

Joint Statement
Recommendations to Include Disparate Populations
In Health Funding Awards

Social Justice in Health

The allied national networks consortium, funded by the Office on Smoking and Health, work on the following principle of social justice in health:

Everyone should have equal access to healthcare and wellness opportunities, equal economic opportunities, and equal health outcomes regardless of group membership.

Problem Statement

While populations experiencing health disparities constitute at least 37% of the United States total population, many health-related funding streams do not include meaningful plans for targeting and tailoring some portion of the work to reduce endemic health disparities. Health disparities have accumulated unevenly in certain populations as a result of disproportionate risk, access and allocation of resources. It is self-evident that a comprehensive approach to public health must include targeted responses to reduce these disparities. Without such investments, general population health will continue to improve but inequalities in health will continue. In fact, they may widen.¹

Recommendations

Using our combined experience and knowledge in reducing health disparities and the national network of constituents we have built, the National Networks offer the following specific recommendations to counter this problem:

1. Ensure all requests for awards (RFAs) and/or Funding Announcement Opportunities (FAOs) mandate substantive plans for grantees to:
 - a. Train project staff to deliver services in a culturally competent manner that effectively responds to the race, ethnicity, age, gender identity, cultural practices, sexual orientation, socioeconomic status, educational background and language of the target population. Note: It is important to name all of these populations in the funding



announcement, a legacy of discrimination against funding some populations has created an environment whereby omission conveys lack of inclusion.

- b. Assemble a local advisory council that reflects the diversity of the target populations in terms of: race/ethnicity, age, gender identity, cultural practices, sexual orientation, socioeconomic status, educational background and language.
 - c. Partner with community-based organizations with expertise in disparate populations. If possible, use local organizations.
 - d. Include outreach to and services for disparate populations in action plan.
 - e. Incorporate evaluation process and outcome measures that assess project reach and impact on disparity populations, including promotion of routine data collection on the above named groups.
2. Provide seamless access to technical assistance (TA) for grantees in need of additional training or resources to successfully incorporate disparity elimination measures.
 - a. The establishment of the National Networks as a TA resource for the CDC Office on Smoking and Health state tobacco awards is an example of one such model.
 3. Ensure all possible funding streams include awards directly to disparate population community-based organizations or networks.
 - a. The three-pronged funding stream of the Communities Putting Prevention to Work (CPPW) initiative is an example of one such set of funding announcements that allowed for a government component, a community component, and a national organization component.
 - b. Defining communities by geographical boundaries alone can hinder disparity reduction. Many disparate populations are woven into a larger geographical area yet still carry shared risk due to their commonalities.
 - i. Allow definitions of community by membership in a disparate population.
 - c. Provide access to surveillance data to analyze project impact or, if needed, supplement projects with alternate data collection options to monitor impact. NCI's Tobacco Research Network on Disparities provides information on alternative monitoring strategies for hard-to-reach populations.
 - d. Ensure that all funding announcements that allow non-profit or academic entities to apply give preference to applicants that demonstrate expertise in single or multiple disparate populations, and ensure they have proven track records in convening and engaging constituents.
 - e. Work with existing national networks and other partners addressing health disparities to ensure all funding announcements are promoted to expert applicants with expertise in addressing health disparities in specific populations.

Implementation Examples

We have made suggested enhancements to the former CPPW RFAs to provide a model for how to maximize the disparity inclusion in a public health funding stream.

Attachment 1: CPPW state RFA with disparity modifications

Attachment 2: CPPW community RFA with disparity modifications

Attachment 3: CPPW national organizations RFA with disparity modifications

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¹ Frohlich KL, Potvin L. Transcending the known in public health practice: the inequality paradox: the population approach and vulnerable populations. *Am J Public Health* 2008;98:216-21.

Amendment made to section II. Recipient Activities on 09/23/2009

U. S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention (CDC)

American Recovery and Reinvestment Act (Recovery Act)

Communities Putting Prevention to Work

State Supplemental Funding for Healthy Communities, Tobacco Control, Diabetes
Prevention and Control, and Behavioral Risk Factor Surveillance System¹

Announcement Type: Cooperative Agreement

Funding Opportunity Number: CDC-RFA-DP09-90101ARRA09

Catalog of Federal Domestic Assistance Number: 93.723

Key Dates:

Application Submission Date: **Applications must be submitted at least 48 hours prior to the application deadline date to ensure the validation process is successfully completed (free of errors) and made available to the agency for download from Grants.gov.**

Application Deadline: November 24, 2009

Anticipated Award Date:

Components I and III – December 2009

¹ Announcement DP09-901 can be accessed at the following CDC internet address:
<http://www.cdc.gov/od/pgo/funding/DP09-901.htm>

Technical Assistance Conference Calls:

Technical assistance will be available for applicants on three conference calls.

The first call will be for applicants applying for State Competitive and Non-Competitive funding and will be held on October 6, 2009 from 3:00 to 4:30 pm Eastern. The conference can be accessed by calling 1-800-857-4637. The passcode is 1695786. The passcode is required to join the call.

The second call will be for applicants applying for Quitline funding and will be held on October 7, 2009 from 3:00 to 4:30 pm Eastern. The conference can be accessed by calling 1-800-857-4637. The passcode is 1695786. The passcode is required to join the call.

The third call will be all applicants applying for State Competitive, Non-Competitive, or Quitline funding and will be held on October 15, 2009, from 3:00 pm to 4:30 pm Eastern. The conference can be accessed by calling 1-800-857-4637. The passcode is 1695786. The passcode is required to join the call.

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

- Understand the scope and intent of the Supplemental Award for the Communities Putting Prevention to Work Program;
- Understand Recovery Act recipient reporting.
- Understand the Public Health Service policies and procedures for application, review, and funding under this announcement.

Participation in a conference call is not mandatory. Applicants are requested to call in using only one telephone line. If during the call you need technical assistance, press *0 to speak to an operator. Please note, restrictions may exist when accessing freephone/toll free numbers using a mobile telephone.

Recipient Reporting Registration

All grant recipients should register immediately at www.federalreporting.gov

I. Funding Opportunity Description

Authority: This program is authorized under sections 301, 307, 310, and 311 of the Public Health Service Act, as amended, and the Comprehensive Smoking Education Act of 1984, Comprehensive Smokeless Tobacco Health Education Act of 1986, and the American Recovery and Reinvestment Act of 2009 (Recovery Act) [Public Law 111.5].

Eligibility: Only current recipients funded under Announcement DP09-901 may apply. The Pacific Islands will be eligible for a supplement under their existing cooperative agreement, Announcement DP 09-902.

Recipient Financial Participation

Matching funds are not required.

Executive Summary

The American Recovery and Reinvestment Act of 2009 (Recovery Act), signed into law February 17, 2009, is designed to stimulate economic recovery in various ways: to preserve and create jobs; to promote economic recovery; to assist those most impacted by the recession, to stabilize state, territorial and local government budgets in order to minimize and avoid reductions in essential services and counterproductive state, territorial, and local tax increases; to strengthen the Nation's healthcare infrastructure; and to reduce healthcare costs through prevention activities. The Recovery Act includes \$650 million for evidence-based clinical and community-based prevention and wellness strategies that deliver specific, measurable health outcomes. The legislation provides an important opportunity for communities, states, territories, cities, rural areas, and tribes to advance public health across the lifespan and to eliminate health disparities. Of the \$650 million appropriated for this initiative (Communities Putting Prevention to Work), \$125 million will directly support states and territories in promoting wellness and preventing chronic disease through state-wide and local policy, the built environment and environmental change as well as expanding tobacco cessation quitlines for chronic disease prevention.

The Centers for Disease Control and Prevention (CDC), National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP), announces the opportunity to apply for Recovery Act funds to reduce risk factors, prevent/delay chronic disease, and promote wellness in both children and adults.

Funding Opportunity Announcement CDC-RFA-DP09-901 provides funding to states and territories. Activity C in that announcement “Promoting Social, Environmental, Policy, and Systems Approaches at the State and Community Levels,” calls on states and territories to support program capacity to implement effective social, environmental, policy, and system approaches to help reduce the social inequalities in health by creating healthier communities. This supplement expands existing activities to increase the use of policy and systems approaches and reach a greater proportion of the population.

This announcement has three components. Each applicant may apply for each component. The components are:

Component I – **Statewide Policy and Environmental Change**

Component II- *Competitive Special Policy and Environmental Change Initiatives*

Component III- **Tobacco Cessation through Quitlines and Media**

Specific areas that must be addressed through this announcement are obesity, physical activity, nutrition and tobacco prevention and control. This initiative will address:

- Decreased obesity risk factors (decreased physical inactivity and poor nutrition)
- Increased levels of physical activity
- Improved nutrition (e.g. increased fruit/vegetable consumption, reduced salt and trans fats consumption);
- Decreased smoking prevalence and decreased teen smoking initiation; and
- Decreased exposure to secondhand smoke.

The goals to be met by the end of the project period are:

- 75% of the US population will live in states with improved obesity-related (physical activity and/or nutrition) and tobacco policies.
- 80,000 additional successful quitters (above the number that would have quit) via the Quitlines nationally if coupled with a national media strategy

States and territories funded under this announcement will accomplish goals by planning and implementing evidence-based policy and environmental changes to support and institutionalize healthy behaviors related to obesity, physical activity, nutrition and tobacco prevention and control within states and territories and that enhance the built environment. Strategies will follow the MAPPS framework of **Media, Access, Pricing, Point of Decision Information, and Social Support**. These strategies will ultimately help change social norms and make healthier choices easier and more affordable to residents. Awardees may also propose evidence-based interventions not listed within the prescribed MAPPS menu, but must provide a strong justification of how the proposed intervention will have sufficient reach and potential impact consistent with the short and long-term

goals of the initiative. The Centers for Disease Control and Prevention (CDC) will provide programmatic support and tools to strengthen and develop effective strategies tailored to Programs that will focus on policy and environmental changes that both improve state- and territory-wide policies and support community and school based efforts for chronic disease prevention and control, including communities funded as part of the Communities Putting Prevention to Work (CPPW) Initiative. CPPW will fund communities across the United States, including large cities, rural, and tribal communities.

Eligible grantees will include all 50 states, the District of Columbia, Puerto Rico and the U.S. Virgin Islands. States must submit an application of adequate technical merit to achieve the short- and long-term goals of this initiative. Grantees are expected to reach a broad population and demonstrate their capacity and ability to achieve health equity among disparately effected populations ([e.g., racial/ethnic minorities; underserved populations; lesbian, gay, bisexual, and transgender populations; people living with severe and persistent mental illness; people living with disability; etc.](#)) and explain potential impact. A letter of support from the Governor must be included with the application. States are expected to coordinate with tribal entities in their jurisdiction. States are encouraged to link with other community-based efforts and the Office of the Regional Health Administrator, with special attention to leveraging other federally funded (including Recovery Act funded)- and foundation activities. (See Appendix C for examples.) States and territories are required to specifically address plans for sustaining the impact of Recovery Act investments beyond the federal funding provided.

Availability of Funds

\$75 million dollars are available for state- and territory-wide and local policy and environmental change for chronic disease prevention (Components I & II).

Approximately \$45 million dollars will be awarded for Component I activities based on population size and the remaining \$30 million dollars will be awarded for Component II activities based on special policy initiatives proposed. The awards for Component I will range from \$300,000 - \$2,200,000 for the 24 month project period based on a formula that includes a base of \$300,000 per state or territory with a proportional increase based on the state's/territory's population. A table of maximum base funding per state can be found in Appendix D. Applicants must not request funding above the maximum amount designated for their state. Component II awards will be made through a competitive process for special policy and environmental change initiatives. (See Component II). The awards for Component II will range from \$1,000,000 - \$3,000,000 not to exceed \$3 million per applicant. States will be expected to expand impact of special policy initiatives through intensive, innovative efforts to improve health outcomes reaching diverse populations and collaborate with existing recovery funded activities.

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For Component III, up to \$44,500,000 is available to significantly expand and enhance tobacco cessation services through the Quitlines. The award will range from \$400,000 - \$2,500,000 for the 24 month project period based on a formula that includes a base of

\$400,000 per state with a proportional increase based on the population of tobacco users in the state.

Purpose

Recovery Act funds must be used for obesity, nutrition, physical activity and tobacco control strategies to change systems, develop and implement policies, change the environment in which eating, tobacco use, and physical activity occur, and impact population groups, including special populations with health disparities, rather than individuals within the two-year timeframe for this award. To this end, Recovery Act funds may not be used to provide direct services such as patient care, personal health services medications (except for nicotine replacement, therapy as described in this announcement), patient rehabilitation, or other costs associated with the treatment of diseases caused by poor nutrition, tobacco use or physical inactivity.

This announcement is only for non-research activities supported by CDC. If research is proposed, the application will not be reviewed. For the definition of research, please see the CDC web site at the following internet address:

<http://www.cdc.gov/od/science/regs/hrpp/researchDefinition.htm>

II. Component I—Statewide Policy and Environmental Change

Background

Chronic diseases such as cancer, heart disease and diabetes are among the leading causes of death and disability in the United States. Chronic diseases account for 70% of all deaths in the U.S., which corresponds to 1.7 million deaths each year. These diseases also cause major limitations in daily living for almost 1 out of 10 Americans or about 25 million people (www.cdc.gov/nccdphp/overview.htm). Although chronic diseases are among the most common and costly health problems, they are also among the most preventable. Adopting healthy behaviors such as eating nutritious foods, being physically active and avoiding tobacco use can prevent or control the devastating effects of these diseases. Strategies should address both adults and children and lead to reduced obesity, increased physical activity, improved nutrition, and decreased tobacco use, with a special emphasis on underserved populations ([e.g., racial/ethnic minorities, people living with severe and persistent mental illness, people with lower socio-economic status, and lesbian, gay, bisexual, and transgender populations](#)).

States and territories will have a greater likelihood of success if the state- and territory-wide policies impact all levels of the socio-ecological model [and engage diverse community partners](#). Policy and environmental change planning should include the full engagement of the state's political leadership, school boards, state education agencies, large employers, leaders in the philanthropic or non-profit community, state health commissioners, safe neighborhood advocates, aging agencies, state human services agencies (particularly nutrition assistance program administrators), transportation departments, housing agencies, state legislators, builders, city planning and land-use experts, [community organizations representing groups with health disparities](#), and

legal/policy experts. States are also encouraged to leverage other federally funded (See Appendix C for examples.) and foundation activities.

Recipient Activities

A. Implementation of policy, social, and environmental approaches at the state/territorial level

State policy efforts will support policy and environmental changes in the MAPPS framework (**M**edia, **A**ccess, **P**ricing, **P**oint of decision information and **S**ocial support) by establishing or improving state-wide policies and/or supporting policy change in communities and schools throughout the state. State efforts should promote evidence-based policies and interventions at the state and local levels, which establish healthy social norms providing for healthier, affordable choices. Awardees may also propose evidence-based interventions not listed within the prescribed MAPPS menu, but must provide a strong justification of how the proposed intervention will have sufficient reach and potential impact consistent with the short and long-term goals of the initiative.

1. Implement at least one high-impact policy, environment or system change strategy for each area – physical activity, nutrition and tobacco- for development, implementation and evaluation over the two-year project period.
 - a. Implementation activities should be limited to state level strategies that will support the interventions listed in the “MAPPS Intervention Strategies for State and Territory Policy, Environmental Change” table provided in Appendix A.

- b. Applicants have flexibility to propose the appropriate mix of policy changes for their populations and their policy context. Selection of which strategies to pursue should be based on a thorough analysis of the potential for broad reach, impact, successful implementation and to address gaps that exist in the state/territory.
- c. Applicants are expected to propose interventions within the MAPPS strategies that are most likely to affect statewide burden and ~~additionally~~ ~~should~~ emphasize plans to ~~ensure statewide improvements do not exacerbate~~ health ~~in~~equity.

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Applicants must provide detailed implementation plans and projected outcomes.

Specific plans to reduce obesity, increase physical activity, improve nutrition, decrease tobacco use and exposure to second hand smoke must be addressed.

Physical Activity and Nutrition

Applicants must also provide specific information on limiting availability of unhealthy food and beverages and providing safe, attractive, accessible places for physical activity. Applicants should provide current information about such restrictions or provisions, and should include these strategies in the intervention selection unless there is justification based on existing strong policies.

Tobacco Prevention and Control

Applicants should provide a comprehensive plan to reduce tobacco use both through legislative, regulatory, and educational arenas. Applicants must provide specific information on smoke-free air policies within the state/territory and the communities described above. If there is not a comprehensive tobacco ban, the intervention must include a detailed plan for implementation (Healthy People 2010 Objective 27-13).

Applicants are encouraged to counter and curtail tobacco promotion and advertising, as allowed by Federal law, which can include but is not limited to: restricting or eliminating “power walls” of cigarettes offered for sale at retail outlets, limiting the number or size of tobacco product ads at retail outlets, posting graphic warning posters near points of sale of tobacco products and requiring that all tobacco products be kept away from cash registers.

Performance will be measured by evidence that an appropriate array of strategies has been selected per the MAPPs strategies; specific implementation plans and projected outcomes are proposed for the chosen policy and environmental changes in nutrition, physical activity and tobacco; strategies implemented reach all or a substantial portion of the state’s population; engage populations with related health disparities in promoting policy and environmental changes; progress on output and outcome targets related to implementation of the policy and environmental changes; progress in the recipient’s ability to achieve health equity; likelihood of policy and environmental changes being sustained beyond the funding period.

B. Program Readiness, Oversight and Management

Program infrastructure should ensure the organizational capacity to rapidly implement selected statewide obesity, nutrition, physical activity and tobacco policy and environmental changes.

1. Hire or retain staff or contractors with the appropriate competencies to implement the work plan. It may be necessary to ensure staff positions exist within the health department, education agencies, communities and key partner organizations. Civil service or other contractual mechanisms may be used to meet implementation goals, as well as support from other recovery funded activities.
2. Align new staff and program activities with existing CDC-funded programs in a manner that minimizes duplication, capitalizes on existing activities, and fosters rapid implementation. Demonstrate that staff have experience in policy development/implementation, including the built environment, or provide a training plan.
3. Demonstrate collaborative public health approaches to prevent and control chronic diseases in policy development and implementation activities through close collaboration with other systems in the state such as departments of planning, transportation, agriculture, parks and recreation, public safety, environmental protection, education, mental and substance abuse, and housing, as well as with other health related programs (e.g., diabetes screening and self-management and cancer screening).
4. Provide supporting documentation regarding state partnerships, including coordination with other Recovery Act-funded state activities such as transportation, education, health care delivery, agriculture, as well as state and

local agencies on aging, foundations, and HHS Regional Offices. Demonstrate staff experience with news outlets, public relations, and advertising. See Appendix C for suggestions.

5. Demonstrate staff experience with policy-making and briefing political leaders and policy makers.
6. Demonstrate staff experience working with school-based policy initiatives.
7. Demonstrate staff capacity in epidemiological analyses, surveillance and evaluation or submit a policy plan that describes how your state data will be utilized to inform policy development and implementation.
8. Support program staff to travel to participate in required trainings.
9. Specifically address in the application the state's plans for sustaining the impact of Recovery Act investments beyond the federal funding provided.

Performance will be measured by evidence of appropriate competencies to implement the work plan; alignment of program activities with existing nutrition, physical activity and tobacco programs; participation in required trainings; collaboration and partnerships with the state education agency and other health-related systems. Grantees will be held accountable for approved proposed activities in work plans by monitoring the grantees activities via conference calls, site visits, and reported performance measures and required ARRA reporting.

C. Statewide Support for Community Level Change

State Health Departments are uniquely positioned to facilitate and support local efforts for chronic disease control and prevention.

1. Implement state level policy and environmental changes to address obesity, nutrition, physical activity and tobacco that support programmatic goals in communities, and schools state wide, including, but not limited to communities that will be awarded Recovery Act funding through the CPPW Initiative.
2. Educate on the importance of policies related to obesity, physical activity, nutrition, and tobacco that allow for communities to build upon related state laws. The ability to advance policy at the local level is critical to changing social norms about physical activity, nutrition and tobacco use. Eliminating preemptive language in tobacco control is one of the Healthy People 2010 objectives for the Nation. (Healthy People 2010 Objective 27-19)
3. Deliver training, technical assistance and consultation to partners, communities and schools to support policy and environmental change strategies for nutrition, physical activity and tobacco.
4. Create a statewide environment supportive of local changes. This could include development and dissemination of materials and tools, educational outreach to key decision makers, and media strategies to the public to address the role of the policy change in obesity, nutrition, physical activity and tobacco behaviors. States should coordinate the efforts proposed here with any community activities funded as part of CPPW in large cities, urban areas, tribal areas or state-coordinated small cities and rural areas.

Performance will be measured by evidence of linkages with and support for local initiatives implementing policy and environmental changes; provision of training, programmatic support, and consultation, to relevant partners and communities; provision of educational and outreach strategies to inform public and policy-maker opinion.

D. Surveillance, Program Monitoring, & Reporting

1. Utilize population level data for analysis, interpretation, monitoring, reporting accurate health information and evidence base as a guide for creating public health policies.
2. Increase surveillance and measurement of policy and environmental recommendations, their implementation, and their impact on chronic disease risk factors in adults and children and factors that influence those behaviors. This includes improvements in statewide public health surveillance systems to capture changes in special populations.
3. Document the impact of program activities by monitoring existing appropriate data systems, e.g., the National Health and Nutrition Examination Survey (NHANES) Behavioral Risk Factor Surveillance System (BRFSS), the Youth Risk Behavior Surveillance System (YRBSS), the Adult Tobacco Survey (ATS), the Youth Tobacco Survey (YTS) and CDC's National Environmental Public Health Tracking Network (NEPHTN).
4. Document the steps taken to implement policy changes by describing successes, barriers, and challenges.

5. Report performance measures to the CDC and provide Recovery Act-required reporting to the FederalReporting.gov web site.
6. Participate in Recovery Act-related or other national evaluation activities, including participation in case study evaluation if selected.
7. Submit with application a comprehensive written evaluation plan that includes activities for both process and outcome measures;
8. Include a description of evaluation activities consistent with the CDC Framework for Evaluation (<http://www.cdc.gov/eval/framework.htm>) including stakeholder involvement, questions developed, indicators, data sources, and use of evaluation information for decision making and program improvement
9. Attendance at CDC surveillance and evaluation annual meeting and participation in CDC technical assistance webinars

Performance will be measured by evidence of compliance with monitoring and reporting requirements detailed in Recovery Act legislation, including timely and accurate submission of data on Recovery Act output and outcome performance. Evidence of an evaluation, sustainability and enforcement plan for monitoring the longer-term impact of policy and environmental changes on risk behavior, risk factors, and related health outcomes, including how BRFSS, YRBSS, and other systems (e.g., NEPHTN) will be used to monitor these outcomes, in aggregate and among specific population groups; documentation of steps taken to implement policy changes; participation in national evaluation activities. Implementation of a written, comprehensive evaluation plan consistent with the CDC Framework for

Program Evaluation and including both process and outcome indicators to evaluate recipient activities; attendance at CDC surveillance and evaluation annual meeting and participation in CDC technical assistance webinars.

E. Sustainability

1. Incorporate sustainability approaches into implementation plans for each strategy.
2. Utilize the CDC Evaluation Framework to ensure the intended effect of policy change strategies which will provide guidance for program development, monitoring and evaluation.
3. Submit a plan to acquire funding and/or resources from non-federal sources to sustain the policy impact after Recovery Act funding has ended.

Performance will be measured by evidence of a plan for sustaining program activities, informed by the CDC Evaluation Framework, and including those steps have been taken to secure funds from other non-federal sources.

F. Fiscal Management

1. Provide funding to support policy and environmental change initiatives that focus on population-based strategies, are evidence-based, will reach diverse groups, and are achievable in the two year funding cycle of this supplement.
2. Utilize fiscal management procedures as determined in the Recovery Act legislation for this funding to track and monitor expenditures separate from other federal funding streams. (See Sections IV and VI.4)

3. Implement reporting systems to meet the online reporting criteria and timelines as stated in the Recovery Act and in this supplement. (See Sections IV and VI.4)

Performance will be measured based on evidence that the State or Territory Health Department provides funding to local agencies, tribal governments, and partner organizations to support evidence based policy strategies; has established procedures to track and report expenditures separate from other federal funding; is preparing required reports submitted on the designated schedule; participates in scheduled conference calls.

Application Content for Component I

The narrative should address activities to be conducted over the entire project period of this supplemental award, and follow the order of the sections provided below. The base and population specific funding application page limit is 25 pages, not including appendices and curriculum vitae.

1. Implementation of social, environmental, policy and systems approaches at the state level

- a. Approach and rationale: This section should describe the overall approach to improving the statewide environment related to obesity, physical activity, nutrition, and tobacco as a result of this funding. The narrative should briefly assess and identify the current status of MAPPS intervention strategies in the state, and identify and justify each statewide policy initiative proposed for

implementation based on that analysis. The justification should at a minimum address the factors in Appendix B: Sample Policy Analysis Worksheet.

- b. Implementation Plan: For **each** statewide policy initiative, describe detailed implementation activities to be undertaken during the project period, including milestones and timelines for achieving intervention implementation. A suggested format can be found in Appendix C: Sample Implementation Work Plan. Work plans should at a minimum address the following:
1. Goals
 2. Objectives
 3. Action steps
 4. Milestones for implementation of action steps and progress on objectives
 5. Key Partners including input and linkages with special population groups
 6. Evaluation strategies, including key output and outcome measures related to the action steps and objectives, and data source for collection of these measures.

2. Program Readiness, Oversight and Management

This section should briefly describe the proposed program infrastructure that will be required to implement the work plan. Applicants should address staffing needs for the State Health Department and where appropriate staff support provided to key partners (such as the state education agency) to carry out the goals of the program. Clearly identify the creation of new positions, as well as positions that will be retained as a result

of this funding, and describe the linkages to existing obesity, nutrition, physical activity, and tobacco control programs. Identify commitment from the Governor's Office to hire or retain appropriate staff and to support program staff travel to attend required training. If new staff are hired, please justify how funding will be continued after recovery funding has ended.

3. Statewide Support for Community Level Change

This section should describe current and needed linkages with local community initiatives to include, when funded, communities that are awarded Recovery Act funding through the CPPW Initiative, and the activities that will be implemented to support local efforts. Describe training, programmatic support and consultation needs and steps to address those needs. Describe communication and marketing approaches that will be used to create a supportive statewide environment to facilitate the achieving the goals of the proposal. Include detailed implementation work plans where appropriate. States should coordinate the efforts proposed here with any community activities funded as part of this initiative in large cities, urban areas, tribal areas or state-coordinated small cities and rural areas.

4. Surveillance, Program Monitoring, & Reporting

This section should describe activities and steps to fulfill program monitoring and reporting requirements including development of new, or enhancements to existing, systems for surveillance and measurement of policy and environmental change activities as described in the recipient activities. Applicants should clarify commitment to report

Recovery Act output and outcome performance measures and other Recovery Act reporting requirements, and participate in Recovery Act or other national evaluation activities, including participation in case study evaluation if selected as a case study site.

5. Sustainability

This section should describe plans for working with partners to sustain the impact of program efforts beyond the project period including sustaining and pursuing non-federal sources of funding. This section should also describe activities and plans to ensure the intended and sustained effect of the policy changes after Recovery Act funding has ended.

6. Fiscal Management

This section should describe steps to ensure responsible and effective use of the funds in accordance with the requirements of receiving Recovery Act funding. Include provisions for capacity to track and monitor expenditures separate from other federal funding streams and development and use of reporting systems to meet the online reporting criteria and timelines as stated in Recovery Act and in this supplement.

Budget and Justification

States are encouraged to follow recommended guidance for completing a detailed justified budget found on the CDC Web site, at the following Internet address:

<http://www.cdc.gov/od/pgo/funding/budgetguide.htm>.

Evaluation Criteria for Component I – Non-Competitive Policy and Environmental Change

Applicants will be evaluated individually for strengths and weaknesses against the following criteria respectively and receive recommendations for improvement, where warranted:

Criteria for Component I (Non-Competitive Proposal):

1. Implementation of social, environmental, policy and system approaches at the state level

The applicant provides a detailed implementation plan for at least one high-impact, policy or environmental change for physical activity, nutrition, and tobacco. The extent to which the implementation plan describes an appropriate mix of evidence-based strategies of broad reach and impact that support the interventions selected including the MAPPS Intervention Strategies for State and Territorial Policy, Environmental Change table provided in Appendix A. The applicant proposes strategies that will address gaps that exist in the state; strategies that will impact health outcomes state-wide; strategies created to achieve health equity for special population groups; policies to enhance the built environment where appropriate.

2. Program readiness, oversight and management

The applicant describes the following: the capacity to successfully implement the plan; staff experience and appropriate competencies in policy development/implementation

or training plan; collaboration and partnership with other programs, organizations, and other Recovery Act-funded programs within the state; experience with news outlets, public relations, policy makers, political leaders, etc.; experience using state data to inform policy development and implementation; and the ability to support program travel to participate in required meetings.

3. Statewide support for community level change

The applicant describes: a plan to collaborate with and provide state-wide support to communities; plans to provide training, technical assistance and consultation to partners and communities; and strategies for educational outreach to politicians and other policy makers for successful policy and environmental changes. Provision of a letter from the state's governor which supports the recipient activities proposed in this announcement.

4. Surveillance, program monitoring, & reporting

The use of population level data for analyses, interpretation, and monitoring, as a guide for creating public health policies and environmental changes. When population-level is not available through state health surveillance systems, describe alternative steps to monitor and report on progress. The applicant provides the following: a detailed plan to document the short and long term impact of the program activities which include existing data systems, communication of program achievements to partners, collaborators, policy makers; and detailed plan for all required reporting to the CDC and FederalReporting.gov.

5. Sustainability

The applicant describes a sustainability plan for each strategy along including the ability to sustain the policy impact after ARRA funding has ended, and the utilization of the CDC Evaluation Framework to ensure the intended effect of policy change strategies.

6. Fiscal Management

The applicant describes a plan to utilize and manage ARRA funds as described in this announcement and track and monitor expenditures separate from other funding streams.

7. Budget and Justification

The applicant should include a separate line item budget and justification for each initiative proposed for “Special Policy and Environmental Initiative”.

III. Component II – Competitive Special Policy and Environmental Change

Initiatives

Eligible applicants will have the opportunity to apply for additional funds to be awarded on a competitive basis. Additional funds will be awarded to State Health Departments that demonstrate readiness to implement special large scale, statewide policy or environmental change initiatives within the overall intent of this cooperative agreement

supplement. Award amounts will range from \$1,000,000, - \$3,000,000 to fund 10 - 15 applicants for special policy initiatives. Depending on the strength of each proposed initiative, applicants may be eligible to receive funds to support more than one special initiative. These additional activities must align with the above stated recipient activities, support the local communities including but not limited to communities that will be awarded Recovery Act funding under the CPPW Initiative, and are expected to demonstrate a policy or environmental change that may have a substantial impact on the burden of obesity, physical inactivity, poor nutrition or tobacco use in the state. Additional guidance can be found in the Application Content section.

1. Implement at least one or more high-impact additional policy, environment **or** system change strategy to achieve health equity/eliminate health disparities for special population groups (e.g., racial/ethnic minorities, people with severe and persistent mental illness, people with low socio-economic status, lesbian, gay, bisexual, and transgender populations, etc.) in the area of physical activity, nutrition, or tobacco or a combination thereof for development, implementation and evaluation over the 2 year project period.

Deleted: underserved geographic locations

Implementation activities should be related to state level strategies that will support the interventions listed in the “MAPPS Intervention Strategies for State and Territory Policy, Environmental Change” table provided in Appendix C. Awardees may also propose evidence-based interventions not listed within the prescribed MAPPS menu, but must provide a strong justification of how the

proposed intervention will have sufficient reach and potential impact consistent with the short and long-term goals of the initiative.

2. Strategies selected should be best practices or evidence-based with a thorough analysis of the source of burden in the state, current state of policy and environmental supports, potential for reach, impact, successful implementation and to address gaps that exist.
3. Applicants are expected to propose strategies that are most likely to affect statewide burden and therefore, where appropriate, emphasize plans to achieve health equity.
4. The level of funding awarded under competitive “Special Policy and Environmental Change Initiative” will depend on the strength of the proposed strategy and likelihood of affecting the burden in the state, as well as impacting national obesity and tobacco trends either through improved health behaviors in the state, through innovative strategies for implementing high-impact policy and environmental change, or through major contributions to the practice-based evidence for policy and environmental strategies. Funding decisions will be determined through an objective review process. Applicants must provide detailed implementation plans and projected outcomes.

Application Content for Component II – Competitive Special Policy and Environmental Change Initiatives

Applicants requesting additional support to implement activities under Recipient Activity Component II – Competitive Special Policy and Environmental Change Initiatives should

submit an additional narrative and budget request as described under Special Policy and Environmental Change Initiative below. The application page limit for Component II is an additional 20 pages.

This optional section of the proposal will be reviewed separately by appropriate subject matter experts working in the field of obesity, nutrition, physical activity, and tobacco.

Note: Proposed initiatives are limited to what is listed in Appendix A. Proposals for strategies not found in Appendix A may be considered *depending on the strength of the analysis and justification* for pursuing that initiative. Applicants will be considered for more than one special initiative. All applicants are limited to \$3 million total. For each special policy and environmental change initiative proposed provide the following:

- a. **Burden Analysis:** Clearly and succinctly describe the source of disease burden in the state for the targeted risk factor i.e., obesity, physical inactivity, poor nutrition or tobacco use (or the combination addressed by each selected strategy). This should include analysis of the policy and environmental factors found to be contributing most to the population-level burden of disease, and the likely impact of addressing those factors as they effect both on disparately impacted populations and the broader state population to reduce that the statewide burden.
- b. **Rationale:** Describe rationale for selection of this initiative by addressing all of the following:

1. Description of readiness to implement special large scale, statewide policy or environmental change initiatives within the overall intent of this cooperative agreement;
2. Evidence that selected strategies further implement stated goals and objectives in a state-approved state strategic plan that was developed with partners and stakeholders and that focuses on policy and environmental change strategies to address any or all of the risk factors, i.e., obesity, physical inactivity, poor nutrition or tobacco use;
3. Results from small scale initiatives that are ready to be expanded to larger scale initiatives;
4. Linkage of proposed strategy to reduction in burden;
5. Justify the initiative by addressing the factors in Appendix B: Sample Policy Analysis Worksheet.

c. **Implementation Plan:** Describe detailed implementation activities to be undertaken during the project period. Work plan should at a minimum address the following:

1. Goals
2. Objectives
3. Action steps
4. Milestones for implementation of action steps and progress on objectives
5. Key Partners (including linkages with special populations)

6. Evaluation strategies, including key output and outcome measures related to the action steps and objectives, and data source for collection of these measures.

d. Program Readiness, Oversight and Management

This section should briefly describe the additional program infrastructure that will be required to implement the activities proposed under “Optional Component II.”

Applicants should address staffing needs for the State Health Department and where appropriate staff support provided to key partners to carry out the goals of the special initiative. Clearly identify the creation of new positions, as well as positions that will be retained as a result of funding this initiative as required by the Recovery Act. If additional staffing is not necessary to implement this special initiative, describe how oversight and management will be addressed by the infrastructure proposed under the non-competitive proposal.

e. Surveillance, Program Monitoring, & Reporting

This section should describe activities and steps to include the special policy initiative in all program monitoring and reporting requirements described in the recipient activities for the non-competitive portion of this announcement. Applicants should clarify commitment to submit Recovery Act output and outcome performance measures, and participate in additional national evaluation activities related to “Optional Component II.”

f. Budget and Justification:

A separate line item budget and justification must be submitted for each initiative proposed under this section. States are encouraged to follow recommended guidance for completing a detailed justified budget found on the CDC Web site, at the following Internet address:

<http://www.cdc.gov/od/pgo/funding/budgetguide.htm>.

CDC Activities:

To assist recipients in achieving the purpose of this award, CDC will conduct the following activities:

- 1) Provide ongoing guidance, programmatic support and training in the following areas:
 - a. Policy assessment and planning
 - b. Evidence-based and practice-based approaches
 - c. Partnership and collaborative development
- 2) Convene trainings, meetings, web forums, conference calls and site visits with grantees.
- 3) Provide policy development monitoring and evaluation:
 - a. Provide expertise to assist in the utilization and analyses of state data to assess and improve public health policies.

Evaluation Criteria for Component II – Competitive Special Policy and Environmental Change Initiatives

Applicants will be evaluated individually for strengths and weaknesses against the following criteria respectively and receive recommendations for improvement, where warranted:

Objective Review Criteria for Component II (Competitive Special Policy and

Environmental Change Initiative): All applications will undergo an objective review process and will be evaluated individually for strengths and weaknesses against the criteria that follows, respectively. Each proposed special initiative will be scored by intervention category (physical activity, nutrition, or tobacco control), and funding for each category will be determined in rank order based on scores of the review panel.

Degree of completeness of

1. Burden Analysis (20 points)

The source of disease burden in the state for the targeted risk factor (i.e. obesity, physical activity, nutrition and/or tobacco). The applicant describes the population, and environmental factors contributing to the disease burden state-wide.

2. Rationale (10 points)

A rationale for the initiative selected which includes: a description of readiness to implement special large scale, state-wide policy or environmental change initiatives within the overall intent of this cooperative agreement; evidence that selected strategies further implement stated goals and objectives in a state-approved strategic plan that focuses on policy and environmental change

strategies to address obesity, physical activity, nutrition and tobacco; results from small scale initiatives that are ready to be expanded to larger scale initiatives; initiatives should address factors in Appendix A.

3. Implementation Plan (40)

Detailed implementation plan that addresses the goals, objectives, action steps, timeline with milestones highlighting action steps and objectives, and key partners. [The plan includes strategies for addressing endemic health disparities, including relevant linkages with local health disparity experts.](#) The plan [also](#) describes the evaluation strategies, key outcome measures related to the action steps and objectives, and data source for collection of these measures.

4. Program readiness, oversight and management (15 points)

The program infrastructure that will be required to implement the activities proposed under the competitive Special Policy and Environmental Change Initiative.

5. Surveillance, program monitoring, & reporting (15 points)

Activities and steps to include the Special Policy and Environmental Change Initiative in all program monitoring and reporting requirement described in the recipient activities for the non-competitive portion of this announcement.

6. Budget and justification (0 points)

The applicant should include a separate line item budget and justification for each initiative proposed for “Special Policy and Environmental Change Initiative”.

Objective Review Process

All applications will under go an objective review process. An objective review panel will evaluate complete and responsive applications according to the criteria listed in the “Objective Review Criteria Section” above. The panel will be comprised of CDC program officials inside and outside of the NCCDPHP and will be scored using the pre-determined weight criteria listed in the “Application Content Section” above. The objective review process will follow the policy requirements as stated in the GPD 2.04 at <http://198.102.218.46/doc/gpd204.doc>. Applications will be funded in order by score and rank determined by the review panel.

In addition, funding decisions may be made to ensure:

- Representation of tobacco, physical activity, and nutrition across states, including a variety of interventions and evidence-based strategies.
- Geographic distribution of special policy initiatives nationwide.

CDC will provide justification for any decision to fund out of rank order.

IV. Component III—Tobacco Cessation through Quitlines and Media

Background

Interventions that increase quitting can decrease premature mortality and tobacco-

related health care costs in the short-term. Quitting by age 30 eliminates nearly all excess risk associated with smoking, and smokers who quit smoking before age 50 cut in half their risk of dying in the next 15 years. Although quitting smoking has immediate as well as long-term benefits, tobacco use is addictive. More than 40% of smokers try to quit each year, but without assistance, most will relapse. The *Community Guide to Preventive Services* recommends a number of effective interventions to support tobacco cessation.

Purpose

The Centers for Disease Control and Prevention (CDC), National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP), Office on Smoking and Health (OSH), announces the opportunity to apply for Recovery Act funds to create 80,000 additional tobacco quitters, beyond what states and jurisdictions have achieved in the past, by expanding and promoting tobacco cessation quitlines.

These awards are to provide financial and programmatic assistance to strengthen the abilities of States, the District of Columbia, and eligible U.S. Territories that were funded under Funding Opportunity Announcement DP09-901 to enhance and expand the national network of tobacco cessation quitlines to significantly increase the number of smokers who quit each year to reduce mortality and morbidity from tobacco use, and associated health care costs. This supplemental announcement supports the “Healthy People 2010” objectives that promote

tobacco cessation in adults and youth. The establishment of a National Network of Tobacco Quitlines is also a key recommendation of the Subcommittee on Cessation of the Interagency Committee on Smoking and Health. An effective state health communications intervention should deliver strategic, culturally appropriate, and high impact messages in sustained and adequately funded campaigns. [Targeted messages for special populations can supplement universal approaches to quitline promotion.](#)

Availability of Funds

Up to \$44,500,000 is available to significantly expand and enhance tobacco cessation services through the Quitlines. The award will range from \$400,000 - \$2,500,000 for the 24 month project period based on a formula that includes a base of \$400,000 per state with a proportional increase based on the population of tobacco users in the state. A table of maximum base funding per state can be found in Appendix E. Receipt and amount of base funding will be dependent on submission of a highly qualified proposal outlining specific actions to be taken and outcomes to be achieved in accordance with recipient activities in this announcement. Applicants must not request funding above the maximum amount designated for their state. Funding for eligible U.S. Territories will be based on the population size and capacity to expand services.

It is expected that awards will begin December 2009, and will be made for a 24-month project period. Funding estimates may vary and are subject to change.

See Appendix A - Recovery Act State Quitline Supplemental Funding.

Use of Funds

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

Cooperative agreement funds must be used to support a core infrastructure for the delivery of quitline services which include proactive counseling and promotion/outreach. Proactive quitlines exist when a trained counselor telephones the smoker to provide support in initiating a quit attempt and maintaining prolonged abstinence. Funds may be used to expand and promote proactive counseling capacity, enhance and expand integration of online and other electronic information support technologies, expand media and marketing efforts, extend hours of service, expand outreach to specific populations ([e.g., pregnant women, racial/ethnic minorities, people with low socio-economic status, lesbian, gay, bisexual, and transgender populations, etc.](#)), provide multiple language services, increase collaborations with health care systems and providers, and for evaluation.

A portion of funds awarded with this Supplemental Program Announcement must be used to develop or expand effective media campaigns that drive tobacco user to quit. Evidence regarding optimal use of quitlines demonstrates that 30 percent of funds should be used for media campaigns.

The amount of media needed should be justified by the applicant as it relates to

current efforts and demand for Quitline and other cessation services. Media campaigns designed strictly to advertise the availability of Quitline services are not eligible under this award. Quitline availability should be paired with media that is designed to motivate quitting among all smokers, including those who may or may not seek quitline assistance.

Up to five percent (5%) of Recovery Act funds awarded for Component III can be used for the purchase of nicotine replacement therapy medications. FDA-approved nicotine replacement therapy (e.g., nicotine patch, gum, nasal spray, inhaler, and lozenge) is effective in helping people quit smoking. Awardees must engage the broader community resources, such as other federal funding sources, Medicaid, health insurance providers, and employers for the provision of nicotine replacement therapy and sustaining cessation services.

Recipient Activities

1) Proactive Quitline Services

- Employ the preferred enhancement/expansion sequence to reach the goal of 80,000 additional tobacco quitters above the current number of quitters is as follows:
 - 1) Expand proactive counseling to tobacco users in the state,
 - 2) Promote the quitline statewide,
 - 3) Enhance and expand integration of online and other electronic information support technologies,

- 4) Expand outreach to population groups that may be experiencing health disparities,
 - 5) Develop additional language capacity where relevant,
 - 6) Expand outreach to health care systems for referrals, and
 - 7) Expand the evaluation of the quitline to improve services and increase effectiveness.
- Ensure a focus on populations and/or communities and local areas with a disproportionate burden of tobacco use and who tend to experience disparities in access to and use of preventive and tobacco cessation services. These populations include: racial and ethnic minorities; low-income persons; the medically underserved; persons with disabilities; persons affected by mental illness; lesbian, gay, bisexual, or transgender people; or persons affected by substance abuse.

Performance will be measured by evidence of implementation of one or more of the improvements in the capacity or quality of quitlines indicated above; efforts focusing on populations and/or neighborhoods indicated above with disproportionate burden of tobacco use; adequate progress on key output and outcome measures.

2) Program Infrastructure: Staffing, Program Management and Support

- Hire and/or retain staffing or contractors to successfully implement a proactive quitline. Staff functions include program management, fiscal management, media coordination, evaluation, administrative support, and Recovery Act reporting requirements. Staff must be sufficient in number

and expertise to ensure project success, i.e., program management should demonstrate skills and experience in coalition and partnership development, community mobilization, health care systems, public health, program evaluation, epidemiology, data management, health promotion, policy and environmental interventions, media advocacy, communications, community planning, and resource development.

Performance will be measured by evidence that the program is appropriately staffed to administer, manage, and evaluate the program, and that additional staff have or will develop knowledge and skills to competently support state wide proactive quitline services.

3) Fiscal Management

- Track and monitor expenditures separate from other federal funding streams.
- Implement reporting systems to meet the online reporting criteria and timelines as stated in section VI.4 Reporting of this supplemental Program Announcement.

Performance will be measured by evidence that the grantee has established procedures to track and report expenditures separate from other federal funding, prepare required reports, and submit such reports in accordance with the designated schedule.

4) Media, Communication and Partnerships

- Develop and expand statewide media messages targeted for adults and young adults who smoke that use emotional and graphic messages—including

messages about the harmful effects of secondhand smoke exposure to children—in order to motivate quitting, cue action to call quit lines, and build public support for smoke free air policies. Revise or add to the existing community consortium or consortia committed to participating actively in the expansion, promotion, and evaluation of the state-based quitline. Partners should include a wide representation of community leaders and community members, including media and communication experts, health care systems, medical community, educational agencies, key community, voluntary, and professional organizations; community organizations representing special populations with health disparities; employers, community and faith-based leaders, universities, mental health/substance abuse organizations, health plans and other community partners working together to promote quitting and expand sustained cessation services, including a proactive quitline.

Performance will be measured by evidence of development of messages with appropriate emotional and graphic quality; reach of the media; communication plans; sufficient levels of partner engagement throughout the project period including the involvement of key community-based and public health partners.

5) Monitoring and Evaluation

- Collect the designated Recovery Act performance and evaluation measures presented in section VI.3 below, provide information in the required format and according to the time schedule provided.
- Report accurate and thorough information on the number of persons who call the quitline (call volume), number of tobacco users receiving a quitline

service, types of services available and eligibility requirements for each service, the type/number of services each user received, individual user characteristics (i.e., demographics, type of tobacco used, referral source(s)), quit rates by type of service received, demonstrate access to individual-level user information at intake (for user characteristics) and 7-month follow-up (for calculation of quit rates) and that data will be sent to CDC, and other relevant information.

- Assess key outcomes including: caller satisfaction with service, “reach” of services, (e.g., number of callers to the quitline and number of tobacco users receiving counseling services), the number of tobacco users receiving a quitline service and number of tobacco users who receive a quitline service who quit (assessed at 7 month follow-up).
- Describe how current surveillance and evaluation activities will be enhanced and demonstrate access to individual-level user information at intake (for user characteristics) and follow-up (for calculation of quit rates).
- Submit with application a comprehensive written evaluation plan that includes activities for output and outcome measures;
- Include a description of evaluation activities consistent with the CDC Framework for Evaluation (<http://www.cdc.gov/eval/framework.htm>) including stakeholder involvement, questions developed, indicators, data sources, and use of evaluation information for decision making and program improvement

- Attendance at CDC surveillance and evaluation annual meeting and participation in CDC technical assistance webinars

Performance will be measured by evidence of compliance with reporting requirements, formats, and timelines for reporting Recovery Act output and outcome measures; intent to collect and monitor key measures indicated above including characteristics of callers, reach of services, quit attempts and successful quit attempts; use of evaluation and performance measurement findings for program modification and improvement. Implementation of a written, comprehensive evaluation plan consistent with the CDC Framework for Program Evaluation and including both output and outcome indicators to evaluate recipient activities; attendance at CDC surveillance and evaluation annual meeting and participation in CDC technical assistance webinars.

6) Participate in CDC Training Activities

- Ensure that the Program Manager and other appropriate member(s) attend a CDC Training that will focus on increasing quitline usage.
- Participate in regular peer-to-peer learning opportunities.

Performance will be measured by evidence of attendance and participation in training programs and peer-to-peer meetings.

CDC Activities

To assist Recipients in achieving the purpose of this award, CDC will conduct the following activities:

- 1) Provide ongoing guidance, technical assistance, training and support in the following areas:
 - a. Community assessment and planning
 - b. Evidence-based and practice-based approaches
 - c. Access to the Media Campaign Resource Center
 - d. Community mobilization and partnership development
 - e. Program sustainability and program strategies
 - f. Monitoring and evaluation of service utilization and quit rates
 - g. Developing and revising tobacco strategic plans
- 2) Foster the transfer of successful evidence- and practice- based interventions, program models, and other forms of technical assistance by convening meetings, workshops, trainings, Web forums, conferences, conference calls, and site visits with grantees. Continue to collaborate with NIH to enhance and expand their national quit line portal, 1-800-Quit-Now.
- 3) Provide Project Monitoring and Evaluation
 - a. Provide expert resources to assist in the design, collection, analysis, and use of comparable evaluation data to assess and strengthen programs.
 - b. Provide consistency in measurement; ensure comparability across grantee programmatic activities.

- c. Provide appropriate performance measures to meet Recovery Act requirements along with guidance on formats and timelines for submission of this information.

Application Content for Component III

The program announcement title and number must appear on the supplemental application. Use the information in the Program Recipient Activities and Evaluation Criteria sections to develop the application content. Your application will be evaluated on the criteria listed, so it is important to follow the criteria in laying out your program plan. Recovery Act funds are intended to expand your current quitline services. The expanded activities must be clearly stated and well documented in your Recipient Activities. The narrative, including the Executive Summary, should be no longer than 15 double-spaced pages, printed on one side, with one-inch margins and unreduced 12-point New Times Roman font. Appendices should total no more than 10 pages, excluding letters of support and the budget.

Focus the application content ONLY on the planned *Recipient Activities* for which you seek CDC funding. All grant recipients will be expected to demonstrate progress that the quitline is increasing the number of quitters beyond the previous year's totals in effort to reach the national target of 80,000 additional quitters.

The applicant should provide a brief summary of their proposed activities for the 24 month project period of proposed activities including measurable objectives, work plan, and timelines. The narrative should address the following items in the order listed:

- I. Program Infrastructure: Staffing, Program Management and Support
- II. Fiscal Management
- III. Media, Communication and Partnerships
- IV. Proactive Quitline Services
- V. Monitoring and Evaluation including discussion of Recovery Act performance measures and ability to collect these in the format and timelines required.
- VI. Participate in CDC Training Activities
- VII. Budget

Include travel for a minimum of one staff member or selected representative(s) to attend two CDC-sponsored training meetings in the 24 month project period. For the purposes of planning, this meeting will occur in Atlanta for two days at a date to be determined.

If a state or territory 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 supplemental award will be reduced by the amount of estimated travel, plus an additional 20% administrative cost.

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

Evaluation Criteria

Applicants will be evaluated individually for strengths and weaknesses against the following criteria respectively and receive recommendations for improvement, where warranted:

1. Proactive Quitline Services

The applicant describes how it will provide proactive quitline services to increase the number of tobacco quitters in the state or eligible jurisdiction.

2. Program Infrastructure: Staffing, Program Management and Support. The

applicant provides evidence that the program is appropriately staffed to administer, manage and evaluate the program and training plans for less experienced staff to competently support statewide proactive quitline services.

Resume and/or curriculum vitae for the Program Manager should be submitted.

3. Fiscal Management

The applicant describes efforts to provide fiscal management as required for Recovery Act funds in the Fiscal Management section of this program announcement.

4. Media, Communication, and Partnerships

The applicant describes plans to deliver advertising and media messages targeted to adults and young adults who smoke that use emotional and graphic messaging.

The extent to which the applicant includes participation of partners in the design, implementation, and evaluation of media, communication, and cessation quitline services.

5. Monitoring and Evaluation

The applicant provides a plan to collect demographic, in-take and follow-up data and report that data to CDC on a timely basis. The extent to which the applicant describes plans to evaluate program reach, report quit rates, and the number of persons who quit and progress toward all objectives in the Recipient Activities section.

6. Participate in CDC Training Activities

The extent to which the applicant describes a plan for staff to participate in CDC trainings and peer-to-peer opportunities.

7. Budget (not scored)

The extent to which the budget is clear, concise, and accurate.

V. Award Information

V.1. Type of Award: Cooperative Agreement - Supplemental

CDC's involvement in this program is listed in the Activities Section above.

Award Mechanism: U58 Chronic Disease Prevention and Control

Fiscal Year Funds: 2009-2010 Recovery Act

Approximate Current Fiscal Year Funding: \$125M (This amount is an estimate, and is subject to availability of funds. This includes direct and indirect costs.)

Approximate Number of Awards:

Components I & III - 53 Awards

Component II - 10-15 Awards

Approximate Total Project Period Funding: \$125,000,000 (This amount is an estimate, and is subject to availability of funds. This includes direct and indirect costs.)

Approximate Average Award:

Components I & III - Approximately \$500,000

Component II – Approximately \$1.5M

Floor of Individual Award:

Component I (See Appendix D)

Component II \$1M

Component III (See Appendix E)

Ceiling of Individual Award:

Component I (See Appendix D)

Component II \$3M

Component III (See Appendix E)

Anticipated Award Date: Component I & III December 2009; Component II January 2010

Budget Period Length: 24 months

Project Period Length: 24 months

V. 2. Cost Sharing or Matching

Cost Sharing or matching funds is not required for Recovery Act program funds.

V. 3. Other

Special Requirements:

If the application is incomplete or non-responsive to the special requirements listed in this section, it will not be entered into the review process. The applicant will be notified the application did not meet submission requirements.

- Late applications will be considered non-responsive. See section “VI.2. Submission Dates and Times” for more information on deadlines.
- Note: Title 2 of the United States Code Section 1611 states that an organization described in Section 501(c)(4) of the Internal Revenue Code that engages in lobbying activities is not eligible to receive Federal funds constituting a grant, loan, or an award.

VI. Application and Submission Information

Address to Request Application Package

To apply for this funding opportunity, use the application forms package posted in Grants.gov.

Electronic Submission:

The applicant must submit the application electronically by utilizing the forms and instructions posted for this announcement on www.Grants.gov, the official Federal agency wide E-grant Web site.

Registering your organization through www.Grants.gov is the first step in submitting applications on line. Registration information is located in the “Get Registered” screen of www.Grants.gov.

Please visit www.Grants.gov at least 30 days prior to filing your application to familiarize yourself with the registration and submission processes. Under “Get Registered,” the one-time registration process will take three to five days to complete; however, as part of the Grants.gov registration process, registering your organization with the Central Contractor Registry (CCR) annually, could take an additional one to two days to complete. We suggest submitting electronic applications prior to the closing date so if difficulties are encountered they can be addressed.

If access to the Internet is not available or if there is difficulty accessing the forms online, contact the CDC Procurement and Grants Office Technical Information Management Section (PGO-TIMS) staff at 770-488-2700 and the application forms may be considered for submission and acceptance by U.S. Postal Service.

VI.1. Content and Form of Submission

A letter of intent is not applicable to this funding opportunity announcement.

Application:

An Executive Summary must be submitted with the application forms for posting on Recovery.com website. All electronic executive summary abstracts must be uploaded in a PDF file format when submitting via Grants.gov. The summary must be submitted in the following format:

- Maximum of 2-3 paragraphs.
- Font size: 12 point unreduced, Times New Roman

- Single spaced
- Paper size: 8.5 by 11 inches
- Page margin size: One inch

The Project Abstract must contain a summary of the proposed activity suitable for dissemination to the public. It should be a self-contained description of the project and should contain a statement of objectives and methods to be employed. It should be informative to other persons working in the same or related fields and insofar as possible understandable to a technically literate lay reader. This Abstract must not include any proprietary/confidential information.

A project narrative must be submitted with the application forms. All electronic narrative must be uploaded in a PDF file format when submitting via grants.gov. The narrative must be submitted in the following format:

- Maximum number of pages for each of the following application components:
 - Component I, Statewide Policy and Environmental Change - 25 pages
 - Component II Competitive -Special Policy and Environmental Change Initiatives - 20 pages
 - Component III, Tobacco Cessation through Quitlines and Media - 15 pages

If any of the component narratives exceeds the page limit, only the first pages which are within the page limit will be reviewed.

- Font size: 12 point unreduced, Times New Roman

- Double spaced
- Paper size: 8.5 by 11 inches
- Page margin size: One inch
- Printed only on one side of page.
- Number all narrative pages; not to exceed the maximum number of pages.

The narrative should address activities to be conducted over the entire project period and must include the following items in the order listed.

1. The applicant should identify activities that are new to the program funded under announcement DP09-901.
2. The applicant should outline the status of any activities that are currently in progress but are intended to be expanded.
3. The applicant should provide a detailed description of its capacity to carry out the proposed activities and the collaborative efforts and partnerships that will be necessary for success within the project time period.
4. The applicant should describe the method of assessing the success or progress of each objective, such as:
 - a. Number and type of evidence-based strategies to policies and interventions were implemented
5. A staffing plan that demonstrates an understanding of the labor needed to accomplish each activity. Identify staff members by name and title as well as additional staff to be hired or contracted (number and roles/responsibilities).

Additional information may be included in the application appendices. The appendices will not be counted toward the narrative page limit.

- Additional information submitted via Grants.gov should be uploaded in a PDF file format and should be labeled clearly with the name of the document or a clear descriptive title when uploaded into Grants.gov.
- No more than 5 electronic attachments should be uploaded per application.

The agency or organization is required to have a Dun and Bradstreet Data Universal Numbering System (DUNS) number to apply for a grant or cooperative agreement from the Federal government. The DUNS number is a nine-digit identification number, which uniquely identifies business entities. Obtaining a DUNS number is easy and there is no charge. To obtain a DUNS number, access the [Dun and Bradstreet website](#) or call 1-866-705-5711.

Additional requirements that may request submission of additional documentation with the application are listed in section “VI.2. Administrative and National Policy Requirements.”

VI.2. Submission Dates and Times

Note: Application submission is not concluded until successful completion of the validation process.

After submission of your application package, applicants will receive a “submission receipt” email generated by Grants.gov. Grants.gov will then generate a second e-mail message to applicants which will either validate or reject their submitted application package. This validation process may take as long as two (2) calendar days. Applicants are strongly encouraged check the status of their application to ensure submission of

their application package is complete and no submission errors exists. To guarantee that you comply with the application deadline published in the Funding Opportunity Announcement, applicants are also strongly encouraged to allocate additional days prior to the published deadline to file their application. Non-validated applications will not be accepted after the published application deadline date.

In the event that you do not receive a “validation” email within two (2) calendar days of application submission, please contact Grants.gov. Refer to the email message generated at the time of application submission for instructions on how to track your application or the Application User Guide, Version 3.0 page 57.

Application Deadline Date: November 24, 2009

Explanation of Deadlines: Applications must be received in the CDC Procurement and Grants Office by 5:00 p.m. Eastern Time on the deadline date.

Applications must be submitted electronically at www.Grants.gov. Applications completed on-line through Grants.gov are considered formally submitted when the applicant organization’s Authorizing Organization Representative (AOR) electronically submits the application to www.Grants.gov. Electronic applications will be considered as having met the deadline if the application has been successfully submitted electronically by the applicant organization’s AOR to Grants.gov on or before the deadline date and time.

When submission of the application is done electronically through Grants.gov (<http://www.grants.gov>), the application will be electronically time/date stamped and a tracking number will be assigned, which will serve as receipt of submission. The AOR will receive an e-mail notice of receipt when HHS/CDC receives the application.

IMPORTANT NOTICE: It is the applicant's responsibility to determine that the application has been received. If you do not receive a receipt confirmation and either a validation confirmation or a rejection email message within 48 hours, please contact Grants.gov. The Grants.gov Contact Center can be reached by email at support@grants.gov, or by telephone at 1-800-518-4726. Always include your Grants.gov tracking number in all correspondence. The tracking numbers issued by Grants.gov look like GRANTXXXXXXXX.

If your application is successfully validated and subsequently retrieved by the CDC Procurement and Grants Office from the Grants.gov system, you will receive an additional e-mail. This e-mail may be delivered several days or weeks from the date of submission, depending on when the application is retrieved.

You may also monitor the processing status of your submission within the Grants.gov system by using the following steps:

1. Go to <http://www.grants.gov>
2. Click on the "Track Your Application" link on the left side navigation bar on the Grants.gov homepage.
3. Login to the system using your AOR user ID and password
4. Click on the "Check Application Status" link on the left side navigation bar.

Note: Once the CDC Procurement and Grants Office has retrieved your application from Grants.gov, you will need to contact the CDC Procurement and Grants Office directly for any subsequent status updates. Grants.gov does not participate in making any award decisions.

This announcement is the definitive guide on application content, submission address, and deadline. It supersedes information provided in the application instructions. If the application submission does not meet the deadline above, it will not be eligible for review. The application face page will be returned by HHS/CDC with a written explanation of the reason for non-acceptance. The applicant will be notified the application did not meet the submission requirements.

VI.3. Intergovernmental Review of Applications

The application is subject to Intergovernmental Review of Federal Programs, as governed by Executive Order (EO) 12372. This order sets up a system for state and local governmental review of proposed federal assistance applications. Contact the state single point of contact (SPOC) as early as possible to alert the SPOC to prospective applications and to receive instructions on the State's process. Visit the following Web address to get the current SPOC list:

<http://www.whitehouse.gov/omb/grants/spoc.html>

VI.4. Funding Restrictions

Restrictions, which must be taken into account while writing the budget, are as follows:

- Recipients may not use funds for research.
- Recipients may not use funds for clinical care.
- Recipients may only expend funds for reasonable program purposes, including personnel, travel, supplies, and services, such as contractual.
- Recipients may not generally use HHS/CDC/ATSDR funding for the purchase of furniture or equipment. However, if equipment purchase is integral to a selected MAPPS strategy, it will be considered. Any such proposed spending must be identified in the budget.
- Recipients may not use funding for construction.
- The direct and primary recipient in a cooperative agreement program must perform a substantial role in carrying out project objectives and not merely serve as a conduit for an award to another party or provider who is ineligible.
- Reimbursement of pre-award costs is not allowed.
- Recipients may not spend more than 5% of the total award for tobacco prevention and control on nicotine replacement therapy (NRT).

If requesting indirect costs in the budget, a copy of the indirect cost rate agreement is required. If the indirect cost rate is a provisional rate, the agreement should be less than 12 months of age. The indirect cost rate agreement should be uploaded as a PDF file with “Other Attachment Forms” when submitting via Grants.gov.

VI.5. Administrative and National Policy Requirements

- Successful applicants must comply with the administrative requirements outlined in 45 CFR Part 74 and Part 92, as appropriate. The following additional requirements apply to this project:

- AR-9 Paperwork Reduction Act Requirements
- AR-10 Smoke-Free Workplace Requirements
- AR-11 Healthy People 2010
- AR-12 Lobbying Restrictions
- AR-14 Accounting System Requirements
- AR-15 Proof of Non-Profit Status
- AR-20 Conference Support
- AR-21 Small, Minority, And Women-owned Business
- AR 23 Compliance with 45 C.F.R. Part 87
- AR 26 National Historic Preservation Act of 1966
- AR-27 Conference Disclaimer and Use of Logos

Additional information on the requirements can be found on the CDC Web site at the following Internet address: http://www.cdc.gov/od/pgo/funding/Addtl_Reqmnts.htm.

CDC Assurances and Certifications can be found on the CDC Web site at the following Internet address: <http://www.cdc.gov/od/pgo/funding/grants/foamain.shtm>

For more information on the Code of Federal Regulations, see the National Archives and Records Administration at the following Internet address:

<http://www.access.gpo.gov/nara/cfr/cfr-table-search.html>

VI.6. Reporting Requirements

The applicant must provide reports as described below that provide the necessary information related to the output and outcome measures appropriate to the activities which they have undertaken. And in addition, they will submit a final evaluation report reflecting program outputs, outcomes, and environmental impacts within 90 days from funding conclusion. The final evaluation report should include evaluation information related to outlined recipient activities. As noted, grantees will be monitored on the following output and outcome measures.

The Following Sections Apply to Component I. State Policy and Environmental Change & Component II. Competitive Special Policy and Environmental Change Initiatives

Outcome Measures

- **Measure:** Report progress on development and submission (to the appropriate authority) for each chosen policy/system/environmental change in [specific focus area: physical activity, nutrition, tobacco].
- **Frequency:** Semi-annually. Funded recipients will report to CDC.

- Measure: Report progress on approval (by the appropriate authority) of each chosen policy/system/environmental change in [specific focus area: physical activity, nutrition, tobacco].
- Frequency: Semi-annually. Funded recipients will report to CDC.

Output Measures

- Measure: Report progress on implementation of activities in approved implementation plan for each chosen policy/system/environmental change strategies in [specific focus area: physical activity, nutrition, tobacco]
- Reporting: Progress report
- Frequency: Quarterly. Grantee will report to CDC; CDC will compile into average scores for aggregate reporting across grantees

The Following Sections Apply to Component III. Tobacco Cessation through Quitlines and Media

Outcome Measures

- Measure Total number of quitline calls
- Reporting: Progress report
- Frequency: Quarterly. Recipients will report to CDC; CDC will compile into total scores for aggregate reporting across recipients
- Measure: # of (unduplicated) quitline callers who received a service

- Reporting: Progress report
- Frequency: Quarterly. Recipients will report to CDC; CDC will compile into total scores for aggregate reporting across recipients
- Measure: # of (unduplicated) quitline callers who received a service who quit
- Reporting: Progress report and 7 month follow up data
- Frequency: Quarterly. Recipients will report to CDC; CDC will compile into average scores for aggregate reporting across recipients

Output Measures

- Measure: # of site-appropriate modifications to improve quality and /or capacity of state quitline per inventory of potential improvements**
- Reporting: Progress report
- Frequency: Quarterly. Recipients will report to CDC; CDC will compile into total number of states that made each improvement (per list below) for aggregate reporting across recipients

** Recipients will indicate which of the following inventory of potential improvements are relevant to their state and indicate progress on implementing them:

- Increased the amount of service provided (counseling, medications) and/or expanded the eligibility criteria for receiving services (describe amount of proactive counseling provided and who is eligible and type and amount of medication, whether it is free or discounted, and who is eligible to receive it

- Increased the number of hours quitline was open to provide live pick-up and counseling of incoming calls (list hours)
- Increased the number of languages in which quitline services were available
- Increased the number of health systems that utilize a quitline referral protocol (i.e., fax to quit, etc.) (list health care system; give total number of proactive referrals, number of proactive fax referrals, and number of other referrals (web referrals, click to quit, online ads, etc.)).
- Increased the number of calls that are answered live (give number and proportion of total calls that are answered live)
- Increased the number of callers from populations with a disproportionate burden of tobacco use who received a service (define high-risk population(s) and give number of (unduplicated) quitline callers from selected population(s) who receive a service)
- Developed a sustainability plan (submit plan)

Additionally, the applicant must provide CDC with an original, plus two hard copies of the following reports:

1. Financial Status Report (FSR) no more than 90 days after the end of the budget period.
2. Final performance and Financial Status reports no more than 90 days after the end of the project period. Due to separate accounting requirements please submit both summary and individual FSR addressing Recovery Act Activities.

These reports must be submitted to the attention of the Grants Management Specialist listed in the “VII. Agency Contacts” section of this announcement.

Specific Reporting Requirements

1. Other Standard Terms and Conditions

All other grant policy terms and conditions contained in applicable Department of Health and Human Services (HHS) Grant Policy Statements apply unless they conflict or are superseded by the following terms and conditions implementing the American Recovery and Reinvestment Act of 2009 (Recovery Act) requirements below. Recipients are responsible for contacting their HHS grant/program managers for any needed clarifications.

2. Recovery Act-Specific Requirements

Recipients of Federal awards from funds authorized under Division A of the Recovery Act must comply with all requirements specified in Division A of the Recovery Act (Public Law 111-5), including reporting requirements outlined in Section 1512 of the Act and designated Recovery Act [outcome and output measures as detailed in V1.6 Reporting Requirements]. For purposes of reporting, Recovery Act recipients must report on Recovery Act sub-recipient (sub-grantee and sub-contractor) activities as specified below.

Not later than 10 days after the end of each calendar quarter, starting with the quarter ending March 31, 2010_ and reporting by April 10, 2010, the recipient must submit quarterly reports to HHS that will posted to Recovery.gov, containing the following information:

- a. The total amount of Recovery Act funds under this award;
- b. The amount of Recovery Act funds received under this award that were obligated and expended to projects or activities;
- c. The amount of unobligated award balances;
- d. A detailed list of all projects or activities for which Recovery Act funds under this award were obligated and expended, including
 - The name of the project or activity;
 - A description of the project or activity;
 - An evaluation of the completion status of the project or activity;
 - An estimate of the number of jobs created and the number of jobs retained by the project or activity; [[additional guidance below on how to measure jobs created and retained forthcoming from OMB] and
 - For infrastructure investments made by State and local governments, the purpose, total cost, and rationale of the agency for funding the infrastructure investment with funds made available under this Act, and the name of the person to contact at the agency if there are concerns with the infrastructure investment.

- e. Detailed information on any sub-awards (sub-contracts or sub-grants) made by the grant recipient to include the data elements required to comply with the Federal Funding Accountability and Transparency Act of 2006 (Public Law 109-282).

For any sub-award equal to or larger than \$25,000, the following information:

- The name of the entity receiving the sub-award;
- The amount of the sub-award;
- The transaction type;
- The North American Industry Classification System code or Catalog of Federal Domestic Assistance (CFDA) number;
- Program source;
- An award title descriptive of the purpose of each funding action;
- The location of the entity receiving the award;
- The primary location of performance under the award, including the city, State, congressional district, and county.
- A unique identifier of the entity receiving the award and of the parent entity of the recipient, should the entity be owned by another entity;
- The date the sub-award was issued;
- The term of the sub-award (start/end dates);
- The scope/activities of the sub-award;
- The amount of the total sub-award that has been obligated or disbursed by the sub-recipient; and

- The amount of the total sub-award that remains unobligated by the sub-recipient.
- f. All sub-awards less than \$25,000 or to individuals may be reported in the aggregate, as prescribed by HHS.
 - g. Recipients must account for each Recovery Act award and sub-award (sub-grant and sub-contract) separately. Recipients will draw down Recovery Act funds on an award-specific basis. Pooling of Recovery Act award funds with other funds for drawdown or other purposes is not permitted.
 - h. Recipients must account for each Recovery Act award separately by referencing the assigned CFDA number for each award.

The definition of terms and data elements, as well as any specific instructions for reporting, including required formats, will be provided in subsequent guidance issued by HHS.

Note: HHS will not accept statistical sampling methods to estimate the number of jobs created and retained. All recipients must report a direct and comprehensive count of jobs, as specified by OMB guidance M-09-21. See Section 5.3 of the OMB guidance for more information on calculating jobs, including job estimation examples.

3. Buy American - Use of American Iron, Steel, and Manufactured Goods

Recipients may not use any funds obligated under this award for the construction, alteration, maintenance, or repair of a public building or public work unless all of

the iron, steel, and manufactured goods used in the project are produced in the United States unless HHS waives the application of this provision. (Recovery Act Sec. 1605)

4. Wage Rate Requirements

[This term and condition shall not apply to tribal contracts funded with this appropriation. (Recovery Act Title VII—Interior, Environment, and Related Agencies, Department of Health and Human Services, Indian Health Facilities)]

Subject to further clarification issued by the Office of Management and Budget, and notwithstanding any other provision of law and in a manner consistent with other provisions of Recovery Act, all laborers and mechanics employed by contractors and subcontractors on projects funded directly by or assisted in whole or in part by and through the Federal Government pursuant to this award shall be paid wages at rates not less than those prevailing on projects of a character similar in the locality as determined by the Secretary of Labor in accordance with subchapter IV of chapter 31 of title 40, United States Code. With respect to the labor standards specified in this section, the Secretary of Labor shall have the authority and functions set forth in Reorganization Plan Numbered 14 of 1950 (64 Stat. 1267; 5 U.S.C. App.) and section 3145 of title 40, United States Code. (Recovery Act Sec. 1606)

5. Preference for Quick Start Activities (Recovery Act)

In using funds for this award for infrastructure investment, recipients shall give preference to activities that can be started and completed expeditiously, including a goal of using at least 50 percent of the funds for activities that can be initiated not later than 120 days after the date of the enactment of Recovery Act.

Recipients shall also use grant funds in a manner that maximizes job creation and economic benefit. (Recovery Act Sec. 1602)

6. Limit on Funds (Recovery Act)

None of the funds appropriated or otherwise made available in Recovery Act may be used by any State or local government, or any private entity, for any casino or other gambling establishment, aquarium, zoo, golf course, or swimming pool.

(Recovery Act Sec. 1604)

7. Disclosure of Fraud or Misconduct

Each recipient or sub-recipient awarded funds made available under the Recovery Act shall promptly refer to the HHS Office of Inspector General any credible evidence that a principal, employee, agent, contractor, sub-recipient, subcontractor, or other person has submitted a false claim under the False Claims Act or has committed a criminal or civil violation of laws pertaining to fraud, conflict of interest, bribery, gratuity, or similar misconduct involving those funds.

The HHS Office of Inspector General can be reached at

<http://www.oig.hhs.gov/fraud/hotline/>

8. Recovery Act: One-Time Funding

Unless otherwise specified, Recovery Act funding to existent or new awardees should be considered one-time funding.

9. Schedule of Expenditures of Federal Awards

Recipients agree to separately identify the expenditures for each grant award funded under Recovery Act on the Schedule of Expenditures of Federal Awards (SEFA) and the Data Collection Form (SF-SAC) required by Office of Management and Budget Circular A-133, “Audits of States, Local Governments, and Non-Profit Organizations.” This identification on the SEFA and SF-SAC shall include the Federal award number, the Catalog of Federal Domestic Assistance (CFDA) number, and amount such that separate accountability and disclosure is provided for Recovery Act funds by Federal award number consistent with the recipient reports required by Recovery Act Section 1512(c). (2 CFR 215.26, 45 CFR 74.26, and 45 CFR 92.26)

10. Responsibilities for Informing Sub-recipients

Recipients agree to separately identify to each sub-recipient, and document at the time of sub-award and at the time of disbursement of funds, the Federal award number, any special CFDA number assigned for Recovery Act purposes, and amount of Recovery Act funds. (2 CFR 215.26, 45 CFR 74.26, and 45 CFR 92.26)

VII. Agency Contacts

CDC encourages inquiries concerning this announcement.

For programmatic assistance:

Please send questions to the ARRA mailbox at arra@cdc.gov. Answers to questions will be provided during the scheduled technical assistance conference calls.

If you require further programmatic technical assistance, contact:

For Nutrition/Physical Activity and Obesity

Claire Heiser, Team Leader

Division of Nutrition, Physical Activity and Obesity

Centers for Disease Control and Prevention

4770 Buford Highway MS-K03

Atlanta, GA 30341

Telephone Number: 770-488-5284

Fax: 770-488-6027

E-mail: cheiser@cdc.gov

For Quitline and Tobacco Assistance:

Kevin Collins, Team Leader

Office on Smoking and Health

National Center for Chronic Disease Prevention and Health Promotion
Centers for Disease Control and Prevention
4770 Buford Hwy, Mailstop K-50
Atlanta, GA 30341
Telephone Number: (770) 488-1218
Fax: (770) 488-1220
E-mail: ksc5@cdc.gov

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

Anella Higgins, Grants Management Specialist
Procurement and Grants Office
Centers for Disease Control and Prevention 2920 Brandywine Road,
MS E-09
Atlanta, GA 30341
Telephone Number: 770-488-2936
Fax: 770/488-2777
E- mail: AHiggins@cdc.gov

For general questions, contact:

Technical Information Management Section
Department of Health and Human Services
CDC Procurement and Grants Office

2920 Brandywine Road, MS E-14

Atlanta, GA 30341

Telephone: 770-488-2700

Email: pgotim@cdc.gov

CDC Telecommunications for the hearing impaired or disabled is available at: TTY 770-488-2783.

This funding announcement is subject to restrictions on oral conversations during the period of time commencing with the submission of a formal application² by an individual or entity and ending with the award of the competitive funds. Federal officials may not participate in oral communications initiated by any person or entity concerning a pending application for a Recovery Act competitive grant or other competitive form of Federal financial assistance, whether or not the initiating party is a federally registered lobbyist. This restriction applies unless:

- (i) the communication is purely logistical;
- (ii) the communication is made at a widely attended gathering;
- (iii) the communication is to or from a Federal agency official and another Federal Government employee;

² Formal Application includes the preliminary application and letter of intent phases of the program.

(iv) the communication is to or from a Federal agency official and an elected chief executive of a state, local or tribal government, or to or from a Federal agency official and the Presiding Officer or Majority Leader in each chamber of a state legislature; or

(v) the communication is initiated by the Federal agency official.

For additional information see

http://www.whitehouse.gov/omb/assets/memoranda_fy2009/m09-24.pdf.

Appendix A: MAPPS Interventions for Communities Putting Prevention to Work

Five evidence-based MAPPS strategies, when combined, can have a profound influence on improving health behaviors by changing community environments: Media, Access, Point of decision information, Price, and Social support/services. The evidence-based interventions below are drawn from the peer-reviewed literature as well as expert syntheses from the community guide and other peer-reviewed sources, cited below. Communities and states have found these interventions to be successful in practice. Awardees are expected to use this list of evidence-based strategies to design a comprehensive and robust set of strategies to produce the desired outcomes for the initiative.

	Tobacco	Nutrition	Physical Activity
Media	<ul style="list-style-type: none"> • Media and advertising restrictions consistent with federal law. (k) • Hard hitting counter-advertising (l-n) • Ban brand-name sponsorships (o) • Ban branded promotional items and prizes (p) 	<ul style="list-style-type: none"> • Media and advertising restrictions consistent with federal law. (38-44) • Promote healthy food/drink choices (42, 43, 45) • Counter-advertising for unhealthy choices (46) 	<ul style="list-style-type: none"> • Promote increased physical activity (i, ii, vi, ix, xxix-xxx) • Promote use of public transit (i, ii, vi, ix, xxix-xxx) • Promote active transportation (bicycling and walking for commuting and leisure activities) (i, ii, vi, ix, xxix-xxx) • Counter-advertising for screen time (i, ii, vi, ix, xxix-xxx)
Access	<ul style="list-style-type: none"> • Usage bans (i.e. 100% smoke-free policies or 100% tobacco-free policies) (f, g, v) • Usage bans (tobacco-free school campuses) (e-g, h-j) • Zoning restrictions (e-g) • Restrict sales (e.g. internet; sales to minors; stores/events w/o tobacco) (e-g) • Ban self-service displays & vending (e-g) 	<ul style="list-style-type: none"> • Healthy food/drink availability (e.g., incentives to food retailers to locate/offer healthier choices in underserved areas, healthier choices in child care, schools, worksites) (7-9, 10-21, 63-68, 76-82) • Limit unhealthy food/drink availability (whole milk, sugar sweetened beverages, high-fat snacks) (17, 22-25, 69-73) • Reduce density of fast food establishments (15, 26) • Eliminate transfat through purchasing actions, labeling initiatives, restaurant standards (29-31) • Reduce sodium through purchasing actions, labeling initiatives, restaurant standards 	<ul style="list-style-type: none"> • Safe, attractive accessible places for activity (i.e., access to outdoor recreation facilities, enhance bicycling and walking infrastructure, place schools within residential areas, increase access to and coverage area of public transportation, mixed use development, reduce community design that lends to increased injuries) (xxxix – xli) • City planning, zoning and transportation (e.g., planning to include the provision of sidewalks, parks, mixed use, parks with adequate crime prevention measures, and Health Impact Assessments) (ii,iii,iv,v,viii,ix) • Require daily quality PE in schools

		<p>(32-34)</p> <ul style="list-style-type: none"> • Procurement policies and practices (8, 9, 13, 14, 35, 36) • Farm to institution, including schools, worksites, hospitals, and other community institutions (35, 36, 37) 	<p>(xvi – xxiii)</p> <ul style="list-style-type: none"> • Require daily physical activity in afterschool/childcare settings (i, ii, iii, v, viii, ix, xxiv-xxvii) • Restrict screen time (afterschool, daycare) (x, xi, xii, xiii, xiv)
Point of Purchase/ Promotion	<ul style="list-style-type: none"> • Restrict point of purchase advertising as allowable under federal law. (q) • Product placement (q) 	<ul style="list-style-type: none"> • Signage for healthy vs. less healthy items (8, 9, 47, 48, 74-75) • Product placement & attractiveness (8, 9, 47, 48, 49, 74-75) • Menu labeling (50-53) 	<ul style="list-style-type: none"> • Signage for neighborhood destinations in walkable/mixed-use areas (library, park, shops, etc) (ii, iii, iv, ix, xlxiii) • Signage for public transportation, bike lanes/boulevards (ii, iii, iv, ix, xlxii, xlxiii)
Price	<ul style="list-style-type: none"> • Use evidence-based pricing strategies to discourage tobacco use (a-c) • Ban free samples and price discounts (d) 	<ul style="list-style-type: none"> • Changing relative prices of healthy vs. unhealthy items (e.g. through bulk purchase/procurement/competitive pricing) (5-9, 60-62) 	<ul style="list-style-type: none"> • Reduced price for park/facility use (xxxvi – xxxviii) • Incentives for active transit (xxxvii, xxxviii) • Subsidized memberships to recreational facilities (ii, iii, viii, ix)
Social Support & Services	<ul style="list-style-type: none"> • Quitline and other cessation services (r-t) 	<ul style="list-style-type: none"> • Support breastfeeding through policy change and maternity care practices (54-59) 	<ul style="list-style-type: none"> • Safe routes to school (vii, xv, xxxi-xxxv) • Workplace, faith, park, neighborhood activity groups (e.g., walking, hiking, biking) (ii, iii, viii, ix)

Tobacco references

Use evidence-based strategies to discourage tobacco use

- Centers for Disease Control and Prevention. Reducing tobacco use: a report of the Surgeon General. Atlanta, GA: US Department of Health and Human Services, CDC; 2000
- Institute of Medicine. Ending the tobacco problem: a blueprint for the nation. Washington, DC: The National Academies Press; 2007.
- Task Force on Community Preventive Services. Guide to community preventive services: tobacco use prevention and control. Am J Prev Med 2001;20(2 Suppl 1):1--87.

Ban free samples and price discounts

- d. Loomis BR, Farrelly MC, Mann NH. The Association of retail promotions for cigarettes with the Master Settlement Agreement, tobacco control programmes and cigarette excise taxes. *Tob. Control* 2006; 15:458-63.

Access (youth specific)

- e. Centers for Disease Control and Prevention. Reducing tobacco use: a report of the Surgeon General. Atlanta, GA: US Department of Health and Human Services; 2000
- f. Institute of Medicine. Ending the tobacco problem: a blueprint for the nation. Washington, DC: The National Academies Press; 2007.
- g. Task Force on Community Preventive Services. Guide to community preventive services: tobacco use prevention and control. *Am J Prev Med* 2001;20(2 Suppl 1):1--87.

Usage bans (smoke free campuses)

- h. Pentz MA. The power of policy: the relationship of smoking policy to adolescent smoking. *American journal of public health* 1989;79(7):857-62.
- i. Wakefield MA. Effect of restrictions on smoking at home, at school, and in public places on teenage smoking: cross sectional study. *BMJ* 2000;321(7257):333-7.
- j. Kumar R. School tobacco control policies related to students' smoking and attitudes toward smoking: national survey results, 1999-2000. *Health education & behavior* 2005;32(6):780-94.

Media and advertising restrictions

- k. National Cancer Institute. The role of the media in promoting and reducing tobacco use. Tobacco Control Monograph, No. 19; 2008.

Hard-hitting counter-advertising

- l. Task Force on Community Preventive Services. Guide to community preventive services: tobacco use prevention and control. *Am J Prev Med* 2001;20(2 Suppl 1):1--87.
- m. National Cancer Institute. The role of the media in promoting and reducing tobacco use. Tobacco Control Monograph, No. 19; 2008.
- n. Institute of Medicine. Ending the tobacco problem: a blueprint for the nation. Washington, DC: The National Academies Press; 2007.

Ban Brand-name sponsorship

- o. National Cancer Institute. The role of the media in promoting and reducing tobacco use. Tobacco Control Monograph, No. 19; 2008.

Ban Branded promotional items and prizes

- p. National Cancer Institute. The role of the media in promoting and reducing tobacco use. Tobacco Control Monograph, No. 19; 2008.

Restrict point of purchase advertising/product placement

- q. National Cancer Institute. The role of the media in promoting and reducing tobacco use. Tobacco Control Monograph, No. 19; 2008.

Quitline and other cessation services

- r. Fiore MC, Jaen CR, Baker, TB, et al. Treating tobacco use and dependence: 2008 Update. Quick Reference Guide for Clinicians. Public Health Service; 2008.
- s. Task Force on Community Preventive Services. Guide to community preventive services: tobacco use prevention and control. *Am J Prev Med* 2001;20(2 Suppl 1):1--87.
- t. Institute of Medicine. Ending the tobacco problem: a blueprint for the nation. Washington, DC: The National Academies Press; 2007.

Nutrition References

1. Dietary Guidelines for Americans, 2005. U.S. Department of Health and Human Services and U.S. Department of Agriculture. Dietary Guidelines for Americans, 2005. 6th Edition, Washington, DC: U.S. Government Printing Office, January 2005. Foods Encouraged, Available at: <http://www.health.gov/DietaryGuidelines/dga2005/document/html/chapter5.htm>
5. French, S.A., M. Story, and R.W. Jeffery, *Environmental influences on eating and physical activity*. *Annu Rev Public Health*, 2001. 22: p. 309-35.
6. French SA, Wechsler H. School-based research and initiatives: fruit and vegetable environment, policy, and pricing workshop. *Prev Med*. 2004 Sep;39 Suppl 2:S101-7.
7. Ayala G. et al., 2009 – Evaluation of the Healthy Tienda project. The Public Health Effects of Food Deserts. Workshop Summary. Institute of Medicine and National Research Council, p 49-51. <http://www.iom.edu/Object.File/Master/62/082/Session%204%20920%20am%20Ayala.pdf>.
8. Glanz K, Yaroch AL. Strategies for increasing fruit and vegetable intake in grocery stores and communities: policy, pricing, and environmental change. *Prev Med*. 2004 Sep;39 Suppl 2:S75-80. Review.
9. Nonas C, 2009. Health Bucks in New York City. The Public Health Effects of Food Deserts. Workshop Summary. Institute of Medicine and National Research Council, p 59-60. Available at <http://www.iom.edu/CMS/3788/59640/62040/62078.aspx>

Increase healthy food/drink availability (e.g., grocery, child care, schools, worksites)

Grocery

10. Bodor, J. N., Rose, D., Farley, T. A., Swalm, C., & Scott, S. K. (2007). Neighbourhood fruit and vegetable availability and consumption: the role of small food stores in an urban environment. *Public Health Nutrition*.
11. Gittelsohn J, Ethelbah M. Evaluation of the White Mountain and San Carlos Apache Healthy Stores Program, a multi-component intervention that included stocking healthier food items. Available at <http://www.farmfoundation.org/news/articlefiles/450-Gittelsohn.pdf>.
12. Morland K, Diez Roux AV, Wing S. *Am J Prev Med*. 2006 Apr;30(4):333-9 Supermarkets, other food stores, and obesity: the atherosclerosis risk in communities study.
13. Larson, N., Story, M., & Nelson, M. (2009). Neighborhood Environments Disparities in Access to Healthy Foods in the U. S. *American Journal of Preventive Medicine*. 36(1):74-81.
14. Story M, Kaphingst KM, Robinson-O'Brien R, Glanz K. Creating healthy food and eating environments: policy and environmental approaches. *Annu Rev Public Health*. 2008;29:253-72.
15. Moore, L.V., et al., *Associations of the local food environment with diet quality--a comparison of assessments based on surveys and geographic information systems: the multi-ethnic study of atherosclerosis*. *Am J Epidemiol*, 2008. 167(8): p. 917-24.

Childcare

16. Ward, D. S., Benjamin, S. E., Ammerman, A. S., Ball, S. C., Neelon, B. H., & Bangdiwala, S. I. (2008). Nutrition and physical activity in child care: results from an environmental intervention. *Am J Prev Med.*, 35(4), 352-356. Epub 2008.

School

17. IOM (2007). Nutrition Standards for Foods in Schools: Leading the Way Toward Healthier Youth Committee on Nutrition Standards for Foods in Schools. Washington, D.C., The National Academies Press.

18. Ritenbaugh C, Tuefel-Shone N, et al. A lifestyle intervention improves plasma insulin levels among Native American high school youth. *Prev Med.*2003;36:309-319.

19. Jaime, P.C. and K. Lock, Do school based food and nutrition policies improve diet and reduce obesity? *Prev Med*, 2009. 48(1): p. 45-53.

Worksite

20. Sorensen, G., Linnan, L., & Hunt, M. K. (2004). Worksite-based research and initiatives to increase fruit and vegetable consumption. *Prev.Med.*, 39 Suppl 2, S94-100.

21. The Community Guide to Preventive Services. Obesity prevention through worksite programs. Available at <http://www.thecommunityguide.org/obesity/workprograms.html>

Limit unhealthy food/drink availability (whole milk, sugar sweetened beverages, snacks)

See Ref 17

22. Schwartz, M. B., Novak, S. A., & Fiore, S. S. (2009). The Impact of Removing Snacks of Low Nutritional Value From Middle Schools. *Health Educ Behav*, 5, 5.

23. Kubik, M.Y., et al., *The association of the school food environment with dietary behaviors of young adolescents*. *Am J Public Health*, 2003. 93(7): p. 1168-73.

24. Cullen, K.W. and I. Zakeri, *Fruits, vegetables, milk, and sweetened beverages consumption and access to a la carte/snack bar meals at school*. *Am J Public Health*, 2004. 94(3): p. 463-7.

25. Templeton, S.B., M.A. Marlette, and M. Panemangalore, *Competitive foods increase the intake of energy and decrease the intake of certain nutrients by adolescents consuming school lunch*. *J Am Diet Assoc*, 2005. 105(2): p. 215-20.

Reduce density fast food establishments

See Refs 12, 15

26. Ashe M, Jernigan D, Kline R, Galaz R. Land use planning and the control of alcohol, tobacco, firearms, and fast food restaurants. *Am J Pub Health*. 2003;93(9):1404-1408.

Eliminate trans fat

29. Mozaffarian D. Katan MB. Ascherio A. Stampfer MJ. Willett WC. Trans Fatty Acids and Cardiovascular Disease. *New England Journal of Medicine*. April 13, 2006. 354;15:1601-13.

30. Panel on Macronutrients, Institute of Medicine. Letter report on dietary reference intakes for trans fatty acids drawn from the Report on dietary reference intakes for energy, carbohydrate, fiber, fat, fatty acids, cholesterol, protein, and amino acids. Washington, DC 2003.

31. Trans Fat Regulation: NYC Department of Health and Mental Hygiene – Board of Health Approves Regulation to Phase Out Artificial Trans Fat. Available at:

<http://www.nyc.gov/html/doh/html/cardio/cardio-transfat-healthcode.shtml>; How to Comply: What Restaurants, Caterers, Food-Vending Units, and Others Need to Know” Accessed June 24, 2009
<http://www.nyc.gov/html/doh/downloads/pdf/cardio/cardio-transfat-bro.pdf>

Reduce sodium

32. Sacks, FM et al.(2001) Effects on blood pressure of reduced dietary sodium and the Dietary Approaches to Stop Hypertension (DASH) diet. DASH-Sodium Collaborative Research Group. New England Journal of Medicine 344(1):3-10.

33. City Purchasing Standards: New York City executive order for formal nutrition standards for all food purchased or served by New York City agencies including sodium. Available at :
<http://www.nyc.gov/html/doh/downloads/pdf/cardio/cardio-food-standards.pdf>

34. New York City, Advocacy for External Efforts: Initiative to develop a voluntary partnership with industry leaders to reduce the level of sodium in processed and prepared foods nationwide. Available at:
<http://www.nyc.gov/html/doh/html/cardio/cardio-salt-initiative.shtml>

Procurement policies and practices

See Refs 8, 9, 13, 14

35. Joshi, A., & Azuma, A. (2008). Do Farm-to-School Programs Make a Difference? Findings and Future Research Needs. *Journal of Hunger & Environmental Nutrition*, 3, 2-3.

36. Zudrow D (2005) Food Security Begins at Home: Creating Community Food Coalitions in the South. Southern Sustainable Agriculture Working Group, pp 45-67, Available at: <http://www.ssawg.org/cfs-handbook.html>

Farm to institution

See Ref 35

37. Texas, Farm to Work program. Farm to Work Initiative of the Texas State Health Service provides a Farm to Work Toolkit. Available at <http://www.texasbringinghealthyback.org/> and <http://www.dshs.state.tx.us/obesity/pdf/F2WToolkit1008.pdf>

Media and advertising restrictions

38. The Guide to Community Preventive Services - Obesity Prevention: Interventions to Reduce Screen Time <http://www.thecommunityguide.org/obesity/screentime/index.html>

39. Story M, French S. Food Advertising and Marketing Directed at Children and Adolescents in the US. Int J Behav Nutr Phys Act. 2004 Feb 10;1(1):3.

40. Chou SY, Rashad I, Grossman M. Fast-Food Restaurant Advertising on Television and Its Influence on Childhood Obesity. *The Journal of Law and Economics*, 2008;51; p 599-618

41. Coon KA, Tucker KL: Television and children's consumption patterns. A review of the literature. *Minerva Pediatr* 2002, 54:423-436.

42. WHO. 2004. Global Strategy on Diet, Physical Activity and Health. WHA 57.17. Geneva: WHO. Available at
http://apps.who.int/gb/ebwha/pdf_files/WHA57/A57_R17-en.pdf

43. Norwegian ministry of Children and Family Affairs, 2005. Norway enacted a ban on TV advertisements to children ages 12 years and younger in 1992. Available at <http://www.regjeringen.no/en/dep/bld/Documents/Reports-and-plans/Plans/2003-2/The-Norwegian-action-plan-to-reduce-comm.html?id=462256>

44. Kwate, NOA. Take one down, pass it around, 98 alcohol ads on the wall: outdoor advertising in New York City's Black neighbourhoods. *International Journal of Epidemiology*. 2007; 36 (5): 988-990.

Promote healthy food/drink choices

See Refs 42, 43

45. Evidence of impact of advertising on food and beverage purchase requests of 2-11 year olds and usual dietary intake of 2-5 year olds: IOM (2006), Committee on Food Marketing and the Diets of Children and Youth. Food Marketing to Children and Youth: Threat or Opportunity? Washington, D.C., National Academies Press.

Counteradvertising for unhealthy choices

46. Dixon HG, Scully ML, Wakefield MA, White VM, Crawford DA. The effects of television advertisements for junk food versus nutritious food on children's food attitudes and preferences. *Soc Sci Med*. 2007 Oct;65(7):1311-23.

Signage for healthy vs. less healthy items

See Refs 8, 9

47. Seymour JD, Yaroch AL, Serdula M, Blanck HM, Khan LK. Impact of nutrition environmental interventions on point-of-purchase behavior in adults: a review. *Prev Med*. 2004 Sep;39 Suppl 2:S108-36. Review.

48. Glanz K, Hoelscher D. Increasing fruit and vegetable intake by changing environments, policy and pricing: restaurant-based research, strategies, and recommendations. *Prev Med*. 2004 Sep;39 Suppl 2:S88-93.

Product placement & attractiveness

Ref 8, 9, 47, 48

49. Curhan, R.C., The effects of merchandising and temporary promotional activities on the sales of fresh fruit and vegetables in supermarket. *Journal of Marketing Research* 1974. 11: p. 286-94.

Menu labeling

50. Bassett, M.T., et al., Purchasing behavior and calorie information at fast-food chains in New York City, 2007. *Am J Public Health*, 2008. 98(8): p. 1457-9.

51. Simon, Jarosz, Kuo & Fielding. Menu Labeling as a Potential Strategy for Combating the Obesity Epidemic: A Health Impact Assessment. Los Angeles, CA: Los Angeles County Dept of Public Health; 2008

52. Burton S and Creyer EH. "What Consumers Don't Know Can Hurt Them: Consumer Evaluations and Disease Risk Perceptions of Restaurant Menu Items." *Journal of Consumer Affairs*, 38(1): 121-45, 2004.

53. Kozup KC, Creyer EH and Burton S. "Making Healthful Food Choices: The Influence of Health Claims and Nutrition Information on Consumers' Evaluations of Packaged Food Products and Restaurant Menu Items." *Journal of Marketing*, 67(2): 19-34, 2003.

Support Breastfeeding

54. Philipp BL et al. 2001. Baby-Friendly Hospital Initiative Improves Breastfeeding Initiation Rates in a US Hospital Setting. *Pediatrics* 108(3):677-681.
55. DiGirolamo AM, Grummer-Strawn LM, Fein SB. Effect of Maternity-Care Practices on Breastfeeding. *Pediatrics* 2008 October 1;122(Supplement_2):S43-S49.
56. Baby-Friendly USA. Implementing the UNICEF/WHO Baby Friendly Hospital Initiative in the U.S; Available at: <http://www.babyfriendlyusa.org/eng/index.html> Accessed June 24, 2009.
57. Cohen R, Mrtek MB. The impact of two corporate lactation programs on the incidence and duration of breastfeeding by employed mothers. *American Journal of Health Promotion* 1994;8(6):436-41.
58. Fein SB, Mandal B, Roe BE. Success of Strategies for Combining Employment and Breastfeeding. *Pediatrics* 2008 October 1;122(Supplement_2):S56-S62.
59. Health Resources and Services Administration. The Business Case for Breastfeeding Toolkit. HRSA 2008; Available at: <http://ask.hrsa.gov/detail.cfm?PubID=MCH00254&recommended=1> Accessed June 2, 2009.

Selective Pricing (schools)

60. French, S.A., Story, M., Jefferey, R.W., Snyder, P., Marla, E., Sidebottom, A., & Murray, D. (1997). Pricing strategy to promote fruit and vegetable purchase in high school cafeterias. *J Am Diet Assoc*, 97(9): 1008-1010.
61. French, S.A., Jefferey, R.W., Story, M., Breitlow, K.K., Baxter, J.S., Hannan, P., & Snyder, M.P. (2001). Pricing and promotion effects on low-fat vending snack purchases: The CHIPS study. *Am J Public Health*, 91(1): 112-117.
62. Hannan, P., French, S.A., Story, M., & Fulkerson, J.A. (2002). A pricing strategy to promote sales of lower fat foods in high school cafeterias: Acceptability and sensitivity analysis. *Am J Hlth Prom*, 17(1): 1-6.

Healthy food/drink availability (schools)

63. Cullen, K.W., Hartstein, J., Reynolds, K.D., Vu, M., Resnicow, K., Greene, N., et al., 2007. Improving the school food environment: results from a pilot study in middle schools. *J. Am. Diet Assoc.* 107 (3), 484-489.
64. Lytle, L.A., Kubik, M.Y., Perry, C., Story, M., Birnbaum, A.S., Murray, D.M., 2006. Influencing healthful food choices in school and home environments: results from the TEENS study. *Prev. Med.* 43 (1), 8-13.
65. Perry, C.L., Bishop, D.B., Taylor, G.L., Davis, M., Story, M., Gray, C., et al., 2004. A randomized school trial of environmental strategies to encourage fruit and vegetable consumption among children. *Health Educ. Behav.* 31 (1), 65-76.
66. Sahota, P., Rudolf, M.C., Dixey, R., Hill, A.J., Barth, J.H., Cade, J., 2001. Evaluation of implementation and effect of primary school based intervention to reduce risk factors for obesity. *BMJ* 323 (7320), 1027-1029.
67. Sahota, P., Rudolf, M.C., Dixey, R., Hill, A.J., Barth, J.H., Cade, J., 2001. Randomised controlled trial of primary school based intervention to reduce risk factors for obesity. *BMJ* 323 (7320), 1029-1032.

68. Muckelbauer R, Libuda L, Clausen K, Toschke AM, Reinehr T, Kersting M. Promotion and provision of drinking water in schools for overweight prevention: Randomized, controlled cluster trial. *Pediatrics* 2009;123:e661-e667

Limit unhealthy food/drink

69. Cullen, K.W., Hartstein, J., Reynolds, K.D., Vu, M., Resnicow, K., Greene, N., et al., 2007. Improving the school food environment: results from a pilot study in middle schools. *J. Am. Diet Assoc.* 107 (3), 484–489.

70. Cullen, K.W., Watson, K., Zakeri, I., Ralston, K., 2006. Exploring changes in middle-school student lunch consumption after local school food service policy modifications. *Public Health Nutr.* 9 (6), 814–820.

71. Cullen, K.W., Watson, K. 2009. The Impact of the Texas Public School Nutrition Policy on Student Food Selection and Sales in Texas. *Am J Public Health.* 2009 Apr;99(4):706-12

72. Kubik M, Lytle L, Hannan P, Perry C, Story M. The association of the school food environment with dietary behaviors of young adolescents. *Am J Public Health* 2003;93:1168-73.

73. Stone, E.J., Osganian, S.K., McKinlay, S.M., Wu, M.C., Webber, L.S., Luepker, R.V., et al., 1996. Operational design and quality control in the CATCH multicenter trial. *Prev. Med.* 25 (4), 384–399.

Farm to institution

See Ref 35

Point of purchase promotion (in schools)

74. French, S. A., Jeffery, R. W., Story, M., Breitlow, K. K., Baxter, J. S., Hannan, P. & Snyder, M. P. (2001) Pricing and promotion effects on low-fat vending snack purchases: The CHIPS study. *Am. J. Public Health* 91:112-117.

75. French SA, Story M, Fulkerson JA, Hannan P. An Environmental Intervention to Promote Lower-Fat Food Choices in Secondary Schools: Outcomes of the TACOS Study. *Am J Public Health* 2004;94:1507-12

76. Institute of Medicine. *Local Government Actions to Prevent Childhood Obesity*. Washington, DC: The National Academies Press; 2009.

77. COCOMO

78. Ed Bolen et al., *Neighborhood Groceries: New Access to Healthy Food in Low-Income Communities*, (San Francisco, CA: California Food Policy Advocates, 2003).

79 PolicyLink: Equitable Development Toolkit: Healthy Food Retailing provides an online tool that focuses on increasing access to retail outlets that sell nutritious, affordable food in low-income communities of color. <http://www.policylink.org/EDTK/HealthyFoodRetailing>

80. Gittelsohn, J., et al., Process Evaluation of Baltimore Healthy Stores: A Pilot Health Intervention Program With Supermarkets and Corner Stores in Baltimore City. *Health Promot Pract*, 2009.

81. Flournoy R and Treuhaft S (2005). *Healthy food, healthy communities: improving access and opportunities through food retailing*. Oakland, CA: PolicyLink.

82. Bitler, M., and S. J. Haider. *An Economic View of Food Deserts in the United States. Research Conference on Understanding the Economic Concepts and Characteristics of Food Access*. Washington, DC: USDA, Economic Research Service and University of Michigan National Poverty Center, 2009.

Physical Activity References

- i. US Department of Health and Human Services. Physical Activity Guidelines for Americans. Available at: <http://www.health.gov/PAGuidelines/>
- ii. The Guide to Community Preventive Services: What works to Promote Health?. Oxford University Press, 2005, pp 80-113.
The Guide to Community Preventive Services is also Available at:
<http://www.thecommunityguide.org/pa/index.html>
- iii. Kahn, E.B., Ramsey, L.T., Brownson, R.C., Heath, G.W., Howze, E.H., Powell, K.E. et al. 2002. The effectiveness of interventions to increase physical activity. A systematic review by the U.S. Task Force on Community Preventive Services. *American Journal of Preventive Medicine* 22, S73–102.
- iv. Heath GW, Brownson RC, Kruger J, et al. The effectiveness of urban design and land use and transport policies and practices to increase physical activity: a systematic review. *J Phys Act Health*. 2006;3(suppl 1):S55-S76.
- v. Hoehner CM, Soares J, Parra DP, Ribeiro IC, Joshi C, Pratt M et al. 2008. Systematic review of physical activity interventions in Latin America. *Am J Prev Med* 34(3), 224-233
- vi. Roux L, Pratt M, Tengs TO, Yanagawa T, Yore M, et al., 2008. Cost Effectiveness of Community-based Physical Activity Interventions. *Am J Prev Med* 35(6), 578-588
- vii. Active Living Research Brief. Walking and biking to school, physical activity and health outcomes. May 2009
- viii. Ramsey LT, Brownson RC. Increasing physical activity. *Am J Prev Med* 2002 (4S); 73-107
- ix. Centers for Disease Control and Prevention. Planning, implementing and evaluating interventions. Available at: http://www.cdc.gov/nccdphp/dnpa/physical/health_professionals/interventions/index.htm
- x. The Guide to Community Preventive Services - Obesity Prevention: Interventions to Reduce Screen Time. <http://www.thecommunityguide.org/obesity/screentime/index.html>
- xi. New York City Amendments to the NYC Health Code (established limits on passive, sedentary TV viewing in group childcare services to 60 minutes or less per day. http://www.frac.org/pdf/nyc_cacfp_childcare_nutrphysact_law.pdf
- xii. Delaware Child Care Policy to Improve Children's Health: regulatory changes through the Office of Child Care Licensing for all childcare in DE (center-based, family and after-school) that limit sedentary and media exposure to a maximum of 1 hour per day for children >2 years. <http://www.nemours.org/department/nhps/policy-leader/child-care.html>
- xiii. Benjamin SE, Cradock A Walker EM, Slining M, Gillman MW. Obesity prevention in child care: a review of U.S. state regulations. *BMC Public Health*. 2008;8:188.
- xiv. Kaphingst LM, Story M. Child care as an untapped setting for obesity prevention: State child care licensing regulations related to nutrition, physical activity, and media use for preschool-aged children in the United States. *Preventing Chronic Disease*. 2009;6:1.

xv. Centers for Disease Control and Prevention. Kids Walk to School. Available at: <http://www.cdc.gov/nccdphp/dnpa/kidswalk/>

Require daily quality PE

xvi. Kahn EB, Ramsey LT, Brownson RC, Heath GW, Howze EH, Powell KE. The effectiveness of interventions to increase physical activity: a systematic review. *Am J Prev Med* 2002; 22(4S): 73-107.

xvii. McKenzie TL, Nader PL, Strikmiller PK, Yang M, Stone EJ, Perry CL, et al. School physical education: effect of the Child and Adolescent Trial for Cardiovascular Health. *Prev Med* 1996 25:423-431.

xviii. Pangrazi RP, Beighle A, Vehige T, Vack C. Impact of Promoting Lifestyle Activity for Youth (PLAY) on children's physical activity. *J Sch Health* 73(8): 317-321.

xix. Pate RR, Ward DS, Saunders RP, Felton G, Dishman RK, Dowda M. Promotion of physical activity among high school girls: a randomized controlled trial. *Am J Public Health* 2005; 95(9): 1582-1587.

xx. Harrell JS, McMurray RG, Bangdiwala SI, Frauman AC, Gansky SA, Bradley CB. Effects of a school-based intervention to reduce cardiovascular disease risk factors in elementary-school children: The Cardiovascular Health in Children (CHIC Study). *J Pediatr* 1996; 128:797-805.

xxi. Reed KE, Warburton DER, Macdonald HM, Naylor PJ, McKay HA. Action schools! BC: a school-based physical activity intervention designed to decrease cardiovascular risk factors in children. *Prev Med* 2008; 46:525-531.

xxii. Webber LS, Catellier DJ, Lytle LA, Murray DM, Pratt CA, Young DR, et al. Promoting physical activity in middle school girls: Trial of Activity for Adolescent Girls. *Am J Prev Med* 2008; 34(3): 173-184.

xxiii. Manios Y, Moschandreas J, Hatzis C, Kafatos A. Evaluation of a health and nutrition education program in primary school children of Crete over a three-year period. *Prev Med* 1999; 28:149-159.

Daily physical activity in after school

xxiv. Sallis JF, McKenzie TL, Conway TL, Elder JP, Prochaska JJ, Brown M et al. Environmental interventions for eating and physical activity: a randomized controlled trial in middle schools. *Am J Prev Med* 2003;24:209-17.

xxv. Kelder S, Hoelscher DM, Barroso CS, Walker JL, Cribb P, Shaohua H. The CATCH Kids Club: a pilot after-school study for improving elementary students' nutrition and physical activity. *Public Health Nutrition* 2005; 8(2): 133-140.

xxvi. Story M, Sherwood NE, Himes JH, Davis M, Jacobs DR, et al. An after-school obesity prevention program for African American girls: the Minnesota GEMS pilot study. *Ethn Dis* 2003; 13(1 suppl 1): S54-64.

xxvii. Yin, et al. Medical College of Georgia Fitkid Project. *Evaluation & the Health Professions* 2005; 67-89.

xxviii. Kien LC & Chiodo AR. Physical activity in middle school-aged children participating in a school-based recreation program. *Arch Pediatr Adolesc Med* 2003; 157:811-815.

Media to promote increased physical activity

xxix. Huhman M, Potter LD, Wong FL, Banspach SW, Duke JC, Heitzler CD. Effects of a mass media campaign to increase physical activity among children: year 1 results of the VERB campaign. *Pediatrics* 2005;116:e277-3284.

xxx. Huhman M, Bauman A, Bowles HR. Initial outcomes of the VERB campaign: tweens' awareness and understanding of campaign messages. *Am J Prev Med* 2008; 34(6S):S241-S248.

Safe routes to school

xxxii. Cooper AR, Page AS, Foster LJ, Qahwaji D. Commuting to school: are children who walk more physically active? *Am J Prev Med* 2003;25:273-6.

xxxiii. Cooper AR. Physical activity levels of children who walk, cycle, or are driven to school. *Am J Prev Med* 2005;29:179-84.

xxxiiii. Tudor-Locke C, Neff LJ, Ainsworth BE, Addy CL, Popkin BM. Omission of active commuting to school and the prevalence of children's health-related physical activity levels: the Russian Longitudinal Monitoring Study. *Child Care Health Dev* 2002;28:507-12.

xxxv. Alexander LM, Inchley J, Todd J, Currie D, Cooper AR, Currie C. The broader impact of walking to school among adolescents: seven day accelerometry based study. *BMJ* 2005;331:1061-2.

xxxvi. Sirard J, Riner WJ, McIver K, Pate R. Physical activity and active commuting to elementary school. *Med Sci Sports Exerc* 2005;37:2062-9.

Reduced cost and use

xxxvii. Managed-Medicare health club benefit and reduced health care costs among older adults. Nguyen HQ, Ackerman RT, Maciejewski M, Berke E, Patrick M, Williams B, LoGerfo JP. *Prev. Chronic Disease*, 2008 Jan 5(1) A14. Epub 2007 Dec 15.

xxxviii. Economic interventions to promote physical activity. Application of the SLOTH model. Pratt, M, Macera CA, Sallis JF, O'Donnell M, Frank LD. *Am J Prev. Med* 2004, 27(S1)

xxxix. The economics of physical activity: Societal trends and rationales for interventions. Strum R, *Am J Prev. Med*, 2004, 27 (S1).

Safety and Park Use

xl. The built environment, neighborhood crime and constrained physical activity: An exploration of inconsistent findings. Foster, S, Giles-Corti B. *Prev Med* 2008, 47 (3) pp 241-251.

xli. Unsafe to play? Neighborhood disorder and lack of safety predict reduced physical activity among urban children and adolescents. Molnar, S, Gortmaker, S, Bull F, Buka SL. *Am J Health Prom* 2004, 18(5) pp 378-386.

xlii. Parents' perceptions of neighborhood safety and children's physical activity. Weir, L, Etelson D, Brand D. *Prev. Med* 2006, 43(3) pp 212-217.

xliii. Besser LM, Dannenberg AL. Walking to public transit: steps to help meet physical activity recommendations. *Am J Prev Med*. 2005; 29(4):273-80.

xliv. MMWR: Morbidity and Mortality Weekly Report. Recommended community strategies and measurements to prevent obesity in the United States. Centers for Disease Control and Prevention. July 24, 2009 58(RR07);1-26. <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5807a1.htm>

Additional references

Comprehensive State and Community Programs

Arkansas Center for Health Improvement. Assessment of childhood and adolescent obesity in Arkansas; Year Four

Economos CD, et al. A community intervention reduces BMI z-score in children: Shape Up Somerville first year results. *Obesity* 2007;15:1325

Hoelscher DM et al. Regional and state initiatives lead to significant decreases in the prevalence of child overweight in Texas. Manuscript submitted.

Other references for “Signage prompts” for deterring sedentary behavior:

R.E Andersen, S.C Franckowiak, J Snyder, S.J Bartlett and K.R Fontaine, Can inexpensive signs encourage the use of stairs? Results from a community intervention, *Ann Intern Med* **129** (1998), pp. 363–369.

J Kerr, F Eves and D Carroll, Posters can prompt less active people to use the stairs, *J Epidemiol Community Health* **54** (2000), pp. 942–943.

W Russell, D Dzewaltowski and G Ryan, The effectiveness of a point-of-decision prompt in deterring sedentary behavior, *Am J Health Promot* **13** (1999), pp. 257–259.

APPENDIX B: Sample Policy Analysis Worksheet (*text in blue italics should be replaced as you use the worksheet*)

Domain: (*Nutrition, Physical Activity, Tobacco*)

Current Status of Policy/Environmental Supports and Barriers:

Policy or Environmental Change Strategy: (*selected from the table in Appendix C: Intervention Strategies for State and Territory Policy, Environmental Change*)

Potential Reach: (*How many members of the population will be affected by the policy change and what will the effect of the policy change be on nutrition, physical activity or tobacco issues in the population*) [*intended effect here looks redundant with the impact items below. Suggest reworking and reordering as follows:*

Intended Effect/Impact: (*what will the effect of the policy change be on nutrition, physical activity or tobacco issues in the population in both the short and long-run*)

Short Term Health Impact: (*What is the short term impact of implementing this strategy?*)

Long Term Health Impact: (*What is the long term impact of implementing this strategy?*)

Key Partners: (*Identify the most influential partners and decision makers who will be critical to the successful implementation of this strategy.*)

Coordination With Other Recovery Act Efforts: (*Identify opportunities for coordination with related Recovery Act efforts from other sectors, such as transportation, education, health care delivery, agriculture and others. See attachment X for examples*)

Supportive Factors: (*What is taking place in the state that is working in favor of this change? Are there opportunities to leverage existing activities/initiatives?*)

Restraining Factors: (*What is taking place in the state that might work against this change?*)

Past Attempts and Lessons Learned: (*Brief description of past efforts to implement this or similar changes in the state? What lessons were learned and what steps will be taken to mitigate risk?*)

Sustainability Strategies: (*Describe steps to sustain the impact of Recovery Act investments beyond the federal funding provided.*)

Appendix C: US Government-funded Recovery Act Programs Potentially Leveraged by the Prevention and Wellness Communities Program

Applicants showing collaboration and leveraging across agencies similar to the ones noted below will help demonstrate the applicants' commitment to the public health issues addressed in this FOA. These are potential areas of collaboration, not required projects.

US Department of Transportation

- Federal Highway Administration funding for park roads, parkways, forest highways, ferry boats, etc.
- Special discretionary grant program to fund large transportation projects of all modes with costs between \$20 and \$300 million.
- Supplemental Grants for a National Surface Transportation System.
- Federal Transit Administration capital assistance grants to public transit agencies for capital improvements to assist in reducing energy consumption.

US Department of Agriculture

- Special Supplemental Nutrition Program for Women, Infants, and Children The Emergency Food Assistance Program
- Food Distribution Programs on Indian Reservations
- National School Lunch Program funding for schools to make necessary improvements to school kitchens in order to handle and process healthy foods.
- US Forest Service projects involving capital improvement, bridges, trails, reconstruction, forest improvement and enhancement.
- Recognize excellence in nutrition and physical activity by increasing the number of schools certified as a Healthier US School Challenge School
- Rural Development Water and Waste Disposal program to provide loans and grants for rural water and wastewater infrastructure
- Rural Community Facilities Program loans and grants to develop essential community facilities in rural areas and towns of up to 20,000 in population. Funds to be used for facility acquisition, construction, renovation, or the purchase of equipment and furnishings
- Team Nutrition is an initiative of the USDA Food and Nutrition Service to support the Child Nutrition Programs through training and technical assistance for foodservice, nutrition education for children and their caregivers, and school and community support for healthy eating and physical activity.
- Expanded Food and Nutrition Education Program (EFNEP) is designed to assist limited-resource audiences in acquiring the knowledge, skills, attitudes, and changed behavior necessary for nutritionally sound diets, and to contribute to their personal development and the improvement of the total family diet and nutritional well-being.
- Community Food Projects are designed to increase food security in communities by bringing the whole food system together to assess strengths, establish linkages, and create systems that improve the self-reliance of community members over their food needs.

- Kids in the Woods is an agency-wide effort to focus attention and resources in connecting children with nature and their public lands. Efforts encompass a range of activities and programs including summer camping and hiking programs, service opportunities, classroom presentations and engagement, and special events such as National Get Outdoors Day and National Public Lands Day.
- Get Fit with US - Forests are working with communities as a part of Get Fit with US to increase participation in outdoor recreation, thereby leading to healthier lifestyles.
- Winter Trails Day - Numerous forests are partnering with communities to host Winter Trails Day (and Winter Feels Good) activities to promote winter recreation activities like snowshoeing and cross country skiing to increase physical activity during the winter months.
- Summer Food Service Program is the single largest Federal resource available for local organizations that want to combine a feeding program with a summer activity program for children.
- School Breakfast Program provides cash assistance to States to operate nonprofit breakfast programs in schools and residential childcare institutions.
- National School Lunch Program funding for schools to make necessary improvements to school kitchens in order to handle and process healthy foods.
- Participates in the National School Lunch Program and receives and utilizes Team Nutrition materials.
- Conservation Youth Corps - Provides “at risk” youth with additional education and skills so they can make better health choices and avoid risky behavior.

US Department of Interior

- Construction projects at US Fish and Wildlife Service facilities
- US Fish and Wildlife programs for habitat restoration, deferred maintenance, trail maintenance, and renewable energy projects.
- Bureau of Indian Affairs construction projects, including improvements and repairs to buildings, roads, schools, and jails on Tribal lands.
- National Park Service construction and rehabilitation of major buildings, roads, and historic sites

US Department of Education

- Carol M. White Physical Education Program (page G-56: <http://www.ed.gov/about/overview/budget/budget10/justifications/g-ssce.pdf>)
- Safe and drug-free schools and communities: National programs (Page G-24: <http://www.ed.gov/about/overview/budget/budget10/justifications/g-ssce.pdf>)

Environmental Protection Agency

- Clean Water State Revolving Fund.
- Brownfields projects to address environmental site assessment and cleanup. Funds will capitalize revolving funds and provide low interest loans, job training grants and technical assistance to local governments and non-profit organizations.

US Department of Housing and Urban Development

- Community Development Block Grants (& Indian CDBG) with eligible activities include housing rehab that will include site improvements and development of community infrastructure which can improve walkable community design and investments that promote physical activity.
- Public Housing Capital Fund for capital repairs and improvements to federally-subsidized public housing, including renovations and retrofits that improve walkability and community investments that promote physical activity.
- Native American Housing Block Grants for capital investments in energy efficiency and development of sustainable communities, including walkability and investments that promote physical activity.
- Lead Hazard Reduction Grants invested in lead paint hazard reduction abatement activities (not directly related to initiative's goals, but health-related)
- The OHHLHC Healthy Homes Demonstration (HHD) grants are well-suited for leveraging with HHS's initiative. There were 20 ARRA HHD grants awarded in the past few months in communities across the country.
- Specifically, the purpose of the HHD grant program is to "develop, demonstrate, and promote cost-effective, preventive measures to correct
- The Healthy Homes Demonstration Program is committed to supporting the Departmental Strategic Goal of strengthening communities by addressing housing conditions that threaten health.

US Federal Emergency Management Administration

- Emergency Food and Shelter Program

US Department of Health and Human Services

- The Community Health Center Program which provides community-based primary and preventive health services including outreach and health education.
- Head Start which supports a comprehensive array of health, nutritional and social services to eligible four and five year old preschoolers and their families.
- Early Head Start which promotes healthy prenatal outcomes for pregnant women, enhances the development of very young children, and promotes healthy family functioning.
- Senior Nutrition Programs to support congregate nutrition services provided at senior centers and other community sites, home delivered nutrition services delivered to frail elders at home, and Native American nutrition programs.
- Child Care and Development Fund enables low-income parents and parents receiving Temporary Assistance for Needy Families (TANF) to work or to participate in the educational or training programs they need in order to work. Funds may also be used to serve children in protective services. In addition, a portion of CCDF funds must be used to enhance child care quality and availability.

Appendix D – State Policy and Environmental Change Funding Chart (Non-Competitive)

State maximums were calculated with a base of \$300,000, and a per capita amount of \$.11 based on US Census data as of July, 2008. The maximum state award is \$2.2 million

State	Maximum Award	State	Maximum Award
Alabama	\$766,190	Nebraska	\$478,343
Alaska	\$368,629	Nevada	\$560,017
Arizona	\$950,018	New Hampshire	\$431,581
Arkansas	\$585,539	New Jersey	\$1,168,266
California	\$2,200,000	New Mexico	\$498,436
Colorado	\$793,946	New York	\$2,200,000
Connecticut	\$650,125	North Carolina	\$1,222,241
Delaware	\$387,309	North Dakota	\$364,148
District of Columbia	\$359,183	Ohio	\$1,448,591
Florida	\$2,132,834	Oklahoma	\$664,236
Georgia	\$1,268,574	Oregon	\$679,006
Hawaii	\$428,820	Pennsylvania	\$1,544,828
Idaho	\$452,382	Rhode Island	\$405,079
Illinois	\$1,590,156	South Carolina	\$747,980
Indiana	\$937,679	South Dakota	\$380,419
Iowa	\$600,256	Tennessee	\$921,489
Kansas	\$580,213	Texas	\$2,200,000
Kentucky	\$726,925	Utah	\$573,642
Louisiana	\$741,080	Vermont	\$362,127
Maine	\$431,646	Virginia	\$1,076,909
Maryland	\$863,360	Washington	\$954,922
Massachusetts	\$949,797	West Virginia	\$481,447
Michigan	\$1,300,342	Wisconsin	\$862,797
Minnesota	\$822,039	Wyoming	\$353,267
Mississippi	\$593,862	USVI	\$311,191
Missouri	\$891,161	Puerto Rico	\$695,404
Montana	\$396,744		

Appendix E – State Quitline Funding Chart

State maximums were calculated using a base of \$400,000, and a per smoker amount of \$0.55 (\$0.548) based on the 2008 BRFSS.

State	Maximum Award	State	Maximum Award
Alabama	\$830,666	Montana	\$475,739
Alaska	\$460,221	Nebraska	\$534,756
Arizona	\$817,621	Nevada	\$636,143
Arkansas	\$664,274	New Hampshire	\$495,252
California	\$2,501,528	New Jersey	\$938,132
Colorado	\$759,976	New Mexico	\$557,545
Connecticut	\$635,775	New York	\$1,788,538
Delaware	\$465,049	North Carolina	\$1,199,290
District of Columbia	\$443,122	North Dakota	\$449,712
Florida	\$1,773,681	Ohio	\$1,369,204
Georgia	\$1,162,651	Oklahoma	\$771,878
Hawaii	\$484,642	Oregon	\$661,049
Idaho	\$502,908	Pennsylvania	\$1,535,931
Illinois	\$1,534,828	Puerto Rico	\$588,909
Indiana	\$1,085,407	Rhode Island	\$478,403
Iowa	\$635,919	South Carolina	\$775,999
Kansas	\$606,155	South Dakota	\$458,437
Kentucky	\$852,144	Tennessee	\$1,002,155
Louisiana	\$771,040	Texas	\$2,194,059
Maine	\$503,884	Utah	\$495,125
Maryland	\$750,534	Vermont	\$445,327
Massachusetts	\$847,399	Virgin Islands	\$50,000
Michigan	\$1,251,099	Virginia	\$937,628
Minnesota	\$782,489	Washington	\$830,873
Mississippi	\$670,176	West Virginia	\$608,202
Missouri	\$1,015,150	Wisconsin	\$870,403
		Wyoming	\$442,973

1 The following amendments have been incorporated into FOA CDC-RFA-DP09-912ARRA09 – American
2 Recovery and Reinvestment Act of 2009 – Communities Putting Prevention to Work:

- 3
4
5
6 1. Under pre-application support, the time zone for each of the pre-application calls – **Eastern Daylight**
7 **Time** – is now included.
- 8
9 2. The MAPPS Strategy Tables under Section I. and Attachment C., have an added phrase, “consistent
10 with federal law,” to the media and advertising restrictions in both nutrition and tobacco categories.
- 11
12 3. Under Section III.1. Eligible Applicants, the language has been slightly edited to clarify the eligible
13 applicants.
- 14
15 4. Under Section III. Eligibility Information, the following has been added to section III.3 Other to
16 clarify the allowable number of applications per state health department: **“Only one application can**
17 **be submitted per state for Category A and only one application per state for Category B, for a**
18 **maximum of two applications per state if applying for Category A and Category B. Within**
19 **each state application, states may only submit up to 2 communities to fund: i.e. a combination**
20 **of one small city and one rural community; two small cities; or two rural communities. State**
21 **health departments that have not identified a maximum of 2 communities per application will**
22 **be considered non-responsive and not entered into the review process.”**
- 23
24 5. Under Section III.3 Other, the following has been changed to more accurately describe the Letter of
25 Intent: **“Applicants** ~~You~~ are required to submit a Letter of Intent (LOI) to be eligible to apply for this
26 program. Failure to submit a LOI will result in non-responsiveness and the applicant will be
27 prohibited from applying.” See Sections IV.2, IV.3, and IV.6 of this announcement for more
28 information on LOI submission. The LOI must identify the type of applicant, ~~the size of the~~
29 **jurisdiction**, and the risk factor area to be addressed. If an applicant wishes to apply for both tobacco
30 and obesity/ physical activity/ nutrition funding, one LOI can be submitted to indicate that intention.”
- 31
32 6. Under Section III. Eligibility Information, Special Requirements, the following sentence has been
33 deleted: “CDC reserves the flexibility to redirect funding from poor performing grants to those
34 performing in the green benchmark level” and has been replaced with the following sentence: **“In**
35 **accordance with applicable laws and regulations including 45 CFR 92.43, CDC may take**
36 **certain enforcement actions, including termination of funding, against poor performing**
37 **grants.”**
- 38
39 7. Under Section III. Eligibility Information, Special Requirements, the paragraph describing quarterly
40 benchmarks has been moved to section VI.3. Reporting Requirements, Recovery Act-Specific
41 Reporting Requirements, item 2: Quarterly Benchmarks.
- 42
43 8. Under Section III. Eligibility Information, Special Requirements, the following change has been
44 made: “If the application is non-responsive ~~incomplete or non-responsive to the special~~
45 **requirements listed in this section**, it will not be entered into the review process.”
- 46
47 9. Under Section IV.6. Other Submission Requirements, the following sentence has been moved under
48 IV. 3. Submission Dates and Times: “HHS/CDC strongly recommends that submittal of the
49 application to Grants.gov should be prior to the closing date to resolve any unanticipated difficulties
50 prior to the deadline.”
- 51

- 52 10. Under Section V.1. Criteria, A. Program Infrastructure and Fiscal Management, separate scoring for
53 State applications has been included and highlighted.
54
- 55 11. Under Section V.1. Criteria, B. Leadership team and community coalitions, vii. sub-points have been
56 increased from 2 to 3.
57
- 58 12. Under Section VI.3. Reporting Requirements, Recovery Act-Specific reporting Requirements, the
59 following dates have been added: “Not later than 10 days after the end of each calendar quarter,
60 starting with the quarter ending **March 30, 2010** and reporting by **April 10, 2010**, the recipient must
61 submit quarterly reports to HHS that will posted to Recovery.gov, containing the following
62 information:”
63
- 64 13. In Attachment B, the first sentence has been revised as follows: “*Applicants showing collaboration*
65 *across these and similar programs will receive ~~extra~~ points in the application review.*”
66
- 67 14. In Attachment C, Reference #77 has been changed from “COCOMO” to the following: **Centers for**
68 **Disease Control and Prevention. Recommended Community Strategies and Measurements to**
69 **Prevent Obesity in the United States. MMWR 2009; 58(No. RR-07): 1-26.**
70
- 71 15. **The deadline for the Letter of Intent has been changed to Friday, November 6, 2009.**
72
- 73 16. **The Submission Deadline date language has been changed to Suggested Submission Date.**
74
- 75 17. **Applicants that submit for Category A or Category B or both must complete two separate**
76 **applications in Grants.gov and identify the applications as Category A or Category B with the**
77 **organization’s name, in the Application Filing Name field, on the Grant Application Package page.**
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U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

111 Centers for Disease Control and Prevention (CDC)

112 American Recovery and Reinvestment Act of 2009

113 *Communities Putting Prevention to Work*

114

115 Announcement Type: Cooperative Agreement

116 Funding Opportunity Number: CDC-RFA-DP09-912ARRA09

117 Catalog of Federal Domestic Assistance Number: 93.724

118 Key Dates:

119 Letter of Intent Deadline: **November 6, 2009**

120 **Suggested Submission Date: November 27, 2009**

121 Application Deadline: December 1, 2009

122

123 **Pre-Application Support:**

124 Pre-Application Conference Calls:

125 Funding Opportunity Announcement (FOA) information will be available for potential

126 applicants on three separate conference calls, conducted by the Centers for Disease Control and

127 Prevention (CDC), as follows:

128 • The first call will be for potential applicants (see section III) that are in Mountain or

129 Pacific Time zones, and will be held on Wednesday, September 30 from 3:00 – 4:30

130 Eastern Daylight Time (EDT). The conference call can be accessed by calling 1-888-
131 390-0788. The leader for this call is Amy Bell and the pass code is 3746637. The pass
132 code and leader's name is required to join the call.

133 • The second call will be for potential applicants (see section III) that are in Atlantic,
134 Eastern, or Central time zones, and will be held on Thursday, October 1 from 11:00 –
135 12:30 EDT. The conference call can be accessed by calling 1-888-390-0788. The leader
136 for this call is Amy Bell and the pass code is 3746637. The pass code and leader's name
137 is required to join the call.

138 • A third call will be held particularly for tribal and territorial organizations on Thursday,
139 October 1 from 3:00 – 4:30 EDT. The conference call can be accessed by calling 1-888-
140 390-0788. The leader for this call is Amy Bell and the pass code is 3746637. The pass
141 code and leader's name is required to join the call.

142

143 The purpose of the conference calls is to 1) help potential applicants understand the scope and
144 intent of the FOA for the *Communities Putting Prevention to Work* Initiative and 2) become
145 familiar with the Public Health Services funding policies and application and review procedures.

146

147 Participation in a conference call is voluntary. Potential applicants are requested to call in using
148 only one telephone line. If during the call you need technical assistance, press *0 to speak to an
149 operator. Please note restrictions may exist when accessing free phone/toll free numbers using a
150 mobile telephone. Since this is a competitive selection process, applicants should follow the
151 requirements as they are laid out in the FOA and any related amendments. Should applicants

152 find they have questions or need clarification prior to this call, please see section VII Agency

153 Contacts.

154

155 Other Pre-application support:

- 156 • A dedicated mailbox for inquiries: CPPW@cdc.gov
- 157 • A series of expert-led webinars, each offered live and then available by web archive
- 158 covering the following topics: Obesity/ Physical activity/ Nutrition Policy, Tobacco
- 159 Policy, and Evidence-based Policy Intervention. The scheduled dates and times for these
- 160 webinars is located on CDC's Community Health Web Portal at
- 161 www.cdc.gov/CommunityHealthResources
- 162 • A single source for community tools for application development via CDC's Community
- 163 Health Web Portal www.cdc.gov/CommunityHealthResources
- 164 • Engagement of foundations with expertise in community-based tobacco and obesity/
- 165 physical activity/ nutrition programming in advising on pre-application work and
- 166 encouraging them to support high quality community applications.

167

168 **I. Funding Opportunity Description**

169 Authority: This program is authorized under section 311 and 317(k)(2) of the Public Health
170 Service Act, 42 U.S. Code 243 and 247b(k)2.

171

172 **Executive Summary:** The American Recovery and Reinvestment Act of 2009 (Recovery Act),
173 signed into law February 17, 2009, is designed to stimulate economic recovery in various ways,
174 including preserving and creating jobs and promoting economic recovery, assisting those most
175 impacted by the recession, stabilizing State and local government budgets in order to minimize
176 and avoid reductions in essential services and counterproductive state and local tax increases,
177 and strengthening the Nation's healthcare infrastructure and reducing healthcare costs through

178 prevention activities. The Recovery Act includes \$650 million for evidence-based clinical and
179 community-based prevention and wellness strategies that support specific, measurable health
180 outcomes to reduce chronic disease rates. The legislation provides an important opportunity for
181 states, cities, rural areas, and tribes to advance public health across the lifespan and to reduce
182 health disparities. The CDC will support intensive community approaches to chronic disease
183 prevention and control in selected communities (urban and rural), to achieve the following
184 prevention outcomes:

- 185 • Increased levels of physical activity;
- 186 • Improved nutrition (e.g. increased fruit/vegetable consumption, reduced salt and
187 transfats);
- 188 • Decreased overweight/obesity prevalence
- 189 • Decreased smoking prevalence and decreased teen smoking initiation; and
- 190 • Decreased exposure to secondhand smoke.

191
192 The Centers for Disease Control and Prevention (CDC), National Center for Chronic Disease
193 Prevention and Health Promotion (NCCDPHP), Division of Adult and Community Health
194 (DACH), announces the opportunity to apply for Recovery Act funds to reduce risk factors,
195 prevent and/or delay chronic disease, and promote wellness. This initiative, entitled
196 *Communities Putting Prevention to Work* (CPPW), will address obesity, physical inactivity, poor
197 nutrition and tobacco use/exposure with the anticipated long term goals of:

198

199 **OBESITY, PHYSICAL ACTIVITY, AND NUTRITION**

200 Measures for communities addressing physical activity and nutrition:

201 Adults

- 202 • Stabilize or begin to decrease (up to 2%) adult overweight/obesity prevalence, thus reversing
203 long term trends.
- 204 • 20% increase in the percentage of adults getting adequate physical activity, meaning 20%
205 more adults meeting Physical Activity Guidelines.
- 206 • 5% decrease in consumption of sugar-sweetened beverages, for adults, a decrease of about 5
207 gallons per person per year.
- 208 • A 20% increase in average daily fruit and vegetable consumption, an increase of
209 approximately 1 serving.
- 210 • 15% increase in the percentage of adults with a heart-healthy diet based USDA's Healthy
211 Eating Index (HEI), meaning 15% more adults with diet including adequate fruits and
212 vegetables and reduced intake of fats
- 213 • 6% decrease in the percentage of adults getting excess calories based on USDA's Healthy
214 Eating Index (HEI).
- 215 • Stabilize and reduce health inequities between the general population and special populations
216 with documented health disparities in the above measures (e.g., racial/ethnic minorities;
217 people with low socio-economic status; sexual and gender minorities, etc.).

219 Youth

- 220 • Stabilize or begin to decrease (up to 2%) youth overweight/obesity prevalence (up to age 2-
221 18), thus reversing long term trends.

- 222 • 35% increase in the percentage of high school students getting adequate physical activity
223 (duration, frequency, intensity) meaning 35% more high school students meeting Physical
224 Activity Guidelines.
- 225 • 5% decrease in consumption of sugar-sweetened beverages in high school students, a
226 decrease of approximately 4 gallons per person per year.
- 227 • A 30% increase in average daily fruit and vegetable consumption among high school
228 students, an increase of approximately 1 serving.
- 229 • 15% increase in the percentage of youth (ages 2-18) with a heart-healthy diet based on the
230 USDA’s Healthy Eating Index (HEI), meaning 15% more youth with diets including
231 adequate fruits and vegetables and reduced intake of fats.
- 232 • 6% decrease in the percentage of youth (ages 2-18) getting excess calories based on USDA’s
233 Healthy Eating Index (HEI).
- 234 • Stabilize and reduce health inequities between the general population and special populations
235 with documented health disparities in the above measures (e.g. racial/ethnic minorities;
236 people with low socio-economic status; sexual and gender minorities, etc.).

237

238

239 **TOBACCO**

240 Measures for communities addressing tobacco:

241 ***Adults***

- 242 • 10% decrease in adult smoking prevalence, preventing tobacco-related death in 1/3 of these
243 adults.
- 244 • 40% decrease in the percentage of non-smokers exposed regularly to secondhand smoke.

- 245 • Stabilize and reduce health inequities between the general population and special populations
246 with documented health disparities in the above measures (e.g., racial/ethnic minorities;
247 people with low socio-economic status; sexual and gender minorities, etc.).

248

249

250 **Youth**

- 251 • 25% decrease in youth smoking prevalence (up to age 18), preventing tobacco-related death
252 in 1/3 of these youth.

- 253 • 30% decrease in the percentage of youth (ages 2-18) exposed regularly to secondhand smoke.

- 254 • Stabilize and reduce health inequities between the general population and special populations
255 with documented health disparities in the above measures (e.g., racial/ethnic minorities;
256 people with low socio-economic status; sexual and gender minorities, etc.).

257

258

259 This effort aims to address the needs of the diverse demographics of the United States by

260 identifying five well-established types of communities: large cities; urban areas; tribal

261 communities; state-coordinated small cities and rural areas; and geographically diverse

262 communities united by membership in a health disparity population. The focal points for the

263 implementation of plans for this effort are state health departments, local health departments,

264 tribes (see section III. 1. “Eligible Applicants” for specific requirements), and health disparity

265 expert organizations, which possess the infrastructure to rapidly deploy programs and

266 interventions to their target populations. Funding will provide support to address the risk factors

267 within the defined demographic areas set out below.

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- 268 • **Large cities:** For this announcement, the term “large city” is defined as a local health
269 department that serves a jurisdiction with a population of more than 1 million people.
- 270 • **Urban areas:** For this announcement, the term “urban area” is defined as a local health
271 department that serves a jurisdiction with a population more than 500,000 and up to 1
272 million people.
- 273 • **Tribal communities:** For this announcement, “tribal communities” is defined as
274 Federally recognized Tribal Governments, Regional Area Indian Health Boards, Urban
275 Indian organizations, and Inter-Tribal Councils.
- 276 • **State-coordinated small cities and rural areas:** State health departments will
277 coordinate the small city and rural area applications. For this announcement, the term
278 “small city” is defined as a local health department that serves a jurisdiction with a
279 population between 50,000 – 500,000 people and the term “rural area” is defined as a
280 local health department that serves a jurisdiction with a population of 50,000 people and
281 below.
- 282 • **Groups with disparities:** For this announcement, “groups with disparities” is defined as
283 communities defined by identity, characteristics, and/or social standing with documented
284 health inequalities resulting in poorer health outcomes (e.g., racial/ethnic minorities;
285 people living with severe and persistent mental illness; people with low socio-economic
286 status; and sexual and gender minorities.)

287

288 This FOA focuses on two categories of activities: Category A: Obesity prevention, physical
289 activity and nutrition and Category B: Tobacco prevention and control. Applicants will be asked

290 to propose activities in Category A or Category B or both. If applying for both categories, a
291 separate application must be submitted for each category.

292 In order to address the selected risk factors, awardees will implement population-based
293 approaches such as policy, systems, and environmental changes across 5 evidence-based MAPPS
294 strategies –**Media, Access, Point of decision information, Price and, Social support services** – in
295 both communities and schools such that the entire jurisdiction of the health department or tribal
296 area is impacted. Reach across both components (community and school) is necessary to
297 achieve behavior change in youth and to sustain healthy behavior into adulthood. Awardees will
298 work from a prescribed menu of MAPPS strategies and interventions (referenced in recipient
299 activities) and will be required to implement specific high priority interventions, including
300 implementing comprehensive smoke free air policies, using evidence-based pricing strategies
301 that discourage tobacco use, and/or limiting availability of unhealthy food and beverages.
302 Awardees may also propose evidence-based interventions not listed within the prescribed
303 MAPPS menu, but must provide a strong justification of how the proposed intervention will have
304 sufficient reach and potential impact consistent with the short and long-term goals of the
305 initiative. The Centers for Disease Control and Prevention (CDC) will provide community
306 programmatic support and tools to strengthen and develop effective strategies tailored to
307 community needs.

308

309 States that propose coordinating community awards will be responsible for the following
310 activities:

- 311 • Identifying in their application up to two pre-selected communities (a combination of one
312 small city and one rural community; two small cities; or two rural communities) that will

313 be expected, with state assistance, to conduct the same activities and for achieving the
314 same performance measure identified below in either Category A or Category B. Each
315 community must have an established coalition and will be monitored for progress toward
316 benchmarks, performance measures, and outcomes.

- 317 • Establishing and coordinating a State-Community Management Team, including
318 participation from the funded communities and key state-level public health officials.
319 Representation from groups with health disparities is strongly encouraged.
- 320 • Providing or facilitating the provision of programmatic support and consultation to their
321 funded communities in risk factor surveillance; program evaluation; sustainability;
322 evidence-based and practice-based policies, systems, and environmental changes
323 (including the built environment where applicable); community engagement, and
324 intervention selection and development.
- 325 • Ensuring that at least 75% of the total award is distributed to the identified communities
326 in the state-coordinated application.

327

328 Monitoring and evaluation of the Recovery Act-funded efforts in communities will focus on the
329 implementation of community-wide policy, systems, and environmental changes. These are the
330 expected changes during the funding period, and are also demonstrated to be major drivers of the
331 more downstream changes in risk behaviors and risk factors. Awardees are also expected to
332 participate in national evaluation activities, including tracking relevant behavioral outcomes
333 using BRFSS and YRBSS, participating in modeling studies, and examining cost and context
334 within which community change occurs. Applicants will be asked to participate in monitoring
335 and evaluation efforts within funded communities, including pre and post measurement.

336 This may include the collection of biometric measurements especially among applicants
337 who already have such measurement systems in place. Applicants may also wish to include
338 plans to improve the quality of these efforts.

339 The intent of this announcement is to fund highly qualified applications from applicants with the
340 following experience and support in place: active coalitions and demonstrated experience
341 working with community leaders to implement policy, systems, and environmental change
342 strategies; demonstrated support from the mayor, county executive, tribal leader, or other
343 equivalent governmental official for this initiative; demonstrated support from all public school
344 districts within the intervention area for the collection of Youth Risk Behavior Surveillance
345 System (YRBSS) data among a representative sample of 9th-12th grade students for baseline
346 during fall 2010 and follow-up at the end of the project period using standard YRBSS protocol;
347 and demonstrated ability to meet reporting requirements such as programmatic, financial, and
348 management benchmarks as required by the Recovery Act in section VI.3. Reporting
349 Requirements under “Recovery Act-Specific Reporting Requirements.”

350

351 Awardees will be responsible for coordinating with CDC on national-level activities outlined
352 under “CDC Activities.” Awards will vary with size of jurisdiction, the proposed activities, and
353 the needs of each community. Approximately 30-40 awards will be made for the CPPW
354 Initiative, but the number of awards will depend on the preceding factors and may be outside of
355 this approximate range of number of awards and amount of funding per award. Awardees will
356 be funded with awards beginning on or about February 26, 2010 for a 24-month budget period.

357

358 Following the award of funds, up to \$10 million will be made available for a limited set of
359 awardees to provide peer-to-peer mentorship to other funded communities (more information can
360 be found in Category A, item 9 and Category B, item 9 under Recipient activities). These funds
361 will be awarded as a competitive supplement.

362 **Background:** In the United States today, seven of ten deaths and the vast majority of serious
363 illness, disability, and health care costs are caused by chronic diseases, such as obesity, diabetes
364 and cardiovascular disease. Key risk factors—lack of physical activity, poor nutrition and tobacco
365 use—are major contributors to the nation’s leading causes of death. More than 75% of health care
366 expenditures in the United States are spent to meet the health needs of persons with chronic
367 conditions (www.cdc.gov/nccdphp/overview.htm). Many Americans die prematurely and suffer
368 from diseases that could be prevented or more effectively managed.

369
370 Understanding patterns of health or disease requires a focus not only on personal behaviors and
371 biologic traits, but also on characteristics of the social and physical environments that offer or
372 limit opportunities for positive health outcomes. These characteristics of communities – social,
373 physical, and economic – are a major influence on the public’s health and have both short- and
374 long-term consequences for health and quality of life. [Patterns of difference between and among](#)
375 [communities can create risk patterns that promote and perpetuate health disparities.](#) Research
376 has shown that implementing policy, systems, and environmental changes, such as improving
377 physical education in schools, improving safe options for active transportation, providing access
378 to nutritious foods, and other broad-based policy change strategies, can result in positive
379 behavior changes related to physical activity, nutrition, and tobacco use, which positively impact
380 multiple chronic disease outcomes.

381
382 The key to the success of this initiative, *Communities Putting Prevention to Work*, will be to
383 implement community-wide policies, systems, and environmental changes that reach across all
384 levels of the socio-ecological model and include the full engagement of the leadership in city
385 government, boards of health, schools, businesses, community and faith-based organizations
386 (including those representing groups with disparities), community developers, transportation and
387 land use planners, parks and recreation officials, health care purchasers, health plans, health care
388 providers, academic institutions, foundations, other Recovery Act-funded community activities,
389 and many other community sectors working together to promote health and prevent chronic
390 diseases. Funded programs need to build on, but not duplicate current Federal programs as well
391 as state, local, or community programs and coordinate fully with existing programs and
392 resources in the community.

393
394 **Purpose:** The purpose of this FOA is to create healthier communities through sustainable,
395 proven, population-based approaches such as broad-based policy, systems, organizational and
396 environmental changes in communities and schools. Awardees funded under this FOA will work
397 collaboratively to promote and sustain policy change efforts in communities and schools. It is
398 recommended that awardees include a strong focus on the needs of populations who suffer
399 disproportionately from the burden of disease.

400
401 Proposals should focus on implementing broad-based policy changes that are chosen from the
402 prescribed set of evidence-based interventions. Each community will address all 5 evidence-

403 based MAPPS strategies (**M**edia, **A**ccess, **P**oint of decision information, **P**rice and, **S**ocial
404 support services) for each application: tobacco and/or obesity/physical activity/nutrition.

405

406 This FOA addresses the “Healthy People 2010” focus areas of nutrition and overweight, physical
407 activity, environmental health: healthy homes and communities, and tobacco use.

408

409 This announcement is only for non-research activities supported by CDC. If research is
410 proposed, the application will not be reviewed. For the definition of research, please see the
411 CDC Web site at the following Internet address:

412 <http://www.cdc.gov/od/science/regs/hrpp/researchDefinition.htm>

413

414 **Recipient Activities**

415

416 Applicant activities for this program are as follows:

417

418 Activities will be awarded for two categories:

419

420 **Category A:** Applicants addressing obesity, physical activity, and nutrition.

421 **Category B:** Applicants addressing tobacco prevention and control.

422

423 Applicants can propose activities in Category A or Category B or both. If applying for both
424 categories, a separate application must be submitted for each category. **Applicants that submit**
425 **for Category A or Category B or both must complete two separate applications in Grants.gov and**
426 **identify the applications as Category A or Category B with the organization’s name, in the**
427 **identify the applications as Category A or Category B with the organization’s name, in the**
428 **identify the applications as Category A or Category B with the organization’s name, in the**
429 **identify the applications as Category A or Category B with the organization’s name, in the**
430

431 **Application Filing Name field, on the Grant Application Package page.**
432

433 Should an applicant compete successfully in both categories to receive two awards, CDC will
434 conduct budget negotiations with the applicant to merge the staffing plans and reduce the
435 requested budgets accordingly in order to reflect a combined operating structure.

436
437 For state-coordinated small city and rural areas, the State Health Department is responsible for
438 ensuring that the state application contains the community applications and that they fulfill the
439 requirements highlighted in this FOA. State Health Departments will identify in their application
440 up to two pre-selected communities (a combination of one small city and one rural community;
441 two small cities; or two rural communities) that will be expected, with state assistance, to
442 conduct the same activities and for achieving the same performance measure identified below in
443 either Category A or Category B. If applying for both categories, a separate application must be
444 submitted for each category.

445

446 **Category A. Applicants addressing obesity, physical activity, and nutrition**

447 1) Program infrastructure, staffing, program management and support.

- 448 • Establish and maintain required paid project or contract staff sufficient in number and
449 expertise to ensure project success on the following timeline:
 - 450 o 30 days post-award, establish and/or retain the minimum staffing requirements to
451 include a representative of the leadership of the health department, such as a
452 Program Director; a full-time staff person or equivalent responsible for managing
453 the planning, implementation, and evaluation of the program, with management
454 experience in physical activity and/or nutrition; and the identification of

- 455 individuals with demonstrated capacity in media planning, administrative, and
456 fiscal management support necessary to meet the needs of the program.
- 457 ○ 90 days post-award, establish and/or retain the required additional staff,
458 contractors, or collaborations to include leadership and expertise within the
459 education agency for school health, and leadership and expertise for
460 fiscal/accountability, community outreach and coordination, injury and crime
461 reduction, built environment, evaluation, and YRBSS coordination (responsible
462 for conducting a YRBSS in the intervention area). The awardee should ensure that
463 this complement of staff and contract support is sufficient to meet the
464 requirements of this FOA.
 - 465 ● Over the course of the project period, establish and maintain other part-time or full-
466 time staff, contactors, and consultants sufficient in number and expertise to ensure
467 project success and have demonstrated skills and experience in coalition and
468 partnership development, community mobilization, health care systems, public health,
469 program evaluation, epidemiology, data management, health promotion, policy and
470 environmental interventions, built environment (e.g. urban and regional planning,
471 transportation, parks, community development), health care quality improvement,
472 communications, resource development, school health, and the policies related to
473 physical activity/nutrition targeted by the FOA.
 - 474 ● For state-coordinated small city and rural areas, State Health Departments must
475 establish and coordinate a State-Community Management Team, including
476 participation from the funded communities; the state health department's
477 collaborative FOA designated healthy communities coordinator; the state education

478 agency, the state planning agency, the state obesity or physical activity/nutrition
479 coordinator, and the Office of Rural Health (where appropriate).

- 480 • Recovery Act funding should be considered one-time funding. Ensure that a
481 sustainability plan is in place that leverages all resources available, including federal,
482 state, and local sources, taking into account staffing levels and contractor
483 commitments that support the CPPW Initiative.

484 Performance will be measured by evidence that the program is appropriately staffed to
485 administer, manage, and evaluate the program as evidenced by the submission of
486 staff/contractor name, date of hire and/or projected date of hire or staff to be retained due
487 to Recovery Act funds and by the submission of resumés and/or curriculum vitae for key
488 personnel and position descriptions for other positions supported by funds under this
489 cooperative agreement. In addition, performance will be measured by the state health
490 department’s ability, with assistance from the funded communities, to develop a State-
491 Community Management Team. Performance related to sustainability will be measured
492 by outreach to resources, including leveraging other Federal Government recovery funds
493 to meet the above mentioned skill set (See Attachment B), and the number of
494 commitments achieved by the end of the program.

495

496 2) Fiscal management.

- 497 • Provide funding to local entities and organizations that will: support the goals of the
498 initiative and the selected interventions, focus on population-based strategies, are
499 evidence-based and policy-focused, and will reach diverse groups.

- 500 • Utilize fiscal management procedures for this funding to track and monitor
501 expenditures separate from other federal funding streams.
- 502 • Implement reporting systems to meet the online reporting criteria and timelines as
503 stated for the Recovery Act required reporting located in section VI.3. Reporting
504 Requirements under “Recovery Act-Specific Reporting Requirements” of this FOA.
- 505 • Recovery Act funding to existing or new awardees should be considered one-time
506 funding. Ensure that a sustainability plan is in place that leverages all resources
507 available, including federal, state, and local sources, taking into account funding
508 commitments that support the CPPW Initiative.

509 Performance will be measured by evidence that the awardee will provide funding to local
510 agencies and partner organizations committed to the goals of the initiative and the
511 selected interventions; has established procedures to track and report expenditures
512 separate from other federal funding; and is able to prepare required reports submitted on
513 the designated schedule.

514

515 3) Leadership team and community coalition.

- 516 • 60 days post award, develop a Leadership Team consisting of 8-10 high-level
517 community leaders (e.g. the mayor, tribal leaders, city and county officials, school
518 superintendents, local business association or corporation leaders, hospital and health
519 systems directors, boards of health) or other leaders of influence in the community.

520 The Leadership Team should also include the Program Director and the overall
521 manager of the program. The Leadership Team will: oversee the strategic direction of
522 the project activities, be responsible for enacting policies related to the evidence-

523 based MAPPS strategies recommended in item 4 of this section, establish and
524 maintain an organizational structure and governance for the community coalition or
525 coalitions, and participate in project-related local and national meetings.

- 526 • 90 days post-award, revise or add to the existing community coalition (or coalitions)
527 committed to participating actively in the planning, implementation, and evaluation of
528 the *Communities Putting Prevention to Work Initiative*. Partners should include a
529 wide representation of community leaders and community members familiar with
530 promoting physical activity and nutrition. Examples could include representatives
531 from education agencies (local education agencies, school districts, school board
532 members, or parent teacher organizations); school health advocates, community
533 development/planning agencies (land use and/or transportation); key community-
534 based governmental and non-governmental organizations, health care, voluntary, and
535 professional organizations; business, community, faith-based leaders; local Aging
536 centers and senior centers; universities; leaders from community organizations
537 representing groups with disparities; and at least one lay person representative of the
538 population to be served. Linkages with mental health/substance abuse organizations,
539 health plans, foundations, and other community partners working together to promote
540 health and prevent chronic diseases are encouraged. The community coalition will
541 advise the Leadership Team on the planning, implementation, and evaluation of the
542 CPPW Initiative.
- 543 • Encourage linkages with other community-based efforts and the Office of the
544 Regional Health Administrator, with special attention to leveraging other Federally
545 funded (including Recovery Act funded) and foundation activities. Applicants will

546 also be asked to demonstrate through letters of support that they have political
547 support and connections with other community development and livability efforts,
548 and that they build on and leverage existing place-based revitalization and reform
549 projects funded by the US Government. These could include efforts funded by the
550 US Department of Health and Human Services (HHS), and programs supported by
551 other agencies such as the US Department of Housing and Urban Development, the
552 Environmental Protection Agency, the US Park Service, US Department of
553 Transportation, US Department of Agriculture, the Corporation for National and
554 Community Service, and the US Department of Education. Applicants are also
555 encouraged to coordinate with other US Government-funded Recovery Act efforts in
556 multiple sectors, such as transportation, education, health care delivery, agriculture
557 and others, as well as coordinating with HHS Regional Offices. See Attachment B for
558 examples.

559 Performance will be measured by the level of partner engagement throughout the project
560 period including the involvement of key community-based and public health partners
561 comprising an alliance of partnerships and coalitions committed to participating actively
562 in planning, implementation, and evaluation of CPPW. This will include evidence of
563 regularly scheduled meetings, membership lists, attendance rates, participation, and
564 meeting minutes.

565

566 4) Intervention area and selection of interventions.

- 567
- Ensure that the intervention area encompasses the entire jurisdiction of the health
568 department so that the focus of policies, systems, and environmental changes will

569 have the broadest impact possible. The mix of interventions, taken together, must
 570 address physical activity and nutrition with sufficient reach and potential impact.

- 571 • Choose a mix of interventions that addresses obesity/nutrition/physical activity for all
 572 five evidence-based MAPPS strategies in communities and schools. Awardees are not
 573 required to select strategies in each MAPPS area for *both* physical activity and
 574 nutrition (i.e.10 strategies). Rather, the mix of MAPPS interventions, taken together,
 575 must address obesity and related risk factors consistent with the long term goals of the
 576 initiative, and therefore must include robust interventions in both nutrition and
 577 physical activity.
- 578 • The evidence-based interventions below are drawn from the peer-reviewed literature
 579 as well as expert syntheses from the community guide and other peer-reviewed
 580 sources (for a complete list of citations, please see Attachment C). Communities and
 581 states have found these interventions to be successful in practice. Awardees are
 582 expected to use this list of evidence-based strategies to design a comprehensive and
 583 robust set of strategies to produce the desired outcomes for the initiative. Other
 584 evidence-based strategies may be proposed but must be documented as to their
 585 evidence base, their likely addition to the overall outcomes, and the rationale for the
 586 choice of intervention (e.g., identified need or opportunity).

587 **MAPPS Table**

	Nutrition	Physical Activity
Media	<ul style="list-style-type: none"> • Media and advertising restrictions consistent with federal law • Promote healthy food/drink choices • Counter-advertising for unhealthy choices 	<ul style="list-style-type: none"> • Promote increased activity • Promote use of public transit • Promote active transportation (bicycling and walking) • Counter-advertising for screen time
Access	<ul style="list-style-type: none"> • Healthy food/drink availability (e.g., incentives to food retailers to locate/offer healthier choices in underserved areas, healthier choices in child care, schools, 	<ul style="list-style-type: none"> • Safe, attractive accessible places for activity (e.g. access to outdoor recreation facilities, enhance bicycling and walking infrastructure, place schools within residential areas, increase

	<ul style="list-style-type: none"> worksites) Limit unhealthy food/drink availability (whole milk, sugar sweetened beverages, high-fat snacks) Reduce density of fast food establishments Eliminate transfat through purchasing actions, labeling initiatives, restaurant standards Reduce sodium through purchasing actions, labeling initiatives, restaurant standards Procurement policies and practices Farm to institution, including schools, worksites, hospitals and other community institutions 	<ul style="list-style-type: none"> access to and coverage area of public transportation, mixed use development, reduce community designs that leads to injuries). City planning, zoning and transportation (e.g., planning to include the provision of sidewalks, mixed use, parks with adequate crime prevention measures, and Health Impact Assessments) Require daily quality PE in schools Require daily physical activity in afterschool/childcare settings Restrict screen time (afterschool, daycare)
Point of Purchase/Promotion	<ul style="list-style-type: none"> Signage for healthy vs. less healthy items Product placement & attractiveness Menu labeling 	<ul style="list-style-type: none"> Signage for neighborhood destinations in walkable/mixed-use areas Signage for public transportation, bike lanes/boulevards.
Price	<ul style="list-style-type: none"> Changing relative prices of healthy vs. unhealthy items (e.g. through bulk purchase/procurement/competitive pricing). 	<ul style="list-style-type: none"> Reduced price for park/facility use Incentives for active transit Subsidized memberships to recreational facilities
Social Support & Services	<ul style="list-style-type: none"> Support breastfeeding through policy change and maternity care practices 	<ul style="list-style-type: none"> Safe routes to school Workplace, faith, park, neighborhood activity groups (e.g., walking hiking, biking)

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- Selection of evidence-based interventions to pursue should be based on a thorough analysis of gaps and opportunities that exist in the community and should reflect the potential for broad reach, impact, and successful implementation.

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- Propose strategies that are most likely to affect community-wide burden and therefore where appropriate emphasize plans to reduce health disparities.

593

594

- Select interventions that limit the availability of unhealthy food and beverages.

595

Applicants should provide current information about such restrictions, and should

596

include this strategy in the intervention selection unless there is justification based on

597

existing strong policies.

- 598 • Engage existing coalition or coalitions and potential members of the leadership team
599 in the selection process.

600 Performance will be measured by evidence that the intervention area encompasses the
601 jurisdiction of the health department; the communities have selected interventions that
602 address all five evidence-based MAPPS strategies and; the interventions have broad
603 reach and impact in the community.

604

605 5) Community Action Plan (CAP).

- 606 • Submit a two-year CAP as part of the application that describes an overall integrated
607 strategy that identifies the selected interventions; describes key activities; describes
608 milestones and timelines on achieving intervention implementation; identifies
609 anticipated policy outcomes; and includes SMART Objectives (Specific, Measurable,
610 Achievable, Relevant, Time-Framed) for each intervention.
- 611 • 90 days post-award, finalize the two-year CAP utilizing recommendations from the
612 application objective review process and input from community information, HHS
613 agencies, other sources of programmatic support, and on-going discussions with
614 internal staff and community partners.
- 615 • Clearly articulate how activities and interventions highlighted in the CAP will be
616 sustained after Recovery Act funding has ceased.

617 Performance will be measured by evidence that the CAP contains program objectives that
618 are SMART, that there are plans for sustainability, and that the plan is approved by CDC.

619 Additionally, performance will be measured on a quarterly basis that the awardee is
620 successfully meeting milestones and benchmarks as indicated in the CAP.

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6) Community-wide and school-based policy, systems, and environmental change strategies.

- Address all five evidence-based MAPPs strategies for obesity/physical activity/nutrition in communities and in schools, such that the reach and potential impact is consistent with achieving the long-term goal of the initiative (e.g. PE in schools that impact an entire school district in the jurisdiction, menu labeling that impacts the entire jurisdiction).
- Where applicable, implement a targeted strategy in areas with a disproportionate burden of chronic diseases/conditions that tend to experience disparities in access to and use of preventive and health care services. This focused strategy should include significant areas of the community in order to have the broadest impact possible (e.g. not one school, but an entire school district; not one corner store stocked with fresh produce, but the availability of fresh produce in an entire neighborhood, not one health clinic, but a major health care system).
- Work with media-buying contractors to develop and refine a media-buy strategy.
- Collaborate with CDC to implement emotional, hard-hitting counter-marketing and messaging and normative marketing to promote active behaviors and healthy eating. Co-brand and locally tag all campaign advertisements and materials with locally relevant information and resources.

Performance will be measured by evidence of progress in building community capacity to institute policy, systems, and environmental changes.

Comment [JGL1]: Helpful language for promoting inclusion of disparity work.

644 7) Evaluation to monitor/measure progress.

- 645 • 60 days post award, establish a monitoring plan that includes the following:
- 646 ○ The systematic collection of data on a bi-annual basis (twice a year) of progress
- 647 on and implementation of existing policy, systems, and environmental change
- 648 strategies using the Community Health Assessment aNd Group Evaluation
- 649 (CHANGE) tool related to chronic disease prevention and health promotion, to
- 650 evaluate the process and outcomes of program activities. For awardees who
- 651 have failed to meet benchmarks in Year 1, reporting of some elements of the
- 652 CHANGE tool will be required quarterly.
- 653 ○ The collection of implementation cost information for each initiative, to evaluate
- 654 the process and outcomes of program activities.
- 655 • 120 days post award, finalize a comprehensive evaluation plan that is directly tied to
- 656 the Community Action Plan.
- 657 • Track progress on implementing activities to create policy, system, and
- 658 environmental changes utilizing the CHANGE Tool.
- 659 • Collaborate with and provide necessary information to your state health department,
- 660 which will be responsible for collecting BRFSS data at the community level at
- 661 baseline and follow-up.
- 662 • Work with state and local education and health agencies and CDC to conduct a
- 663 YRBSS using standard YRBSS protocol among a representative sample of as many
- 664 as 1,500 to 2,000 9th - 12th grade students in the intervention area during the fall
- 665 semester of the 2010-2011 school year that measures at least dietary behaviors and
- 666 physical activity. Repeat the YRBSS among another representative sample of 9th-12th

667 grade students at the end of the project period. Cooperative agreement funds may be
668 spent on school incentives.

- 669 • If selected as a case study site, collaborate with CDC and contractors in implementing
670 a site-specific case study that examines contextual and environmental factors that act
671 as facilitators or barriers to program implementation and achievement of intended
672 outcomes and lead to variations in implementation costs across sites.
- 673 • Monitor and evaluate efforts, including pre and post measurement. This includes the
674 use of biometric measurements for those applicants already engaged in biometric
675 measurements and who wish to improve the quality of those efforts as they relate to
676 collection of height and weight in school-age children and youth. All applicants
677 should describe any current activities to collect these data in school-age populations.
- 678 • In collaboration with CDC, provide information that will assist with modeling
679 studies, which will allow, even in the short term, some estimation of long-term impact
680 of policy and environmental changes on risk behavior and health outcomes.
- 681 • In collaboration with CDC, provide implementation cost information in a uniform
682 format that will permit examination of efficiency and cost effectiveness of program
683 activities.

684 Performance will be measured by evidence that the evaluation plan addresses the lifespan
685 of the program; that the awardee is appropriately participating in any national evaluation
686 activities; and that adequate progress is made on targets for specific outcome and output
687 measures.

688

689 8) Participation in Programmatic Support Activities

- 690 • 30 days post-award, ensure that three members of the Leadership Team (the Program
691 Director, the program coordinator or equivalent, and one additional leader outside the
692 health department) attend a kick-off meeting in Atlanta.
- 693 • 90 days post-award, ensure that all 8-10 members of the Leadership Team participate
694 in an Action Institute that will promote the importance of policy, systems, and
695 environmental change strategies.
- 696 • Ensure that two members of the Leadership Team attend two peer-peer meetings
697 during the project period.
- 698 • Ensure that the YRBSS lead attends a CDC-led 3-day YRBSS training in August
699 2010.
- 700 • In collaboration with CDC, work with currently-funded community-based programs
701 (e.g. Healthy Communities, REACH, Active Living by Design, and others) to learn
702 about cutting-edge policy and environmental change strategies and interventions to
703 eliminate health disparities.
- 704 • If applicable, invite national experts and health-related foundations to provide
705 programmatic support with the selected interventions.
- 706 • In collaboration with CDC, provide information on successful initiatives at the
707 community level that can be published on the web and shared with other
708 communities.
- 709 • For state-coordinated small city and rural areas, the State-Community Management
710 Team should provide or facilitate the provision of programmatic support and
711 consultation to their funded communities in risk factor surveillance, program

712 evaluation, evidence-based and practice-based policies, systems, and environmental
713 changes; community engagement, and intervention selection and development.

- 714 • For state-coordinated small city and rural areas, the State Health Department is
715 responsible for ensuring that at least 75% of the total award is distributed to the
716 identified communities in the state-coordinated application.

717 Performance will be measured by attendance and participation in training programs, peer-
718 peer meetings, and dissemination activities. State health department performance will be
719 measured by the level of programmatic support provided and the percentage of funds
720 distributed to identified communities.

721

722 Peer-to-Peer Mentorship

723 Note: There will be an opportunity for successful applicants to apply for up to \$10
724 million supplement (April 2010) to support peer-to-peer mentoring in the following
725 areas:

- 726 • Serving as an expert center in selected areas of expertise by coordinating
727 programmatic support to communities that request information sharing and on-
728 the-ground lessons learned in specific intervention areas.
- 729 • Providing on-site workshops to profile outstanding success and give peer
730 communities on-the-ground access to seeing interventions in place, information
731 sharing sessions with leadership and staff, and sharing lessons learned.
- 732 • Serving as an information warehouse of broad-based policy change interventions,
733 implementation tools, promising approaches, and strategies for addressing broad-
734 based policy changes.

735
736 **Category B. Applicants addressing tobacco prevention and control**

737 1) Program infrastructure, staffing, program management and support.

- 738 • Establish and maintain required paid project or contract staff sufficient in number and
739 expertise to ensure project success on the following timeline:
 - 740 ○ 30 days post-award, establish and/or retain the minimum staffing requirements to
741 include a representative of the leadership of the health department, such as a
742 Program Director; a full-time staff person or equivalent responsible for managing
743 the planning, implementation, and evaluation of the program, with management
744 experience in tobacco prevention and control; and the identification of individuals

- 745 with demonstrated capacity in media planning, administrative, and fiscal
746 management support necessary to meet the needs of the program.
- 747 ○ 90 days post-award, establish and/or retain the required additional staff,
748 contractors, or collaborations to include leadership and expertise within the
749 education agency for school health, and leadership and expertise for
750 fiscal/accountability, community outreach and coordination, evaluation, and
751 YRBSS coordination (responsible for conducting a YRBSS in the intervention
752 area). The awardee should ensure that this complement of staff and contract
753 support is sufficient to meet the requirements of this FOA.
 - 754 ● Over the course of the project period, establish and maintain other part-time or full-
755 time staff, contactors, and consultants sufficient in number and expertise to ensure
756 project success and have demonstrated skills and experience in coalition and
757 partnership development, community mobilization, health care systems, public health,
758 program evaluation, epidemiology, data management, health promotion, policy and
759 environmental interventions, health care quality improvement, communications,
760 resource development, school health, and the policies related to tobacco control
761 targeted by the FOA.
 - 762 ● For state-coordinated small city and rural areas, State Health Departments must
763 establish and coordinate a State-Community Management Team, including
764 participation from the funded communities; the state health department's
765 collaborative FOA designated healthy communities coordinator; the state education
766 agency, the state tobacco control coordinator, and the Office of Rural Health (where
767 appropriate).

768 Performance will be measured by evidence that the program is appropriately staffed to
769 administer, manage, and evaluate the program as evidenced by the submission of
770 staff/contractor name, date of hire and/or projected date of hire or staff to be retained due
771 to Recovery Act funds and by the submission of resumés and/or curriculum vitae for key
772 personnel and position descriptions for other positions supported by funds under this
773 cooperative agreement. In addition, performance will be measured by the state health
774 department's ability, with assistance from the funded communities, to develop a State-
775 Community Management Team. Performance related to sustainability will be measured
776 by outreach to resources, including leveraging other Federal Government recovery funds
777 to meet the above mentioned skill set (See Attachment B), and the number of
778 commitments achieved by the end of the program.

779

780 2) Fiscal management.

- 781 • Provide funding to local entities and organizations that will: support the goals of the
782 initiative and the selected interventions, focus on population-based strategies, are
783 evidence-based and policy-focused, and will reach diverse groups.
- 784 • Utilize fiscal management procedures for this funding to track and monitor
785 expenditures separate from other federal funding streams.
- 786 • Implement reporting systems to meet the online reporting criteria and timelines as
787 stated for the Recovery Act required reporting located in section VI.3. Reporting
788 Requirements under "Recovery Act-Specific Reporting Requirements" of this FOA.
789 Recovery Act funding to existing or new awardees should be considered one-time
790 funding.

- 791 • Recovery Act funding to existing or new awardees should be considered one-time
792 funding. Ensure that a sustainability plan is in place that leverages all resources
793 available, including federal, state, and local sources, taking into account funding
794 commitments that support the CPPW Initiative.

795 Performance will be measured by evidence that the awardee will provide funding to local
796 agencies and partner organizations committed to the goals of the initiative and the
797 selected interventions; has established procedures to track and report expenditures
798 separate from other federal funding; and is able to prepare required reports submitted on
799 the designated schedule.

800

801 3) Leadership team and community coalition.

- 802 • 60 days post award, develop a Leadership Team consisting of 8-10 high-level
803 community leaders (e.g. the mayor, tribal leaders, city and county officials, school
804 superintendents, local business association or corporation leaders, hospital and health
805 systems directors, boards of health) or other leaders of influence in the community.

806 The Leadership Team should also include the Program Director and the overall
807 manager of the program. The Leadership Team will: oversee the strategic direction of
808 the project activities, be responsible for enacting policies related to the evidence-
809 based MAPPs strategies recommended in item 4 of this section, establish and
810 maintain an organizational structure and governance for the community coalition or
811 coalitions, and participate in project-related local and national meetings.

- 812 • 90 days post-award, revise or add to the existing community coalition (or coalitions)
813 committed to participating actively in the planning, implementation, and evaluation of

814 the *Communities Putting Prevention to Work Initiative*. Partners should include a
815 wide representation of community leaders and community members familiar with
816 tobacco prevention and control. Examples could include representatives from
817 education agencies (local education agencies, school districts, school board members,
818 or parent teacher organizations); school health advocates, key community based
819 governmental and non-governmental organizations, health care, voluntary, and
820 professional organizations; business, community, faith-based leaders; leaders from
821 organizations representing groups with disparities; local Aging centers and senior
822 center; universities; and at least one lay person representative of the population to be
823 served. Linkages with mental health/substance abuse organizations, health plans,
824 foundations and other community partners working together to promote health and
825 prevent chronic diseases are encouraged. The community coalition will advise the
826 Leadership Team on the planning, implementation, and evaluation of the CPPW
827 Initiative.

- 828 • Encourage linkages with other community-based efforts and the Office of the
829 Regional Health Administrator, with special attention to leveraging other Federally
830 funded (including Recovery Act funded)- and foundation activities. See Attachment
831 B for examples.

832 Performance will be measured by the level of partner engagement throughout the project
833 period including the involvement of key community-based and public health partners
834 comprising an alliance of partnerships and coalitions committed to participating actively
835 in planning, implementation, and evaluation of CPPW. This will include evidence of

836 regularly scheduled meetings, membership lists, attendance rates, participation, and
837 meeting minutes.

838 4) Intervention area and selection of interventions.

- 839 • Ensure that the intervention area encompasses the entire jurisdiction of the health
840 department so that the focus of policies, systems, and environmental changes will
841 have the broadest impact possible. The mix of interventions, taken together, must
842 address tobacco prevention and control with sufficient reach and potential impact.
- 843 • Choose interventions that address all five evidence-based MAPPS strategies in
844 communities and schools (as relevant) from the table of evidence-based interventions.
- 845 • The evidence-based interventions below are drawn from the peer-reviewed literature
846 as well as expert syntheses from the community guide and other peer-reviewed
847 sources (for a complete list of citations, please see Attachment C). Communities and
848 states have found these interventions to be successful in practice. Awardees are
849 expected to use this list of evidence-based strategies to design a comprehensive and
850 robust set of strategies to produce the desired outcomes for the initiative. Other
851 evidence-based strategies may be proposed but must be documented as to their
852 evidence base, their likely addition to the overall outcomes, and the rationale for the
853 choice of intervention (e.g., identified need or opportunity).

854 **MAPPS Table**

	Tobacco
Media	<ul style="list-style-type: none">• Media and advertising restrictions consistent with federal law• Hard hitting counter-advertising• Ban brand-name sponsorships• Ban branded promotional items and prizes
Access	<ul style="list-style-type: none">• Usage bans (i.e. 100% smoke-free policies or 100% tobacco-free policies)• Usage bans (tobacco-free worksites and or school campuses)• Zoning restrictions• Restrict sales (e.g. internet; sales to minors; stores/events w/o tobacco)

	<ul style="list-style-type: none"> Ban self-service displays & vending
Point of Purchase/ Promotion	<ul style="list-style-type: none"> Restrict point of purchase advertising Labeling/ signage/ placement to discourage consumption of tobacco
Price	<ul style="list-style-type: none"> Use evidence-based pricing strategies that discourage tobacco use Ban free samples and price discounts
Social Support & Services	<ul style="list-style-type: none"> Quitline and other cessation services (please note that only up to 5% of the total award for tobacco prevention and control can be spent on nicotine replacement therapy (NRT)).

- 855
- 856
- 857 Selection of evidence-based interventions to pursue should be based on a thorough
 - 858 analysis of the gaps and opportunities that exist in the community and should reflect
 - 859 the potential for broad reach, impact, and successful implementation.
 - 860
 - 861 • Propose strategies that are most likely to affect community-wide burden and therefore
 - 862 where appropriate emphasize plans to eliminate health disparities.
 - 863
 - 864 • Select interventions to implement smoke free air policies within the jurisdiction. If
 - 865 there is not a comprehensive tobacco ban, the applicant must include a detailed plan
 - 866 for implementation.
 - 867
 - 868 • Select evidence-based pricing interventions demonstrated to discourage tobacco use.
 - 869 Applicants must provide current information and plans to address the price of tobacco
 - 870 consistent with the evidence base cited in Attachment C.
 - 871
 - 872 • Applicants should engage the existing coalition or coalitions and potential members
 - 873 of the leadership team in the selection process.

869 Performance will be measured by evidence that the intervention area encompasses the

870 jurisdiction of the health department and that the communities have selected interventions

871 that address all five evidence-based MAPPs strategies and that the interventions have

872 broad reach and impact in the community.

874 5) Community Action Plan (CAP).

- 875 • Submit a two-year CAP as part of the application that describes an overall integrated
876 strategy that identifies the selected interventions; describes key activities; describes
877 milestones and timelines on achieving intervention implementation; identifies
878 anticipated policy outcomes; and includes SMART Objectives (Specific, Measurable,
879 Achievable, Relevant, Time-Framed) for each intervention.
- 880 • 90 days post-award, finalize the two-year CAP utilizing recommendations from the
881 application objective review process and input from community information, HHS
882 agencies, other sources of programmatic support, and on-going discussions with
883 internal staff and community partners.
- 884 • Clearly articulate how activities and interventions highlighted in the CAP will be
885 sustained after Recovery Act funding has ceased.

886 Performance will be measured by evidence that the CAP contains program objectives that
887 are SMART, that there are plans for sustainability, and that the plan is approved by CDC.
888 Additionally, performance will be measured on a quarterly basis that the awardee is
889 successfully meeting milestones and benchmarks as indicated in the CAP.

890

891 6) Community-wide and school-based policy, systems, and environmental change
892 strategies.

- 893 • Address all five evidence-based MAPPS strategies for tobacco prevention and control
894 in communities and, as relevant, in schools, such that the reach and potential impact
895 is consistent with achieving the long-term goal of the initiative (e.g. a smoke-free

896 indoor air policy that impacts the entire jurisdiction, evidence-based pricing strategies
897 that discourage tobacco use that impacts the entire jurisdiction).

898 • Where applicable, implement a targeted strategy in areas with a disproportionate
899 burden of chronic diseases/conditions (e.g., racial/ethnic minorities; people with
900 severe and persistent mental illness; lesbian, gay, bisexual, and transgender
901 populations) that tend to experience disparities in access to and use of preventive and
902 health care services. This focused strategy should include significant areas of the
903 community in order to have the broadest impact possible (e.g. low literacy media
904 messages that influence quitting or lead smokers to the quitline; county wide smoke-
905 free air policies not just one worksite, school or health care)

Comment [JGL2]: Again, helpful language.

- 906 • Work with media-buying contractors to develop and refine a media-buy strategy.
- 907 • Collaborate with CDC to implement emotional, hard-hitting counter-marketing and
908 messaging and normative marketing to reduce tobacco use and prevent youth
909 initiation. Co-brand and locally tag all campaign advertisements and materials with
910 locally relevant information and resources.
- 911 • Severely curtail tobacco promotion and advertising consistent with federal law, which
912 can include but is not limited to, restricting or eliminating “power walls” of cigarettes
913 offered for sale at retail outlets, limiting the number or size of tobacco product ads at
914 retail outlets, and requiring that all tobacco products be kept away from cash
915 registers.

916 Performance will be measured by evidence of progress in building community capacity to
917 institute policy, systems, and environmental changes.

918

919 7) Evaluation to monitor/measure progress.

- 920 • 60 days post award, establish a monitoring plan that includes the following:
 - 921 ○ The systematic collection of data on a bi-annual basis (twice a year) of progress
 - 922 on and implementation of existing policy, systems, and environmental change
 - 923 strategies using the Community Health Assessment aNd Group Evaluation
 - 924 (CHANGE) tool related to chronic disease prevention and health promotion, to
 - 925 evaluate the process and outcomes of program activities. For awardees who
 - 926 have failed to meet benchmarks in Year 1, reporting of some elements of the
 - 927 CHANGE tool will be required quarterly.
 - 928 ○ The collection of implementation cost information for each initiative, to evaluate
 - 929 the process and outcomes of program activities.
- 930 • 120 days post award, finalize a comprehensive evaluation plan that is directly tied to
- 931 the Community Action Plan.
- 932 • Track progress on implementing activities to create policy, system, and
- 933 environmental changes utilizing the CHANGE Tool.
- 934 • Collaborate with and provide necessary information to your state health department,
- 935 which will be responsible for collecting BRFSS data at the community level at
- 936 baseline and follow-up.
- 937 • Work with state and local education and health agencies and CDC to conduct a
- 938 YRBSS using standard YRBSS protocol among a representative sample of as many
- 939 as 1,500 to 2,000 9th - 12th grade students in the intervention area during the fall
- 940 semester of the 2010-2011 school year that measures at least tobacco use. Repeat the

- 941 YRBSS among another representative sample of 9th-12th grade students at the end of
942 the project period. Cooperative agreement funds may be spent on school incentives.
- 943 • If selected as a case study site, collaborate with CDC and contractors in implementing
944 a site-specific case study that examines contextual and environmental factors that act
945 as facilitators or barriers to program implementation and achievement of intended
946 outcomes and lead to variations in implementation costs across sites.
 - 947 • In collaboration with CDC, provide information that will assist with modeling
948 studies, which will allow, even in the short term, some estimation of long-term impact
949 of policy and environmental changes on risk behavior and health outcomes.

950 Performance will be measured by evidence that the evaluation plan addresses the lifespan
951 of the program; that the awardee is appropriately participating in any national evaluation
952 activities; and that adequate progress is made on targets for specific outcome and output
953 measures.

954

955 8) Participation in Programmatic Support Activities

- 956 • 30 days post-award, ensure that three members of the Leadership Team (the Program
957 Director, the program coordinator or equivalent, and one additional leader outside the
958 health department) attend a kick-off meeting in Atlanta.
- 959 • 90 days post-award, ensure that all 8-10 members of the Leadership Team participate
960 in an Action Institute that will promote the importance of policy, systems, and
961 environmental change strategies.
- 962 • Ensure that two members of the Leadership Team attend two peer-peer meetings
963 during the project period.

- 964 • Ensure that the YRBSS lead attends a CDC-led 3-day YRBSS training in August
965 2010.
- 966 • In collaboration with CDC, work with currently-funded community-based programs
967 (e.g. Healthy Communities, REACH, Active Living by Design, and others) to learn
968 about cutting-edge policy and environmental change strategies and interventions to
969 eliminate health disparities.
- 970 • If applicable, invite national experts and health-related foundations to provide
971 programmatic support with the selected interventions.
- 972 • [It is strongly encouraged that all communities invite experts to provide programmatic](#)
973 [support on tailoring some portion of their intervention to local health disparity](#)
974 [populations.](#)
- 975 • In collaboration with CDC, provide information on successful initiatives at the
976 community level that can be published on the web and shared with other
977 communities.
- 978 • For state-coordinated small city and rural areas, the State-Community Management
979 Team should provide or facilitate the provision of programmatic support and
980 consultation to their funded communities in risk factor surveillance, program
981 evaluation, evidence-based and practice-based policies, systems, and environmental
982 changes, community engagement, and intervention selection and development.
- 983 • For state-coordinated small city and rural areas, the State Health Department is
984 responsible for ensuring that at least 75% of the total award is distributed to the
985 identified communities in the state-coordinated application.

986 Performance will be measured by attendance and participation in training programs, peer-
987 peer meetings, and dissemination activities. State health department performance will be
988 measured by the level of programmatic support provided and the percentage of funds
989 distributed to identified communities.

990

991 Peer-to-Peer Mentorship

992 Note: There will be an opportunity for successful applicants to apply for up to \$10
993 million supplement (April 2010) to support peer-to-peer mentoring in the following
994 areas:

- 995 • Serving as an expert center in selected areas of expertise by coordinating
996 programmatic support to communities that request information sharing and on-
997 the-ground lessons learned in specific intervention areas.
- 998 • Providing on-site workshops to profile outstanding success and give peer
999 communities on-the-ground access to seeing interventions in place, information
1000 sharing sessions with leadership and staff, and sharing lessons learned.
- 1001 • Serving as an information warehouse of broad-based policy change interventions,
1002 implementation tools, promising approaches, and strategies for addressing broad-
1003 based policy changes.

1004 **CDC Activities**
1005

1006
1007 In a cooperative agreement, CDC staff is substantially involved in the program activities, above
1008 and beyond routine grant monitoring.

1009
1010 CDC activities for this program, applicable to all applicants, are as follows:

- 1011
- 1012 • Provide ongoing community programmatic support to ensure success for Recovery
1013 Act-funded communities in the following areas:
1014 1. Community assessment and planning,

- 1015 2. Evidence-based and practice-based approaches,
- 1016 3. Community mobilization and partnership development,
- 1017 4. Implementation of broad-based policy, systems, and environmental changes,
- 1018 5. Program sustainability,
- 1019 6. Evaluation of policy, system, and environmental level change,
- 1020 7. Monitoring of risk behavior change and longer-term health outcomes,
- 1021 8. Developing and revising Community Action Plans.
- 1022
- 1023 • Foster the transfer of successful evidence and practice-based interventions, program
- 1024 models and other forms of community programmatic support by convening meetings,
- 1025 workshops, web forums, conferences, and conference calls with awardees.
- 1026
- 1027 • Conduct on-site visits to awardees to ensure achievement of quarterly benchmarks
- 1028 and project success as determined by the Recovery Act and outlined within this FOA.
- 1029
- 1030 • Plan, implement, and organize Recovery Act Action Institutes and Peer-to-Peer
- 1031 meetings for awardees and teams.
- 1032
- 1033 • Participate in a national media campaign strategy and coordinate with local
- 1034 implementation of media interventions that will foster effective and hard-hitting
- 1035 prevention and wellness messages and advertisements that will complement and
- 1036 reinforce state and community activities.
- 1037

- 1038
- Maintain an electronic community health web portal and other mechanisms for
1039 information sharing among awardees that includes a web-site and web-board.
1040
- 1041
- Record best practices and community experiences for dissemination to existing
1042 awardees and other communities for replication of successful interventions.
1043
- 1044
- Fund national experts to provide programmatic support in implementing the
1045 prescribed set of evidence-based MAPPs strategies and the selected interventions.
1046
- 1047
- Provide project monitoring that includes the analysis of performance measures and
1048 the consistency of measurement and comparability of Recovery Act reporting
1049 measures and CHANGE tool data.
1050
- 1051
- Coordinate with other Federal agencies and existing place-based revitalization and
1052 reform projects funded by the US Government, including community development
1053 and livability efforts and activities funded by the Recovery Act.
1054
- 1055
- In addition to community evaluation efforts, HHS has allocated \$39.5 million to
1056 support evaluation of community efforts through community and state level risk
1057 factor surveillance, case studies in funded communities and states, cost tracking, and
1058 modeling. Behavioral outcomes will be tracked using existing BRFSS and YRBSS
1059 tools, and the CDC CHANGE Tool data collected in funded communities. CDC will
1060 utilize data from BRFSS, YRBSS, and modeling techniques to monitor behavior

1061 changes and changes to chronic disease risk factors on a national scale, supplemented
1062 by cost studies as well as case studies in selected sites.

1063

- 1064 • Provide a 3-day YRBSS training in August 2010 and prior to administration of the
1065 second YRBSS at the end of the project period and ongoing technical assistance to
1066 support implementation of the YRBSS using standard YRBSS protocols.

1067

1068 **II. Award Information**

1069 Type of Award: Cooperative Agreement.

1070 CDC's involvement in this program is listed in the Activities Section above.

1071 Award Mechanism: U58

1072 Fiscal Year Funds: 2009-2010 Recovery Act

1073 Approximate Current Fiscal Year Funding: \$373 million

1074 Approximate Total Project Period Funding: \$373 million. This amount is an estimate, and is
1075 subject to availability of funds. This includes direct and indirect costs.

1076

1077 Awards for both categories will vary with size of jurisdiction, the proposed activities, and the
1078 needs of each community. Approximately 30-40 awardees will be made for the CPPW Initiative,
1079 but the number of awards will depend on the preceding factors and may fall outside of this
1080 approximate range of number of awards and amount of funding per award.

1081

1082 Illustrative ranges are:

1083

1084 **Category A: Obesity/Physical Activity/Nutrition**

- 1085 • Large city applicants: \$10 million – \$20 million
- 1086 • Urban area applicants: \$4 million – \$10 million
- 1087 • Tribal applicants: \$500,000 – \$1.2 million
- 1088 • State coordinated small city and rural area applicants: \$3 million - \$8 million

1089

1090 **Category B: Tobacco Prevention and Control**

- 1091 • Large city applicants: \$10 million – \$20 million
- 1092 • Urban area applicants: \$4 million – \$10 million
- 1093 • Tribal applicants: \$500,000 – \$1.2 million
- 1094 • State coordinated small city and rural area applicants: \$3 million - \$8 million

1095

1096 This amount is for the 24-month budget period, and includes both direct and indirect costs.

1097 Anticipated Award Date: February 26, 2010

1098 Budget Period Length: 24 months

1099 Project Period Length: 24 months

1100

1101 The specific amount of funding per community will be determined by a mix of interventions,
1102 population size, ability to reduce health disparities, and likelihood of success.

1103

1104 Throughout the project period, CDC's commitment to continuation of awards will be
1105 conditioned on the availability of funds, evidence of satisfactory progress by the recipient (as

1106 documented in required reports), and the determination that continued funding is in the best
1107 interest of the Federal government.

1108

1109 Please note: Applicants who apply for both Categories A and B of this announcement will
1110 submit two separate applications. Should an applicant compete successfully in both categories to
1111 receive two awards, CDC will conduct budget negotiations with the applicant to merge the
1112 staffing plans and reduce the requested budgets accordingly in order to reflect a combined
1113 operating structure.

1114

1115 **III. Eligibility Information**

1116 **III.1. Eligible Applicants**

1117 Eligible applicants that can apply for this funding opportunity are listed below:

- 1118 • An official local health department (or its bona fide agent), or its equivalent, as
1119 designated by the mayor, county executive, or other equivalent governmental official,
1120 will serve as the lead/fiduciary agent for a **Large City** application. For this
1121 announcement, the term “large city” is defined as a local health department that serves a
1122 jurisdiction with a population of more than 1 million people.
- 1123 • An official local health department (or its bona fide agent), or its equivalent, as
1124 designated by the mayor, county executive, or other equivalent governmental official,
1125 will serve as the lead/fiduciary agent for an **Urban Area** application. For this
1126 announcement, the term “urban area” is defined as a local health department that serves a
1127 jurisdiction with a population more than 500,000 and up to 1 million people.

- 1128 • Federally recognized Tribal Governments, Regional Area Indian Health Boards, Urban
1129 Indian organizations, and Inter-Tribal Councils as designated by the Principal Tribal
1130 elected official or chief executive officer will serve as the lead/fiduciary agency for
1131 **Tribal Community** applications.
- 1132 • An official state health department (or its bona fide agent), or its equivalent, as
1133 designated by the Governor, is to serve as the lead/fiduciary agency for **Small City and**
1134 **Rural Community** applications. For this announcement, the term “State” includes the
1135 50 states, the Commonwealth of Puerto Rico, the Virgin Islands, the Commonwealth of
1136 the Northern Marianna Islands, American Samoa, Guam, the Federated States of
1137 Micronesia, the Republic of the Marshall Islands, and the Republic of Palau. The term
1138 “small city” is defined as a local health department that serves a jurisdiction with a
1139 population between 50,000 – 500,000 people. The term “rural area” is defined as a local
1140 health department that serves a jurisdiction with a population of 50,000 people and
1141 below.
- 1142 • [A community-based organization with a demonstrated expertise in managing an award of](#)
1143 [this magnitude and running health intervention programs that reach and target a specific](#)
1144 [health disparity population as defined earlier in this RFA.](#)

1146 III.2. Cost Sharing To Promote Sustainability

1147

1148 There is no match requirement for this program. However, leveraging other resources and
1149 related on-going efforts to promote sustainability is encouraged. Examples include foundation

1150 funding, other US government funding sources including the Recovery Act, and state
1151 appropriations. (See Attachment B)

1152

1153 III.3. Other

1154

1155 Applications that do not address all activities will be considered non-responsive, and will not be
1156 entered into the review process.

1157

1158 For state-coordinated small city and rural areas, state health department applicants that have not
1159 pre-selected the communities to be funded under this initiative will be considered non-responsive
1160 and not entered into the review process. Only one application can be submitted per state for
1161 Category A and only one application per state for Category B, for a maximum of two
1162 applications per state if applying for Category A and Category B. Within each state application,
1163 states may only submit up to 2 communities to fund: i.e. a combination of one small city and one
1164 rural community; two small cities; or two rural communities. State health departments that have
1165 not identified a maximum of 2 communities per application will be considered non-responsive
1166 and not entered into the review process.

1167

1168 The applicant will be notified the application did not meet the submission requirements.

1169

1170 Applicants are required to submit a Letter of Intent (LOI) to be eligible to apply for this program.

1171 Failure to submit a LOI will result in non-responsiveness and the applicant will be prohibited

1172 from applying. See Sections IV.2, IV.3, and IV.6 of this announcement for more information on

1173 LOI submission. The LOI must identify the type of applicant and the risk factor area to be

1174 addressed. If an applicant wishes to apply for both tobacco and obesity/ physical activity/
1175 nutrition funding, one LOI can be submitted to indicate that intention.

1176

1177 Note: Title 2 of the United States Code section 1611 states that an organization described in
1178 section 501(c)(4) of the Internal Revenue Code that engages in lobbying activities is not eligible
1179 to receive Federal funds constituting an award, grant, or loan.

1180

1181 Special Requirements:

1182

1183 If the application is non-responsive it will not be entered into the review process. The applicant
1184 will be notified the application did not meet submission requirements.

1185 • Late applications will be considered non-responsive. See section “IV.3. Submission
1186 Dates and Times” for more information on deadlines.

1187 In accordance with applicable laws and regulations including 45 CFR 92.43, CDC may take
1188 certain enforcement actions, including termination of funding, against poor performing grants.

1189

1190 **IV. Application and Submission Information**

1191 IV.1. Address to Request Application Package

1192 To apply for this funding opportunity use the application forms package posted in Grants.gov.

1193

1194 Electronic Submission:

1195 CDC strongly encourages the applicant to submit the application electronically by utilizing the
1196 forms and instructions posted for this announcement on www.Grants.gov, the official Federal

1197 agency wide E-grant Web site. Only applicants who apply on-line are permitted to forego paper
1198 copy submission of all application forms.

1199

1200 Registering your organization through www.Grants.gov is the first step in submitting
1201 applications online. Registration information is located in the “Get Registered” screen of
1202 www.Grants.gov. While application submission through www.Grants.gov is optional, we
1203 strongly encourage you to use this online tool.

1204

1205 Please visit www.Grants.gov at least 30 days prior to filing your application to familiarize
1206 yourself with the registration and submission processes. Under “Get Registered,” the one-time
1207 registration process will take three to five days to complete; however, as part of the Grants.gov
1208 registration process, registering your organization with the Central Contractor Registry (CCR)
1209 annually, could take an additional one to two days to complete. We suggest submitting electronic
1210 applications prior to the closing date so if difficulties are encountered, you can submit a hard
1211 copy of the application prior to the deadline.

1212

1213 Application forms and instructions are available on the CDC Web site, at the following Internet
1214 address: http://www.cdc.gov/od/pgofunding/grants/app_and_forms.shtm

1215

1216 IV.2. Content and Form of Submission

1217

1218 **Letter of Intent (LOI):**

1219 Prospective applicants are required to submit a letter of intent that includes the following
1220 information (failure to submit a LOI will result in non-responsiveness and the applicant will be
1221 prohibited from applying):

- 1222 • Program announcement title and number;
- 1223 • Whether the application will be from a Large City, Urban Area, Tribal Community or a
1224 State-Coordinated Small City/ Rural Area, as defined in section III.1. Eligible Applicants;
- 1225 • The name of the lead/fiduciary agency or organization, the official contact person and
1226 that person's telephone number, fax number, mailing and email addresses; and
- 1227 • Each risk factor area (tobacco and/or obesity/ physical activity/ nutrition) for which the
1228 applicant intends to apply.

1229

1230 *Format:*

1231 The LOI should be no more than two pages (8.5 x 11), double-spaced, printed on one side, with
1232 one-inch margins, written in English (avoiding jargon), and unreduced 12-point font.

1233

1234 **Letter of Intent (LOI):** A letter of intent (LOI) from the Chief Health Officer (Local Health
1235 Officer, Tribal Health Officer, State Health Officer, or other equivalent governmental official) is
1236 required from all potential applicant communities for the purposes of planning the competitive
1237 review process. Failure to submit a LOI will result in non-responsiveness and the applicant will
1238 be prohibited from applying.

1239

1240 Although the LOI will not be scored as part of the application process, submission of the LOI is
1241 considered the submission of a formal application and the applicant will be subject to lobbying

1242 restrictions highlighted in section VIII. “Recovery Act Lobbying Restrictions.” Applicants will
1243 be notified by email upon receipt of the LOI by CDC.

1244

1245 **Application:**

1246 A Project Abstract must be submitted with the application forms. All electronic project abstracts
1247 must be uploaded in a PDF file format when submitting via Grants.gov. The abstract must be
1248 submitted in the following format, if submitting a paper application:

- 1249 • Maximum of 2-3 paragraphs.
- 1250 • Font size: 12 point unreduced, Times New Roman
- 1251 • Single spaced
- 1252 • Paper size: 8.5 by 11 inches
- 1253 • Page margin size: One inch

1254

1255 The Project Abstract must contain a summary of the proposed activity suitable for dissemination
1256 to the public. It should be a self-contained description of the project and should contain a
1257 statement of objectives and methods to be employed. It should be informative to other persons
1258 working in the same or related fields and insofar as possible understandable to a technically
1259 literate lay reader. This Abstract must not include any proprietary/confidential information.

1260 A project narrative must be submitted with the application forms. All electronic narratives must
1261 be uploaded in a PDF file format when submitting via Grants.gov. The narrative must be
1262 submitted in the following format:

1263

- 1264 • Maximum number of pages: 30. If your narrative exceeds the page limit, only the first
- 1265 pages which are within the page limit will be reviewed.
- 1266 • Font size: 12 point unreduced, Times New Roman
- 1267 • Double spaced
- 1268 • Paper size: 8.5 by 11 inches
- 1269 • Page margin size: One inch
- 1270 • Number all narrative pages; not to exceed the maximum number of pages.

1271

1272 The narrative should address activities to be conducted over the entire project period for either

1273 Category A or Category B and must include the following items in the order listed:

1274

1275 I. Program Infrastructure and Fiscal Management

- 1276 A. Identify required staff, qualifications, and responsibilities.
- 1277 B. For state-coordinated small city and rural areas, state health departments need to
- 1278 identify staff, qualifications, and responsibilities for the state-community
- 1279 management team. Describe plans for programmatic support to the funded
- 1280 communities.
- 1281 C. Describe financial management systems that are in place to fulfill the Recovery
- 1282 Act reporting requirements outlined in section VI.3. Reporting Requirements
- 1283 under “Recovery Act-Specific Reporting Requirements.”
- 1284 D. Describe how proposed efforts will be sustained after Recovery Act funding has
- 1285 ceased.

1286

1287 II. Leadership Team and Coalitions

- 1288 A. Identify potential members of the Leadership Team, including letters of support
1289 that detail their commitment to advancing the broad-based policy changes
1290 selected from the menu of evidence-based MAPPS strategies or other proposed
1291 interventions (letters of support can be included as part of the Appendices).
- 1292 B. Provide a description of the existing community coalition or coalitions, including
1293 the types of groups represented (membership lists can be included as part of the
1294 Appendices). Describe the past successes of the existing coalition(s) working with
1295 community leaders in advancing broad-based policy, systems, and environmental
1296 change strategies.
- 1297 C. Include a letter of support from the mayor, county executive, tribal leader, or
1298 other equivalent official that demonstrates their commitment to supporting the
1299 CPPW Initiative and the reporting requirements as highlighted in this FOA (letter
1300 of support can be included as part of the Appendices).
- 1301 D. Include list of other Federal ARRA collaborations.

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1303 III. Intervention Area and Populations of Need

- 1304 A. Describe the jurisdiction of the intervention area including a thorough description
1305 of the exact population size and location of the populations to be served.
- 1306 B. Include local data (where available), that provides the population size;
1307 substantiates the existing burden and/or disparities of chronic diseases and
1308 conditions; substantiates existing health risk behaviors and risk factors related to
1309 chronic diseases; and describes assets and barriers to successful program
1310 implementation, including an understanding of the policy, systems, and

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1311 environmental policies in the community. Ensure that these data highlight
1312 geographic areas and populations of high need, which should include description
1313 of racial and ethnic minorities, low-income persons, sexual and gender minorities,
1314 the medically underserved, persons with disabilities, persons affected by mental
1315 illness, or persons affected by substance abuse.

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1316
1317 IV. Selection of Risk Factors and Interventions

- 1318 A. Clearly indicate which risk factors will be addressed: tobacco or obesity/ physical
1319 activity/ nutrition. If selecting both, please provide separate descriptions of how
1320 each risk factor will be addressed.
- 1321 B. Identify intervention strategies across the five evidence-based MAPPs strategies,
1322 provide a justification of why these interventions were selected including an
1323 assessment of the current needs and assets in the community related to tobacco or
1324 obesity/physical activity/nutrition, and indicate plans for sustainability and
1325 leveraging resources. Identify how the applicant has addressed priority
1326 interventions (tobacco smoke free policies and evidence-based pricing strategies
1327 OR removing/limiting availability of unhealthy food and beverages).
- 1328 C. If proposing an intervention not included in the prescribed menu of interventions,
1329 provide a justification for the choice of the intervention (e.g. identified need or
1330 opportunity) and demonstrate that it has the potential for broad reach and impact
1331 not achievable with a listed intervention.
- 1332 D. Explain how the intervention strategies will impact the entire jurisdiction of the
1333 health department and how they have the potential for broad reach and impact.

1334 | Ensure that the selection of interventions takes into account the [health disparities](#),
1335 | gaps and opportunities that exist in the community.

1336 | E. Include a Community Action Plan that describes an overall integrated strategy
1337 | that identifies the selected interventions; describes key activities; describes
1338 | milestones and timelines on achieving intervention implementation; identifies
1339 | anticipated policy outcomes; and includes SMART Objectives (Specific,
1340 | Measurable, Achievable, Relevant, Time-Framed) for each intervention.
1341 | (Community Action Plans can be included as part of the Appendices).

1342 | F. Provide examples of how the awardee will interact with the state health
1343 | department, national experts, [health disparity experts](#), foundations and CDC on
1344 | the implementation of selected interventions.

1345 |

1346 | V. Evaluation to Monitor/Measure Progress

1347 | A. Include a description of the overall plan to evaluate the initiative at the
1348 | community level, including participation in the national evaluation strategy.

1349 | B. Provide letters of support from all public school districts within the intervention
1350 | area indicating support for implementing the YRBSS survey using standard
1351 | YRBSS protocol for baseline during the fall semester of the 2010-2011 school
1352 | year and follow-up at the end of the project period (letters of support can be
1353 | included as part of the Appendices).

1354 | C. Provide examples of how the awardees will interact with the state health
1355 | department, national contractors, and CDC on evaluation activities.

1356 | D. [Provide examples of how health disparity population impact will be monitored](#)
1357 | [and evaluated.](#)

1358 | E. For those communities engaged in biometric data collection and who wish to
1359 | improve their efforts, describe current approach (e.g. target audience including
1360 | which school-age populations (which ages/grades), method of data collection,
1361 | frequency of data collection, and evidence of validity and reliability of data
1362 | collected) as well as plans for upgrading the current approach with these funds.
1363 | All applicants should describe any current activities to collect these data in
1364 | school-age populations.

1365 | VI. Community Programmatic Support Needs

1366 | A. Include a detailed description of support needed that could be addressed by CDC,
1367 | national experts, and/or expert communities.

1368 |

1369 | The budget and budget justification will be included as separate attachments, not to be counted in
1370 | the narrative page limit.

1371 |

1372 | Additional information may be included in the application appendices. The appendices will not
1373 | be counted toward the narrative page limit. This additional information includes:

1374 | • Curricula Vitae, Resumés, Organizational Charts, Letters of Support, Membership Lists,
1375 | and Indirect Cost Agreement.

1376 | • Community Action Plan that includes the selected evidence-based MAPPs strategies;
1377 | describes key activities; identifies anticipated policy outcomes; and includes SMART

1378 Objectives (Specific, Measurable, Achievable, Relevant, Time-Framed) for each
1379 intervention.

1380

1381 Additional information submitted via Grants.gov should be uploaded in a PDF file format, and
1382 should be named:

1383 • “807_(state two letter abbreviation)_(document name)”

1384 (e.g., 807_GA_ResuméSmith.pdf; 807_GA_OrgChartDivision.pdf)

1385

1386 No more than 10 appendices should be uploaded per application. Letters of support can be
1387 included as one appendix.

1388 The agency or organization is required to have a Dun and Bradstreet Data Universal Numbering
1389 System (DUNS) number to apply for a grant or cooperative agreement from the Federal
1390 government. The DUNS number is a nine-digit identification number, which uniquely identifies
1391 business entities. Obtaining a DUNS number is easy and there is no charge. To obtain a DUNS
1392 number, access the [Dun and Bradstreet website](#) or call 1-866-705-5711.

1393

1394 Additional requirements that may request submission of additional documentation with the
1395 application are listed in section “VI.2. Administrative and National Policy Requirements.”

1396

1397 IV.3. Submission Dates and Times

1398 **Letter of Intent (LOI) Deadline Date: November 6, 2009 (EDT)**

1399 **Suggested Submission Date: November 27, 2009**

1400 ***Note: The application is not complete until you have completed the validation process. After***
1401 ***you receive the submission receipt email, the next email you will receive will be a message***

1402 *validating or rejecting your submitted application package with errors. Validation may take at*
1403 *least two (2) calendar days; however, you may check the status of your application to ensure*
1404 *submission is complete. To guarantee that you comply with the Funding Opportunity*
1405 *Announcement, allocate additional days to file. Non-validated applications will not be*
1406 *accepted after the due date. If no validation is received within two (2) calendar days of*
1407 *submission, you may contact Grants.gov. Please refer to the email message generated at the*
1408 *time of application submission for instructions on how to track your application or the*
1409 *Application User Guide, Version 3.0 page 57.*

1410
1411 Application Deadline Date: December 1, 2009 (EST)

1412

1413 Explanation of Deadlines: Applications must be received in the CDC Procurement and Grants

1414 Office by 5:00 p.m. Eastern Daylight/Standard Time on the deadline date.

1415

1416 Applications must be submitted electronically at www.Grants.gov. Applications completed on-

1417 line through Grants.gov are considered formally submitted when the applicant organization's

1418 Authorizing Organization Representative (AOR) electronically submits the application to

1419 www.Grants.gov. Electronic applications will be considered as having met the deadline if the

1420 application has been successfully submitted electronically by the applicant organization's AOR

1421 to Grants.gov on or before the deadline date and time.

1422

1423 When submission of the application is done electronically through Grants.gov

1424 (<http://www.grants.gov>), the application will be electronically time/date stamped and a tracking

1425 number will be assigned, which will serve as receipt of submission. The AOR will receive an e-

1426 mail notice of receipt when HHS/CDC receives the application.

1427

1428 IMPORTANT NOTICE: It is the applicant's responsibility to determine that the application has

1429 been received. If you do not receive a receipt confirmation and either a validation confirmation

1430 or a rejection email message within 48 hours, please contact Grants.gov. The Grants.gov Contact
1431 Center can be reached by email at support@grants.gov, or by telephone at 1-800-518-4726.
1432 Always include your Grants.gov tracking number in all correspondence. The tracking numbers
1433 issued by Grants.gov look like GRANTXXXXXXXX. HHS/CDC strongly recommends that
1434 submittal of the application to Grants.gov should be prior to the closing date to resolve any
1435 unanticipated difficulties prior to the deadline.

1436
1437 If your application is successfully validated and subsequently retrieved by the CDC Procurement
1438 and Grants Office from the Grants.gov system, you will receive an additional e-mail. This e-
1439 mail may be delivered several days or weeks from the date of submission, depending on when
1440 the application is retrieved.

1441
1442 You may also monitor the processing status of your submission within the Grants.gov system by
1443 using the following steps:

- 1444
- 1445 1. Go to <http://www.grants.gov>
 - 1446 2. Click on the “Track Your Application” link on the left side
1447 navigation bar on the Grants.gov homepage.
 - 1448 3. Login to the system using your AOR user ID and password
 - 1449 4. Click on the “Check Application Status” link on the left side
1450 navigation bar.

1451

1452 Note: Once the CDC Procurement and Grants Office have retrieved your application from
1453 Grants.gov, you will need to contact the CDC Procurement and Grants Office directly for any
1454 subsequent status updates. Grants.gov does not participate in making any award decisions.

1455
1456 This announcement is the definitive guide on letter of intent (LOI) and application content,
1457 submission address, and deadline. It supersedes information provided in the application
1458 instructions. If the application submission does not meet the deadline above, it will not be
1459 eligible for review. The application face page will be returned by HHS/CDC with a written
1460 explanation of the reason for non-acceptance. The applicant will be notified the application did
1461 not meet the submission requirements.

1462

1463 IV.4. Intergovernmental Review of Applications

1464 Executive Order 12372 does not apply to this program.

1465

1466 IV.5. Funding Restrictions

1467 Restrictions, which must be taken into account while writing the budget, are as follows:

- 1468 • Recipients may not use funds for research.
- 1469 • Recipients may not use funds for clinical care, but can include funds for clinical services
1470 where appropriate.
- 1471 • Recipients may only expend funds for reasonable program purposes, including personnel,
1472 travel, supplies, and services, such as contractual.
- 1473 • Recipients may not generally use HHS/CDC/ATSDR funding for the purchase of
1474 furniture or equipment. However, if equipment purchase is integral to a selected MAPPs

1475 strategy, it will be considered. Any such proposed spending must be identified in the
1476 budget.

- 1477 • Recipients may not use funding for construction.
- 1478 • The direct and primary recipient in a cooperative agreement program must perform a
1479 substantial role in carrying out project objectives and not merely serve as a conduit for an
1480 award to another party or provider who is ineligible.
- 1481 • Reimbursement of pre-award costs is not allowed.
- 1482 • Recipients may not spend more than 5% of the total award for tobacco prevention and
1483 control on nicotine replacement therapy (NRT).

1484
1485 If requesting indirect costs in the budget, a copy of the indirect cost rate agreement is required.

1486 If the indirect cost rate is a provisional rate, the agreement should be less than 12 months of age.

1487 The indirect cost rate agreement should be uploaded as a PDF file with “Other Attachment
1488 Forms” when submitting via Grants.gov.

1489
1490 The recommended guidance for completing a detailed justified budget can be found on the CDC
1491 Web site, at the following Internet address:

1492 <http://www.cdc.gov/od/pgo/funding/budgetguide.htm>.

1493

1494 IV.6. Other Submission Requirements

1495

1496 LOI Submission Address: Submit the LOI by express mail, delivery service, fax, or E-mail to:

1497 Tracey Sims, Grants Management Specialist

1498 Procurement and Grants Office
1499 Centers for Disease Control and Prevention
1500 2920 Brandywine Road, MS E-09
1501 Atlanta, GA 30341
1502 Phone Number: 770-488-2739
1503 Fax Number: 770-488-2778
1504 E- mail: atu9@cdc.gov

1505

1506 Please send a courtesy copy of the LOI by express mail, delivery service, fax, or E-mail to:

1507

1508 Adrienne S. Brown, Public Health Analyst
1509 Division of Adult and Community Health
1510 National Center for Chronic Disease Prevention and Health Promotion
1511 Centers for Disease Control and Prevention
1512 3005 Chamblee-Tucker Road, Mailstop K-45
1513 Atlanta, GA 30341
1514 Fax: (770) 488-5964

1515

1516 The information contained within the LOI is required and allows CDC Program staff to estimate
1517 the potential review workload and plan the review of applications. Failure to submit a LOI will
1518 result in non-responsiveness and the applicant will be prohibited from applying.

1519

1520 Application Submission Address:

1521 Electronic Submission:
1522 HHS/CDC strongly encourages applicants to submit applications electronically at
1523 www.Grants.gov. The application package can be downloaded from www.Grants.gov.
1524 Applicants are able to complete it off-line, and then upload and submit the application via the
1525 Grants.gov Web site. E-mail submissions will not be accepted. If the applicant has technical
1526 difficulties in Grants.gov, customer service can be reached by E-mail at support@grants.gov or
1527 by phone at 1-800-518-4726 (1-800-518-GRANTS). The Customer Support Center is open from
1528 7:00a.m. to 9:00p.m. Eastern Time, Monday through Friday.

1529
1530 The applicant must submit all application attachments using a PDF file format when submitting
1531 via Grants.gov. Directions for creating PDF files can be found on the Grants.gov Web site. Use
1532 of file formats other than PDF may result in the file being unreadable by staff.

1533

1534 **V. Application Review Information**

1535 V.1. Criteria

1536

1537 The application will be evaluated against the following criteria:

1538

1539 Application will be scored on the extent to which the proposed plan provides a robust
1540 combination of interventions with broad reach, and provides evidence that this plan is likely to
1541 produce the long term outcomes of this initiative. The applicant should provide evidence that
1542 performance measures will be achieved during the annual project years or cooperative agreement

1543 project period, as appropriate, in each of the following areas (points indicate the weight of each
1544 criterion):

1545

1546 Evaluation criteria for all applicants are listed under number 1 below.

1547

1548 **1. Applicants**

1549

1550 **A. Program Infrastructure and Fiscal Management (20 points) NOTE: Scoring**
1551 **criteria applicable only to State applications are represented in bold type.**

- 1552 i. Is the lead/fiduciary agency clearly identified? (2 pts) / **(2 pts)**
- 1553 ii. Does the lead/fiduciary agency exhibit the capacity to ensure
1554 accountability for expenditures in relationship to performance of all key
1555 partners and Recovery Act requirements? (4 pts)/ **(3 pts)**
- 1556 iii. How well does the applicant provide evidence of the ability to implement
1557 funding for this program in the time required? (2 pts) / **(2 pts)**
- 1558 iv. Does the applicant identify the required staff for the program, including
1559 the provision of resumés or CVs? How well does the applicant identify
1560 ways in which to engage the required skill sets to fulfill the CPPW
1561 benchmarks? (3 pts) / **(2 pts)**
- 1562 v. Does the applicant provide letters of support from government [and health](#)
1563 [disparity population](#) leaders (e.g. the mayor, the Governor, or Tribal
1564 Council Leader) indicating support for the CPPW Initiative? (3 pts) / **(2**
1565 **pts)**

- 1589 i. Is the leadership team identified and defined to the extent that they will
1590 actively participate in overseeing the strategic direction of project
1591 activities, be responsible for enacting the selected policy changes selected
1592 from the prescribed set of interventions, establish and maintain an
1593 organizational structure and governance for the community coalition or
1594 coalitions, and participate in project-related local and national meetings?
1595 What roles will they play in meeting the purpose of the Initiative? (4 pts)
- 1596 ii. Do members of the leadership team represent the leadership of the
1597 organizations or institutions that they represent? (2 pts)
- 1598 iii. Do the members of the leadership team demonstrate a high-level
1599 commitment to the CPPW Initiative, including a commitment of time and
1600 other resources? (3 pts)
- 1601 iv. Does the applicant have an established community coalition that is
1602 inclusive of key partners, [health disparity experts](#), and related coalitions?
1603 Does the applicant include a list of current members, meeting minutes, or
1604 a memorandum of understanding? (5 pts)
- 1605 v. How well does the applicant describe the capacity of the existing coalition
1606 in terms of leadership, expertise, community representation, collaborative
1607 experience/abilities, [expertise with disparity populations](#), and agency
1608 representation? (3 pts)
- 1609 vi. Have members of the existing coalition successfully worked together and
1610 in collaboration with community leaders to implement broad-based policy,

1611 systems, and environmental change initiatives? Does the applicant provide
1612 examples of past successes? (5 pts)

1613 vii. Does the applicant provide evidence that they will encourage linkages
1614 with other community-based efforts and the Office of the Regional Health
1615 Administrator, with special attention to leveraging other Federally funded
1616 (including Recovery Act funded)- and foundation activities? See
1617 Attachment B for examples. (3 pts)

1618

1619 **C. Intervention Area, Community Action Plan, and Intervention Strategies (30**
1620 **points)**

1621 i. Is the plan sufficiently robust to impact the entire jurisdiction and to
1622 achieve the short and long-term goals of the initiative? (2 pts)

1623 ii. Does the proposed intervention area encompass the entire jurisdiction of
1624 the health department or CBO, including a thorough description of the
1625 exact size and location of the populations to be served? (2 pts)

1626 iii. Are data provided that substantiate the existing burden and/or disparities
1627 of chronic diseases, conditions, existing health behaviors, and risk factors
1628 in the jurisdiction and populations to be served? For health disparity
1629 populations, best possible data must be presented, and data gaps described
1630 (if applicable). (2 pts)

1631 iv. Are assets and barriers to successful program implementation identified,
1632 including an understanding of the policy, systems, and environmental
1633 policies in the community? (3 pts)

- 1634 v. Does the applicant clearly articulate which risk factors they will address:
1635 tobacco or obesity/physical activity/nutrition? Has the applicant selected
1636 from the prescribed set of MAPPS evidence-based strategies and the
1637 appropriate mix of interventions? (2 pts)
- 1638 vi. How well does the applicant justify the selected of interventions? Does the
1639 justification reflect the assets and needs of the community, the decision to
1640 include or to not include the required interventions, and the potential for
1641 broad reach ([inclusive of disparity populations](#)) and impact consistent with
1642 the short and long-term goals of the initiative? (4 pts)
- 1643 vii. Does the two -year community action plan describe an overall integrated
1644 strategy that identifies the selected interventions; describes key activities;
1645 describes milestones and timelines on achieving intervention
1646 implementation; identifies anticipated policy outcomes; and includes
1647 SMART Objectives (Specific, Measurable, Achievable, Relevant, Time-
1648 Framed) for each intervention? (5 pts)
- 1649 viii. Does the applicant describe realistic plans to coordinate proposed
1650 activities with state- and community-level programs to prevent and control
1651 chronic disease? (2 pts)
- 1652 ix. Do the intervention strategies build on and complement, but not duplicate,
1653 existing programs and the potential synergy created through multiple
1654 interventions? (2 pts)
- 1655 x. Does the applicant clearly articulate how the activities and interventions
1656 highlighted in the CAP will be sustained after Recovery Act spending is

1657 complete? Does the applicant provide evidence of leveraging other
1658 resources in the community (e.g. foundations, state funding, private sector
1659 funds, etc.)? (4 pts)

1660 xi. How well does the applicant incorporate cultural and linguistic diversity
1661 and the needs of specific populations disproportionately impacted by
1662 chronic diseases (i.e. low-income groups, racial and ethnic groups, [sexual](#)
1663 [and gender minorities](#), persons with disabilities, and people with clinical
1664 and sub-clinical substance use and/or mental disorders) in their
1665 intervention strategies? (2 pts)

Comment [NS3]: Increase point value of this item to 5 pts minimum. Or continue to include disparity population plans across many scored areas.

1666
1667 **D. Plan for Project Monitoring and Evaluation (20 points)**

- 1668 i. Does the applicant indicate that they will collect Recovery Act
1669 performance measures in the required format and according to the required
1670 schedule? (Highlighted in section VI.3. Reporting Requirements under
1671 “Recovery Act-Specific Reporting Requirements”). (5 pts)
- 1672 ii. Does the applicant describe plans to collaborate fully in external,
1673 independently coordinated evaluation activities to evaluate the overall
1674 impact of the initiative, especially the national evaluation activities? (3
1675 pts)
- 1676 iii. How well does the applicant describe the overall plan to evaluate the
1677 initiative at the community level? (3 pts)
- 1678 iv. Does the applicant describe a detailed plan to collect YRBSS data
1679 according to standard YRBSS protocol, including the identification of a

1680 YRBSS lead who will attend a 3-day YRBSS training in August 2010 and
1681 methods for collecting the data? (4 pts)

1682 v. Does the application contain letters of support from school districts and
1683 schools in the intervention area indicating that school districts and schools
1684 are aware and supportive of the upcoming YRBSS data collection during
1685 the fall semester of the 2010-2011 school year and at the end of the project
1686 period? (4 pts)

1687 vi. How well does the applicant describe their plans to upgrade or expand
1688 their biometric data collection (if applicable)? (1 pt)

1689

1690 **E. Programmatic Support Needs (5 points)**

1691 i. Does the applicant identify opportunities, supports and barriers to
1692 achieving intended outcomes? (1 pts)

1693 ii. How realistically does the applicant describe barriers to achieving broad
1694 reach and impact? (2 pts)

1695 iii. Does the applicant identify specific topic areas where programmatic
1696 support will be needed? (2 pts)

1697

1698 **F. Budget (not scored)**

1699 i. Is the budget reasonable and consistent with the proposed activities and
1700 intent of the initiative?

1701

1702 V.2. Review and Selection Process

1703 Applications will be reviewed for responsiveness by the Procurement and Grants Office (PGO)
1704 and the National Center for Chronic Disease Prevention and Health Promotion. Applications that
1705 are non-responsive to the eligibility criteria will not advance through the review process.

1706 Applicants will be notified the application did not meet submission requirements.

1707 An objective review panel will evaluate complete and responsive applications according to the
1708 criteria listed in the “V.1. Criteria” section above. The panel will be comprised of HHS
1709 employees. A primary, secondary, and tertiary reviewer will score the applications and
1710 document their strengths and weaknesses. The applications will be scored against the criteria not
1711 against one another. These comments will be presented to the panel and a vote will take place by
1712 the panel to determine if the application is approved, disapproved, or deferred.

1713

1714 Applications will be provided to the funding office in order by score and rank determined by the
1715 review panel.

1716

1717 In addition, funding decisions may be made to ensure:

- 1718 • Representation of tobacco and obesity/physical activity/nutrition across communities,
1719 including a varied type of interventions and evidence-based strategies.
- 1720 • Geographic distribution of The Communities Putting Prevention to Work Initiative
1721 nationwide.
- 1722 • Inclusion of communities of varying sizes, including rural, suburban, and urban
1723 communities.
- 1724 • Inclusion of populations disproportionately affected by chronic disease and associated
1725 risk factors.

1726

1727 CDC will provide justification for any decision to fund out of rank order.

1728

1729 VI. Award Administration Information

1730 VI.1. Award Notices

1731 Successful applicants will receive a Notice of Award (NoA) from the CDC Procurement and
1732 Grants Office. The NoA shall be the only binding, authorizing document between the recipient
1733 and CDC. The NoA will be signed by an authorized Grants Management Officer and emailed to
1734 the program director and a hard copy mailed to the recipient fiscal officer identified in the
1735 application.

1736

1737 Unsuccessful applicants will receive notification of the results of the application review by mail.

1738

1739 VI.2. Administrative and National Policy Requirements

1740 • Successful applicants must comply with the administrative requirements outlined in 45
1741 CFR Part 74 and Part 92, as appropriate. The following additional requirements apply to
1742 this project:

1743 • AR-9 Paperwork Reduction Act Requirements

1744 • AR-10 Smoke-Free Workplace Requirements

1745 • AR-11 Healthy People 2010

1746 • AR-12 Lobbying Restrictions

1747 • AR-14 Accounting System Requirements

1748 • AR-15 Proof of Non-Profit Status

- 1749 • AR-20 Conference Support
- 1750 • AR-21 Small, Minority, And Women-owned Business
- 1751 • AR 23 Compliance with 45 C.F.R. Part 87
- 1752 • AR 26 National Historic Preservation Act of 1966
- 1753 • AR-27 Conference Disclaimer and Use of Logos

1754 Additional information on the requirements can be found on the CDC Web site at the following
1755 Internet address: http://www.cdc.gov/od/pgo/funding/Addtl_Reqmnts.htm.

1756

1757 CDC Assurances and Certifications can be found on the CDC Web site at the following Internet
1758 address: <http://www.cdc.gov/od/pgo/funding/grants/foamain.shtm>

1759

1760 For more information on the Code of Federal Regulations, see the National Archives and
1761 Records Administration at the following Internet address:

1762 <http://www.access.gpo.gov/nara/cfr/cfr-table-search.html>

1763

1764 VI.3. Reporting Requirements

1765

1766 The applicant must provide quarterly reports that provide the necessary information related to the
1767 output and outcome measures appropriate to the activities which they have undertaken. As
1768 noted, awardees will be monitored on the following output and outcome measures.

1769

1770 **Outcome Measures**

- 1771 • Measure: Number of policies or strategies fully implemented from the family of
1772 recommended evidence-based policies and strategies in [specific focus area: physical
1773 activity and nutrition or tobacco]
- 1774 • Reporting: CHANGE Tool outcome module
- 1775 • Frequency: Semi-annually. Awardee will report to CDC; CDC will compile into
1776 average scores for aggregate reporting. For awardees who have failed to meet
1777 benchmarks in Year 1, reporting of some elements of the CHANGE tool will be
1778 required quarterly.

1779

1780 **Output Measures**

- 1781 • Measure: Rating (on 1-5 scale) of progress implementing each of the chosen
1782 strategies in [specific focus area: physical activity and nutrition or tobacco]
- 1783 • Reporting: CHANGE Tool progress module
- 1784 • Frequency: Semi-annually. Awardee will report to CDC; CDC will compile into
1785 average scores for aggregate reporting. For awardees who have failed to meet
1786 benchmarks in Year 1, reporting of some elements of the CHANGE tool will be
1787 required quarterly.
- 1788
- 1789 • Measure: Score (green, yellow, red) on quarterly implementation scorecard during the
1790 first year of implementation.
- 1791 • Reporting: Awardee progress reporting “benchmark” scorecard
- 1792 • Frequency: Quarterly report by awardee to Project Officer

1793

- 1794 • Measure: Score (green, yellow, red) on quarterly implementation of Community
- 1795 Action Plan during the second year of implementation.
- 1796 • Reporting: Awardee progress reporting on CAP benchmarks
- 1797 • Frequency: Quarterly report by awardee to Project Officer

1798 **Recovery Act-Specific Reporting Requirements**

1799

1800 1. Other Standard Terms and Conditions

1801 All other grant policy terms and conditions contained in applicable Department of Health
1802 and Human Services (HHS) Grant Policy Statements apply unless they conflict or are
1803 superseded by the following terms and conditions implementing the American Recovery
1804 and Reinvestment Act of 2009 (Recovery Act) requirements below. Recipients are
1805 responsible for contacting their HHS grant/program managers for any needed
1806 clarifications.

1807

1808 2. Quarterly Benchmarks

1809 Awardees are required to meet quarterly benchmarks in the first year of implementation,
1810 located in Attachment A. During year 1, at the end of each quarter, the awardee will
1811 receive a score card that indicates the percentage of benchmarks being met (100%-70%
1812 of benchmarks = green; 70%-50% of benchmarks = yellow; less than 50% of benchmarks
1813 = red). Leadership within CDC will be made aware of those awardees that are scoring in
1814 the yellow and red. Quarterly scores resulting in a red designation will result in an
1815 immediate on-site meeting with CDC staff, community leadership and selected national
1816 experts to establish an emergency plan for overcoming barriers to success. Depending on

1817 the type of community, state and/or local government leaders (e.g. the Governor, Mayor,
1818 or Tribal Council leader) will also be informed. Awardees within the red scorecard
1819 category will be asked to submit a performance improvement plan, and teams of experts
1820 will be available to provide intensive programmatic support and to verify progress. In
1821 accordance with applicable laws and regulations including 45 CFR 92.43, CDC may take
1822 certain enforcement actions, including termination of funding, against poor performing
1823 grants.

1824

1825 3. Recovery Act-Specific Requirements

1826 Recipients of Federal awards from funds authorized under Division A of the Recovery
1827 Act must comply with all requirements specified in Division A of the Recovery Act
1828 (Public Law 111-5), including reporting requirements outlined in Section 1512 of the Act
1829 and designated Recovery Act outcome and output measures as detailed at the end of this
1830 section. For purposes of reporting, Recovery Act recipients must report on Recovery Act
1831 sub-recipient (sub-grantee and sub-contractor) activities as specified below.

1832 Not later than 10 days after the end of each calendar quarter, starting with the quarter
1833 ending March 30, 2010 and reporting by April 10, 2010, the recipient must submit
1834 quarterly reports to HHS that will posted to Recovery.gov, containing the following
1835 information:

1836

- 1837 a. The total amount of Recovery Act funds under this award;
- 1838 b. The amount of Recovery Act funds received under this award that were obligated and
1839 expended to projects or activities;

- 1840 c. The amount of unobligated award balances;
- 1841 d. A detailed list of all projects or activities for which Recovery Act funds under this
- 1842 award were obligated and expended, including
- 1843 • The name of the project or activity;
- 1844 • A description of the project or activity;
- 1845 • An evaluation of the completion status of the project or activity;
- 1846 • An estimate of the number of jobs created and the number of jobs retained by
- 1847 the project or activity (see OMB Guidance M-09-21, June 22, 2009) and;
- 1848 • For infrastructure investments made by State and local governments, the
- 1849 purpose, total cost, and rationale of the agency for funding the infrastructure
- 1850 investment with funds made available under this Act, and the name of the
- 1851 person to contact at the agency if there are concerns with the infrastructure
- 1852 investment.
- 1853 e. Detailed information on any sub-awards (sub-contracts or sub-grants) made by the
- 1854 grant recipient to include the data elements required to comply with the Federal
- 1855 Funding Accountability and Transparency Act of 2006 (Public Law 109-282).
- 1856
- 1857 For any sub-award equal to or larger than \$25,000, the following information:
- 1858 • The name of the entity receiving the sub-award;
- 1859 • The amount of the sub-award;
- 1860 • The transaction type;
- 1861 • The North American Industry Classification System code or Catalog of
- 1862 Federal Domestic Assistance (CFDA) number;

- 1863 • Program source;
- 1864 • An award title descriptive of the purpose of each funding action;
- 1865 • The location of the entity receiving the award;
- 1866 • The primary location of performance under the award, including the city,
1867 State, congressional district, and county.
- 1868 • A unique identifier of the entity receiving the award and of the parent entity of
1869 the recipient, should the entity be owned by another entity;
- 1870 • The date the sub-award was issued;
- 1871 • The term of the sub-award (start/end dates);
- 1872 • The scope/activities of the sub-award;
- 1873 • The amount of the total sub-award that has been obligated or disbursed by the
1874 sub-recipient; and
- 1875 • The amount of the total sub-award that remains unobligated by the sub-
1876 recipient.
- 1877 f. All sub-awards less than \$25,000 or to individuals may be reported in the aggregate,
1878 as prescribed by HHS.
- 1879 g. Recipients must account for each Recovery Act award and sub-award (sub-grant and
1880 sub-contract) separately. Recipients will draw down Recovery Act funds on an
1881 award-specific basis. Pooling of Recovery Act award funds with other funds for
1882 drawdown or other purposes is not permitted.
- 1883 h. Recipients must account for each Recovery Act award separately by referencing the
1884 assigned CFDA number for each award.
- 1885

1886 The definition of terms and data elements, as well as any specific instructions for
1887 reporting, including required formats, will be provided in subsequent guidance issued by
1888 HHS.

1889 4. Buy American - Use of American Iron, Steel, and Manufactured Goods
1890 Recipients may not use any funds obligated under this award for the construction,
1891 alteration, maintenance, or repair of a public building or public work unless all of the
1892 iron, steel, and manufactured goods used in the project are produced in the United States
1893 unless HHS waives the application of this provision. (Recovery Act Sec. 1605)

1894

1895 5. Wage Rate Requirements

1896 *[This term and condition shall not apply to tribal contracts funded with this*
1897 *appropriation. (Recovery Act Title VII—Interior, Environment, and Related Agencies,*
1898 *Department of Health and Human Services, Indian Health Facilities)]*

1899 Subject to further clarification issued by the Office of Management and Budget, and
1900 notwithstanding any other provision of law and in a manner consistent with other
1901 provisions of Recovery Act, all laborers and mechanics employed by contractors and
1902 subcontractors on projects funded directly by or assisted in whole or in part by and
1903 through the Federal Government pursuant to this award shall be paid wages at rates not
1904 less than those prevailing on projects of a character similar in the locality as determined
1905 by the Secretary of Labor in accordance with subchapter IV of chapter 31 of title 40,
1906 United States Code. With respect to the labor standards specified in this section, the
1907 Secretary of Labor shall have the authority and functions set forth in Reorganization Plan
1908 Numbered 14 of 1950 (64 Stat. 1267; 5 U.S.C. App.) and section 3145 of title 40, United
1909 States Code. (Recovery Act Sec. 1606)

1910

1911 6. Preference for Quick Start Activities (Recovery Act)

1912 In using funds for this award for infrastructure investment, recipients shall give
1913 preference to activities that can be started and completed expeditiously, including a goal
1914 of using at least 50 percent of the funds for activities that can be initiated not later than
1915 120 days after the date of the enactment of Recovery Act. Recipients shall also use grant
1916 funds in a manner that maximizes job creation and economic benefit. (Recovery Act Sec.
1917 1602)

1918

1919 7. Limit on Funds (Recovery Act)

1920 None of the funds appropriated or otherwise made available in Recovery Act may be
1921 used by any State or local government, or any private entity, for any casino or other
1922 gambling establishment, aquarium, zoo, golf course, or swimming pool. (Recovery Act
1923 Sec. 1604)

1924

1925 8. Disclosure of Fraud or Misconduct

1926 Each recipient or sub-recipient awarded funds made available under the Recovery Act
1927 shall promptly refer to the HHS Office of Inspector General any credible evidence that a
1928 principal, employee, agent, contractor, sub-recipient, subcontractor, or other person has
1929 submitted a false claim under the False Claims Act or has committed a criminal or civil
1930 violation of laws pertaining to fraud, conflict of interest, bribery, gratuity, or similar
1931 misconduct involving those funds. The HHS Office of Inspector General can be reached
1932 at <http://www.oig.hhs.gov/fraud/hotline/>

1933

1934 9. Recovery Act: One-Time Funding

1935 Unless otherwise specified, Recovery Act funding to existent or new awardees should be
1936 considered one-time funding.

1937

1938 10. Schedule of Expenditures of Federal Awards

1939 Recipients agree to separately identify the expenditures for each grant award funded
1940 under Recovery Act on the Schedule of Expenditures of Federal Awards (SEFA) and the
1941 Data Collection Form (SF-SAC) required by Office of Management and Budget Circular
1942 A-133, “Audits of States, Local Governments, and Non-Profit Organizations.” This
1943 identification on the SEFA and SF-SAC shall include the Federal award number, the
1944 Catalog of Federal Domestic Assistance (CFDA) number, and amount such that separate
1945 accountability and disclosure is provided for Recovery Act funds by Federal award
1946 number consistent with the recipient reports required by Recovery Act Section 1512(c).
1947 (2 CFR 215.26, 45 CFR 74.26, and 45 CFR 92.26)

1948

1949 11. Responsibilities for Informing Sub-recipients

1950 Recipients agree to separately identify to each sub-recipient, and document at the time of
1951 sub-award and at the time of disbursement of funds, the Federal award number, any
1952 special CFDA number assigned for Recovery Act purposes, and amount of Recovery Act
1953 funds. (2 CFR 215.26, 45 CFR 74.26, and 45 CFR 92.26)

1954

1955 12. Reporting Jobs Creation
1956 HHS' recipients of Recovery Act funding who are subject to Section 1512 reporting
1957 should report job-created data as prescribed in Section 5 of the Office of Management
1958 and Budget (OMB) guidance M-09-21. HHS will not accept statistical sampling methods
1959 to estimate the number of jobs created and retained. All recipients must report a direct
1960 and comprehensive count of jobs, as specified by OMB guidance M-09-21. See Section
1961 5.3 of the OMB guidance for more information on calculating jobs, including job
1962 estimation examples. For the full OMB guidance, please visit:
1963 http://www.whitehouse.gov/omb/assets/memoranda_fy2009/m09-21.pdf

1964
1965
1966 To fulfill Paperwork Reduction Act requirements, CDC will utilize a modified version of form
1967 OMB 0970-0334 - Performance Progress Report (SF-PPR) as a standard quarterly reporting
1968 format to facilitate uniform collection of performance measures as set forth in the Recovery
1969 Program Plan, Funding Opportunity Announcement (FOA), and Notice of Grant Award Standard
1970 Terms and Conditions (as appropriate) for all CDC Recovery Act funded financial assistance
1971 award recipients. This requirement is in addition to the financial reporting requirements outlined
1972 in Section 1512 of the Recovery Act.

1973 Additionally, the applicant must provide CDC with an original, plus two hard copies of the
1974 following reports:

- 1975 1. Final performance and Financial Status reports, no more than 90 days after the end of the
1976 project period.

1977

1978 These reports must be submitted to the attention of the Grants Management Specialist listed in
1979 the “VII. Agency Contacts” section of this announcement.

1980

1981 VII. Agency Contacts

1982 CDC encourages inquiries concerning this announcement.

1983

1984 For programmatic assistance:

1985

1986 **Please send questions to the CPPW mailbox at CPPW@cdc.gov. Responses will be posted**
1987 **on the Community Health Resources website at www.cdc.gov/communityhealthresources**

1988

1989 If you need further assistance, contact:

1990 Adrienne S. Brown, Public Health Analyst

1991 Division of Adult and Community Health

1992 National Center for Chronic Disease Prevention and Health Promotion

1993 Centers for Disease Control and Prevention

1994 3005 Chamblee-Tucker Road, Mailstop K-45

1995 Atlanta, GA 30341

1996 E-mail: CPPW@cdc.gov

1997

1998 For financial, grants management, or budget assistance, contact:

1999 Tracey Sims

2000 Procurement and Grants Office

2001 Centers for Disease Control and Prevention
2002 2920 Brandywine Road, MS E-09
2003 Atlanta, GA 30341
2004 Phone Number: 770-488-2739
2005 Fax Number: 770-488-2778
2006 E- mail: atu9@cdc.gov

2007

2008 For general questions, contact:

2009 Technical Information Management Section
2010 Department of Health and Human Services
2011 CDC Procurement and Grants Office
2012 2920 Brandywine Road, MS E-14
2013 Atlanta, GA 30341
2014 Telephone: 770-488-2700
2015 E-mail: pgotim@cdc.gov

2016

2017

2018 CDC Telecommunications for the hearing impaired or disabled is available at: TTY 770-488-
2019 2783.

2020

2021 VIII. Recovery Act Lobbying Restrictions

2022 This funding announcement is subject to restrictions on oral conversations during the period of
2023 time commencing with the submission of a formal application* by an individual or entity and
2024 ending with the award of the competitive funds. Federal officials may not participate in oral
2025 communications initiated by any person or entity concerning a pending application for a
2026 Recovery Act competitive grant or other competitive form of Federal financial assistance,
2027 whether or not the initiating party is a federally registered lobbyist. This restriction applies
2028 unless:
2029
2030 (i) the communication is purely logistical;
2031 (ii) the communication is made at a widely attended gathering;
2032 (iii) the communication is to or from a Federal agency official and another Federal Government
2033 employee;
2034 (iv) the communication is to or from a Federal agency official and an elected chief executive of a
2035 state, local or tribal government, or to or from a Federal agency official and the Presiding Officer
2036 or Majority Leader in each chamber of a state legislature; or
2037 (v) the communication is initiated by the Federal agency official.
2038 For additional information see [http://www.whitehouse.gov/omb/assets/memoranda_fy2009/m09-](http://www.whitehouse.gov/omb/assets/memoranda_fy2009/m09-24.pdf)
2039 [24.pdf](http://www.whitehouse.gov/omb/assets/memoranda_fy2009/m09-24.pdf) .
2040
2041 VIII. Other Information

* Formal Application includes the preliminary application and letter of intent phases of the program.

2042 Other CDC funding opportunity announcements can be found on the CDC Web site, [Internet](#)
2043 [address: http://www.cdc.gov/od/pgo/funding/FOAs.htm](http://www.cdc.gov/od/pgo/funding/FOAs.htm).

2044

2045 Applicants may access the application process and other awarding documents using the
2046 Electronic Research Administration System (eRA Commons). A one-time registration is
2047 required for interested institutions/organizations at
2048 <http://era.nih.gov/ElectronicReceipt/preparing.htm>

2049 Program Directors/Principal Investigators (PD/PIs) should work with their
2050 institutions/organizations to make sure they are registered in the eRA Commons.

2051 1. [Organizational/Institutional Registration in the eRA Commons](#)

2052 • To find out if an organization is already eRA Commons-registered, see the "[List of](#)
2053 [Grantee Organizations Registered in eRA Commons.](#)"

2054 • Direct questions regarding the eRA Commons registration to:

2055 eRA Commons Help Desk

2056 Phone: 301-402-7469 or 866-504-9552 (Toll Free)

2057 TTY: 301-451-5939

2058 Business hours M-F 7:00 a.m. – 8:00 p.m. Eastern Time

2059 Email commons@od.nih.gov

2060 2. Project Director/Principal Investigator (PD/PI) Registration in the eRA Commons: Refer
2061 to the [NIH eRA Commons System \(COM\) Users Guide](#).

- 2062 • The individual designated as the PD/PI on the application must also be registered in the
2063 eRA Commons. It is not necessary for PDs/PIs to register with Grants.gov.
- 2064 • The PD/PI must hold a PD/PI account in the eRA Commons and must be affiliated with
2065 the applicant organization. This account cannot have any other role attached to it other
2066 than the PD/PI.
- 2067 • This registration/affiliation must be done by the Authorized Organization
2068 Representative/Signing Official (AOR/SO) or their designee who is already registered in
2069 the eRA Commons.
- 2070 • Both the PD/PI and AOR/SO need separate accounts in the eRA Commons since both
2071 hold different roles for authorization and to view the application process.

2072 Note that if a PD/PI is also an HHS peer-reviewer with an Individual DUNS and CCR
2073 registration, that particular DUNS number and CCR registration are for the individual reviewer
2074 only. These are different than any DUNS number and CCR registration used by an applicant
2075 organization. Individual DUNS and CCR registration should be used only for the purposes of
2076 personal reimbursement and should not be used on any grant applications submitted to the
2077 Federal Government.

2078 Several of the steps of the registration process could take four weeks or more. Therefore,
2079 applicants should check with their business official to determine whether their
2080 organization/institution is already registered in the eRA [Commons](#). HHS/CDC strongly
2081 encourages applicants to register to utilize these helpful on-line tools when applying for funding
2082 opportunities.

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**Attachment A: Communities Putting Prevention to Work - Year 1 & Year 2 Benchmarks
Federal Quarters**

2nd – 3rd Quarters	<u>1-30 days</u> -Establish minimum staffing requirements. -3 members of the Leadership Team attend the kick-off meeting (1 should be the leader of the fiduciary agent).	<u>30-60 days</u> -Leadership Team is finalized based on feedback from the project officers. -Formalize monitoring plan.	<u>60-90 days</u> -Collect data using the CHANGE Tool. -Ensure that the majority of staff/contractors are hired. -Leadership Team attends Action Institute. -Finalize the Community Action Plan (CAP). -Submission of quarterly measures that will be included in community performance plans.
3rd – 4th Quarters	<u>90 – 120 days</u> -Report on ARRA requirements to recovery.gov and report on CHANGE Tool. -Refine media-buy strategy in concert with national media contractors. -Identify and begin to implement intervention/policy strategies. -Initiate evaluation plan.	<u>120 – 150 days</u> -Implement media campaign and counter advertising strategies. -Continue to implement intervention/policy strategies.	<u>150 – 180 days</u> -Ensure that at least 25% of the interventions are being established as outlined in the CAP. -Submission of quarterly measures that will be included in community performance plans.
4th – 5th Quarters	<u>180 – 210 days</u> -Report on ARRA requirements to recovery.gov.	<u>210 – 240 days</u>	<u>240 – 270 days</u> -Collect data using the CHANGE Tool. -Ensure that at least 50% of the interventions are being established as outlined in the CAP. - Submission of quarterly measures that will be included in community performance plans.
5th - 6th Quarters	<u>270 – 300 days</u> -Report on ARRA requirements to recovery.gov and report on CHANGE Tool.	<u>300 – 330 days</u> -Attend peer-peer meeting.	<u>330 – 360 days</u> - Ensure that at least 75% of the interventions are being established as outlined in the CAP. - Submission of quarterly measures that will be included in community performance plans.
6th - 11th Quarters	Awardees will submit quarterly reports on the implementation and evaluation of interventions contained within the CAP and anticipated policy outcomes.		
Federal Quarters	Quarter 1: Oct - Dec 2009 Quarter 2: Jan - Mar 2010 Quarter 3: Apr - Jun 2010 Quarter 4: Jul - Sep 2010	Quarter 5: Oct - Dec 2010 Quarter 6: Jan - Mar 2011 Quarter 7: Apr - Jun 2011 Quarter 8: Jul - Sep 2011	Quarter 9: Oct - Dec 2011 Quarter 10: Jan - Mar 2012 Quarter 11: Apr - Jun 2012

2086 **Attachment B: US Government-funded Recovery Act Programs Potentially Leveraged by**
2087 **the Prevention and Wellness Communities Program**

2088
2089 *Applicants showing collaboration across these and similar programs will receive points in the*
2090 *application review.*

2091
2092 **US Department of Transportation**

- 2093 • Federal Highway Administration funding for park roads, parkways, forest highways, ferry
- 2094 boats, etc.
- 2095 • Special discretionary grant program to fund large transportation projects of all modes with
- 2096 costs between \$20 and \$300 million.
- 2097 • Supplemental Grants for a National Surface Transportation System.
- 2098 • Federal Transit Administration capital assistance grants to public transit agencies for capital
- 2099 improvements to assist in reducing energy consumption.

2100
2101 **US Department of Agriculture**

- 2102 • Special Supplemental Nutrition Program for Women, Infants, and Children The Emergency
- 2103 Food Assistance Program
- 2104 • Food Distribution Programs on Indian Reservations
- 2105 • National School Lunch Program funding for schools to make necessary improvements to
- 2106 school kitchens in order to handle and process healthy foods.
- 2107 • US Forest Service projects involving capital improvement, bridges, trails, reconstruction,
- 2108 forest improvement and enhancement.
- 2109 • Recognize excellence in nutrition and physical activity by increasing the number of schools
- 2110 certified as a Healthier US School Challenge School
- 2111 • Rural Development Water and Waste Disposal program to provide loans and grants for rural
- 2112 water and wastewater infrastructure
- 2113 • Rural Community Facilities Program loans and grants to develop essential community
- 2114 facilities in rural areas and towns of up to 20,000 in population. Funds to be used for facility
- 2115 acquisition, construction, renovation, or the purchase of equipment and furnishings
- 2116 • Team Nutrition is an initiative of the USDA Food and Nutrition Service to support the Child
- 2117 Nutrition Programs through training and technical assistance for foodservice, nutrition
- 2118 education for children and their caregivers, and school and community support for healthy
- 2119 eating and physical activity.
- 2120 • Expanded Food and Nutrition Education Program (EFNEP) is designed to assist limited-
- 2121 resource audiences in acquiring the knowledge, skills, attitudes, and changed behavior
- 2122 necessary for nutritionally sound diets, and to contribute to their personal development and the
- 2123 improvement of the total family diet and nutritional well-being.
- 2124 • Community Food Projects are designed to increase food security in communities by bringing
- 2125 the whole food system together to assess strengths, establish linkages, and create systems that
- 2126 improve the self-reliance of community members over their food needs.
- 2127 • Kids in the Woods is an agency-wide effort to focus attention and resources in connecting
- 2128 children with nature and their public lands. Efforts encompass a range of activities and
- 2129 programs including summer camping and hiking programs, service opportunities, classroom
- 2130 presentations and engagement, and special events such as National Get Outdoors Day and
- 2131 National Public Lands Day.

- 2132 • Get Fit with US - Forests are working with communities as a part of Get Fit with US to
2133 increase participation in outdoor recreation, thereby leading to healthier lifestyles.
- 2134 • Winter Trails Day - Numerous forests are partnering with communities to host Winter Trails
2135 Day (and Winter Feels Good) activities to promote winter recreation activities like
2136 snowshoeing and cross country skiing to increase physical activity during the winter months.
- 2137 • Summer Food Service Program is the single largest Federal resource available
2138 for local organizations that want to combine a feeding program with a summer activity
2139 program for children.
- 2140 • School Breakfast Program provides cash assistance to States to operate nonprofit breakfast
2141 programs in schools and residential childcare institutions.
- 2142 • National School Lunch Program funding for schools to make necessary improvements to
2143 school kitchens in order to handle and process healthy foods.
- 2144 • Participates in the National School Lunch Program and receives and utilizes Team Nutrition
2145 materials.
- 2146 • Conservation Youth Corps - Provides “at risk” youth with additional education and skills so
2147 they can make better health choices and avoid risky behavior.

2148
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US Department of Interior

- 2150 • Construction projects at US Fish and Wildlife Service facilities
- 2151 • US Fish and Wildlife programs for habitat restoration, deferred maintenance, trail
2152 maintenance, and renewable energy projects.
- 2153 • Bureau of Indian Affairs construction projects, including improvements and repairs to
2154 buildings, roads, schools, and jails on Tribal lands.
- 2155 • National Park Service construction and rehabilitation of major buildings, roads, and historic
2156 sites

2157
2158

US Department of Education

- 2159 • Carol M. White Physical Education Program (page G-56:
2160 <http://www.ed.gov/about/overview/budget/budget10/justifications/g-ssce.pdf>)
- 2161 • Safe and drug-free schools and communities: National programs (Page G-24:
2162 <http://www.ed.gov/about/overview/budget/budget10/justifications/g-ssce.pdf>)

2163
2164

Environmental Protection Agency

- 2165 • Clean Water State Revolving Fund.
- 2166 • Brownfields projects to address environmental site assessment and cleanup. Funds will
2167 capitalize revolving funds and provide low interest loans, job training grants and technical
2168 assistance to local governments and non-profit organizations.

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US Department of Housing and Urban Development

- 2171 • Community Development Block Grants (& Indian CDBG) with eligible activities include
2172 housing rehab that will include site improvements and development of community
2173 infrastructure which can improve walkable community design and investments that promote
2174 physical activity.

- 2175 • Public Housing Capital Fund for capital repairs and improvements to federally-subsidized
2176 public housing, including renovations and retrofits that improve walkability and community
2177 investments that promote physical activity.
- 2178 • Native American Housing Block Grants for capital investments in energy efficiency and
2179 development of sustainable communities, including walkability and investments that promote
2180 physical activity.
- 2181 • Lead Hazard Reduction Grants invested in lead paint hazard reduction abatement activities
2182 (not directly related to initiative’s goals, but health-related)
- 2183 • The OHHLHC Healthy Homes Demonstration (HHD) grants are well-suited for leveraging
2184 with HHS’s initiative. There were 20 ARRA HHD grants awarded in the past few months in
2185 communities across the country.
- 2186 • Specifically, the purpose of the HHD grant program is to “develop, demonstrate, and promote
2187 cost-effective, preventive measures to correct
- 2188 • The Healthy Homes Demonstration Program is committed to supporting the Departmental
2189 Strategic Goal of strengthening communities by addressing housing conditions that threaten
2190 health.
- 2191

2192 **US Federal Emergency Management Administration**

- 2193 • Emergency Food and Shelter Program
- 2194

2195 **US Department of Health and Human Services**

- 2196 • The Community Health Center Program which provides community-based primary and
2197 preventive health services including outreach and health education.
- 2198 • Head Start which supports a comprehensive array of health, nutritional and social services to
2199 eligible four and five year old preschoolers and their families.
- 2200 • Early Head Start which promotes healthy prenatal outcomes for pregnant women, enhances
2201 the development of very young children, and promotes healthy family functioning.
- 2202 • Senior Nutrition Programs to support congregate nutrition services provided at senior centers
2203 and other community sites, home delivered nutrition services delivered to frail elders at
2204 home, and Native American nutrition programs.
- 2205 • Child Care and Development Fund enables low-income parents and parents receiving
2206 Temporary Assistance for Needy Families (TANF) to work or to participate in the
2207 educational or training programs they need in order to work. Funds may also be used to serve
2208 children in protective services. In addition, a portion of CCDF funds must be used to enhance
2209 child care quality and availability.
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Attachment C: MAPPS Interventions for Communities Putting Prevention to Work

Five evidence-based MAPPS strategies, when combined, can have a profound influence on improving health behaviors by changing community environments: Media, Access, Point of decision information, Price, and Social support/services. Communities will take evidence-based action in each of these areas, choosing from the actions listed in the table. Each community will address all 5 strategies for each risk factor area. These actions will change policy and environment in schools and communities, including in worksites and businesses, health care settings, faith-based communities, and other places where people live, work and play.

	Tobacco	Nutrition	Physical Activity
Media	<ul style="list-style-type: none"> • Media and advertising restrictions consistent with federal law (k) • Hard hitting counter-advertising (l-n) • Ban brand-name sponsorships (o) • Ban branded promotional items and prizes (p) 	<ul style="list-style-type: none"> • Media and advertising restrictions consistent with federal law (38-44) • Promote healthy food/drink choices (42, 43, 45) • Counter-advertising for unhealthy choices (46) 	<ul style="list-style-type: none"> • Promote increased physical activity (i, ii, vi, ix, xxix-xxx) • Promote use of public transit (i, ii, vi, ix, xxix-xxx) • Promote active transportation (bicycling and walking for commuting and leisure activities) (i, ii, vi, ix, xxix-xxx) • Counter-advertising for screen time (i, ii, vi, ix, xxix-xxx)
Access	<ul style="list-style-type: none"> • Usage bans (i.e. 100% smoke-free policies or 100% tobacco-free policies) (f, g, v) • Usage bans (tobacco-free school campuses) (e-g, h-j) • Zoning restrictions (e-g) • Restrict sales (e.g. internet; sales to minors; stores/events w/o tobacco) (e-g) • Ban self-service displays & vending (e-g) 	<ul style="list-style-type: none"> • Healthy food/drink availability (e.g., incentives to food retailers to locate/offer healthier choices in underserved areas, healthier choices in child care, schools, worksites) (7-9, 10-21, 63-68, 76-82) • Limit unhealthy food/drink availability (whole milk, sugar sweetened beverages, high-fat snacks) (17, 22-25, 69-73) • Reduce density of fast food establishments (15, 26) • Eliminate transfat through purchasing actions, labeling initiatives, restaurant standards (29-31) • Reduce sodium through purchasing actions, labeling initiatives, restaurant standards (32-34) • Procurement policies and 	<ul style="list-style-type: none"> • Safe, attractive accessible places for activity (i.e., access to outdoor recreation facilities, enhance bicycling and walking infrastructure, place schools within residential areas, increase access to and coverage area of public transportation, mixed use development, reduce community design that lends to increased injuries) (xxxix – xli) • City planning, zoning and transportation (e.g., planning to include the provision of sidewalks, parks, mixed use, parks with adequate crime prevention measures, and Health Impact Assessments) (ii,iii,iv,v,viii,ix) • Require daily quality PE in schools (xvi – xxiii) • Require daily physical

		<p>practices (8, 9, 13, 14, 35, 36)</p> <ul style="list-style-type: none"> • Farm to institution, including schools, worksites, hospitals, and other community institutions (35, 36, 37) 	<p>activity in afterschool/childcare settings (i, ii, iii, v, viii, ix, xxiv-xxvii)</p> <ul style="list-style-type: none"> • Restrict screen time (afterschool, daycare) (x, xi, xii, xiii, xiv)
Point of Purchase/Promotion	<ul style="list-style-type: none"> • Restrict point of purchase advertising (q) • Product placement (q) 	<ul style="list-style-type: none"> • Signage for healthy vs. less healthy items (8, 9, 47, 48, 74-75) • Product placement & attractiveness (8, 9, 47, 48, 49, 74-75) • Menu labeling (50-53) 	<ul style="list-style-type: none"> • Signage for neighborhood destinations in walkable/mixed-use areas (library, park, shops, etc) (ii, iii, iv, ix, xlxiii) • Signage for public transportation, bike lanes/boulevards (ii, iii, iv, ix, xlxii, xlxiii)
Price	<ul style="list-style-type: none"> • Use evidence-based pricing strategies to discourage tobacco use (a-c) • Ban free samples and price discounts (d) 	<ul style="list-style-type: none"> • Changing relative prices of healthy vs. unhealthy items (e.g. through bulk purchase/procurement/competitive pricing) (5-9, 60-62) 	<ul style="list-style-type: none"> • Reduced price for park/facility use (xxxvi – xxxviii) • Incentives for active transit (xxxvii, xxxviii) • Subsidized memberships to recreational facilities (ii, iii, viii,ix)
Social Support & Services	<ul style="list-style-type: none"> • Quitline and other cessation services (r-t) 	<ul style="list-style-type: none"> • Support breastfeeding through policy change and maternity care practices (54-59) 	<ul style="list-style-type: none"> • Safe routes to school (vii, xv, xxxi-xxxv) • Workplace, faith, park, neighborhood activity groups (e.g., walking hiking, biking) (ii, iii, viii, ix)

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Tobacco references

Use evidence-based strategies to discourage tobacco use

- a. Centers for Disease Control and Prevention. Reducing tobacco use: a report of the Surgeon General. Atlanta, GA: US Department of Health and Human Services, CDC; 2000
- b. Institute of Medicine. Ending the tobacco problem: a blueprint for the nation. Washington, DC: The National Academies Press; 2007.
- c. Task Force on Community Preventive Services. Guide to community preventive services: tobacco use prevention and control. Am J Prev Med 2001;20(2 Suppl 1):1--87.

Ban free samples and price discounts

- d. Loomis BR, Farrelly MC, Mann NH. The Association of retail promotions for cigarettes with the Master Settlement Agreement, tobacco control programmes and cigarette excise taxes. Tob. Control 2006; 15:458-63.

- 2240 Access (youth specific)
 2241
 2242 e. Centers for Disease Control and Prevention. Reducing tobacco use: a report of the Surgeon General.
 2243 Atlanta, GA: US Department of Health and Human Services; 2000
 2244 f. Institute of Medicine. Ending the tobacco problem: a blueprint for the nation. Washington, DC: The
 2245 National Academies Press; 2007.
 2246 g. Task Force on Community Preventive Services. Guide to community preventive services: tobacco use
 2247 prevention and control. *Am J Prev Med* 2001;20(2 Suppl 1):1--87.
 2248
 2249 Usage bans (smoke free campuses)
 2250
 2251 h. Pentz MA. The power of policy: the relationship of smoking policy to adolescent smoking. *American*
 2252 *journal of public health* 1989;79(7):857-62.
 2253
 2254 i. Wakefield MA. Effect of restrictions on smoking at home, at school, and in public places on teenage
 smoking: cross sectional study. *BMJ* 2000;321(7257):333-7.
 2255
 2256 j. Kumar R. School tobacco control policies related to students' smoking and attitudes toward smoking:
 2257 national survey results, 1999-2000. *Health education & behavior* 2005;32(6):780-94.
 2258 Media and advertising restrictions
 2259
 2260 k. National Cancer Institute. The role of the media in promoting and reducing tobacco use. Tobacco Control
 2261 Monograph, No. 19; 2008.
 2262
 2263 Hard-hitting counter-advertising
 2264
 2265 l. Task Force on Community Preventive Services. Guide to community preventive services: tobacco use
 2266 prevention and control. *Am J Prev Med* 2001;20(2 Suppl 1):1--87.
 2267 m. National Cancer Institute. The role of the media in promoting and reducing tobacco use. Tobacco Control
 2268 Monograph, No. 19; 2008.
 2269 n. Institute of Medicine. Ending the tobacco problem: a blueprint for the nation. Washington, DC: The
 2270 National Academies Press; 2007.
 2271
 2272 Ban Brand-name sponsorship
 2273
 2274 o. National Cancer Institute. The role of the media in promoting and reducing tobacco use. Tobacco Control
 2275 Monograph, No. 19; 2008.
 2276
 2277 Ban Branded promotional items and prizes
 2278
 2279 p. National Cancer Institute. The role of the media in promoting and reducing tobacco use. Tobacco Control
 2280 Monograph, No. 19; 2008.
 2281
 2282 Restrict point of purchase advertising/product placement
 2283
 2284 q. National Cancer Institute. The role of the media in promoting and reducing tobacco use. Tobacco Control
 2285 Monograph, No. 19; 2008.
 2286
 2287 Quitline and other cessation services
 2288
 2289 r. Fiore MC, Jaen CR, Baker, TB, et al. Treating tobacco use and dependence: 2008 Update. Quick Reference
 2290 Guide for Clinicians. Public Health Service; 2008.
 2291 s. Task Force on Community Preventive Services. Guide to community preventive services: tobacco use
 2292 prevention and control. *Am J Prev Med* 2001;20(2 Suppl 1):1--87.

2293 t. Institute of Medicine. Ending the tobacco problem: a blueprint for the nation. Washington, DC: The
2294 National Academies Press; 2007.

2296 Nutrition References

- 2297
2298
2299 1. Dietary Guidelines for Americans, 2005. U.S. Department of Health and Human Services and U.S. Department of
2300 Agriculture. Dietary Guidelines for Americans, 2005. 6th Edition, Washington, DC: U.S. Government Printing
2301 Office, January 2005. Foods Encouraged, Available at:
2302 <http://www.health.gov/DietaryGuidelines/dga2005/document/html/chapter5.htm>
2303
2304 5. French, S.A., M. Story, and R.W. Jeffery, *Environmental influences on eating and physical activity*. Annu Rev
2305 Public Health, 2001. 22: p. 309-35.
2306
2307 6. French SA, Wechsler H. School-based research and initiatives: fruit and vegetable environment, policy, and
2308 pricing workshop. Prev Med. 2004 Sep;39 Suppl 2:S101-7.
2309
2310 7. Ayala G. et al., 2009 – Evaluation of the Healthy Tienda project. The Public Health Effects of Food Deserts.
2311 Workshop Summary. Institute of Medicine and National Research Council, p 49-51.
2312 <http://www.iom.edu/Object.File/Master/62/082/Session%204%20920%20am%20Ayala.pdf>
2313
2314 8. Glanz K, Yaroch AL. Strategies for increasing fruit and vegetable intake in grocery stores and communities:
2315 policy, pricing, and environmental change. Prev Med. 2004 Sep;39 Suppl 2:S75-80. Review.
2316
2317 9. Nonas C, 2009. Health Bucks in New York City. The Public Health Effects of Food Deserts. Workshop
2318 Summary. Institute of Medicine and National Research Council, p 59-60. Available at
2319 <http://www.iom.edu/CMS/3788/59640/62040/62078.aspx>
2320
2321 Increase healthy food/drink availability (e.g., grocery, child care, schools, worksites)
2322
2323 *Grocery*
2324 10. Bodor, J. N., Rose, D., Farley, T. A., Swalm, C., & Scott, S. K. (2007). Neighbourhood fruit and vegetable
2325 availability and consumption: the role of small food stores in an urban environment. *Public Health Nutrition*.
2326
2327 11. Gittelsohn J, Ethelbah M. Evaluation of the White Mountain and San Carlos Apache Healthy Stores Program, a
2328 multi-component intervention that included stocking healthier food items. Available at
2329 <http://www.farmfoundation.org/news/articlefiles/450-Gittelsohn.pdf>.
2330
2331 12. Morland K, Diez Roux AV, Wing S. Am J Prev Med. 2006 Apr;30(4):333-9 Supermarkets, other food stores,
2332 and obesity: the atherosclerosis risk in communities study.
2333
2334 13. Larson, N., Story, M., & Nelson, M. (2009). Neighborhood Environments Disparities in Access to Healthy
2335 Foods in the U. S. *American Journal of Preventive Medicine*. 36(1):74-81.
2336
2337 14. Story M, Kaphingst KM, Robinson-O'Brien R, Glanz K. Creating healthy food and eating environments: policy
2338 and environmental approaches. Annu Rev Public Health. 2008;29:253-72.
2339
2340 15. Moore, L.V., et al., *Associations of the local food environment with diet quality--a comparison of assessments*
2341 *based on surveys and geographic information systems: the multi-ethnic study of atherosclerosis*. Am J Epidemiol,
2342 2008. 167(8): p. 917-24.
2343
2344 *Childcare*
2345 16. Ward, D. S., Benjamin, S. E., Ammerman, A. S., Ball, S. C., Neelon, B. H., & Bangdiwala, S. I. (2008).
2346 Nutrition and physical activity in child care: results from an environmental intervention. *Am J Prev Med.*, 35(4),
2347 352-356. Epub 2008.
2348

2349 *School*
2350 17. IOM (2007). Nutrition Standards for Foods in Schools: Leading the Way Toward Healthier Youth Committee on
2351 Nutrition Standards for Foods in Schools. Washington, D.C., The National Academies Press.
2352
2353 18. Ritenbaugh C, Tufel-Shone N, et al. A lifestyle intervention improves plasma insulin levels among Native
2354 American high school youth. *Prev Med*.2003;36:309-319.
2355
2356 19. Jaime, P.C. and K. Lock, Do school based food and nutrition policies improve diet and reduce obesity? *Prev*
2357 *Med*, 2009. 48(1): p. 45-53.
2358
2359 *Worksite*
2360 20. Sorensen, G., Linnan, L., & Hunt, M. K. (2004). Worksite-based research and initiatives to increase fruit and
2361 vegetable consumption. *Prev.Med.*, 39 *Suppl* 2, S94-100.
2362
2363 21. The Community Guide to Preventive Services. Obesity prevention through worksite programs. Available at
2364 <http://www.thecommunityguide.org/obesity/workprograms.html>
2365
2366
2367 Limit unhealthy food/drink availability (whole milk, sugar sweetened beverages, snacks)
2368
2369 See Ref 17
2370
2371 22. Schwartz, M. B., Novak, S. A., & Fiore, S. S. (2009). The Impact of Removing Snacks of Low Nutritional Value
2372 From Middle Schools. *Health Educ Behav*, 5, 5.
2373
2374 23. Kubik, M.Y., et al., *The association of the school food environment with dietary behaviors of young adolescents*.
2375 *Am J Public Health*, 2003. 93(7): p. 1168-73.
2376
2377 24. Cullen, K.W. and I. Zakeri, *Fruits, vegetables, milk, and sweetened beverages consumption and access to a la*
2378 *carte/snack bar meals at school*. *Am J Public Health*, 2004. 94(3): p. 463-7.
2379
2380 25. Templeton, S.B., M.A. Marlette, and M. Panemangalore, *Competitive foods increase the intake of energy and*
2381 *decrease the intake of certain nutrients by adolescents consuming school lunch*. *J Am Diet Assoc*, 2005. 105(2): p.
2382 215-20.
2383
2384 Reduce density fast food establishments
2385
2386 See Refs 12, 15
2387
2388 26. Ashe M, Jernigan D, Kline R, Galaz R. Land use planning and the control of alcohol, tobacco, firearms, and fast
2389 food restaurants. *Am J Pub Health*. 2003;93(9):1404-1408.
2390
2391 Eliminate trans fat
2392
2393 29. Mozaffarian D. Katan MB. Ascherio A. Stampfer MJ. Willett WC. Trans Fatty Acids and Cardiovascular
2394 Disease. *New England Journal of Medicine*. April 13, 2006. 354;15:1601-13.
2395
2396 30. Panel on Macronutrients, Institute of Medicine. Letter report on dietary reference intakes for trans fatty acids
2397 drawn from the Report on dietary reference intakes for energy, carbohydrate, fiber, fat, fatty acids, cholesterol,
2398 protein, and amino acids. Washington, DC 2003.
2399
2400 31. Trans Fat Regulation: NYC Department of Health and Mental Hygiene – Board of Health Approves Regulation
2401 to Phase Out Artificial Trans Fat. Available at:
2402 <http://www.nyc.gov/html/doh/html/cardio/cardio-transfat-healthcode.shtml>; How to Comply: What Restaurants,
2403 Caterers, Food-Vending Units, and Others Need to Know” Accessed June 24, 2009
2404 <http://www.nyc.gov/html/doh/downloads/pdf/cardio/cardio-transfat-bro.pdf>

2405
2406 Reduce sodium
2407
2408 32. Sacks, FM et al.(2001) Effects on blood pressure of reduced dietary sodium and the Dietary Approaches to Stop
2409 Hypertension (DASH) diet. DASH-Sodium Collaborative Research Group. New England Journal of Medicine
2410 344(1):3-10.
2411
2412 33. City Purchasing Standards: New York City executive order for formal nutrition standards for all food purchased
2413 or served by New York City agencies including sodium. Available at :
2414 <http://www.nyc.gov/html/doh/downloads/pdf/cardio/cardio-food-standards.pdf>
2415
2416 34. New York City, Advocacy for External Efforts: Initiative to develop a voluntary partnership with industry
2417 leaders to reduce the level of sodium in processed and prepared foods nationwide. Available at:
2418 <http://www.nyc.gov/html/doh/html/cardio/cardio-salt-initiative.shtml>
2419
2420 Procurement policies and practices
2421
2422 See Refs 8, 9, 13, 14
2423
2424 35. Joshi, A., & Azuma, A. (2008). Do Farm-to-School Programs Make a Difference? Findings and Future Research
2425 Needs. *Journal of Hunger & Environmental Nutrition*, 3, 2-3.
2426
2427 36. Zudrow D (2005) Food Security Begins at Home: Creating Community Food Coalitions in the South. Southern
2428 Sustainable Agriculture Working Group, pp 45-67, Available at: <http://www.ssawg.org/cfs-handbook.html>
2429
2430 Farm to institution
2431
2432 See Ref 35
2433
2434 37. Texas, Farm to Work program. Farm to Work Initiative of the Texas State Health Service provides a Farm to
2435 Work Toolkit. Available at <http://www.texasbringinghealthyback.org/> and
2436 <http://www.dshs.state.tx.us/obesity/pdf/F2WToolkit1008.pdf>
2437
2438
2439 Media and advertising restrictions
2440
2441 38. The Guide to Community Preventive Services - Obesity Prevention: Interventions to Reduce Screen
2442 Time <http://www.thecommunityguide.org/obesity/screentime/index.html>
2443
2444 39. Story M, French S. Food Advertising and Marketing Directed at Children and Adolescents in the US. Int J
2445 Behav Nutr Phys Act. 2004 Feb 10;1(1):3.
2446
2447 40. Chou SY, Rashad I, Grossman M. Fast-Food Restaurant Advertising on Television and Its Influence on
2448 Childhood Obesity. *The Journal of Law and Economics*, 2008;51; p 599-618
2449
2450 41. Coon KA, Tucker KL: Television and children's consumption patterns. A review of the literature. *Minerva*
2451 *Pediatr* 2002, 54:423-436.
2452
2453 42. WHO. 2004. Global Strategy on Diet, Physical Activity and Health. WHA 57.17. Geneva: WHO. Available at
2454 http://apps.who.int/gb/ebwha/pdf_files/WHA57/A57_R17-en.pdf
2455
2456 43. Norwegian ministry of Children and Family Affairs, 2005. Norway enacted a ban on TV advertisements to
2457 children ages 12 years and younger in 1992. Available at
2458 <http://www.regjeringen.no/en/dep/bld/Documents/Reports-and-plans/Plans/2003-2/The-Norwegian-action-plan-to-reduce-comm.html?id=462256>
2459

2460
2461 44. Kwate, NOA. Take one down, pass it around, 98 alcohol ads on the wall: outdoor advertising in New York
2462 City's Black neighbourhoods. *International Journal of Epidemiology*. 2007; 36 (5): 988-990.
2463
2464 Promote healthy food/drink choices
2465
2466 See Refs 42, 43
2467
2468 45. Evidence of impact of advertising on food and beverage purchase requests of 2-11 year olds and usual dietary
2469 intake of 2-5 year olds: IOM (2006), Committee on Food Marketing and the Diets of Children and Youth. Food
2470 Marketing to Children and Youth: Threat or Opportunity? Washington, D.C., National Academies Press.
2471
2472 Counteradvertising for unhealthy choices
2473
2474 46. Dixon HG, Scully ML, Wakefield MA, White VM, Crawford DA. The effects of television advertisements for
2475 junk food versus nutritious food on children's food attitudes and preferences. *Soc Sci Med*. 2007 Oct;65(7):1311-23.
2476
2477 Signage for healthy vs. less healthy items
2478
2479 See Refs 8, 9
2480
2481 47. Seymour JD, Yaroch AL, Serdula M, Blanck HM, Khan LK. Impact of nutrition environmental interventions on
2482 point-of-purchase behavior in adults: a review. *Prev Med*. 2004 Sep;39 Suppl 2:S108-36. Review.
2483
2484 48. Glanz K, Hoelscher D. Increasing fruit and vegetable intake by changing environments, policy and pricing:
2485 restaurant-based research, strategies, and recommendations. *Prev Med*. 2004 Sep;39 Suppl 2:S88-93.
2486
2487 Product placement & attractiveness
2488 Ref 8, 9, 47, 48
2489
2490 49. Curhan, R.C., The effects of merchandising and temporary promotional activities on the sales of fresh fruit and
2491 vegetables in supermarket. *Journal of Marketing Research* 1974. 11: p. 286-94.
2492
2493 Menu labeling
2494
2495 50. Bassett, M.T., et al., Purchasing behavior and calorie information at fast-food chains in New York City, 2007.
2496 *Am J Public Health*, 2008. 98(8): p. 1457-9.
2497
2498 51. Simon, Jarosz, Kuo & Fielding. Menu Labeling as a Potential Strategy for Combating the Obesity Epidemic: A
2499 Health Impact Assessment. Los Angeles, CA: Los Angeles County Dept of Public Health; 2008
2500
2501 52. Burton S and Creyer EH. "What Consumers Don't Know Can Hurt Them: Consumer Evaluations and Disease
2502 Risk Perceptions of Restaurant Menu Items." *Journal of Consumer Affairs*, 38(1): 121-45, 2004.
2503
2504 53. Kozup KC, Creyer EH and Burton S. "Making Healthful Food Choices: The Influence of Health Claims and
2505 Nutrition Information on Consumers' Evaluations of Packaged Food Products and Restaurant Menu Items." *Journal*
2506 *of Marketing*, 67(2): 19-34, 2003.
2507
2508 Support Breastfeeding
2509
2510 54. Philipp BL et al. 2001. Baby-Friendly Hospital Initiative Improves Breastfeeding Initiation Rates in a US
2511 Hospital Setting. *Pediatrics* 108(3):677-681.
2512
2513 55. DiGirolamo AM, Grummer-Strawn LM, Fein SB. Effect of Maternity-Care Practices on Breastfeeding.
2514 *Pediatrics* 2008 October 1;122(Supplement_2):S43-S49.
2515

- 2516 56. Baby-Friendly USA. Implementing the UNICEF/WHO Baby Friendly Hospital Initiative in the U.S; Available
 2517 at: <http://www.babyfriendlyusa.org/eng/index.html> Accessed June 24, 2009.
 2518
- 2519 57. Cohen R, Mrtek MB. The impact of two corporate lactation programs on the incidence and duration of
 2520 breastfeeding by employed mothers. *American Journal of Health Promotion* 1994;8(6):436–41.
 2521
- 2522 58. Fein SB, Mandal B, Roe BE. Success of Strategies for Combining Employment and Breastfeeding. *Pediatrics*
 2523 2008 October 1;122(Supplement_2):S56-S62.
 2524
- 2525 59. Health Resources and Services Administration. The Business Case for Breastfeeding Toolkit. HRSA 2008;
 2526 Available at: <http://ask.hrsa.gov/detail.cfm?PubID=MCH00254&recommended=1> Accessed June 2, 2009.
 2527
- 2528 Selective Pricing (schools)
 2529
- 2530 60. French, S.A., Story, M., Jefferey, R.W., Snyder, P., Marla, E., Sidebottom, A., & Murray, D. (1997). Pricing
 2531 strategy to promote fruit and vegetable purchase in high school cafeterias. *J Am Diet Assoc*, 97(9): 1008-1010.
 2532
- 2533 61. French, S.A., Jefferey, R.W., Story, M., Breitlow, K.K., Baxter, J.S., Hannan, P., & Snyder, M.P. (2001). Pricing
 2534 and promotion effects on low-fat vending snack purchases: The CHIPS study. *Am J Public Health*, 91(1): 112-117.
 2535
- 2536 62. Hannan, P., French, S.A., Story, M., & Fulkerson, J.A. (2002). A pricing strategy to promote sales of lower fat
 2537 foods in high school cafeterias: Acceptability and sensitivity analysis. *Am J Hlth Prom*, 17(1): 1-6.
 2538
- 2539 Healthy food/drink availability (schools)
 2540
- 2541 63. Cullen, K.W., Hartstein, J., Reynolds, K.D., Vu, M., Resnicow, K., Greene, N., et al., 2007. Improving the
 2542 school food environment: results from a pilot study in middle schools. *J. Am. Diet Assoc.* 107 (3), 484–489.
 2543
- 2544 64. Lytle, L.A., Kubik, M.Y., Perry, C., Story, M., Birnbaum, A.S., Murray, D.M., 2006. Influencing healthful food
 2545 choices in school and home environments: results from the TEENS study. *Prev. Med.* 43 (1), 8–13.
 2546
- 2547 65. Perry, C.L., Bishop, D.B., Taylor, G.L., Davis, M., Story, M., Gray, C., et al., 2004. A randomized school trial of
 2548 environmental strategies to encourage fruit and vegetable consumption among children. *Health Educ. Behav.* 31 (1),
 2549 65–76.
 2550
- 2551 66. Sahota, P., Rudolf, M.C., Dixey, R., Hill, A.J., Barth, J.H., Cade, J., 2001. Evaluation of implementation and
 2552 effect of primary school based intervention to reduce risk factors for obesity. *BMJ* 323 (7320), 1027–1029.
 2553
- 2554 67. Sahota, P., Rudolf, M.C., Dixey, R., Hill, A.J., Barth, J.H., Cade, J., 2001. Randomised controlled trial of
 2555 primary school based intervention to reduce risk factors for obesity. *BMJ* 323 (7320), 1029–1032.
 2556
- 2557 68. Muckelbauer R, Libuda L, Clausen K, Toschke AM, Reinehr T, Kersting M. Promotion and provision of
 2558 drinking water in schools for overweight prevention: Randomized, controlled cluster trial. *Pediatrics*
 2559 2009;123:e661-e667
 2560
- 2561 Limit unhealthy food/drink
- 2562 69. Cullen, K.W., Hartstein, J., Reynolds, K.D., Vu, M., Resnicow, K., Greene, N., et al., 2007. Improving the
 2563 school food environment: results from a pilot study in middle schools. *J. Am. Diet Assoc.* 107 (3), 484–489.
 2564
- 2565 70. Cullen, K.W., Watson, K., Zakeri, I., Ralston, K., 2006. Exploring changes in middle-school student lunch
 2566 consumption after local school food service policy modifications. *Public Health Nutr.* 9 (6), 814–820.
 2567
- 2568 71. Cullen, K.W., Watson, K. 2009. The Impact of the Texas Public School Nutrition Policy on Student Food
 2569 Selection and Sales in Texas. *Am J Public Health.* 2009 Apr;99(4):706-12
 2570

2571 72. Kubik M, Lytle L, Hannan P, Perry C, Story M. The association of the school food environment with dietary
2572 behaviors of young adolescents. *Am J Public Health* 2003;93:1168-73.
2573
2574 73. Stone, E.J., Osganian, S.K., McKinlay, S.M., Wu, M.C., Webber, L.S., Luepker, R.V., et al., 1996. Operational
2575 design and quality control in the CATCH multicenter trial. *Prev.*
2576 *Med.* 25 (4), 384-399.
2577
2578 Farm to institution
2579
2580 See Ref 35
2581
2582 Point of purchase promotion (in schools)
2583
2584 74. French, S. A., Jeffery, R. W., Story, M., Breitlow, K. K., Baxter, J. S., Hannan, P. & Snyder, M. P. (2001)
2585 Pricing and promotion effects on low-fat vending snack purchases: The CHIPS study. *Am. J. Public Health* 91:112-
2586 117.
2587
2588 75. French SA, Story M, Fulkerson JA, Hannan P. An Environmental Intervention to Promote Lower-Fat Food
2589 Choices in Secondary Schools: Outcomes of the TACOS Study. *Am J Public Health* 2004;94:1507-12
2590
2591 76. Institute of Medicine. *Local Government Actions to Prevent Childhood Obesity*. Washington, DC: The National
2592 Academies Press; 2009.
2593
2594 77. Centers for Disease Control and Prevention. Recommended Community Strategies and Measurements to Prevent
2595 Obesity in the United States. *MMWR* 2009;58(No. RR-07): 1-26.
2596
2597 78. Ed Bolen et al., *Neighborhood Groceries: New Access to Healthy Food in Low-Income Communities*, (San
2598 Francisco, CA: California Food Policy Advocates, 2003).
2599
2600 79 PolicyLink: Equitable Development Toolkit: Healthy Food Retailing provides an online tool that focuses on
2601 increasing access to retail outlets that sell nutritious, affordable food in low-income communities of color.
2602 <http://www.policylink.org/EDTK/HealthyFoodRetailing>
2603
2604 80. Gittelsohn, J., et al., Process Evaluation of Baltimore Healthy Stores: A Pilot Health Intervention Program With
2605 Supermarkets and Corner Stores in Baltimore City. *Health Promot Pract*, 2009.
2606
2607 81. Flournoy R and Treuhaft S (2005). *Healthy food, healthy communities: improving access and opportunities*
2608 *through food retailing*. Oakland, CA: PolicyLink.
2609
2610 82. Bitler, M., and S. J. Haider. *An Economic View of Food Deserts in the United States. Research Conference on*
2611 *Understanding the Economic Concepts and Characteristics of Food Access*. Washington, DC: USDA, Economic
2612 Research Service and University of Michigan National Poverty Center, 2009.
2613
2614
2615

Physical Activity References

2616
2617
2618 i. US Department of Health and Human Services. Physical Activity Guidelines for Americans. Available at:
2619 <http://www.health.gov/PAGuidelines/>
2620
2621 ii. The Guide to Community Preventive Services: What works to Promote Health?. Oxford University Press, 2005,
2622 pp 80-113.
2623 The Guide to Community Preventive Services is also Available at:
2624 <http://www.thecommunityguide.org/pa/index.html>
2625

- 2626 iii. Kahn, E.B., Ramsey, L.T., Brownson, R.C., Heath, G.W., Howze, E.H., Powell, K.E. et al. 2002. The
2627 effectiveness of interventions to increase physical activity. A systematic review by the U.S. Task Force on
2628 Community Preventive Services. *American Journal of Preventive Medicine* 22, S73–102.
2629
- 2630 iv. Heath GW, Brownson RC, Kruger J, et al. The effectiveness of urban design and land use and transport policies
2631 and practices to increase physical activity: a systematic review. *J Phys Act Health*. 2006;3(suppl 1):S55-S76.
- 2632
- 2633 v. Hoehner CM, Soares J, Parra DP, Ribeiro IC, Joshu C, Pratt M et al. 2008. Systematic review of physical activity
2634 interventions in Latin America. *Am J Prev Med* 34(3), 224-233
2635
- 2636 vi. Roux L, Pratt M, Tengs TO, Yanagawa T, Yore M, et al., 2008. Cost Effectiveness of Community-based
2637 Physical Activity Interventions. *Am J Prev Med* 35(6), 578-588
2638
- 2639 vii. Active Living Research Brief. Walking and biking to school, physical activity and health outcomes. May 2009
2640
- 2641 viii. Ramsey LT, Brownson RC. Increasing physical activity. *Am J Prev Med* 2002 (4S); 73-107
2642
- 2643 ix. Centers for Disease Control and Prevention. Planning, implementing and evaluating interventions. Available at:
2644 http://www.cdc.gov/nccdphp/dnpa/physical/health_professionals/interventions/index.htm
2645
- 2646 x. The Guide to Community Preventive Services - Obesity Prevention: Interventions to Reduce Screen
2647 Time. <http://www.thecommunityguide.org/obesity/screentime/index.html>
2648
- 2649 xi. New York City Amendments to the NYC Health Code (established limits on passive, sedentary TV viewing in
2650 group childcare services to 60 minutes or less per day.
2651 http://www.frac.org/pdf/nyc_cacfp_childcare_nutrphysact_law.pdf
2652
- 2653 xii. Delaware Child Care Policy to Improve Children's Health: regulatory changes through the Office of Child Care
2654 Licensing for all childcare in DE (center-based, family and after-school) that limit sedentary and media exposure to
2655 a maximum of 1 hour per day for children >2 years. [http://www.nemours.org/department/nhps/policy-leader/child-](http://www.nemours.org/department/nhps/policy-leader/child-care.html)
2656 [care.html](http://www.nemours.org/department/nhps/policy-leader/child-care.html)
2657
- 2658 xiii. Benjamin SE, Cradock A Walker EM, Slining M, Gillman MW. Obesity prevention in child care: a review of
2659 U.S. state regulations. *BMC Public Health*. 2008;8:188.
2660
- 2661 xiv. Kaphingst LM, Story M. Child care as an untapped setting for obesity prevention: State child care licensing
2662 regulations related to nutrition, physical activity, and media use for preschool-aged children in the United States.
2663 *Preventing Chronic Disease*. 2009;6:1.
2664
- 2665 xv. Centers for Disease Control and Prevention. Kids Walk to School. Available at:
2666 <http://www.cdc.gov/nccdphp/dnpa/kidswalk/>
2667
Require daily quality PE
2668
2669
- 2670 xvi. Kahn EB, Ramsey LT, Brownson RC, Heath GW, Howze EH, Powell KE. The effectiveness of interventions to
2671 increase physical activity: a systematic review. *Am J Prev Med* 2002; 22(4S): 73-107.
2672
- 2673 xvii. McKenzie TL, Nader PL, Strikmiller PK, Yang M, Stone EJ, Perry CL, et al. School physical education: effect
2674 of the Child and Adolescent Trial for Cardiovascular Health. *Prev Med* 1996 25:423-431.
2675
- 2676 xviii. Pangrazi RP, Beighle A, Vehige T, Vack C. Impact of Promoting Lifestyle Activity for Youth (PLAY) on
2677 children's physical activity. *J Sch Health* 73(8): 317-321.
2678
- 2679 xix. Pate RR, Ward DS, Saunders RP, Felton G, Dishman RK, Dowda M. Promotion of physical activity among
2680 high school girls: a randomized controlled trial. *Am J Public Health* 2005; 95(9): 1582-1587.

- 2681
2682 xx. Harrell JS, McMurray RG, Bangdiwala SI, Frauman AC, Gansky SA, Bradley CB. Effects of a school-based
2683 intervention to reduce cardiovascular disease risk factors in elementary-school children: The Cardiovascular Health
2684 in Children (CHIC Study). *J Pediatr* 1996; 128:797-805.
- 2685
2686 xxi. Reed KE, Warburton DER, Macdonald HM, Naylor PJ, McKay HA. Action schools! BC: a school-based
2687 physical activity intervention designed to decrease cardiovascular risk factors in children. *Prev Med* 2008; 46:525-
2688 531.
- 2689
2690 xxii. Webber LS, Catellier DJ, Lytle LA, Murray DM, Pratt CA, Young DR, et al. Promoting physical activity in
2691 middle school girls: Trial of Activity for Adolescent Girls. *Am J Prev Med* 2008; 34(3): 173-184.
- 2692
2693 xxiii. Manios Y, Moschandreas J, Hatzis C, Kafatos A. Evaluation of a health and nutrition education program in
2694 primary school children of Crete over a three-year period. *Prev Med* 1999; 28:149-159.
- 2695
2696 Daily physical activity in after school
- 2697
2698 xxiv. Sallis JF, McKenzie TL, Conway TL, Elder JP, Prochaska JJ, Brown M et al. Environmental interventions for
2699 eating and physical activity: a randomized controlled trial in middle schools. *Am J Prev Med* 2003;24:209-17.
- 2700
2701 xxv. Kelder S, Hoelscher DM, Barroso CS, Walker JL, Cribb P, Shaohua H. The CATCH Kids Club: a pilot after-
2702 school study for improving elementary students' nutrition and physical activity. *Public Health Nutrition* 2005; 8(2):
2703 133-140.
- 2704
2705 xxvi. Story M, Sherwood NE, Himes JH, Davis M, Jacobs DR, et al. An after-school obesity prevention program for
2706 African American girls: the Minnesota GEMS pilot study. *Ethn Dis* 2003; 13(1 suppl 1): S54-64.
- 2707
2708 xxvii. Yin, et al. Medical College of Georgia Fitkid Project. *Evaluation & the Health Professions* 2005; 67-89.
- 2709
2710 xxviii. Kien LC & Chiodo AR. Physical activity in middle school-aged children participating in a school-based
2711 recreation program. *Arch Pediatr Adolesc Med* 2003; 157:811-815.
- 2712
2713 Media to promote increased physical activity
- 2714
2715 xxix. Huhman M, Potter LD, Wong FL, Banspach SW, Duke JC, Heitzler CD. Effects of a mass media campaign to
2716 increase physical activity among children: year 1 results of the VERB campaign. *Pediatrics* 2005;116:e277-3284.
- 2717
2718 xxx. Huhman M, Bauman A, Bowles HR. Initial outcomes of the VERB campaign: tweens' awareness and
2719 understanding of campaign messages. *Am J Prev Med* 2008; 34(6S):S241-S248.
- 2720
2721 Safe routes to school
- 2722
2723 xxxi. Cooper AR, Page AS, Foster LJ, Qahwaji D. Commuting to school: are children who walk more physically
2724 active? *Am J Prev Med* 2003;25:273-6.
- 2725
2726 xxxii. Cooper AR. Physical activity levels of children who walk, cycle, or are driven to school. *Am J Prev Med*
2005;29:179-84.
- 2727
2728 xxxiii. Tudor-Locke C, Neff LJ, Ainsworth BE, Addy CL, Popkin BM. Omission of active commuting to school and
2729 the prevalence of children's health-related physical activity levels: the Russian Longitudinal Monitoring Study.
Child Care Health Dev 2002;28:507-12.
- 2730
2731 xxxiv. Alexander LM, Inchley J, Todd J, Currie D, Cooper AR, Currie C. The broader impact of walking to school
among adolescents: seven day accelerometry based study. *BMJ* 2005;331:1061-2.

2732 xxxv. Sirard J, Riner WJ, McIver K, Pate R. Physical activity and active commuting to elementary school. *Med Sci*
2733 *Sports Exerc* 2005;37:2062-9.

2734 Reduced cost and use

2735
2736 xxxvi. Managed-Medicare health club benefit and reduced health care costs among older adults. Nguyen HQ,
2737 Ackerman RT, Maciejewski M, Berke E, Patrick M, Williams B, LoGerfo JP. *Prev. Chronic Disease*, 2008 Jan 5(1)
2738 A14. Epub 2007 Dec 15.

2739
2740 xxxvii. Economic interventions to promote physical activity. Application of the SLOTH model.
2741 Pratt, M, Macera CA, Sallis JF, O'Donnell M, Frank LD. *Am J Prev. Med* 2004, 27(S1)

2742
2743 xxxviii. The economics of physical activity: Societal trends and rationales for interventions. Strum R, *Am J Prev.*
2744 *Med*, 2004, 27 (S1).

2745
2746 Safety and Park Use

2747
2748 xxxix. The built environment, neighborhood crime and constrained physical activity: An exploration of inconsistent
2749 findings. Foster, S, Giles-Corti B. *Prev Med* 2008, 47 (3) pp 241-251.

2750
2751 xl. Unsafe to play? Neighborhood disorder and lack of safety predict reduced physical activity among urban children
2752 and adolescents. Molnar, S, Gortmaker, S, Bull F, Buka SL. *Am J Health Prom* 2004, 18(5) pp 378-386.

2753
2754 xli. Parents' perceptions of neighborhood safety and children's physical activity. Weir, L, Etelson D, Brand D. *Prev.*
2755 *Med* 2006, 43(3) pp 212-217.

2756
2757 xlii. Besser LM, Dannenberg AL. Walking to public transit: steps to help meet physical activity recommendations.
2758 *Am J Prev Med*. 2005; 29(4):273-80.

2759
2760 xliiii. MMWR: Morbidity and Mortality Weekly Report. Recommended community strategies and measurements
2761 to prevent obesity in the United States. Centers for Disease Control and Prevention. July 24, 2009 58(RR07);1-26.
2762 <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5807a1.htm>

2763
2764
2765 **Additional references**

2766
2767 Comprehensive State and Community Programs

2768
2769 Arkansas Center for Health Improvement. Assessment of childhood and adolescent obesity in Arkansas; Year Four

2770
2771 Economos CD, et al. A community intervention reduces BMI z-score in children: Shape Up Somerville first year
2772 results. *Obesity* 2007;15:1325

2773
2774 Hoelscher DM et al. Regional and state initiatives lead to significant decreases in the prevalence of child overweight
2775 in Texas. Manuscript submitted.

2776
2777 **Other references for "Signage prompts" for deterring sedentary behavior:**

2778
2779 R.E Andersen, S.C Franckowiak, J Snyder, S.J Bartlett and K.R Fontaine, Can inexpensive signs encourage the use
2780 of stairs? Results from a community intervention, *Ann Intern Med* **129** (1998), pp. 363-369.

2781
2782 J Kerr, F Eves and D Carroll, Posters can prompt less active people to use the stairs, *J Epidemiol Community Health*
2783 **54** (2000), pp. 942-943.

2784
2785 W Russell, D Dzawaltowski and G Ryan, The effectiveness of a point-of-decision prompt in deterring sedentary
behavior, *Am J Health Promot* **13** (1999), pp. 257-259.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Office of Public Health and Science (OPHS)

American Recovery and Reinvestment Act (Recovery Act) of 2009

Funding Opportunity Title: ARRA Prevention and Wellness- Leveraging National Organizations

Announcement Type: Competitive Initial Announcement of Availability of Funds

Funding Opportunity Number: OS-PAW-10-001

Catalog of Federal Domestic Assistance Number: 93.731

Statutory Authority:

This cooperative agreement program is authorized under 42 U.S.C. 300k-1, 300, section 1701 of the Public Health Service Act, as amended.

KEY DATES: To receive consideration, applications must be received electronically through www.Grants.gov or www.GrantSolutions.Gov before 11:00 P.M. Eastern Time on April 19, 2010. Should an applicant choose to submit a hard copy mail submission, these applications must be received by the Office of Grants Management, Office of Public Health and Science (OPHS), Department of Health and Human Services (DHHS) c/o Grant Application Center, 1515 Wilson Blvd., Suite 100, Arlington, VA 22209, no later than 5:00 p.m. Eastern Time on April 19, 2010. Applications will not be accepted by fax, nor will the submission deadline be extended. The application due date requirement specified in this announcement supersedes the instructions in the OPHS-1. Applications which do not meet the deadline will be returned to the applicant unread. See Section IV.3. Submission Dates and Times for information on application submission mechanisms.

Applicants are required to submit a Letter of Intent (LOI) to be eligible to apply for this program and must be received by the Office of Grants Management, Office of Public Health and Science (OPHS), Department of Health and Human Services (DHHS) c/o Grant Application Center, 1515 Wilson Blvd., Suite 100, Arlington, VA 22209, no later than 5:00 p.m. Eastern Time on **April 6, 2010**. Failure to submit a LOI will result in non-responsiveness and the applicant will be prohibited from applying. **If you experience any difficulty submitting the LOI please email: natorg.cppw@hhs.gov.**

Pre-Application Support:

Funding Opportunity Announcement (FOA) information will be available for potential applicants on a conference call to be conducted by the Office of Public Health and Science. The call will be held on Monday, March 15, 2010 from 3:00-4:30pm Eastern Daylight Time. The conference call can be accessed by calling 1-800-972-9342. The leader for this call is Julie Moreno and the pass code is 69106. Frequently asked application questions can be accessed at: <http://www.hhs.gov/ophs/funding/index.html>. Additional inquiries may be sent to the following email address: natorg.cppw@hhs.gov.

Executive Summary

This notice announces the availability of \$10 million as part of the Communities Putting Prevention to Work (CPPW) initiative for National Organizations to work in partnership with communities to achieve the following goals: (1) increase levels of physical activity; (2) improve nutrition (e.g. increase fruit/vegetable consumption, reduce salt and transfats); (3) decrease

overweight/obesity prevalence; (4) decrease smoking prevalence and teen smoking initiation; and (5) decrease exposure to second-hand smoke. National organizations play a critical role in disease prevention and health promotion by building partnerships, providing expert guidance, and implementing strategies that positively impact policies, systems, and environments.

This National Organizations Initiative will focus on:

- Providing resources [including but not limited to policy briefs, guidance, tools, training (e.g., outreach and cultural competency), technical assistance, linkages with other federally funded activities and program delivery] and promoting prevention efforts to CPPW-funded communities through the national organizations' systems and networks.

This required activity is the priority component of the National Organizations Initiative;

- Sustaining community prevention efforts beyond Recovery Act CPPW funding;
- Supporting a National Prevention Media Initiative through co-branding and augmenting HHS-developed media campaigns in communities.

I. Funding Opportunity Description

This cooperative agreement program is authorized under 42 U.S.C. 300k-1, 300, section 1701 of the Public Health Service Act, as amended.

This Funding Opportunity Announcement (FOA) focuses on two categories of activities:

- Category A: Obesity prevention through improved nutrition and increased physical activity
- Category B: Tobacco prevention and control

Eligible applicants may propose activities in one or both categories and must specify the category(s) in their application. If applicants are applying to both categories, separate applications must be submitted for each category. Eligible applicants may be public or private nonprofit organizations and have an established (two years or longer) national outreach infrastructure with an existing focus on population based approaches such as policy, systems, and environmental change in the areas of obesity, nutrition, physical activity, and/or tobacco.

Proposals from national organizations seeking funding must include a description of the organization, including its mission, infrastructure, and staffing; a budget; a description of the proposed approach to helping select communities implement evidence-based strategies; an estimate of the impact of their efforts; and, an evaluation plan.

Monitoring and evaluation of the Recovery Act-funded efforts will focus on the augmentation and implementation of community-wide policy, systems, and environmental changes, as well as community approaches to reducing the prevalence of obesity and tobacco.

I.1. Background

In the United States today, seven of ten deaths, the vast majority of serious illness and disability, and more than 75% of health care costs are caused by chronic diseases, such as obesity, diabetes and cardiovascular disease (www.cdc.gov/nccdphp/overview.htm). Key behavioral risk factors, such as – lack of physical activity, poor nutrition and tobacco use – are major contributors to these statistics. Many Americans die prematurely and suffer from diseases that could be

prevented or more effectively managed. Additionally, many populations, including racial ~~and~~ ethnic minority populations, are disproportionately impacted by chronic disease.

Research has shown that implementing policy, systems, and environmental changes, such as improving physical education in schools, 100% smoke-free policies, or providing access to nutritious foods can result in positive behavior changes related to physical activity, nutrition, and tobacco use, which positively impact multiple chronic disease outcomes.

The Recovery Act, signed into law February 17, 2009, is designed to stimulate economic recovery in various ways, including strengthening the Nation's healthcare infrastructure and reducing healthcare costs through prevention activities. The Recovery Act includes a Prevention & Wellness Fund (Fund) of \$1 billion, of which \$650 million was provided for evidence-based clinical and community-based prevention and wellness strategies that support specific, measurable health outcomes to reduce chronic disease rates. The legislation provides an important opportunity for states, territories, cities, rural areas, and tribes to advance public health across the lifespan and to reduce health disparities.

The HHS Centers for Disease Control and Prevention (CDC) has previously announced the availability of the first portion of the Fund (Funding Opportunity Number: CDC-RFA-DP09-912ARRA09; Catalog of Federal Domestic Assistance Number: 93.724) for an initiative entitled Communities Putting Prevention to Work (CPPW) to support intensive community approaches to chronic disease prevention and control in selected communities (territories, urban and rural), to achieve the following prevention outcomes:

- Increased levels of physical activity;
- Improved nutrition (e.g. increased fruit/vegetable consumption, reduced salt and trans fats);
- Decreased overweight/obesity prevalence
- Decreased smoking prevalence and decreased teen smoking initiation; and
- Decreased exposure to secondhand smoke.

Note: Specific long-term target measures that align with the broad goals above are outlined in Appendix A.

Note: The CDC expects to make awards for the CPPW-funded communities on or around February 26.

In addition, CDC has announced that a second portion of the CPPW (funding opportunity number: CDC-RFA-DP09-90101ARRA09) will support states in two critical areas: (1) policy and environmental change: under direction of CDC, states will receive funding to promote state-wide policy and environmental changes in support of community efforts; and (2) tobacco cessation: under direction of CDC, all currently funded states and territories will be eligible to apply for and expected to receive funding to expand tobacco quit lines, in concert with expanded media campaigns. The HHS Administration on Aging will also have responsibility for implementing a component of the CPPW that enables all states to be eligible and apply for funds to develop or expand chronic disease self management programs. In addition, a National Prevention Media campaign will be developed and launched by CDC in the near future to support the overall CPPW initiative. To assess overall progress of the initiative, the CDC will have responsibility for evaluating community and national-level progress using national data surveillance systems.

I.2. Purpose

The purpose of the National Organizations Initiative is to augment, implement, and disseminate community-wide policies, systems, and environmental changes - first and foremost in the selected CPPW-funded communities and second across affiliates and networks nationwide.

Selected national organizations will collaborate with partners in government, health, education and academia, business, community and faith-based organizations, development, transportation and land use, parks and recreation, foundations, and other community sectors to promote health and prevent chronic diseases.

The National Organizations Initiative will address the following areas, consistent across the CPPW initiative:

- Obesity -- prevention efforts through improved nutrition and increased physical activity, and
- Tobacco -- prevention and control activities.

I.3. Recipient Activities

Applicants can seek funding in two general categories:

Category A: obesity prevention efforts through improved nutrition and increased physical activity

Category B: tobacco prevention and control activities

Applicants can propose activities in Category A or Category B or both. If applying for both categories, a separate application must be submitted for each category. Should an applicant compete successfully in both categories, HHS will work with the grantee to merge the staffing plans and reduce the requested budgets accordingly in order to reflect a combined operating structure. Applicants for Categories A or B may request funding up to \$1.5 million for the 24 month budget period.

All applications, regardless of category must include the following:

I.3.i. Description of the National Organization

The description should include a brief history, the mission and vision, major programs/initiatives/activities, the organizational and management structure, and funding sources of the organization. As national organizations will support the CPPW-funded communities as part of their workplan, national organizations must demonstrate evidence that the organization operates nationally within the United States and/or its territories and has affiliate offices, or chapters, in a minimum of five of the regions of HHS. National Organizations that are wholly tribal-focused need not meet the five regions requirement and are encouraged to apply. OPHS as part of its management responsibility will work with grantees to align with CPPW-funded communities within their network. Additionally, the national organization's description should demonstrate knowledge and experience in addressing health disparities in populations disproportionately impacted by chronic disease (e.g. racial and ethnic minority populations, persons with disabilities, etc).

I.3.ii. Budget and Statement of Fiscal Management and Integrity

The budget should:

- demonstrate how awarded funds will be used to support the goals of the initiative and achieve the proposed interventions;
- not exceed a request of \$1.5 Million;
- include information about all other sources of funding, including whether any of the national organization’s affiliates or stakeholders have applied for CPPW funding;
- provide evidence of the sustainability of planned interventions beyond the award amount and project period. This may include plans to leverage other resources available, including federal, state, and local sources, both during and after the project period;
- include a staffing plan and resumes of key personnel.

The fiscal management statement should:

- describe the organization’s fiscal management procedures to track and monitor expenditures separate from other federal funding streams;
- describe systems to meet the online reporting criteria and timelines associated with Recovery Act funding. (For additional information, see Reporting Requirements under “Recovery Act-Specific Reporting Requirements” of this FOA.)

I.3.iii. Work Plan

The CDC supported CPPW-funded communities will implement evidence-based strategies in accordance with the CDC MAPPS strategy. MAPPS strategies for obesity (nutrition and physical activity) and tobacco are outlined below. As grantees are required to support the CDC-funded CPPW communities as part of their work plan, applicants must be prepared to support

these communities in their implementation of the MAPPS strategies. OPHS will match the funded national organizations with the CDC-funded CPPW communities based on the expertise of the national organization and the selected MAPPS strategies of the CPPW-funded community.

MAPPS Strategies for Category A; Obesity

	Nutrition	Physical Activity
Media	<ul style="list-style-type: none"> • Media and advertising restrictions consistent with federal law • Promote healthy food/drink choices • Counter-advertising for unhealthy choices 	<ul style="list-style-type: none"> • Promote increased activity • Promote use of public transit • Promote active transportation (bicycling and walking) • Counter-advertising for screen time
Access	<ul style="list-style-type: none"> • Healthy food/drink availability (e.g., incentives to food retailers to locate/offer healthier choices in underserved areas, healthier choices in child care, schools, worksites) • Limit unhealthy food/drink availability (whole milk, sugar sweetened beverages, high-fat snacks) • Reduce density of fast food establishments • Eliminate transfat through purchasing actions, labeling initiatives, restaurant standards • Reduce sodium through purchasing actions, labeling initiatives, restaurant standards • Procurement policies and practices • Farm to institution, including schools, worksites, hospitals and other community institutions 	<ul style="list-style-type: none"> • Safe, attractive accessible places for activity (e.g. access to outdoor recreation facilities, enhance bicycling and walking infrastructure, place schools within residential areas, increase access to and coverage area of public transportation, mixed use development, reduce community designs that leads to injuries). • City planning, zoning and transportation (e.g., planning to include the provision of sidewalks, mixed use, parks with adequate crime prevention measures, and Health Impact Assessments) • Require daily quality PE in schools • Require daily physical activity in afterschool/childcare settings • Restrict screen time (afterschool, daycare)
Point of Purchase/Promotion	<ul style="list-style-type: none"> • Signage for healthy vs. less healthy items • Product placement & attractiveness • Menu labeling 	<ul style="list-style-type: none"> • Signage for neighborhood destinations in walkable/mixed-use areas • Signage for public transportation, bike lanes/boulevards.
Price	<ul style="list-style-type: none"> • Changing relative prices of healthy vs. unhealthy items (e.g. through bulk purchase/procurement/competitive pricing). 	<ul style="list-style-type: none"> • Reduced price for park/facility use • Incentives for active transit • Subsidized memberships to recreational facilities
Social Support & Services	<ul style="list-style-type: none"> • Support breastfeeding through policy change and maternity care practices 	<ul style="list-style-type: none"> • Safe routes to school • Workplace, faith, park, neighborhood activity groups (e.g., walking hiking, biking)

MAPPS Strategies for Category B; Tobacco

	Tobacco
Media	<ul style="list-style-type: none"> • Media and advertising restrictions consistent with federal law • Hard hitting counter-advertising • Ban brand-name sponsorships • Ban branded promotional items and prizes
Access	<ul style="list-style-type: none"> • Usage bans (i.e. 100% smoke-free policies or 100% tobacco-free policies) • Usage bans (tobacco-free worksites and or school campuses) • Zoning restrictions • Restrict sales (e.g. internet; sales to minors; stores/events w/o tobacco) • Ban self-service displays & vending
Point of Purchase/ Promotion	<ul style="list-style-type: none"> • Restrict point of purchase advertising • Labeling/ signage/ placement to discourage consumption of tobacco
Price	<ul style="list-style-type: none"> • Use evidence-based pricing strategies that discourage tobacco use • Ban free samples and price discounts
Social Support & Services	<ul style="list-style-type: none"> • Quitline and other cessation services

The national organizations workplan must:

- Identify whether the proposed activities are in Category A or Category B:
 - Category A: Obesity prevention through improved nutrition and increased physical activity
 - Category B: Tobacco prevention and control
- Include the following key activities (all items are required and listed by priority)
 - Demonstrate expertise in a minimum of three MAPPS strategies through previous community level policy interventions, trainings convened, and/or program delivery;
 - Develop a plan for providing stated MAPPS expert resources to CPPW-funded communities (soon to be identified) through national organization's headquarters or affiliate network, mentoring, social networking assistance and/or direct technical assistance to the communities;

- Incorporate the development and utilization of policy briefs and other similar tools to promote policy and environmental reforms consistent with applicant's expert MAPPS strategy;
 - Incorporate the convening of policy roundtable discussions or other similar forums to promote policy and environmental reforms consistent with proposed expert MAPPS strategies;
 - Provide resources (including outreach, training, technical assistance, evaluation support and/or program delivery) and promote MAPPS prevention efforts in non CPPW-funded communities through the national organizations' networks;
 - Disseminate and promote effective population-based approaches to obesity and tobacco prevention and control to support communities' changes in policy, systems, and environment nation-wide; and,
 - Enhance a National Prevention Media Initiative (currently under development) through co-branding and augmenting media campaigns in select communities (CPPW-funded and non CPPW-funded).
- Provide a timeline for implementation of activities that demonstrates utilization of resources within the CPPW-funded communities as the first and most significant activity of the workplan followed by; (2) activities engaging other affiliates and/or networks and (3) support for a National Media Initiative.
 - Articulate a clear understanding of the CPPW Initiative and the relationship of the proposed activities of the national organization to the goals of the overall CPPW initiative.

- Include a plan for sustaining efforts beyond federal funding through this initiative. Including and/or citing established partnerships to leverage additional support for the workplan is encouraged and will receive additional considerations in the application scoring process. Memorandums of understanding citing partnerships, deliverables, and amount of support must be included in the application's appendix for additional point consideration.
- Include a staffing and management plan that delineates organizational lines of authority, proposed staff experience and clearly articulates staff roles as they relate to the overall workplan.

I.3.iv. Evaluation Plan and Recovery Act Reporting Requirement: Output and Outcome Measures

Since a critical component of the National Organizations is to support and assist CPPW-funded communities with their expert resources, the National Organizations and the CPPW-funded communities will share ownership of the same outcome measures— approval/enactment of MAPPS-related policy, systems, and environmental change in physical activity, nutrition, and tobacco in funded communities. Because the National Organizations and their local affiliates have a distinct supporting role in these community-wide efforts, the output measures track the kinds of added-value to be derived from involvement of the National Organizations and its local affiliates in the community-wide efforts which should help drive the outcome measure. All grantees will be monitored on the following outcome and output reporting measures:

Outcome Measure

- Measure: *Percentage of relevant MAPPS strategies on which the National Organization/its local chapters are collaborating with ARRA-funded communities for which the intended policy, systems, or environmental change has been approved/enacted.*
- Frequency: Quarterly. Funded recipients will report to OPHS.

Output Measures

- Measure: Number of Recovery Act-funded communities in which the National Organizations' local affiliates are co-branding media messages and materials from national media campaign and/or where the National Organization itself is using and distributing co-branded materials.
- Measure: Number of peer-to-peer mentorships/technical assistance relationships provided by the National Organizations' local affiliates to programs in CPPW-funded communities and/or instances of direct consultation/assistance by the national organization to programs in CPPW-funded communities.
- Measure: Estimated financial and in-kind additional support national organizations were successful in leveraging for sustaining community prevention activities.
- Measure: Development and use of policy documents:
 - Number of policy issue briefs/policy documents developed and issued by the National Org or its local affiliates.
 - Number of community programs using the policy issue briefs/policy documents in their policy mobilization work.
- Measure: Development and participation in policy sessions
 - Number of policy workshops, roundtables, forums or similar activities organized by the National Organizations or its local affiliates.

- Number of participants in these policy workshops, roundtables, forums and similar activities from programs in CPPW-funded communities
- Frequency (all output measures): Quarterly. Funded recipients will report to OPHS.

In addition to the requirements outlined above, applicants must develop an evaluation approach that captures key information on what implementation and guidance strategies were successful, why, and other lessons learned. The evaluation plan should include qualitative and/or quantitative measures that document the degree to which the applicant's efforts: (1) have contributed to policy change at community and/or national levels; (2) have resulted in implementation of broad-based prevention efforts within the national organizations affiliate network; (3) have included appropriate partnerships/growth in partnerships to augment strategies and interventions; ~~and~~ (4) promoted sustainability of community-based prevention activities. A report on this evaluation component will be due mid-project period (12 months) and at the end of the project period (24 months).

A minimum of ten percent of the proposed budget for the entire work plan should support ARRA reporting and evaluation requirements.

I.4. OPHS Activities

Through a cooperative agreement, OPHS staff will have substantial involvement in the program activities above and beyond routine grant monitoring. Additionally, OPHS will work closely with CDC program staff to ensure linkages between funded national organizations and CPPW-funded communities.

OPHS activities for this program are as follows:

- Provide ongoing programmatic support to the national organizations to ensure success for Recovery Act-funded activities in the following areas:
 - Evidence-based and practice-based approaches
 - Partnership development
 - Implementation of broad-based policy, systems, and environmental changes
 - Evaluation of policy, system, and environmental level change
 - Monitoring of risk behavior change and longer-term health outcomes
- Match funded national organizations with the select CPPW-funded communities and continually redirect as appropriate or necessary.
- Foster the transfer of successful evidence and practice-based interventions, program models and other information by convening meetings, workshops, web forums, conferences, and conference calls with awardees and stakeholders;
- Conduct on-site visits to awardees to ensure achievement of quarterly benchmarks and project success as necessary and as determined by the Recovery Act.

II. Award Information

Type of Award: Cooperative Agreement

OPHS's substantial involvement in this program is listed in the Activities Section above.

Fiscal Year Funds: 2010

Approximate Current Fiscal Year Funding: \$10 Million available

Range and Average of Financial Assistance: Up to \$1.5 Million per award

Number of Awards: Up to 10 awards will be made under this funding announcement, approximately five in Category A and five in Category B. Additionally, geographic diversity across the HHS Regions will be considered in making awards. Awards will vary with size of the national organization, proposed activities, and strength of the proposed workplan in achieving results within the specified timeframe.

Anticipated Award Date: May 2010.

Budget Period Length: 24 months

Project Period Length: 24 months

The Recovery Act appropriation for this activity states that funding will support evidence-based clinical and community-based prevention and wellness strategies. Therefore, this announcement is categorized as a training and technical assistance grant and applies only to non-research, non-demonstration activities. If research or demonstration projects are proposed, the application will not be reviewed.

Please note: Applicants who apply for both Categories A and B of this announcement must submit two separate applications. Should an applicant receive awards in both categories, OPHS will work with the grantee to merge the staffing plans and reduce the requested budgets accordingly in order to reflect a combined operating structure.

III. Eligibility Information

III.1. Eligible Applicants

Eligible applicants may be public or private nonprofit organizations and have an established (two years or longer) national outreach infrastructure with an existing focus on population based approaches such as policy, systems, and environmental change in the areas of tobacco, obesity,

nutrition, and/or physical activity. Additionally, applicants must provide performance data that documents health outcome changes that have resulted from previous projects and/or campaigns. National reach must include established networks and/or affiliates within five or more of the ten HHS regions. An established relationship or proposed collaboration with an HHS Regional Health Administrator is preferred. Applications from organizations representing tribal communities and/or nations will be treated uniquely and separately.

Eligible organizations are required to have experience in collaborating with organizations that address health disparities and experience working with non-traditional partners. Examples include partnerships with organizations focusing on education, housing, labor, transportation, and commerce.

Eligible applicants must have adequate infrastructure to support community interventions during planning, implementation, and evaluation phases.

Note: Title 2 of the United States Code section 1611 states that an organization described in section 501(c)(4) of the Internal Revenue Code that engages in lobbying activities is not eligible to receive Federal funds constituting an award, grant, or loan.

III.2. Cost Sharing To Promote Sustainability

There is no match requirement for this program. However, leveraging other resources and related on-going efforts to promote sustainability is encouraged and demonstration of leveraged

support will receive additional consideration in the application scoring process. Additional requirements on sustainability are highlighted in the program workplan section.

III.3. Other

- Applications that do not address all activities will be deemed incomplete and considered non-responsive and will not be entered into the review process.
- Unqualified and/or non-responsive applicants will be notified that their applications did not meet the submission requirements.
- Applicants are required to submit a Letter of Intent (LOI) to be eligible to apply for this program. Failure to submit a LOI will result in non-responsiveness and the applicant will be prohibited from applying. See Sections (IV.2) of this announcement for more information on LOI submission.

IV. Application and Submission Information

IV.1. Address to Request Application Package

To apply for this funding opportunity use the application forms package posted on Grants.gov at <http://www.grants.gov> or the GrantSolutions system at <http://www.grantsolutions.gov>. To obtain a hard copy of the application kit for this grant program, contact the OPHS Office of Grants Management, 1101 Wootton Parkway, Suite 550, Rockville, Maryland 20852; or by telephone at (240) 453-8822. Applications must be prepared using Form OPHS-1, which can be obtained at the web sites noted above.

Please visit www.Grants.gov at least 30 days prior to filing your application to familiarize yourself with the registration and submission processes. Under “Get Registered,” the one-time registration process will take three to five days to complete; however, as part of the Grants.gov registration process, registering your organization with the Central Contractor Registry (CCR) annually, could take an additional one to two days to complete. We suggest submitting electronic applications prior to the closing date so if difficulties are encountered, you can submit a hard copy of the application prior to the deadline.

IV.2. Content and Form of Application Submission

Letter of Intent (LOI):

A letter of intent (LOI) from the Executive Director or President of the National Organization is required from all potential applicants for the purposes of planning the competitive review process. Failure to submit a LOI will result in non-responsiveness and the applicant will be prohibited from applying.

A letter of intent should be no more than two pages (8.5 x 11), double-spaced, printed on one side, with one-inch margins, written in English (avoiding jargon), and unreduced 12-point font. Additionally, a letter of intent must include following information (failure to submit a LOI will result in non-responsiveness and the applicant will be prohibited from applying):

- ARRA Prevention and Wellness- Leveraging National Organizations; CFDA 93.731
- Category A or B or both: each risk factor area (tobacco and/or obesity through physical activity and/or nutrition) for which the applicant intends to apply; and
- A program point of contact (including email) at the applicant organization.

Although the LOI will not be scored as part of the application process. Letters of intent can be submitted electronically (www.GrantSolutions.gov or www.Grants.Gov) or via mail (OPHS Office of Grants Management, 1101 Wootton Parkway, Suite 550, Rockville, Maryland 20852). Applicants will be notified by email upon receipt of the LOI by OPHS.

Application:

A Project Abstract must be submitted with the application forms. All electronic project abstracts must be uploaded in a PDF file format when submitting via Grants.gov. The abstract must be submitted in the following format:

- Maximum of two pages
- Maximum of 3-4 paragraphs
- Font size: 12 point unreduced, Times New Roman
- Single spaced
- Paper size: 8.5 by 11 inches
- Page margin size: one inch

The project abstract must contain which category of activities the national organization is applying for (either Category A or Category B), a summary of the proposed activities suitable for dissemination to the public, and evidence that the organization operates nationally within the United States and/or its territories and has affiliate offices, or chapters, in a minimum of five of the regions of HHS. If applying for both categories, a separate project abstract is required for each category. The abstract should be a self-contained description of the project and should contain a statement of objectives and methods to be employed. This abstract must not include any proprietary/confidential information.

As indicated above, a project narrative/workplan must be submitted with the application forms.

All electronic narratives must be uploaded in a PDF file format when submitting via Grants.gov.

The narrative must be submitted in the following format:

- Maximum number of pages: 30. If your narrative exceeds the page limit, only the first 30 pages will be reviewed.
- Font size: 12 point unreduced, Times New Roman
- Double spaced
- Paper size: 8.5 by 11 inches
- Page margin size: one inch
- Single-sided printing
- Number all narrative pages (not to exceed 30)
- Paper application should be held together only by rubber bands or metal clips; not bound in any other way.

The applicant organization is required to have a Dun and Bradstreet Data Universal Numbering System (DUNS) number to apply for a grant or cooperative agreement from the Federal government. The DUNS number is a nine-digit identification number, which uniquely identifies business entities. Obtaining a DUNS number is easy and there is no charge. To obtain a DUNS number, access the [Dun and Bradstreet website](#) or call 1-866-705-5711.

Additional requirements that may request submission of additional documentation with the application are listed in section “VI.2. Administrative and National Policy Requirements.”

IV.3. Submission Dates and Times

Application Submission Deadline Date is April 19, 2010.

Required Letter of Intent is due by **April 6, 2010**.

Applications may be submitted electronically at www.Grants.gov. Applications completed online through Grants.gov are considered formally submitted when the applicant organization's Authorizing Organization Representative (AOR) electronically submits the application to www.Grants.gov. Electronic applications will be considered as having met the deadline if the application has been successfully submitted electronically by the applicant organization's AOR to Grants.gov on or before the deadline date and time.

When submission of the application is done electronically through Grants.gov (<http://www.grants.gov>), the application will be electronically time/date stamped and a tracking number will be assigned, which will serve as receipt of submission. The AOR will receive an e-mail notice of receipt when OPHS receives the application.

If submittal of the application is by the United States Postal Service or commercial delivery service, the applicant must ensure that the carrier will be able to guarantee delivery by the closing date and time. The applicant will be given the opportunity to submit documentation of the carrier's guarantee, if OPHS receives the submission after the closing date due to: (1) carrier error, when the carrier accepted the package with a guarantee for delivery by the closing date and time; or (2) significant weather delays or natural disasters. If the documentation verifies a carrier problem, OPHS will consider the submission as having been received by the deadline.

If a hard copy application is submitted, OPHS will not notify the applicant upon receipt of the submission. If questions arise on the receipt of the application, the applicant should first contact the carrier. If the applicant still has questions, contact the Grants Application Center. The applicant should wait two to three days after the submission deadline before calling. This will allow time for submissions to be processed and logged.

This announcement is the definitive guide on application content, submission address, and deadline. It supersedes information provided in the application instructions. If the application submission does not meet the deadline above, it will not be eligible for review. The application face page will be returned by OPHS with a written explanation of the reason for non-acceptance. The applicant will be notified the application did not meet the submission requirements.

Submission Mechanisms

HHS/OPHS provides multiple mechanisms for the submission of applications, as described in the following Sections. Applicants will receive notification via email from the HHS/OPHS Office of Grants Management to confirm the receipt of applications submitted by using any of these mechanisms. HHS will not accept for review applications submitted to the HHS/OPHS Office of Grants Management after the deadlines described below. HHS will not accept for review applications that do not conform to the requirements of this grant announcement, and will return hard-copy applications to the applicant.

While HHS will accept applications in hard copy, the Directorate encourages the use of the electronic application-submission capabilities provided by the Grants.gov and GrantSolutions.gov systems. Applications may only be submitted electronically via the electronic submission mechanisms specified below. HHS will not accept for review any applications submitted via any other means of electronic communication, including facsimile or electronic mail. All HHS funding opportunities and application kits are available on Grants.gov. If your organization has/had a grantee business relationship with a grant program serviced by the HHS/OPHS Office of Grants Management, and you are applying as part of ongoing, grantee-related activities, please use GrantSolutions.gov.

Applications must be submitted in an electronic file format or typed so that it can be easily viewed, copied and read by reviewers. It is recommended that scanned copies not be submitted through Grants.gov or GrantSolutions unless the applicant confirms the clarity of the documents.

Applicants submitting electronic grant applications must do so no later than 11:00 pm, Eastern Time, on the deadline date specified in the “Dates” Section of this announcement, by using one of the electronic-submission mechanisms specified below. For applications submitted electronically, HHS/OPHS Office of Grants Management must receive all required, hard-copy, original signatures and mail-in items c/o the Grant Application Center, 1515 Wilson Blvd., Suite 100, Arlington, VA 22209, no later than 5:00 p.m., Eastern Time, on the next business day after the deadline date specified in the “Dates” Section of this announcement.

HHS/OPHS must receive hard-copy applications no later than 5:00 p.m., Eastern Time, on the deadline date specified in the “Dates” Section of this announcement.

HHS will not consider applications as valid until the HHS/OPHS Office of Grants Management has received all components of the electronic application; hard-copy with original signatures, and mail-in items, according to the deadlines specified above. HHS will consider as late any application submissions that does not adhere to the due-date requirements, will deem them ineligible. Applicants should initiate electronic applications as early as possible, and should submit early on the due date or before. This will aid in addressing any problems with submissions prior to the application deadline.

Electronic Submissions via the Grants.gov Website Portal

The Grants.gov Website Portal provides organizations with the ability to submit applications for HHS grant opportunities. Organizations must successfully complete the necessary registration processes to submit an application. Information about this system is available on the Grants.gov website, <http://www.grants.gov>.

In addition to electronically submitted materials, applicants may have to submit hard-copy signatures for certain program-related forms, or original materials, as required by this announcement. Applicants must review both the grant announcement, as well as the application guidance provided within the Grants.gov application package, to determine such requirements. Applicants must submit separately any required, hard-copy materials, or documents that require a

signature, via mail to the HHS/OPHS Office of Grants Management, at the address and time specified above; if required, these materials must contain the original signature of an individual authorized to act for the applicant and assume the obligations imposed by the terms and conditions of the grant award. When submitting the required forms, do not send the entire application. HHS will not consider for review complete, hard-copy applications submitted after the electronic submission.

Electronic applications submitted via the Grants.gov Website Portal must contain all completed online forms required by the application kit, the Program Narrative, Budget Narrative, and any appendices or exhibits. Any files uploaded or attached to the Grants.gov application must be of the following file formats – Microsoft Word, Excel or PowerPoint, Corel WordPerfect, ASCII Text, Adobe PDF, or image formats (JPG, GIF, TIFF, or BMP only). Even though Grants.gov allows applicants to attach any file format as part of their application, HHS/OPHS restricts this practice, and only accepts the file formats identified above. HHS/OPHS will not accept for processing any file submitted as part of the Grants.gov application that is not in a file format identified above and will exclude it from the application during the review process.

HHS/OPHS must receive all required, mail-in items by the due date specified above. **Mail-in items only include publications, resumes, or organizational documentation.** When submitting the required forms, do not send the entire application. HHS will not accept for review complete, hard-copy applications submitted after the electronic submission.

Upon completion of a successful electronic application submission via the Grants.gov Website Portal, applicants will receive a confirmation page from Grants.gov that indicates the date and time (Eastern Time) of the submission, as well as a Grants.gov Receipt Number. Applicants must print and retain this confirmation for their records, as well as a copy of the entire application package. Grants.gov will validate all applications submitted via the Grants.gov Website Portal. Any applications deemed “invalid” by the Grants.gov Website Portal will not transfer to the Grant Solutions system, and HHS/OPHS has no responsibility for any application not validated and transferred to HHS/OPHS from the Grants.gov Website Portal. Grants.gov will notify applicants regarding the validation status of applications. Once the Grants.gov Website Portal has successfully validated an application, applicants should immediately mail all required, hard-copy materials to the HHS/OPHS Office of Grants Management, c/o Grant Application Center, 1515 Wilson Blvd., Suite 100, Arlington, VA 22209, by the deadlines specified above. Applicants must clearly identify their organization’s name and Grants.gov Application Receipt Number on all hard-copy materials.

Once Grants.gov has validated an application, it will electronically transfer to the Grant Solutions system for processing. Upon receipt of both the electronic application from the Grants.gov Website Portal, and the required, hard-copy mail-in items, applicants will receive notification via mail from the HHS/OPHS Office of Grants Management to confirm the receipt of the application submitted through the Grants.gov Website Portal. Applicants should contact Grants.gov regarding any questions or concerns regarding the electronic-application process conducted through the Grants.gov Website Portal.

Electronic Submissions via the Grant Solutions System

HHS/OPHS is a managing partner of the GrantSolutions.gov system. Grant Solutions is a full life-cycle grants-management system operated by the HHS Administration for Children and Families, designated by OMB as one of the three, Government-wide grants management systems under the Grants-Management Line-of-Business Initiative (GMLoB). HHS/OPHS uses Grant Solutions for the electronic processing of all grant applications, as well as the electronic management of its entire grant portfolio.

When submitting applications via the Grant Solutions system, applicants must still submit a hard copy of the face page of the application (Standard Form 424), with the original signature of an individual authorized to act for the applicant and assume the obligations imposed by the terms and conditions of the grant award. If required, applicants will also need to submit a hard copy of the Standard Form LLL and/or certain Program related forms (e.g., Program Certifications) with the original signature of an individual authorized to act for the applicant. When submitting the required hard-copy forms, do not send the entire application. HHS will not consider for review complete, hard-copy applications submitted after the electronic submission. Applicants should submit hard-copy materials to the HHS/OPHS Office of Grants Management at the address specified above.

Electronic applications submitted via the Grant Solutions system must contain all completed, on-line forms required by the application kit, the Program Narrative, Budget Narrative, and any appendices or exhibits. Applicants may identify specific, mail-in items to send to the HHS/OPHS Office of Grants Management (see mailing address above) separate from the

electronic submission; however, applicants must enter these mail-in items on the Grant Solutions Application Checklist at the time of electronic submission, which HHS/OPHS must receive by the due date specified above.

Upon completion of a successful, electronic submission, the Grant Solutions system will provide applicants with a confirmation page to indicate the date and time (Eastern Time) of the submission. This confirmation page will also provide a listing of all items that constitute the final application submission, including all components of the electronic application, required, hard-copy original signatures; and mail-in items.

As the HHS/OPHS Office of Grants Management receives items, it will update the electronic application status to reflect the receipt of mail-in items. HHS recommends that applicants monitor the status of their applications in the Grant Solutions system to ensure the receipt of all signatures and mail-in items.

Mailed or Hand-Delivered, Hard-Copy Applications

Applicants who submit applications in hard copy (via mail or hand-delivered) must submit an original, and two copies of the application. An individual authorized to act for the applicant, and to assume for the organization the obligations imposed by the terms and conditions of the grant award, must sign the original application.

HHS will consider mailed or hand-delivered applications having met the deadline if the HHS/OPHS Office of Grants Management receives them c/o Grant Application Center, 1515

Wilson Blvd., Suite 100, Arlington, VA 22209, on or before 5:00 p.m., Eastern Time, on the deadline date specified in the “Dates” Section of this announcement. The application deadline specified in this announcement supersedes the instructions in the OPHS-1. HHS/OPHS will return, unread to the applicant any application that does not meet the deadline.

IV.4. Intergovernmental Review of Applications

Executive Order 12372 does not apply to this program.

IV.5. Funding Restrictions

Restrictions, which must be taken into account while writing the budget, are as follows:

- Recipients may not use funds for research.
- Recipients may not use funds for clinical care.
- Recipients may only expend funds for reasonable program purposes, including personnel, travel, supplies, and services, such as contractual, etc.
- Awardees may not use funding for the purchase of furniture or equipment. The direct and primary recipient in a cooperative agreement program must perform a substantial role in carrying out project objectives and not merely serve as a conduit for an award to another party or provider who is ineligible.
- Reimbursement of pre-award costs is not allowed.

Additionally Grant funds may not be used for:

1. Building alterations or renovations.
2. Construction.

3. Fund-raising activities.
4. Job training
5. Political education and lobbying
6. Vocational rehabilitation.

If requesting indirect costs in the budget, a copy of the indirect cost rate agreement is required.

If the indirect cost rate is a provisional rate, the agreement should be less than 12 months of age.

The indirect cost rate agreement should be uploaded as a PDF file with “Other Attachment Forms” when submitting via Grants.gov.

IV.6. Other Submission Requirements

OPHS strongly encourages applicants to submit applications electronically at www.Grants.gov.

The application package can be downloaded from www.Grants.gov. Applicants are able to complete it off-line, and then upload and submit the application via the Grants.gov web site. E-mail submissions will not be accepted. If the applicant has technical difficulties in Grants.gov, customer service can be reached by E-mail at support@grants.gov or by phone at 1-800-518-4726 (1-800-518-GRANTS). The Customer Support Center is open from 7:00a.m. to 9:00p.m. Eastern Time, Monday through Friday.

OPHS recommends that submittal of the application to Grants.gov should be prior to the closing date to resolve any unanticipated difficulties prior to the deadline. Applicants may also submit a back-up paper submission of the application. Any such paper submission must be received in accordance with the requirements for timely submission detailed in Section IV.3. of the grant announcement. The paper submission must be clearly marked: “BACK-UP FOR ELECTRONIC

SUBMISSION.” The paper submission must conform to all requirements for non-electronic submissions. If both electronic and back-up paper submissions are received by the deadline, the electronic version will be considered the official submission.

The applicant must submit all application attachments using a PDF file format when submitting via Grants.gov. Directions for creating PDF files can be found on the Grants.gov Web site. Use of file formats other than PDF may result in the file being unreadable by staff.

AND/OR

Paper Submission:

Applicants should submit the original and two hard copies of the application by mail or express delivery service to: Grant Application Center, 1515 Wilson Blvd., Suite 100, Arlington, VA 22209, on or before 5:00 p.m., Eastern Time, on the deadline date specified in the “Dates” Section of this announcement.

V. Application Review Information

V.1. Criteria

The application will be evaluated against the following criteria: TOTAL 100 Points

1. WORK PLAN (30 points)
 - a. Does the applicant effectively address applicant activities?
 - b. Is the timeline feasible to achieve outcomes within the two-year timeframe?

- c. As the priority activity is to support the CPPW-funded communities, does the applicant provide a description of ways to provide technical assistance to funded CPPW communities?
 - d. Does the applicant have a reasonable plan for sustaining activities beyond federal funding through this initiative?
2. ORGANIZATIONAL CAPACITY AND STRUCTURE (20 points)
 - a. Does the organization meet the specifications included in the eligibility section of the funding opportunity announcement?
 - b. Does the organization have sufficient infrastructure and capacity to support and enhance the proposed activities?
 - c. Does the organization have experience working with local communities to promote policy, systems, and environmental change strategies to promote tobacco and obesity prevention?
3. STAFFING AND MANAGEMANT PLAN (15 points)
 - a. Do organizational staff members have appropriate experience? Are CVs or resumes attached in the appendices?
 - b. Are staff roles clearly defined in terms of technical assistance and administrative management of the cooperative agreement?
 - c. Are clear lines of authority designated and delineated?
 - d. Will staff be sufficient to accomplish the program goals?
4. PROGRAM REPORTING REQUIREMENTS AND EVALUATION PLAN (15 points)
 - a. Does the applicant have a plan to track and report ARRA-required output and outcome measures?

- b. Does the applicant propose an evaluation plan that includes quantitative and qualitative measures to measure progress on contribution to community policy changes, partnership growth and overall sustainability?

5. SUSTAINABILITY (10 points)

Does the organization provide evidence of partnerships (e.g. letters of support and/or Memorandum of Understandings) to leverage additional support and ongoing sustainability?

6. BUDGET (SF 424A) AND BUDGET NARRATIVE (10 points)

- a. Is the budget reasonable and consistent with the proposed activities and intent of the initiative?
- b. Does the budget support ARRA reporting and evaluation activities?

V.2. Review and Selection Process

Applications will be reviewed for completeness and responsiveness jointly by OPHS grants management and program staff. Incomplete applications and applications that are non-responsive to the eligibility criteria will not advance through the review process. Applicants will be notified that the application did not meet submission requirements.

An objective review panel will evaluate complete and responsive applications according to the criteria listed above.

Applications for funding Category A will compete only with applications for funding Category A. Applicants applying for both categories must submit separate applications for each category

for consideration and will be competing against other applications for that same category. Final award decisions will be made by OPHS and will consider:

- recommendations of the review panel;
- reviews for programmatic and grants management compliance;
- reasonableness of the estimated cost to the government considering the available funding and anticipated results; and
- the likelihood that the proposed project will result in the expected benefits.

V.3. Anticipated Announcement Award Dates

May 2010

VI. Award Administration Information

VI.1. Award Notices

Successful applicants will receive a Notice of Award (NoA) from the OPHS Grants Management Office. The NoA shall include all of the requirements of the cooperative agreement and be the only binding, authorizing document between the recipient and OPHS. The NoA will be signed by an authorized Grants Management Officer and emailed to the program director and a hard copy mailed to the recipient fiscal officer identified in the application. Unsuccessful applicants will receive notification of the results of the application review by mail.

VI.2. Administrative and National Policy Requirements

Successful applicants must comply with the administrative requirements outlined in 45 CFR Part 74 and Part 92, as appropriate. The following additional requirements apply to this project:

- AR-8 Public Health System Reporting Requirements
- AR-9 Paperwork Reduction Act Requirements
- AR-10 Smoke-Free Workplace Requirements
- AR-11 Healthy People 2010
- AR-12 Lobbying Restrictions
- AR-14 Accounting System Requirements
- AR-15 Proof of Non-Profit Status
- AR-21 Small, Minority, and Women-Owned Business
- AR-23 States and Faith-Based Organizations
- AR-25 Release and Sharing of Data
- AR 26 National Historic Preservation Act of 1996
- AR-27 Conference Disclaimer and Use of Logos

Additional information on the requirements can be found on the grants.gov web site:

OPHS Assurances and Certifications can be found on the grants.gov web site:

For more information on the Code of Federal Regulations, see the National Archives and Records Administration at the following Internet address:

<http://www.access.gpo.gov/nara/cfr/cfr-table-search.html>

VI.3. Reporting Requirements

The applicant must provide OPHS with quarterly interim progress reports: A schedule of required reports will be provided via letter to awardees.

Additionally, the applicant must provide OPHS with an original, plus two hard copies of the

following reports:

- a. A Financial Status Report and Annual Progress Report are due by June 1, 2011.
- b. A Final Performance Report and Final Financial Status Report are due by September 1, 2012.

These reports must be submitted to the attention of the Grants Management Officer listed on the Notice of Grant Award.

VI.4. Recovery Act-Specific Reporting Requirements

Other Standard Terms and Conditions

All other grant policy terms and conditions contained in applicable Department of Health and Human Services (HHS) Grant Policy Statements apply unless they conflict or are superseded by the following terms and conditions implementing the American Recovery and Reinvestment Act of 2009 (Recovery Act) requirements below. Recipients are responsible for contacting their HHS grant/program managers for any needed clarifications.

1. Quarterly Benchmarks

Awardees are required to meet quarterly benchmarks in the first year of implementation, located in Attachment A. During year 1, at the end of each quarter, each awardee will receive a score card indicating the percentage of benchmarks being met (100%-70% of benchmarks = green; 70%-50% of benchmarks = yellow; less than 50% of benchmarks = red). Leadership within HHS will be made aware of those awardees that are scoring in

the yellow and red. Quarterly scores resulting in a red designation will result in an immediate on-site meeting with OPHS staff to establish an emergency plan for overcoming barriers to success. Awardees within the red scorecard category will be asked to submit a performance improvement plan, and teams of experts will be available to provide intensive programmatic support and to verify progress. In accordance with applicable laws and regulations including 45 CFR 92.43, OPHS may take certain enforcement actions, including termination of funding, against poor performing grants.

2. Recovery Act-Specific Requirements

Recipients of Federal awards from funds authorized under Division A of the Recovery Act must comply with all requirements specified in Division A of the Recovery Act (Public Law 111-5), including reporting requirements outlined in Section 1512 of the Act and designated Recovery Act outcome and output measures as detailed at the end of this section. For purposes of reporting, Recovery Act recipients must report on Recovery Act sub-recipient (sub-grantee and sub-contractor) activities as specified below and as detailed in OMB Guidance M-10-08

(http://www.whitehouse.gov/omb/assets/memoranda_2010/m10-08.pdf) and any subsequent OMB guidance. Not later than 10 days after the end of each calendar quarter, starting with the quarter ending March 30, 2010 and reporting by April 10, 2010, the recipient must submit quarterly reports to HHS that will be posted to Recovery.gov (Leveraging National Organizations recipients will be required to report starting with the quarter ending June 30, 2010 and reporting by July 10, 2010), containing the following information:

- a. The total amount of Recovery Act funds under this award;
- b. The amount of Recovery Act funds received under this award that were obligated and expended to projects or activities;
- c. The amount of unobligated award balances;
- d. A detailed list of all projects or activities for which Recovery Act funds under this award were obligated and expended, including
 - The name of the project or activity;
 - A description of the project or activity;
 - An evaluation of the completion status of the project or activity;
 - An estimate of the number of jobs created and the number of jobs retained by the project or activity (see OMB Guidance M-09-21, June 22, 2009, updated by OMB Guidance M-10-08, December 18, 2009, and any subsequent updates) and;
 - For infrastructure investments made by state and local governments, the purpose, total cost, and rationale of the agency for funding the infrastructure investment with funds made available under this Act, and the name of the person to contact at the agency if there are concerns with the infrastructure investment.
- e. Detailed information on any sub-awards (sub-contracts or sub-grants) made by the grant recipient to include the data elements required to comply with the Federal Funding Accountability and Transparency Act of 2006 (Public Law 109-282).

For any sub-award equal to or larger than \$25,000, the following information:

- The name of the entity receiving the sub-award;
 - The amount of the sub-award;
 - The transaction type;
 - The North American Industry Classification System code or Catalog of Federal Domestic Assistance (CFDA) number;
 - Program source;
 - An award title descriptive of the purpose of each funding action;
 - The location of the entity receiving the award;
 - The primary location of performance under the award, including the city, state, tribe, congressional district, and county.
 - A unique identifier of the entity receiving the award and of the parent entity of the recipient, should the entity be owned by another entity;
 - The date the sub-award was issued;
 - The term of the sub-award (start/end dates);
 - The scope/activities of the sub-award;
 - The amount of the total sub-award that has been obligated or disbursed by the sub-recipient; and
 - The amount of the total sub-award that remains unobligated by the sub-recipient.
- f. All sub-awards less than \$25,000 or to individuals may be reported in the aggregate, as prescribed by HHS.

- g. Recipients must account for each Recovery Act award and sub-award (sub-grant and sub-contract) separately. Recipients will draw down Recovery Act funds on an award-specific basis. Pooling of Recovery Act award funds with other funds for drawdown or other purposes is not permitted.
- h. Recipients must account for each Recovery Act award separately by referencing the assigned CFDA number for each award.

The definition of terms and data elements, as well as any specific instructions for reporting, including required formats, will be provided in subsequent guidance issued by HHS.

3 Buy American - Use of American Iron, Steel, and Manufactured Goods

Recipients may not use any funds obligated under this award for the construction, alteration, maintenance, or repair of a public building or public work unless all of the iron, steel, and manufactured goods used in the project are produced in the United States unless HHS waives the application of this provision. (Recovery Act Sec. 1605)

4. Wage Rate Requirements

[This term and condition shall not apply to tribal contracts funded with this appropriation. (Recovery Act Title VII—Interior, Environment, and Related Agencies, Department of Health and Human Services, Indian Health Facilities)]

Subject to further clarification issued by the Office of Management and Budget, and notwithstanding any other provision of law and in a manner consistent with other

provisions of Recovery Act, all laborers and mechanics employed by contractors and subcontractors on projects funded directly by or assisted in whole or in part by and through the Federal Government pursuant to this award shall be paid wages at rates not less than those prevailing on projects of a character similar in the locality as determined by the Secretary of Labor in accordance with subchapter IV of chapter 31 of title 40, United States Code. With respect to the labor standards specified in this section, the Secretary of Labor shall have the authority and functions set forth in Reorganization Plan Numbered 14 of 1950 (64 Stat. 1267; 5 U.S.C. App.) and section 3145 of title 40, United States Code. (Recovery Act Sec. 1606)

5. Preference for Quick Start Activities (Recovery Act)

In using funds for this award for infrastructure investment, recipients shall give preference to activities that can be started and completed expeditiously, including a goal of using at least 50 percent of the funds for activities that can be initiated not later than 120 days after the date of the enactment of Recovery Act. Recipients shall also use grant funds in a manner that maximizes job creation and economic benefit. (Recovery Act Sec. 1602)

6. Limit on Funds (Recovery Act)

None of the funds appropriated or otherwise made available in Recovery Act may be used by any state, local, or tribal government, or any private entity, for any casino or other gambling establishment, aquarium, zoo, golf course, or swimming pool. (Recovery Act Sec. 1604)

7. Disclosure of Fraud or Misconduct

Each recipient or sub-recipient awarded funds made available under the Recovery Act shall promptly refer to the HHS Office of Inspector General any credible evidence that a principal, employee, agent, contractor, sub-recipient, subcontractor, or other person has submitted a false claim under the False Claims Act or has committed a criminal or civil violation of laws pertaining to fraud, conflict of interest, bribery, gratuity, or similar misconduct involving those funds. The HHS Office of Inspector General can be reached at <http://www.oig.hhs.gov/fraud/hotline/>

8. Recovery Act: One-Time Funding

Unless otherwise specified, Recovery Act funding to existent or new awardees should be considered one-time funding.

9. Schedule of Expenditures of Federal Awards

Recipients agree to separately identify the expenditures for each grant award funded under Recovery Act on the Schedule of Expenditures of Federal Awards (SEFA) and the Data Collection Form (SF-SAC) required by Office of Management and Budget Circular A-133, "Audits of States, Local Governments, and Non-Profit Organizations." This identification on the SEFA and SF-SAC shall include the federal award number, the Catalog of Federal Domestic Assistance (CFDA) number, and amount such that separate accountability and disclosure is provided for Recovery Act funds by federal award

number consistent with the recipient reports required by Recovery Act Section 1512(c).
(2 CFR 215.26, 45 CFR 74.26, and 45 CFR 92.26)

10. Responsibilities for Informing Sub-recipients

Recipients agree to separately identify to each sub-recipient, and document at the time of sub-award and at the time of disbursement of funds, the federal award number, any special CFDA number assigned for Recovery Act purposes, and amount of Recovery Act funds. (2 CFR 215.26, 45 CFR 74.26, and 45 CFR 92.26)

11. Reporting Jobs Creation

HHS' recipients of Recovery Act funding who are subject to Section 1512 reporting should report job-created data as prescribed in Section 5 of the Office of Management and Budget (OMB) guidance M-09-21, as updated by OMB guidance M-10-08 and any subsequent guidances. HHS will not accept statistical sampling methods to estimate the number of jobs created and retained. All recipients must report a direct and comprehensive count of jobs, as specified by OMB guidance. For the full OMB guidance, please visit: (http://www.whitehouse.gov/omb/assets/memoranda_2010/m10-08.pdf)

VII. Agency Contacts

Where to Obtain Additional Information

If you are interested in obtaining additional information regarding this project, contact Ms. Julie Moreno, Project Officer, Division, Office of Public Health and Science, 200 Independence

Avenue, 701-H, Washington DC, 20201, by telephone at 202-401-9581 or by email at natorg.cppw@hhs.gov.

For questions regarding administrative and budgetary requirements, or the submission process, please contact the OPHS Office of Grants Management, 1101 Wootton Parkway, Suite 550, Rockville, Maryland 20852; or by telephone at (240) 453-8822.

VIII. Recovery Act Lobbying Restrictions

This funding announcement is subject to restrictions on oral conversations during the period of time commencing with the submission of a formal application¹ by an individual or entity and ending with the award of the competitive funds. Federal officials may not participate in oral communications initiated by any person or entity concerning a pending application for a Recovery Act competitive grant or other competitive form of Federal financial assistance, whether or not the initiating party is a federally registered lobbyist. This restriction applies unless:

1. The communication is purely logistical;
2. The communication is made at a widely attended gathering;
3. The communication is to or from a Federal agency official and another Federal Government employee;
4. The communication is to or from a Federal agency official and an elected chief executive of a state, local or tribal government, or to or from a Federal agency official and the Presiding Officer or Majority Leader in each chamber of a state legislature; or

¹ Formal Application includes the preliminary application and letter of intent phases of the program.

5. The communication is initiated by the Federal agency official.

For additional information see http://www.whitehouse.gov/omb/assets/memoranda_fy2009/m09-24.pdf .