DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[Program Announcement 04234]

Steps to a Healthier US: A Community-Focused Initiative To Reduce the Burden of Asthma, Diabetes, and Obesity

Announcement Type: New.

Funding Opportunity Number: 04234.

Catalog of Federal Domestic Assistance Number: 93.283.

Key Dates:

Letter of Intent Deadline: May 27, 2004.

Application Deadline: June 21, 2004.

I. Funding Opportunity Description

Authority: This program is authorized under section 301(a) and 317(k)(2) of the Public Health Service Act, (42 U.S.C. 241(a) and 247b(k)(2)), as amended.

Purpose: The Department of Health and Human Services (HHS), acting through the Centers for Disease Control and Prevention (CDC), and combining the strengths and resources of all relevant HHS agencies and programs, announces the availability of fiscal year (FY) 2004 funds for a cooperative agreement program to implement the Secretary of HHS initiative for Americans, entitled ''Steps to a HealthierUS'' (hereafter referred to as STEPS). The relevant HHS agencies and offices include, but are not limited to, the Administration for Children and Families, Administration on Aging, Agency for Healthcare Research and Quality, CDC, Centers for Medicare and Medicaid Services, Food and Drug Administration, Health Resources and Services Administration, Indian Health Service, National Institutes of Health, Office of Disease Prevention and Health Promotion, and the Substance Abuse and Mental Health Services Administration hereafter referred to as ''HHS agencies''.

The centerpiece of STEPS is a five-year cooperative agreement program to create healthier communities by improving the lives of Americans through innovative and effective community-based health promotion and chronic disease prevention and control programs.

STEPS is based on the President's HealthierUS Initiative, which highlights the influence that healthy lifestyles and behaviors—such as making healthful nutritional choices, being physically active, and avoiding tobacco use and exposure—have in achieving and maintaining good health for persons of all ages. STEPS will work through public-private partnerships at the community level to support community-driven programs that enable persons to adopt healthy lifestyles that contribute directly to the prevention, delay, and/or mitigation of the consequences of diabetes, asthma, and obesity.

The initiative's goals are to:

- Prevent 75,000 to 100,000 Americans from developing diabetes.
- Prevent 100,000 to 150,000 Americans from developing obesity.
- Prevent 50,000 Americans from being hospitalized for asthma.

The purpose of STEPS is to enable communities to reduce the burden of chronic disease, including: Preventing diabetes among populations with pre-diabetes; increasing the likelihood that persons with undiagnosed diabetes are diagnosed; reducing complications of diabetes; preventing overweight and obesity; reducing overweight and obesity; and reducing the complications of asthma. STEPS will achieve these outcomes by improving nutrition; increasing physical activity; preventing tobacco use and exposure, targeting adults who are diabetic or who live with persons with asthma; increasing tobacco cessation, targeting adults who are diabetic or who live with persons with asthma; increasing use of appropriate health care services; improving the quality of care; and increasing effective self-management of chronic diseases and associated risk factors.

The key to the success of STEPS will be community-focused programs that include the full engagement of schools, businesses, faith-communities, health care purchasers, health plans, health care providers, academic institutions, senior centers, and many other community sectors working together to promote health and prevent chronic disease. STEPS programs need to build on, but not duplicate current and prior HHS programs and coordinate fully with existing programs and resources in the community.

Background

In the United States today, seven of ten deaths and the vast majority of serious illness, disability, and health care costs are caused by chronic diseases, such as diabetes, asthma, and obesity. Underlying these serious diseases are several important risk factors that can be modified years before they contribute to illness and death. Three risk factors—poor nutrition, lack of physical activity, and tobacco use and exposure—are major contributors to the nation's leading causes of death and must be addressed as part of this initiative. The first two of these risk factors contribute primarily to obesity and diabetes. Tobacco use contributes primarily to asthma, but it also contributes to the risk of poor circulation and heart disease among those who have diabetes. Research has demonstrated a clear link between exposure to tobacco smoke and exacerbation of asthma, and has provided evidence of a causal link between exposure to tobacco smoke and the development of asthma. Research has also shown that smoking heightens the risk for diabetes-related complications of neuropathy and nephropathy; cigarette use has been shown to be a significant risk factor for death by coronary heart disease in type 2 diabetes. By requiring recipients to address nutrition, physical activity, and tobacco use as core components of their community interventions, STEPS programs will reduce the burden of diabetes, asthma, and obesity.

Efforts to address risk factors and disease management through improved health care access, health care utilization, health care quality, and self-management skills, including adherence to medication and other health regimens, also may be addressed as part of this initiative. While payment for health care services is not an allowable expense under this program announcement, increasing access to and use of diagnostic screening and improved treatment can be accomplished in four primary ways: (1) Identifying existing services and resources in the community and

linking/referring persons to treatment; (2) educating health care providers on current standards of care and methods for implementing those standards; (3) developing consumer awareness and demand for quality health care (*e.g.*, using media to promote increased demand for vaccinations, appropriate screenings, and treatment); (4) helping health care providers implement effective office-based strategies, such as patient reminder systems, that help ensure timely and appropriate care.

Communities funded under this cooperative agreement will join the 23 currently funded communities in establishing community-based, coordinated, comprehensive health promotion, prevention, and control programs of sufficient intensity and durability to create sustainable change and thereby achieve the ''Healthy People 2010'' objectives shown in Attachment A. All referenced attachments are posted with this announcement on the CDC Web site (*http://www.cdc.gov*). Click on ''Funding'' then ''Grants and Cooperative Agreements''.

Resources useful to the preparation of applications and in support of program implementation are available in Attachment B.

Activities: All recipient activities funded under this program announcement need to coordinate with and reinforce, but not duplicate, related, existing Federal, State, and local activities. In conducting activities to achieve the purpose of this program announcement, Large Cities and Urban Community applicants will be responsible for the activities listed under number 1 below, Tribal applicants for the activities listed under number 2 below, State-Coordinated Small City and Rural Community applicants for the activities listed under number 3 below, and HHS Agencies for the activities listed under number 4 below. All recipients must address both community and school-based components. In addition, applications that do not address all of the activities listed in the respective category under which they are applying will be considered non-responsive and will not be entered into the review process. You will be notified that your application did not meet submission requirements. (*See* section III 1., 2., 3. for eligibility criteria and definitions of these applicant categories.)

1. Large City and Urban Community Recipient Activities

(a) Fiduciary Responsibilities

i. Lead Agency. Establish the lead/fiduciary agency to be the local health department, its equivalent, or a *bona fide* agent as designated by the mayor, county executive, or other equivalent governmental official.

ii. Allocate Funds. Allocate and disperse funds to the local education agency or agencies responsible for schools within the intervention area, and additional key partners and collaborators to implement recipient activities. Include adequate funds to participate fully in the substantial data collection and evaluation activities associated with this award.

iii. Contract Services. Contract for services, as needed, to accomplish the objectives of this program announcement.

iv. Link Budget to Performance. Provide integrated progress and financial reports that link the performance and expenditures of the local health department and all key partners.

v. Sustainability. If funded for years three through five, engage in efforts that will sustain successful interventions on a long-term basis.

(b) Community Consortium

Identify key partners and coalitions that focus on the prevention and control of chronic disease and associated risk factors. Build an alliance of partnerships and coalitions committed to participating actively in the planning, implementation, and evaluation of STEPS. Effective partnerships are central to the success and sustainability of STEPS. Key partners should demonstrate a high-level commitment to the initiative by their willingness to invest expertise, leadership, personnel, and other resources in the success of the project.

Partners must include, but are not limited to, the mayor's office (or equivalent); local and State health departments; local and state education agencies; key community, health care, voluntary, and professional organizations; business, community, and faith-based leaders; and at least one lay person representative of the population to be served. Other partners may include, but are not limited to, existing community coalitions (especially those already focusing on chronic diseases), Federally Qualified Health Centers including community health centers, worksite wellness programs, health care purchasers, health plans, unions, health care providers for farm and migrant workers and their families, school-based and school-linked clinics, health care providers for the homeless, primary care associations, social service providers, health maintenance organizations, private providers, hospitals, universities, schools of public health, academic health centers, organizations that serve young children and youth, parks and recreation departments, departments of transportation, public housing authorities, State Medicaid officials, service organizations, food manufacturers and distributors, aging services organizations, senior centers, community action groups, consumer groups, and the media.

(**Note:** Consolidated Health Centers under section 330, of the Public Health Service Act are commonly referred to as community health centers. They include centers that tailor resources for populations such as low-income persons, the uninsured, homeless people, migrant and seasonal farm workers, and public housing residents.)

(c) Leadership, Coordination, and Management

i. Leadership Team. Establish and coordinate a leadership team responsible for overseeing project activities, establishing and maintaining an organizational structure and governance for the community consortium (including decision-making procedures), determining the project budget and subcontracts, and participating in project-related local and national meetings. The leadership team must include, but is not limited to, the local health department, the local education agency or agencies, and other key leaders from the community.

ii. Project Staff. Establish and maintain paid project staff to include a full-time project coordinator with management experience in risk factor interventions and community-based chronic disease prevention and control. Other part-time or full-time staff, contractors, and consultants must be sufficient in number and expertise to ensure project success and have demonstrated 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, health care quality improvement, communications, resource development, school health, and the risk factor and disease areas targeted by the program.

iii. Project Management. The project coordinator with the other project staff and leadership team, should:

a. Encourage active participation of consortium members in project activities and decisions, through regular meetings and other proactive methods of communication.

b. Actively oversee all project activities during their planning, development, implementation, and evaluation phases.

c. Track performance in relationship to the achievement of short-term and intermediate outcomes and budgetary expenditures.

d. Seek technical assistance from the State, HHS agencies, other Federal agencies, other recipients, national voluntary organizations, universities, or other sources.

e. Keep the Program Consultant informed and seek Program Consultant input and assistance.

f. Take corrective action promptly when necessary to ensure project success.

g. Participate in STEPS-wide program evaluations.

iv. Coordinate with State Plans and Activities. Ensure that community objectives, activities, and interventions are consistent with and supportive of State plans and activities for the prevention and control of diabetes, asthma, obesity, and associated risk factors. Ensure that community objectives, activities, and interventions do not duplicate existing efforts.

(d) Community Action Plan, Community and School-Based Interventions

Identify and implement high priority, eligible intervention strategies proven to prevent and control diabetes, asthma, and obesity. To establish such priorities, communities must examine their chronic disease burden, at-risk populations, current services and resources, and partnership capabilities to develop a comprehensive community action plan.

All communities must address nutrition, physical activity, and tobacco use and exposure since these areas will positively impact primary and/or secondary prevention in diabetes, asthma, and obesity. Additionally, communities are expected to implement other specific interventions to reduce the burden of the diseases/conditions addressed by STEPS (asthma, diabetes, and obesity). Such interventions might include: (1) Conducting community-wide campaigns to implement a diabetes assessment questionnaire (*e.g.*, American Diabetes Association's ''Are You at Risk?''); (2) promoting quality care by providing health care settings with effective systems for handling referrals, follow-ups, and patient reminder systems; and (3) providing training for health care providers on how to establish effective asthma care plans with patients and their families.

i. Community Interventions. Programs are expected to employ multiple, evidence-based public health strategies based on the existing and emerging research base and careful scientific reviews such as the Guide to Community Preventive Services (*http://www.thecommunityguide.org/*), the Guide to Clinical Preventive Services (*http://www.odphp.osophs.dhhs.gov/pubs/guidecps/* and *http://www.ahrq.gov/clinic/prevnew.htm*), and the National Registry for Effective Programs (*http://modelprograms.samhsa.gov/template.cfm?page=nrepbutton*). Effective public health strategies may include changes to the social and physical environments; health promotion, public education, and information; media and other communication strategies; technological advances; economic incentives and disincentives; system improvements; provider education and medical office-based improvement strategies. (*See* Attachment C for additional, example intervention strategies).

While project activities should reach all persons in an identified intervention area, special efforts should be taken to ensure focus on populations with disproportionate burden of chronic diseases/conditions who also tend to experience disparities in access to and use of preventive and health care services. Populations of special focus might include racial and ethnic minorities, low-income persons, the medically underserved, persons with disabilities, and others with special needs. Programs must be culturally competent, and meet the health literacy and linguistic needs of target populations in the intervention area.

Programs should optimize resources by coordinating and partnering with existing programs and resources in the community, surrounding areas, and the State (*e.g.*, State incentive grant programs). Programs should expand the resources available through public-private ventures, foundation grants, public funding, and in-kind contributions in order to achieve and sustain STEPS outcomes.

Collaborative partnerships with, for example, professional organizations; health care providers, employers/purchasers, and plans; faith-based organizations; schools; child care, early childhood programs, and other organizations that serve children and youth; senior centers or service organizations; primary care associations; area health education centers; community health centers; local, regional, and state chapters of national chronic disease organizations (*e.g.*, the American Diabetes Association, the American Heart Association, the American Lung Association, the Asthma and Allergy Foundation of America, the American Cancer Society); and many others will be key to reaching affected populations and delivering and sustaining effective programs. Strong, cooperative linkages between clinical preventive care and community public health should be established and maintained.

With direction and coordination from the leadership team, the community consortium should develop and implement priority community health interventions to prevent and control diabetes, asthma, obesity, and associated risk factors in the identified intervention area. Such interventions may include:

a. Actively engaging members of the intended audience in community assessments, program planning (including establishing program goals and specifying intervention content and design), delivery, evaluation, and program improvement.

b. Supporting community-based initiatives to increase physical activity, improve nutrition, and eliminate tobacco use and exposure.

c. Increasing healthy food choices in restaurants, grocery stores, vending machines, worksites, shopping malls, senior centers, and other community settings. (*http://www.cdc.gov/nccdphp/dnpa/obesity/index.htm*)

d. Increasing access to and use of attractive and safe locations for engaging in physical activity.

e. Increasing access to and use of effective cessation programs for persons who use tobacco, targeting adults who are diabetic or who live with persons with asthma. (*http://www.surgeongeneral.gov/tobacco/default.htm*)

f. Improving strategic communication through the use of media and information technologies to improve public awareness and motivation to establish healthy nutrition, physical activity, and avoidance of tobacco use.

g. Developing supportive environments to complement and sustain individual change efforts.

h. Providing social support, reinforcement, and inducements to make healthy choices.

i. Enlisting the support of organizations and settings (*e.g.*, after school programs, worksites, youth-serving organizations, families, faith-based organizations, senior centers, and

health care partners) to encourage and support healthy behavior.

j. Working with health care providers, health plans, and employer/purchasers to increase the use of evidence-based preventive care practices.

k. Improving access to and utilization of quality health care services for primary and secondary prevention of the STEPS diseases/conditions (asthma, diabetes, and obesity).

l. Increasing self-management skills, including adherence to medication and other health regimens, among persons with established risk factors or chronic disease.

m. Ensuring adequate provider education, including strategies to implement national guidelines on quality care, and improving provider communication and counseling skills.

n. Educating persons with chronic disease on the proper management of their disease and the importance of seeking early, appropriate care to prevent and minimize complications.

o. Raising levels of health literacy to enable persons to make informed health decisions.

ii. School interventions. With guidance from the local education agency or agencies, implement school health interventions to prevent and control diabetes, asthma, and obesity in the same intervention area being served by the community interventions. Such interventions may include:

a. Identifying or establishing a full-time school health program coordinator and School Health Council to direct project activities and assist in their implementation. See the American Cancer Society's Guide on the Role of the School Health Coordinator and Guide to School Health Councils. (*http://www.schoolhealth.info*)

b. Reviewing and strengthening the schools' health-related policies and instructional programs using the CDC's School Health Index (*http://www.cdc.gov/nccdphp/dash/SHI/*), and the National Association of State Boards of Education's *Fit, Healthy and Ready to Learn: A School Health Policy Guide*. (*http://www.nasbe.org/HealthySchools/fithealthy.mgi*)

c. Providing adequate physical education for all students throughout the school year and increasing opportunities for physical activity through recess, intramural activities, and other offerings. (*http://www.cdc.gov/nccdphp/dash/healthtopics/physical_activity/guidelines/index.htm*)

d. Providing professional development for staff to enable them to deliver effective, skills-based health instruction for students. (*http://www.nasn.org/*)

e. Implementing staff wellness programs that include health assessment, health promotion, and health management components.

f. Ensuring that school food service personnel are qualified and trained in the use of United States Department of Agriculture (USDA) guidelines for healthy eating.

g. Wherever food is served in school, make appealing foods available that are low in fat, sodium, and added sugars. Limit the sale and distribution of foods of minimal nutritional value. (*http://www.cdc.gov/nccdphp/dash/healthtopics/nutrition/guidelines/index.htm*)

h. Establishing a tobacco-free school environment that prohibits tobacco use on school property, in school vehicles, at school-sponsored events (on and off school property) for students, staff, and visitors, at all times in order to reduce potential exposure to those with asthma. Offer or refer students and staff to school-or community-based tobacco use cessation programs, targeting those who have diabetes or who live with persons with asthma. (*http://www.cdc.gov/nccdphp/dash/healthtopics/tobacco/guidelines/index.htm*)

i. Alleviating indoor air quality problems caused by allergens and irritants such as smoke, dust, mites, molds, warm-blooded animals, and cockroaches.

j. Establishing management and support systems for students with targeted health problems. Ensure communication and coordination among students, families, relevant school staff, and community health and mental health providers.

k. Coordinating school, family, and community efforts. Assist families to support a healthy lifestyle for their children and families. Link school efforts to community programs and activities.

l. Working with school-based and school-linked clinics, assist students and families in meeting their chronic disease-related health needs.

(e) Updated Community Action Plans

Within the first eight months, finalize a five-year community action plan, based on the guidelines of this announcement, the preliminary plan submitted with this application, input from the application review process, newly available community information, HHS agencies and other sources of technical support, and continuing discussions with the community consortium. Base your revised action plan on a logic model that serves as the foundation for prioritizing, planning, and budgeting interventions, program management, and program sustainability (*See* Attachment B for references regarding logic model development and use). Review and update the community action plan annually to reflect community needs, opportunities, resources, and program evaluation findings. Formulate an activity-based budget for years 2 through 5 of the program that directly corresponds to the logic model, revised community action plan, and completed evaluation plan.

(f) Project Monitoring and Evaluation

i. Risk Factor Surveillance. Work with the state health department and CDC to expand existing surveillance mechanisms to collect representative Behavioral Risk Factor Surveillance System (BRFSS) baseline data for 1,500 to 2,000 adults within the intervention area, and repeat such assessments on an annual basis. (*http://www.cdc.gov/brfss/*)

Work with the state education agency and CDC to collect representative baseline data from the Youth Risk Behavior Surveillance System (YRBSS) (including, at a minimum, information on nutrition, physical activity, asthma, and tobacco) for 1,500 to 2,000 middle and/or high school students within the intervention area, and repeat such assessments on at least a biennial basis. (*http://www.cdc.gov/nccdphp/dash/yrbs/about_yrbss.htm*)

ii. Existing Data Sources. Identify existing data sources that can be used to design and monitor STEPS interventions, including hospital discharge data; medical care practice data; vital statistics data; Women, Infants, and Children (WIC) data; community health centers data; Medicaid and Medicare data; school data such absentee rates, academic, health, and risk information; and other sources of information about individual, group, or community health status, needs, and resources.

iii. Common Performance Measures. STEPS recipients will participate in establishing a common set of core performance measures to track the number and types of persons served by various intervention strategies and the achievement of related short-term, intermediate, and long-term outcomes. Recipients must agree to collect and report on core performance measures using standardized methodology to document how intervention strategies are being implemented and are successfully addressing STEP priorities. Performance goals should show the link between program activities and the

achievement of the initiative's overarching goals. *See* Attachment A for selected ''Healthy People 2010'' objectives that are anticipated to form part of the core performance measures.

iv. Comprehensive Evaluation Plan. Agree to participate fully in a STEPS-wide independent, external evaluation to examine and document the effectiveness of this cooperative agreement program. An important mechanism for changing behavior and implementing effective practices in a variety of settings is the ability to examine and act on successes, barriers to success, and failures. The recipients are expected to be full partners in the evaluation of this initiative by actively gathering and submitting data on selected outcome and performance measures. Grantees will also participate in other evaluation activities that may include regular debriefings, descriptive case studies, special analyses, and mid-course adjustments.

v. Data-Based Decision Making. Projects are expected to use all the information above, in consultation with their Program Consultant, to design and modify intervention strategies and the community action plan; revise budgets and subcontracts; request technical assistance from HHS agencies and/or contracted experts; recruit new members to the consortium; and/or change the structure of the consortium to improve project participation and outcomes.

(g) Information Sharing

Actively promote the sharing of experiences, strategies, and results with both funded and unfunded cities, communities, and interested partners. Ensure effective, timely communication and exchange of information, experiences, and results through the use of the Internet; management information systems; other electronic approaches and formats; workshops; site visits to and between communities and cities; and other activities.

2. Tribal Recipient Activities

Recipient activities are the same as the activities outlined above under sections 1.(a) through (g) for Large Cities and Urban Communities.

3. State-Coordinated Small City and Rural Community Recipient Activities

(a) State Fiduciary Responsibilities

i. Lead Agency. Establish the lead/fiduciary agency to be the State health department, its equivalent, or a *bona fide* agent as designated by the Governor.

ii. Allocate Funds. Allocate and disperse funds to communities, the State education agency, other key partners to implement recipient activities at the community level. Include adequate funds to participate fully in the substantial data collection and evaluation activities associated with this award.

iii. Contract Services. Contract for services, as needed, to accomplish the objectives of this program announcement.

iv. Link Budget to Performance. Provide integrated progress and financial reports that link the performance and expenditures of the communities and all key partners.

v. Sustainability. If funded for years three through five, engage in efforts that will sustain successful community programs on a long-term basis.

(b) Small City and Rural Community Responsibilities

Each of the two to four identified communities is expected, with State assistance, to assume the responsibilities identified above under Large City and Urban Community Recipient Activities section 1(a) through (g).

(c) Leadership/Coordination/Management

In support of the communities, the State health department should establish and coordinate a State-Community Management Team, including participation from the funded communities, the State health department, education agency, Office of Rural Health, any city or large community that is funded within the State borders under this program announcement, and other key public and private sector partners.

i. Coordinate community objectives with State health plans. Ensure that community, and city objectives, activities, and interventions are consistent with, and supportive of, State plans and activities for the prevention and control of diabetes, asthma, and obesity.

ii. Collaboration. Ensure collaboration between the community and city programs funded under this program announcement and other State and local chronic disease prevention and control programs.

iii. Project Staff. Establish and maintain project staff sufficient to provide oversight and technical assistance to the funded communities.

(d) Technical Assistance

The State health department and State education agency should provide or facilitate the provision of technical assistance, consultation, and support to the funded communities in:

i. Monitoring Disease Burden. Defining and monitoring the burden of chronic diseases and disparities through surveillance, epidemiology, and existing data sources (*e.g.*, vital statistics, hospital discharge data, WIC data, community health centers data, Health Centers Uniform Data System, Medicaid and Medicare data).

ii. Risk Factor Surveillance. Working with participating communities and other interested parties, ensure that surveillance mechanisms are in place to monitor changes in risk factors (*e.g.*, BRFSS & YRBSS).

iii. Program Evaluation. Work with funded communities on on-going evaluation, including assessing the effectiveness of, targeting of, number of persons reached by, and use of intervention strategies; tracking the accomplishment of activities and the achievement of short-term and intermediate outcomes; monitoring changes in health outcomes; tracking performance in relationship to budget execution; and using program evaluation findings to adjust plans and strengthen the program.

iv. Evidence-Based Practices. Accessing and sharing with funded communities current prevention effectiveness, intervention effectiveness, and other research and program evaluation findings. Identifying and sharing promising practices.

v. Community Support. Helping to build community engagement, mobilization, ownership, and organization.

vi. Intervention Selection and Development. Identifying, recommending, and adapting, evidence-based intervention strategies consistent with the needs, cultures, and resources of the communities.

vii. Resource Development. Promoting public and private resource development in support of community-based intervention strategies and long-term sustainability.

(e) Project Monitoring and Evaluation

The State health department should work with each of the selected communities to ensure that surveillance mechanisms collect representative data for program planning and monitoring. Obtain existing and new data sources to better understand the burden and trends of chronic diseases, and associated risk factors, and the effects of the STEPS program.

(f) Information Sharing

The State health department should actively promote the sharing of

experiences, strategies, and results among communities and cities within the State, between States funded under this program announcement, and with other interested communities. Support community efforts by ensuring effective, timely communication and exchange of information, experiences, and results through the use of the internet; management information systems; other electronic approaches and formats; workshops; site visits to and between communities and cities; and other activities.

4. HHS Activities

In a cooperative agreement, HHS staff is substantially involved in the program activities, above and beyond routine grant monitoring. HHS Activities for this program are as follows:

(a) Leadership and Coordination

i. HHS Steps to a HealthierUS Steering Committee. An HHS Steps to a HealthierUS Steering Committee has been established to coordinate and organize the ''Steps to a HealthierUS'' initiative and is comprised of high-level representatives of relevant HHS agencies and offices. The Committee provides ongoing policy oversight and direction to STEPS and will continue to coordinate technical assistance from each agency in support of the successful achievement of the purposes and performance objectives of this program announcement.

ii. STEPS workgroup. A STEPS workgroup has been established and is coordinated by the HHS Steps to a HealthierUS Steering Committee. The STEPS National Workgroup is comprised of representatives from funded communities, cities, tribes and States, and a wide variety of national partner organizations to:

a. Ensure collaboration between the recipients and their key partners funded under this program announcement and other local and State chronic disease prevention and control programs.

b. Anticipate the priority needs of recipients and prepare to meet these needs on a timely basis so that STEPS is implemented efficiently and successfully.

c. Assist in organizing and facilitating approaches to sharing experiences, lessons learned, results, and resources among recipients and existing community and State local chronic disease programs.

d. Make available the expertise, staff, and evidence-based resources of HHS agencies to assist and enhance the work of funded communities, States, and tribes.

iii. In concert with all of the HHS activities planned in support of STEPS, the Indian Health Service will provide additional coordination and assistance to tribes funded under this announcement.

(b) Technical Assistance

Provide technical assistance, training, and support to funded projects in the areas of surveillance and epidemiology, community assessment and planning, evidence-based interventions, community mobilization and partnership development, monitoring of program performance outcomes, data management, program sustainability, and other areas as needed. Provide on-site assistance, workshops, webforums, training and intervention materials.

(c) Evaluation Oversight and Coordination

HHS will separately fund and direct an independent, external evaluation of STEPS. However, recipients are expected to budget for their full participation in the data collection associated with this external review. Additionally, HHS will coordinate cross-site evaluation activities, including the establishment of core performance measures. HHS will provide, or ensure the provision of, expert resources to assist communities, States and tribes in the design, collection, analysis, and use of comparable evaluation data for evaluating and strengthening their programs.

II. Award Information

Type of Award: Cooperative agreement. HHS involvement in this program is listed in the Activities section above.

Fiscal Year Funds: 2004.

Approximate Total Funding: $10,500,000 total; $5,000,000 for Large City and Urban Community applicants; $1,000,000 for Tribal applicants; $4,500,000 for State-Coordinated Small City and Urban Community applicants. Total funding in each category is subject to change based on the number of applications received and funding amounts requested.

Approximate Number of Awards: 8 to 12 total; up to 5 Large City and Urban Community applicants; up to 2 Tribal applicants; up to 3 State-Coordinated Small City and Urban Community applicants. The total number of awards in each category is subject to change based on the number of applications received and funding amounts requested.

Approximate Average Award: $1,000,000 for Large City and Urban Community applicants; $500,000 for Tribal applicants; $1,500,000 for State-Coordinated Small City and Rural Community applicants. (This amount is for the first 12-month budget period, and includes both direct and indirect costs.)

Floor of Award Range: $750,000 for large city and Urban Community applicants; $300,000 for Tribal applicants; $1,000,000 for State-Coordinated Small City and Rural Community applicants.

Ceiling of Award Range: $1,250,000 for Large City and Urban Community applicants; $600,000 for Tribal applicants; $2,000,000 for State-Coordinated Small City and Rural Applicants.

If you request a funding amount greater than the ceiling of the award range, your application will be considered non-responsive, and will not be entered into the review process. You will be notified that your application did not meet the submission requirements.

Anticipated Award Date: September 22, 2004.

Budget Period Length: 12 months.

Project Period Length: 5 years.

Throughout the project period, CDC's commitment to continuation of awards will be conditioned on the availability of funds, evidence of satisfactory progress by the recipient (as documented in required reports), and the determination that continued funding is in the best interest of the Federal government.

The lead/fiduciary agent for State-Coordinated Small City and Rural Community awardees Health Departments must ensure that 75 percent of the total STEPS award is distributed on an annual basis to the identified communities in the State-coordinated application within four months of the award date. The remaining 25 percent of funds should be used to support the funded communities through technical assistance and other means. The 25 percent of the award described above is subject to a match requirement as described in section III.2. of this announcement.

Awarded communities must show progress toward objectives during the first two years of funding to be eligible for continued funding in years three through five of the program. Continuation awards and level of funding within an approved project period (FY 2005 through FY 2008) will be based on the availability of funds and satisfactory progress in achieving performance measures as evidenced by required progress reports.

Funding for FY 2005 and beyond is expected to range from $1,000,000 to $2,000,000 for each Large City and Urban Community recipient; $300,000 to $1,000,000 for each Tribal recipient; and from $2,000,000 to $2,500,000 for each State-Coordinated Small City and Rural Community recipient.

It is also anticipated that additional FY 2005 resources may enable the Secretary to fund additional prevention initiatives based on this announcement or a separate announcement. Applicants funded for the first time in FY 2005 will be required to submit a revised work plan and budget in order to receive funds at FY 2005 funding levels during their first year of funding.

Pending availability of funds, beginning in FY 2005 and each of the remaining years of this program announcement (September 22, 2005, through September 21, 2009), there may be an open season for new competitive applications. Specific guidance will be provided with exact application due dates and funding levels each year.

III. Eligibility Information

III.1. Eligible Applicants

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

Cities and urban communities, and tribes or tribal consortia are eligible to apply directly under this announcement. In addition, States may coordinate the applications of up to four small cities and rural communities that do not meet the eligibility criteria for large cities/urban communities or independent tribal applicants (*see* numbers 1 and 2 below). In determining eligibility, Large City and Urban Community applicants must meet the criteria under number 1 below, Tribal applicants must meet the criteria under number 2 below, and State-Coordinated Small City and Rural Community applicants must meet the criteria under number 3 below.

1. Large City and Urban Community Applicants

The term ''large cities and urban communities'' is defined as any contiguous geographic area (including counties) with a population exceeding 400,000 persons with substantial expertise and infrastructure for the design, delivery and evaluation of chronic disease prevention and control interventions. The District of Columbia is eligible to apply for funding under this section of the program announcement. Eligible applicants in this category must specify the intervention area that will be the focus of the STEPS program. The intervention area can be smaller than the entire city or community, but must be geographically contiguous and must include a population of at least 150,000 residents but not more than 500,000 residents.

The large city/urban community applicant must select a lead/fiduciary agent designated by the mayor, county executive, or other equivalent governmental official. In many cases, the official local health department or its equivalent will serve as the lead/fiduciary agent. However, the mayor, county executive or other equivalent governmental official may name a different entity as the *bona fide* agent to serve as the lead/fiduciary agency.

A *bona fide* agent is the official fiscal agent the mayor (or other equivalent official) determines will function on behalf of the community for this award. In most instances, the *bona fide* agent is a foundation or non-profit organization that serves as the legal agent for applying for Federal grants for the local health agency. Other entities (such as departments of education, community-based organizations or universities) may be proposed as a *bona fide* agent but the mayor must determine those agents and the agents must have an established capability to serve as fiduciary agents. If you are applying as a *bona fide* agent of a local government, you must provide a letter from the local government as documentation of your status. Place this documentation behind the first page of your application form.

Only one application will be accepted from each eligible large city and urban community.

2. Tribal Applicants

The term ''tribal applicants'' is defined as federally recognized tribal governments, Regional Area Indian Health Boards, Urban Indian organizations, tribal consortia and inter-tribal Councils which serve 10,000 or more American Indians/Alaskan Natives in their catchment area(s). The tribal applicant must select a lead/fiduciary agent as designated by the Principal tribal elected official or chief executive officer. Only one application will be accepted from each eligible tribal entity.

3. State-Coordinated Small City and Rural Community Applicants

The term ''State'' includes the 50 states, the Commonwealth of Puerto Rico, the Virgin Islands, the Commonwealth of the Northern Marianna Islands, American Samoa, Guam, the Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau. To be eligible, States must identify two to four communities of total resident size not to exceed 800,000 persons combined. Each selected community must be geographically contiguous and include a minimum population of 10,000 persons. Neighboring small or rural counties may be grouped together to form a single, contiguous ''community.'' States are strongly encouraged to include diverse communities that vary in size and location. HHS anticipates funding some programs that encompass rural communities as well as small cities.

The State applicant must select a lead/fiduciary agent designated by the Governor. In many cases, the official state health department or its equivalent will serve as the lead/fiduciary agent. However, the Governor may name a different entity as the *bona fide* agent to serve as the lead/fiduciary agency.

A *bona fide* agent is the official fiscal agent the Governor determines will function on behalf of the community for this award. In most instances, the *bona fide* agent is a foundation or non-profit organization that serves as the legal agent for applying for Federal grants for the State health agency. Other entities (such as departments of education, community-based organizations, universities) may be proposed as a *bona fide* agent but the Governor must determine those agents and the agents must have an established capability to serve as fiduciary agents. If you are applying as a *bona fide* agent of a state government, you must provide a letter from the state government as documentation of your status. Place this documentation behind the first page of your application form.

Only one application will be accepted from each State.

III.2. Cost Sharing or Matching

Matching funds are required for this project. Matching funds are required from non-Federal sources in an amount not less than 25 percent of Federal funds awarded to Large City and Urban Community Grantees. State grantees funded under the State-Coordinated Small City and Rural Community Program are required to provide a match not less than 50 percent of the funds retained by the States to support the funded communities through technical assistance and other means. In no case shall the amount to be matched be less than 25 percent of the award to the State.

In an effort to move grantees toward a self-sustaining program, the HHS

Secretary may require an increase in the match requirements in years 2 through 5 of the program. For the purpose of the initial application's 5 year plan and budget, applicants should calculate budgets based on the first year match requirements listed above.

The matching funds may be cash or its equivalent in-kind or donated services, fairly evaluated. The contribution may be made directly or through donations from public or private entities. Matching funds must be consistent with the community action plans that are submitted and approved. The total amount of Federal funds requested (including direct and indirect costs), combined with the amount for matching shall constitute the grantee's proposed costs for the budget period.

Matching funds may not be met through: (1) The payment of treatment services or the donation of treatment, or direct patient education services; (2) services assisted or subsidized by the Federal government; or (3) the indirect or overhead of an organization.

Matching funds are not required of Tribal Applicants. However, Tribal Applicants are encouraged to identify financial and in-kind contributions from their own organization and their partners to support and sustain the activities of this program announcement. Applications from tribal entities that include private partners who contribute in-kind or funding support and incentives to these efforts are strongly encouraged.

III.3. Other Eligibility Requirements

If you request a funding amount greater than the ceiling of the award range, your application will be considered non-responsive, and will not be entered into the review process. You will be notified that your application did not meet the submission requirements.

You must respond to all of the activities stipulated in section I ''Activities'' to be eligible for this program. Applications that do not address all activities will be considered non-responsive, and will not be entered into the review process.

You must submit a timely Letter of Intent (LOI) to be eligible to apply for this program. *See* sections IV.2, IV.3, and IV.6 of this announcement for more information on LOI submission.

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.

Applications that do not meet the matching requirements stipulated in section III.2 above will be considered non-responsive and will not be entered into the review process.

IV. Application and Submission Information

IV.1. How To Obtain Application Forms and Form Instructions

To apply for this funding opportunity use application form CDC 1246. Application forms and instructions are available on the CDC Web site, at the following Internet address: *http://www.cdc.gov/od/pgo/forminfo.htm.*

If you do not have access to the Internet, or if you have difficulty accessing the forms on-line, you may contact the CDC Procurement and Grants Office Technical Information Management Section (PGO-TIM) staff at: 770–488–2700. Application forms can be mailed to you.

IV.2. Content and Form of Submission

Letter of Intent (LOI): A Letter of Intent (LOI) from the Chief Executive Officer (Mayor, county executive, tribal chief, Governor or other equivalent governmental official) is required from all potential applicant communities for the purposes of determining eligibility and planning the competitive review process. As only one application per community will be accepted, LOIs will be used to identify communities that might inadvertently submit more than one application. If multiple LOIs from a single community are received, those organizations will be contacted to facilitate communication among the various parties so that a single application can be developed for that community, and the lead/fiduciary agent identified for the community. Failure to submit a LOI will preclude you from submitting an application. In addition, organizations submitting LOIs from communities that do not meet the eligibility criteria will be contacted.

Format: The LOI 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.

Content: LOIs should include the following information:

(1) The program announcement title and number;

(2) Whether the application will be from a Large City and Urban Community applicant, a Tribal applicant, or a State-Coordinated Small City and Rural Community applicant; and

(3) The name of the lead/fiduciary agency or organization, the official contact person and that person's telephone number, fax number, mailing and e-mail addresses.

If the LOI is being sent from a Large City and Urban Community applicant, also provide the exact boundaries and total population size of the contiguous geographic area with population exceeding 400,000 persons that qualifies the applicant as eligible for this program announcement.

Application: The program announcement title and number must appear in the application. Use the information in the Activities section, Review Criteria section, and this section to develop the application content. Your application will be evaluated on the criteria listed, so it is important to follow this guidance carefully. Content requirements for Large City and Urban Community applicants are listed under number 1 below; for Tribal applicants under number 2 below; and for State-Coordinated Small City and Rural Community applicants under number 3 below. You must submit a project narrative with your application forms. The narrative must be submitted in the following format:

- Maximum number of pages: 50 pages for Large City and Urban Community applicants; 50 pages for Tribal applicants; 100 pages for State-Coordinated Small City and Rural Community Applicants. If your narrative exceeds the page limit, only the first pages which are within the page limit will be reviewed.
- Font size: 12 point unreduced.
- Double-spaced.
- Paper size: 8.5 by 11 inches.
- Page margin size: One inch.
- Printed only on one side of page.
- Held together only by rubber bands or metal clips; not bound in any other way.
- Other format requirements:

1. Large City and Urban Community Applicants

In addition to the application forms, the application must contain the following in this order:

(a) Official Transmittal Letter

Letter of transmittal from the Chief Executive Officer (Mayor, county executive, or other equivalent governmental official) committing local government support, identifying the lead agency (local health department, *bona fide* agent, or equivalent) and citing the amount requested.

(b) Table of Contents

Table of Contents with page numbers for each of the following sections.

(c) Executive Summary

Executive summary briefly describing the overall project, intervention area and population size, partnerships, intervention strategies, and major short-term and intermediate outcomes. The executive summary is limited to 2 pages.

(d) Application Narrative

The narrative (excluding appendices) must be no more than 50 pages, double-spaced, printed on one side, with one-inch margins, and unreduced 12-point font. If your narrative exceeds the page limit, only the first 50 pages will be reviewed. The narrative consists of sections (e)–(m), described as follows:

(e) Lead Agency

Description of the lead agency, including fiduciary and programmatic capabilities, as well as an inventory of current agency activities related to this announcement.

(f) Intervention Area

Description of the intervention area, including its demographic, geographic and political boundaries, target populations to receive special focus under this award, as well as evidence of the burden of disease, disparities in diabetes, asthma, obesity, associated risk factors, and access to and use of proven prevention and control interventions. Description of current activities and projects underway to address chronic diseases in the intervention area. Overview of the assets and deficiencies of the intervention area, including State, local, and private sector efforts, and a description of findings from any community assessments or asset mapping done in the past three years.

(g) Staff

Description of the proposed STEPS staff, including resumes or job descriptions for the full-time project coordinator and other key staff, the qualifications and responsibilities of each staff member and the percent of time each are committing to STEPS.

(h) Community

Description of the community consortium, including a list of key partners, and documentation of their capabilities; their commitment to specific functions, responsibilities, and resources; and evidence of prior successful collaborations. The structure, decision-making processes, and methods for accountability of the members should be described as well as how coordination and linkage with existing programs and interventions with similar focus will be maintained.

(i) Community Action Plan

A preliminary five-year community action plan that includes the community and school interventions to be employed in the intervention area. The community action plan should include time-phased, specific, measurable, and realistic short-term and intermediate outcomes based on the needs of the community and gaps in current prevention and control activities. The community action plan should identify likely approaches, strategies, and interventions to be used over the entire five-year project period to address nutrition, physical activity, and tobacco use and exposure as well as additional interventions to address the targeted STEPS chronic diseases or conditions. The organizations responsible for the interventions should be clearly identified as well as the target populations to be addressed. The community action plan should address first year activities in depth and their relationship to attaining specific short-term and intermediate outcomes. The community action plan should include a plan to ensure long-term sustainability of project efforts and outcomes.

(j) Financial Contributions

Description of financial and in-kind resources, if any, that will be contributed toward activities initiated as part of STEPS.

(k) Evaluation and Monitoring

A plan for data identification, collection, and use for program planning and monitoring. Describe efforts to obtain existing and new data sources to better understand chronic disease burden and trends, related risk factors and the effects of STEPS. Provide specific assurances to track common performance measures and participate fully in an independent, external evaluation of STEPS processes and outcomes. Performance goals should directly link program activities to the achievement of the initiative's overarching goals. Describe how the project is anticipated to improve specific performance measures and outcomes compared to baseline performance.

(l) Communications Plan

A plan to communicate and share information with the members of the consortium, the community, and other key partners. The plan should describe the proposed exchange of information, the means and proposed timing of communication, with an emphasis on communications innovations such as electronic formats, management information systems, webforums, etc.

(m) Letters of Support

The narrative must include a summary of the organizations that have submitted letters of support and Memoranda of Understanding (as appropriate) from the local health agencies, local Education Agency or agencies, Health Center Networks or Primary Care Associations and other key members of the consortium that specify their roles, responsibilities, and resources. Actual letters and memoranda should be placed in an appendix.

(n) Budget and Budget Justification/ Narrative

i. Allocate Budget

Clearly indicate estimated budget amounts to be allocated and dispersed to the local education agency or agencies and other key consortium members. Provide a description of the funding mechanisms and timelines that will be used to disperse these funds.

ii. One-Year and Five-Year Budgets

In support of the five-year community action plan, provide both a detailed budget and budget justification or narrative for the first budget year, and a budget estimate for budget years two through five.

a. Provide a detailed budget for the first budget year in support of each activity that must be completed in the first year of program operations to accomplish the short-term and intermediate outcomes specified in the five-year community action plan. Develop a budget justification and narrative that describes all requested funds by object class category: Personnel, fringe benefits, travel, equipment, supplies, contractual, and other direct costs. As part of the request for travel funds in FY 2004, applicants should budget for a 5-day trip to Atlanta for 5 to 6 key leadership team and project staff for a workshop early in the first budget year, and a 2-to-4-day trip to Washington, DC for 5 to 6 key leadership team and project staff for a conference later in the first budget year. Use Standard Form 424A (Budget Information—Non-Construction Programs).

b. Provide estimated budgets for FY 2005 through FY 2008 that are linked to the accomplishment of intermediate outcomes. For each budget year, include budget estimates for two trips to workshops and/or conferences for key staff members of the lead/ fiduciary organization and its key partners. For

planning purposes, use Atlanta and Washington, DC as the travel destinations. Provide budget estimates for each year for each object class category in section B of a separate Standard Form 424A (Budget Information—Non-Construction Programs).

(o) Appendices

The following additional information may be included in appendices. The appendices will not be counted toward the narrative page limit. Appendices are limited to the following items:

- Curriculum vitae.
- Resumes.
- Organizational charts.
- Letters of support or memoranda of understanding.

Any material submitted in the appendices that is not listed here will not be reviewed. All information included in appendices should be clearly referenced within the 50-page narrative to aid reviewers in connecting information in the appendices to that provided in the narrative.

2. Tribal Applicants

In addition to the application forms, the application must contain the following in this order:

(a) Official Transmittal Letter

Letter of transmittal from the Principal tribal elected official or the chief executive officer of the tribe, inter-tribal council, Urban Indian Organization, or Regional Area Indian Health Board identifying the lead agency and citing the amount requested.

(b) Table of Contents

A table of contents should be provided as described in 1.(b) above for Large Cities and Urban Communities.

(c) Executive Summary

An executive summary should be provided as described in 1.(c) above for Large Cities and Urban Community applications. The executive summary is limited to 2 pages.

(d) Narrative Content

The narrative (excluding appendices) should be no more than 50 pages double-spaced, printed on one side, with one-inch margins, and unreduced 12-point font. If your narrative exceeds the page limit, only the first 50 pages will be reviewed. The narrative should address the content described under 1.(e) through (m) above for Large Cities and Urban Community applications.

(e) Budget and Budget Justification/ Narrative

The budget should be included as described under 1.(n) above for Large Cities and Urban Communities. Travel estimates should be made as for Large Cities and Urban Communities, for 3 to 5 staff.

(f) Appendices

Appendices should be included as described under 1.(o) above for Large Cities and Urban Community applications.

3. State-Coordinated Small City and Rural Community Applicants

In addition to the application forms, the application must contain the following in this order:

(a) Official Transmittal Letter

Letter of transmittal from the Governor committing state support, identifying the lead agency (state health department, *bona fide* agent, or equivalent) and citing the amount requested.

(b) Table of Contents

Table of Contents with page numbers for each of the following sections.

(c) Executive Summary

Executive Summary briefly describing the overall project; intervention area(s) and population sizes; partnerships, intervention strategies, and major short-term and intermediate outcomes. The executive summary is limited to 3 pages.

(d) Application Narrative

The narrative (excluding appendices) must be no more than 100 pages, double-spaced, printed on one side, with one-inch margins, and unreduced 12-point font. If your narrative exceeds the page limit, only the first 100 pages will be reviewed. The narrative consists of sections e–n, described as follows:

(e) State Lead Agency

Description of the lead agency including fiduciary and programmatic capabilities, as well as an inventory of current agency activities related to this announcement. Description of the state health department's ability to provide, and history of providing, expert assistance to local communities in the design and delivery of evidence-based approaches to chronic disease prevention and control.

(f) Community Lead Agencies

Description of the lead agency (local health department or equivalent) for each of two to four separate community intervention areas, including fiduciary and programmatic capabilities, as well as an inventory of current agency activities related to this announcement.

(g) Intervention Areas

Description of each of the community intervention areas, including their demographic, geographic and political boundaries, target populations to receive special focus under this award, as well as evidence of the burden of disease, and disparities in diabetes, asthma, obesity, associated risk factors, and access to and use of proven prevention and control interventions. Description of current State, local, and private-sector activities underway to address chronic diseases in the intervention areas. Overview of the assets and deficiencies of the intervention areas including a description of findings from any community assessments or asset mapping done in the past three years.

(h) Staffing

Description of the proposed STEPS staff including resumes or job descriptions for full-time project coordinators in each community and other key staff at the State and community levels, the qualifications and responsibilities of each staff member and percent of time each is committing to STEPS.

(i) Community Consortia

Description of the community consortia for each community including a list of key partners and documentation of their capabilities; their commitment to specific functions, responsibilities, and resources; and evidence of prior successful collaborations. The structure, decision-making processes, and methods for accountability of the members should be described as well as how coordination and linkage with existing programs and interventions with similar focus will be maintained.

(j) Community Action Plans

A preliminary five-year community action plan for each community that includes the community and school interventions to be employed in the intervention areas. The community action plans should include time-phased, specific, measurable, and realistic short-term and intermediate outcomes that are based on the needs of the communities and gaps in current prevention and control activities. The community action plans should identify likely approaches, strategies, and interventions to be used over the entire five-year project period to address nutrition, physical activity, and tobacco

use and exposure as well as additional interventions to address the STEPS chronic diseases/conditions (asthma, diabetes, and obesity). The organizations responsible for the interventions should be clearly identified as well as the target populations to be addressed. The community action plan should address first year activities in depth and their relationship to attaining specific short-term and intermediate outcomes. The community action plan should include a plan to ensure long-term sustainability of project efforts and outcomes.

(k) Financial Contributions

Description of financial and in-kind resources that will be contributed toward new activities initiated as part of STEPS.

(l) Evaluation and Monitoring

A plan for data identification, collection, and use for program planning and monitoring for each community. Describe efforts to obtain existing and new data sources to better understand the burden and trends of chronic diseases and their risk factors and the effects of the STEPS program. Provide specific assurance from each community, and from the state, to track common performance measures and to participate fully in an independent, external evaluation of STEPS outcomes. Describe for each community how the project is anticipated to improve specific performance measures and outcomes compared to baseline performance.

(m) Communication Plans

A plan for each community to communicate and share information with the members of their consortia, other key partners, and their own communities broadly, as well as with other funded communities and the state. The plans should describe the proposed exchange of information, the proposed means and timing of communication, with an emphasis on communications innovations such as electronic formats, management information systems, webforums, etc.

(n) Letters of Support

The narrative must include a summary of the organizations that have submitted letters of support and Memoranda of Understanding (as appropriate) from the local health agencies, local Education Agency or agencies, Health Center Networks or Primary Care Associations and other key members of the consortium that specify their roles, responsibilities, and resources. Actual letters and memoranda should be placed in an appendix.

(o) Budget and Budget Justification/ Narrative

The budget tables and justification are not included in the 100 page application narrative. The following must be included in the budget:

i. Community Funding. Provide a description of how the state will distribute a minimum of 75 percent of total STEPS funds to the identified communities within four months of the receipt of their award.

ii. Allocate Budget. Clearly indicate estimated budget amounts to be allocated and dispersed to the funded communities, the State Education Agency, and other state partners. Provide a description of the funding mechanisms and timelines that will be used to disperse these funds.

iii. One-Year and Five-Year Budgets. In support of the five-year community action plans, provide a detailed budget and budget justification/narrative for the first budget year and a budget estimate for years two through five.

a. Provide a detailed budget for the first budget year in support of each activity that must be completed in the first year of program operations to accomplish the short-term and intermediate outcomes specified in the five-year community action plans. This detailed budget must include:

- State expenditures. A budget justification and narrative that describes all requested funds for the State Health and Education Agencies, and other key state partners by object class category: personnel, fringe benefits, travel, equipment, supplies, contractual, and other direct costs. State expenditures should clearly reflect activities that support the efforts of the funded communities. As part of the request for travel funds in FY 2004, applicants should budget for a 5-day trip to Atlanta for 7 to 10 key leadership team and project staff for a workshop early in the first budget year, and a 2-to-4-day trip to Washington, DC for 7 to 10 key leadership team and project staff for a conference later in the first budget year.
- Community expenditures. For each community, a budget justification and narrative that describe all requested funds for the local health department, the local education agency or agencies, and other key community partners by object class category in support of first-year activities in the five-year community action plan. As part of the request for travel funds in FY 2004, applicants should budget for two trips to workshops and/or conferences for key community members. For planning purposes, use Atlanta and Washington, DC as the travel destinations. Use Standard Form 424A (Budget Information—Non-Construction Programs).

b. Provide estimated budgets for FY 2004 through FY 2007 that are linked to the accomplishment of intermediate outcomes for each funded community. For each budget year, include budget estimates for two trips to workshops and/or conferences for key staff members of the lead/fiduciary organization and its key partners. For planning purposes, use Atlanta and Washington, DC as the travel destinations. Provide the estimated total budget for each year (*i.e.*, state plus all funded communities) for each object class category in Section B of Standard Form 424A (Budget Information—-Non-Construction Programs).

(p) Appendices

The following additional information may be included in appendices. The appendices will not be counted toward the narrative page limit. Appendices are limited to the following items:

- Curriculum vitae.
- Resumes.
- Organizational charts.
- Letters of support or memoranda of understanding.

Any material submitted in the appendices that is not listed here will not be reviewed. All information included in appendices should be clearly referenced within the 50-page narrative to aid reviewers in connecting information in the appendices to that provided in the narrative.

You are 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 *http://www.dunandbradstreet.com* or call 1–866–705–5711. For more information, *see* the CDC Web site at: *http://www.cdc.gov/od/pgo/funding/pubcommt.htm*. If your application form does not have a DUNS number field, please write your DUNS number at the top of the first page of your application, and/or include your DUNS number in your application cover letter.

Additional requirements that may require you to submit additional documentation with your application are listed in section ''VI.2. Administrative and National Policy Requirements.''

IV.3. Submission Dates and Times

LOI Deadline Date: May 27, 2004. CDC requires that you send a LOI if you intend to apply for this program.

Application Deadline Date: June 21, 2004.

Explanation of Deadlines: LOIs and Applications must be received in the CDC Procurement and Grants Office by 4 p.m. eastern time on the deadline date. If you send your LOI or application by the United States Postal Service or commercial delivery service, you must ensure that the carrier will be able to guarantee delivery of the application by the closing date and time. If CDC receives your LOI or application after closing 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, you will be given the opportunity to submit documentation of the carriers guarantee. If the documentation verifies a carrier problem, CDC will consider the LOI or application as having been received by the deadline.

This announcement is the definitive guide on LOI and application submission address and deadline. It supersedes information provided in the application instructions. If your LOI or application does not meet the deadline above, it will not be eligible for review, and will be discarded. You will be notified that your LOI or application did not meet the submission requirements.

CDC will not notify you upon receipt of your LOI or application. If you have a question about the receipt of your LOI or application, first contact your courier. If you still have a question, contact the PGO–TIM staff at: 770–488–2700. Before calling, please wait two to three days after the LOI or application deadline. This will allow time for applications to be processed and logged.

IV.4. Intergovernmental Review of Applications

Executive Order 12372 does not apply to this program.

IV.5. Funding restrictions

Use of Funds

Cooperative agreement funds may be used to expand, enhance, or complement existing activities to accomplish the objectives of this program announcement. Funds may be used to pay for, but are not limited to: Staffing, consultants, contractors, materials, resources, travel, and associated expenses to implement and evaluate intervention activities such as those described under the ''Activities'' section of this announcement.

Funds received under this announcement may not be used to supplant or replace existing local, State, or Federal funds or activities. Cooperative agreement funds may not be used for direct patient care, diagnostic medical testing, patient rehabilitation, pharmaceutical purchases, facilities construction, lobbying, basic research or controlled trials.

Direct assistance, that is, assistance provided by the Federal government in the form of Federal employee staffing when detailed to the recipient (pay, allowances, and travel), supplies, or equipment in lieu of cooperative agreement/financial assistance funds, is not available as part of FY 2004 STEPS awards. Direct assistance in lieu of cash may be available in subsequent years.

Funded agencies are eligible to receive indirect costs in this program. However the indirect costs allowed in this program are limited to the negotiated indirect cost rate or 5 per cent of the total award amount, whichever is less. If you are requesting indirect costs in your budget, you must include a copy of your current indirect cost rate agreement. If your indirect cost rate is a provisional rate, the agreement should be less than 12 months of age.

Awards will not allow reimbursement of pre-award costs.

Guidance for completing your budget can be found on the CDC Web site, at the following Internet address: *http://www.cdc.gov/od/pgo/funding/budgetguide.htm*.

IV.6. Other Submission Requirements

LOI Submission Address: Submit your LOI by express mail, delivery service, fax, or e-mail to: Technical Information Management—PA#04234, CDC Procurement and Grants Office, 2920 Brandywine Road, Atlanta, GA 30341.

Application Submission Address: Submit the original and two hard copies of your application by mail or express delivery service to: Technical Information Management—PA#04234, CDC Procurement and Grants Office, 2920 Brandywine Road, Atlanta, GA 30341.

LOIs and applications may not be submitted electronically at this time.

V. Application Review Information

V.1. Review Criteria

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

An Independent Objective Review Group appointed by HHS will evaluate the quality of each application against the following criteria.

Evaluation criteria for Large City and Urban Communities are listed under number 1 below, for Tribes under number 2 below, and for State-Coordinated Small City and Rural Communities under number 3 below.

1. Large City and Urban Community Applicants

(a) Intervention Strategies (40 Points)

i. Community Interventions (30 of 40 Points)

a. Does the five-year community action plan include objectives and activities that are specific, time-phased, measurable, realistic, and related to identified needs and gaps in existing programs, program requirements, and purposes and goals of this cooperative agreement program?

b. Is the community action plan and its evaluation based on sound scientific evidence of community intervention effectiveness?

c. Are the individual intervention strategies and the action plan as a whole likely to be effective? This includes the estimated efficacy of each intervention based on existing science, the likely reach of each intervention (percentage of the community likely to be engaged or impacted by the intervention), the extent to which interventions build on and complement, but do not duplicate, existing programs, and the potential synergy created through multiple interventions.

d. Does the proposed plan include interventions/strategies to address all of the disease, condition and risk factor areas covered by STEPS (nutrition, physical activity, tobacco, asthma, diabetes, and obesity)?

e. How well does the plan reflect and build on a substantiated and comprehensive understanding of the assets, attributes, and deficiencies of the communities including non-STEPS-related activities completed or on-going in these communities?

f. Does the applicant include a plan to sustain the project long term?

ii. School Interventions (10 of 40 Points)

a. Does the applicant describe plans to implement school-based interventions

that promote healthy lifestyles among students and their families, and address the prevention and control of chronic diseases within the same intervention area as the community interventions?

b. Does the applicant provide a feasible plan to establish a full-time school health program coordinator and a school health council that will direct school-based activities and assist in their implementation?

c. Are the school-based interventions and the evaluation of them based on sound scientific evidence of their effectiveness?

d. Are the proposed objectives and activities for school-based interventions specific, time-phased, measurable, realistic, feasible, and related to identified needs and gaps in existing programs, program requirements, and purposes and goals of this cooperative agreement program?

(b) Project Leadership and Management (20 Points)

i. Is the lead/fiduciary agency clearly identified?

ii. Does the lead/fiduciary agency have the capacity to ensure accountability for expenditures in relationship to performance of all key partners?

iii. Does the applicant clearly and fully describe the proposed structure of the project including decision-making processes?

iv. Does the applicant provide letters of support and memoranda of understanding (as appropriate) with partner agencies and organizations?

v. Do letters of support and memoranda of understanding describe specific collaborative actions to be undertaken and the role of the partners?

vi. Do the key partner organizations within the applicant community provide financial or in-kind contributions toward the success of the STEPS initiative?

vii. Does the applicant describe realistic plans to coordinate proposed activities with state- and community-level programs to prevent and control chronic disease?

viii. How well qualified are proposed staff regarding relevant background, expertise, qualifications, and experience to successfully accomplish the goals of the STEPS Program?

ix. Does the proposed staffing plan appear appropriate to the level of work proposed and demonstrate the intent to minimize staff levels in order to maximize funding for interventions?

x. Does the applicant describe clearly defined roles of project staff and an appropriate percent of time each is committing to STEPS?

(c) Plan for Project Monitoring and Evaluation (15 Points)

i. Does the applicant describe plans to collaborate with other STEPS recipients in developing and implementing a set of common performance measures to monitor the success of funded projects?

ii. Are appropriate data sources currently available or will they be made available?

iii. Does the evaluation plan include the use of BRFSS and YRBS?

iv. Are appropriate data sources used to monitor and track changes in community capacity; the extent to which interventions reach populations at high risk; changes in risk factors, chronic disease burden, and disparities; the relationship between interventions and outcomes; and changes in program efficiency?

v. Does the applicant describe plans to collaborate fully in external, independently coordinated evaluation activities to evaluate the overall impact of STEPS?

vi. Does the applicant demonstrate the capability to conduct surveillance and program evaluation, access and analyze official data sources, and use evaluation to strengthen the program?

vii. Does the applicant describe how the project is anticipated to improve specific performance measures and outcomes compared to baseline performance?

(d) Background and Need (10 Points)

i. Is the proposed intervention area clearly and thoroughly described, including the populations to be served?

ii. Are data provided that substantiate the existing burden and/or disparities of chronic diseases and conditions, specifically diabetes, asthma, and obesity in the proposed intervention area and populations to be served?

iii. Are data provided that substantiate existing health risk behaviors and risk factors related to chronic diseases in the proposed intervention area and populations to be served?

iv. Are assets and barriers to successful program implementation identified?

v. How well are existing resources being leveraged and used to complement or contribute to the effort planned in the proposal?

(e) Community Consortium (10 Points)

i. Does the applicant demonstrate the ability to establish a consortium that is inclusive of key partners, and related coalitions?

ii. Are all of the required partner organizations (*see* E.1.b.) included in the community consortium?

iii. Does the applicant describe the capacity of the proposed consortium in terms of leadership, expertise, community representation, collaborative experience/abilities, and agency representation?

iv. Do the key partners demonstrate a high-level commitment to planning, implementing, and evaluating the proposed project, including a commitment of staff and other resources?

v. Have members of the proposed consortia successfully worked together or with others in the past to achieve improved health outcomes?

(f) Communication and Information Sharing (5 Points)

i. Does the applicant describe plans to share experiences, strategies, and results with other interested States, communities, and partners?

ii. Does the applicant describe plans to ensure effective and timely communication and exchange of information, experiences and results through mechanisms such as the internet, management information systems, other electronic formats, workshops, publications, and other innovations?

(g) Budget (Not Scored)

Is the budget reasonable and consistent with the proposed activities and intent of the program?

2. Tribal Applicants

Will be evaluated according to the Large City and Urban Community evaluation criteria listed under ''Evaluation Criteria'' V.1.a) through g) above.

3. State-Coordinated Small City and Rural Community Applicants

a. Intervention Strategies (40 Points)

The points for this section will be divided equally between the two to four pre-selected communities where project activities and interventions will occur (*i.e.*, 20 points per community if the project proposes to work in two communities, 13 points per community if three communities, 10 points per community if four communities). This section will be evaluated according to the same criteria for Large City and Urban Community proposals under ''Evaluation Criteria'' V.1.a) (i–ii) above.

b. Project Leadership, Collaboration, and Proposed Structure (15 Points)

i. Is the lead/fiduciary agency clearly identified?

ii. Does the lead/fiduciary agency have the capacity to ensure accountability for expenditures in

relationship to performance of all key partners?

iii. Does the applicant clearly and fully describe the proposed structure of the project including decision-making processes, monitoring, problem solving, and providing support to community-based programs?

iv. Does the applicant provide letters of support and memoranda of understanding (as appropriate) with partner agencies and organizations?

v. Do letters of support and memoranda of understanding describe specific collaborative actions to be undertaken and the role, responsibilities, and commitment of resources of the partners?

vi. Do the key partner organizations within the State and proposed communities provide financial or in-kind contributions toward the success of the STEPS initiative?

vii. Does the applicant describe realistic plans to coordinate proposed activities with State- and community-level programs to prevent and control chronic disease?

viii. Do the proposed staff have the relevant background, qualifications, and experience to successfully accomplish the goals of the STEPS Program?

ix. Does the proposed staffing plan appear appropriate to the level of work proposed and demonstrate the intent to minimize staff levels in order to maximize funding for interventions?

x. Does the applicant describe clearly defined roles of project staff and an appropriate percent time each is committing to STEPS?

xi. Does the proposed local consortia have the capacity for leadership, technical expertise, community representation, collaborative experience/abilities, and agency representation to successfully accomplish the goals of the STEPS Program?

x. Does the applicant describe the past history and evidence of effectiveness of community-State partnerships in relation to health issues and interventions (especially those related to chronic disease prevention and control, and those involving the specific communities selected for this program)?

xi. Does the applicant describe the past history and evidence of effectiveness of community partnerships within the proposed communities in relation to health issues and interventions (especially those involving chronic disease prevention and control)?

c. Plan for Project Monitoring and Evaluation (15 Points)

i. Does the applicant describe plans to collaborate with other STEPS recipients in developing and implementing a set of common performance measures to monitor the success of funded projects?

ii. Are appropriate data sources currently available or will they be made available?

iii. Does the evaluation plan include the use of BRFSS and YRBS?

iv. Are appropriate data sources used to monitor and track changes in community capacity; the extent to which interventions reach populations at high risk; changes in risk factors, chronic disease burden, and disparities; the relationship between interventions and outcomes; and changes in program efficiency?

v. Does the applicant describe plans for the State, proposed communities, and other key partners to collaborate fully in external, independently coordinated evaluation activities to evaluate the overall impact of STEPS?

vi. Does the applicant demonstrate the capability to conduct surveillance and program evaluation, access and analyze official data sources, and use evaluation to strengthen the program?

vii. Does the applicant describe how the project is anticipated to improve specific performance measures and outcomes compared to baseline performance?

d. Capacity To Guide and Support Intervention Communities (15 Points)

i. Does the applicant propose a State-Community Management Team fully capable of guiding and directing the overall project?

ii. Does the state have sufficient experience, expertise, and capacity to assist local communities in the activities of this project?

iii. Does the applicant include evidence of having provided guidance and support to local communities that resulted in successful implementation and outcomes?

iv. Are specific methods to assist local communities in the activities of this project described?

e. Background and Need (10 Points)

i. Is the proposed intervention area clearly and thoroughly described, including the populations to be served?

ii. Are data provided that substantiate the existing burden and/or disparities of chronic diseases and conditions, specifically diabetes, asthma, and obesity in the proposed intervention area and populations to be served?

iii. Are data provided that substantiate existing health risk behaviors and risk factors related to chronic diseases in the proposed intervention area and populations to be served?

iv. Are assets and barriers to successful program implementation identified?

v. How well are existing resources being leveraged and used to complement or contribute to the effort planned in the proposal?

f. Communication and Information Sharing (5 Points)

i. Does the applicant describe plans to share experiences, strategies, and results with other interested states, communities, and partners?

ii. Does the applicant describe plans to ensure effective and timely communication and exchange of information, experiences and results through mechanisms such as the internet, management information systems, other electronic formats, workshops, publications, and other innovations?

g. Budget (Not Scored)

Is the budget reasonable and consistent with the proposed activities and intent of the program?

V.2. Review and Selection Process

Eligibility: LOIs and applications will be reviewed for eligibility. Applications that are non-responsive to the eligibility criteria will not advance through the review process. Applicants will be notified that their application did not meet submission requirements.

Completeness: Applications will be reviewed for timeliness and completeness. Late applications, applications for which an LOI was not submitted, and incomplete applications (*i.e.*, those that do not include all required forms and all elements described in section IV.2 of this program announcement) will not be entered into the review process. Applicants will be notified that their application did not meet submission requirements.

Responsiveness: Applications will be reviewed for responsiveness. Applications that do not address all of the activities described in sections I.1, I.2, or I.3 of this program announcement will be considered non-responsive and will not be entered into the review process. Applicants will be notified that their application did not meet submission requirements.

Review Process: An objective review panel will evaluate complete and responsive applications according to the criteria listed in the ''V.1. Review Criteria.'' The following factors affect the award selection.

1. The scores provided by the objective review. A minimum score of 80 points must be received for further consideration.

2. Geographic distribution across the country, considering the location of existing Steps grantee communities.

3. Standardized scores. Multiple objective review panels will be used to evaluate the volume of applications generated by this announcement. HHS reserves the right to consider the applicant's rank on the objective review panel and/or a calculated standardized score. Standardized scores are used to normalize variations in scoring among the panels identified by the panels' average scores, standard deviations, median scores, minimum scores, maximum scores. Standardized scores take into account the average and standard deviation of the panel scores, thereby setting each panel's average score equal to zero, and allowing direct comparisons across panels.

In addition, the following factors may affect the funding decision. Preference in funding, based on well-documented data, may be given to ensure:

- Inclusion of populations disproportionately affected by chronic disease and associated risk factors.
- Inclusion of geographic areas with high, age-adjusted rates of chronic disease and associated risk factors.
- Geographic distribution of STEPS programs nationwide.
- Inclusion of communities of varying sizes, including rural, suburban, and urban communities.

V.3. Anticipated Announcement and Award Dates

September 22, 2004.

VI. Award Administration Information

VI.1. Award Notices

Successful applicants will receive a Notice of Grant Award (NGA) from the CDC Procurement and Grants Office. The NGA shall be the only binding, authorizing document between the recipient and CDC. The NGA will be signed by an authorized Grants Management Officer, and 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

45 CFR parts 74 and 92.

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.*

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.

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

VI.3. Reporting Requirements

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

1. Interim progress report will be due May 30, 2005, and subsequent interim progress reports will be due on the 30th of May each year through May 30, 2009. The progress report will serve as the non-competing continuation application for the subsequent year, and must contain the following elements:

(a) A succinct description of the program accomplishments/narrative and progress made in achieving short-term and intermediate outcomes and other performance measures within the planned budget during the first six months of the budget period.

(b) The reason(s) for not achieving established short-term and intermediate outcomes and other performance measures within the planned budget and what will be done to achieve unmet objectives.

(c) Current budget period financial progress.

(d) New budget period proposed program activities and objectives. Detailed changes in the activity-based budget, the line-item budget, existing contracts, summary budget, and budget justification. For newly proposed contracts, provide the name of the contractor(s), method of selection, period of performance, scope of work, and itemized budget and budget justification or narrative.

2. An annual progress report summarizing the budget period (12 month) accomplishments for each budget period objective. The annual progress report will be due on November 20, 2005 and subsequent annual progress reports will be due on the 20th of November each year through November 20, 2009.

3. Financial status report, no more than 90 days after the end of the budget period.

4. Final financial, performance, and evaluation reports, no more than 90 days after the end of the five-year project period.

Send all reports to the Grants Management Specialist identified in the ''Agency Contacts'' section of this announcement.

VII. Agency Contacts

For general questions about this announcement, contact: Technical Information Management Section, CDC Procurement and Grants Office,2920 Brandywine Road, Atlanta, GA 30341, telephone: 770–488–2700.

For program technical assistance, contact: Dr. Mary Vernon-Smiley, Centers for Disease Control and Prevention, 4770 Buford Highway, NE., Mailstop K–40, Atlanta, GA 30341, telephone: 770–488–6164, e-mail address: *StepsInfo@cdc.gov*.

For financial, grants management, or budget assistance, contact: Sylvia Dawson, Grants Management Specialist, CDC Procurement and Grants Office, 2920 Brandywine Road, Atlanta, GA 30341, telephone: 770–488–2771, e-mail: *snd8@cdc.gov*.

For business management and budget assistance, in the territories contact: Vincent Falzone, Procurement and Grants Office, Centers for Disease Control and Prevention, 2920 Brandywine Rd., Room 3000, Atlanta, GA 30341–4146, telephone: 770–488–2763, e-mail address: *vcf6@cdc.gov*.

VIII. Other Information

A live, interactive webcast about this announcement and the STEPS Program will be held on May 19, 2004, starting at 1 p.m. eastern standard time. Information about the webcast, including directions on how to participate, as well as common questions and answers about this program announcement can be found at *http://www.HealthierUS.gov*.

This and other CDC announcements, the necessary applications, and associated forms can be found on the CDC Web site, Internet address: *http://www.cdc.gov*. Click on ''Funding'' then ''Grants and Cooperative Agreements''.

Dated: April 30, 2004.

William P. Nichols,

Acting Director, Procurement and Grants Office, Centers for Disease Control and Prevention.

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