Link Community Resources and Clinical Services that Support Bidirectional Referrals, Self-Management, and Lifestyle Change to Address Social Determinants that Put the Priority Populations at Increased Risk for Cardiovascular Disease with a Focus on Hypertension and High Cholesterol.</i>			
3A. Create and enhance community-clinical links to identify SDOH (e.g., inferior housing, lack of transportation, inadequate access to care, and limited community resources) and respond to social services and support needs of populations at highest risk of CVD with a focus on hypertension and high cholesterol.	Increased community clinical links to identify and respond to social services and support needs of populations at highest risk of CVD with a focus on hypertension and high cholesterol.		
3B. Identify and deploy dedicated CHWs (or their equivalents) to provide a continuum of care and services which extend the	Increased engagement of CHWs (or their equivalents) to provide a continuum of care extending		

benefits of clinical interventions and address social services and support needs leading to optimal health outcomes.	clinical interventions and addressing social services and support needs.		
3C. Promote use of self-measured blood pressure monitoring (SMBP) with clinical support within populations at highest risk of hypertension.	Increased use of SMBP with clinical support within populations at highest risk of hypertension.		

i. Purpose

This NOFO supports state investments in implementing and evaluating evidence-based and evidence-informed strategies to prevent and manage CVD in select populations in each state and the District of Columbia. This must be achieved by joining or creating an LC and demonstrating capacity to reduce hypertension and high cholesterol in alignment with specified strategies. The persons of focus are impacted by a high prevalence of CVD, exacerbated by health inequities and disparities, social determinants, such as inadequate health care, education, poverty, and unfair opportunity structures.

ii. Outcomes

Short-term outcomes by strategy

Strategy 1:

- Increased use of EHRs or HIT to report, monitor, and track clinical and social services and support needs data to improve detection of health care disparities and the identification, management, and treatment of patients at highest risk of cardiovascular disease, with a focus on hypertension and high cholesterol.
- Increased use of standardized processes or tools to identify, assess, track, and address the social services and support needs of patient populations at highest risk of CVD.

Strategy 2:

- Increased use of EHRs or HIT to support communication and coordination among care team members to monitor and address patients’ hypertension and high cholesterol.
- Increased use of multidisciplinary care teams adhering to evidence-based guidelines to address patients' social services and support needs and improve the management and treatment of hypertension and high cholesterol.
- Increased multidisciplinary partnerships that address identified barriers to social services and support needs within populations at highest risk of CVD.

Strategy 3:

- Increased community clinical links to identify and respond to social services and support needs of populations at highest risk of CVD with a focus on hypertension and high cholesterol.
- Increased engagement of CHWs (or their equivalents) to provide a continuum of care extending clinical interventions and addressing social services and support needs.
- Increased use of SMBP with clinical support within populations at highest risk of hypertension.

Intermediate outcomes include:

- Improved blood pressure control among populations within partner health care and community settings.
- Reduced disparities in hypertension control among populations within partner health care and community settings.
- Increased utilization of social services and support among populations at highest risk of CVD, with a focus on hypertension and high cholesterol.

iii. Strategies and Activities

Applicants must address all strategies.

Strategy 1: Track and Monitor Clinical and Social Services and Support Needs Measures Shown to Improve Health and Wellness, Health Care Quality, and Identify Patients at the Highest Risk of Cardiovascular Disease (CVD) with a Focus on Hypertension and High Cholesterol.

- 1A: Advance the adoption and use of electronic health records (EHR) or health information technology (HIT), to identify, track, and monitor measures for clinical and social services and support needs to address health care disparities and health outcomes for adults at highest risk of cardiovascular disease (CVD) with a focus on hypertension and high cholesterol.
- 1B: Promote the use of standardized processes or tools to identify the social services and support needs of patient populations at highest risk of CVD, with a focus on hypertension and high cholesterol, and monitor and assess the referral and utilization of those services, such as food assistance, transportation, housing, childcare, etc.

Strategy 2: Implement Team-Based Care to Prevent and Reduce CVD Risk with a Focus on Hypertension and High Cholesterol Prevention, Detection, Control, and Management Through the Mitigation of Social Support Barriers to Improve Outcomes.

- 2A: Advance the use of health information systems that support team-based care to monitor population health with a focus on health disparities, hypertension, and high cholesterol.
- 2B: Assemble or create multidisciplinary teams (e.g., nurses, nurse practitioners, pharmacists, nutritionists, physical therapists, social workers, and community-based workers) to identify patients' social services and support needs and to improve the management and treatment of hypertension and high cholesterol.

- 2C: Build and manage a coordinated network of multidisciplinary partnerships that address identified barriers to social services and support needs (e.g., childcare, transportation, language translation, food assistance, and housing) within populations at highest risk of CVD.

Strategy 3: Link Community Resources and Clinical Services That Support Bidirectional Referrals, Self-Management, and Lifestyle Change to Address Social Determinants That Put the Priority Populations at Increased Risk of Cardiovascular Disease with a Focus on Hypertension and High Cholesterol.

- 3A: Create and enhance community-clinical links to identify SDOH (e.g., inferior housing, lack of transportation, inadequate access to care, and limited community resources) and respond to the social services and support needs of populations at highest risk of CVD with a focus on hypertension and high cholesterol.
- 3B: Identify and deploy dedicated CHWs (or their equivalents) to provide a continuum of care and services which extend the benefits of clinical interventions and address social services and support needs leading to optimal health outcomes.
- 3C: Promote use of self-measured blood pressure monitoring (SMBP) with clinical support within populations at highest risk of hypertension.

Previous CDC-supported initiatives provided opportunities for a limited number of states already receiving direct funding from CDC to support their core heart disease and stroke prevention programs to participate in the Heart Disease and Stroke Learning Collaboratives (LC) which were also funded by CDC. For the purposes of this NOFO, an LC is defined as a group of public health entities, health systems, health care providers, and community leaders and their partners with experience working to address and implement evidence-based or evidence-informed practices for CVD prevention, detection, control, and management among approved priority populations of focus. The LC is expected to facilitate communication and the exchange of ideas between health systems, community health organizations, and public health entities. The applicant must demonstrate a history of collaborating to achieve sustainable change and improvement in the areas outlined in the NOFO. They will leverage technical and financial resources to support programs to improve cardiovascular health outcomes for all persons but specifically focus on those with or at the highest risk of poorer health outcomes.

The LC may be an alliance of public health entities, housing, commerce, and transportation agencies, health systems, health care providers, clinical quality improvement organizations, health information technology experts, public and private payers, pharmacists, mental and behavioral health professionals, community-based health care professionals, community organizations, safety net providers, health departments, tribal organizations and others. These partners may also directly intervene on a clinical or community basis to address the social determinants of health (SDOH).

The goals of a heart disease and stroke learning collaborative are:

- Prioritizing populations and communities with the highest prevalence of CVD, with a focus on advancing health equity for individuals with hypertension and high cholesterol.

- Serving populations and communities affected disproportionately by CVD, specifically hypertension, high cholesterol, or stroke, due to unfair opportunity structures and social determinants, such as limited access to care, inadequate or poor quality of care, or economic instability.
- Achieving optimal health outcomes for priority populations through culturally informed program services that use focused strategies to advance universal health equity goals that are mindful of the social determinants.

This new funding opportunity will build on the accomplishments and outcomes achieved in the healthcare system and community-clinical link domains of CDC-RFA-DP18-1815 and CDC-RFA-DP18-1817 and provide a structured environment for states to work more deliberately on systems change and the advancement of health equity. It will allow state health departments (SHD) to collaborate with a heart disease and stroke LC or similar entity. If one does not exist, SHDs will be able to create new LCs. The LC must adhere to and have the following characteristics:

- Recipients must ensure there is no duplication in the establishment of LCs in the same local or regional jurisdictions identified under CDC-RFA-DP-23-0005: The Innovative Cardiovascular Health Program.
- Recipients must be able to document, explain, and report on the effects of efforts to address the impact of racism and other social injustices on cardiovascular health outcomes, specifically hypertension, high cholesterol, and stroke.
- Post-award, in response to the Technical Review, recipients will be expected to develop detailed action plans that list key partners and complement the work plan, the first of which must be in place within the first 180 days.
- Within the first three (3) months, use Geographic Information System (GIS) mapping technology to identify census areas with priority populations at the highest risk for cardiovascular health conditions. This includes identifying thresholds to determine the number of persons the state health departments (SHDs) must reach to achieve predetermined health equity goals.
- Newly established LCs and partnerships with existing LCs must ensure at least 51% of participating collaborators and partners represent approved priority populations of focus.
- A dedicated staff person must be identified, as evidenced by explicit inclusion in the work plan and budget, who will focus on health inequities and build relationships at the designated levels to decrease health care disparities and advance health equity. This person can be the learning collaborative lead.
- Design and implement strategies using EHR/HIT to detect and mitigate health care disparities and utilize Quality Improvement techniques, resulting in optimal health outcomes.
- Create and enhance community-clinical links. These partnerships should reflect an interdisciplinary team that resembles the identified communities and populations and can respond to SDOH, and social services and support needs. Referrals must include agencies in the community that serve the priority population and provide safety net services.
- LC partnerships must strengthen efforts to expand care teams to include health care providers, community health workers, social workers, patient navigators, pharmacists,

and other members of the care team in community settings outside of health care facilities to enhance follow-up, communication, and coordination among identified communities and populations.

- Members of the LC must examine existing policies that are barriers to optimal health outcomes and engage in mitigation strategies aimed at system-level changes that reduce health and health care disparities, and improve community conditions.

During the Period of Performance, the Learning Collaborative is also charged with:

- Increasing the percentage of patients 18–85 years of age who have had a hypertension diagnosis and among those diagnosed, blood pressure was adequately controlled during the measurement year.
- Examine and implement models for collaboration between public health, health care, and community partners.

1. Collaborations

a. With other CDC projects and CDC-funded organizations:

An applicant should describe the ability to establish strategic partnerships with other CDC-funded programs in and outside the state health departments, tribes and tribal organizations and community-based organizations. This will allow for more efficient use of existing resources. These include but are not limited to other CDC-funded heart disease and stroke programs such as WISEWOMAN, The Innovative Cardiovascular Health Program, Paul Coverdell National Acute Stroke Program, Good Health and Wellness in Indian Country (GHWIC), Community Health Workers for COVID Response and Resilient Communities, and the Million Hearts® initiative.

It is important that an applicant identify and leverage opportunities and partnerships that will help address unfair opportunity structures and the social determinants of health. This will enhance the recipient’s work with other state health department programs that address related chronic diseases or their underlying risk factors.

An applicant is encouraged to engage and garner support from both internal and external partners with varied expertise. Applicants must include MOUs or MOAs, as appropriate, name the file “MOUs/MOAs”, and upload it as a PDF file at www.grants.gov.

b. With organizations not funded by CDC:

An applicant should describe its history of establishing or partnering with multi-sectoral learning collaboratives (LC) and collaborating with organizations with a history of working with populations impacted by the high prevalence of CVD, with specific emphasis on hypertension and high cholesterol exacerbated by health inequities and disparities, social determinants, such as low incomes, poor health care, and unfair opportunity structures. The applicant should describe proposed collaborations relevant to strategies in the NOFO. These partners may include employers, hospitals, non-profit agencies, other federal, state, or local government agencies, tribes or tribal organizations, professional associations (e.g., a state medical society, medical specialty associations, etc.), quality improvement organizations, housing, commerce, or transportation agencies, health systems, health care providers, health information technology

experts, public and private payers, pharmacists, mental and behavioral health professionals, community-based health care professionals, community organizations, safety net providers, and others. It is critical to demonstrate meaningful collaboration with state level Offices of Health Equity, Offices of Minority Health or their equivalent. If an agency does not have this resource, efforts should be made to locate an organization at the state or regional level that possesses this expertise, including expertise in health equity.

The applicant should include letters of support, memoranda of understanding (MOU), or memoranda of agreement (MOA) with a firm commitment from providers and partners that outline the relationship, needs, and resources to be provided. The applicant should submit letters of support from organizations and providers that will have a role in helping to achieve specific NOFO activities and outcomes. Letters and Memoranda must be dated within 45 days of the application. The files should be named “MOUs/MOAs.Applicant Name” and uploaded as a PDF file at www.grants.gov.

2. Target Populations

Applicants must identify criteria for selecting their priority populations based on disease and risk factor burden data and combined potential to impact large numbers of adults across the state. Priority populations should include those affected disproportionately by hypertension and high cholesterol due to socioeconomic or other factors, including inadequate access to care, poor quality of care, or low income. Emphasis should be placed on achieving maximum reach and impact across populations who can benefit from the strategies included in this NOFO.

a. Health Disparities

This NOFO will address the challenges and health inequities in priority populations disproportionately impacted by cardiovascular disease. These efforts will help determine the public health impact of programs intended to improve specific risks, conditions, and barriers experienced by populations living with high levels of disease burden for hypertension and high cholesterol.

Racial and ethnic minority groups across the US experience a disproportionate impact of CVD. Higher risk of CVD, including hypertension and high cholesterol, is the result of unfair opportunity structures and social determinants that reflect low socioeconomic factors, such as living in underfunded urban, rural, and frontier communities, being uninsured or underinsured, having limited access to routine medical care, or other related factors.

iv. Funding Strategy

The table below provides guidance related to the maximum amount of funding available by state for this program. This funding is based on a formula that includes factors for base funding, population, poverty, and disease burden.

State	Total Dollar Amount to Request
Alabama	\$1,147,666
Alaska	\$877,496

Arizona	\$1,105,715
Arkansas	\$1,106,612
California	\$1,857,270
Colorado	\$966,208
Connecticut	\$946,106
Delaware	\$949,314
District of Columbia	\$942,849
Florida	\$1,483,919
Georgia	\$1,233,901
Hawaii	\$879,794
Idaho	\$925,161
Illinois	\$1,206,246
Indiana	\$1,098,455
Iowa	\$961,997
Kansas	\$967,608
Kentucky	\$1,144,748
Louisiana	\$1,173,237
Maine	\$947,063
Maryland	\$1,015,605
Massachusetts	\$1,018,690
Michigan	\$1,200,813
Minnesota	\$980,632
Mississippi	\$1,177,592
Missouri	\$1,082,121
Montana	\$934,260
Nebraska	\$899,275
Nevada	\$1,011,841
New Hampshire	\$858,677
New Jersey	\$1,100,267
New Mexico	\$1,032,286
New York	\$1,398,077
North Carolina	\$1,212,817
North Dakota	\$893,177

Ohio	\$1,247,505
Oklahoma	\$1,102,086
Oregon	\$987,674
Pennsylvania	\$1,241,244
Rhode Island	\$910,571
South Carolina	\$1,126,495
South Dakota	\$923,416
Tennessee	\$1,172,233
Texas	\$1,658,437
Utah	\$880,310
Vermont	\$879,920
Virginia	\$1,081,945
Washington	\$1,052,352
West Virginia	\$1,112,042
Wisconsin	\$1,008,833
Wyoming	\$877,446

b. Evaluation and Performance Measurement

i. CDC Evaluation and Performance Measurement Strategy

Recipients are required to work with professional evaluators (either internal or external) to meet the evaluation and performance reporting requirements of this NOFO by identifying these efforts in the workplan, evaluation plans, and budget. Therefore, CDC strongly recommends allocating at least 10% of the total funding award to evaluation and performance monitoring and to consider both development and implementation costs. For information on developing an evaluation plan, please refer to the CDC Framework for Program Evaluation in Public Health (Centers for Disease Control and Prevention. Framework for Program Evaluation in Public Health. MMWR 1999; 48, No. RR-11.

<https://www.cdc.gov/mmwr/preview/mmwrhtml/rr4811a1.htm>

Evaluation and performance measurement help demonstrate program accomplishments, strengthen the evidence for strategy implementation, and guide program improvement for CDC and recipients.

Throughout the five-year cooperative agreement, CDC will work individually and collectively with recipients to track the implementation of recipient strategies and activities and assess progress on achieving the five-year NOFO outcomes. Both the process and outcome evaluation

will seek to answer the following overarching evaluation questions:

Process (Implementation) Evaluation:

- To what extent have recipients increased the reach of the program strategies to prevent and control cardiovascular disease?
- To what extent has program strategy implementation led to improved health outcomes among the identified population(s) at the highest risk of cardiovascular disease?
- What factors were associated with effective implementation of the program strategies?
- What factors were associated with identifying and addressing social services and support needs and social determinants of health for populations at the highest risk of cardiovascular disease?
- To what extent can the implemented program strategies be sustained after the NOFO ends?

Outcome Evaluation:

- To what extent have the implemented program strategies contributed to a measurable change in health outcomes, health equity, and health systems in a defined community, population, organization, or system?
- To what extent have the program strategies contributed to reduced healthcare disparities and improved health outcomes within populations at the highest risk of cardiovascular disease?

CDC will use an evaluation approach that consists of (1) ongoing monitoring and evaluation through the collection and reporting of performance measures, (2) a CDC-led national evaluation, and (3) recipient-led evaluations.

Performance measures developed for this program correspond to the strategies and outcomes described in the logic model. Recipients will report all short-term and intermediate performance measures. Recipients are not required to report long term measures. CDC will work with recipients on operationalizing and further defining each performance measure, and guidance will be provided prior to the first reporting period. Performance measures will be reported annually to CDC, and CDC will manage and analyze the data to assess recipient program progress, respond to broader technical assistance needs, and report to partners. CDC will analyze performance measure data annually and develop aggregate performance measure reports to be disseminated to recipients and other key partners, including federal partners, other funded and non-funded partners, and policy makers, as appropriate. These aggregate findings may also be presented during site visits and recipient meetings. In addition to performance measures reported by recipients, CDC will track additional measures relevant to the program through national datasets or national evaluation activities.

For the CDC-led national evaluation activities, CDC will lead the design, data collection, analysis, and reporting. CDC will engage recipients in developing and implementing the evaluation and recipients will be asked to participate in national evaluation activities such as surveys, interviews, case studies, and other data collection efforts. Recipients may also be asked to participate in special studies led by CDC that further explore specific components of the

program or across DHDSP-funded programs. An appropriate level of guidance and support will be provided to the recipients to ensure their effective participation in the comprehensive evaluation. CDC will use findings from these evaluation efforts to refine its technical assistance and, in turn, maximize and sustain program outcomes. Evaluation findings will be shared with recipients on a regular basis.

For recipient-led evaluations, CDC will assist recipients in developing and implementing evaluation plans that are useful for state-level program improvement and for the overall evaluation of the program. For all components of the evaluation, CDC and recipients will only collect data that will be analyzed and used.

CDC will provide recipients with guidance for developing evaluation plans and reporting performance measures and evaluation results. CDC will also provide ongoing evaluation technical assistance and ensure that the tools and services provided best meet the needs of the recipients. All information will be stored using a secure system. All evaluation findings produced by CDC and recipients, where appropriate, will contribute to: (1) continuous improvement of quality and effectiveness of program strategies; (2) the evidence base; (3) documentation and sharing of lessons learned to support replication and scaling of these program strategies; and (4) future funding opportunities supported by CDC.

The data collected by CDC for performance measurement and evaluation are directly related to the implementation of the strategies and the desired outcomes indicated in the logic model. The data collected for this NOFO for performance measurement and national evaluation do not include any personally identifiable information. Data being collected are strictly related to the implementation of the NOFO strategies and shall be used for assessing and reporting progress and for other pertinent program improvement actions. All performance measure data will be stored using a secure data system. Recipients will report their performance measure data annually and will only have access to their data. Over the five-year period of performance, data will be secured with limited access to authorized CDC program and evaluation staff to the extent allowed under applicable Federal law. CDC will aggregate data across all recipients to publish annual and summative reports. Applicants should submit a Data Management Plan (DMP). A template provided by NCCDPHP can be found at <https://www.cdc.gov/chronicdisease/programs-impact/nofo/index.htm> . Applicants are not required to use the sample template; however, all elements included in the template must be addressed.

The table below aligns with the logic model and shows the relationship between the overarching focus areas, specific strategies, outcomes, and performance measures. **Recipients are required to address all strategies and report all short term and intermediate performance measures.**

Strategies	Short-term Outcomes and Performance Measures (reported by recipients)	Intermediate Outcomes and Performance Measures (reported by recipients)
<i>Strategy 1. Track and Monitor Clinical and Social Services and Support Needs Measures shown to improve health and wellness, health care quality, and identify patients at highest risk</i>		<i>Improved blood pressure control among populations within partner health care and community settings.</i> Measure: # and % of

<p>1A: Advance the adoption and use of electronic health records (EHR) or health information technology (HIT), to identify, track, and monitor measures for clinical and social services and support needs to address health care disparities and health outcomes for patients at highest risk of cardiovascular disease (CVD) with a focus on hypertension and high cholesterol.</p>	<p><i>Increased use of EHRs or HIT to report, monitor, and track clinical and social services and support needs data to improve detection of health care disparities and the identification, management, and treatment of patients at highest risk of cardiovascular disease, with a focus on hypertension and high cholesterol.</i></p>	<p>achieved or are currently maintaining blood pressure control.</p> <p><i>Reduced disparities in blood pressure control among populations within partner health care and community settings.</i></p>
<p>1B: Promote the use of standardized processes or tools to identify the social services and support needs of patient populations at highest risk of CVD, with a focus on hypertension and high cholesterol, and monitor and assess the referral and utilization of those services, such as food assistance, transportation, housing, childcare, etc.</p>	<p>Measure 1A.: # and % of clinics or health care systems that have policies/protocols in place requiring the use of EHRs and standardized clinical quality measures to track hypertension control measures by race, ethnicity, and other populations of focus.</p>	<p>Measure: # and % of adults within partner health care and community settings, reported by race and ethnicity, with known hypertension who have achieved or are currently maintaining blood pressure control.</p>
<p>1B: Promote the use of standardized processes or tools to identify the social services and support needs of patient populations at highest risk of CVD, with a focus on hypertension and high cholesterol, and monitor and assess the referral and utilization of those services, such as food assistance, transportation, housing, childcare, etc.</p>	<p><i>Increased use of standardized processes or tools to identify, assess, track, and address the social services and support needs of patient populations at highest risk of CVD.</i></p>	<p><i>Increased utilization of social services and support among populations at highest risk of CVD, with a focus on hypertension and high cholesterol.</i></p>
<p>1B: Promote the use of standardized processes or tools to identify the social services and support needs of patient populations at highest risk of CVD, with a focus on hypertension and high cholesterol, and monitor and assess the referral and utilization of those services, such as food assistance, transportation, housing, childcare, etc.</p>	<p>Measure 1B:# and % of clinics or health care systems that use standardized processes or tools to identify, assess, track, and address the social services and support needs of patient populations at highest risk of CVD.</p>	<p>Measure: # and % of adults who were referred to social services and support needs and lifestyle interventions</p>

<p><i>Strategy 2. Implement Team-Based Care to Prevent and Reduce CVD Risk with a Focus on Hypertension and High Cholesterol Prevention, Detection, Control, and Management through the Mitigation of Social Support Barriers to Improve Outcomes.</i></p>		<p>who access the social services and support or participate in lifestyle interventions.</p>
<p>2A: Advance the use of health information systems that support team-based care to monitor population health with a focus on health disparities, hypertension, and high cholesterol.</p>	<p><i>Increased use of EHRs or HIT to support communication and coordination among care team members to monitor and address patients' hypertension and high cholesterol.</i></p> <p>Measure 2A: # and % of clinics or health systems that have policies/protocols in place requiring the use of clinical data from EHRs or HIT to support communication within the care team to coordinate care for patients with hypertension and high cholesterol.</p>	
<p>2B: Assemble or create multidisciplinary teams (e.g., nurses, nurse practitioners, pharmacists, nutritionists, physical therapists, social workers, and community-based workers) to identify patients' social services and support needs and to improve the management and treatment of hypertension and high cholesterol.</p>	<p><i>Increased use of multidisciplinary care teams adhering to evidence-based guidelines to address patients' social services and support needs and improve the management and treatment of hypertension and high cholesterol.</i></p> <p>Measure 2B: # of adults within clinics or health care systems that use multidisciplinary care teams that adhere to evidence-based guidelines.</p>	

<p>2C: Build and manage a coordinated network of multidisciplinary partnerships that address identified barriers to social services and support needs (e.g., childcare, transportation, language translation, food assistance, and housing) within populations at highest risk of CVD.</p>	<p><i>Increased multidisciplinary partnerships that address identified barriers to social services and support needs within populations at highest risk of CVD.</i></p>	
	<p>Measure 2C:# and type of social services and support within the recipient’s network that address the social needs at highest risk of CVD.</p>	
<p><i>Strategy 3. Link Community resources and Clinical Services That Support Bi-Directional Referrals, Self-management, and Lifestyle Change to Address Social Determinants That Put the Priority Populations at Increased Risk of Cardiovascular Disease with a Focus on Hypertension and High Cholesterol.</i></p>		
<p>3A: Create and enhance community-clinical links to identify SDOH (e.g., housing, transportation, access to care, and community resources) and respond to the social services and support needs of populations at highest risk of cardiovascular disease with a focus on</p>	<p><i>Increased community clinical links to identify and respond to social services and support needs of populations at highest risk of cardiovascular disease with a focus on hypertension and high cholesterol.</i></p>	
	<p>Measure 3A: # of adults with hypertension, high cholesterol, or other risk of cardiovascular disease who are referred to lifestyle change programs or</p>	

hypertension and high cholesterol.	social services and support.	
3B: Identify and deploy dedicated CHWs (or their equivalents) to provide a continuum of care and services which extend the benefits of clinical interventions and address social services and support needs leading to optimal health outcomes.	<i>Increased engagement of CHWs (or their equivalents) to provide a continuum of care extending clinical interventions and addressing social services and support needs.</i>	
	Measure 3B: # of CHWs (or their equivalent) who engage with community organizations to extend care beyond the clinical environment to address social services and support needs for those with hypertension, high cholesterol, or other risk of cardiovascular disease.	
3C: Promote use of self-measured blood pressure monitoring (SMBP) with clinical support within populations at highest risk of hypertension.	<i>Increased use of SMBP with clinical support within populations at highest risk of hypertension.</i>	
	Measure 3C: # of patients participating in SMBP programs with clinical support.	

ii. Applicant Evaluation and Performance Measurement Plan

Applicants must provide an evaluation and performance measurement plan that demonstrates how the recipient will fulfill the requirements described in the CDC Evaluation and Performance Measurement and Project Description sections of this NOFO. At a minimum, the plan must describe:

- How the applicant will collect the performance measures, respond to the evaluation questions, and use evaluation findings for continuous program quality improvement.
- How key program partners will participate in the evaluation and performance measurement planning processes.
- Available data sources, feasibility of collecting appropriate evaluation and performance data, and other relevant data information (e.g., performance measures proposed by the applicant)
- Plans for updating the Data Management Plan (DMP) as new pertinent information becomes available. If applicable, throughout the lifecycle of the project. Updates to DMP should be provided in annual progress reports. The DMP should provide a description of the data that will be produced using these NOFO funds; access to data; data standards ensuring released data have documentation describing methods of

collection, what the data represent, and data limitations; and archival and long-term data preservation plans. For more information about CDC's policy on the DMP, see <https://www.cdc.gov/grants/additional-requirements/ar-25.html>.

Where the applicant chooses to, or is expected to, take on specific evaluation studies, the applicant should be directed to:

- Describe the type of evaluations (i.e., process, outcome, or both).
- Describe key evaluation questions to be addressed by these evaluations.
- Describe other information (e.g., measures, data sources).

Recipients will be required to submit a more detailed Evaluation and Performance Measurement plan, including a DMP, if applicable, within the first 6 months of award, as described in the Reporting Section of this NOFO.

In addition, the applicant's evaluation and performance measurement plans should:

- Describe data collection approaches, measures, and data sources.
- Align each evaluation question with the approach, instruments/data sources, and timeline.
- Propose analyses for at least two time points (baseline and follow-up), and assess program impact on any intended health disparate populations.
- Describe how the applicant will use GIS to identify priority populations in census geographies disproportionately impacted by cardiovascular disease.
- Describe how much of the overall funding amount will be allocated to evaluation and performance measurement.
- Describe how applicants will work with professional evaluators (either internal or external) to meet the evaluation and performance measurement requirements.
- Use the NDCCPHP DMP template at: <https://www.cdc.gov/chronicdisease/programs-impact/nofo/index.htm>

Applicants must demonstrate a clear plan to work with professional evaluators (either internal or external) to meet the evaluation and performance reporting requirements of this NOFO by identifying these efforts in the workplan, evaluation plans, and budget. Therefore, CDC strongly recommends allocating at least 10% of the total funding award to evaluation and performance monitoring and to consider both development and implementation costs. For information on developing an evaluation plan, please refer to the CDC Framework for Program Evaluation in Public Health (Centers for Disease Control and Prevention. Framework for Program Evaluation in Public Health. MMWR 1999; 48, No. RR-11) <https://www.cdc.gov/mmwr/preview/mmwrhtml/rr4811a1.htm> .

For the detailed Evaluation and Performance Measurement Plan due 6 months post award, CDC will work closely with recipients to develop the detailed plan to ensure that it is appropriate for the activities conducted as part of this cooperative agreement, for compliance with the monitoring and evaluation guidance established by CDC, or other guidance otherwise applicable to this cooperative agreement. CDC will provide additional guidance for developing the Evaluation and Performance Measurement Plan.

c. Organizational Capacity of Recipients to Implement the Approach

Applicants must describe their organizational capacity to carry out all of the strategies outlined in the Activities and Strategies section. CDC anticipates that all applicants will be able to demonstrate capacity to carry out the activities outlined over the 5-year period of performance.

Organizational Capacity

Applicants must:

- Describe how they will coordinate efforts with other federally- and privately- funded programs within the state to leverage resources and maximize reach and impact to address SDOH and social services and support needs related to CVD, specific to hypertension and high cholesterol in their state and their overall approach to addressing the populations at the highest risk.
- Describe their capacity to manage programs and resources ensuring the administrative, financial, and staff support necessary to sustain activities. This includes describing an adequate staffing plan, providing CVs or resumes for proposed personnel, an organizational chart, and a project management structure that clearly defines staff roles and reporting structure, as it applies to this funding opportunity. Applicants must name these files “CVs/Resumes” and “Organizational Charts” respectively, and upload them as PDFs in grants.gov. Describe previous experience in the management of CVD programs specific to hypertension and high cholesterol within populations at the highest risk.
- Describe a dedicated staff person explicitly included in the work plan and budget, who will focus on health inequities and build relationships at the designated levels to decrease health care disparities and advance health equity.
- Describe the organization/proposed program plan that demonstrates the ability to document and disseminate evaluation findings, outcomes, and recommendations, including the outcomes and achievements resulting from collaborative work with partners.
- Describe how program performance will be monitored and how the program will be adjusted to address identified problems.

Collaborations

Applicants must:

- Describe how they will collaborate with CDC-funded programs and health equity subject matter experts in the state health department.
- Describe how they will establish or partner with learning collaboratives (LC) or collaborate with organizations outside the state health department.
- Provide Letters of Support or Memorandums of Agreement from proposed LC partners. These files should be named "MOUs/MOAs.Applicant Name" and uploaded as a PDF file at www.grants.gov

d. Work Plan

Applicants must submit a detailed work plan for Year 1 of the award and provide a general summary of work plan activities for Years 2–5. The work plan must describe how the applicant will address all strategies to achieve NOFO outcomes. These activities must be in alignment

with the NOFO logic model and should include the required performance measures for accomplishing tasks. Baselines, Year 1 targets, and data sources should be provided for all performance measures (short-term and intermediate).

A sample work plan format is provided below. Applicants are not required to use the sample work plan format but are required to include all the elements. Applicants must name this file “Workplan_Name of Applicant” and upload it as a PDF file. CDC will provide feedback and technical assistance to award recipients to finalize the work plan activities post-award. The Workplan is not included in the 20-page limit.

Sample DP-23-0004 Work Plan format

<i>Strategy 1: Track and Monitor Clinical and Social Services and Support Needs Measures Shown to Improve Health and Wellness, Health Care Quality, and Identify Patients at the Highest Risk of Cardiovascular Disease (CVD) with a Focus on Hypertension and High Cholesterol.</i>		
1A: Advance the adoption and use of electronic health records (EHR) or health information technology (HIT), to identify, track, and monitor measures for clinical and social services and support needs to address health care disparities and health outcomes for patients at highest risk of cardiovascular disease (CVD) with a focus on hypertension and high cholesterol.		
Activities	Responsible Position/Party	Start Date / Completion Date
Short Term Performance Outcome	Short Term Performance Measures	
Increased use of EHRs or HIT to report, monitor, and track clinical and social services and support needs data to improve detection of health care disparities and the identification, management, and treatment of patients at highest risk of CVD, with a focus on hypertension and high cholesterol.	Measure 1A.: # and % of clinics or health care systems that have policies/protocols in place requiring the use of EHRs and standardized clinical quality measures to track hypertension control measures by race, ethnicity, and other populations of focus.	
1B: Promote the use of standardized processes or tools to identify the social services and support needs of patient populations at highest risk of CVD, with a focus on hypertension and high cholesterol, and monitor and assess the referral and utilization of those services, such as food assistance, transportation, housing, childcare, etc.		
Activities	Responsible Position/Party	Start Date / Completion Date

Short Term Performance Outcome	Short Term Performance Measure	
Increased use of standardized processes or tools to identify, assess, track, and address the social services and support needs of patient populations at highest risk of CVD.	Measure 1B:# and % of clinics or health care systems that use standardized processes or tools to identify, assess, track, and address the social services and support needs of patient populations at highest risk of CVD.	
<p>Years 2-5 Provide a general summary of work plan activities that address Strategy 1 proposed for Years 2-5 (maximum of one page narrative).</p>		
<p><i>Strategy 2: Implement Team-Based Care to Prevent and Reduce CVD Risk with a Focus on Hypertension and High Cholesterol Prevention, Detection, Control, and Management through the Mitigation of Social Support Barriers to Improve Outcomes.</i></p>		
<p>2A: Advance the use of health information systems that support team-based care to monitor population health with a focus on health disparities, hypertension, and high cholesterol.</p>		
Activities	Responsible Position/Party	Start Date / Completion Date
Short Term Outcome	Short Term Performance Measure	
Increased use of EHRs or HIT to support communication and coordination among care team members to monitor and address patients' hypertension and high cholesterol.	Measure 2A: # and % of clinics or health systems that have policies/protocols in place requiring the use of clinical data from EHRs or HIT to support communication within the care team to coordinate care for patients with hypertension and high cholesterol.	
<p>2B: Assemble or create multidisciplinary teams (e.g., nurses, nurse practitioners, pharmacists, nutritionists, physical therapists, social workers, and community-based workers) to identify patients' social services and support needs and to improve the management and treatment of hypertension and high cholesterol.</p>		
Activities	Responsible Position/Party	Start Date / Completion Date

Short Term Outcome	Short Term Performance Measure	
Increased use of multidisciplinary care teams adhering to evidence-based guidelines to address patients' social services and support needs and improve the management and treatment of hypertension and high cholesterol.	Measure 2B: # of adults within clinics or health care systems that use multidisciplinary care teams that adhere to evidence-based guidelines.	
2C: Build and manage a coordinated network of multi-disciplinary partnerships that address identified barriers to social services and support needs (e.g., childcare, transportation, language translation, food assistance, and housing) within populations at highest risk of CVD.		
Activities	Responsible Position/Party	Start Date / Completion Date
Short Term Outcome	Short Term Performance Measure	
Increased multidisciplinary partnerships that address identified barriers to social services and support needs within populations at highest risk of CVD.	Measure 2C:# and type of social services and support within the recipient's network that address the social needs at highest risk of CVD.	
Years 2-5 Provide a general summary of work plan activities that address Strategy 2 proposed for Years 2-5 (maximum of one page narrative).		
<i>Strategy 3: Link Community Resources and Clinical Services that support bidirectional referrals, self-management, and lifestyle change to address social determinants that put the priority populations at increased risk of cardiovascular disease with a focus on hypertension and high cholesterol.</i>		
3A: Create and enhance community-clinical links to identify SDoH (e.g., inferior housing, lack of transportation, inadequate access to care, and limited community resources) and respond to the social services and support needs of populations at highest risk of CVD with a focus on hypertension and high cholesterol.		
Activities	Responsible Position/Party	Start Date / Completion Date

Short Term Outcome	Short Term Performance Measure	
Increased community clinical links to identify and respond to social services and support needs for populations at highest risk of cardiovascular disease with a focus on hypertension and high cholesterol.	Measure 3A: # of adults with hypertension, high cholesterol, or other risk of cardiovascular disease who are referred to lifestyle change programs or social services and support.	
3B: Identify and deploy dedicated CHWs (or their equivalents) to provide a continuum of care and services which extend the benefits of clinical interventions and address social services and support needs leading to optimal health outcomes.		
Activities	Responsible Position/Party	Start Date / Completion Date C
Short Term Outcome	Short Term Performance Measure	
Increased engagement of CHWs (or their equivalents) to provide a continuum of care extending clinical interventions and addressing social services and support needs.	Measure 3B: # of CHWs (or their equivalent) who engage with community organizations to extend care beyond the clinical environment to address social services and support needs for those with hypertension, high cholesterol, or other risk of cardiovascular disease.	
3C: Promote use of self-measured blood pressure monitoring (SMBP) with clinical support within populations at highest risk of hypertension.		
Activities	Responsible Position/Party	Start Date / Completion Date Co
Short Term Outcome	Short Term Performance Measure	
Increased use of SMBP with clinical support within populations at highest risk of hypertension.	Measure 3C: # of patients participating in SMBP programs with clinical support.	
Years 2-5 Provide a general summary of work plan activities that address Strategy 3 proposed for		

Years 2-5 (maximum of one page narrative).	
Intermediate Outcomes	Intermediate Required Performance Measures
Improved blood pressure control among populations within partner health care and community settings.	Measure: # and % of adults within partner health care and community settings with known hypertension who have achieved or are currently maintaining blood pressure control.
Reduced disparities in blood pressure control among populations within partner health care and community settings.	Measure: # and % of adults within partner health care and community settings, reported by race and ethnicity, with known hypertension who have achieved or are currently maintaining blood pressure control.
Increased utilization of social services and support among populations at highest risk of CVD, with a focus on hypertension and high cholesterol.	Measure: # and % of adults who were referred to social services and support needs and lifestyle interventions who access the social services and support or participate in lifestyle interventions.

e. CDC Monitoring and Accountability Approach

Monitoring activities include routine and ongoing communication between CDC and recipients, site visits, and recipient 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 recipient progress in achieving the desired outcomes.
- Ensuring the adequacy of recipient 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 deemed necessary to monitor the award:

- Ensuring that work plans are feasible based on the budget and consistent with the intent of the award.
- Ensuring that recipients are performing at a sufficient level to achieve outcomes within stated timeframes.
- Working with recipients 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.

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 recipients.

The proposed work plan and performance measures will be reviewed annually by the project officer and evaluation staff, and may need to be altered to better reflect program activities as outlined in the NOFO. Post-award cooperative agreement monitoring and provision of technical assistance and training will include:

- Ensuring that work plans are feasible, fiscally responsible, consistent with the intent of the award, and have acceptable milestones and timelines.
- Ensuring that the activities outlined in the NOFO are being completed.
- Assisting recipients in adjusting work plan activities based on achievement of objectives or budget changes.
- Communicating as needed, or at minimum monthly, with the project coordinator and other program staff on conference calls/webinars.
- Sponsoring webinars and other meetings/trainings associated with the NOFO.
- Providing tools/resources aligned with program activities and NOFO outcomes, assessment, and implementation support.

CDC will analyze performance measurement data to review progress and identify technical assistance needs for all NOFO strategies on an annual basis. The performance measure data will be triangulated with other internal and external sources of appropriate data to arrive at a rational assessment of progress. Findings from the annual analysis of performance measure data will be used to identify areas of program improvement, broader technical assistance needs, and for accountability reporting. CDC will develop annual, aggregate and individual performance measure reports to be disseminated to recipients, federal partners, other funded and non-funded partners, policy makers, and the public as appropriate. Reports may also be presented during site visits and recipient meetings. In addition to performance measures reported by recipients, CDC will track other measures that are relevant to the program through national datasets and national evaluation activities.

f. CDC Program Support to Recipients

CDC will be substantially involved beyond site visits and regular performance and financial monitoring during the period of performance. Substantial involvement means that the recipient can expect federal programmatic partnership in carrying out efforts under the award. CDC will work in partnership with the recipient to ensure the success of the cooperative agreement by:

- Supporting recipients in implementing cooperative agreement requirements and meeting program outcomes.
- Assisting recipients in advancing program activities to achieve project outcomes.
- Providing scientific subject matter expertise and resources in support of the required strategies.
- Collaborating with recipients to develop and implement evaluation plans that align with CDC evaluation activities.

- Providing technical assistance on recipients’ evaluation and performance measurement plans.
- Providing technical assistance to define and operationalize performance measures and reports.
- Engaging in and facilitating varied means of communication and peer sharing opportunities among recipients and with CDC to communicate and share tools and resources.
- Establishing learning opportunities to facilitate the sharing of information among recipients.
- Providing professional development and training opportunities – either in person or through virtual, web-based training formats – for the purpose of sharing the latest science, best practices, success stories, and program models.
- Participating in relevant meetings, committees, conference calls, and working groups related to the cooperative agreement requirements to achieve outcomes.
- Coordinating communication and program links with other CDC programs and federal agencies, such as the Health Resources and Services Administration (HRSA), Centers for Medicare & Medicaid Services (CMS), Indian Health Service (IHS), and the National Institutes of Health (NIH), as appropriate.
- Providing surveillance technical assistance and state-specific data collected by CDC.
- Translating and disseminating lessons learned through publications, meetings, and other means on promising and best practices to expand the evidence base.

B. Award Information

1. Funding Instrument Type:

CA (Cooperative Agreement)

CDC's substantial involvement in this program appears in the CDC Program Support to Recipients Section.

2. Award Mechanism:

U58

3. Fiscal Year:

2023

4. Approximate Total Fiscal Year Funding:

\$55,000,000

5. Total Period of Performance Funding:

\$275,000,000

This amount is subject to the availability of funds.

Estimated Total Funding:

\$275,000,000

6. Total Period of Performance Length:

5 year(s)

year(s)

7. Expected Number of Awards:

51

8. Approximate Average Award:

\$1,000,000

Per Budget Period

9. Award Ceiling:

\$2,000,000

Per Budget Period

This amount is subject to the availability of funds.

10. Award Floor:

\$850,000

Per Budget Period

11. Estimated Award Date:

May 30, 2023

12. Budget Period Length:

12 month(s)

Throughout the project period, CDC will continue the award based on the availability of funds, the evidence of satisfactory progress by the recipient (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 period of performance comprises the initial competitive segment and any subsequent non-competitive continuation award(s).

13. Direct Assistance

Direct Assistance (DA) is not available through this NOFO.

If you are successful and receive a Notice of Award, in accepting the award, you agree that the award and any activities thereunder are subject to all provisions of 45 CFR part 75, currently in effect or implemented during the period of the award, other Department regulations and policies in effect at the time of the award, and applicable statutory provisions.

C. Eligibility Information

1. Eligible Applicants

Eligibility Category:

00 (State governments)

25 (Others (see text field entitled "Additional Information on Eligibility" for clarification))

Additional Eligibility Category:

Government Organizations:

State governments or their bona fide agents (includes the District of Columbia)

2. Additional Information on Eligibility

Per the program's authorizing statute or regulation: Sec 317(a) of the Public Health Service Act [42 USC 247b] only State governments, including the District of Columbia, or their bona fide agents are eligible to apply. Local health departments are eligible to compete under a separate NOFO (The Innovative Cardiovascular Health Program), and Tribes and Tribal-serving organizations are and will continue to be funded under separate NOFOs (<https://www.cdc.gov/healthytribes/index.htm>).

FY22 House Report language asserts the significant increases to DHDSP's budget allocations should be directed to "support, strengthen, and expand current evidence-based initiatives at the State, local, tribal, and territorial level." Committee language further supports a continuation of DHDSP's current efforts and "recognizes the vital importance of addressing cardiovascular disease among women and underserved communities, communities of color, those communities with limited access to information about cardiovascular health disease, and communities at risk for delaying regular monitoring of cardiovascular health as a result of the COVID-19 pandemic. The Committee supports CDC's efforts to improve our understanding of the outcomes and health effects of COVID-19 infection, including cardiovascular disease." [House Committee Report 117-96, p. 89. Available at: [CRPT-117hrpt96.pdf \(congress.gov\)](#)]

More recently, FY23 House Report language directs efforts to "support, strengthen, and expand evidence-based initiatives at the State, local, tribal, and territorial level. The Committee recognizes the vital importance of addressing cardiovascular disease among women, particularly women of color, and further recognizes that the resulting costs to the health care system of unrecognized cardiovascular disease in women can be substantially reduced with appropriate public awareness and prevention". [FY23 House Report 117-403, p. 80. Available at: [CRPT-117hrpt403.pdf \(congress.gov\)](#)] FY23 Explanatory Statement asserts the agreement includes an increase to strengthen and expand evidence-based heart disease and stroke prevention activities focused on high risk populations.

Applicants should refer to the funding table for specific funding amounts for each state.

3. Justification for Less than Maximum Competition

N/A

4. Cost Sharing or Matching

Cost Sharing / Matching Requirement:

No

5. Maintenance of Effort

Maintenance of effort is not required for this program.

D. Application and Submission Information

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.

PLEASE NOTE: Effective April 4, 2022, applicants must have a Unique Entity Identifier (UEI) at the time of application submission (SF-424, field 8c). The UEI is generated as part of SAM.gov registration. Current SAM.gov registrants have already been assigned their UEI and can view it in SAM.gov and Grants.gov. Additional information is available on the [GSA website](#), [SAM.gov](#), and [Grants.gov- Finding the UEI](#).

a. Unique Entity Identifier (UEI):

All applicant organizations must obtain a Unique Entity Identifier (UEI) number by registering in SAM.gov prior to submitting an application. A UEI number is a unique twelve-digit identification number assigned to the registering organization.

If funds are awarded to an applicant organization that includes sub-recipients, those sub-recipients must provide their UEI 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 a recipient. All applicant organizations must register with SAM, and will be assigned a SAM number and a Unique Entity Identifier (UEI). 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 can require 10 or more business days, and registration must be renewed annually. Additional information about registration procedures may be found at [SAM.gov](#) and the [SAM.gov Knowledge Base](#).

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 "Applicant Registration" 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 should start the registration process as early as possible.

Step	System	Requirements	Duration	Follow Up
1	System for Award Management (SAM)	1. Go to SAM.gov and designate an E-Biz POC (You will need to have an active SAM account before you can register on grants.gov). The UEI is generated as part of your registration.	3-5 Business Days but up to 2 weeks and must be renewed once a year	For SAM Customer Service Contact https://fsd.gov/ fsd.gov/home.do Calls: 866-606-8220
2	Grants.gov	1. Set up an individual account in Grants.gov using organization's new UEI number to become an Authorized Organization Representative (AOR) 2. Once the account is set up the E-BIZ POC will be notified via email 3. Log into grants.gov using the password the E-BIZ POC received and create new password 4. This authorizes the AOR to submit applications on behalf of the organization	It takes one day (after you enter the EBiz POC name and EBiz POC email in SAM) to receive a UEI (SAM) which will allow you to register with Grants.gov and apply for federal funding.	Register early! Applicants can register within minutes.

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 notice of funding opportunity at www.grants.gov.

4. Submission Dates and Times

If the application is not submitted by the deadline published in the NOFO, it will not be processed. Office of Grants Services (OGS) 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 OGS.

a. Letter of Intent Deadline (must be emailed)

b. Application Deadline

Number Of Days from Publication 60

04/25/2023

11:59 pm U.S. Eastern Time, at www.grants.gov. If Grants.gov is inoperable and cannot receive applications, and circumstances preclude advance notification of an extension, then applications must be submitted by the first business day on which Grants.gov operations resume.

Due Date for Information Conference Call

The National Cardiovascular Health Program

Applicant Informational Webinar

Thursday, March 9, 2023

2:00pm - 3:00pm ET

Click the link below to join the webinar:

<https://cdc.zoomgov.com/j/1604944328?pwd=VXJNUmZ6TFE4VE0wcVRUVVV3b21HUT09>

Or join by phone:

US: +1 669 254 5252 or +1 646 828 7666 or +1 646 964 1167 or +1 551 285 1373 or +1 669 216 1590 or +1 415 449 4000

Webinar ID: 160 494 4328

Passcode: 51291371

Additional information about this and other DHDSP funding opportunities may be found at:

<https://www.cdc.gov/dhdsp/funding-opps/index.htm>

Questions about this NOFO may be submitted via email: NationalCVH@cdc.gov

Responses will be posted to the NOFO informational website.

5. Pre-Award Assessments

Risk Assessment Questionnaire Requirement

CDC is required to conduct pre-award risk assessments to determine the risk an applicant poses to meeting federal programmatic and administrative requirements by taking into account issues such as financial instability, insufficient management systems, non-compliance with award conditions, the charging of unallowable costs, and inexperience. The risk assessment will include an evaluation of the applicant's CDC Risk Questionnaire, located at <https://www.cdc.gov/grants/documents/PPMR-G-CDC-Risk-Questionnaire.pdf>, as well as a review of the applicant's history in all available systems; including OMB-designated repositories of government-wide eligibility and financial integrity systems (see 45 CFR 75.205(a)), and other sources of historical information. These systems include, but are not limited to: FAPIIS (<https://www.fapiis.gov/>), including past performance on federal contracts as per Duncan Hunter

National Defense Authorization Act of 2009; Do Not Pay list; and System for Award Management (SAM) exclusions.

CDC requires all applicants to complete the Risk Questionnaire, OMB Control Number 0920-1132 annually. This questionnaire, which is located at <https://www.cdc.gov/grants/documents/PPMR-G-CDC-Risk-Questionnaire.pdf>, along with supporting documentation must be submitted with your application by the closing date of the Notice of Funding Opportunity Announcement. If your organization has completed CDC's Risk Questionnaire within the past 12 months of the closing date of this NOFO, then you must submit a copy of that questionnaire, or submit a letter signed by the authorized organization representative to include the original submission date, organization's EIN and UEI.

When uploading supporting documentation for the Risk Questionnaire into this application package, clearly label the documents for easy identification of the type of documentation. For example, a copy of Procurement policy submitted in response to the questionnaire may be labeled using the following format: Risk Questionnaire Supporting Documents _ Procurement Policy.

Duplication of Efforts

Applicants are responsible for reporting if this application will result in programmatic, budgetary, or commitment overlap with another application or award (i.e. grant, cooperative agreement, or contract) submitted to another funding source in the same fiscal year. Programmatic overlap occurs when (1) substantially the same project is proposed in more than one application or is submitted to two or more funding sources for review and funding consideration or (2) a specific objective and the project design for accomplishing the objective are the same or closely related in two or more applications or awards, regardless of the funding source. Budgetary overlap occurs when duplicate or equivalent budgetary items (e.g., equipment, salaries) are requested in an application but already are provided by another source. Commitment overlap occurs when an individual's time commitment exceeds 100 percent, whether or not salary support is requested in the application. Overlap, whether programmatic, budgetary, or commitment of an individual's effort greater than 100 percent, is not permitted. Any overlap will be resolved by the CDC with the applicant and the PD/PI prior to award.

Report Submission: The applicant must upload the report in Grants.gov under "Other Attachment Forms." The document should be labeled: "Report on Programmatic, Budgetary, and Commitment Overlap."

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 is not requested or required as part of the application for this NOFO.

8. Table of Contents

(There is no page limit. The table of contents is not included in the project narrative page limit.): The applicant must provide, as a separate attachment, the “Table of Contents” for the entire submission package.

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

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

10. Project Narrative

(Unless specified in the "H. Other Information" section, maximum of 20 pages, single spaced, 12 point font, 1-inch margins, number all pages. This includes the work plan. Content beyond the specified page number will not be reviewed.)

Applicants must submit a Project Narrative with the application forms. Applicants must name this file “Project Narrative” and upload it at www.grants.gov. The Project Narrative must include **all** of the following headings (including subheadings): Background, Approach, Applicant Evaluation and Performance Measurement Plan, Organizational Capacity of Applicants to Implement the Approach, and Work Plan. 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 period of performance as identified in the CDC Project Description section. Applicants should use the federal plain language guidelines and Clear Communication Index to respond to this Notice of Funding Opportunity. Note that recipients should also use these tools when creating public communication materials supported by this NOFO. Failure to follow the guidance and format may negatively impact scoring of the application.

a. Background

Applicants must provide a description of relevant background information that includes the context of the problem (See CDC Background).

b. Approach

i. Purpose

Applicants must describe in 2-3 sentences specifically how their application will address the public health problem as described in the CDC Background section.

ii. Outcomes

Applicants must clearly identify the outcomes they expect to achieve by the end of the project period, as identified in the logic model in the Approach section of the CDC Project Description. Outcomes are the results that the program intends to achieve and usually indicate the intended direction of change (e.g., increase, decrease).

iii. Strategies and Activities

Applicants must provide a clear and concise description of the strategies and activities they will use to achieve the period of performance outcomes. Applicants must select existing evidence-based strategies that meet their needs, or describe in the Applicant Evaluation and Performance Measurement Plan how these strategies will be evaluated over the course of the project period. See the Strategies and Activities section of the CDC Project Description.

1. Collaborations

Applicants must describe how they will collaborate with programs and organizations either internal or external to CDC. Applicants must address the Collaboration requirements as described in the CDC Project Description.

2. Target Populations and Health Disparities

Applicants must describe the specific target population(s) in their jurisdiction and explain how such a target will achieve the goals of the award and/or alleviate health disparities. The applicants must also address how they will include specific populations that can benefit from the program that is described in the Approach section. Applicants must address the Target Populations and Health Disparities requirements as described in the CDC Project Description.

c. Applicant Evaluation and Performance Measurement Plan

Applicants must provide an evaluation and performance measurement plan that demonstrates how the recipient will fulfill the requirements described in the CDC Evaluation and Performance Measurement and Project Description sections of this NOFO. At a minimum, the plan must describe:

- How applicant will collect the performance measures, respond to the evaluation questions, and use evaluation findings for continuous program quality improvement. The Paperwork Reduction Act of 1995 (PRA): Applicants are advised that any activities involving information collections (e.g., surveys, questionnaires, applications, audits, data requests, reporting, recordkeeping and disclosure requirements) from 10 or more individuals or non-Federal entities, including State and local governmental agencies, and funded or sponsored by the Federal Government are subject to review and approval by the Office of Management and Budget. For further information about CDC's requirements under PRA see <http://www.hhs.gov/ocio/policy/collection/>.
- How key program partners will participate in the evaluation and performance measurement planning processes.
- Available data sources, feasibility of collecting appropriate evaluation and performance data, data management plan (DMP), and other relevant data information (e.g., performance measures proposed by the applicant).

Where the applicant chooses to, or is expected to, take on specific evaluation studies, they should be directed to:

- Describe the type of evaluations (i.e., process, outcome, or both).
- Describe key evaluation questions to be addressed by these evaluations.
- Describe other information (e.g., measures, data sources).

Recipients will be required to submit a more detailed Evaluation and Performance Measurement plan (including the DMP elements) within the first 6 months of award, as described in the Reporting Section of this NOFO.

d. Organizational Capacity of Applicants to Implement the Approach

Applicants must address the organizational capacity requirements as described in the CDC Project Description.

11. Work Plan

(Included in the Project Narrative's page limit)

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 recipient plans to carry out achieving the period of performance outcomes, strategies and activities, evaluation and performance measurement.

12. Budget Narrative

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
- Contractual costs
- Total Direct costs
- Total Indirect costs

Indirect costs could include the cost of collecting, managing, sharing and preserving data.

Indirect costs on grants awarded to foreign organizations and foreign public entities and performed fully outside of the territorial limits of the U.S. may be paid to support the costs of compliance with federal requirements at a fixed rate of eight percent of MTDC exclusive of tuition and related fees, direct expenditures for equipment, and subawards in excess of \$25,000. Negotiated indirect costs may be paid to the American University, Beirut, and the World Health Organization.

If applicable and consistent with the cited statutory authority for this announcement, applicant entities may use funds for activities as they relate to the intent of this NOFO to meet national standards or seek health department accreditation through the Public Health Accreditation Board (see: <http://www.phaboard.org>). Applicant entities to whom this provision applies include state, local, territorial governments (including the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, the Commonwealth of the Northern Mariana Islands, American Samoa, Guam, the Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau), or their bona fide agents, political subdivisions of states (in consultation with states), federally recognized or state-recognized American Indian or Alaska Native tribal governments, and American Indian or Alaska Native tribally designated organizations. Activities include those that enable a public health organization to deliver public health services such as activities that ensure a capable and qualified workforce, up-to-date information systems, and the capability to assess and respond to public health needs. Use of these funds must focus on achieving a minimum of one national standard that supports the intent of the NOFO. Proposed activities must be included in the budget narrative and must indicate which standards will be addressed.

Vital records data, including births and deaths, are used to inform public health program and policy decisions. If applicable and consistent with the cited statutory authority for this NOFO, applicant entities are encouraged to collaborate with and support their jurisdiction's vital records office (VRO) to improve vital records data timeliness, quality and access, and to advance public health goals. Recipients may, for example, use funds to support efforts to build VRO capacity through partnerships; provide technical and/or financial assistance to improve vital records timeliness, quality or access; or support vital records improvement efforts, as approved by CDC.

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 costs are requested, include a copy of the current negotiated federal indirect cost rate agreement or a cost allocation plan approval letter for those Recipients under such a plan. Applicants must name this file "Indirect Cost Rate" and upload it at www.grants.gov.

Applicants are encouraged to work with professional evaluators (either internal or external) to meet the evaluation and performance reporting requirements of this NOFO. Therefore, CDC strongly recommends allocating at least 10% of the total funding award to evaluation and performance monitoring and to consider both development and implementation costs.

CDC will not consider funding amounts higher than the specified amount for the state indicated in the table found under the Funding Strategy section.

13. Funds Tracking

Proper fiscal oversight is critical to maintaining public trust in the stewardship of federal funds. Effective October 1, 2013, a new HHS policy on subaccounts requires the CDC to set up payment subaccounts within the Payment Management System (PMS) for all new grant awards. Funds awarded in support of approved activities and drawdown instructions will be identified on the Notice of Award in a newly established PMS subaccount (P subaccount). Recipients will be required to draw down funds from award-specific accounts in the PMS. Ultimately, the subaccounts will provide recipients and CDC a more detailed and precise understanding of financial transactions. The successful applicant will be required to track funds by P-accounts/sub accounts for each project/cooperative agreement awarded. Applicants are encouraged to demonstrate a record of fiscal responsibility and the ability to provide sufficient and effective oversight. Financial management systems must meet the requirements as described 45 CFR 75 which include, but are not limited to, the following:

- Records that identify adequately the source and application of funds for federally-funded activities.
- Effective control over, and accountability for, all funds, property, and other assets.
- Comparison of expenditures with budget amounts for each Federal award.
- Written procedures to implement payment requirements.
- Written procedures for determining cost allowability.
- Written procedures for financial reporting and monitoring.

14. Pilot Program for Enhancement of Employee Whistleblower Protections

Pilot Program for Enhancement of Employee Whistleblower Protections: All applicants will be subject to a term and condition that applies the terms of 48 Code of Federal Regulations (CFR) section 3.908 to the award and requires that recipients inform their employees in writing (in the predominant native language of the workforce) of employee whistleblower rights and protections under 41 U.S.C. 4712.

15. Copyright Interests Provisions

This provision is intended to ensure that the public has access to the results and accomplishments of public health activities funded by CDC. Pursuant to applicable grant regulations and CDC's Public Access Policy, Recipient agrees to submit into the National Institutes of Health (NIH) Manuscript Submission (NIHMS) system an electronic version of the final, peer-reviewed manuscript of any such work developed under this award upon acceptance for publication, to be made publicly available no later than 12 months after the official date of publication. Also at the time of submission, Recipient and/or the Recipient's submitting author must specify the date the final manuscript will be publicly accessible through PubMed Central (PMC). Recipient and/or Recipient's submitting author must also post the manuscript through PMC within twelve (12) months of the publisher's official date of final publication; however the author is strongly encouraged to make the subject manuscript available as soon as possible. The recipient must obtain prior approval from the CDC for any exception to this provision.

The author's final, peer-reviewed manuscript is defined as the final version accepted for journal publication, and includes all modifications from the publishing peer review process, and all graphics and supplemental material associated with the article. Recipient and its submitting authors working under this award are responsible for ensuring that any publishing or copyright agreements concerning submitted articles reserve adequate right to fully comply with this provision and the license reserved by CDC. The manuscript will be hosted in both PMC and the CDC Stacks institutional repository system. In progress reports for this award, recipient must identify publications subject to the CDC Public Access Policy by using the applicable NIHMS identification number for up to three (3) months after the publication date and the PubMed Central identification number (PMCID) thereafter.

16. Funding Restrictions

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

- Recipients may not use funds for research.
- Recipients may not use funds for clinical care except as allowed by law.
- Recipients may use funds only for reasonable program purposes, including personnel, travel, supplies, and services.
- Generally, recipients may not use funds to purchase furniture or equipment. Any such proposed spending must be clearly identified in the budget.
- Reimbursement of pre-award costs generally is not allowed, unless the CDC provides written approval to the recipient.
- Other than for normal and recognized executive-legislative relationships, no funds may be used for:
 - publicity or propaganda purposes, for the preparation, distribution, or use of any material designed to support or defeat the enactment of legislation before any legislative body
 - the salary or expenses of any grant or contract recipient, or agent acting for such recipient, related to any activity designed to influence the enactment of legislation, appropriations, regulation, administrative action, or Executive order proposed or pending before any legislative body
- See [Additional Requirement \(AR\) 12](#) for detailed guidance on this prohibition and [additional guidance on lobbying for CDC recipients](#).
- The direct and primary recipient in a cooperative agreement program must perform a substantial role in carrying out project outcomes and not merely serve as a conduit for an award to another party or provider who is ineligible.

17. Data Management Plan

As identified in the Evaluation and Performance Measurement section, applications involving data collection or generation must include a Data Management Plan (DMP) as part of their evaluation and performance measurement plan unless CDC has stated that CDC will take on the

responsibility of creating the DMP. The DMP describes plans for assurance of the quality of the public health data through the data's lifecycle and plans to deposit the data in a repository to preserve and to make the data accessible in a timely manner. See web link for additional information:

<https://www.cdc.gov/grants/additional-requirements/ar-25.html>.

18. Other Submission Requirements

a. Electronic Submission:

Applications must be submitted electronically by using the forms and instructions posted for this notice of funding opportunity at www.grants.gov. Applicants can complete the application package using Workspace, which allows forms to be filled out online or offline. All application attachments must be submitted using a PDF file format. Instructions and training for using Workspace can be found at www.grants.gov under the "Workspace Overview" option.

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 NOFO. 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 Grants.gov Online User Guide.

https://www.grants.gov/help/html/help/index.htm?callingApp=custom#t=Get_Started%2FGet_Started.htm

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@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@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 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 received via e-mail to the GMS/GMO listed below 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, OGS will advise the applicant of specific instructions for submitting the application via email.

E. Review and Selection Process

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

a. Phase 1 Review

All applications will be initially reviewed for eligibility and completeness by CDC Office of Grants Services. Complete applications will be reviewed for responsiveness by the Grants Management Officials and Program Officials. Non-responsive applications will not advance to Phase II review. Applicants will be notified that their applications did not meet eligibility and/or published submission requirements.

b. Phase II Review

A review panel will evaluate complete, eligible applications in accordance with the criteria below.

- i. Approach
- ii. Evaluation and Performance Measurement
- iii. Applicant's Organizational Capacity to Implement the Approach

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

i. Approach

Maximum Points: 0

Applications will not be scored.

A technical review will be conducted by the CDC Program staff using the criteria noted in the Phase II Review Criteria Section.

Program Strategy

Extent to which an applicant:

- Describes how they will align with and join an existing, or establish a new, learning collaborative (LC) that focuses on developing innovative approaches to improve overall cardiovascular health. The LC must be equipped to apply those approaches to mitigate social services and support needs and other associated risk factors for CVD with a focus on high blood pressure, high cholesterol and stroke.
- Describes data (e.g., GIS or other data) used to identify priority populations and communities to be served. At minimum data must reflect highest prevalence of CVD-related morbidity and mortality outcomes and incorporate SDOH.
- Demonstrates through partnerships the ability to increase the percentage of patients 18–85 years of age who have had a hypertension diagnosis and among those diagnosed, blood pressure was adequately controlled during the measurement year for the identified priority populations.

Strategy 1. Track and Monitor Clinical and Social Services and Support Needs Measures Shown to Improve Health and Wellness, Health Care Quality, and Identify Patients at Highest Risk of CVD with a Focus on Hypertension and High Cholesterol.

Extent to which an applicant:

- Describes how they will advance the adoption and use of electronic health records (EHR) or health information technology (HIT), to identify, track, and monitor measures for clinical and social services and support needs to address health care disparities and health outcomes for patients at highest risk of CVD, with a focus on hypertension and high cholesterol.
- Describes how they will promote the use of standardized processes or tools to identify the social services and support needs of patient populations at highest risk of CVD, with a focus on hypertension and high cholesterol, and monitor and assess the referral and utilization of those services, such as food assistance, transportation, housing, childcare, etc.

Strategy 2. Implement Team-Based Care to Prevent and Reduce CVD Risk with a Focus on Hypertension and High Cholesterol Prevention, Detection, Control, and Management through Mitigation of Social Support Barriers to Improve Outcomes.

Extent to which an applicant:

- Describes how they will advance the use of health information systems that support team-based care to monitor population health with a focus on health disparities, hypertension, and high cholesterol.

- Describes how they will assemble or create multi-disciplinary teams (e.g., nurses, nurse practitioners, pharmacists, nutritionists, physical therapists, social workers, and community-based workers) to identify patients' social services and support needs and to improve the management and treatment of hypertension and high cholesterol.
- Describes how they will build and manage a coordinated network of multi-disciplinary partnerships that address identified barriers to social services and support needs (e.g., childcare, transportation, language translation, food assistance, and housing) within populations at highest risk of CVD.

Strategy 3. Link Community Resources and Clinical Services that support Bi-Directional Referrals, Self-Management, and Lifestyle Change to Address Social Determinants that Put the Priority Populations at Increased Risk for CVD, with a Focus on Hypertension and High Cholesterol.

Extent to which an applicant:

- Describes how they will create and enhance community-clinical links to identify SDOH (e.g., inferior housing, lack of transportation, inadequate access to care, and limited community resources) and respond to social services and support needs of populations at highest risk of CVD with a focus on hypertension and high cholesterol.
- Describes how they will identify and deploy dedicated CHWs (or their equivalents) to provide a continuum of care and services which extend the benefits of clinical interventions and address social services and support needs leading to optimal health outcomes.
- Describes how they will promote use of self-measured blood pressure monitoring with clinical support within populations at highest risk of hypertension.

Work Plan

Extent to which an applicant:

- Provides a detailed work plan for the first year of the award.
- Provides a work plan which:
 - Describes how the applicant will address all strategies to achieve NOFO outcomes.
 - Contains activities in alignment with the NOFO logic model.
 - Includes the required performance measures for accomplishing tasks, with baselines, Year 1 targets, and data sources for all performance measures (short-term and intermediate).
- Describes staff person(s) responsible for activity oversight along with start and end dates.

ii. Evaluation and Performance Measurement

Maximum Points: 0

Extent to which an applicant:

- Describes evaluation strategies that include process and outcome evaluation questions.

- Describes how they will use data, like GIS mapping, to identify their priority populations.
- Describes how multidisciplinary partners (e.g., learning collaborative, state partners, and community-based organizations) will be engaged in the evaluation and performance measurement planning process. Details should include partner's capacity to collect, store, and disseminate program data.
- Describes how evaluation findings will be used for continuous program improvement.
- Describes their existing capacity in program evaluation or plans to develop such expertise. The description should include details of existing capacity to collect and report on required program data or plans to implement a data collection and reporting system with a timeline.
- Describes how funding is allocated to evaluation and performance measurement. This should be explicitly described in the Evaluation and Performance Measurement section and documented in the staffing plans and budget.

iii. Applicant's Organizational Capacity to Implement the Approach

Maximum Points: 0

Organizational Capacity

Extent to which an applicant:

- Describes how they will coordinate efforts with other federally and privately funded programs within the state to leverage resources and maximize reach and impact to address SDOH and social support needs related to CVD, specific to hypertension, in their state and their overall approach to addressing the populations at highest risk.
- Describes their capacity to manage programs and resources ensuring the administrative, financial, and staff support necessary to sustain activities. This includes describing an adequate staffing plan, providing CVs/Resumes for proposed personnel, an organizational chart, and a project management structure that clearly defines staff roles and reporting structure, as it applies to this funding opportunity. Describes previous experience in management of CVD programs specific to hypertension within the highest at-risk populations.
- Describes a dedicated staff explicitly included in the work plan and budget, who will focus on health inequities and build relationships at the designated levels to decrease health care disparities and advance health equity.
- Describes the organization/proposed program plan that demonstrates the ability to document and disseminate evaluation findings, outcomes, and recommendations, including the outcomes and achievements resulting from collaborative work with partners.
- Describes how program performance will be monitored and how the program will be adjusted to address identified problems.

Collaborations

Extent to which an applicant:

- Describes how they will collaborate with CDC-funded programs and health equity subject matter experts in the state health department.

- Describes how they will establish or partner with learning collaboratives (LC) or collaborate with organizations outside the state health department
- Provides Letters of Support or Memorandums of Agreement from proposed LC partners.

Budget

Maximum Points: 0

The extent to which an applicant:

- Describes how the budget supports the work plan and evaluation plan.
- Provides an accurate and reasonable budget.
- Describes how the budget is allocated to evaluation efforts.

c. Phase III Review

Applications will not be scored. A technical review will be conducted by the CDC Program staff using the criteria noted in the Phase II Review Criteria Section.

Review of risk posed by applicants.

Prior to making a Federal award, CDC is required by 31 U.S.C. 3321 and 41 U.S.C. 2313 to review information available through any OMB-designated repositories of government-wide eligibility qualification or financial integrity information as appropriate. See also suspension and debarment requirements at 2 CFR parts 180 and 376.

In accordance 41 U.S.C. 2313, CDC is required to review the non-public segment of the OMB-designated integrity and performance system accessible through SAM (currently the Federal Recipient Performance and Integrity Information System (FAPIIS)) prior to making a Federal award where the Federal share is expected to exceed the simplified acquisition threshold, defined in 41 U.S.C. 134, over the period of performance. At a minimum, the information in the system for a prior Federal award recipient must demonstrate a satisfactory record of executing programs or activities under Federal grants, cooperative agreements, or procurement awards; and integrity and business ethics. CDC may make a Federal award to a recipient who does not fully meet these standards, if it is determined that the information is not relevant to the current Federal award under consideration or there are specific conditions that can appropriately mitigate the effects of the non-Federal entity's risk in accordance with 45 CFR §75.207.

CDC's framework for evaluating the risks posed by an applicant may incorporate results of the evaluation of the applicant's eligibility or the quality of its application. If it is determined that a Federal award will be made, special conditions that correspond to the degree of risk assessed may be applied to the Federal award. The evaluation criteria is described in this Notice of Funding Opportunity.

In evaluating risks posed by applicants, CDC will use a risk-based approach and may consider any items such as the following:

- (1) Financial stability;

(2) Quality of management systems and ability to meet the management standards prescribed in this part;

(3) History of performance. The applicant's record in managing Federal awards, if it is a prior recipient of Federal awards, including timeliness of compliance with applicable reporting requirements, conformance to the terms and conditions of previous Federal awards, and if applicable, the extent to which any previously awarded amounts will be expended prior to future awards;

(4) Reports and findings from audits performed under subpart F 45 CFR 75 or the reports and findings of any other available audits; and

(5) The applicant's ability to effectively implement statutory, regulatory, or other requirements imposed on non-Federal entities.

CDC must comply with the guidelines on government-wide suspension and debarment in 2 CFR part 180, and require non-Federal entities to comply with these provisions. These provisions restrict Federal awards, subawards and contracts with certain parties that are debarred, suspended or otherwise excluded from or ineligible for participation in Federal programs or activities.

2. Announcement and Anticipated Award Dates

Successful applicants can anticipate notice of funding approximately 30 days prior to the project start date of June 30, 2023.

F. Award Administration Information

1. Award Notices

Recipients will receive an electronic copy of the Notice of Award (NOA) from CDC OGS. The NOA shall be the only binding, authorizing document between the recipient and CDC. The NOA will be signed by an authorized GMO and emailed to the Recipient Business Officer listed in application and the Program Director.

Any applicant awarded funds in response to this Notice of Funding Opportunity will be subject to annual 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.

2. Administrative and National Policy Requirements

Recipients must comply with the administrative and public policy requirements outlined in 45 CFR Part 75 and the HHS Grants Policy Statement, as appropriate.

Brief descriptions of relevant provisions are available at <https://www.cdc.gov/grants/additional-requirements/index.html>.

The HHS Grants Policy Statement is available at <http://www.hhs.gov/sites/default/files/grants/grants/policies-regulations/hhsgps107.pdf>.

[AR-1: Human Subjects Requirements](#)

[AR-2: Requirements for Inclusion of Women and Racial and Ethnic Minorities in Research](#)

[AR-3: Animal Subjects Requirements](#)

[AR-9: Paperwork Reduction Act Requirements](#)

[AR-10: Smoke-Free Workplace Requirements](#)

[AR-11: Healthy People 2030](#)

[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-17: Peer and Technical Reviews of Final Reports of Health Studies – ATSDR](#)

[AR-21: Small, Minority, And Women-owned Business](#)

[AR-22: Research Integrity](#)

[AR-24: Health Insurance Portability and Accountability Act Requirements](#)

[AR-25: Data Management and Access](#)

[AR-26: National Historic Preservation Act of 1966](#)

[AR-28: Inclusion of Persons Under the Age of 21 in Research](#)

[AR-29: Compliance with EO13513, “Federal Leadership on Reducing Text Messaging while Driving”, October 1, 2009](#)

[AR-30: Information Letter 10-006, - Compliance with Section 508 of the Rehabilitation Act of 1973](#)

[AR-31: Research Definition](#)

[AR-32: Appropriations Act, General Provisions](#)

[AR-33: United States Government Policy for Institutional Oversight of Life Sciences Dual Use Research of Concern](#)

[AR-37: Prohibition on certain telecommunications and video surveillance services or equipment for all awards issued on or after August 13, 2020](#)

The full text of the Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards, 45 CFR 75, can be found at: <https://www.ecfr.gov/cgi-bin/text-idx?node=pt45.1.75>

Should you successfully compete for an award, recipients of federal financial assistance (FFA) from HHS will be required to complete an HHS Assurance of Compliance form (HHS 690) in which you agree, as a condition of receiving the grant, to administer your programs in compliance with federal civil rights laws that prohibit discrimination on the basis of race, color,

national origin, age, sex and disability, and agreeing to comply with federal conscience laws, where applicable. This includes ensuring that entities take meaningful steps to provide meaningful access to persons with limited English proficiency; and ensuring effective communication with persons with disabilities. Where applicable, Title XI and Section 1557 prohibit discrimination on the basis of sexual orientation, and gender identity. The HHS Office for Civil Rights provides guidance on complying with civil rights laws enforced by HHS. See <https://www.hhs.gov/civil-rights/for-providers/provider-obligations/index.html> and <https://www.hhs.gov/civil-rights/for-individuals/nondiscrimination/index.html>.

- For guidance on meeting your legal obligation to take reasonable steps to ensure meaningful access to your programs or activities by limited English proficient individuals, see <https://www.hhs.gov/civil-rights/for-individuals/special-topics/limited-english-proficiency/fact-sheet-guidance/index.html> and <https://www.lep.gov>.
- For information on your specific legal obligations for serving qualified individuals with disabilities, including providing program access, reasonable modifications, and to provide effective communication, see <http://www.hhs.gov/ocr/civilrights/understanding/disability/index.html>.
- HHS funded health and education programs must be administered in an environment free of sexual harassment, see <https://www.hhs.gov/civil-rights/for-individuals/sex-discrimination/index.html>.
- For guidance on administering your project in compliance with applicable federal religious nondiscrimination laws and applicable federal conscience protection and associated anti-discrimination laws, see <https://www.hhs.gov/conscience/conscience-protections/index.html> and <https://www.hhs.gov/conscience/religious-freedom/index.html>.

3. Reporting

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

- Helps target support to recipients;
- Provides CDC with periodic data to monitor recipient progress toward meeting the Notice of Funding Opportunity outcomes and overall performance;
- Allows CDC to track performance measures and evaluation findings for continuous quality and program improvement throughout the period of performance 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 NOFO.

The table below summarizes required and optional reports. All required reports must be sent electronically to GMS listed in the “Agency Contacts” section of the NOFO copying the CDC Project Officer.

Report	When?	Required?
Recipient Evaluation and Performance Measurement Plan, including Data Management Plan (DMP)	6 months into award	Yes
Annual Performance Report (APR). This includes Data on Performance Measures.	No later than 120 days before end of budget period. Serves as yearly continuation application. Data on Performance Measures are reported annually.	Yes
Federal Financial Reporting Forms	90 days after the end of the budget period	Yes
Final Performance and Financial Report	90 days after end of period of performance	Yes
Payment Management System (PMS) Reporting	Quarterly reports due January 30; April 30; July 30; and October 30	Yes

a. Recipient Evaluation and Performance Measurement Plan (required)

With support from CDC, recipients must elaborate on their initial applicant evaluation and performance measurement plan. This plan must be no more than 20 pages; recipients must submit the plan 6 months into the award. HHS/CDC will review and approve the recipient’s monitoring and evaluation plan to ensure that it is appropriate for the activities to be undertaken as part of the agreement, for compliance with the monitoring and evaluation guidance established by HHS/CDC, or other guidance otherwise applicable to this Agreement.

Recipient Evaluation and Performance Measurement Plan (required): This plan should provide additional detail on the following:

Performance Measurement

- Performance measures and targets
- The frequency that performance data are to be collected.
- How performance data will be reported.
- How quality of performance data will be assured.
- How performance measurement will yield findings to demonstrate progress towards achieving NOFO goals (e.g., reaching target populations or achieving expected outcomes).
- Dissemination channels and audiences.
- Other information requested as determined by the CDC program.

Evaluation

- The types of evaluations to be conducted (e.g. process or outcome evaluations).
- The frequency that evaluations will be conducted.
- How evaluation reports will be published on a publicly available website.

- How evaluation findings will be used to ensure continuous quality and program improvement.
- How evaluation will yield findings to demonstrate the value of the NOFO (e.g., effect on improving public health outcomes, effectiveness of NOFO, cost-effectiveness or cost-benefit).
- Dissemination channels and audiences.

HHS/CDC or its designee will also undertake monitoring and evaluation of the defined activities within the agreement. The recipient must ensure reasonable access by HHS/CDC or its designee to all necessary sites, documentation, individuals and information to monitor, evaluate and verify the appropriate implementation the activities and use of HHS/CDC funding under this Agreement.

b. Annual Performance Report (APR) (required)

The recipient must submit the APR via www.Grantsolutions.gov no later than 120 days prior to the end of the budget period. This report must not exceed 45 pages excluding administrative reporting. Attachments are not allowed, but web links are allowed.

This report must include the following:

- **Performance Measures:** Recipients must report on performance measures for each budget period and update measures, if needed.
- **Evaluation Results:** Recipients must report evaluation results for the work completed to date (including findings from process or outcome evaluations).
- **Work Plan:** Recipients must update work plan each budget period to reflect any changes in period of performance outcomes, activities, timeline, etc.
- **Successes**
 - Recipients must report progress on completing activities and progress towards achieving the period of performance outcomes described in the logic model and work plan.
 - Recipients must describe any additional successes (e.g. identified through evaluation results or lessons learned) achieved in the past year.
 - Recipients must describe success stories.
- **Challenges**
 - Recipients must describe any challenges that hindered or might hinder their ability to complete the work plan activities and achieve the period of performance outcomes.
 - Recipients must describe any additional challenges (e.g., identified through evaluation results or lessons learned) encountered in the past year.
- **CDC Program Support to Recipients**
 - Recipients must describe how CDC could help them overcome challenges to complete activities in the work plan and achieving period of performance outcomes.

- **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.

The recipients must submit the Annual Performance Report via www.Grantsolutions.gov no later than 120 days prior to the end of the budget period.

c. Performance Measure Reporting (optional)

CDC programs may require more frequent reporting of performance measures than annually in the APR. If this is the case, CDC programs must specify reporting frequency, data fields, and format for recipients at the beginning of the award period.

d. Federal Financial Reporting (FFR) (required)

The annual FFR form (SF-425) is required and must be submitted 90 days after the end of the budget period through the Payment Management System (PMS). The report must include only those funds authorized and disbursed during the timeframe covered by the report. The final FFR must indicate the exact balance of unobligated funds, and may not reflect any unliquidated obligations. There must be no discrepancies between the final FFR expenditure data and the Payment Management System's (PMS) cash transaction data. Failure to submit the required information by the due date may adversely affect the future funding of the project. If the information cannot be provided by the due date, recipients are required to submit a letter of explanation to OGS and include the date by which the Grants Officer will receive information.

e. Final Performance and Financial Report (required)

The Final Performance Report is due 90 days after the end of the period of performance. The Final FFR is due 90 days after the end of the period of performance and must be submitted through the Payment Management System (PMS). CDC programs must indicate that this report should not exceed 40 pages. This report covers the entire period of performance and can include information previously reported in APRs. At a minimum, this report must include the following:

- Performance Measures – Recipients must report final performance data for all process and outcome performance measures.
- Evaluation Results – Recipients must report final evaluation results for the period of performance for any evaluations conducted.
- Impact/Results/Success Stories – Recipients must use their performance measure results and their evaluation findings to describe the effects or results of the work completed over the project period, and can include some success stories.
- A final Data Management Plan that includes the location of the data collected during the funded period, for example, repository name and link data set(s)
- Additional forms as described in the Notice of Award (e.g., Equipment Inventory Report, Final Invention Statement).

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

Federal Funding Accountability and Transparency Act of 2006 (FFATA), P.L. 109–282, as amended by section 6202 of P.L. 110–252 requires full disclosure of all entities and organizations receiving Federal funds including awards, contracts, loans, other assistance, and payments through a single publicly accessible Web site, <http://www.USASpending.gov>.

Compliance with this law is primarily the responsibility of the Federal agency. However, two elements of the law require information to be collected and reported by applicants: 1) information on executive compensation when not already reported through the SAM, and 2) similar information on all sub-awards/subcontracts/consortiums over \$25,000.

For the full text of the requirements under the FFATA and HHS guidelines, go to:

- <https://www.gpo.gov/fdsys/pkg/PLAW-109publ282/pdf/PLAW-109publ282.pdf>,
- https://www.frs.gov/documents/ffata_legislation_110_252.pdf
- <http://www.hhs.gov/grants/grants/grants-policies-regulations/index.html#FFATA>.

5. Reporting of Foreign Taxes (International/Foreign projects only)

A. Valued Added Tax (VAT) and Customs Duties – Customs and import duties, consular fees, customs surtax, valued added taxes, and other related charges are hereby authorized as an allowable cost for costs incurred for non-host governmental entities operating where no applicable tax exemption exists. This waiver does not apply to countries where a bilateral agreement (or similar legal document) is already in place providing applicable tax exemptions and it is not applicable to Ministries of Health. Successful applicants will receive information on VAT requirements via their Notice of Award.

B. The U.S. Department of State requires that agencies collect and report information on the amount of taxes assessed, reimbursed and not reimbursed by a foreign government against commodities financed with funds appropriated by the U.S. Department of State, Foreign Operations and Related Programs Appropriations Act (SFOAA) (“United States foreign assistance funds”). Outlined below are the specifics of this requirement:

1) Annual Report: The recipient must submit a report on or before November 16 for each foreign country on the amount of foreign taxes charged, as of September 30 of the same year, by a foreign government on commodity purchase transactions valued at 500 USD or more financed with United States foreign assistance funds under this grant during the prior United States fiscal year (October 1 – September 30), and the amount reimbursed and unreimbursed by the foreign government. [Reports are required even if the recipient did not pay any taxes during the reporting period.]

2) Quarterly Report: The recipient must quarterly submit a report on the amount of foreign taxes charged by a foreign government on commodity purchase transactions valued at 500 USD or more financed with United States foreign assistance funds under this grant. This report shall be submitted no later than two weeks following the end of each quarter: April 15, July 15, October 15 and January 15.

3) Terms: For purposes of this clause:

“Commodity” means any material, article, supplies, goods, or equipment;
“Foreign government” includes any foreign government entity;
“Foreign taxes” means value-added taxes and custom duties assessed by a foreign government on a commodity. It does not include foreign sales taxes.

4) Where: Submit the reports to the Director and Deputy Director of the CDC office in the country(ies) in which you are carrying out the activities associated with this cooperative agreement. In countries where there is no CDC office, send reports to VATreporting@cdc.gov.

5) Contents of Reports: The reports must contain:

- a. recipient name;
- b. contact name with phone, fax, and e-mail;
- c. agreement number(s) if reporting by agreement(s);
- d. reporting period;
- e. amount of foreign taxes assessed by each foreign government;
- f. amount of any foreign taxes reimbursed by each foreign government;
- g. amount of foreign taxes unreimbursed by each foreign government.

6) Subagreements. The recipient must include this reporting requirement in all applicable subgrants and other subagreements.

6. Termination

CDC may impose other enforcement actions in accordance with 45 CFR 75.371- Remedies for Noncompliance, as appropriate.

The Federal award may be terminated in whole or in part as follows:

- (1) By the HHS awarding agency or pass-through entity, if the non-Federal entity fails to comply with the terms and conditions of the award;
- (2) By the HHS awarding agency or pass-through entity for cause;
- (3) By the HHS awarding agency or pass-through entity with the consent of the non-Federal entity, in which case the two parties must agree upon the termination conditions, including the effective date and, in the case of partial termination, the portion to be terminated; or
- (4) By the non-Federal entity upon sending to the HHS awarding agency or pass-through entity written notification setting forth the reasons for such termination, the effective date, and, in the case of partial termination, the portion to be terminated. However, if the HHS awarding agency or pass-through entity determines in the case of partial termination that the reduced or modified portion of the Federal award or subaward will not accomplish the purposes for which the Federal award was made, the HHS awarding agency or pass-through entity may terminate the Federal award in its entirety.

G. Agency Contacts

CDC encourages inquiries concerning this notice of funding opportunity.

Program Office Contact

For programmatic technical assistance, contact:

First Name:

Rebekah

Last Name:

Buckley

Project Officer

Department of Health and Human Services

Centers for Disease Control and Prevention

Address:

Telephone:

Email:

NationalCVH@cdc.gov

Grants Staff Contact

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

First Name:

Monique

Last Name:

Tatum

Grants Management Specialist

Department of Health and Human Services

Office of Grants Services

Address:

Telephone:

Email:

itn8@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.

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 **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
- Report on Programmatic, Budgetary and Commitment Overlap
- Table of Contents for Entire Submission

For international NOFOs:

- SF424
- SF424A
- Funding Preference Deliverables

Optional attachments, as determined by CDC programs:

Resumes / CVs

Letters of Support

Organization Charts

Indirect Cost Rate, if applicable

Memorandum of Agreement (MOA)

Memorandum of Understanding (MOU)

Bona Fide Agent status documentation, if applicable

I. Glossary

Activities: The actual events or actions that take place as a part of the program.

Administrative and National Policy Requirements, Additional Requirements

(ARs): Administrative requirements found in 45 CFR Part 75 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 NOFO; recipients must comply with the ARs listed in the NOFO. To view brief descriptions of relevant provisions, see <https://www.cdc.gov/grants/additional-requirements/index.html>. Note that 2 CFR 200 supersedes the administrative requirements (A-110 & A-102), cost principles (A-21, A-87 & A-122) and audit requirements (A-50, A-89 & A-133).

Approved but Unfunded: Approved but unfunded refers to applications recommended for approval during the objective review process; however, they were not recommended for funding by the program office and/or the grants management office.

Assistance Listings: A government-wide collection of federal programs, projects, services, and activities that provide assistance or benefits to the American public.

Assistance Listings Number: A unique number assigned to each program and NOFO throughout its lifecycle that enables data and funding tracking and transparency

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

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

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

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

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

Contracts: An award instrument used to acquire (by purchase, lease, or barter) property or services for the direct benefit or use of the Federal Government.

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. Substantial involvement means that the recipient can expect federal programmatic collaboration or participation in carrying out the effort under the award.

Cost Sharing or Matching: Refers to program costs not borne by the Federal Government but by the recipients. It may include the value of allowable third-party, in-kind contributions, as well as expenditures by the recipient.

Direct Assistance: A financial assistance mechanism, which must be specifically authorized by statute, whereby goods or services are provided to recipients in lieu of cash. DA generally involves the assignment of federal personnel or the provision of equipment or supplies, such as vaccines. DA is primarily used to support payroll and travel expenses of CDC employees assigned to state, tribal, local, and territorial (STLT) health agencies that are recipients of grants and cooperative agreements. Most legislative authorities that provide financial assistance to STLT health agencies allow for the use of DA. <https://www.cdc.gov/grants/additional-requirements/index.html>.

Evaluation (program evaluation): The systematic collection of information about the activities, characteristics, and outcomes of programs (which may include interventions, policies, and specific projects) to make judgments about that program, improve program effectiveness, and/or inform decisions about future program development.

Evaluation Plan: A written document describing the overall approach that will be used to guide an evaluation, including why the evaluation is being conducted, how the findings will likely be used, and the design and data collection sources and methods. The plan specifies what will be done, how it will be done, who will do it, and when it will be done. The NOFO evaluation plan is used to describe how the recipient and/or CDC will determine whether activities are implemented appropriately and outcomes are achieved.

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 website at www.USAspending.gov.

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

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

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

Grants Management Officer (GMO): The individual designated to serve as the HHS official responsible for the business management aspects of a particular grant(s) or cooperative agreement(s). The GMO serves as the counterpart to the business officer of the recipient organization. In this capacity, the GMO is responsible for all business management matters associated with the review, negotiation, award, and administration of grants and interprets grants administration policies and provisions. The GMO works closely with the program or project officer who is responsible for the scientific, technical, and programmatic aspects of the grant.

Grants Management Specialist (GMS): A federal staff member who oversees the business and other non-programmatic aspects of one or more grants and/or cooperative agreements. These activities include, but are not limited to, evaluating grant applications for administrative content and compliance with regulations and guidelines, negotiating grants, providing consultation and technical assistance to recipients, post-award administration and closing out grants.

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

Health Equity: Striving for the highest possible standard of health for all people and giving special attention to the needs of those at greatest risk of poor health, based on social conditions.

Health Inequities: Systematic, unfair, and avoidable differences in health outcomes and their determinants between segments of the population, such as by socioeconomic status (SES), demographics, or geography.

Healthy People 2030: 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.

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 visual representation showing the sequence of related events connecting the activities of a program with the programs' desired outcomes and results.

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 non-government 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.

Nonprofit Organization: Any corporation, trust, association, cooperative, or other organization that is operated primarily for scientific, educational, service, charitable, or similar purposes in the public interest; is not organized for profit; and uses net proceeds to maintain, improve, or expand the operations of the organization. Nonprofit organizations include institutions of higher education, hospitals, and tribal organizations (that is, Indian entities other than federally recognized Indian tribal governments).

Notice of Award (NoA): The official document, signed (or the electronic equivalent of signature) by a Grants Management Officer that: (1) notifies the recipient of the award of a grant; (2) contains or references all the terms and conditions of the grant and Federal funding limits and obligations; and (3) provides the documentary basis for recording the obligation of Federal funds in the HHS accounting system.

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 results of program operations or activities; the effects triggered by the program. For example, increased knowledge, changed attitudes or beliefs, reduced tobacco use, reduced morbidity and mortality.

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.

Period of performance –formerly known as the project period - : The time during which the recipient may incur obligations to carry out the work authorized under the Federal award. The start and end dates of the period of performance must be included in the Federal award.

Period of Performance Outcome: An outcome that will occur by the end of the NOFO's funding period

Plain Writing Act of 2010: The Plain Writing Act of 2010 requires that federal agencies use clear communication that the public can understand and use. NOFOs must be written in clear, consistent language so that any reader can understand expectations and intended outcomes of the funded program. CDC programs should use NOFO plain writing tips when writing NOFOs.

Program Strategies: Strategies are groupings of related activities, usually expressed as general headers (e.g., Partnerships, Assessment, Policy) or as brief statements (e.g., Form partnerships, Conduct assessments, Formulate policies).

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

Public Health Accreditation Board (PHAB): A nonprofit organization that works to promote and protect the health of the public by advancing the quality and performance of public health departments in the U.S. through national public health department accreditation <http://www.phaboard.org>.

Social Determinants of Health: Conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

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.

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

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.

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

UEI: The Unique Entity Identifier (UEI) number is a twelve-digit number assigned by SAM.gov. When applying for Federal awards or cooperative agreements, all applicant organizations must obtain a UEI number as the Universal Identifier. UEI number assignment is free. If an organization does not know its UEI number or needs to register for one, visit www.sam.gov.

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

NOFO-specific Glossary and Acronyms