

I. 1. Activities for Capacity Building Programs

Awardee activities for the Capacity Building program for both new and existing States are as follows, with new States establishing and maintaining activities and existing States enhancing and maintaining activities:

1. Demonstrate program infrastructure that will enhance the State health department's capacity to address heart disease and stroke prevention by:
 - employing one full-time staff position (one person devoting 100% of time to this cooperative agreement) with the responsibility and authority to carry out the activities identified in the work plan provided to CDC for funding under this program announcement and to serve as the project manager and the primary point of contact for CDC;
 - employing a one-half time epidemiologist with education in chronic disease epidemiology;
 - establishing and maintaining sources of skilled people for carrying out activities under this cooperative agreement including expertise in program evaluation, program planning, and partnership development and maintenance;
 - establishing and maintaining methods of collaboration between State health department programs that relate to heart disease and stroke prevention, and
 - committing to send two representatives to two 3-day CDC-sponsored

meetings or trainings related to content update and promising practices designed for State Heart Disease and Stroke Prevention Program awardees.

2. Develop and maintain partnerships that can collaborate on developing:

- a comprehensive State plan that addresses heart disease and stroke prevention and related risk factors (e.g., high blood pressure, high blood cholesterol, tobacco use, diabetes, obesity) as well as the program priority areas 1-6. Describe how an official body or work group will be established to develop the State plan and implement its objectives and strategies.
- strategies to leverage resources and coordinate interventions that address program priority areas 1-6.

a. Develop and maintain strategic multi-sector partnerships within the following sectors:

- State health department, those who address related risk factors (e.g., high blood pressure, high blood cholesterol, tobacco use, diabetes, obesity), populations, or settings, and data partners such as vital statistics and the State's Behavioral Risk Factor Surveillance System (BRFSS).
- State government, those who address heart disease and stroke or related risk factors or conditions, populations or

settings, and data partners such as Medicaid.

- State organizations, those who: address heart disease and stroke or related risk factors (with emphasis on prevention and control of high blood pressure and high blood cholesterol), such as the voluntary health organizations, federally qualified health centers, quality improvement organizations; provide knowledge of and access to Priority Populations (e.g., State black nurses' association); provide knowledge of and access to settings (e.g., business coalition on health); improve health (e.g., emergency medical services association); and others such, as academia and the media.

b. Develop a plan for convening and maintaining State partnerships:

- Define partner roles and responsibilities in letters of understanding and memoranda of agreement or similar formalized arrangements.
- Assess the training needs of staff and partners and provide or collaborate with partners, within or external to the State health department, to meet training needs. Assure training is conducted which focuses on identified needs and is part

of a larger strategy to meet required program activities (e.g., the background and skills to develop a State plan).

Training should focus on increasing the skill levels of staff and partners in areas such as population-based interventions, policy and systems change strategies, communication, use of data for program planning, program evaluation, cultural competence, and program planning.

- Assess partnerships and coordinate efforts to enhance effectiveness to address the mission and purpose of the partnerships. Describe means of collaboration with partners within the State health department and partners outside the State health department to accomplish work plan goals, objectives, and activities.

3. Define and Monitor the Burden of Heart Disease and Stroke:

The burden should be monitored and interpreted for program planning by:

- a. Applying chronic disease epidemiology, statistics, monitoring, and data analysis to existing data systems (e.g., vital statistics, hospital discharges, Behavioral Risk Factor Surveillance System (BRFSS), State Medicaid) and data from partners (e.g., quality improvement organizations, health plans, employer groups).

- b. Collecting cardiovascular-related information using the BRFSS modules, protocols, and time line. It is required that the BRFSS sections or modules on Actions to Control High Blood Pressure be collected in odd years (i.e., 2009, 2011) and the module on Heart Attack and Stroke Signs and Symptoms be collected in 2009 and every four years after 2009 as a minimum.
- c. Developing a profile (e.g., a summary of data in a format suitable for use in program planning) of the burden of heart disease, stroke, and related risk factors within the State during year 1 of funding and at least every two years or more frequently as needed for program planning and evaluation; publish a heart disease and stroke burden document in print or electronic format no later than year 2 of funding and at least every five years or more frequently as needed. The burden document may be a stand-alone document or an identifiable section within another State burden document. The burden information should include:
- Description of heart disease and stroke health outcomes (e.g., mortality, hospitalizations) and risk factor data by race and age groups.
 - Trends in heart disease and stroke health outcomes for race and age groups, with emphasis on disparities and trends for Priority Populations.
 - Trends from the core BRFSS and the required BRFSS HDSP

modules and sections (e.g., disparities in awareness of signs and symptoms, awareness of high blood pressure).

- Geographic distribution of health outcomes (e.g., mortality).
- Disparities in outcomes and related risk factors by race, ethnicity, gender, geography, and socio-economic status.
- A summary or interpretation of the burden information.

- d. Identifying Priority Population(s) for interventions and provide a rationale for the selection of one or more population groups. Rationale for identifying a population as a priority should be supported by data (e.g., mortality, access to care, behavioral risk factors) showing disparities (e.g., race/ethnicity, gender, geographic, geography, socioeconomic status).
- e. Develop a plan for dissemination of the burden document.

4. Develop, update, and facilitate the implementation of a comprehensive State heart disease and stroke prevention plan. The State heart disease and stroke prevention plan may be a stand-alone plan or an identifiable section within another State health promotion-related plan. It might reference or build upon other State health promotion-related plans, as appropriate.

- a. Develop the process and structure used to develop or update a State plan or facilitate work among partners to implement an existing State plan. The comprehensive State plan should include specific objectives that can impact prevention of heart disease and stroke and related risk factors (e.g.,

high blood pressure, high blood cholesterol, tobacco use, diabetes, obesity), as well as address the program priority areas 1-6.

- When developing a plan or enhancing a plan that does not have all the components described, gather and analyze information needed (e.g., a thorough description of the burden of cardiovascular disease as described in the Activity 3 above; gain commitments from partners from multiple sectors, and jointly define roles and timeline for completing the plan.
- When implementing an existing plan, gain commitments from partners from multiple sectors and jointly define roles and timeline for implementing the plan.
- Ensure the plan includes goals and measurable objectives for general and Priority Populations; population-specific intervention strategies for achieving the objectives; use of policy and systems change strategies and education.

b. Describe how the State plan was or will be disseminated and implemented with partners.

5. Develop Plans to Implement Population-Based Intervention Strategies;

- a. Develop plans for public health population-based interventions to address the program priority areas 1-6 for the prevention of heart disease and stroke. Plans must address high blood pressure and high

blood cholesterol within the health care and worksite settings. Show how information regarding the heart disease and stroke burden in the State and existing policy and system data were used to identify priority areas for interventions for general populations and Priority Populations.

Plan interventions that:

- Focus on at least one of the program priority areas 1-6 using population-based education, policy, and systems change strategies;
- Are implemented at the highest level appropriate within the system, for example, develop activities with business coalitions rather than individual worksites;
- Identify priority population(s) and address these populations;
- Assure collaboration with partners within and external to the State health department.

6. Enhance program evaluation:

- a. Develop a plan to evaluate program activities to assess progress toward meeting stated work plan objectives. Develop a more detailed evaluation plan for Partnerships, the Capacity Building activity #2. Possible evaluation issues might include partner satisfaction, commitment, and involvement, infrastructure and functioning of the partnership, effectiveness and outcomes of partnership, and sustainability. (See the DHDSP Evaluation Guide Developing an

Evaluation Plan at www.cdc.gov/dhdsp).

- b. Develop an overall program logic model that graphically describes the relationship between program activities and expected outcomes and reflects program priorities. (See the DHDSP Evaluation Guide Logic Models at www.cdc.gov/dhdsp).

- c. Utilize the HDSP Management Information System (MIS) for post award administration and development of Interim and Annual Progress Reports. Programs should enter progress information into the MIS at least quarterly or more frequently to address technical assistance needs. (Office of Management and Budget (OMB) approval No. 0920-0679; expiration date 5/31/08).