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Chronic Disease Prevention and Health Promotion Programs; Notice

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[Program Announcement 03022]

Chronic Disease Prevention and Health Promotion Programs

The Centers for Disease Control and Prevention (CDC) announces the availability of fiscal year (FY) 2003 funds for a cooperative agreement program for Chronic Disease Prevention and Health Promotion Programs.

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A. Authority and Catalog of Federal Domestic Assistance Number

Components 1 (Tobacco), 2 (Nutrition, Physical Activity, Obesity), 4 (Oral Disease), 6 (BRFSS), and 7 (Genomics)

This program is authorized under section 301 (a) and 317 (k) (2) of the Public Health Service Act, [42 U.S.C. section 241 (a) and 247b(k) (2), as amended]. The Catalog of Federal Domestic Assistance number is 93.283.

Component 3—WISEWOMAN

This program is authorized under sections 1501–1509 [42 U.S.C. 300k–300n–4a] of the Public Health Service Act, as amended. The consolidated Appropriations Act, 2000, Public Law 106–113, also authorizes this program. The Catalog of Federal Domestic Assistance (CFDA) number is 93.283. See *http://www.cdc.gov/wisewoman/legislationhighlight.htm* for WISEWOMAN authorization and link to BCCEDP legislation.

Component 5—Arthritis

This program is authorized under section 301(a) and 317(k) (2) of the Public Health Service Act, [42 U.S.C. section 241 (a) and 247b(k) (2), as amended]. The Catalog of Federal Domestic Assistance number is 93.945.

B. Purpose

The Centers for Disease Control and Prevention (CDC) announces the availability of fiscal year (FY) 2003 funds for a cooperative agreement program for Chronic Disease Prevention and Health Promotion Programs. This program addresses the ''Healthy People 2010'' focus areas of Tobacco Use, Physical Activity and Fitness, Nutrition and Overweight, Public Health Infrastructure, Oral Health, Arthritis, Osteoporosis, Back Conditions, Educational and Community-Based Programs, Cancer, Diabetes, Genomics, and Surveillance and Data Systems.

The purpose of the program is to support capacity building, support program planning, development, implementation, evaluation, and surveillance for current and emerging chronic diseases conditions.

The Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP) is issuing this program announcement in an effort to simplify and streamline the grant pre-award and post-award administrative process, provide increased flexibility in the use of funds, measure performance related to each grantee's stated objectives and identify and establish the long-term goals of Health Promotion programs through stated performance measures. These efforts include incorporation of improved performance measures, enhancement of short and long term objectives, combining multiple reports, establishment of consistent reporting requirements, and advancing from one public health program funding level to a higher level based on performance.

This program announcement incorporates funding guidance for the following seven program components: Tobacco; Nutrition, Physical Activity, and Obesity; Well Integrated Screening and Evaluation for Women Across the Nation (WISEWOMAN); State-based Oral Disease Prevention; Arthritis; Behavior Risk Factor Surveillance Systems (BRFSS); and Genomics and Chronic Disease Prevention programs.

CDC encourages recipients to identify opportunities to link chronic disease and health promotion efforts across this and related program announcements, where appropriate (*i.e.* cardiovascular health, diabetes, genomics, tobacco, nutrition and physical activity, obesity, etc.). These efforts could include co-funding of recipient activities and cost sharing of staff time, in support of shared, overlapping objectives across program components and cooperative agreements. Such complementary activities must meet the program objectives of the funded component/program.

Your application should be submitted as one application but should consist of each separate Specific Categorical Component. Applications will be due on March 28, 2003. The categorical components and specific purposes for each are:

Component 1: Comprehensive State-Based Tobacco Prevention and Control Programs—The purpose of this program is to achieve four Program Goals through community interventions and mobilization; counter-marketing; policy development and implementation; and surveillance and evaluation. The goals are: prevent initiation to tobacco use among young people; eliminate exposure to second hand smoke; promote cessation among adults and young people who use tobacco; and identify and eliminate tobacco-related disparities among specific population groups.

Component 2: State Nutrition and Physical Activity Programs to Prevent Obesity and Other Chronic Diseases—The purpose of the program is to prevent and control obesity and other chronic diseases by supporting States in the development and implementation of science-based nutrition and physical activity interventions. Major program areas are: balancing caloric intake and expenditure; improved nutrition through increased breastfeeding and increased consumption of fruits and vegetables; increased physical activity; and reduced television time. See Goals at *http://www.cdc.gov/nccdphp/dnpa/rfainformation.htm.*

Component 3: Well integrated Screening and Evaluation for Women Across the Nation (WISEWOMAN)—The purpose of this program is to support health promotion efforts through the WISEWOMAN program, focusing on early detection of chronic diseases and their associated risk factors and prevention of chronic diseases through lifestyle interventions. The WISEWOMAN program promotes a healthy lifestyle through increased physical activity, improved nutrition, weight control, and smoking cessation. The target population is women aged 40–64 years old who are participants in the National Breast and Cervical Cancer Early Detection Program (NBCCEDP) comprehensive screening programs funded by the Centers for Disease Control and Prevention (CDC). Because eligibility for the NBCCEDP is based on inadequate health insurance coverage and lack of financial resources, the WISEWOMAN program aims to increase access to quality care through screening

for conditions such as high cholesterol and high blood pressure using methods detailed in national clinical guidelines. Along with lifestyle interventions, medical referral and follow-up are also important components of the program.

Component 4: State-Based Oral Disease Prevention Programs—The purpose of this program is to establish, strengthen and expand the capacity of States, Territories, and tribes to plan, implement, and evaluate population-based oral disease prevention and health promotion programs, targeting populations and oral disease burden, as outlined in ''Oral Health in America: A Report of the Surgeon General,'' and can be found using the following link *http://www.surgeongeneral.gov/library/oralhealth.*

Component 5: Arthritis—The purpose of this program is to assist States in developing, implementing, and evaluating State level programs to control of arthritis and other rheumatic conditions. This program emphasizes State-based leadership in coordinating State Health Department capacity to reduce the burden of arthritis within the State. Programmatic efforts should focus on persons affected by arthritis, *i.e.*, persons already experiencing the systems of arthritis, their families, and others treating or providing services for persons with arthritis. By targeting persons affected by arthritis, prevention strategies are secondary and tertiary, focusing on prevention of disability and improving quality of life. There will be two levels of activities for this component: Capacity Building Program Level A and Capacity Building Level B. See ''Recipient Activities'' for specific activities for each level.

Component 6: Behavior Risk Factor Surveillance Systems (BRFSS)—The purpose of this program is to provide financial and programmatic assistance to State Health Departments to maintain and expand (1) specific surveillance using telephone survey methodology of the behaviors of the general population that contribute to the occurrence of prevention of chronic diseases and injuries, and (2) the collection, analysis, and dissemination of BRFSS data to State categorical programs for their use in assessing trends, directing program planning, evaluating programs, establishing program priorities, developing policy, and targeting relevant population groups.

Component 7: Genomics and Chronic Disease Prevention—The purpose of the program is to assist States in developing agency-level genomics leadership and coordination capacity that ensures effective planning, implementation and evaluation of knowledge and tools for using genetic risk factors and family history in improving chronic disease prevention and health outcomes. The study of genes and their function has led to recent advances in genomics and our understanding of the molecular mechanisms of disease, including the complex interplay of genetic and environmental factors. This program requires the integration of genomics and family history assessments into ongoing and new population-based strategies for identifying and reducing the burden of specific chronic, infectious and other diseases. Of particular importance is enhanced planning and coordination to integrate genomics into core State public health specialties of genomics within State core public health specialties (such as epidemiology, laboratory activities, and environmental health) and to facilitate the effective application of new knowledge, enable effective application of new knowledge about gene-environment interactions, and crosscutting family history information to chronic disease prevention opportunities.

Note: The following statements are applicable for all Components: Measurable outcomes of the program will be in alignment with one or more of the following performance goals for the National Center for Disease Prevention and Health Promotion (NCCDPHP): Reduce cigarette smoking among youth; support prevention research to develop sustainable and transferable community-based behavioral interventions; increase the capacity of State arthritis programs to address the prevention of arthritis and its complications at the community level; help States monitor the prevalence of major behavioral risks associated with premature morbidity and mortality in adults to improve the planning, implementation, and evaluation of disease prevention and health promotion programs; support high-priority State and local disease prevention and health promotion programs, and to help State use genetic information in their public health programs.

Applicants are required to provide measures of effectiveness that will demonstrate the accomplishment of the various identified objectives of the grant or cooperative agreement. Measures of effectiveness must relate to the performance goal (or goals) as stated in section ''B. Purpose'' of this announcement. Measures must be objective and quantitative and must measure the intended outcome. These measures of effectiveness shall be submitted with the application and shall be an element of evaluation.

C. Eligible Applicants

Limited Competition

Assistance will be provided only to the health departments of States or their bona fide agents, 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, the Republic of Palau, and Federally recognized Indian tribal governments. A bona fide agent is an agency/organization identified by the State as eligible to submit an application under the State eligibility in lieu of a state application.

All applications received from current grant recipients under Program Announcements 99038, Component 1, (Comprehensive State-Based Tobacco Use Prevention and Control Programs); 00115 and 99135, Component 3 (Well Integrated Screening and Evaluation for Women Across the Nation WISEWOMAN) and 01098 (WISEWOMAN Enhanced); 01046, Component 4 (Support for State Oral Disease Prevention Programs); 01097, Component 5 (Reducing the Impact of Arthritis and Other Rheumatic Conditions); 99044, Component 6, (Behavior Risk Factor Surveillance Systems) will be funded upon receipt and approval of a technically acceptable application. In addition to the eligible applicants above, potential applicants that are eligible for specific components 2, 3, 4, 5, 6, and 7 are:

Component 2—State Nutrition and Physical Activity Programs to Prevent Obesity and Other Chronic Diseases: Eligibility for this component is limited to States, Territories, and the District of Columbia. Applicants can apply for either or both programs, ''Capacity Building or Basic Implementation funding.'' Applicants awarded Basic Implementation funds will not be considered for Capacity funding. Applicants applying for both programs must submit two separate applications for this component.

Component 3—WISEWOMAN: Assistance will be provided only to the health departments of certain States/Territories/Tribes or their bona fide agents who are currently receiving grants under Section 1501 of the Public Health Service Act. Applicants are eligible for one of two levels of funding for one of two types of projects, Standard or Enhanced (see Appendix A: Eligibility and Appendix B: Type of Program and Performance Requirements for more details).

Component 4—State-Based Oral Disease Prevention Programs: The 13 States currently receiving CDC funds for CORE Programs under Program Announcement 01046 are eligible to apply for Part 1 Capacity Building Program: Alaska, Arkansas, Colorado, Illinois, Michigan, New York, Nevada,

North Dakota, Oregon, the Republic of Palau, Rhode Island, South Carolina, and Texas.

Current CORE Program grantees that apply for Basic Implementation Program funding in year two and are not funded will continue to receive funding for the CORE (Capacity Building) Program. To make this possible, currently funded CORE (Capacity Building) Program grantees must provide a separate CORE (Capacity Building) Program Logic Model, Work Plan, budget, and budget justifications that addresses CORE (Capacity Building) Program activities to expedite the award process.

Component 5—Arthritis: The only eligible applicants for Capacity Building Level B Funding during year one of this program announcement are the following 27 States which are currently funded under Program Announcement 01097, Reducing the Impact of Arthritis and Other Rheumatic Conditions: Alaska, Arizona, Arkansas, Colorado, Connecticut, Idaho, Indiana, Iowa, Kentucky, Maryland, Michigan, Nebraska, Nevada, New Mexico, New York, North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, Tennessee, Texas, Vermont, Virginia, and Wisconsin. These States may not apply for Capacity Building Program Level A funding during year one of this announcement.

Eligible applicants for Capacity Building Program Level A are those currently funded under Program Announcement 99074 and health departments other than those listed above who meet the requirements outlined in the ''Recipient Activities'' section of this Component for Capacity Building Program Level B and Capacity Program Level A.

Component 6—Behavior Risk Factor Surveillance Systems (BRFSS): Assistance will be provided only to the existing 54 health departments funded under the Behavioral Risk Factor Surveillance, Program Announcement Number 99044.

Component 7—Genomics: Assistance will be provided only to the health departments of States or their bona fide agents. A *bona fide* agent is an agency/organization identified by the state as eligible to submit an application under the State eligibility in lieu of a State application.

D. Availability of Funds

Approximately $91,700,000 is available in FY 2003 to fund approximately 194 awards.

It is expected that the awards will begin on or about June 30, 2003 and will be made for a 12-month budget period within a project period of up to five years.

Pending availability of funds, beginning in year two and each of the remaining years for this program announcement (June 30, 2004 through June 30, 2008), there will be an open season for competitive applications. Specific guidance will be provided with exact due dates and funding levels each year.

Applications from all new applicants as well as all currently funded programs, whose project period have ended or will end in FY 2003, will be competitively reviewed by an independent Objective Review Panel.

Continuation awards for year two and beyond will be made on the basis of satisfactory progress made toward the attainment of the goals, objectives, and corresponding performance measures as evidenced by required reports, and based on the availability of funds. Additional information is listed on a component-by-component basis.

Component 1: Comprehensive State-Based Basic Tobacco Prevention and Control Programs

D.1. Availability of Funds

Approximately $57 million is available in FY 2003 to fund 59 awards.

In year one, States and Territories currently funded under program announcement 99038 should apply for the same base amount that is currently received on a non-competitive basis. Applicants should refer to ''Recipient Financial Participation'' for information on required matching funds. The remaining unfunded Territory is Marshall Island that is eligible to apply for funds in the amount of $100,000 to $125,000. If Marshall Island submits an application, it will be reviewed under a competitive review process.

Continuation award amounts may be adjusted should a State receive lawsuit settlement funds, general funds, or excise tax funds for the State's comprehensive program.

Use of Funds

CDC funds cannot be used to supplant existing State funding. Applicants may not use these funds to supplant funds from Federal or State sources, the Preventive Health and Health Service Block Grant or Center for Substance Abuse Prevention funding for youth access enforcement. Applicants must maintain current levels of support dedicated to tobacco use prevention and control from Federal, State sources, or the Preventive Health and Health Services Block Grant.

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

Cooperative agreement funds must be used for focused strategies to change systems, develop and implement policies, change the environment in which tobacco use occurs, and impact population groups rather than individuals. To this end, cooperative agreement funds may not be used to provide direct services such as individual and group cessation services, patient care, personal health services medications, patient rehabilitation, or other costs associated with the treatment of diseases caused by tobacco use. Funds may be used to support activities in line with CDC ''Guidelines for School Health Program to Prevent Tobacco Use and Addiction'' including curricula but may not be used for staff time to provide direct classroom instruction of students. Cooperative agreement funds may not be used to directly enforce tobacco control policies unless there are extenuating circumstances within the State. A justification must be provided and reviewed.

Recipient Financial Participation

Federal sources as follows. During the first year of the award, States receiving funding from another source(s) that is equal to or greater than the CDC award will match one dollar of direct cash match from non-Federal sources for every dollar of Federal funds. All other States and Territories that do not receive funds from non-Federal sources that are equal to or greater than the CDC award will provide one dollar of cash or in-kind match from non-Federal sources for every ten dollars of Federal funds.

Beginning in the second year and in each subsequent year of the award, all States and Territories will provide one dollar from non-Federal sources for every four dollars of Federal funding. The match may be cash, in-kind, or a combination from State and/or public and private sources.

Technical assistance will be available for potential applicants through the following means: a minimum of two conference calls to be held on or around December 12, 2002 and January 10, 2003.

E.1. Program Requirements

In conducting activities to achieve the purpose of this program component, the recipient will be responsible for the activities under ''1. Recipient Activities,'' and CDC will be responsible for the activities listed under ''2. CDC Activities.''

1. Recipient Activities. a. Program Management. Identify and hire staff with the appropriate competencies to manage a tobacco prevention and control program and provide information to demonstrate that management staff are at a level within the agency to affect the decision making process related to the tobacco program.

A suggested minimum number of staff would be seven FTEs including one FTE Program Manager and one FTE for administrative support. Staff should have knowledge and skills in: Program development, coordination and management; fiscal management including management of funding to State and local partners; leadership development; tobacco control and prevention content; cultural competence; public health policy including analysis, development and implementation; community outreach and mobilization; training and technical assistance, health communications including counter-marketing; strategic use of media including media advocacy, earned and paid media; strategic planning; gathering and analyzing data (surveillance); and evaluation methods.

Funding from other sources increases the scope of the program, requiring additional staff to administer and monitor the program. A suggested number of staff based on increased funding levels would be an additional one to eight FTEs for a total of eight to sixteen FTEs with program justification including description of activities funded through other sources. The Program Manager and the administrative support position should be FTEs within the State Health Department (SHD). Other positions may be SHD FTEs or may be contractual.

Performance will be measured by evidence that the SHD has dedicated human resources to administer and manage the program effectively that is consistent with the competencies and staffing levels identified above in item (a) ''Program Management.''

Evidence of the provision of ongoing training for staff can be demonstrated through staff participation in CDC sponsored training, meetings and conferences and other continuing education opportunities as identified by SHD program staff.

Evidence of organizational impact could be demonstrated by providing evidence that management staff have organizational access to the State Health Officer and by providing information to support senior level management involvement in the tobacco program.

b. Fiscal Management. 1. Describe how funding to support State and local programs that focus on population-based strategies, are science-based and policy-focused, and reach diverse groups will be accomplished.

2. Track and monitor the health and economic burden of tobacco use in the State through surveillance and evaluation activities, program activities supporting goals and objectives, tracking policy development and implementation.

Performance will be measured by evidence that the SHD activities resulted in accomplishment of items (a) through (d) above.

c. Strategic Planning. Develop a five-year strategic plan with active participation of State and local partners. The strategic plan should reflect all tobacco prevention and control activities in the State. It should be linked to and complement the SHD comprehensive cancer control plan, the cardiovascular health plan and other SHD plans to reduce tobacco-related chronic diseases. The five-year strategic plan should include: Description of evidence-based program and policy strategies tailored to data determined State needs; a logic model linking activities to outputs and short-term and intermediate outcomes using specific, measurable, achievable, relevant, and time bound program objectives; program evaluation activities including a summary and time-line for data collection activities; program components that address counter-marketing and strategic use of media advocacy and paid media when appropriate); strategies to address the four program goal areas.

Performance will be measured by evidence that a five-year basic implementation, strategic State tobacco control plan has been developed and will be updated based on environmental changes. Evidence can be shown by a description of how the plan was developed and the submission of a plan that is consistent with the activities described above in item (a) ''Strategic Planning.''

d. Surveillance and Evaluation. Develop and implement a basic implementation evaluation plan with stakeholder's involvement. The evaluation plan should include clear goal-based logic models, with outputs, short, intermediate, and long-term objectives; data collection on key tobacco-related indicators using valid methods that are comparable across States; data collection timetables, the production and dissemination of evaluation reports and establishment of a method to track the number and type of policy and systems changes that promote cessation. References U.S. HHS CDC ''Introduction to Program Evaluation for Comprehensive Tobacco Control Programs, November 2001'' and the upcoming report on key indicators that can be used to monitor and evaluate State level tobacco control programs (expected publication date: Spring 2003) for additional information.

Performance will be measured by accomplishment of the activities described above in item (a) ''Surveillance and Evaluation'' and by providing the following evidence: A description of a comprehensive evaluation plan, including the involvement of stakeholders in the evaluation planning process; recommendations made and/or actions taken by an advisory group or task force composed of diverse State and local representation; a description of the data collection activities, including methodologies and data analysis; a description of process and outcome objectives and indicators to be used in program evaluation; a description of the SHD's role in coordinating surveillance and evaluation efforts and providing technical assistance and training on program monitoring, data collection, and evaluation; the production of useful evaluation reports, and the utilization of evaluation findings to improve, expand, or maintain the tobacco control program.

e. Collaboration and Communication with Partners. Develop and maintain Statewide and local active partnerships that support the goal of reducing or eliminating the health and economic burden of tobacco use and an effective communication system with partners at the State and local level. Partnerships may include Statewide and local organizations, voluntary health organizations, universities, local health departments, organizations that represent diverse communities, community based organizations, Statewide and local coalition, and boards commissions, and advisory groups with responsibility for the State Tobacco Control Program. Working with partners includes capacity building with those organizations through technical assistance, training and educational activities.

Performance will be measured by accomplishment of the activities described above in item (a) ''Collaboration and Communication with Partners'' and by providing the following evidence: Submission of letters of support that clearly define the level of commitment from the organization; description of grants, contacts, and memoranda of understanding; membership lists; active participation in meetings; clear role definitions for partners; active

participation in Statewide and local planning including media campaigns, tobacco control plans, and conference. Evidence can be shown by: Description of stakeholder communication plan which employs multiple channels including Statewide list serve; Statewide conference, trainings, and information exchanges; electronic newsletters and updates; Statewide teleconferences; Web site postings; site visits; and videos.

f. Local Grant Programs. Support local programs to establish grassroots networks at the community level. Support should be sufficient for designated staff at the local level to establish and participate in local coalitions, partnerships, and task forces for local policy development and implementation; local environmental scan; development and implementation of a written plan to work toward policy goals and participation in State participation in State evaluation and data collection efforts; access to tobacco control information through a variety of sources such as journals, Internet Web sites and list serves. Refer to U.S. HHS, CDC ''Best Practices for Comprehensive Tobacco Control Programs-August 1999,'' and American Journal of Preventive Medicine ''Community Prevention Services Guidelines for Tobacco Use, February 2001'' for information about local programs.

Performance will be measured by accomplishment of the activities described above in item (a) ''Local grant program.''

g. Training and Technical Assistance. Develop and implement a technical assistance and training process to address the needs of local health department staff, coalitions, and partners involved in tobacco prevention and control activities.

Performance will be measured by evidence that training and technical assistance needs have been assessed and provided by the State Tobacco Control Program to local health department staff, coalitions, and partners. Evidence can be shown by: The number and description of trainings planned and/or provided that include the strategic purpose of the trainings and anticipated impacts as related to short-term and long-term outcomes, description of the process and strategy to provide technical assistance.

h. Prevent Initiation of Tobacco Use Among Young People. Develop and implement science-based policy-focused strategies identified in the State strategic plan to prevent youth initiation of tobacco use.

Performance will be measured by accomplishment of the activities described above in item ''(a) Prevent Initiation to Tobacco Use Among Young People.'' Evidence can be shown by describing: Multi-component community interventions to reduce youth initiation that are science-based and policy focused such as price increase for tobacco products; educational activities that address the efficacy of policy initiatives such as restrictions on tobacco advertising, promotion and sponsorships and retailer licensing regulations; tobacco-free school policies school policies; identification of disparities related to youth initiation to tobacco use; partnerships with State and local education organizations to promote CDC ''Guidelines for School Health Programs to Prevent Tobacco Use and Addiction;'' Counter-marketing strategies that include media advocacy and paid advertising to disseminate messages regarding youth access; pro-health messages; State evaluation and data collection efforts to demonstrate local programs toward policies to reduce youth initiation.

i. Eliminate Exposure to Second Hand Smoke. Develop and implement science-based policy-focused strategies to reduce exposure to second hand smoke.

Performance will be measured by accomplishment of the activities described above in item (a) ''Eliminate Exposure to Secondhand Smoke.'' Evidence can be shown by describing: Local coalition objectives and evidence-based activities that are linked to a policy change leading to short-term and long-term outcomes as identified within the State plan; counter-marketing strategies that are supportive of local policy efforts, including both earned and paid media and the numbers of people reached through earned and paid media strategies; recommendations made and/or actions taken by an advisory group or task force composed of diverse State and local representation; a description of disparities related to exposure to secondhand smoke and strategies to reduce those disparities; actions taken to expand policy coverage to new communities and/or to strengthen policies in communities where they are already in place. Evidence can also be shown by a State-specific database that tracks local clean indoor air ordinances work, where pre-emption exists, voluntary policies and reporting of the number of policies implemented; State evaluation and data collection efforts to demonstrate local progress toward policies to eliminate exposure to secondhand smoke.

j. Promote Cessation Among Adults and Youth. Implement science-based policy-focused strategies as defined in the State strategic plan to promote cessation among adults and youth.

Performance will be measured by accomplishment of the activities described above in item ''(a) Promote Cessation Among Adults and Youth.'' Evidence can be shown by describing: Strategies to promote guidelines published in ''U.S. DHHS Public Health Services Treating Tobacco Use and Dependence'' and ''Community Prevention Services Guidelines for Tobacco Use;'' strategies to reduce identified disparities; counter-marketing strategies that incorporate earned and paid media to provide information about and motivation for quitting and reach diverse populations and the number of people reached with paid media; Statewide activities, as detailed in the State strategic plan, to promote effective methods for quitting including support for and promotion of policy development and initiatives related to cessation services; links between the State program and other organizations to support and promote cessation.

k. Identify and Eliminate Tobacco-related Disparities among Specific Population Groups. Identify and eliminate disparities in specific population groups related to (1) preventing initiation among young people; (2) eliminating exposure to secondhand smoke; and (3) promoting cessation among adults and youth.

Performance will be measured by accomplishment of activities in item (a) ''Identify and eliminate tobacco-related disparities among specific population groups.'' Evidence can be shown by: Assessing national data sources and research related to at-risk populations; outlining demographics reflecting Statewide diversity; coordinating available State and national data with at-risk populations in the State; augmenting State data with qualitative data (*i.e.* population assessments of specific population groups); examining the potential limitations of data used; identifying and developing new quantitative and qualitative-based methodologies for data collection among specific population groups, developing strategies and initiatives to build capacity and infrastructure among disparately-affected population groups. If States have participated in the Office on Smoking and Health's Disparities Pilot Training, additional evidence can be shown by demonstrating the implementation of interventions based on strategic plan to identify and eliminate tobacco-related disparities

developed by a diverse and inclusive workgroup.

1. Information Exchange. Develop and implement mechanisms to facilitate information exchange between the State Tobacco Control Program, the CDC, tobacco control program personnel in other States, and national partners.

Performance will be measured by accomplishment of the activities described above in item (a) ''Information Exchange.''

Evidence can be shown by: Establishing a communication loop with CDC for the exchange and dissemination of information about program effectiveness, progress toward short and long-term objectives as defined in the strategic plan; participation on CDC sponsored workgroups/task forces and the frequency of that participation, number of presentations at national meetings and conferences, number of publications of data and evaluation outcomes via ''Morbidity and Mortality Weekly Report'' (MMWR), peer-reviewed journals or as reports, number of reports on collaboration with programs and partners in neighboring States; posting information and resources on the CDC State forum; participation with Association of State Territorial Health Officers (ASTHO) regional networks and Tobacco Control Resource council and/or other tobacco-related projects sponsored by ASTHO.

2. CDC Activities. a. Provide ongoing guidance, consultation, technical assistance, and training in tobacco use prevention and control as described under ''Recipient Activities.''

b. Provide up-to-date information that includes diffusion of best practices for tobacco use prevention and control.

c. Provide resources and technical assistance to develop and improve monitoring and surveillance systems. Provide guidance to States to identify indicators that can be used to monitor and evaluate State level tobacco control programs.

d. Facilitate adoption of effective practices among grantees and other partners through workshops, conferences, training sessions, electronic and verbal communications.

e. Identify, develop, and disseminate media campaign materials for use by programs; facilitate coordination of counter advertising materials between programs; provide technical assistance on design, development, and evaluation of media.

f. Maintain an electronic center for State information sharing, State Forum, and the Chronicle, for progress reporting.

g. Develop and maintain partnerships with Federal and non-Federal organizations to assist in tobacco control and create a national infrastructure to complement State infrastructure.

h. Serve as a resource to States with regard to identifying and eliminating tobacco-related disparities among population groups.

i. Maintain a Web site with access to a data warehouse that contains comparable measures of tobacco use prevention and control from different data sources.

F.1. Content

The program announcement title and number must appear in the application. Use the information in the Program Requirements, Other Requirements, and Evaluation Criteria sections to develop the application content. Your application will be evaluated on the criteria listed, so it is important to follow them in laying out your program plan. The narrative for this component, including the Executive Summary, should be no more than 45 double-spaced pages, printed on one side, with one-inch margins, and unreduced 12-point font. The annual action plan may be 20 pages, which will allow a total of 65 pages for the application (excluding budget and appendices). Appendices should total no more than 20 pages, excluding letters of support and the budget.

Focus the application content ONLY on the planned ''Recipient Activities'' for which you seek CDC funding. However, the Background and Need content should describe accomplishments regardless of funding source. Include a description of why CDC funding is needed and how these funds will be used strategically to complement other funding sources.

Provide supporting documentation such as resumes, job descriptions, and descriptions of coalitions and committees as appropriate. All materials must be suitable for photocopying.

1. Executive Summary. Provide a narrative, not to exceed two pages and summarize: The environment in which tobacco control has been conducted, including barriers and supportive factors; accomplishments; anticipated needs; plans to address the Program Goals. Indicate major areas of future program focus.

2. Program Narrative. Provide a narrative, not to exceed 43 pages, describing the burden of tobacco use, accomplishments to date, and areas of unmet needs. Provide specific reference to the following elements of State health department tobacco control program.

a. Background and Need. Describe the burden of tobacco use including prevalence rates and the economic costs of tobacco use. Describe existing policies at the State and local level. Describe progress toward reducing the burden of tobacco use. Describe major tobacco control activities conducted in the State and how CDC funds will enhance these programs as well as other chronic disease and health promotion areas. Describe, if applicable, the impact of State budget cuts on program priorities and activities that will not be accomplished.

b. State Health Department Infrastructure and Program Management. Describe current staff. Describe plans to develop a staffing pattern consisting of qualified technical, program, and administrative staff that are diverse and representative of the State population. Describe how program staff will have access to opportunities for professional training. Describe how the staffing pattern will enable sharing of information, resources, and materials with CDC and the national program. Describe how involvement of senior management and communication with the State Health Officer will be assured.

3. Organization. Provide an organizational chart showing placement of the tobacco control program within the organization, indicating accountability and lines of communication.

4. Fiscal Management. Describe plans to fill vacancies to minimize start-up delays, assure out-of-State travel, and administer funds to governmental and non-governmental entities at the State and local level. Describe accomplishments and barriers in providing funding to support State efforts. Describe accomplishments and barriers in providing funding to support State efforts. Describe accomplishments and barriers in filling staff vacancies, supporting out-of-State travel, and reducing start-up delays. Describe a plan for maintaining adequate staffing to administer the program should budget cuts, hiring freezes, etc. occur.

5. Strategic Plan. Provide a copy of the five-year comprehensive strategy that meets the criteria in Recipient Activities (2) Strategic Planning and describe how the plan was developed based on the process in Recipient Activities (2). Demonstrate how the plan links to and complements the SHD's comprehensive cancer control plan, the cardiovascular health plan, and other SHD plans to reduce tobacco-related chronic diseases. If a comprehensive strategic plan does not currently exist, describe how a plan will be developed and the expected completion date. Describe the process by which the strategic plan will be updated. Indicate

who will be responsible for maintaining the plan.

6. Surveillance and Evaluation. Describe accomplishments. List the tracking systems used and/or needed at the State and local levels. Describe surveillance and evaluation activities currently being undertaken. Refer to U.S. HHS CDC ''Introduction to Program Evaluation for Comprehensive Tobacco Control Programs, November 2001.'' Describe involvement of stakeholders or advisory group in development of surveillance and evaluation approach. Describe barriers and identify methods to overcome them. Describe unmet needs and plans to address them.

7. Collaboration and Partnerships. Describe plans to develop, strengthen and maintain partnerships and coalitions through linkages with other national, regional, State, and local level governmental, and non-governmental entities. Specify partner organizations and the purpose of those partnerships. Describe current State coalition members and plans to recruit new members. Describe plans to identify new partners including proposed partners and purpose of partnerships. Describe plans to maintain and strengthen participation by groups identified as experiencing tobacco related health disparities.

Describe plans to collaborate with CDC and other Federal agencies, including participation in national or regional meetings and workgroups, and using the Internet to communicate and disseminate information.

Describe how the State's and partners' roles will complement each other as part of the overall effort. Provide letters of support demonstrating collaborative activities, roles, responsibilities, and/or commitment of funds or other resources.

Describe communication methods and channels used to inform and solicit information from stakeholders. Describe how the stakeholder communication plan was developed. Describe barriers in communicating with stakeholders. Describe plans to improve communication.

8. Local Grant Programs. Describe existing local grants programs including funded organizations and level of funding, policy-focused activities, and collaboration with partners, and participation in coalitions. Describe the rationale for funding local organizations. Describe local environmental scans and how the scans inform a planning process. Describe progress toward policy goals and objectives. Describe how personnel access tobacco control information. Describe barriers and methods to address them. Describe unmet needs and plans to address them. If a local grants program does not currently exist, describe how such a program will be developed and implemented, including a timeline for implementation, a description of the grant process and eligible organizations.

9. Training and Technical Assistance. Describe the audiences for whom training and technical assistance is provided. Describe how training and technical assistance needs will be determined. Describe activities and how they contribute to advancing the program goals and objectives. Describe barriers and methods used to overcome them. Identify unmet needs and plans to address them.

10. Prevention Initiation of Tobacco Use Among Youth. Describe activities at the State and local level, including activities that are science-based and promote policy interventions. Describe activities to promote tobacco-free policy in schools. Describe surveillance and evaluation activities. Describe barriers and identify methods to overcome them. Describe unmet needs and plans to address them.

11. Eliminate Exposure to Secondhand Smoke. Describe activities to move toward policy development at the local level, identify and eliminate disparities, collect and analyze data, conduct counter-marketing. Describe activities undertaken by State and local coalitions/task forces and partnerships. Describe barriers and identify methods to overcome them. Describe unmet needs and plans to address them.

12. Promote Cessation for Adults and Youth. Describe activities and strategies to promote science-based cessation services and policies. Applicants should refer to the ''Community Prevention Services Guidelines for Tobacco Use'' and ''U.S. DHHS Public Health Services Treating Tobacco Use and Dependence.'' Describe disparities and strategies to reduce them. Describe methods used to promote and encourage cessation, including counter-marketing, policy development, and implementation, and population-based and systems change strategies. Describe barriers and methods to overcome them. Describe unmet needs and plans to address them.

13. Identify and Eliminate Tobacco-Related Disparities in Specific Populations. Describe the process for identifying and eliminating tobacco-related disparities. Include a description of: the national and/or State data sources used; the State population demographics; rationale for addressing tobacco-related disparities in specific population groups; specific strategies and initiatives to build capacity and infrastructure among disparately-affected population group. Describe the process for developing a strategic plan, if one exists, including who was involved and progress in implementation. Attach a copy of the plan.

14. Information Exchange. Describe how State personnel communicate and exchange information with Federal, regional, State, and local tobacco control personnel in government and partner organizations. Describe participation in and collaboration with State and national organizations. Describe participation in local, State, regional, and national conferences and meetings and the benefits accrued. Describe barriers and identify methods to overcome them. Describe unmet needs and plans to address them.

15. Annual Action Plan (no more than 20 pages). Submit an annual action plan detailing how the above requirements will be addressed. Include objectives with indicators and data sources. When writing long-term, intermediate, short-term, and annual objectives, use specific, measurable, achievable, relevant, and time-bound (SMART) objectives. For each of the four program components in the Annual Action Plan, indicate key activities. For each activity, include the target group, lead role, timeline, and anticipated output. The Annual Action Plan: Program Goals form can be used to complete this requirement and will be provided at the pre-application workshop.

16. Budget and Accompanying Justification (no page limit). Provide a line-item budget and justification consistent with the stated objectives, planned activities, and time frame of the project. Identify matching funds. Matching funds may be cash, in-kind or donated services or a combination of these made directly or through donations from public or private entities. All costs used to satisfy the matching requirements must be documented by the applicant. Commit a minimum of 10 percent of award to surveillance and evaluation efforts. Program resources may be used for consultants; staff, survey design and implementation, data analysis, or other expenses associated with surveillance and evaluation efforts. These activities may fulfill the match requirement.

A maximum of five percent of the award may be used to directly support a statewide telephone cessation counseling service with program justification.

Include travel for a minimum of three staff members or selected representatives to attend each of two CDC-sponsored training meetings per

year, one staff person to attend a media training, a minimum of two staff people to attend one CDC-sponsored Program Management meeting, a minimum of two staff people to attend a training on the NTCP Chronicle, and a minimum of two staff people to attend the CDC-sponsored national tobacco control conference. For purposes of planning, these meetings/conferences should be budgeted for travel to Atlanta, Boston, and Phoenix.

Meeting	Number of staff	Location
CDC sponsored training meeting (surveillance and evaluation)	3	Atlanta, GA.
CDC sponsored media training	1	Atlanta, GA.
OSH Program managers meeting	2	Atlanta, GA.
OSH NCTP Chronicle training	2	Atlanta GA.
CDC sponsored national training program	3	Phoenix, AZ.
CDC sponsored national tobacco control conference	2	Boston, MA.

States and Territories can request that CDC cover the travel costs of out-of-State trainings and meetings for one staff person per required meeting or conference. If a State program elects to have CDC cover travel costs, clearly state that the program is electing this option and provide an estimated expense for travel. Under this arrangement, the State award will be reduced by the amount estimated for travel plus an additional administrative cost.

G.1. Evaluation Criteria

Application. Applications received from current grantees that are funded under Program Announcement 99038 will be reviewed utilizing the Technical Review process. Total possible points equal one hundred. Total points = 100.

a. Background and Need (12 points). The extent to which the applicant describes Background and Need in Application Content, 2a.

b. Annual Action Plan (11 points). The extent to which the annual action plan is based on the strategic plan and include activities in line with Recipient Activities and Application Content for tobacco control program.

c. Program Management (7 points). The extent to which the applicant describes specific Recipient Activities in section 1a–d above and activities in Application Content, 2b.

d. Strategic Plan (7 points). The extent to which the applicant has addressed specific Recipient Activities in Section (2); and Application Content, b 5.

e. Surveillance and Evaluation (7 points). The extent to which the applicant clearly describes specific Recipient Activities in Section (3); and Application Content, b 6.

f. Collaboration and Communication with Partners (7 points). The extent to which the applicant describes specific Recipient Activities in Section (4a); and Application Content, b 7.

g. Local Grant Programs (7 points). The extent to which the applicant describes specific Recipient Activities, Section (5); and Application Content, b 8.

h. Training and Technical Assistance (7 points). The extent to which the applicant demonstrates specific Recipient Activities in Section (6); and Application Content, b 9.

i. Prevent Initiation to Tobacco Use Among Young People (7 points). The extent to which the applicant describes specific Recipient Activities in Section (7a); and Application Content, b 10.

j. Eliminate Exposure to Secondhand Smoke (7 points). The extent to which the applicant describes specific Recipient Activities in Section (8a); and Application Content, b 11.

k. Promote Cessation Among Adults and Young People (7 points). The extent to which the applicant describes specific Recipient Activities in Section (9a); and Application Content, b 12.

l. Identify and Eliminate Tobacco-Related Disparities Among Specific Population Groups (7 points). The extent to which the applicant describes specific Recipient Activities in Section (10a); and Application Content, b 13.

m. Information Exchange (7 points). The extent to which the applicant describes specific Recipient Activities in Section (11) and Application Content, b 14.

n. Executive Summary (not scored). The extent to which an overview of the program is provided in a clear and concise manner.

Component 2: State Nutrition and Physical Activity Programs to Prevent Obesity and Other Chronic Diseases

D.2. Availability of Funds

Approximately $7,000,000 is available in FY 2003 to fund approximately 16 State program awards for this component. Approximately $2,000,000 is available to fund one to two Basic Implementation Programs; approximately $5,000,000 is available to fund twelve to fourteen Capacity Building Programs. The average Capacity Building Program award will be $400,000 ranging from $350,000 to $450,000. The average Basic Implementation Program award will be $700,000 in year one ranging from $600,000 to $800,000.

Use of Funds

Funds awarded under this component of this program announcement may not be used to supplant existing State or local funds. Cooperative agreement funds may be used to support personnel and to purchase equipment, supplies, and services directly related to program activities and consistent with the scope of the cooperative agreement. Cooperative agreement funds cannot be used to provide patient care, health screening, personal health services, medications, patient rehabilitation, or other costs associated with the treatment of obesity and chronic diseases. Population-based behavioral interventions are acceptable.

Recipient Financial Participation

Recipient financial participation (matching funds) is required for only Basic Implementation programs in accordance with this Program Announcement. If applying for Basic Implementation programs, matching funds are required from non-Federal sources in an amount not less than one dollar for each four dollars. The matching funds may be cash or its equivalent in-kind or donated services, fairly evaluated. The contribution may be made directly or through donations from public or private entities.

Matching funds may not be met through: (1) The payment of treatment services or the donation of treatment, or direct patient education services; (2) services assisted or subsidized by the Federal Government; or (3) the indirect or overhead of an organization. Matching funds must be consistent with the work plan activities that are submitted and approved.

E.2. Program Requirements

In conducting activities to achieve the purpose of this program, the recipient will be responsible for the activities

under 1.a. (Recipient Activities for Capacity Building Program) or 1.b. (Recipient Activities for Basic Implementation Programs) and CDC will be responsible for the activities listed under 2. (CDC Activities).

The focus of this program component is implementation of nutrition and physical activity strategies for health promotion for the entire population and for the prevention and control of obesity. Major program areas are: obesity prevention and control including balancing caloric intake and expenditure; improved nutrition including increased breastfeeding and increased consumption of fruits and vegetables, increased physical activity; and reduced television time. For all capacity building and basic implementation program recipient activities, efforts to address poor nutrition and physical inactivity should be coordinated with State Health Agency programs in cardiovascular health, cancer, diabetes, oral health, maternal and child health (including breastfeeding), arthritis, and WISEWOMAN, as well as with the State Agriculture Agency, and coordinated school health programs in the State Education Agency (*see http://www.cdc.gov/nccdphp/dash/cshpdef.htm* for a description of a coordinated school health program), and other relevant State Agencies.

1.a. Recipient Activities for Capacity Building Programs

Note: As part of this program component, detailed descriptions of the program and additional information related to Capacity Building and Basic Implementation programs are located in ''Technical Assistance Manual for State Nutrition and Physical Activity Programs to Prevent Obesity and Other Chronic Diseases'' at *http://www.cdc.gov/nccdphp/dnpa/rfainformation.htm.* The referenced Web site information will assist you in addressing the details of the recipient activities when completing your application.

(1) Develop a Coordinated Nutrition and Physical Activity Program Infrastructure. Provide indicators of sound program infrastructure including program staff placed high in the organization to coordinate the program with other related programs, high level administrative commitment to sustain the program, access to resources such as physical space, funding, and training, access to scientific resources such as subject matter specialists and surveillance resources, and broad partnerships to institutionalize nutrition and physical activity. Examples of coordination include shared positions; joint planning, and combined strategy development and implementation. Organizational location of the program is recommended to be in the agency's chronic disease or health promotion section so that this program is aligned with chronic disease programs, such as cardiovascular health and diabetes, to allow for maximum collaboration. (*See* referenced Web site above).

(a) Staffing. Identify, hire, or reassign, and supervise at least three dedicated full-time staff with appropriate competencies to plan and implement the program (major program areas: Obesity prevention and control including caloric intake and expenditure, improved nutrition including increased breastfeeding and increased consumption of fruits and vegetables, increased physical activity, and reduced television time). Staff includes a full-time high-level program coordinator to coordinate the crosscutting nutrition and physical activity functions for health department programs and other partners, a full-time physical activity coordinator, and a full-time nutrition coordinator. Staffing patterns are encouraged to include program skills and expertise necessary to carry out the program. Part of staff capacity building must be in 5 A Day fruit and vegetable promotion efforts.

(b) Training. Participation in training, conferences, and frequent communication with national and State collaborators including other funded States.

(2) Collaborate and coordinate with State and local government and private partners, including members of the population throughout the planning process. (*See* referenced Web site above).

(a) Develop new linkages and maintain collaborations with State and local partners to coordinate nutrition and physical activity efforts, especially State Health Agency programs in cardiovascular health, cancer, diabetes, oral health, maternal and child health (including breastfeeding), arthritis, and WISEWOMAN, as well as the State Agriculture Agency, coordinated school health in the State Education Agency, and other relevant State Agencies. State programs should serve as a training and technical assistance resource for local health departments and others to conduct nutrition, physical activity, and obesity prevention interventions.

(b) Collaborate with Prevention Research Centers, academic partners, and other relevant organizations in the State.

(3) Conduct a planning process that leads to a comprehensive nutrition and physical activity plan to prevent and control obesity and other chronic diseases, and start to implement the plan. (*See* referenced Web site above.)

(a) Describe the obesity epidemic and other chronic diseases in the State related to poor nutrition and physical inactivity.

(b) Describe the nutrition and physical activity risk factors associated with obesity and other chronic diseases.

(c) Describe the population subgroups affected by obesity that will be targeted for interventions.

(d) Conduct inventories of strategies and programs currently used in the State to prevent or control obesity and other chronic diseases in one or more settings, such as worksite, faith-based organizations, health care services, or communities.

(e) Establish priorities with and for the subgroups; identify the behaviors and influences of the population subgroups which are priorities for intervention.

(f) Use the social-ecological theoretical model to guide State planning to address obesity and other chronic diseases in these populations; select and implement interventions from the list of proven strategies at *http://www.cdc.gov/nccdphp/dnpa/rfainformation.htm* so that multiple levels of influence in the social-ecological model are addressed. Consider using a social marketing approach in the intervention.

(g) With key stakeholders, write the comprehensive State plan for nutrition and physical activity for the State, not just for the State Department of Public Health. One reference document to consider when developing the plan is the ''Guidelines for Comprehensive Programs to Promote Healthy Eating and Physical Activity'' at *http://www.astphnd.org.* Documents guiding coordinated school health programs are at *http://www.cdc.gov/nccdphp/dash/.*

Design the plan to address nutrition and physical activity needs of the population including the pediatric population. The State plan should address at a minimum the following major program areas: Obesity prevention and control including caloric intake and expenditure, improved nutrition including increased breastfeeding and increased consumption of fruits and vegetables, increased physical activity, and reduced television time.

Include descriptions of how the State Health Department will work with the State Education Agency to address nutrition and physical activity needs of the population through school programs.

(h) Begin to implement components of the comprehensive State plan for

nutrition and physical activity by year two.

(4) Identify and assess data sources to define and monitor the burden of obesity. Strengthen capacity to assess the burden of obesity and the impact of the program to change overweight and obesity related behaviors, particularly nutrition and physical activity. Data systems should monitor trends, disseminate data/information, and support evaluation efforts. Monitor at minimum, body mass index (BMI), BMI-for-age, and dietary and physical activity behaviors. Data sources may include established surveillance systems (*e.g.*, the Behavioral Risk Factor Surveillance System [BRFSS], Pediatric Nutrition Surveillance System, Pregnancy Nutrition Surveillance System, and Youth Risk Behavior Surveillance System) or alternative sources. Include a review process of considering potential changes needed in current surveillance systems and designate who is responsible for implementing and maintaining the surveillance system. (*See* referenced Web site above.)

CDC will work with States to develop standard measures/indicators, and States will need to adopt these standardized measures. States are encouraged to retain flexible systems that can be modified as needed.

(5) Implement and evaluate an intervention to prevent obesity and other chronic diseases. (Complete between years two to five.)

Address one or more of the major program areas from the State plan in the intervention: Obesity prevention and control including caloric intake and expenditure, improved nutrition including increased breastfeeding and increased fruit and vegetable consumption, increased physical activity, and reduced television time. Provide a balance between nutrition and physical activity related interventions. Consider using a social marketing approach in the intervention. Specify clear, measurable process and impact objectives, and outcome objectives where feasible. Programs are encouraged to approach change at the State, community (towns, cities, counties, or regions), organizational (*e.g.*, worksites), and group level (*e.g.*, families). (*See* referenced Web site above.)

(6) Evaluate progress and impact of the State plan and intervention projects.

Develop an evaluation plan that includes baseline data and intermediate outcomes for the State plan's objectives. CDC has developed a plan for evaluating the State Nutrition and Physical Activity Programs to Prevent Obesity and Other Chronic Diseases based on a logic model framework. State evaluation plans should include issues addressed in the national evaluation plan as well as specific State program components.

1.b. Recipient Activities for Basic Implementation Programs. Basic Implementation programs will expand their efforts to fully implement the State plan by enhancing surveillance activities, implementing Statewide interventions, funding communities to implement interventions, rigorously evaluating a new or existing intervention, and enhancing partnership efforts particularly with coordinated school health programs in the State Education Agency and with secondary prevention partners. In addition to providing evidence of and enhancing the Recipient Activities for Capacity Building Programs, Activities 1–6, Basic Implementation programs will address the following activities.

(1) Expand the existing coordinated nutrition and physical activity program infrastructure. (Year One) Expand staffing beyond the capacity building program to fully implement the State plan. Support and expand the program infrastructure at the local/regional level throughout the State.

(2) Implement the State comprehensive plan for nutrition and physical activity and review and update the plan periodically. Develop and provide mini-grants and other assistance to support communities to adopt effective interventions. (Years One-Five) Assure that there is a continuing focus on strategic planning to reach objectives agreed upon within the State and to respond to new challenges and events. Review the written State plan annually. Adopt and diffuse effective interventions statewide or in communities and populations based on the State plan. Select and implement interventions from proven strategies so that multiple levels of influence in the social-ecological model are addressed, as guided by the State plan. Interventions can target the full State or local populations. Implement the ''Community Guide to Preventive Services'' physical activity recommended interventions in more depth or in more communities. Build community capacity to carry out and sustain an effective nutrition program. Provide intervention mini-grants to communities. Basic implementation programs located in States with CDC-funded coordinated school health programs must include a school-based intervention, working closely with the State Education Agency.

(3) Expand partnerships with State Health Department units, the State Education Agency, other State agencies, local communities, and private partners to maximize impacts of the basic implementation program. (Years One-Five)

Leverage resources for nutrition and physical activity working with the health department director, other health department units, the State Education Agency, other State agencies that share mutual goals, and other partners including local health partners and community groups. Identify environmental and policy issues; promote optimal standards and practices for nutrition and physical activity programs; and increase capacity through shared resources and expertise.

(4) Develop a new or apply an existing intervention and evaluate its effectiveness to prevent or control obesity and other chronic diseases every five years. Provide a balance between nutrition and physical activity interventions. Basic implementation programs should design the intervention project to detect realistic changes in post-intervention outcome measures when compared with pre-intervention measures. Sample sizes should provide adequate power to detect these changes. Specify clear, measurable evaluation objectives using process, impact, and outcome objectives. Intervention protocol development, project evaluation, and the preparation of publications and presentation of findings should be done in collaboration with community partners, Prevention Research Centers, university affiliates, relevant experts, and CDC, as appropriate.

(5) Collaborate with partners on secondary prevention strategies. (Years One-Five).

Describe activities supporting secondary prevention related to obesity. Integrate secondary prevention strategies and activities into the State plan, partnerships, policy and environmental changes, and training for health professionals to ensure that recognized national guidelines are followed. (*See http://www.cdc.gov/nccdphp/dnpa/rfainformation.htm* for additional information regarding this activity.)

(6) Develop resources and training materials to help other State and local projects adopt successful programs. (Years Four-Five).

Develop one or more training reports on at least one component of a program that works and train staff from other State or local programs. Assist in the dissemination and training of other State and local partners regarding the report findings. (*See http://www.cdc.gov/nccdphp/dnpa/*

rfainformation.htm for additional information regarding this activity.)

(7) Identify, assess, or develop data sources to further define and monitor the burden of obesity. See previous description of this activity under Capacity Building Recipient Activity 4.

(8) Evaluate progress and impact of the State plan and intervention projects. See previous description of this activity under Capacity Building Recipient Activity 6.

2. CDC Activities. a. Convene workshop and/or teleconferences of recipient programs for information sharing and problem-solving.

b. Provide ongoing guidance, consultation, and technical assistance to plan, implement, and evaluate all aspects of nutrition and physical activity program activities. Activities include coordinating national surveillance activities, monitoring data quality of national surveillance systems, assisting with analyses and interpretation of findings from qualitative and quantitative research; assisting in the social marketing process, guiding program evaluation, and sharing community, environmental and policy strategies to promote physical activity and healthy eating. Disseminate to recipients relevant state-of-the-art research findings and public health recommendations related to obesity and other chronic disease prevention and control through nutrition and physical activity interventions.

c. On a consultant basis, assist in the development and review of the intervention protocols and program evaluation methods.

d. Coordinate national level partnerships with relevant organizations and agencies involved in the promotion of physical activity and nutrition for the prevention and control of obesity and other chronic diseases.

Note: *Special Guidelines for Technical Assistance Telephone Conference Call.* Technical assistance will be available for potential applicants on one conference call. Potential applicants are requested to call in using only one telephone line. The call will be on February 3, 2003 from 2 p.m. to 3:30 p.m. EST. This conference can be accessed by calling 1–800–713–1971 [Federal call (404) 639–4100] and entering access code 996903.

The purpose of the telephone conference call is to help potential applicants:

—Understand the scope and intent of the Program Announcement for State Nutrition and Physical Activity Programs to Prevent Obesity and Other Chronic Diseases;
—Understand the role of nutrition and physical activity population-based approaches, such as policy-level change and environmental support, in preventing and reducing obesity and other chronic diseases;
—Be familiar with the CDC funding policies and application and review procedures.

F.2. Content

Use the information in the Program Requirements, Other Requirements, and Evaluation Criteria sections to develop the application content. The application will be evaluated based on the evaluation criteria listed, so it is important to follow them when writing the program plan. The narrative for this component, not including budget justification, should be no more than 30 double-spaced pages for Capacity Building program applications or 40 double-spaced pages for Basic Implementation program applications, printed on one side, with one-inch margins and 12-point font. Applicants may also submit appendices that include State nutrition and physical activity plan, resumes, job descriptions, organizational chart, facilities, and other supporting documentation not to exceed 100 total pages. Letters of support should include the specific roles and responsibilities of the collaborator/partner to the State plan or intervention. All materials must be suitable for photocopying (*i.e.*, no audiovisual materials, posters, tapes, *etc.*).

1. Background and Recent History. Provide information on the background and recent history of your State health agency's capacity for the prevention and control of obesity and other chronic diseases through nutrition and physical activity. Describe how the State has built nutrition and physical activity capacity with CDC funds or other funding and complete the following table describing the current nutrition and physical staff, including their education. Describe the kinds of staffing contract services/options if used to augment agency staffing.

Program	Dollar level and source	FTE for nutrition dedicated to the program, include credentials	FTE for physical activity dedicated to the program, include credentials	Type of staffing contract services/ options used for nutrition or physical activity	Number of nutrition and physical activity graduate students
Nutrition/Physical Activity/Obesity (CDC funded)					
Nutrition/Physical Activity/Obesity (non-CDC funded, not including WIC), please specify					
Other:					
Other:					

Describe how the State has fulfilled the capacity building recipient activities to date, including developing a comprehensive State nutrition and physical activity plan to prevent obesity and other chronic diseases, descriptions of the development, implementation, and evaluation of nutrition and physical activity interventions relevant to obesity and other chronic diseases, prevention activities, and what programs and partners were involved. If applying as a basic implementation program, include an appendix responding to the evaluation questions in Attachment 10 located at *http://www.cdc.gov/nccdphp/dnpa/rfainformation.htm*.

2. Management Plan. a. Describe the management structure for the nutrition and physical activity program to prevent obesity and other chronic diseases. Describe plans with dates for hiring key staff. Include brief resumes of designated staff, the percentage of time they allocate to other health department programs, and job descriptions of existing and proposed staff.

b. Identify organizational placement of the program. Submit an organizational chart identifying

relationships between programs such as cardiovascular disease, diabetes, cancer, health education and promotion. Identify clear and direct lines of authority, supervisory and fiscal controls, and the extent which the existing and proposed staff and organizational structure and systems demonstrate sufficient capacity and capability to efficiently and effectively conduct the proposed activities.

c. Identify staffing and contracting barriers for the State health agency in the last year. Describe how work plans addressing nutrition, physical activity or obesity changed or were delayed because of the barriers. Also, identify strategies to carry out the proposed work plan considering current barriers. In particular, describe how the program will change if vacancies or hiring freezes occur.

3. Program Past Performance. Provide documentation to support your previous accomplishments that addressed the prevention and control of obesity and other chronic diseases through nutrition and physical activity. Include the following:

a. Evidence of State or community nutrition and physical activity policies, environmental supports, and/or legislative actions that are planned, initiated or modified for the prevention or control of obesity and other chronic diseases.

b. Evidence that communities have implemented a nutrition and physical activity plan for the prevention and control of obesity and other chronic diseases.

c. Evidence that an intervention for nutrition and physical activity was implemented and evaluated. If applying for Basic Implementation funds, submit the State nutrition and physical activity plan for the prevention and control of obesity and other chronic diseases as well as any intervention protocols and outcomes in the appendix. Capacity Building applicants submit if available.

4. Burden (please limit to no more than three pages). Provide information such as estimated prevalence of obesity and overweight and other chronic disease, its geographic and demographic distribution within the State using existing epidemiological data. Cite the source for and time period covered by these data. Describe high-risk populations, at a minimum by racial/ethnic, gender, age, and socioeconomic factors. If available, describe profiles of potential or already selected populations regarding their knowledge, attitudes, beliefs, health practices, and consumer patterns and habits relative to nutrition and physical activity aspects of obesity and other chronic diseases.

5. Program Work Plan—Provide a work plan that includes the following information:

a. Key Goal(s) and Objectives. Five-year project period impact objectives and one-year budget period process objectives that are specific, measurable, achievable, relevant, and time-framed to help achieve the goal(s) of the program as outlined in the ''Recipient Activities'' of this program component. If applying as a Basic Implementation program, attach the State's program logic model and evaluation plan. Capacity Building applicants submit if available.

b. Program Work Plan Methods. Provide a detailed description of the State's plan for conducting all program activities as outlined in the ''Recipient Activities'' of this program announcement, including methods for achieving each of the proposed objectives, time-lines for all activities, responsible parties, and methods for monitoring progress. Describe the mechanism to regularly review, evaluate, and update the State plan to meet evolving needs.

Chronic disease prevention programs, by their nature, must be integrated and well coordinated due to common risk factors. Resources are scarce; it is essential that efforts not be duplicated. Explain how the State will avoid duplication (but enhance coordination and integration) with other CDC-funded programs that address nutrition and physical activity. Basic Implementation funded nutrition, physical activity, and obesity programs will be the primary location for the leadership and delivery of population-based health promotion rather than those responsibilities falling to CVD, Diabetes or other chronic disease specific programs. If a comprehensive State nutrition and physical activity plan already exists, describe how the process used to develop the plan included and integrated the activities of other chronic disease programs. Include the plan in the appendix.

6. Budget and Justification. Provide a detailed budget and line-item justification that is consistent with the stated objectives, purpose, and planned activities of the project. Distinguish budget lines that are related to planning activities versus those that are related to data collection and intervention activities. Applicants are asked to include budget items for travel for two trips, one trip to Atlanta, Georgia for three staff to attend a three-day training and technical assistance workshop and another trip for three staff to the annual national conference on chronic disease prevention and control. If in-kind contributions are being provided by the applicant, these should be documented.

G.2. Evaluation Criteria (100 Points)

Each set of the evaluation criteria is scored using a 100-point system. Evaluation criteria 1 through 5 are applicable for both programs. Specific Program Work Plan criteria are provided for each funding level. Applications will be evaluated individually against the following criteria by an independent review group appointed by CDC.

1. Program Work Plan (Total 50 points). The extent to which the applicant addresses the items in Recipient Activities in E.2. and the Application Content in F.2. item 5.

Point distribution for Capacity Building programs goals, objectives, and work plan methods by recipient activities:

a. Develop a coordinated nutrition and physical activity program infrastructure. (10 points).

b. Conduct a planning process that leads to a comprehensive nutrition and physical activity plan to prevent and control obesity and other chronic diseases and start to implement the plan. (10 points).

c. Evaluate progress and impact of the State plan and intervention projects. (10 points).

d. Implement and evaluate an intervention to prevent obesity and other chronic diseases. (10 points).

e. Collaborate and coordinate with State and local government and private partners, including members of the population throughout the planning process. (5 points).

f. Identify and assess data sources to define and monitor the burden of obesity. (5 points).

2. Background and Recent History (15 points). The extent to which the applicant addresses the items in Recipient Activities in E.2. and Application Content in F.2. item 1.

3. Management Plan (15 points). The extent to which the applicant addresses the items in Recipient Activities in E.2. and the Application Content in F.2. item 2.

4. Program Past Performance (15 points). The extent to which the applicant addresses the items in Recipient Activities in E.2. and the Application Content in F.2. item 3.

5. Burden (5 points). The extent to which the applicant addresses the items in Recipient Activities in E.2. and the Application Content in F.2. item 4.

6. Point distribution for Basic Implementation programs goals, objectives, and work plan methods by recipient activities:

a. Develop a new or apply an existing intervention and evaluate it to prevent

obesity and other chronic diseases. (10 points).

b. Implement the State comprehensive plan for nutrition and physical activity and review and update the plan periodically. Develop mini-grants and other mechanisms to support communities to adopt effective interventions. (10 points).

c. Evaluate progress and impact of the State plan and intervention projects. (10 points).

d. Identify, assess, or develop data sources to further define and monitor the burden of obesity. (6 points).

e. Expand the existing coordinated nutrition and physical activity program infrastructure. (5 points).

f. Expand partnerships with State Health Department units, the State Education Agency, other State agencies, local communities, and private partners to maximize impacts of the comprehensive program (3 points).

g. Collaborate with partners on secondary prevention strategies. (3 points).

h. Develop resources and training materials to help other State and local projects to adopt successful programs. (3 points).

6. Budget and Justification (Not weighted). The extent to which the line item budget justification is reasonable and consistent with the purpose and program goal(s) and objectives of the cooperative agreement. (Both programs).

7. Human Subjects (Not weighted). Does the application adequately address the requirements of Title 45 CFR Part 46 for the protection of human subjects? (Both programs).

The degree to which the applicant has met the CDC Policy requirements regarding the inclusion of women, ethnic, and racial groups in any proposed research. This includes:

a. The proposed plan for the inclusion of both sexes and racial and ethnic minority populations for appropriate representation.

b. The proposed justification when representation is limited or absent.

c. A statement as to whether the design of the study is adequate to measure differences when warranted.

d. A statement as to whether the plans for recruitment and outreach for study participants include the process of establishing partnerships with community(ies) and recognition of mutual benefits.

Program Performance Measures

See Appendix C for the framework that will be used for measuring performance of the State Programs. Capacity Building Performance Measures for transitioning to basic implementation programs should include evidence that the applicant has significant capacity as specified in the Capacity Building Program Recipient Activities 1–6 and the program evaluation plan (*See* Attachment 10 located at *http://www.cdc.gov/nccdphp/dnpa/rfainformation.htm*) covering the following measurement areas:

1. Evidence of States conducting strategic planning activities to develop a comprehensive State nutrition and physical activity plan to prevent and control obesity and other chronic diseases.

2. Evidence that a quality comprehensive State nutrition and physical activity plan to prevent and control obesity and other chronic diseases promotes coordination of activities across all relevant State and community programs in which relevant partners are identified in substantive roles.

3. Evidence of at least one community that implemented a nutrition and physical activity plan for the prevention and control of obesity and other chronic diseases.

4. Evidence of outcomes/impacts of at least one intervention evaluating nutrition and physical activity strategies to prevent or control obesity and other chronic diseases.

5. Evidence of State or community nutrition and physical activity policies, environmental supports, and/or legislative actions that were initiated, modified, or planned for the prevention or control of obesity and other chronic diseases.

Five-Year Performance Measures for State Nutrition and Physical Activity Programs include:

1. Evidence that communities have implemented a nutrition and physical activity plan for the prevention and control of obesity and other chronic diseases.

2. Evidence of outcomes/impacts of interventions evaluating nutrition and physical activity strategies to prevent or control obesity and other chronic diseases.

3. Evidence of State or community nutrition and physical activity policies, environmental supports, and/or legislative actions that were initiated, modified, or planned for the prevention or control of obesity and other chronic diseases.

4. Evidence of increased physical activity and better dietary behaviors in communities reached through interventions.

5. Evidence that the levels of obesity decrease or the rate of growth of obesity is reduced in communities reached through interventions.

Component 3—Well-Integrated Screening and Evaluation for Women Across the Nation (WISEWOMAN)

D.3. Availability of Funds

Approximately $9,200,000 is available to fund approximately 12 awards for grantees currently funded under program announcements 99135, 00115, and 01098. These grantees are only eligible for the second funding level (See Appendix A). To determine eligibility for first or second funding level see Appendices A and B which is found at the bottom of this document and at the CDC Web site address at *http://www.cdc.gov/od/pgo/funding/grantmain.htm*. Scroll down the Web page to ''Chronic Disease Prevention/Health Promotion Heading.'' Click on Program Announcement Number 03022. The attachments will be located at the bottom of the program announcement. The project period is five years. The average award for Standard Demonstration Projects will be approximately $500,000. Projects that screen substantially more women than 2,500 per year and exceed the performance expectations may qualify for higher awards. Information on performance expectations are found in Appendix B which is found at the bottom of this document and at the CDC Web site address *http://www.cdc.gov/od/pgo/funding/grantmain.htm*. Scroll down the Web page to ''Chronic Disease Prevention/Health Promotion Heading.'' Click on Program Announcement Number 03022. The attachments will be located at the bottom of the program announcement. The average award for Enhanced Projects will be approximately $1,000,000.

In addition, approximately $750,000 is available in FY 2003 to fund up to three WISEWOMAN Projects at the first funding level. Requests for these funds will be competitive. The project period is five years. In the first year, Standard Demonstration Project funding will range from $50,000 to $250,000. If all performance measures (*see* Appendix B) are completed at the first funding level, applicants may apply for the second funding level through their continuation applications.

Use of Funds

60/40 Requirements: Not less than 60 percent of cooperative agreement funds must be spent for screening, tracking, follow-up, lifestyle intervention, health education, and the provision of appropriate individually provided support services. Cooperative agreement funds supporting public education and outreach, professional education, quality assurance and improvement,

surveillance and program evaluation, partnerships, and management may not exceed 40 percent of the approved budget [WISEWOMAN follows the same legislative requirements as the NBCCEDP, Section 1503(a) (1) and (4) of the PHS Act, as amended; *see http://www.cdc.gov/wisewoman/legislationhighlight.htm* for more information on legislation]. Further information about the 60/40 distribution is provided in the WISEWOMAN Guidance Document: Interpretation of Legislative Language and Existing Documents. This can be accessed through the Internet at *http://www.cdc.gov/wisewoman* or by contacting the program technical assistant contact listed in Section ''J. Where to Obtain Additional Information.''

a. Inpatient Hospital Services: Cooperative agreement funds must not be spent to provide inpatient hospital or treatment services [Section 1504g of the PHS Act, as amended].

b. Administrative Expense: Not more than 10 percent of the total funds awarded may be spent annually for administrative expenses. These administrative expenses are in lieu of and replace indirect costs [Section 1504(f) of the PHS Act, as amended]. Administrative expenses comprise a portion of the 40 percent component of the budget.

c. Limit of Use of Funds for Case Management: Use of Federal funds for case management of women without alert values is strongly discouraged. This policy and the definition of alert values are found on the WISEWOMAN Web site Guidance Document at *http://www.cdc.gov/wisewoman*.

Recipient Financial Participation—Matching Requirement

a. Recipient financial participation is required for this program in accordance with the authorizing legislation. Section 1502(a) and (b) (1), (2), and (3) or the PHS Act, as amended, requires matching funds from non sources in an amount not less than one dollar for every three dollars of Federal funds awarded under this program. However, Title 48 of the U.S. Code 1469a (d) requires DHHS to waive matching fund requirements for Guam, U.S. Virgin Islands, American Samoa and the Commonwealth of the Northern Mariana Islands up to $200,000.

b. Matching funds may be cash, in-kind, or donated services, or equipment. Contributions may be made directly or through donations from public or private entities. Public Law 93–638 authorizes tribal organizations contracting under the authority of Title 1 to use funds received under the Indian Self-Determination Act as matching funds.

c. All costs used to satisfy the matching requirements must be documented by the applicant and will be subject to audit. Specific rules and regulations governing the matching fund requirement are included in the PHS Grants Policy Statement, Section 6. Matching funds are not subject to the 60/40 requirements described above under ''Use of Funds.'' For further information about the matching fund requirement, see the WISEWOMAN Guidance Document.

Direct Assistance

No direct assistance funds will be awarded in lieu of financial assistance to successful WISEWOMAN component recipients.

E.3. Program Requirements

In conducting activities to achieve the purpose of this program, the recipient will be responsible for the activities under ''1. Recipient Activities,'' and CDC will be responsible for the activities listed under ''2. CDC Activities.''

Standard Project

Standard Demonstration Project (available for new applicants in FY 2003 and FY 2004, not available for new applicants in FY 2005 or later).

The major goal of a Standard Demonstration Project is to demonstrate the effectiveness of operational approaches to conducting the following activities for women aged 40–64 who participated in the NBCCEDP: Outreach, screenings for blood pressure, cholesterol, smoking, and other conditions (when appropriate); referral; lifestyle intervention (to include promotion of heart-healthy diet, increased physical activity, and tobacco cessation); tracking and follow-up; evaluation; professional and public education; and community engagement.

Enhanced Project

One major goal of an Enhanced Project is to use scientifically rigorous methods to test the effectiveness and cost-effectiveness of a behavioral or lifestyle intervention that is grounded in the social and cultural context of the target population and aimed at preventing cardiovascular disease. The other major goal is to translate and transfer successful interventions and program strategies to other programs that serve financially disadvantaged women. Some important resources for understanding the scope of these translation and transfer activities can be found at *http://www.replication.org/infores.html* and *http://www.replication.org/pdf/tool.pdf.*

1. Recipient Activities for Standard Demonstration Projects and Enhanced Projects: a. Develop a preventive health services program or a preventive health services research study/studies to include cardiovascular disease risk factor screening with mandatory cholesterol and blood pressure measurements built upon an extremely strong State, Territorial, or Tribal Breast and Cervical Cancer Early Detection Program with evidence provided of the strength of the BCCEDP Program.

b. Staff with at least two professional staff members to work full-time on WISEWOMAN (one of whom should be a full-time program coordinator and the other should have experience in nutrition, physical activity, or health education), or a plan for hiring such staff members. If staff must be hired, describe the staff that will manage the program until the hiring is completed. Describe the WISEWOMAN evaluation team and provide information on their experience and academic degrees.

c. Work with health care systems that can effectively deliver WISEWOMAN services and that target the population in need of these services. This can best be accomplished by working with a health care system in which the State, Territory, or Tribal BCCEDP has previously been effective and that has successfully engaged the community to provide additional services/support to the population in need.

d. Establish a cardiovascular disease prevention program as the primary focus, with culturally appropriate interventions addressing multiple risk factors that must include physical inactivity, poor nutrition (high intake of saturated fat and low intake of fruit and vegetables), and tobacco use. Other cardiovascular risk factors may be addressed such as overweight or obesity, and pre-diabetes or undiagnosed diabetes.

Recipients may develop other preventive services to be delivered, such as intervention services aimed at prevention or relief of the following: Osteoporosis, arthritis, influenza or other diseases for which vaccines are readily available, or other significant conditions/diseases which affect large numbers of older women.

e. States, Territories, and Tribal Agencies should implement screening, referral, and follow-up according to the recommendations of the National Cholesterol Education Program (NCEP) of the National Heart, Lung, and Blood Institute for cholesterol screening using the Adult Treatment Panel III (ATP–III)

and the recommendations set forth for hypertension according to the 6th Joint National Report on the Detection, Evaluation and Treatment of High Blood Pressure published by the National Institutes of Health, National Heart, Lung, and Blood Institute. The guidelines can be obtained electronically at *http://www.nhlbi.nih.gov/guidelines/index.htm.* National guidelines for addressing other risk factors can be found at *http://www.cdc.gov/wisewoman.* Laboratories must be accredited under the Clinical Laboratory Improvement Amendments of 1988 (CLIA) and meet all applicable Federal and State quality assurance standards in the provision of any test performed. However, if a new, improved, or superior screening procedure becomes widely available and is recommended for use, this superior procedures will be utilized in the program. [Section 1503(b) of the PHS Act, as amended.]

f. Recipients should design culturally appropriate lifestyle interventions aimed at lowering blood pressure or cholesterol, improving physical activity or nutrition, or achieving smoking cessation in a similar target population. A New Leaf Choices for Healthy Living is an example of an intervention that has been effective in improving nutrition (*see http://www.hpdp.unc.edu/wisewoman/newleaf.htm*).

Alternatively, the intervention can be newly designed if it incorporates sound theoretical principles of behavioral change such as use of the socio-ecologic model to intervene at multiple levels, individual tailoring, self-efficacy, self-monitoring and reinforcement, readiness for change, small achievable steps, social support, collaborative goal setting, and strategies to overcome barriers (see monograph entitled *Integrating Cardiovascular Disease Prevention into Existing Health Services: The Experience of the North Carolina WISEWOMAN Program* at *http://www.hpdp.unc.edu/wisewoman/manual.htm.* If applying as a Standard Best Practices project (available in FY 2005 and later), interventions should be designed following WISEWOMAN recommended best practices (available in FY 2005).

g. Recipients should propose methods aimed at sustaining behavioral change. Maintaining behavioral change should involve strategies to provide the participant with ongoing contact such as with health facility staff or community health workers (either in person or by mail) and to educate regarding relapse prevention. The use of computer-tailored education can be especially useful (to view recommendations detailed in the monograph entitled *Integrating Cardiovascular Disease Prevention into Existing Health Services: The Experience on the North Carolina WISEWOMAN Program* see *http://www.hpdp.unc.edu/wisewoman/manual.htm.*

Environmental supports aimed at sustaining behavioral change such as increased walking, healthier food choices, and smoking cessation should also be considered. These might include activities such as improving the safety of neighborhoods, advocating for walking groups at shopping malls, improving the quality of foods in local grocery stores and changing community norms around tobacco. Although WISEWOMAN applicants may not be able to completely fund these environmental strategies due to restrictions on the use of funds (*see* 60/40 Requirement in under ''Use of Funds''), they may be able to establish strong partnerships with other CDC programs in their health department or agency that use community environmental and/or policy approaches (*e.g.*, Nutrition/Physical Activity/Obesity, Tobacco Control, Diabetes, and Cardiovascular Health).

h. Recipients should propose methods aimed at sustaining the program in future years. Methods include using the principles of community engagement (for more information, see CDC's monograph entitled ''Principles of Community Engagement'' at *http://www.cdc.gov/phppo/pce/index.htm.* Emphasis should be placed on developing traditional and non-traditional partnerships in the community through partnering with other CDC funded programs.

i. Plan or conduct evaluation strategies to include reporting of suggested minimum data elements and cost information (see WISEWOMAN Guidance Document at *http://www.cdc.gov/wisewoman* for a list of the suggested minimum data elements). Other evaluations are strongly encouraged and might include measures of program feasibility and acceptability, mapping neighborhood assets to determine resources before and after program implementation, increases in partnerships as a result of the program, improvements in medical care, the usefulness of community health workers in the program, increases in knowledge of providers, improvements in participant's self-efficacy, and so forth;

j. Formalize plans for Recipient Activities (a) to (i) through development of program protocols or conduct program operations according to previously developed and approved program protocols. Newly funded projects should conduct all program startup activities as detailed on page 18 of the monograph *Integrating Cardiovascular Disease Prevention into Existing Health Services: The Experience of the North Carolina WISEWOMAN Program* at *http://www.cdc.gov/phppo/pce/index.htm* and should be prepared to pilot test their methods.

k. Work collaboratively with other State, Territorial, or Tribal WISEWOMAN program staff and partners (such as CDC contractors) to develop methods that have the potential to be implemented in other WISEWOMAN programs.

2. CDC Activities: a. Convene workshops, trainings, and/or teleconferences of the funded projects for sharing of information and solving problems of mutual concern.

b. Provide ongoing consultation and technical assistance to plan, implement, and evaluate program activities.

c. Conduct site visits to assess program progress and mutually resolve problems, as needed, and/or coordinate reverse site visits to CDC in Atlanta, GA.

d. Assist in the development of a research study protocol for IRB review by all cooperating institutions participating in the research project. If CDC IRB review is necessary, the CDC IRB will review and approve the protocol initially and on at least an annual basis until the research project is completed. For more detailed information on the CDC IRB *see http://www.cdc.gov/od/ads/hsr2.htm.*

e. Collaborate with WISEWOMAN projects in the analysis of data and development of abstracts and publications that informs the program, public, scientific community, and Congress as to program progress and results.

f. Copy and distribute materials developed by State, Territorial, or Tribal WISEWOMAN projects for the purpose of aiding other WISEWOMAN projects and public health partners.

F.3. Content

Applications. The program announcement title and number must appear in the application. Use the information in the ''Program Requirements, Other Requirements, and Evaluation Criteria'' sections to develop the content. Your narrative should be no more than 30 double-spaced pages, printed on one side, with one-inch margins, and unreduced font.

WISEWOMAN Application Outline: Please provide the following information and, as appropriate, a preliminary but realistic time-phased

work plan that addresses all of the points below. Only existing WISEWOMAN projects are required to provide WISEWOMAN-specific information requested below. Applicants may apply for either the Standard Demonstration Project or the Enhanced Project, but not both.

1. Background and Need. Provide a brief description of the extent of the disease burden and the need among the priority populations and the background of the health care system to include:

a. The number of uninsured women living in the State/Territory/Tribal area by race/ethnicity by two age categories if possible, *i.e.* 40–49 years and 50–64 years.

b. The current health care system in which State, Territorial, or Tribal BCCEDP and WISEWOMAN sites operate (*e.g.* are the sites county health department clinics, community health centers, private providers, managed care organizations, etc.) and the appropriateness of the health care system for implementing effective interventions, adhering to program protocols, tracking difficult to reach women, and providing timely information on women who have high values of cholesterol and blood pressure.

c. Community involvement or engagement in the BCCEDP and/or WISEWOMAN project to include use of community health workers, use of community members, engagement in partnership activities with community agencies that serve financially disadvantaged women, use of referral systems to other community services, and so forth.

2. Infrastructure. Document the current State, Territorial, or Tribal BCCEDP and WISEWOMAN (if applicable) infrastructure including:

a. An organizational chart that shows the location of The WISEWOMAN Program in relationship to the agency's health promotion section, chronic disease section, minority, or women's health section, Breast and Cervical Cancer Early Detection Program, and to other programs that address chronic disease (*e.g.* cardiovascular health, tobacco, physical activity, nutrition, 5 A Day, diabetes, and obesity). Describe lines of communication between WISEWOMAN and the above-mentioned sections and programs.

b. The number of BCCEDP and WISEWOMAN sites in operation as of the January preceding the date of this application.

c. The total number of political subdivisions (*e.g.*, counties) and the number of these subdivisions that had a BCCEDP site and the number that had a WISEWOMAN site as of January preceding the date of this application.

d. During the most recent program year include:

(1) The number of women served by BCCEDP and The WISEWOMAN Programs in the State, Territory, or Tribal area (provide data for each of the past 5 years, if available).

(2) The racial/ethnic characteristics of the population served (include educational Characteristics, if available).

(3) The percentage of women with a positive mammogram or pap test who did not go on for further diagnostics and reasons why women did not go on;

(4) The percentage of women with a WISEWOMAN alert value who did not go on for further diagnostics and reasons why women did not go on.

(5) The average length of time between a positive mammogram or Pap test and the receipt of a diagnostic test.

(6) The average length of time between detection of a WISEWOMAN alert value and the receipt of diagnostic test (*see* WISEWOMAN Guidance Document at *http://www.cdc.gov/od/ads/hsr2.htm* for the definition for alert values).

3. Program Planning for Upcoming Year. Describe how the program will decide or is currently conducting the following:

a. Site selection, the approximate number of sites to receive WISEWOMAN services, the characteristics of the sites, the proportion of State or Territorial BCCEDP sites that will receive WISEWOMAN services, and estimated number of women who are expected to receive such services during the upcoming year.

b. Screening and intervention services and start-up activities (if applying for Standard Demonstration Project funding level; see checklist of start-up activities in the WISEWOMAN Guidance Document at *http://www.cdc.gov/wisewoman* to be provided along with a time line for determining and implementing start-up activities, screening and intervention services [allowable screening and diagnostic procedures for the demonstration programs include resting pulse, blood pressure, serum total cholesterol, HDL-cholesterol, LDL-cholesterol, height and weight measurements, automated blood chemistry (to assess fasting blood glucose, potassium, calcium, creatinine, uric acid, triglyceride, or micronutrient levels), urine analysis (including urine cotinine), and paper and pencil tests, interviews, or computerized methods that measure level of physical activity, dietary intake, smoking, osteoporosis risk status, immunization status, or other chronic disease risk factors or preventable health problems. The use of program funds for other tests will require substantial justification by the program. The schedule of fees/charges should not exceed the maximum allowable charges established by the Medicare Program for the same or similar laboratory tests. (Fees/charges for services covered by Medicare may vary by location, thus, States or Territories should determine the appropriate reimbursement rates for their areas.)

c. A pilot study to test proposed methods.

d. Inclusion of letters of support for WISEWOMAN from a substantial number of State/Territorial BCCEDP site directors and medical staff.

e. Methods for tracking women through the system and after they leave the system [(for the purpose of bringing them back for further screening and intervention)(Standard Projects should ensure that at least 60 percent of new women receive the complete intervention)], for flagging, tracking, and managing women who need immediate referral because of extremely high blood pressure (≥180 systolic blood pressure or 110 diastolic blood pressure), cholesterol (>400 mg/dL), or glucose levels (>375 mg/dL).

f. Program tracking to determine which women receive which interventions; routine reporting on the progress of the program (see suggested quarterly report format in WISEWOMAN Guidance Document at *http://www.cdc.gov/wisewoman* and reporting of minimum data elements. These minimum data elements will yield the performance measures that will determine whether a project qualifies for additional funding. The complete set of performance measures are detailed in Appendix B.

4. *Screening and Intervention.* Document the ability of the program to screen and intervene upon women enrolled in the WISEWOMAN program including implementation of WISEWOMAN screening activities, the rationale and guidelines for implementing WISEWOMAN intervention activities, methods for reaching women from the State or Territorial BCCEDP for the purpose of WISEWOMAN screening and intervention and the use of outreach and community health workers to address barriers to program involvement, barriers to behavioral change, and barriers to maintaining contact for future health screenings and interventions.

5. *Evaluation—(Standard Program):*

a. Describe the current evaluation team or propose a plan to establish the evaluation team using criteria such as prior work experience, professional training, and academic degrees.

b. Describe the current evaluation plan or propose an evaluation plan that includes clearly stated evaluation objectives with a time line for the collection of data throughout the project.

c. Describe the current database or propose a database that details data elements, methods for data management, the creation of unique identifiers, methods for identifying women who need immediate treatment, and other important data procedures.

6. *Evaluation—(Enhanced Program):* Submit an evaluation design to: (1) Examine the impact of chronic disease risk factor intervention(s) on lowering blood pressure, improving cholesterol levels (lowering total cholesterol levels and raising HDL cholesterol levels), and improving other risk factors such as poor nutrition and inadequate physical activity at six and twelve months after intervention and program strategies. The plan for effectiveness should include:

a. The extent to which a university or Prevention Research Center will be involved in the evaluation design.

b. The preliminary evaluation questions to be answered.

c. The type of evaluation design (*e.g.* randomized controlled design) and rationale for using this type of design.

d. Length of follow-up and measurement intervals.

e. Protocol used to ensure that the maximum number of women will return for each evaluation.

f. Statistical techniques that will be used to analyze the data with preliminary estimates of the sample size needed to achieve adequate statistical power. To obtain the statistical power to evaluate the intervention, the program should add cholesterol and blood pressure screenings (and other optional screenings, if desired) to a sufficiently large number of State or Territorial BCCEDP sites to provide adequate statistical power for evaluating program effectiveness. States or Territories may want to consider including a total of at least 20 sites. The study design for this type of evaluation might include women from a number of sites assigned to intervention (*i.e.*, the special intervention group) compared to women from a number of sites assigned to usual standard practice (*i.e.*, the usual care group or comparison group). Other study designs may be proposed including randomizing women to each of arm of the study. A method of collecting information for the purpose of program evaluation should be developed and implemented. Voluntary reporting of Minimum Data Elements is recommended as part of the program evaluation. The plan for translation and transferring successful strategies should include:

(1) The extent to which the evaluation team includes staff with expertise in translation and transfer activities;

(2) Clear objectives regarding translating strategies into products using lay language, compiling information in clear, user-friendly format, testing of the translation package for usability;

(3) Methods for providing technical assistance, orientation and training on implementing and ensuring fidelity with regard to implementing the translation package;

(4) Methods for evaluating and refining the translation package and plans for dissemination of the final package;

(5) A timeline with regard to translation and transfer activities. Some important resources for understanding the scope of these translation and transfer activities are found at *http://www.replication.org/infores.html* and *http://www.replication.org/pdf/tool.pdf.*

7. Collaborative Efforts. Provide a concise collaboration plan that addresses program methods and analyzing and publishing data with CDC and others. The following areas should be addressed:

a. Meeting and teleconferences attendance for the purpose of developing forms, tracking systems, measurements, policy, etc.

b. Analyzing data and co-authoring abstracts and publications; sharing information with CDC and its contractors (stripped of identifying information) on a twice-yearly basis.

c. Plans to collaborate with other health promotion experts in the health agency including nutritionists, physical activity experts, tobacco control experts, and others who promote a healthy lifestyle through better eating, weight management, physical activity, and smoking cessation.

d. For Enhanced projects, plans for developing a monograph and/or training on methods to help other projects adopt successful program practices (See example ''Integrating Cardiovascular Disease Prevention into Existing Health Services: The Experience of the North Carolina WISEWOMAN Program'' at *http://www.hpdp.unc.edu/wisewoman/manual.htm.*

8. Budget and Justification: Provide a detailed budget and line-item justification that is consistent with the stated objectives, purpose, and planned activities of the project. Applicants should note the following budget-related issues:

a. Budget for the following travel:

(1) Up to two persons to attend the Nutrition and Public Health Course that is sponsored by the University of North Carolina Prevention Research Center and the Centers for Disease Control and Prevention. This is a five-day course. For more information see *http://www.hpdp.unc.edu/nph.* Future topics and place to be determined. This is a mandatory training course that provides training with regard to WISEWOMAN Best Practices.

(2) Up to two persons to participate in the annual WISEWOMAN Project Directors Meeting that is held in conjunction with NCCDPHP Annual Chronic Disease Conference (four days) or other CDC Conferences. Details are provided at *http://www.cdc.gov/nccdphp/conference/index.htm.* This is a mandatory meeting for the purpose of sharing projects successes and challenges.

(3) One person to attend the Physical Activity and Public Health Course that is sponsored by the University of South Carolina Prevention Research Center and the Centers for Disease Control and Prevention. This is an eight-day Postgraduate Course on Research Directions and Strategies and a six-day Practitioner's Course on Community Interventions. *See http://prevention.sph.sc.edu/seapines/index.htm.* Or one person to participate in a non-CDC sponsored professional meeting directly relevant to the program. (A tobacco cessation training course is highly recommended.)

(4) Cost Data and Minimum Data Elements: Budget for collecting and reporting cost data and minimum data elements. (See WISEWOMAN Guidance Document at *http://www.cdc.gov/wisewoman* for list of minimum data elements.) Section 1505 [42 U.S.C. 300n–1] requires that applicants provide assurance that the grant funds be used in the most cost-effective manner.

G.3. Evaluation Criteria

Applications received from current grantees that are funded under program announcements 00115, 99135, and 01098 will be reviewed utilizing the Technical Review process. For applicants that apply competitively as Standard Demonstration Projects or Enhanced Projects, an independent objective review group appointed by CDC will evaluate each application individually using the following criteria:

1. Program Plan (35 points). The extent to which the applicant has addressed Recipient Activities 1.a

through 1.j and items 3.a through 3.g in the Application Content sections.

2. Screening and Intervention (Standard Projects: 25 points and Enhanced program: 15 points). The extent to which the applicant has addressed Recipient Activities 1.b through 1.f and items 4 in the Application Content sections.

3. Evaluation Plan—(Standard Program: 15 points). The extent to which the applicant has addressed Recipient Activities 1.h and items 5 in the Application Content sections.

Evaluation Plan—(Enhanced Program—25 points). The extent to which the applicant has addressed Recipient Activities 1.h and items 6 in the Application Content sections.

4. Background, Need, and Potential for Community Involvement (10 points). The extent to which the applicant has addressed Recipient Activities 1.a and items 1.a through 1.c in the Application Content sections.

5. Infrastructure (10 points). The extent to which the applicant has addressed Recipient Activities 1.b and 1.d and items 2.a through 2.c in the Application Content sections.

6. Collaborative Efforts (5 points). The extent to which the applicant has addressed Recipient Activities 1.a and items 7 in the Application Content sections.

7. Human Subjects (not scored). Does the application adequately address the requirements of Title 45 CFR Part 46 for the protection of human subjects? Not scored; however, an application can be disapproved if the research risks are sufficiently serious and protection against risks is so inadequate as to make the entire application unacceptable. Does the application adequately address the CDC Policy requirements regarding the inclusion of women, ethnic, and racial groups in the proposed research? This includes:

1.1 The proposed plan for the inclusion of both sexes and racial and ethnic minority populations for appropriate representation.

1.2 The proposed justification when representation is limited or absent.

1.3 A statement as to whether the design of the study is adequate to measure differences when warranted.

1.4 A statement as to whether the plans for recruitment and outreach for study participants includes the process recognition of mutual benefits.

Component 4:—State-Based Oral Disease Prevention Program D.4. Availability of Funds

Approximately $2,600,000 is available in FY 2003 to fund approximately 13 Part 1 Capacity Building Program awards. It is expected that the Capacity Building Program average award will be $200,000, ranging from $65,000 to $400,000. Funding estimates may vary and are subject to change.

No funding is available in FY 2003 for Part 2 Basic Implementation Program awards. Pending available funding resources, applications will be accepted in years two through five.

Use of Funds

Applicants may not use these funds to supplant oral health program funds from local, State, or Federal sources. Applicants must maintain current levels of support dedicated to oral health from other funding sources. Funding received under this program announcement cannot be used for the purchase of dental services, dental sealant equipment, or materials.

Recipient Financial Participation

Applicants requesting funding for community water fluoridation equipment will be required to provide matching funds. Matching funds are required from State and/or local sources in an amount of not less than one dollar for each four dollars of Federal funds awarded for community water fluoridation equipment under this program announcement.

Matching funds are required from State and/or local sources in an amount of not less than one dollar for each four dollars of Federal funds awarded for a Basic Implementation Program.

Matching funds may be in cash or its equivalent, including donated or in-kind appropriate equipment, supplies, and or services. Do not include funds from other Federal sources including the Preventive Health and Health Services Block Grant.

CDC funding covers some of the costs of oral health core capacity, infrastructure, and community-based prevention interventions, but it is not intended to fully support all aspects of the oral health program.

Direct Assistance

You may request Federal personnel as direct assistance in years two through five, in lieu of a portion of financial assistance.

To request new direct-assistance assignees, include:

a. Number of assignees requested.

b. Description of the position and proposed duties.

c. Ability or inability to hire locally with financial Assistance.

d. Justification for request.

e. Organizational chart and name of intended supervisor opportunities for training, education, and work.

f. Opportunities for training, education, and work experience for assignees.

g. Description of assignee's access to computer equipment for communication with CDC (*e.g.*, personal computer at home, personal computer at workstation, shared computer at workstation on site, shared computer at a central office).

E.4. Program Requirements

In conducting activities to achieve the purpose of this program, the recipient will be responsible for the activities under 1.a and 1.b (Recipient Activities), and CDC will be responsible for the activities listed under 2. CDC Activities.

1.a. Part 1 Capacity Building Program Recipient Activities and Performance Measures:

(1) Develop oral health program leadership capacity. Develop a State oral health team. Leadership capacity should include: (a) full-time dental director (oral health professional with public health training); (b) .25 time epidemiologic support at a minimum; (c) demonstrated access to at least .50 time of a water fluoridation engineer/specialist or coordinator, and (d) demonstrated access to appropriate program support, .50 to one time dental sealant coordinator, .25 time capacity for health education, health communication, and .25 time support staff, through leveraging of dollars, shared dedicated resources and letters of support.

Performance will be measured by evidence of established leadership capacity. Evidence of leadership capacity can be shown by: The composition of an oral health program team consistent with (1) above.

(2) Describe the oral disease burden, health disparities, and unmet needs in the State. Describe the oral disease burden within the State and document unmet oral health needs of target populations and existing oral health assets (*e.g.*, professional dental/dental hygiene schools, prevention interventions undertaken within the State).

Performance will be measured by evidence that State oral disease burden has been accurately described. Evidence can be shown by: (a) a publicly available disease burden document describing oral disease burden and oral health disparities, issued in the past five years using the most recent data, preferably data no more than five years old; and (b) document includes oral health status with indicators consistent with the National Oral Health System (NOHSS), the Water Fluoridation Reporting

System (WFRS), and the ASTDD State Synopsis.

(3) Develop or update a comprehensive State Oral Health Plan. Develop or update a comprehensive State Oral Health Plan for oral health promotion, disease prevention, and control that includes specific objectives for future reductions in oral disease and related risk factors and objectives for the promotion of oral health. The plan should provide specific, measurable, and time-phased objectives to accomplish each goal related to the logic model (*see http://www.cdc.gov/OralHealth/index.htm* for additional information). In addition, develop a comprehensive State Oral Health Plan (suggest five-year plan) that is available to the public, periodically updated, and developed in collaboration with the assistance of stakeholders. The Plan should address the following oral health areas: (a) Oral health infrastructure including current resources, gaps in resources and recommendations for their elimination; (b) Healthy People 2010 objectives; (c) caries; (d) water fluoridation and school-based or school-linked sealant programs; (e) description of priority populations and burden of disease; (f) strategies to address oral health promotion across the lifespan; (g) strategies to identify best practices that can be replicated; (h) evaluation strategies and recommendations for monitoring the outcomes and impacts of plan implementation; (i) implementation strategies, leveraging of resources, partnerships, and plan maintenance including roles and responsibilities of State and local agencies; and (j) oral cancer, periodontal diseases, and infection control.

Performance will be measured by evidence that a comprehensive State Oral Health Plan has been completed. Evidence can be shown by development of a plan consistent with the process described and with elements (a) through (j) above.

(4) Establish and sustain a diverse Statewide oral health coalition. Establish a coalition to assist in the formulation of plans, guide project activities, and identify additional financial resources for this project. Coalition membership should be representative of stakeholder organizations within the State health department, within the State government and groups external to State government, for examples *see http://www.cdc.gov/OralHealth/index.htm.*

Performance will be measured by evidence of a sustained, diverse statewide oral health coalition. Evidence can be shown by: (a) Extent of progress towards coalition sustainability, such as written by-laws, goals and objectives, plans and procedures for operation, past accomplishments, clerical staff support, and evidence of leveraging of resources; (b) membership entities representing each, but not limited to, categories in the coalition framework at Web site; (c) clear responsibility; (d) coalition activity in infrastructure, community water fluoridation, and sealants. Coalition activities must address all of the following activities: Infrastructure development, community water fluoridation, school-based/school-linked dental sealant programs, unless the grantee can document how current activities in the State have already met or exceeded Health People 2010 objectives for these activities.

(5) Develop or enhance oral disease surveillance system. Develop key resources, data sources, and capabilities to promote the State's surveillance needs. *See http://www.cdc.gov/OralHealth/index.htm* for detailed outline of data sources to consider. Activities should include: (a) Establish plan for how data collection, analysis, and dissemination will support program activity, including a surveillance plan logic model consistent with the CDC Surveillance Logic model (*see http://www.cdc.gov/OralHealth/index.htm*); (b) conduct surveillance so that key oral health indicators have been collected in a valid and timely manner using standard approaches with attention to comparability across States and consistent with annual data submission to the ASTDD's State Synopsis and data submissions to NOHSS, and updated at least every five years; and (c) monitor water fluoridation on a monthly basis comparable and consistent with WFRS.

Performance will be measured by evidence of a developed or enhanced oral disease surveillance system. Evidence can be shown by: Documentation that key resources, data sources, capabilities and surveillance plan are in place to provide an adequate surveillance system via activities consistent with (a) through (c) above.

(6) Identify prevention opportunities for systemic, socio-political and/or policy change to improve oral health. Conduct a periodic assessment of policy and systems level strategies with potential to reduce oral diseases. The assessment should include identification of opportunities to make changes in policy and health systems to overcome barriers, capitalize on assets, increase capacity, and coordinate prevention interventions.

Performance will be measured by evidence of identification of socio-political and policy changes. Evidence can be shown by periodic assessments consistent with the activities above.

(7) Develop and coordinate partnerships to increase State-level and community capacity to address specific oral disease prevention interventions. Identify, consult with and involve appropriate partners to assess areas critical to the development of State-level and community-based oral health promotion and disease prevention programs, avoid duplication of efforts, ensure synergy of resources, and enhance the overall leadership within the State. Partnerships should augment the oral health coalition.

Performance will be measured by evidence of the development and coordination of partnerships. Evidence can be shown by: (a) Collaborative partnerships with Statewide and local entities (*e.g.*, Memorandum of Understanding (MOU) with other State agencies, joint dedication of resources); (b) broad range of partnerships inside and outside of the State Health Department, encouraging the focus on prevention interventions.

(8) Coordinate and implement limited community water fluoridation program management. Provide coordination and management of a fluoridation program, provide/develop fluoridation training materials for engineers and water plant operators, and evaluate community water fluoridation accomplishments and new and/or replacement water fluoridation equipment.

Performance will be measured by the development, implementation, and coordination of a water fluoridation program. Evidence can be shown by: (a) Extent the water fluoridation program incorporates and makes progress towards the 1995 Engineering and Administrative Recommendations for Water Fluoridation (EARWF), including: (1) Daily testing; (2) access to .50 fluoridation engineer; (3) targeted inspection activity; (4) basic fluoridation training; (b) monthly monitoring consistent with the Water Fluoridation Reporting System (WFRS); (c) percent of fluoridated water systems consistently maintaining optimal levels of fluoride as defined by State and consistent with EARWF; (d) document communities and populations receiving new or replacement fluoridation equipment.

(9) Evaluate, document, and share State program accomplishments, best practices, lessons learned, and use of evaluation results. Evaluation activities should: (a) Be consistent with the CDC oral health global logic model, work plan: (*see http://www.cdc.gov/OralHealth/index.htm*) the CDC Evaluation Framework for Evaluating

Public Health Programs (*http://www.cdc.gov/mmwr*), the CDC Guide to Evaluating Surveillance Systems (*http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5013al.htm*), and consider assessments of changes in oral health outcomes, as well as process evaluations consistent with the Association of State and Territorial Dental Directors' Best Practices evaluation criteria (*see http://www.cdc.gov/OralHealth/index.htm*); (b) document outcome evaluation measures including but not limited to percentage of population receiving fluoridated water and dental sealants; (c) include evaluation efforts consistent with indicators developed for ''supported States evaluation plan'' (*see http://www.cdc.gov/OralHealth/index.htm*); (d) be used to improve recipient activities above; and (e) be institutionalized as an on-going activity. Sharing of State program accomplishments, best practices, and lessons learned may include participation in forums for exchanging ideas and identification of methods and avenue for dissemination such as the CDC Chronic Disease Conference, and the National Oral Health Conference as well as local and State supported forums (*e.g.*, State Summits, State dental and dental hygiene association meetings).

Performance will be measured by evidence that evaluation has been completed, State evaluation capacity and activities have become institutionalized; State program accomplishments have been collected, evaluated, and shared with stakeholders; and evaluation results are used to improve program performance. Evidence can be shown by: (1) Documentation of evaluation activities consistent with (a) through (e) above; and (2) documentation of participation in scientific forums consistent with the activities above.

(10) Capacity Building Prevention Intervention (To be undertaken after Part 1 Capacity Building Program 1–9 from above have been met).

a. Develop and Implement a water fluoridation program. Provide or develop fluoridation educational materials, as appropriate, to promote water fluoridation. Implement a program to support new replacement water fluoridation equipment. Evaluate the accomplishments of the water fluoridation program.

Performance will be measured by the development, implementation, and coordination of a water fluoridation program. Evidence can be shown by: (1) Documentation of appropriate education and promotion efforts; (2) documentation of communities and populations receiving replacement fluoridation equipment by funding source; (3) extent of progress towards reaching or exceeding Health People 2010 objective of 75 percent of population on public water supplies receiving fluoridated water.

b. Develop, coordinate and implement limited school-based or school-linked dental sealant programs. Describe and document the number of eligible public elementary or secondary schools, and existing related oral health assets. Document infrastructure is in place for the coordination and management of school-based or school-linked dental sealant program and show collaborative working relationships and formal agreements (*e.g.*, MOA, MOU, or other written agreement between the State Health Department and the State educational agency).

Develop school-based or school-linked dental sealant programs targeting public elementary or secondary schools located in: (a) Urban areas, and in which more than 50 percent of the student population of that school or school entity is participating in Federal or State free and reduced meal programs; or (b) rural school districts having a median income that is at or below 235 percent of the poverty line, as defined in section 673(2) of the Community Services Block Grant Act [42 U.S.C. 9902(2)].

Performance will be measured by the development, implementation, and coordination of school-based/school-linked dental sealant programs. Evidence can be shown by: (1) Extent that priority populations have been identified; (2) extent that implementation strategies appropriate to State setting have been developed; percent and number of children in funded programs receiving at least one permanent molar sealant; proportion of eligible schools participating in program; and proportion of children participating in free and reduced cost lunch program receiving at least one sealant.

Optional Cost Analysis Recipient Activities and Performance Measures: Measures include the collection, tracking, and completion of cost analysis for school-based/school-linked dental sealant program. Evaluate the accomplishments, efficiency, and effectiveness of the implemented school-based/school-linked dental sealant programs. Proposals may include requests for technical assistance for the following optional performance measures:

Performance will be measured by the collection, tracking, and accomplishment of a cost-analysis for school-based or school-linked dental sealant programs. Evidence can be shown by: (a) Documentation of baseline mean pit and fissure caries severity (*i.e.*, pit and fissure DMFS) in targeted permanent molars among children three years older than target population; (b) cost-analysis report published and submission made to the ASTDD Best Practices Project.

1.b. Part 2 BASIC IMPLEMENTATION Program Recipient Activities and Performance Measures: Basic Implementation Recipient Activities and Performance Measures include evidence that applicant continues to meet CAPACITY BUILDING program and CAPACITY BUILDING-PREVENTION INTERVENTION program activities and performance measures in section 1.a. above.

(1) Develop a Statewide community water fluoridation program or maintain Statewide fluoridation program that has reached the Healthy People 2010 objective. Enhance or expand existing community water fluoridation demonstration or pilot project into a statewide program showing annual progress.

Performance will be measured by evidence that water fluoridation efforts result in significant progress towards meeting, maintaining or exceeding Healthy People 2010 goals. Evidence can be shown by: (a) Extent that Statewide water fluoridation program incorporates and makes progress in meeting the Engineering and Administrative Recommendations for Water Fluoridation (EARWF, 1995), including: (1) Monthly monitoring and participation; (2) additional fluoridation engineers and/or specialist if appropriate; (3) all fluoridation engineers and/or specialists attend CDC fluoridation engineers and/or specialists attend CDC fluoridation training or equivalent; (4) all water plant operators receive basic fluoridation training; (5) all adjusted fluoridated water systems have annual inspections to insure that all the technical recommendations, including the (a) safety requirements of EARWF are followed; (b) all split sampling reference labs should participate in the CDC Lab Proficiency Testing Program; (c) document progress in increasing percent of fluoridated water systems consistently maintaining optimal levels of fluoride as defined by State and consistent with recommendations outlined in EARWF; (d) document progress toward reaching or exceeding Healthy People 2010 objective; (e) document communities and populations receiving new or replacement fluoridation equipment.

(2) Develop Statewide school-based or school-linked dental sealant program or

maintain school-based or school-linked dental sealant program if the Healthy People 2010 objective has been met. Enhance or expand existing school-based or school-linked dental sealant demonstration or pilot project into a Statewide program showing annual progress. School eligibility criteria as stated in (10)(b) above will be used.

Performance will be measured by evidence that grantee is implementing and expanding school-based or school-linked dental sealant programs Statewide. Evidence can be shown by: (a) Documentation of progress towards reaching or exceeding goal of school-based or school-linked sealant programs in at least 50 percent of eligible schools; (b) significant progress towards increasing: The percent and number of children in Statewide funded programs receiving at least one permanent molar sealant; proportion of eligible schools participating in program; and proportion of eligible schools participating in program; and proportion of children in funded programs participating in free and reduced cost lunch program receiving at least one sealant; (c) demonstrated participation in ASTDD Best Practices project; (d) demonstrated leadership capacity in dissemination and technical assistance to other State sealant programs; (e) progress towards sustainability and institutionalization of sealant program through leveraging of dollars, partnership participation, billing Medicaid and/or SCHIP or other sources of support.

(3) Develop other evidence-based, population-based, intervention strategies consistent with the State Oral Health Plan. Strategies should include policy and systems level approaches. Interventions should be population based, with objectives that specify the population wide changes sought and may address use of dental sealants, water fluoridation efforts, tobacco use, diabetes, poor nutrition, oral health education and, secondary prevention.

Performance will be measured by demonstration of implementation of evidence-based, population-based strategies. Evidence will be shown by: (a) Documentation of evidence-based for intervention initiative; (b) extent that population-based interventions meet the established objectives specifying the population-wide changes sought; and (c) submission to the ASTDD Best Practices Project.

(4) Evaluate intervention components. Design and implement a public health practice evaluation system that collects and analyzes information to be used to measure program progress, community capacity changes, short-term and distal outcomes. Evaluation results and related findings should be used to add to and/or enhance program implementation.

Performance will be measured by evidence that State evaluation capacity and activities have become an on-going normative activity and that State program accomplishments have been collected, evaluated and shared with stakeholders. Evidence can be shown by: (a) Demonstration that the recipient is taking a leadership role in providing technical assistance and transfer of practice knowledge to other States; and b) quantification (in terms of dollars) of resources used and returns on those resources.

(5) Expand oral health program leadership capacity. Expand State oral health team beyond CAPACITY BUILDING level. Provide National leadership by sharing results, with one another, best practices, and other lessons learned to help shape the national agenda and improving the oral health of the public. Capacity should include: (a) Epidemiologic support .50 time at a minimum; (b) demonstrated access to 1.0 time fluoridation engineer/specialist or coordinator (may be less for States with small number of water systems or more for States with a large number of water systems); and (c) demonstrated access to appropriate program support at a minimum: 1.0 time program coordinator, 1.0 time dental sealant coordinator, .50 time capacity for health education, .50 time health communication, .50 time data manager, .25 time grant writer, 1.0 time support staff, and regional consultants, through leveraging of dollars, shared dedicated resources, and letters of support.

Performance will be measured by evidence of expanded leadership and access to needed functions through personnel, leveraging of dollars, shared dedicated resources and/or letters of support, sharing through publications and presentations at national and regional meetings. Evidence can be shown by: (a) The minimum composition of the oral health program is consistent with the activities outlined above; (b) demonstrated with the activities outlined above; and (c) demonstrated evidence of sharing best practices and other lessons learned inside and outside of the State borders through publications and meeting presentations.

(6) Develop and maintain expanded surveillance capacity. The surveillance system is maintained and sustainable, and able to compare State or smaller area data to those from national data sources. Surveillance system should be able to conduct original analyses or forge good working relationships with in-State agencies that will conduct the original analyses. Refer to surveillance logic model at Web site for more information.

Activities should include: (a) Development of regional or county level indicators; (b) development of surveillance system quality checks, establishment of data cleaning protocol, and document data linkages and security procedures; (c) utilization of original analytic analyses and comparisons to national data in dissemination activities and reports; (d) documentation of regional or county level indicators; and (e) collaboration with other programs in the health department to answer key epidemiological questions of mutual interest, *e.g.*, diabetes, tobacco, cancer, MCH.

Performance will be measured by evidence that surveillance is on-going, sustainable activity within the State, is expanded beyond the basic requirements of a core system, and uses data to direct program planning and oral health promotion. Evidence can be shown by: Documentation of activities (a) through (e) above.

(7) Expand the diverse statewide oral health coalition. Expand statewide oral health coalition and address institutionalization and sustainability.

Performance will be measured by evidence of a sustained, diverse statewide oral health coalition with established plans for membership and recruitment of diverse stakeholders. Evidence can be shown by: (a) Extent that coalition has been significantly expanded in both numbers and types of members and documentation of expanded coalition activities; (b) documentation of dedicated support staff; (c) documentation of established communication measures and outreach to community, policy makers and stakeholders; (d) extent of progress towards coalition sustainability such as meeting minutes, schedule of meeting dates and locations; and (e) documentation of active support from stakeholders including funding sources and in-kind contributions.

(8) Address program sustainability by broadening resources. Address the institutionalization of the oral health unit, oral health surveillance system, statewide coalition, and the State's best practice programs.

Performance will be measured by demonstration of condition supportive of the sustainability of State oral health infrastructure and programs. Evidence can be shown by measures including: (a) Non-award funding and measures that activities are institutionalized; (b) demonstration of environment

conducive to the growth of promotion of oral health in three major support areas: Infrastructure and processes, resources and culture/context in the State, and local health department(s); (c) demonstration of shared dedicated resources, leveraging of dollars, and supportive partnerships; (d) demonstrated legislative and other State government support.

(9) Collect, track and complete cost analysis for school-based or school-linked dental sealant program. Evaluate the accomplishments, efficiency, and effectiveness of the implemented school-based or school-linked dental sealant programs. Performance will be measured by the completion of a cost-analysis for school-based or school-linked dental sealant programs. Evidence can be shown by: (a) Documentation of baseline mean pit and fissure caries severity (*i.e.*, pit and fissure DMFS) in targeted permanent molars among children three years older than target population; and (b) cost-analysis report published and submission made to the ASTDD Best Practices Project.

2. CDC Activities. a. Update and provide information related to the purposes and/or objectives of the program announcement related to recipient activities. b. Provide programmatic and technical assistance for recipients and their stakeholders and partners through programmatic and technical consultation, workshops, information exchanges and other forms of guidance, assistance and information sharing to assist the recipient in: (a) The assessment of oral health status and behaviors of target sub-populations; (b) the design and implementation of strategies for prevention interventions based on best available scientific evidence; (c) the design, evaluation and monitoring of interventions effectiveness; (d) the distribution of information documenting lessons learned, best practices and program costs; and (e) the evaluation of State oral health programs.

c. Communicate and share information, evaluations, data, and programmatic activities with other recipients and partners, as appropriate.

d. Coordinate conference calls, workshops, and other information sharing opportunities, as appropriate.

F.4. Content

The program announcement title and number must appear in the application. Use the information in the Program Requirements, Other Requirements, and Evaluation Criteria sections to develop the application content. Your application will be evaluated on the criteria listed, so it is important to follow them in laying out your program plan.

This section will outline the requirements for each program and will note additional requirements for each specific Part.

The narrative for Part 1 CAPACITY BUILDING Program should be no more than 36 pages, double-spaced, printed on one side, with one-inch margins, and 12-point Universal unreduced font.

(Part 1) CAPACITY BUILDING Program

1. Executive Summary (not to exceed two pages). Provide a clear, concise two-page written summary to include: (a) Synthesis of need for oral health programs; (b) changes in infrastructure required to support proposed programs; (c) major proposed objectives for implementation of Work Plan (*see* section (4) below and *http://www.cdc.gov/OralHealth/index.htm);* (d) amount of Federal funding requested under Part 1 of this cooperative agreement.

2. Statement of Need (not to exceed seven pages) (a) Describe oral disease burden within the State, indicate specific sub-populations and source(s) of data provided; (b) describe current assets and capacity of the State to reduce identified burdens. Current grantees under Program Announcement 01046, should not include CDC funding from Program Announcement 01046 under existing resources; (c) identify barriers and facilitators likely to affect the reduction of oral disease burden; and (d) describe gaps in Statewide infrastructure affecting the capability of the applicant to perform recipient activities and operate prevention programs.

3. Five-year Plan (Goals) (not to exceed five pages). (a) Design a logic model for State oral health program. *See* Web site for the CDC Logic Model Template. Incorporate planned Capacity Building Prevention Interventions if appropriate, into State oral health logic model; (b) Goals: List feasible, realistic goals related to logic model to achieved in five years.

4. One-year Plan, Activities and Timeline (not to exceed nine pages) Objectives: Provide specific, measurable, and time-phased objectives to accomplish each goal related to the logic model and the performance measures outlined in Section E above. (a) State how achievement of objectives will contribute to meeting the goal; (b) describe the one-year work plan for achieving each objective in Section (3) above. *See* Web site for the CDC Work Plan Template; (c) the one-year work plan should describe activities planned to complete each objective. Applicants must link each time-phased objective and performance measure from Section E above, with the activities intended to support that objective; (d) one-year work plan should establish a time line for completion of each component or major activity; (e) identify specific individual (person) responsible for each objective or activity in the one-year work plan.

5. Evaluation Plan (not to exceed seven pages). a. Describe plan for monitoring progress toward achieving objectives stated in Section (4) above;

b. For each objective, specify how achievement will be documented including measures, data collection protocols, and data quality required to obtain needed information;

c. Using the logic model as a framework, specify: (1) Indicators for process and outcome objectives; (2) expected increase in capacity of the State oral health program, delivery systems, and communities; (3) changes in oral health outcomes;

d. Plans for analysis, interpretation and reporting of findings;

e. Plans for use of findings; and

f. Provide a time-line for the completion of the evaluation.

6. Program Management (not to exceed six pages). (a) Describe employing agencies or institutions, as well as professional backgrounds of existing or proposed staff who will be responsible for each functional project aspect, including in-kind staff resources and percent of time commitment (including in-kind staff resources and percent of time commitment (Include Curriculum Vitae as appropriate); (b) provide evidence of State support for proposed project; (c) describe coalitions involvement in planning, implementation, and evaluation; (d) describe management, coordination team and responsibility for different program aspects; and (e) identify staff that will direct evaluation efforts including additional team members assigned to evaluation tasks. Provide a detailed description of expertise, experience, and delineation of staff, and responsibilities for program evaluation.

7. Budget and Accompanying Justification (no page limitation). Submit a detailed budget and line item justification that is consistent with the purpose of the program and the proposed project objectives and activities, using the format of the sample budget provided at *http://www.cdc.gov/OralHealth/index.htm.*

To the extent necessary, applicants are encouraged to include travel for: (a) Up to four persons associated with this project to each annually attend up to two technical assistance workshops. For

the purpose of the initial funding period, budget for the workshops, training courses, and technical assistance meetings to be held in Atlanta, Georgia; and (b) two staff to annually participate in the National Oral Health Conference. For the purpose of the initial funding period, applicant should budget for the 2004 National Oral Health Conference.

The narrative for Part 2 BASIC IMPLEMENTATION Program should be no more than 45 pages, double-spaced, printed on one side, with one-inch margins, and 12 point Universal unreduced font.

(Part 2) BASIC IMPLEMENTATION Program

Use the application guidance from Part 1 Capacity Building Program with the exception of the page limits and the additional section as outlined below.

1. Executive Summary (not to exceed four pages)
2. Statement of Need (not to exceed seven pages)
3. Eligibility (not to exceed seven pages)

(a) Outline how State oral health program has accomplished activities and performance measures under the Capacity Building Program; (b) outline how your demonstration/pilot CAPACITY BUILDING PREVENTION INTERVENTIONS have been successful. Include a description of activities and performance measures under Section E.1.a as appropriate.

4. Five-year plan (Goals) (not to exceed five pages)
5. One-year Plan, Activities and Timeline (not to exceed nine pages)
6. Evaluation Plan (not to exceed seven pages)
7. Program management (not to exceed six pages)
8. Budget and Accompanying Justification (no page limit)

G.4. Evaluation Criteria

Applicants received from current grantees that are funded under Program Announcement 01046, will be reviewed utilizing the Technical Review process. Applications received from unfunded applicants (new), will be evaluated individually against the following criteria by an independent review group appointed by CDC.

Applications received from grantees funded under Program Announcement 01046 will be reviewed by independent reviewers utilizing the Technical Acceptability Review (TAR) process.

CAPACITY BUILDING Program Criteria

a. One Year Plan (30 points). The extent to which the applicant has addressed Recipient Activities 3 and item 4.a in the Application Content section of Component 4.

b. Five Year Plan (20 points). The extent to which the applicant has addressed Recipient Activities 3 and item 3 in the Application Content section of Component 4.

c. Program Management (20 points). The extent to which the applicant has addressed Recipient Activities 1, 7, 8, and 10 and item 6 in the Application Content section of Component 4.

d. Statement of Need (15 points). The extent to which the applicant has addressed Recipient Activities 1 and 2 and item 2 in the Application Content section of Component 4.

e. Evaluation Plan (15 points). The extent to which the applicant has addressed Recipient Activities 5, 6, and 9 and item 5 in the Application Content section of Component 4.

f. Budget (not scored). The extent to which the applicant has addressed item 7 in the Application Content section of Component 4.

BASIC IMPLEMENTATION Program Criteria

a. One Year Plan (30 points). The extent to which the applicant has addressed Recipient Activities 3 and item 4.a in the Application Content section of Component 4.

b. Five Year Plan (20 points). The extent to which the applicant has addressed Recipient Activities 3 and item 3 in the Application Content section of Component 4.

c. Evaluation Plan (20 points). The extent to which the applicant has addressed Recipient Activities 5, 6, and 9 and item 5 in the Application Content section of Component 4.

d. Program Management (20 points). The extent to which the applicant has addressed Recipient Activities 1, 7, 8, and 10 and item 6 in the Application Content section of Component 4.

e. Statement of Need (10 points). The extent to which the applicant has addressed Recipient Activities 1 and 2 and item 2 in the Application Content section of Component 4.

f. Budget (not scored). The extent to which the applicant has addressed item 7 in the Application Content section of Component 4.

Component 5—Arthritis

D.5. Availability of Funds

Approximately $6,000,000 is available in FY 2003 to fund up to 36 awards. Approximately $3,640,000 is available to fund 28 existing Capacity Building Program Level A grantees under Program Announcement 01097. Capacity Building Program Level A grantees will undergo a technical review of their application and will be funded pending receipt and approval of a technically acceptable application. It is expected that the average award will be $135,000 ranging from $120,000 to $150,000.

Approximately $2,360,000 is available to fund six to eight Capacity Building Program Level B programs. Requests for these funds will be competitive and will be reviewed by an independent objective review panel. It is expected that the average award will be $275,000 ranging from $250,000 to $300,000.

Continuation awards within an approved project period will be made on the basis of satisfactory progress as evidenced by required reports and the availability of funds. The interim progress report will be used as evidence of Capacity Building Program Level A attainment of their respective goals and objectives and readiness to compete for the next level of funding should funds be available. Capacity Building Program Level A grantees wishing to compete for the next level of funding should submit an application that is responsive to the Capacity Level B Program Performance Measures, Application Content and Recipient Activities section of this program announcement including a line-item budget and budget justification. Applications for advancement from a Level A to Level B program will be reviewed by CDC staff utilizing the Technical Acceptability Review (TAR) process. Applications can be submitted in fiscal year 2004, 2005, or 2006. Funding decisions will be made on the basis of satisfactory progress on the appropriate Performance Measures as evidenced by required reports and the availability of funds. Capacity Building Program Level A programs that unsuccessfully compete for Capacity Building Program Level B funding will be funded for a Capacity Building Program Level A.

Use of Funds

Cooperative Agreement Funds may not be used to supplant State or Local funds. In addition, funds may not be used to support primary prevention activities.

Recipient Financial Participation

Matching funds are not required for this program.

E.5. Program Requirements

In conducting activities to achieve the purpose of this program, the recipient will be responsible for the activities under 1a. (Recipient Activities for Capacity Building Program Level A) and

1b. (Recipient Activities for Capacity Building Program Level B Programs) and CDC will be responsible for the activities listed under 2. CDC Activities.

1a. Recipient Activities for Capacity Building Program Level A

1. Staffing: Establish a full-time arthritis program manager to oversee arthritis program activities and to promote an arthritis program within the State. All arthritis program managers are strongly encouraged to take the training ''The Arthritis Challenge'' and ''Arthritis: The Public Health Approach'' located at *http://www.astdhpphe.org.* Performance will be measured by the extent to which the program is appropriately staffed in a timely manner as evidenced by the submission of the name of the program manager, the date of hire, and their completion of the training, ''Arthritis: The Public Health Approach'' as documented by a course completion certificate.

2. Partnerships: Establish an advisory group or coalition to guide, review, and provide direction for the State in all activities directed at reducing the burden of arthritis. The advisory group, at a minimum, should include the local chapter(s) of the Arthritis Foundation. In addition, the State should consider the following as members of the advisory board or coalition:

a. Individuals with expertise in arthritis;

b. Agencies/organizations with activities relevant to arthritis, resources for arthritis activities, and access to target populations (*e.g.*, Area Agencies on Aging, Medicaid/Medicare, managed care organizations, American Association of Retired Persons, senior centers, and faith communities); and

c. Persons with arthritis or family members of persons with arthritis.

As appropriate, States should establish internal workgroups with other components of State government that are directly or indirectly involved in some aspect of arthritis control and prevention.

Performance will be measured by the extent to which there is evidence of diverse, active, and viable partnerships. Documentation should include minutes of meetings, lists of members, copies of by-laws or written operating procedures.

3. Surveillance:

a. Define and monitor the prevalence and impact of arthritis using the Behavioral Risk Factor Surveillance System (BRFSS). It is recommended that funded States collect data using the Arthritis Optional Module of the BRFSS in odd years (*i.e.*, 2003, 2005, 2007)

b. Issue a State of Arthritis Report using, at a minimum, 2001 BRFSS arthritis data. (Arthritis data was collected by all States in calendar year 2001 through the BRFSS). This activity should be completed within the first two years of the cooperative agreement.

c. For years two and beyond surveillance activities should be expanded to include the measuring of intervention reach and effects. Measuring reach includes, but is not limited to, establishing mechanisms to determine annual availability and delivery of evidenced-based self-management programs such as ASHC, PACE, and Arthritis Foundation Aquatics programs. Availability measures the number of programs offered and their geographic dispersion; delivery measures both the number of programs given and the number of persons with arthritis attending. Measuring effects includes, but is not limited to, measuring changes in health impacts, improvement in quality of life, or functioning among those attending the above programs.

Performance will be measured by:

a. The extent to which there is evidence that the burden of arthritis has been defined using BRFSS data that identifies demographics, prevalence, and related risk behaviors (*i.e.*, physical activity and obesity). A State of Arthritis Report has been published and disseminated.

b. The extent to which the grantee is able to demonstrate the ability to define and monitor the number of evidenced-based self management courses available within the State and the number of individuals impacted by these programs.

4. State Plan: Develop or update a State Plan for Arthritis that outlines a proposed framework for activities to reduce the burden of arthritis. This document should be planned with partners and include activities to be implemented by the partners. The plan should not address health department activities only and should be completed within the first eighteen months of the cooperative agreement.

Performance will be measured by the extent to which documentation is provided that a written State plan for arthritis is completed. The plan should contain a description of the State burden of arthritis, and assessment of resources and resource gaps, strategies to decrease the burden of arthritis, priorities, and time-line for implementation of interventions. The plan should be endorsed and supported by partner organizations.

5. Interventions: Implement one or more strategies from the State Arthritis Plan that is consistent with the Public Health Framework for Arthritis (*see http://www.cdc.gov/nccdphp/arthritis*) with a focus on the immediate effects and/or short term goals as outlined in this framework. Activities should be data driven. Applicant should develop implementation plans and evaluation strategies for the proposed intervention(s). Activities should be implemented with a focus on one or more of the following areas:

a. Evidence-based Self Management Education and Physical Activity Interventions: Broaden the reach of evidence-based self management programs, *e.g.*, the Arthritis Self Help Course (ASHC), the promotion of physical activity in individuals with arthritis using land-based exercise programs such as People with Arthritis Can Exercise (PACE) or water-based such as the Arthritis Foundation Aquatics Program.

b. Health Communications Campaigns: Develop or utilizing health communications interventions that will increase/enhance knowledge and beliefs necessary for appropriate management of arthritis. Communications strategies should be designed to increase self-management beliefs and behaviors and to increase the belief that self-management is an important part of arthritis management. The communications activity can be targeted to people with arthritis, and their families, the general public, or non-physician health professionals. CDC developed health communication campaign Physical Activity. ''The Arthritis Pain Reliever,'' may be used. A summary of this material will be posted at *http://www.cdc.gov/nccdphp/arthritis.* Physician education efforts, while worthy, will not be considered as part of this activity.

Performance will be measured by the extent that the grantee can provide documentation that one or more evidenced-base intervention was implemented including: the process used for selecting the intervention, the target audience, the location of the intervention, and data used to support the decision to implement.

1b. Recipient Activities for Capacity Level B Programs

In addition to continuing and enhancing the Recipient Activities for Capacity Building Program Level A, Capacity Building Program Level B Program will include:

1. Surveillance: Examine the availability and applicability of other State-based data sources including but not limited to data from outpatient/ambulatory care settings, managed care

organizations, and follow back surveys of BRFSS respondents. Pharmacy data may also prove useful to better define the burden of arthritis within the State. All surveillance activities outside of BRFSS should be directly linked to programmatic activities.

Performance will be measured by the extent to which non-BRFSS data have been examined and have informed program decisions or enhanced existing activities.

2. Interventions: Implement two or more strategies from the State Arthritis Plan that is consistent with the Public Health Framework for Arthritis with a focus on Evidenced-Based Arthritis Education Programs and/or Health Communications. Capacity Building Level B programs may choose to implement and evaluate physical activity or self-management interventions other than ASHC, aquatics and PACE, that may be beneficial and effective in reducing arthritis related pain and disability and improving the quality of life among persons with arthritis. For these interventions, States must propose an implementation and evaluation plan. This plan should include a description of the program, expected program outcomes, implementation strategies, the role of partners and consultants in implementing and evaluating the program, and the evaluation plan. The evaluation should describe how impact will be measured, domains of interest, proposed data collection tools, and how data will be collected and analyzed. A time-line should be included.

Performance will be measured by:

a. The extent to which grantee can provide documentation that two or more evidenced-base interventions were implemented including: the process used for selecting the intervention, the target audience, the location of the intervention, the role of partners, and data used to support the decision to implement.

b. The extent to which non-evidence based programs have been implemented and evaluated.

Notes: All funded States are expected to adhere to the most current surveillance, intervention, and health communication recommendations that will be posted at *http://www.cdc.gov/nccdphp/arthritis/index.htm.*

2. CDC Activities

a. Provide consultation and technical assistance to plan, implement, and evaluate each component of the program.

b. Provide current information on the status of

c. National efforts as they relate to the implementation of recipient activities.

d. As needed, provide technical assistance in the coordination of surveillance efforts and the use of other data systems to measure and characterize the burden of arthritis, provide standard analyses of BRFSS data for States, and provide data for national level comparisons.

e. Facilitate communication among arthritis programs, other government agencies, and others involved in arthritis control and prevention efforts.

F.5. Content

The program announcement title and number must appear in the application. Use the information in the Program Requirements, Other Requirements, and Evaluation Criteria sections to develop the application content. Your application will be evaluated on the criteria listed, so it is important to follow them in laying out your program plan. Applications for Capacity Building Program Level A should be no more than 30 pages and Capacity Building Program Level B Programs no more than 40 pages excluding Federal forms, budget, justification, abstract, and appendixes. All applications should be double-spaced, printed on one side, with one-inch margins, and 12-point font. All applicants should also submit as appendices, resumes, job descriptions, organizational charts, and any other supporting documentation as appropriate. All graphics, maps, overlays, etc., should be in black and white and meet the above criteria. All submitted materials must be suitable for photocopying. Your application must be submitted unstapled and unbound.

1. Abstract (All Applicants). A one-page, single-spaced, typed abstract must be submitted with the application. The heading should include the title of the program, organization, name and address of the project director, telephone number, facsimile number, and e-mail address. The abstract should clearly state which level of activities the applicant is applying for: Capacity Building Program Level A, or Capacity Building Level B Program. The abstract should briefly list major program elements and activities. A table of contents that provides page numbers for each section should follow the abstract.

2. Background/Current Status. Capacity Building Program Level A Programs: Describe the burden of arthritis in the State. Identify what data sources are being used, the barriers the State currently faces in developing and implementing a program for arthritis, and identify the specific needs and resources available for arthritis activities.

Capacity Building Level B Programs:

a. Applicants for Capacity Building Programs Level B should provide evidence that they have significantly met the requirements specified in the Recipient Activities for Capacity Building Programs Level A (see Program Recipient Activities Section).

b. In addition, the applicant should adequately describe the burden of arthritis within the State including how the program defines arthritis using BRFSS and other data.

c. Include a description of the barriers the State currently faces in further developing and implementing programs for the control of arthritis.

3. Work-Plan. Provide a work plan that includes objective, methods, evaluation plans, and a time-line for each for the required elements cited in Recipient Activities above. Objectives should describe what is to happen, by when, by whom, and to what degree. Methods should describe the plan for achieving each of the objectives including a description of how partners will be involved. Also included should be a description of how progress toward attainment of the objectives will be monitored.

a. Staffing (All Applicants). Describe how proposed or existing staff has the relevant background, qualifications, and experience to manage a public health program. Include a description of their role in promoting an arthritis program within the State, their specific responsibilities, their role in coordinating activities between relevant programs within the State, how the organizational structure will support the staff's ability to conduct proposed activities, and the level of effort and time to be devoted to the arthritis program. Job descriptions, resumes if available, and an organizational chart should be included.

b. Partnerships (All Applicants). Include plans for developing partnerships with the local chapter(s) of the Arthritis Foundation, State and local agencies, Federal agencies, and others with an interest in arthritis. If partnerships have already been developed, the applicant should describe the process used, and the role of advisory groups, partnerships, or coalitions in the development and implementation of activities in the State Plan for Arthritis. Partnerships are expected to have been ongoing and viable. Applicants should include copies of agendas for all partnership meetings within the past two calendar years. Letters of support should be submitted and should describe the nature and extent of involvement by outside partners.

c. Surveillance

Capacity Building Program Level B

1. Describe plans to monitor the burden of arthritis within the State using BRFSS data and include plans for the development and dissemination of a State of Arthritis Report.

2. Applicant should also describe the method to be used to develop mechanisms to measure programmatic reach and effects of evidenced-based arthritis self-management programs as defined in the ''Recipient Activities'' section of this announcement.

Capacity Building Level B

3. In addition to criteria under Capacity Building Program Level A, applicants for Capacity Building Level B Programs should present plans to examine the availability and applicability of other State-based data sources as described in the ''Recipient Activities'' section.

d. State Plan

Capacity Building Program Level A

Applicants should describe the process to be used for engaging relevant partners and developing a State arthritis plan. If a State plan has been developed, describe the process used for its development, provide agendas for planning meetings, and provide the executive summary of the State plan.

e. Interventions

1. Applicants should describe the process to be used to select the intervention to be implemented.

2. If an already existing State plan or partnership has provided guidance for the selection of the intervention, describe the relationship between the intervention and strategies identified within the State plan and the Public Health Framework for Arthritis. Provide a description of implementation plans, the proposed intervention(s) activity(ies), the target population, geographic location, the actual methods of implementation, a time-line, evaluation strategy, and the role of partners in this process.

Capacity Building Program Level B

a. Address the elements 1 and 2 under Capacity Building Program Level A.

b. If proposing the implementation of non evidenced-based intervention(s), provide an implementation plan that includes a description of the program and expected outcomes. In addition, the evaluation plan should describe how impact will be measured, domains of interest, proposed data collection tools, and how data will be analyzed.

f. Evaluation (All Applicants). Applicant should provide a plan that is capable of monitoring progress toward meeting specified project objectives.

g. Budget (All Applicants). Provide a detailed line-item budget and justifications consistent with the purpose and proposed objectives. Budgets should include travel for one to two program staff to attend a two-day meeting in Atlanta. Proposed sub-contracts should identify the name of the contractor, if known; describe the services to be performed; provide an itemized budget and justification for the estimated costs of the contract; specify the period of performance; and describe the method of selection. If indirect costs are requested, a copy of the Indirect Cost Rate Agreement should be included.

G.5. Evaluation Criteria (100 Points)

Applications received from current grantees that are funded under Program announcement 01097, will be reviewed utilizing the Technical Review process. Applications received from States funded under program announcement 99074 and all other applicants will be evaluated individually against the following criteria by an independent review group appointed by CDC.

A. Capacity Building Program Level A (100 points)

1. Need/Current Status. Capacity Building Program Level A (15 points) Capacity Level B (25 points). The extent to which the applicant addresses the requirements identified in Section F.5. (Application Content) item 3. Point distribution is listed below.

2. Staffing. Capacity Building Program Level A (20 points) Capacity Building Program Level B (10 points). The extent to which the applicant addresses the requirements identified in section E5 (Recipient Activities) section 1a. item 1 and section F.5 (Application Content) item 3a.

3. Partnerships. Capacity Building Program Level A (15 points) Capacity Building Program Level B (15 points). The extent to which the applicant addresses the requirements identified in Section E.5 (Recipient Activities) section 1a. item 2 and section F.5 (Application Content) item 3b.

4. Surveillance. Capacity Building Program Level A (15 points) Capacity Building Program Level B (20 points). The extent to which the applicant addresses the requirements identified in Section E.5 (Recipient Activities) section 1a. item 3; section 1b item 1 and section F.5 (Application content) item 3c.

5. State Plan. Capacity Building Program Level A (15 points) Capacity Building Program Level B (0 points). The extent to which the applicant addresses the requirements identified in Section E.5 (Recipient Activities) section 1a. item 4 and section F.5 (Application Content) item 3d.

6. Interventions. Capacity Building Program Level A (15 points) Capacity Building Program Level B (25 points). The extent to which the applicant addresses the requirements identified in Section E.5 ''Recipient Activities'' section 1a. item 5; section 1b item 2 and section F.5 ''Application Content'' item 3e.

7. Evaluation. Capacity Building Program Level A (5 points) Capacity Building Program Level B (5 points). The extent to which the applicant addresses the requirements identified in Section F.5 (Application content) item 3f.

8. Budget (not scored). The extent to which the applicant addresses the requirements identified in Section F.5 (Application content) item 3g.

9. Human Subjects (not scored). Does the application adequately address the requirements of title 45 CFR Part 46 for the protection of human subjects? Not scored; however, an application can be disapproved if the research risks are sufficiently serious and protection against risks is so inadequate as to make the entire application unacceptable.

Component 6—Behavior Risk Factor Surveillance Systems (BRFSS)

D.6. Availability of Funds

Approximately $5,000,000 is available in FY 2003 to fund approximately 54 existing grants under program announcement 99044. It is expected that the average award will be $75,000, ranging from $50,000 to $100,000. It is expected that the awards will begin on or about June 30, 2003 and will be made for a 12-month budget period within a project period of up to five years. Funding estimates may change.

Use of Funds

Funds provided under this program announcement cannot be used to conduct community-based pilot or demonstration projects. Cooperative agreement funds may not be used to supplant State or local funds. Cooperative agreement funds may not be used to provide patient care, personal health services, medications, patient rehabilitation, or other cost associated with treatment. Funds awarded under this program announcement may be obligated and expended only for those BRFSS surveillance, data collection, and

related activities identified in the Notice of Grant Award.

E.6. Program Requirements

In conducting activities to achieve the purpose of this program, the recipient will be responsible for the activities under 1. Recipient Activities, and CDC will be responsible for the activities listed under 2. CDC Activities.

1. Recipient Activities. a. At a minimum, identify a program director and BRFSS data coordinator dedicated to overall coordination and operations of BRFSS.

b. Adopt the standard BRFSS written protocol that has been developed and formulate a plan for developing and conducting BRFSS data collection activities in conformance with protocols used by other participating States and delineated in the ''BRFSS User's Guide'' and numbered memorandums (The ''BRFSS User's Guide'' is available at *http://www.cdc.gov/brfss*).

c. Develop and implement plans and written procedures for ongoing analysis of behavioral risk factor data Statewide and for selected local areas.

d. Develop and implement plans and written procedures to ensure the routine use of BRFSS data for directing program planning, evaluating programs, establishing program priorities, developing specific interventions and policies, assessing trends, and targeting relevant population groups.

e. Develop and implement plans for the use of BRFSS data to address emerging Public Health chronic disease and injury issues within the State.

f. Develop and implement procedures to increase collaboration with and among State, local, and, as appropriate, national, public, private, voluntary, for-profit and nonprofit agencies, organizations, and universities that analyze data or seek to reduce chronic disease and injury morbidity and mortality.

g. Assure active cooperation and collaboration with recipients of funding from other CDC supported programs (cancer, tobacco use, diabetes, alcohol use, women's health, etc.) and identify opportunities to link program and BRFSS efforts where appropriate and reinforcing, including co-funding of BRFSS activities.

h. Ensure adequate and, as required, periodic training of State BRFSS interviewers. Interviewers must follow the standard BRFSS questionnaire script developed in collaboration with BRFSS member States and should be trained with appropriate standards for telephone interviewing. (The BRFSS Interviewer Training is located in the training section of the BRFSS Web site referenced above in 1.b.)

i. Develop, maintain, and make available to CDC monthly, electronic BRFSS data sets for data management (*i.e.*, editing, cleaning, and weighting).

j. Conduct monthly, monitoring data quality and data management (*i.e.*, through verification and validation efforts).

k. Develop and implement an analysis plan.

l. Participate with others in individual and multi-State analyses comparing data across BRFSS States.

m. Disseminate BRFSS findings through presentations and publications to health departments, professional societies, voluntary agencies, universities, other BRFSS States, and other interested individuals and organizations.

n. Make data and BRFSS findings available for training workshops and meetings at least once a year (*i.e.*, BRFSS Conference).

o. Assure that CDC receives final end-of-year BRFSS data sets on or before February 15 of the following year.

2. CDC Activities. a. Assist BRFSS member States to develop an annual survey instrument to be used by States with States and CDC programs.

b. Assist BRFSS member States to establish standard survey protocols to be followed by States and disseminate them in the ''BRFSS User's Guide'' and in numbered memorandums; and, as appropriate, assist in the development of State-specific protocols.

c. Assist BRFSS member States with designing and obtaining appropriate telephone samples.

d. Assist BRFSS member States in the development of data processing procedures to be used by States and CDC to produce edited data files with standard, uniform formats. Provide program software, training, and on-going technical assistance for operations management, questionnaire data entry, and development of the BRFSS analysis database.

e. Develop and provide to States semi-annual and annual summary reports on selected risk factors related to the leading causes of State morbidity and mortality in a standardized and uniform manner.

f. Assist in training State staff related to data collection, data analysis, interpretation, and use.

g. Conduct or assist with the specification of cleaning, weighting, data editing, variable and format layouts of all data files.

h. Provide technical assistance to resolve problems regarding data collection procedures, response rates, sampling procedures (unbiased sampling and estimate omissions), and database file completeness.

i. Collaborate with State, Federal, and other programs on joint analysis of BRFSS data.

j. Coordinate and facilitate the interchange of technical information among cooperative agreement recipients.

k. Provide BRFSS States with programmatic, epidemiological, and statistical technical assistance.

l. In collaboration with State(s) conduct multi-State and single-State analyses and facilitate dissemination and translation of findings.

m. Participate with States in workshops, training, and meeting to exchange information.

n. Conduct site visits to monitor program operations and to provide technical assistance as needed.

Performance will be measured based on accomplishment of the activities listed above. Evidence can be demonstrated through the quality of data, adherence to survey recommendations, utilization of BRFSS data for program planning and evaluation.

F.6. Content

The program announcement title and number must appear in the application. Use the information in the Program Requirements, Other Requirements, and Evaluation Criteria sections to develop the application content. Applications will be evaluated on the criteria listed, so it is important to follow them in laying out program plans. The narrative should be no more than 30 double-spaced pages, printed on one side, with one-inch margins, and unreduced font.

Available funds will be allocated first for the costs of an estimated base of 2,000 completed 100-question surveys in each State.

1. Program Management

a. Identify the percentage of the project coordinator's time and related costs for project activities and describe procedures or process (*i.e.*, contractors or in-house) for the management of data collection. Provide job descriptions, resumes, and organizational charts.

b. Include written procedures or describe plans to develop and implement the following:

c. BRFSS data analysis Statewide and for local areas.

d. Use of BRFSS data for directing program planning, program evaluation, setting program priorities, developing interventions, assessing trends, and targeting relevant population groups.

e. To address emerging public health issues.

f. To increase collaboration among State, local, and other agencies, organizations, and universities that analyze data or seek to reduce chronic disease and injury morbidity and mortality.

g. Provide a list of training taken by key BRFSS staff, to include data collection/interviewer staff, within the previous 12 months. Training list should include course title, a brief description of course content, dates of training, and names and titles of staff attending the training.

h. Provide a copy of projected staff training with the course title, course description, dates of training, and names and titles of staff who will be attending training.

2. Operational Plan

a. Provide an estimate of the number of interviews to be completed in addition to the base number of 2000 completed interviews per State per year.

b. Provide a list of the survey questions to be asked in addition to the base-length questionnaire.

c. Identify the percentage of an analyst's time and related costs for analyzing data collected.

d. Provide the title and author(s) of publications produced and/or distributed using BRFSS data.

e. Upgrading computer-assisted telephone interviewing systems and computer systems for analysis and Internet activities.

f. Describe the nature and extent of collaboration and coordination with and support (*i.e.,* financial, shared resources, etc.) from other State programs.

3. Evaluation

Describe the procedures currently used or planned to monitor the performance of the data collection system, adherence to prescribed data collection protocols, and the extent of the use and dissemination of the data.

4. Budget

Provide a detailed budget and line-item justification for all operating expenses. The budget should be consistent with the State's objectives and planned activities of the project. Budget requests should include the cost of two two-day trips to Atlanta for two individuals and the cost of one five-day trip (including travel days) for up to two individuals to attend the annual BRFSS conference. The budget should address funds requested, as well as the applicant's in-kind or direct support.

G.6. Evaluation Criteria (100 points)

Applications received from current grantee that are funded under program announcement 99044, will be reviewed utilizing the Technical Review process.

1. Operational Plan (50 points). The extent to which the applicant has addressed Recipient Activities 1.b, 1.c, 1.d, 1.e, 1.k, 1.m, and items 1 through 6 in the Application Content section.

2. Program Management (25 points). The extent to which the applicant has addressed Recipient Activities 1.a, 1.g, 1.h, 1.i, and items 1 through 5 in the Application Content section.

3. Evaluation (25 points). The extent to which the applicant has addressed Recipient Activities 1.i, 1.j, and 1.o, and item 3 in the Application Content section.

4. Budget (Not Weighted). The extent to which the applicant has addressed item 4 in the Application Content section.

Component 7—Genomics and Chronic Disease Prevention

D.7. Availability of Funds

Approximately $1,000,000 is available in FY 2003 to fund approximately three to five States' program awards. It is expected that the average award will be $200,000 ranging from $150,000 to $250,000.

Use of Funds

Funds awarded under this component may not be used to conduct genomic research or pay for patient services such as genetic testing or counseling. Cooperative agreement funds may be used to develop or enhance the State Health Department's capacity for planning with other agency programs and outside partners, and implementing the use of genomic information (*e.g.* genetic testing and family history data) in public health policy and programs. Funds may also be used to enhance data collection through disease registries and other surveillance systems and to develop public health work-force competency in the use of genomics for disease prevention. Developing genomic leadership capacity will enhance comprehensive chronic disease prevention and health promotion by establishing cross-cutting activities with one or more disease-specific programs and increasing collaboration across the agency in epidemiology, environmental health, infectious disease, maternal and child health, and related programs that increase the effectiveness of chronic disease prevention.

E.7. Program Requirements

In conducting activities to achieve the purpose of this program, the recipient will be responsible for the activities under 1. Recipient Activities, and CDC will be responsible for the activities listed under 2. CDC Activities.

1. Recipient Activities

Note: In this announcement, integrating genomic and the use of family history into chronic disease program planning, policy development, and intervention design includes, but is not limited to, (a) Establishing or expanding leadership capacity in the field of genomics, (b) developing and implementing population-based assessments and incorporating genomic information into disease-specific data collection through surveillance and registries, (c) developing expanded uses of genomics in programmatic activities including BRFSS and the analysis of vital records and other sources important in population-based analysis, (d) educating the health workforce, policy makers, and the public about the importance of understanding the role of family history and genetic risk factors in disease etiology and prevention, and (e) specifically preparing the chronic disease workforce for using genomic tools to reduce the burden of specific diseases and understanding the benefits and limitations of available genetic tests.

a. Develop or strengthen the health agency organizational capacities for assessing and utilizing existing genomics and public health program experience and expertise in planning the integration of genomics into existing chronic disease prevention and health promotion programs.

b. Acquire or enhance the leadership capacity required to integrate genomics into existing or planned chronic disease prevention and health promotion programs. In this effort, coordination of the core public specialties (such as epidemiology, laboratory services, policy development, and infectious disease prevention) to integrate genomics and family history, as appropriate, is required. The use of genomics within public health requires collaboration with academic and health care organizations that can provide technical assistance and expertise in expanding program and policy development. Leadership capacity may include: (a) Designating a State agency-wide, or chronic disease genomics coordinator or team, expanding existing leadership roles to include chronic disease and other disease-specific responsibilities, and/or coordinating a team representing all or selected public health disease programs; (b) the availability of adequate epidemiologic, genomics, laboratory, health education, communications expertise and program support; and (c) a mechanism for assessing and increasing the genomic and public health competency of the chronic disease work-force through technical assistance and specific

training activities. Information of work force competency is available at: *http://www.cdc.gov/genomics/training/competencies/comps.htm.*

c. Utilizes national, regional and State training and technical assistance resources for program development, and expands collaborative relationships with key academic institutions such as the Centers for Genomics and Public Health (Link to: *http://www.cdc.gov/genomics/training/competencies/comps.htm).*

Ensures that State professional organizations, industry, community representatives or key partners and community are key partners throughout the planning process.

d. Develop and implement a plan for integrating genomics and related risk assessment tools such as family history into core public health activities and priorities for one or more chronic infectious, environmental, Maternal and Child Health or other public health programs during the first year.

e. Plan and coordinate the assessment and use of various types of targeted risk assessment strategies related to enhanced disease prevention based on genomics and family history tools. Collaborate with professional, industrial, and academic resources and partners in the testing, assessment, and usage of risk assessment tools that help organize knowledge about inheritable factors into a process for early recognition of increased disease susceptibility and strategies for disease prevention.

f. Plan and coordinate the assessment and use of various types of targeted risk assessment strategies related to enhanced disease prevention based on genomics and family history tools. Collaborate with CDC and the Centers for Genomics and Public Health in the testing, assessment, and usage of family history tools that help organize knowledge about heritable factors into a process for early recognition of increased disease susceptibility and strategies for disease prevention.

2. CDC Activities

a. Convene workshop and/or teleconference of recipient Programs for information-sharing and problem solving.

b. Provide ongoing guidance, consultation, and technical assistance to plan, implement, and evaluate all aspects of program activities. Activities include assisting with analyses and interpretation of the rapidly expanding knowledge base on public health genomics and findings from qualitative and quantitative research; guiding program evaluation, and sharing community, environmental and policy strategies to promote the integration of genomics across health agency programs associated with chronic disease program activities. Disseminate relevant state-of-the-art research findings and public health recommendations related to genomics and disease-specific prevention and control.

c. On a consultative basis, assist in the development and review of intervention protocols and program evaluation methods.

d. Coordinate national level partnerships with relevant organizations and agencies involved in the translation of genomics and family history into relevant guidelines and recommendations for public health policy development and program action.

F.7. Content

The program announcement title and number must appear in the application. Use the information in the Program Requirements, Other Requirements, and Evaluation Criteria sections to develop the application content. Your application will be evaluated on the criteria listed, so it is important to follow them in laying out your program plan. Applications should be no more than 20 pages excluding Federal forms, budget, justifications, abstract, and appendices. All applications should be double spaced, printed on one side, with one-inch margins, and 12-point font. All applicants should also submit as appendices, resumes, job descriptions, organizational charts, and any other supporting documentation as appropriate. All graphics maps, overlays, etc., should be in black and white and meet the above criteria. All submitted materials must be suitable for photocopying. Your application must be submitted UNSTAPLED and UNBOUND.

1. Abstract. A one-page, single-spaced, typed abstract must be submitted with the application. The heading should include the title of the program, organization, name and address of the project director, telephone number, facsimile number, and e-mail address. The abstract should briefly list major program elements and activities. A table of contents that provides page numbers for each section should follow the abstract.

2. Background, Need, and Understanding. Describe the status of health agency activities and capacity for establishing coordinated leadership in genomics to guide crosscutting health policy and program development. Provide status and level of involvement of chronic disease, infectious disease, environmental health, epidemiology, maternal and child health, and laboratory within this agency leadership capacity. Describe the extent to which genomics is integrated into chronic disease programs function and the proposed or actual placement of a focus for genomic activities within that structure. Discuss any agency actions implemented or planned that facilitate the integration of genomics and/or the use of family history in developing risk factor assessments and targeting disease prevention efforts. Provide evidence of the readiness of the agency and its program to integrate genomics and family history into chronic disease prevention and health promotion planning, policy development, and intervention activities. Identify the specific components of this, or other chronic disease program announcements, or the crosscutting issues, to be addressed.

3. Work-plan. Provide a work plan that addresses each of the required elements cited in the Recipient Activities above. The work plan should include:

a. Program Objectives for each of the Recipient Activities. Objectives should describe what is to happen, by when, by whom, and to what degree.

b. The proposed method of achieving each of the objectives.

c. The proposed plan for evaluating progress toward attainment of the objectives.

d. A milestone, time line, and completion chart for all objectives for the project period.

4. Budget. Provide a detailed line-item budget with justifications consistent with the purpose and proposed objectives. Clearly differentiate budget amounts and activities requested through this component from the resources or activities of other components or programs. Budgets should include travel for one to two persons to attend a two-day meeting in Atlanta. Proposed sub-contracts should identify the name of the contractor, if known; describe the services to be performed; provide an itemized budget and justification for the estimated costs of the contract; specify the period of performance; and describe the method of selection. If indirect costs are requested, a copy of the Indirect Cost Rate Agreement should be included.

G.7. Evaluation Criteria

Applications for this component will be objectively reviewed against the following criteria by an independent review group appointed by CDC.

1. Background, Need, and Understanding (25 points). The extent to which the applicant describes

Background, Need as presented in the application content section (F.8.4), and demonstrates an Understanding of the intent and focus of the program as presented in the Recipient Requirements (E.8.1).

2. Work Plan

a. Program Objectives (25 points). The extent to which the applicant presents specific, measurable, and time phased objectives for each Recipient Requirement (E.8.1.a–e).

b. Methods of Achieving the Objectives (25 points). The extent to which the applicant's plan for each Recipient Requirement (E.8.1 a–e) will accurately monitor, and permit re-direction of activities.

c. Plan for Evaluating Progress (15 points). The extent to which the evaluation plan for each Recipient Requirement (E.8.1 a–e) will accurately monitor, and permit re-direction of activities.

d. Milestone, Timeline, and Completion Chart (10 points). The extent to which the chart(s) provided represents an effective tool for monitoring program progress.

3. Abstract (Not scored). The extent to which an overview of the program is provided in a clear and concise manner.

4. Budget and Justification (Not scored). The extent to which the line item budget justification is reasonable and consistent with purpose of this component and program goal(s) and objectives of the cooperative agreement.

Program Performance Measures

Performance measures for the first year: 1. Evidence that States have performed a review of organizational and operational capacities for integrating genomics into public health practices and policies.

2. Evidence that States have identified and defined the nature and scope of population-based data, genomics information, and leadership capacity necessary to integrate genomics into chronic disease and other public health program activities.

3. Evidence that States have developed and initiated a plan for integrating genomics and risk assessment tools such as family history into one or more chronic, infectious, environmental, maternal and child health, or other public health programs.

4. Evidence that the States have formed partnerships with academic institutions, professional organizations, community and industry groups and involved them in the planning of genomic integration activities.

Five Year Performance Measures

1. Evidence that the States have integrated genomics and related risk assessment tools, such as family history, as a routine component of disease investigations and analysis.

2. Evidence that the States have used population-based data and the expanding genomics knowledge base to develop or revise chronic, environmental, and infectious disease programmatic activities, interventions, and policies.

3. Evidence that the States have conducted preliminary evaluations of the impact of genomics in case identification, disease prevention, economic, and disease specific health outcome.

Note: This section applies to all components.

H. Submission and Deadline

Submit the original and two copies of CDC form 0.1246. Forms are available in the application kit and at the following Internet address: *http://www.cdc.gov/od/pgo/forminfo.htm.*

Note: Your application should be submitted as one application but should consist of specific Categorical Components to allow each categorical program to remove their section of the application to assist with the preparation of the application.

The application must be received by 4:00 p.m. Eastern Time March 28, 2003. Submit the application to: Technical Information Management Section—Program Announcement 03022, Procurement and Grants Office, Center For Disease Control and Prevention, 2920 Brandywine Road, Room 3000, Atlanta, Georgia 30341–4146.

Deadline Applications will be considered as meeting the deadline if they are received before 4:00 p.m. Eastern Time on the deadline date. Applicants sending applications by the United States Postal Service or commercial delivery services must ensure that the carrier will be able to guarantee delivery of the application by the closing date and time. If an application is received after closing due to carrier error, when the carrier accepted the package with a guarantee for delivery by the closing date and time, or if significant weather delays or natural disasters, CDC will upon receipt of proper documentation, consider the application as having been received by the deadline.

Applications which do not meet the above criteria will not be eligible for competition and will be discarded. Applicants will be notified of their failure to meet the submission requirements.

I. Other Requirements

Technical Reporting Requirements

Provide CDC with original plus two copies of:

1. Interim progress report, the interim progress report will be due February 15, 2004, and subsequent interim progress reports will be due on the 15th of February each year through February 15, 2008, except for Component 6. The second report (annual progress report) is due 90 days after the end of the budget period (30th of September). The progress report, due in February, will serve as your non-competing continuation application and must include the following elements:

a. A succinct description the program accomplishments/narrative and progress made in meeting each Current Budget Period Activities Objectives during the first six months of the budget period (June 30th through December 31st).

b. A succinct description of the program accomplishments/narrative and progress made in meeting each Current Budget Period Activities Objectives during the first six months of the budget period (June 30th through December 31st).

c. The reason(s) for not meeting established program objectives and strategies to be implemented to achieve unmet objectives.

d. Current Budget Period Financial Progress.

e. New Budget Period Proposed Activities and Objectives.

f. Detailed Line-Item Budget and Justification.

g. For all proposed contracts, provide the name of contractor, method of selection, period of performance, scope of work, and itemized budget and budget justification. If the information is not available, please indicate ''To Be Determined'' until the information becomes available; it should be submitted to CDC Procurement and Grants Management Office contact identified in this program announcement.

Applicable for Program Components 2 (Nutrition, Physical Activity and Obesity), 3 (WISEWOMAN), 4 (State-Based Oral Disease Prevention), and 5 (Arthritis), only:

The interim progress report that is due on the 15th of February will also be used as evidence of a program's readiness to move from level to the next higher level based on attainment of goals and objectives when funding is available. Applicants wishing to

compete for the next funding level should submit items a, b, d, e, f, and g above and the information requested in the next funding level Recipient Activities and Application Content identified in this program announcement including a line item budget and budget justification.

Applicants can be submitted in fiscal years 2004, 2005, 2006, and 2007 but be received by February 15th of the specific submission year. Funding decisions will be made on the basis of attainment of current goals and objectives as evidenced by the require reports, application score, and the availability of funds.

2. Financial status report, no more than 90 days after the end of the budget period. The financial status report should include an attachment that identifies unspent balances for each program component.

3. Final financial and performance reports, no more than 90 days after the end of the project period.

Send all reports to the Grants Management Specialist identified in the ''Where to Obtain Additional Information'' section of this announcement.

The following additional requirements are applicable to this program.

AR–1 Human Subjects Requirements (Component 2 & 3)
AR–2 Requirements for Inclusion of Women and Racial and Ethnic Minorities in Research (Component 2 & 3)
AR–7 Executive Order 12372 Review
AR–8 Public Health System Reporting Requirements
AR–9 Paperwork Reduction Act Requirements
AR–10 Smoke Free Workplace Requirements
AR–11 Health People 2010
AR–12 Lobbying Restrictions

J. Where To Obtain Additional Information

For this and other CDC announcements, the necessary applications, and associated forms can be found on the CDC home page Internet address—*http://www.cdc.gov.* Click on ''Funding'' then ''Grants and Cooperative Agreements.''

Business management and technical assistance may be obtained from: Lucy Picciolo, Grants Management Specialist, Procurement and Grants Office, Centers for Disease Control and Prevention, 2920 Brandywine Road, Room 3000, Atlanta, GA 30341–4146, Telephone number: 770–488–2683, E-mail address: *lip6@cdc.gov.*

Business management technical assistance for the U.S. Territories may be obtained from: Charlotte Flitcraft, Contract Specialist, Procurement and Grants Office, Centers for Disease Control and Prevention, 2920 Brandywine Road, Room 3000, Atlanta, GA 30341–4146, Telephone number: 770–488–2632, E-mail address: *caf5@cdc.gov.*

Business Management technical assistance for Territories may be obtained from: Charlotte Flitcraft, Contract Specialist, Procurement and Grants Office, Centers for Disease Control and Prevention, 2920 Brandywine Road, Room 3000, Atlanta, GA 30341–4146, Telephone number: 770–488–2632, E-mail address: *caf5@cdc.gov.*

For program technical assistance, contact: Component 1—Comprehensive State-Based Tobacco Use Prevention and Control Programs: Dianne May, Program Services Branch, Office on Smoking and Health, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention, 4770 Buford Hwy, NE, MS K50, Atlanta, GA 30341, Telephone number: (770) 488–1104, E-mail address: *dmay@cdc.gov.*

Component 2—State Nutrition and Physical Activity Programs to Prevent Obesity and Other Chronic Diseases: Robin Hamre, Obesity Prevention Programs Team Leader, Division of Nutrition and Physical Activity, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention, 4770 Buford Hwy., NE, MS K24, Atlanta, GA 30341, Telephone number: (770) 488–6050, E-mail address: *rwh9@cdc.gov.*

Component 3—WISEWOMAN: Julie C. Will, PhD, MPH, WISEWOMAN Team Leader, Division of Nutrition and Physical Activity, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention, 4770 Buford Hwy., NE, MS K26, Atlanta, GA 30341, Telephone number: (770) 488–6024, E-mail address: *jxw6@cdc.gov.*

For WISEWOMAN Definitions see WISEWOMAN Guidance Document: Interpretation of Legislative Language and Existing Documents at *http://www.cdc.gov/wisewoman.*

Component 4—State Based Oral Disease Prevention Programs: Kathleen Heiden, RDH, MSPH, Division of Oral Health, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention, 4770 Buford Hwy., NE, MS F10, Atlanta, GA. 30341, Telephone number: (770) 488–6056, E-mail address: *orhealthgrants@cdc.gov.*

Component 5—Arthritis: Sakeena Smith, Division of Adult and Community Health, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention, 4770 Buford Hwy., NE, MS K66, Atlanta, GA 30341–3717, Telephone (770) 488–5440, E-mail address: *szs4@cdc.gov.*

Component 6—BRFSS: Ruth Jiles, Division of Adult and Community Health, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention, 4770 Buford Hwy., NE, MS K66, Atlanta, GA 30341–3717, Telephone (770) 488–2542, E-mail address: *Rjiles@cdc.gov.*

Component 7—Chronic Disease Genomics: Ann Malarcher, Division of Adult and Community Health, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention, 4770 Buford Hwy., NE, MS K47, Atlanta, GA 30341, Telephone: (770) 488–8006, E-mail address: *aym8@cdc.gov.*

Dated: January 13, 2003.

Sandra R. Manning,

CGFM, Director, Procurement and Grants Office, Centers for Disease Control and Prevention (CDC).

K. Appendices

Relevant to WISEWOMAN Component:

APPENDIX A.—ELIGIBILITY

Applicant	Competitive		Funding level		Type of program	
	Yes	No	1st	2nd	Standard	Enhanced
States:						
Alabama	X		X		X	X

APPENDIX A.—ELIGIBILITY—Continued

Applicant	Competitive		Funding level		Type of program	
	Yes	No	1st	2nd	Standard	Enhanced
Alaska	X		X		X	X
Arizona	X		X		X	X
Arkansas	X		X		X	X
California		X		X		X
Colorado	X		X		X	X
Connecticut		X		X	X	
Delaware	X		X		X	X
Florida	X		X		X	X
Georgia	X		X		X	X
Hawaii	X		X		X	X
Idaho	X		X		X	X
Illinois		X		X		X
Indiana	X		X		X	X
Iowa		X		X		X
Kansas	X		X		X	X
Kentucky	X		X		X	X
Louisiana	X		X		X	X
Maine	X		X		X	X
Maryland	X		X		X	X
Massachusetts		X		X	X	
Michigan		X		X	X	
Minnesota	X		X		X	X
Mississippi	X		X		X	X
Missouri	X		X		X	X
Montana	X		X		X	X
Nebraska		X		X	X	
Nevada	X		X		X	X
New Hampshire	X		X		X	X
New Jersey	X		X		X	X
New Mexico	X		X		X	X
New York	X		X		X	X
North Carolina		X		X		X
North Dakota	X		X		X	X
Ohio	X		X		X	X
Oklahoma	X		X		X	X
Oregon	X		X		X	X
Pennsylvania	X		X		X	X
Rhode Island	X		X		X	X
South Carolina	X		X		X	X
South Dakota		X		X	X	
Tennessee	X		X		X	X
Texas	X		X		X	X
Utah	X		X		X	X
Vermont		X		X	X	
Virginia	X		X		X	X
Washington	X		X		X	X
Washington, D.C.	X		X		X	X
West Virginia	X		X		X	X
Wisconsin	X		X		X	X
Wyoming	X		X		X	X
Territories:						
American Samoa	X		X		X	X
Guam	X		X		X	X
N. Mariana Islands	X		X		X	X
Puerto Rico	X		X		X	X
Republic of Palau	X		X		X	X
Virgin Islands	X		X		X	X
Tribes:						
Arctic Slope	X		X		X	X
Cherokee Nation	X		X		X	X
Cheyenne River	X		X		X	X
Consolidated Tribal Health	X		X		X	X
Hopi	X		X		X	X
Indian Community Health	X		X		X	X
KAW Nation	X		X		X	X
NARA	X		X		X	X
Navajo	X		X		X	X
Poach Band	X		X		X	X
South Puget	X		X		X	X
South-central		X		X		X

APPENDIX A.—ELIGIBILITY—Continued

Applicant	Competitive		Funding level		Type of program	
	Yes	No	1st	2nd	Standard	Enhanced
Southeast Alaska	.....	X	.....	X	X	
Yukon-Kuskokwim	X	.....	X	.....	X	X
All other programs funded by NBCCEDP	X	.....	X	.....	X	X
All other programs not funded by NBCCEDP	Not eligible	.....	.....	.....	.....	.....

APPENDIX B.—TYPE OF PROGRAM AND PERFORMANCE REQUIREMENTS

[Depending on type of program and level of funding, a project is expected to complete the performance activities detailed in the appropriate cell]

Funding level	Type of program and performance requirements	
	Standard Demonstration Project (Available for applicants applying in FY 2003 and FY 2004) *Standard Best Practices Project* (Available in FY 2005 and later)	*Enhanced* (Available for applicants applying in FY 2003 and later)
First Annual Funding: $50,000 to $250,000 (Standard); $250,000 to $500,000 (Enhanced)	(1) Complete Program Startup Activities found in checklist*. (2) Test activities using pilot study methods ..... (3) Screen 500 women annually for blood pressure and cholesterol and provide all with health education. (4) Ensure at least 60 percent of newly screened women receive complete lifestyle intervention program. (5) If applying in FY 2005 or later, programs must implement WISEWOMAN-recommended best practices (recommendations available in FY 2005).	(1) Complete Program Startup Activities found in checklist including IRB protocols*. (2) Receive IRB approval. (3) Test methods in pilot study that includes screening and intervention activities. (4) Demonstrate adequate power to test effectiveness of lifestyle interventions in a full-scale study. (5) Prepare publishable manuscript
Second Annual Funding: $250,000 to $750,000 (Standard); $750,000 to $1,250,000 (Enhanced); Funding level for Standard and Enhanced Programs depends on success in meeting or exceeding performance requirements	(1) Screen at least 2500 women each year for blood pressure and cholesterol and provide all with health education**. (2) Ensure at least 60 percent of new women receive complete lifestyle intervention. (3) Demonstrate that newly enrolled participants adopt a healthier lifestyle during the year following enrollment**. (4) Demonstrate that at least one quarter of women screened are newly detected with high blood pressure or high cholesterol**. (5) Demonstrate a reduction in expected coronary heart disease deaths per 1000 women expected in 10 years***.	1) Screen and intervene with enough women to achieve statistical power as determined during 1st level 2) Ensure 75 percent of eligible women in intervention group receive complete intervention 3) Demonstrate that intervention group adopts a healthier lifestyle during the year following enrollment** 4) Demonstrate statistically significant difference on one key outcome. 5) Develop monograph and/or training on methods to help other projects adopt successful program 6) Submit at least one manuscript on methods and results to a peer-reviewed journal

*Program Start-Up Checklist developed by the North Carolina WISEWOMAN program is found on page 18 of the monograph ''Integrating Cardiovascular Disease Prevention into Existing Health Services: The Experience of the North Carolina WISEWOMAN Program'' at *http://www.hpdp.unc.edu/wisewoman/manual.htm.*

**See GPRA measures developed May 17, 2002 found in WISEWOMAN Guidance Document: Interpretation of Legislative Language and Existing Documents at *http://ww.cdc.gov/wisewoman.*

***Use Framingham risk formulation that includes smoking, systolic blood pressure, total cholesterol, and age. This is calculated from minimum data elements.

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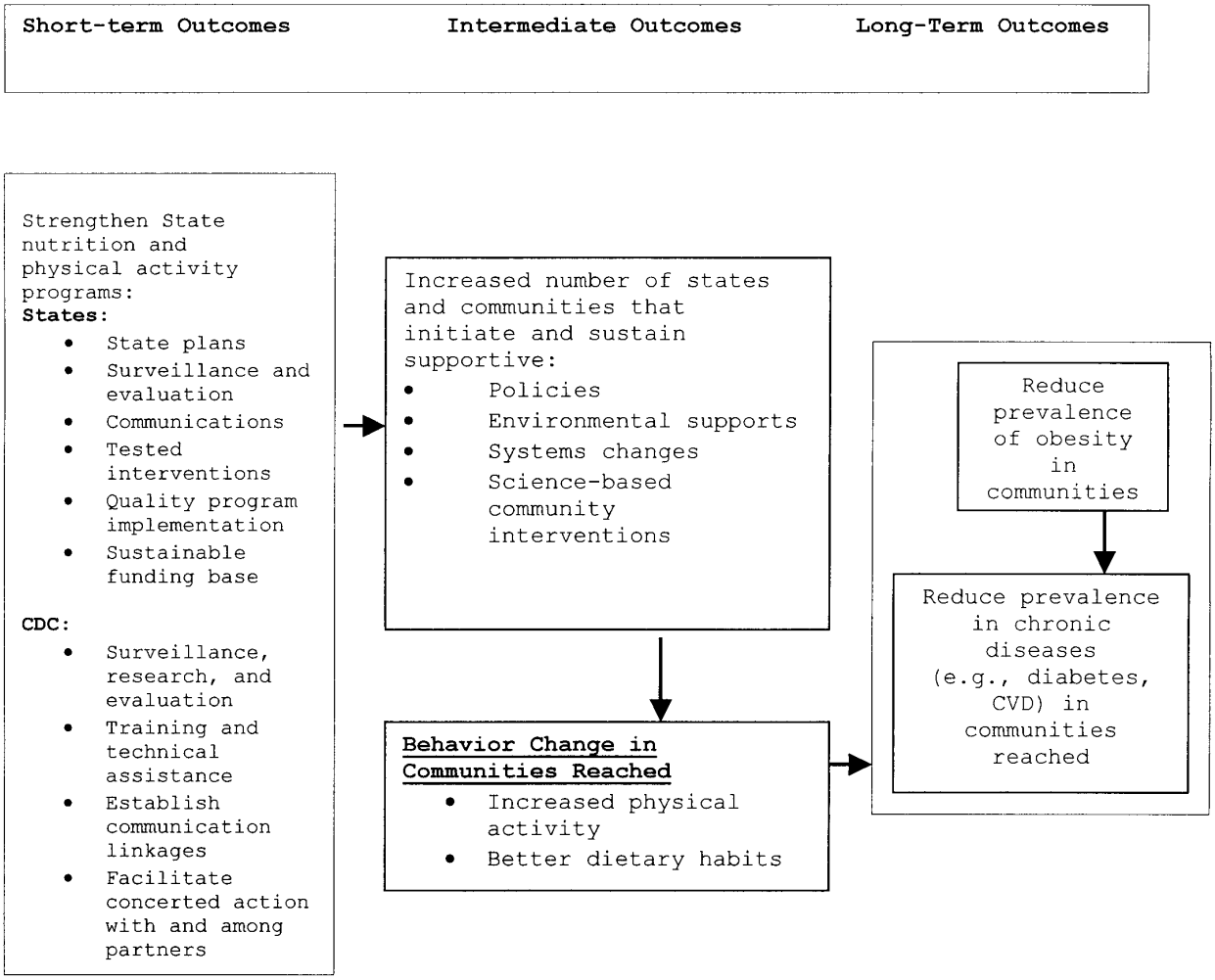
Appendix C

Framework for Performance Measures of Nutrition & Physical Activity Programs to Prevent Obesity & Chronic Diseases



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Appendix D —Eligibility for Program Announcement 03022 Chronic Disease Prevention and Health Promotion Programs

Component 1: State-Based Basic Implementation Tobacco Prevention and Control Programs

Applications received from current grant recipients under: Program Announcement 99038, Comprehensive State-Based Tobacco Use Prevention, and Control Programs, will be funded upon receipt and approval of a technically acceptable application.

Component 3: Well-Integrated Screening and Evaluation for Women Across the Nation

Applications received from current grant recipients under Well Integrated Screening and Evaluation for Woman Across the nation (WISEWOMAN):

Program announcement 00115 WISEWOMAN

Program Announcement 99135 WISEWOMAN

Program Announcement 01098 WISEWOMAN Enhanced, will be funded upon receipt and approval of a technically acceptable application.

Component 4: State-Based Oral Disease Prevention Program

Applications received from current grant recipients under: Program Announcement 01046 Support State Oral Disease Prevention Programs, will be funded upon receipt and approval of a technically acceptable application.

Component 5: Arthritis

Applications received from current grant recipients under: Program Announcement 01097 Reducing the Impact of Arthritis and Other Rheumatic Conditions, will be funded upon receipt and approval of a technically acceptable application.

Component 6: Behavioral Risk Factor Surveillance Systems (BRFSS)

Applications received from current grant recipients under: Program Announcement 99044 Behavioral Risk Factor Surveillance System (BRFSS), will be funded upon receipt and approval of a technically acceptable application.

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