THE BOARD OF SUPERVISORS OF THE COUNTY OF STANISLAUS
ACTION AGENDA SUMMARY

DEPT: Health Services Agency **BOARD AGENDA #** *B-1

Urgent ☐ **Routine** ☒ **AGENDA DATE** November 10, 2009

CEO Concurs with Recommendation YES ☐ **NO** ☐ **4/5 Vote Required YES** ☐ **NO** ☒
(Information Attached)

SUBJECT:

Approval for the Health Services Agency to Submit an Application for The American Recovery and Reinvestment Act of 2009 Centers for Disease Control's (CDC) Communities Putting Prevention to Work (CPPW) Grant to Decrease Overweight/Obesity Prevalence, Increase Levels of Physical Activity and Improve Nutrition, and to Designate Stanislaus County Office of Education to Serve as a Bona Fide Agent to Apply for the CDC's CPPW Grant to Decrease Tobacco Use and Exposure to Secondhand Smoke and if Awarded to Enter the Grant Agreements and fulfill the Grantee's Responsibilities

STAFF RECOMMENDATIONS:

1. Approve the Health Services Agency Managing Director or her designee to submit an application for the American Recovery and Reinvestment Act of 2009 Centers for Disease Control's Communities Putting Prevention to Work (CPPW) grant to decrease overweight/obesity prevalence, increase levels of physical activity and to improve nutrition, and if awarded, to enter the grant agreement.

2. Authorize the designation of the Stanislaus County Office of Education as the Local Health Department's Bona Fide Agent specifically to submit an application for the American Recovery and Reinvestment Act of 2009 Centers for Disease Control's Communities Putting Prevention to Work grant to decrease tobacco use and

(Continued on Page 2)

FISCAL IMPACT:

The term of the grants is a 24-month period, with an anticipated award date of February 26, 2010. The amount of funding provided to urban applicants, which includes Stanislaus County, is estimated to range between $4 million-$10 million for each grant. The specific amount of funding per community will be determined by the variety of interventions, population size, ability to reduce health disparities, and likelihood of success. If the grant(s) are awarded, the Health Services Agency will return to the Board of Supervisors to request the appropriate budget adjustments.

BOARD ACTION AS FOLLOWS:

No. 2009-761

On motion of Supervisor Grover , **Seconded by Supervisor** Chiesa
and approved by the following vote,
Ayes: Supervisors: O'Brien, Chiesa, Grover, Monteith, and Chairman DeMartini
Noes: Supervisors: None
Excused or Absent: Supervisors: None
Abstaining: Supervisor: None

1) X **Approved as recommended**
2) _____ **Denied**
3) _____ **Approved as amended**
4) _____ **Other:**
MOTION:

Christine Ferraro

ATTEST: CHRISTINE FERRARO TALLMAN, Clerk **File No.**

STAFF RECOMMENDATIONS (Continued):

exposure to secondhand smoke, and if awarded, to accept the funding and responsibility to perform the scope of work and to ensure that all grant requirements are appropriately achieved.

3. Authorize the Chairman of the Board of Supervisors to sign the designation letter and to enter the Letter of Agreement with the Stanislaus County Office of Education.

4. Authorize the Health Services Agency Managing Director or her designee to ensure the Local Health Department participation on the grant required leadership teams, and to provide oversight of the agency relationship with the Stanislaus County Office of Education.

DISCUSSION:

The American Recovery and Reinvestment Act of 2009 (Recovery Act), signed into law February 17, 2009, was designed to stimulate economic recovery in various ways, including preserving and creating jobs, promoting economic recovery, assisting those most impacted by the recession, stabilizing State and local government budgets in order to minimize and avoid reductions in essential services and counterproductive state and local tax increases, and strengthening the nation's healthcare infrastructure and reduce healthcare costs through prevention activities. The Recovery Act includes $650 million for evidence-based clinical and community-based prevention and wellness strategies that support specific, measurable health outcomes to reduce chronic disease rates. The legislation provides an important opportunity to advance public health initiatives and reduce health disparities across subpopulations.

In September of 2009, the Centers for Disease Control and Prevention (CDC), National Center for Chronic Disease Prevention and Health Promotion, Division of Adult and Community Health, announced the opportunity to apply for Recovery Act funds to reduce risk factors, prevent and/or delay chronic disease, and promote wellness through an initiative entitled Communities Putting Prevention to Work (CPPW). The CPPW Recovery Act prevention initiative focuses on two categories of activities: Category A: Obesity prevention, physical activity and nutrition, and Category B: Tobacco prevention and control. Applicants can apply and propose activities in Category A or Category B or both. However, if applying for both categories, separate applications must be submitted for each category, as these are separate grant opportunities.

Through the CPPW grant initiatives, the CDC will support intensive community approaches to chronic disease prevention and control in selected communities (urban and rural), to achieve the following:

- Category A:
  - Increased levels of physical activity;
  - Improved nutrition (e.g. increased fruit/vegetable consumption, reduced salt and transfat;
  - Decreased overweight/obesity prevalence
- Category B:
  - Decreased smoking prevalence and decreased teen smoking initiation; and
  - Decreased exposure to secondhand smoke.

The CDC anticipates CPPW awardees will achieve long term goals such as:

Category A: Obesity/Physical Activity/Nutrition

Adults

- Stabilize or begin to decrease (up to 2%) adult overweight/obesity prevalence, thus reversing long term trends.
- 20% increase in the percentage of adults getting adequate physical activity, meaning 20% more adults meeting Physical Activity Guidelines.
- 5% decrease in consumption of sugar-sweetened beverages, for adults, a decrease of about 5 gallons per person per year.

Youth

- Stabilize or begin to decrease (up to 2%) youth overweight/obesity prevalence (up to age 2-18), thus reversing long term trends.
- 35% increase in the percentage of high school students getting adequate physical activity (duration, frequency, intensity) meaning 35% more high school students meeting Physical Activity Guidelines.
- 5% decrease in consumption of sugar-sweetened beverages in high school students, a decrease of approximately 4 gallons per person per year.
- A 30% increase in average daily fruit and vegetable consumption among high school students, an increase of approximately 1 serving.

Category B: Tobacco

Adults

- 10% decrease in adult smoking prevalence, preventing tobacco-related death in 1/3

of these populations.
- 40% decrease in the percentage of non-smokers exposed regularly to secondhand smoke.

Youth
- 25% decrease in youth smoking prevalence (up to age 18), preventing tobacco-related death in 1/3 of these youth.
- 30% decrease in the percentage of youth (ages 2-18) exposed regularly to secondhand smoke.

The Health Services Agency Public Health division has entered into collaborations with community partners to address Obesity and Nutrition related issues. The Category A CPPW grant would allow the Agency's Public Health division to enhance the capacity of staff and broaden existing collaborative efforts to address broad determinants of health that contribute to the current problematic health status, including the built environment, safety and education.

The focus of the grants is prevention and enhancement of the capacity within Public Health.

The grants involve outcome oriented scopes of work and rigorous federal reporting requirements. After consideration of local health trends, current interventions and both benefits and limitations of infrastructure, the Health Services Agency wishes to apply for Category A only. The grant specifications allow however for a Bona Fide Agent to apply for either grant opportunity. The Stanislaus County Office of Education (SCOE) expressed a strong desire to apply for the Category B – tobacco prevention opportunity. SCOE has been an on-going partner of the Health Services Agency to address tobacco related issues in schools, and has conveyed a willingness to serve as the Bona Fide Agent for this purpose. SCOE currently holds other federal grants and is aware of and reportedly capable to meet the rigorous requirements.

A bona fide agent is the official fiscal agent and would function on behalf of Stanislaus County's local health department. According to the grant information, a bona fide agent, in most instances is a foundation, or nonprofit organization, that serves as the legal agent for applying for federal grants for the state or local health agency. Other entities (i.e., Departments of Education, a nonprofit organization, a university) may be proposed as a bona fide agent, and the highest elected official must designate those agents and the agents must have an established capability to serve as fiduciary agents. Stanislaus County Health Services Agency's Public Health division would be required to serve as part of the

required leadership team if the intended SCOE Category B CPPW grant application is successful and SCOE serves as the "bona fide agent".

POLICY ISSUES:

The Board of Supervisors' approval of an application for and acceptance of one or two CPPW grant awards from the Centers for Disease Control will enable the Health Services Agency to continue to work with local partners to implement health-promoting policies and develop interventions aimed at reducing the harmful effects of obesity and chronic disease. This meets with the Board's priorities of *A healthy community* and *Effective partnerships.*

STAFFING IMPACT:

If awarded, additional staffing will be required in order to fulfill the grant agreement scope of work. The Health Services Agency would make the appropriate requests for related staffing.

Stanislaus County
Office of
Education

Prevention Programs

Tom Changnon, Superintendent
1100 H Street • Modesto, CA 95354 • (209) 238-1360 • FAX (209) 238-4252

November 2, 2009

Mary Ann Lee, Managing Director
Stanislaus County Health Services Agency
830 Scenic Drive
Modesto, CA 95350

Dear Ms. Lee:

Thank you for the opportunity to collaborate with Stanislaus County and serve as a bona fide agent in applying for the Tobacco Control grant initiative under the American Recovery and Reinvestment Act of 2009, *Communities Putting Prevention to Work* (CPPW). The Stanislaus County Office of Education (SCOE) is excited to represent the county in applying for the grant and subsequently implementing a comprehensive community-based prevention and wellness program focusing on tobacco control.

We regularly collaborate with the region's leading health, social services, law enforcement and community organizations to identify and address not just pressing social needs but their root causes. This can be seen time and again through such initiatives as the Healthy Start Family Resource Centers and ongoing dropout-, gang- and drug-prevention programs. Our project management experience includes more than a decade of ongoing Prop 99 grant funding through the California Department of Education Tobacco Use Prevention and Education (TUPE) program as well as the leadership of a six-county region for both After School and School Safety initiatives. Our office is fully capable of writing and submitting the grant, and will be able to fill effectively and manage any additional staffing positions required for the project.

We would be pleased to serve as the grantee and fiscal agent of the CPPW initiative and will write and submit the grant application as part of that role. Following a successful application, we look forward to continuing to partner with Stanislaus County in the implementation of the grant-funded program. We are committed to working closely with your agency and other partners to ensure the project is meeting the needs of our county.

Please let us know if you have any questions or if there is any additional information that we can provide. Thank you again for the opportunity to represent Stanislaus County in this initiative. We look forward to hearing from you soon to begin the grant application process.

Sincerely,

Tom Changnon

Tom Changnon
County Superintendent of Schools

Vicki Bauman

Vicki Bauman
Prevention Programs Director II

Stanislaus County
Striving to be the Best

BOARD OF SUPERVISORS

William O'Brien, *1st District*
Vito Chiesa, *2nd District*
Jeff Grover, *3rd District*
Dick Monteith, *4th District*
Jim DeMartini, *5th District*

1010 10th Street, Suite 6500, Modesto, CA 95354
Phone: 209.525.4494 Fax: 209.525.4410

November 10, 2009

Tracey Sims, Grant Management Specialist
Centers for Disease Control and Prevention
2920 Brandywine Road
MSE-09
Atlanta, GA 30341

Re: Designation of Bona Fide Agent
CPPW – Category B – Tobacco Prevention grant opportunity

In accordance with the Centers for Disease Control grant instructions, Stanislaus County hereby designates the Stanislaus County Office of Education (SCOE) as the Bona Fide Agent specifically to submit an application for the American Recovery and Reinvestment Act of 2009 Communities Putting Prevention to Work Category B grant to decrease tobacco use and exposure to secondhand smoke, and if awarded, to accept the funding and responsibility to perform the scope of work and to ensure that all grant requirements are appropriately achieved.

Stanislaus County's Health Services Agency and the Stanislaus County Office of Education have a proven record of collaboration on various public health initiatives. Supported by experience, SCOE has the infrastructure and capability to serve as the fiduciary agent.

If SCOE's grant application is successful, the Stanislaus County Health Services Agency which is the Local Health Department will provide participation on the Stanislaus County of Education's leadership team relative to the grant.

Respectfully submitted,

Jim DeMartini
Chairman
Stanislaus County Board of Supervisors

LETTER OF AGREEMENT
BETWEEN STANISLAUS COUNTY AND
STANISLAUS COUNTY OFFICE OF EDUCATION

This Letter of Agreement sets forth the understanding and agreement between the parties as relates the American Recovery and Reinvestment Act of 2009 Centers for Disease Control's Communities Putting Prevention to Work grant opportunity.

I. Background

A. Pursuant to the grant instructions, funding is available on a competitive basis for two project areas. Category A is focused on Obesity prevention, nutrition and physical activity, while Category B is focused on Tobacco prevention and exposure reduction to secondhand smoke. Eligibility for these grant opportunities in our County is limited to the Local Health Department with one noted exception. The grant instructions allow for the designation of a Bona Fide Agent to apply for one or both of the grant opportunities.

B. Stanislaus County Health Services Agency's Public Health division (HSA - the Local Health Department) is committed to making application for the Category A – Obesity Prevention, Improving Nutrition and Physical Activity grant opportunity.

C. Stanislaus County Office of Education (SCOE) has conveyed interest in applying for the Category B – Tobacco Prevention and Exposure Reduction to Secondhand Smoke grant opportunity as the Bona Fide Agent of the Local Health Department. Additionally SCOE has reported the existence of infrastructure, experience, expertise and flexibility to properly fulfill the expectations as a fiduciary agent. See Attachment A.

II. Terms of Agreement

A. Stanislaus County designates SCOE as the Bona Fide Agent specific to the American Recovery and Reinvestment Act of 2009 Centers for Disease Control's Communities Putting Prevention to Work – Category B Tobacco Prevention and Exposure Reduction to Secondhand Smoke grant opportunity.

B. SCOE accepts the designation as the Bona Fide Agent as set forth above, and further accepts the responsibilities of the grant application, and if awarded, accepts the responsibilities as the fiduciary agent including the scope of work activities and federal reporting requirements, and any liabilities resulting from audit or disallowances by the grantor.

C. Stanislaus County agrees to provide the required participation by the Local Health Department on SCOE's grant leadership team as required in the CDC grant.

D. SCOE will provide periodic reporting to the HSA in support of a reasonable oversight process.

ACKNOWLEDGED AND AGREED

For Stanislaus County

Jim DeMartini
Chairman
Stanislaus County Board of Supervisors

For Stanislaus County Office of Education

Tom Changnon
County Superintendent
of Schools

Approved as to Form
County Counsel

Dean Wright
Deputy County Counsel

HEALTH SERVICES AGENCY

Public Health Services
820 Scenic Drive, Modesto, CA 95350-6194

John A. Walker, M.D.
Public Health Officer

Phone: 209.558.8804 Fax: 209.558.7286
www.hsahealth.org

October 30, 2009

To: Centers for Disease Control and Prevention Procurement and Grants Office

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

Stanislaus County Health Services Agency, which is the Local Health Jurisdiction for Stanislaus County, intends to submit a request for funding for the American Recovery and Reinvestment Act of 2009, Communities Putting Prevention to Work. Funding Opportunity Number: CDC-RFA-DP09-912ARRA09, and Catalog of Federal Domestic Assistance Number: 93.724.

Stanislaus County is located in the central valley of California, with a population of about 525,000, hence considered as an Urban Area. Stanislaus County Health Services Agency will be the lead/fiduciary agency for this grant funding. The Agency intends to apply for risk factor area Category A – Obesity prevention, physical activity and nutrition.

In addition, the Health Services Agency intends to apply for Category B – Tobacco prevention and control, either directly, or via its designated bona fide agent.

The official contact person for both category A and B is as follows:

Cleopathia Moore-Bell, Director of Public Health Services

Stanislaus County Health Services Agency

P.O. Box 3271

Modesto, CA 95353

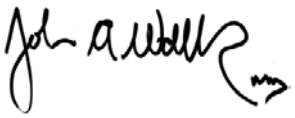
Telephone: (209) 558-6010

Fax: (209) 558-8320

E mail: cmoore@schsa.org

We look forward to submitting our grant applications. Thank you for your attention.

Sincerely,



John A. Walker, MD

Stanislaus County Public Health Officer

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

1. Under pre-application support, the time zone for each of the pre-application calls – **Eastern Daylight Time** – is now included.

2. The MAPPS Strategy Tables under Section I. and Attachment C., have an added phrase, "consistent with federal law," to the media and advertising restrictions in both nutrition and tobacco categories.

3. Under Section III.1. Eligible Applicants, the language has been slightly edited to clarify the eligible applicants.

4. Under Section III. Eligibility Information, the following has been added to section III.3 Other to clarify the allowable number of applications per state health department: **"Only one application can be submitted per state for Category A and only one application per state for Category B, for a maximum of two applications per state if applying for Category A and Category B. Within each state application, states may only submit up to 2 communities to fund: i.e. a combination of one small city and one rural community; two small cities; or two rural communities. State health departments that have not identified a maximum of 2 communities per application will be considered non-responsive and not entered into the review process."**

5. Under Section III.3 Other, the following has been changed to more accurately describe the Letter of Intent: "**Applicants**~~You~~ are required to submit a Letter of Intent (LOI) to be eligible to apply for this program. Failure to submit a LOI will result in non-responsiveness and the applicant will be prohibited from applying." See Sections IV.2, IV.3, and IV.6 of this announcement for more information on LOI submission. The LOI must identify the type of applicant, ~~**the size of the jurisdiction,**~~ and the risk factor area to be addressed. If an applicant wishes to apply for both tobacco and obesity/ physical activity/ nutrition funding, one LOI can be submitted to indicate that intention."

6. Under Section III. Eligibility Information, Special Requirements, the following sentence has been deleted: "CDC reserves the flexibility to redirect funding from poor performing grants to those performing in the green benchmark level" and has been replaced with the following sentence: **"In accordance with applicable laws and regulations including 45 CFR 92.43, CDC may take certain enforcement actions, including termination of funding, against poor performing grants."**

7. Under Section III. Eligibility Information, Special Requirements, the paragraph describing quarterly benchmarks has been moved to section VI.3. Reporting Requirements, Recovery Act-Specific Reporting Requirements, item 2: Quarterly Benchmarks.

8. Under Section III. Eligibility Information, Special Requirements, the following change has been made: "If the application is non-responsive ~~**incomplete or non-responsive to the special requirements listed in this section,**~~ it will not be entered into the review process."

9. Under Section IV.6. Other Submission Requirements, the following sentence has been moved under IV. 3. Submission Dates and Times: "HHS/CDC strongly recommends that submittal of the application to Grants.gov should be prior to the closing date to resolve any unanticipated difficulties prior to the deadline."

10. Under Section V.1. Criteria, A. Program Infrastructure and Fiscal Management, separate scoring for State applications has been included and highlighted.

11. Under Section V.1. Criteria, B. Leadership team and community coalitions, vii. sub-points have been increased from 2 to 3.

12. Under Section VI.3. Reporting Requirements, Recovery Act-Specific reporting Requirements, the following dates have been added: "Not later than 10 days after the end of each calendar quarter, starting with the quarter ending **March 30, 2010** and reporting by **April 10, 2010**, the recipient must submit quarterly reports to HHS that will posted to Recovery.gov, containing the following information:"

13. In Attachment B, the first sentence has been revised as follows: "*Applicants showing collaboration across these and similar programs will receive* ~~***extra***~~ *points in the application review*."

14. In Attachment C, Reference #77 has been changed from "COCOMO" to the following: **Centers for Disease Control and Prevention. Recommended Community Strategies and Measurements to Prevent Obesity in the United States. MMWR 2009; 58(No. RR-07): 1-26.**

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention (CDC)

American Recovery and Reinvestment Act of 2009

Communities Putting Prevention to Work

Announcement Type: Cooperative Agreement

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

Catalog of Federal Domestic Assistance Number: 93.724

Key Dates:

Letter of Intent Deadline: October 30, 2009

Application Deadline: December 1, 2009

Pre-Application Support:

Pre-Application Conference Calls:

Funding Opportunity Announcement (FOA) information will be available for potential applicants on three separate conference calls, conducted by the Centers for Disease Control and Prevention (CDC), as follows:

- The first call will be for potential applicants (see section III) that are in Mountain or Pacific Time zones, and will be held on Wednesday, September 30 from 3:00 – 4:30 Eastern Daylight Time (EDT). The conference call can be accessed by calling 1-888-390-0788. The leader for this call is Amy Bell and the pass code is 3746637. The pass code and leader's name is required to join the call.

- The second call will be for potential applicants (see section III) that are in Atlantic, Eastern, or Central time zones, and will be held on Thursday, October 1 from 11:00 – 12:30 EDT. The conference call can be accessed by calling 1-888-390-0788. The leader for this call is Amy Bell and the pass code is 3746637. The pass code and leader's name is required to join the call.
- A third call will be held particularly for tribal and territorial organizations on Thursday, October 1 from 3:00 – 4:30 EDT. The conference call can be accessed by calling 1-888-390-0788. The leader for this call is Amy Bell and the pass code is 3746637. The pass code and leader's name is required to join the call.

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

Participation in a conference call is voluntary. Potential applicants are requested to call in using only one telephone line. If during the call you need technical assistance, press *0 to speak to an operator. Please note restrictions may exist when accessing free phone/toll free numbers using a mobile telephone. Since this is a competitive selection process, applicants should follow the requirements as they are laid out in the FOA and any related amendments. Should applicants find they have questions or need clarification prior to this call, please see section VII Agency Contacts.

Other Pre-application support:

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

I. Funding Opportunity Description

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

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

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

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

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

OBESITY, PHYSICAL ACTIVITY, AND NUTRITION

Measures for communities addressing physical activity and nutrition:

Adults

- Stabilize or begin to decrease (up to 2%) adult overweight/obesity prevalence, thus reversing long term trends.
- 20% increase in the percentage of adults getting adequate physical activity, meaning 20% more adults meeting Physical Activity Guidelines.
- 5% decrease in consumption of sugar-sweetened beverages, for adults, a decrease of about 5 gallons per person per year.
- A 20% increase in average daily fruit and vegetable consumption, an increase of approximately 1 serving.
- 15% increase in the percentage of adults with a heart-healthy diet based USDA's Healthy Eating Index (HEI), meaning 15% more adults with diet including adequate fruits and vegetables and reduced intake of fats.
- 6% decrease in the percentage of adults getting excess calories based on USDA's Healthy Eating Index (HEI).

Youth

- Stabilize or begin to decrease (up to 2%) youth overweight/obesity prevalence (up to age 2-18), thus reversing long term trends.
- 35% increase in the percentage of high school students getting adequate physical activity (duration, frequency, intensity) meaning 35% more high school students meeting Physical Activity Guidelines.
- 5% decrease in consumption of sugar-sweetened beverages in high school students, a decrease of approximately 4 gallons per person per year.

- A 30% increase in average daily fruit and vegetable consumption among high school students, an increase of approximately 1 serving.
- 15% increase in the percentage of youth (ages 2-18) with a heart-healthy diet based on the USDA's Healthy Eating Index (HEI), meaning 15% more youth with diets including adequate fruits and vegetables and reduced intake of fats.
- 6% decrease in the percentage of youth (ages 2-18) getting excess calories based on USDA's Healthy Eating Index (HEI).

TOBACCO

Measures for communities addressing tobacco:

Adults

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

Youth

- 25% decrease in youth smoking prevalence (up to age 18), preventing tobacco-related death in 1/3 of these youth.
- 30% decrease in the percentage of youth (ages 2-18) exposed regularly to secondhand smoke.

This effort aims to address the needs of the diverse demographics of the United States by identifying four well-established population areas: large cities, urban areas, tribal communities, and state-coordinated small cities and rural areas. The focal points for the implementation of

plans for this effort are state health departments, local health departments, and tribes (see section III. 1. “Eligible Applicants” for specific requirements), which possess the infrastructure to rapidly deploy programs and interventions to their citizens. Funding will provide support to address the risk factors within the defined demographic areas set out below.

- **Large cities:** For this announcement, the term “large city” is defined as a local health department that serves a jurisdiction with a population of more than 1 million people.
- **Urban areas:** For this announcement, the term “urban area” is defined as a local health department that serves a jurisdiction with a population more than 500,000 and up to 1 million people.
- **Tribal communities:** For this announcement, “tribal communities” is defined as Federally recognized Tribal Governments, Regional Area Indian Health Boards, Urban Indian organizations, and Inter-Tribal Councils.
- **State-coordinated small cities and rural areas:** State health departments will coordinate the small city and rural area applications. For this announcement, the term “small city” is defined as a local health department that serves a jurisdiction with a population between 50,000 – 500,000 people and the term “rural area” is defined as a local health department that serves a jurisdiction with a population of 50,000 people and below.

This FOA focuses on two categories of activities: Category A: Obesity prevention, physical activity and nutrition and Category B: Tobacco prevention and control. Applicants will be asked to propose activities in Category A or Category B or both. If applying for both categories, a separate application must be submitted for each category.

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

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

- Identifying in their application up to two pre-selected communities (a combination of one small city and one rural community; two small cities; or two rural communities) that will be expected, with state assistance, to conduct the same activities and for achieving the same performance measure identified below in either Category A or Category B. Each

community must have an established coalition and will be monitored for progress toward benchmarks, performance measures, and outcomes.

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

Monitoring and evaluation of the Recovery Act-funded efforts in communities will focus on the implementation of community-wide policy, systems, and environmental changes. These are the expected changes during the funding period, and are also demonstrated to be major drivers of the more downstream changes in risk behaviors and risk factors. Awardees are also expected to participate in national evaluation activities, including tracking relevant behavioral outcomes using BRFSS and YRBSS, participating in modeling studies, and examining cost and context within which community change occurs. Applicants will be asked to participate in monitoring and evaluation efforts within funded communities, including pre and post measurement. This may include the collection of biometric measurements especially among applicants who already have such measurement systems in place. Applicants may also wish to include plans to improve the quality of these efforts.

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

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

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

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 obesity, diabetes and cardiovascular disease. Key risk factors–lack of physical activity, poor nutrition and tobacco use–are major contributors to the nation's leading causes of death. More than 75% of health care expenditures in the United States are spent to meet the health needs of persons with chronic conditions (www.cdc.gov/nccdphp/overview.htm). Many Americans die prematurely and suffer from diseases that could be prevented or more effectively managed.

Understanding patterns of health or disease requires a focus not only on personal behaviors and biologic traits, but also on characteristics of the social and physical environments that offer or limit opportunities for positive health outcomes. These characteristics of communities – social, physical, and economic – are a major influence on the public's health and have both short- and long-term consequences for health and quality of life. Research has shown that implementing policy, systems, and environmental changes, such as improving physical education in schools, improving safe options for active transportation, providing access to nutritious foods, and other broad-based policy change strategies, can result in positive behavior changes related to physical activity, nutrition, and tobacco use, which positively impact multiple chronic disease outcomes.

The key to the success of this initiative, *Communities Putting Prevention to Work*, will be to implement community-wide policies, systems, and environmental changes that reach across all levels of the socio-ecological model and include the full engagement of the leadership in city government, boards of health, schools, businesses, community and faith-based organizations, community developers, transportation and land use planners, parks and recreation officials,

health care purchasers, health plans, health care providers, academic institutions, foundations, other Recovery Act-funded community activities, and many other community sectors working together to promote health and prevent chronic diseases. Funded programs need to build on, but not duplicate current Federal programs as well as state, local, or community programs and coordinate fully with existing programs and resources in the community.

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

Proposals should focus on implementing broad-based policy changes that are chosen from the prescribed set of evidence-based interventions. Each community will address all 5 evidence-based MAPPS strategies (**M**edia, **A**ccess, **P**oint of decision information, **P**rice and, **S**ocial support services) for each application: tobacco and/or obesity/physical activity/nutrition.

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

This announcement is only for non-research activities supported by CDC. If research is proposed, the application will not be reviewed. For the definition of research, please see the

CDC Web site at the following Internet address:

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

Recipient Activities

Applicant activities for this program are as follows:

Activities will be awarded for two categories:

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

Category B: Applicants addressing tobacco prevention and control.

Applicants can propose activities in Category A or Category B or both. If applying for both categories, a separate application must be submitted for each category. Should an applicant compete successfully in both categories to receive two awards, CDC will conduct budget negotiations with the applicant to merge the staffing plans and reduce the requested budgets accordingly in order to reflect a combined operating structure.

For state-coordinated small city and rural areas, the State Health Department is responsible for ensuring that the state application contains the community applications and that they fulfill the requirements highlighted in this FOA. State Health Departments will identify in their application up to two pre-selected communities (a combination of one small city and one rural community; two small cities; or two rural communities) that will be expected, with state assistance, to conduct the same activities and for achieving the same performance measure identified below in

either Category A or Category B. If applying for both categories, a separate application must be submitted for each category.

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

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

- Establish and maintain required paid project or contract staff sufficient in number and expertise to ensure project success on the following timeline:
  - 30 days post-award, establish and/or retain the minimum staffing requirements to include a representative of the leadership of the health department, such as a Program Director; a full-time staff person or equivalent responsible for managing the planning, implementation, and evaluation of the program, with management experience in physical activity and/or nutrition; and the identification of individuals with demonstrated capacity in media planning, administrative, and fiscal management support necessary to meet the needs of the program.
  - 90 days post-award, establish and/or retain the required additional staff, contractors, or collaborations to include leadership and expertise within the education agency for school health, and leadership and expertise for fiscal/accountability, community outreach and coordination, injury and crime reduction, built environment, evaluation, and YRBSS coordination (responsible for conducting a YRBSS in the intervention area). The awardee should ensure that this complement of staff and contract support is sufficient to meet the requirements of this FOA.

- Over the course of the project period, establish and maintain other part-time or full-time staff, contactors, and consultants 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, built environment (e.g. urban and regional planning, transportation, parks, community development), health care quality improvement, communications, resource development, school health, and the policies related to physical activity/nutrition targeted by the FOA.
- For state-coordinated small city and rural areas, State Health Departments must establish and coordinate a State-Community Management Team, including participation from the funded communities; the state health department's collaborative FOA designated healthy communities coordinator; the state education agency, the state planning agency, the state obesity or physical activity/nutrition coordinator, and the Office of Rural Health (where appropriate).
- Recovery Act funding should be considered one-time funding. Ensure that a sustainability plan is in place that leverages all resources available, including federal, state, and local sources, taking into account staffing levels and contractor commitments that support the CPPW Initiative.

Performance will be measured by evidence that the program is appropriately staffed to administer, manage, and evaluate the program as evidenced by the submission of staff/contractor name, date of hire and/or projected date of hire or staff to be retained due to Recovery Act funds and by the submission of resumés and/or curriculum vitae for key

personnel and position descriptions for other positions supported by funds under this cooperative agreement. In addition, performance will be measured by the state health department's ability, with assistance from the funded communities, to develop a State-Community Management Team. Performance related to sustainability will be measured by outreach to resources, including leveraging other Federal Government recovery funds to meet the above mentioned skill set (See Attachment B), and the number of commitments achieved by the end of the program.

2) Fiscal management.

- Provide funding to local entities and organizations that will: support the goals of the initiative and the selected interventions, focus on population-based strategies, are evidence-based and policy-focused, and will reach diverse groups.
- Utilize fiscal management procedures for this funding to track and monitor expenditures separate from other federal funding streams.
- Implement reporting systems to meet the online reporting criteria and timelines as stated for the Recovery Act required reporting located in section VI.3. Reporting Requirements under "Recovery Act-Specific Reporting Requirements" of this FOA.
- Recovery Act funding to existing or new awardees should be considered one-time funding. Ensure that a sustainability plan is in place that leverages all resources available, including federal, state, and local sources, taking into account funding commitments that support the CPPW Initiative.

Performance will be measured by evidence that the awardee will provide funding to local agencies and partner organizations committed to the goals of the initiative and the

selected interventions; has established procedures to track and report expenditures separate from other federal funding; and is able to prepare required reports submitted on the designated schedule.

3) Leadership team and community coalition.

- 60 days post award, develop a Leadership Team consisting of 8-10 high-level community leaders (e.g. the mayor, tribal leaders, city and county officials, school superintendents, local business association or corporation leaders, hospital and health systems directors, boards of health) or other leaders of influence in the community. The Leadership Team should also include the Program Director and the overall manager of the program. The Leadership Team will: oversee the strategic direction of the project activities, be responsible for enacting policies related to the evidence-based MAPPS strategies recommended in item 4 of this section, establish and maintain an organizational structure and governance for the community coalition or coalitions, and participate in project-related local and national meetings.
- 90 days post-award, revise or add to the existing community coalition (or coalitions) committed to participating actively in the planning, implementation, and evaluation of the *Communities Putting Prevention to Work Initiative.* Partners should include a wide representation of community leaders and community members familiar with promoting physical activity and nutrition. Examples could include representatives from education agencies (local education agencies, school districts, school board members, or parent teacher organizations); school health advocates, community development/planning agencies (land use and/or transportation); key community-

based governmental and non-governmental organizations, health care, voluntary, and professional organizations; business, community, faith-based leaders; local Aging centers and senior centers; universities; and at least one lay person representative of the population to be served. Linkages with mental health/substance abuse organizations, health plans, foundations, and other community partners working together to promote health and prevent chronic diseases are encouraged. The community coalition will advise the Leadership Team on the planning, implementation, and evaluation of the CPPW Initiative.

- Encourage linkages with other community-based efforts and the Office of the Regional Health Administrator, with special attention to leveraging other Federally funded (including Recovery Act funded) and foundation activities. Applicants will also be asked to demonstrate through letters of support that they have political support and connections with other community development and livability efforts, and that they build on and leverage existing place-based revitalization and reform projects funded by the US Government. These could include efforts funded by the US Department of Health and Human Services (HHS), and programs supported by other agencies such as the US Department of Housing and Urban Development, the Environmental Protection Agency, the US Park Service, US Department of Transportation, US Department of Agriculture, the Corporation for National and Community Service, and the US Department of Education. Applicants are also encouraged to coordinate with other US Government-funded Recovery Act efforts in multiple sectors, such as transportation, education, health care delivery, agriculture

and others, as well as coordinating with HHS Regional Offices. See Attachment B for examples.

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

4) Intervention area and selection of interventions.

- Ensure that the intervention area encompasses the entire jurisdiction of the health department so that the focus of policies, systems, and environmental changes will have the broadest impact possible. The mix of interventions, taken together, must address physical activity and nutrition with sufficient reach and potential impact.
- Choose a mix of interventions that addresses obesity/nutrition/physical activity for all five evidence-based MAPPS strategies in communities and schools. Awardees are not required to select strategies in each MAPPS area for *both* physical activity and nutrition (i.e.10 strategies). Rather, the mix of MAPPS interventions, taken together, must address obesity and related risk factors consistent with the long term goals of the initiative, and therefore must include robust interventions in both nutrition and physical activity.
- The evidence-based interventions below are drawn from the peer-reviewed literature as well as expert syntheses from the community guide and other peer-reviewed

sources (for a complete list of citations, please see Attachment C). Communities and states have found these interventions to be successful in practice. Awardees are expected to use this list of evidence-based strategies to design a comprehensive and robust set of strategies to produce the desired outcomes for the initiative. Other evidence-based strategies may be proposed but must be documented as to their evidence base, their likely addition to the overall outcomes, and the rationale for the choice of intervention (e.g., identified need or opportunity).

MAPPS Table

	Nutrition	**Physical Activity**
Media	• Media and advertising restrictions consistent with federal law • Promote healthy food/drink choices • Counter-advertising for unhealthy choices	• Promote increased activity • Promote use of public transit • Promote active transportation (bicycling and walking) • Counter-advertising for screen time
Access	• Healthy food/drink availability (e.g., incentives to food retailers to locate/offer healthier choices in underserved areas, healthier choices in child care, schools, worksites) • Limit unhealthy food/drink availability (whole milk, sugar sweetened beverages, high-fat snacks) • Reduce density of fast food establishments • Eliminate transfat through purchasing actions, labeling initiatives, restaurant standards • Reduce sodium through purchasing actions, labeling initiatives, restaurant standards • Procurement policies and practices • Farm to institution, including schools, worksites, hospitals and other community institutions	• Safe, attractive accessible places for activity (e.g. access to outdoor recreation facilities, enhance bicycling and walking infrastructure, place schools within residential areas, increase access to and coverage area of public transportation, mixed use development, reduce community designs that leads to injuries). • City planning, zoning and transportation (e.g., planning to include the provision of sidewalks, mixed use, parks with adequate crime prevention measures, and Health Impact Assessments) • Require daily quality PE in schools • Require daily physical activity in afterschool/childcare settings • Restrict screen time (afterschool, daycare)
Point of Purchase/ Promotion	• Signage for healthy vs. less healthy items • Product placement & attractiveness • Menu labeling	• Signage for neighborhood destinations in walkable/mixed-use areas • Signage for public transportation, bike lanes/boulevards.
Price	• Changing relative prices of healthy vs. unhealthy items (e.g. through bulk purchase/procurement/competitive pricing).	• Reduced price for park/facility use • Incentives for active transit • Subsidized memberships to recreational facilities
Social	• Support breastfeeding through policy change	• Safe routes to school

Support & Services	and maternity care practices	• Workplace, faith, park, neighborhood activity groups (e.g., walking hiking, biking)

- Selection of evidence-based interventions to pursue should be based on a thorough analysis of gaps and opportunities that exist in the community and should reflect the potential for broad reach, impact, and successful implementation.
- Propose strategies that are most likely to affect community-wide burden and therefore where appropriate emphasize plans to reduce health disparities.
- Select interventions that limit the availability of unhealthy food and beverages. Applicants should provide current information about such restrictions, and should include this strategy in the intervention selection unless there is justification based on existing strong policies.
- Engage existing coalition or coalitions and potential members of the leadership team in the selection process.

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

5) Community Action Plan (CAP).

- Submit a two-year CAP as part of the application that describes an overall integrated strategy that identifies the selected interventions; describes key activities; describes milestones and timelines on achieving intervention implementation; identifies

anticipated policy outcomes; and includes SMART Objectives (Specific, Measurable, Achievable, Relevant, Time-Framed) for each intervention.

- 90 days post-award, finalize the two-year CAP utilizing recommendations from the application objective review process and input from community information, HHS agencies, other sources of programmatic support, and on-going discussions with internal staff and community partners.
- Clearly articulate how activities and interventions highlighted in the CAP will be sustained after Recovery Act funding has ceased.

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

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

- Address all five evidence-based MAPPS strategies for obesity/physical activity/nutrition in communities and in schools, such that the reach and potential impact is consistent with achieving the long-term goal of the initiative (e.g. PE in schools that impact an entire school district in the jurisdiction, menu labeling that impacts the entire jurisdiction).
- Where applicable, implement a targeted strategy in areas with a disproportionate burden of chronic diseases/conditions that tend to experience disparities in access to and use of preventive and health care services. This focused strategy should include

significant areas of the community in order to have the broadest impact possible (e.g. not one school, but an entire school district; not one corner store stocked with fresh produce, but the availability of fresh produce in an entire neighborhood, not one health clinic, but a major health care system).

- Work with media-buying contractors to develop and refine a media-buy strategy.
- Collaborate with CDC to implement emotional, hard-hitting counter-marketing and messaging and normative marketing to promote active behaviors and healthy eating. Co-brand and locally tag all campaign advertisements and materials with locally relevant information and resources.

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

7) Evaluation to monitor/measure progress.

- 60 days post award, establish a monitoring plan that includes the following:
  - The systematic collection of data on a bi-annual basis (twice a year) of progress on and implementation of existing policy, systems, and environmental change strategies using the Community Health Assessment aNd Group Evaluation (CHANGE) tool related to chronic disease prevention and health promotion, to evaluate the process and outcomes of program activities. For awardees who have failed to meet benchmarks in Year 1, reporting of some elements of the CHANGE tool will be required quarterly.
  - The collection of implementation cost information for each initiative, to evaluate the process and outcomes of program activities.

- 120 days post award, finalize a comprehensive evaluation plan that is directly tied to the Community Action Plan.
- Track progress on implementing activities to create policy, system, and environmental changes utilizing the CHANGE Tool.
- Collaborate with and provide necessary information to your state health department, which will be responsible for collecting BRFSS data at the community level at baseline and follow-up.
- Work with state and local education and health agencies and CDC to conduct a YRBSS using standard YRBSS protocol among a representative sample of as many as 1,500 to 2,000 9^{th} - 12^{th} grade students in the intervention area during the fall semester of the 2010-2011 school year that measures at least dietary behaviors and physical activity. Repeat the YRBSS among another representative sample of 9^{th}-12^{th} grade students at the end of the project period. Cooperative agreement funds may be spent on school incentives.
- If selected as a case study site, collaborate with CDC and contractors in implementing a site-specific case study that examines contextual and environmental factors that act as facilitators or barriers to program implementation and achievement of intended outcomes and lead to variations in implementation costs across sites.
- Monitor and evaluate efforts, including pre and post measurement. This includes the use of biometric measurements for those applicants already engaged in biometric measurements and who wish to improve the quality of those efforts as they relate to collection of height and weight in school-age children and youth. All applicants should describe any current activities to collect these data in school-age populations.

- In collaboration with CDC, provide information that will assist with modeling studies, which will allow, even in the short term, some estimation of long-term impact of policy and environmental changes on risk behavior and health outcomes.
- In collaboration with CDC, provide implementation cost information in a uniform format that will permit examination of efficiency and cost effectiveness of program activities.

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

8) Participation in Programmatic Support Activities

- 30 days post-award, ensure that three members of the Leadership Team (the Program Director, the program coordinator or equivalent, and one additional leader outside the health department) attend a kick-off meeting in Atlanta.
- 90 days post-award, ensure that all 8-10 members of the Leadership Team participate in an Action Institute that will promote the importance of policy, systems, and environmental change strategies.
- Ensure that two members of the Leadership Team attend two peer-peer meetings during the project period.
- Ensure that the YRBSS lead attends a CDC-led 3-day YRBSS training in August 2010.

- In collaboration with CDC, work with currently-funded community-based programs (e.g. Healthy Communities, REACH, Active Living by Design, and others) to learn about cutting-edge policy and environmental change strategies and interventions to eliminate health disparities.
- If applicable, invite national experts and health-related foundations to provide programmatic support with the selected interventions.
- In collaboration with CDC, provide information on successful initiatives at the community level that can be published on the web and shared with other communities.
- For state-coordinated small city and rural areas, the State-Community Management Team should provide or facilitate the provision of programmatic support and consultation to their funded communities in risk factor surveillance, program evaluation, evidence-based and practice-based policies, systems, and environmental changes; community engagement, and intervention selection and development.
- For state-coordinated small city and rural areas, the State Health Department is responsible for ensuring that at least 75% of the total award is distributed to the identified communities in the state-coordinated application.

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

Peer-to-Peer Mentorship

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

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

Category B. Applicants addressing tobacco prevention and control

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

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

with demonstrated capacity in media planning, administrative, and fiscal management support necessary to meet the needs of the program.

- 90 days post-award, establish and/or retain the required additional staff, contractors, or collaborations to include leadership and expertise within the education agency for school health, and leadership and expertise for fiscal/accountability, community outreach and coordination, evaluation, and YRBSS coordination (responsible for conducting a YRBSS in the intervention area). The awardee should ensure that this complement of staff and contract support is sufficient to meet the requirements of this FOA.

- Over the course of the project period, establish and maintain other part-time or full-time staff, contactors, and consultants 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 policies related to tobacco control targeted by the FOA.
- For state-coordinated small city and rural areas, State Health Departments must establish and coordinate a State-Community Management Team, including participation from the funded communities; the state health department's collaborative FOA designated healthy communities coordinator; the state education agency, the state tobacco control coordinator, and the Office of Rural Health (where appropriate).

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

2) Fiscal management.

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

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

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

3) Leadership team and community coalition.

- 60 days post award, develop a Leadership Team consisting of 8-10 high-level community leaders (e.g. the mayor, tribal leaders, city and county officials, school superintendents, local business association or corporation leaders, hospital and health systems directors, boards of health) or other leaders of influence in the community. The Leadership Team should also include the Program Director and the overall manager of the program. The Leadership Team will: oversee the strategic direction of the project activities, be responsible for enacting policies related to the evidence-based MAPPS strategies recommended in item 4 of this section, establish and maintain an organizational structure and governance for the community coalition or coalitions, and participate in project-related local and national meetings.
- 90 days post-award, revise or add to the existing community coalition (or coalitions) committed to participating actively in the planning, implementation, and evaluation of

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

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

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

4) Intervention area and selection of interventions.

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

MAPPS Table

	Tobacco
Media	• Media and advertising restrictions consistent with federal law • Hard hitting counter-advertising • Ban brand-name sponsorships • Ban branded promotional items and prizes
Access	• Usage bans (i.e. 100% smoke-free policies or 100% tobacco-free policies) • Usage bans (tobacco-free worksites and or school campuses) • Zoning restrictions • Restrict sales (e.g. internet; sales to minors; stores/events w/o tobacco) • Ban self-service displays & vending
Point of Purchase/	• Restrict point of purchase advertising • Labeling/ signage/ placement to discourage consumption of

Promotion	tobacco
Price	• Use evidence-based pricing strategies that discourage tobacco use • Ban free samples and price discounts
Social Support & Services	• Quitline and other cessation services (please note that only up to 5% of the total award for tobacco prevention and control can be spent on nicotine replacement therapy (NRT).

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

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

5) Community Action Plan (CAP).

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

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

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

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

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

- Where applicable, implement a targeted strategy in areas with a disproportionate burden of chronic diseases/conditions that tend to experience disparities in access to and use of preventive and health care services. This focused strategy should include significant areas of the community in order to have the broadest impact possible (e.g. low literacy media messages that influence quitting or lead smokers to the quitline; county wide smoke-free air policies not just one worksite, school or health care)
- Work with media-buying contractors to develop and refine a media-buy strategy.
- Collaborate with CDC to implement emotional, hard-hitting counter-marketing and messaging and normative marketing to reduce tobacco use and prevent youth initiation. Co-brand and locally tag all campaign advertisements and materials with locally relevant information and resources.
- Severely curtail tobacco promotion and advertising consistent with federal law, which can include but is not limited to, restricting or eliminating "power walls" of cigarettes offered for sale at retail outlets, limiting the number or size of tobacco product ads at retail outlets, and requiring that all tobacco products be kept away from cash registers.

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

7) Evaluation to monitor/measure progress.

- 60 days post award, establish a monitoring plan that includes the following:

- The systematic collection of data on a bi-annual basis (twice a year) of progress on and implementation of existing policy, systems, and environmental change strategies using the Community Health Assessment aNd Group Evaluation (CHANGE) tool related to chronic disease prevention and health promotion, to evaluate the process and outcomes of program activities. For awardees who have failed to meet benchmarks in Year 1, reporting of some elements of the CHANGE tool will be required quarterly.
- The collection of implementation cost information for each initiative, to evaluate the process and outcomes of program activities.

- 120 days post award, finalize a comprehensive evaluation plan that is directly tied to the Community Action Plan.
- Track progress on implementing activities to create policy, system, and environmental changes utilizing the CHANGE Tool.
- Collaborate with and provide necessary information to your state health department, which will be responsible for collecting BRFSS data at the community level at baseline and follow-up.
- Work with state and local education and health agencies and CDC to conduct a YRBSS using standard YRBSS protocol among a representative sample of as many as 1,500 to 2,000 9^{th} - 12^{th} grade students in the intervention area during the fall semester of the 2010-2011 school year that measures at least tobacco use. Repeat the YRBSS among another representative sample of 9^{th}-12^{th} grade students at the end of the project period. Cooperative agreement funds may be spent on school incentives.

- If selected as a case study site, collaborate with CDC and contractors in implementing a site-specific case study that examines contextual and environmental factors that act as facilitators or barriers to program implementation and achievement of intended outcomes and lead to variations in implementation costs across sites.
- In collaboration with CDC, provide information that will assist with modeling studies, which will allow, even in the short term, some estimation of long-term impact of policy and environmental changes on risk behavior and health outcomes.

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

8) Participation in Programmatic Support Activities

- 30 days post-award, ensure that three members of the Leadership Team (the Program Director, the program coordinator or equivalent, and one additional leader outside the health department) attend a kick-off meeting in Atlanta.
- 90 days post-award, ensure that all 8-10 members of the Leadership Team participate in an Action Institute that will promote the importance of policy, systems, and environmental change strategies.
- Ensure that two members of the Leadership Team attend two peer-peer meetings during the project period.
- Ensure that the YRBSS lead attends a CDC-led 3-day YRBSS training in August 2010.

- In collaboration with CDC, work with currently-funded community-based programs (e.g. Healthy Communities, REACH, Active Living by Design, and others) to learn about cutting-edge policy and environmental change strategies and interventions to eliminate health disparities.
- If applicable, invite national experts and health-related foundations to provide programmatic support with the selected interventions.
- In collaboration with CDC, provide information on successful initiatives at the community level that can be published on the web and shared with other communities.
- For state-coordinated small city and rural areas, the State-Community Management Team should provide or facilitate the provision of programmatic support and consultation to their funded communities in risk factor surveillance, program evaluation, evidence-based and practice-based policies, systems, and environmental changes, community engagement, and intervention selection and development.
- For state-coordinated small city and rural areas, the State Health Department is responsible for ensuring that at least 75% of the total award is distributed to the identified communities in the state-coordinated application.

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

Peer-to-Peer Mentorship

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

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

CDC Activities

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

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

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

2. Evidence-based and practice-based approaches,

3. Community mobilization and partnership development,

4. Implementation of broad-based policy, systems, and environmental changes,

5. Program sustainability,

6. Evaluation of policy, system, and environmental level change,

7. Monitoring of risk behavior change and longer-term health outcomes,

8. Developing and revising Community Action Plans.

- Foster the transfer of successful evidence and practice-based interventions, program models and other forms of community programmatic support by convening meetings, workshops, web forums, conferences, and conference calls with awardees.

- Conduct on-site visits to awardees to ensure achievement of quarterly benchmarks and project success as determined by the Recovery Act and outlined within this FOA.

- Plan, implement, and organize Recovery Act Action Institutes and Peer-to-Peer meetings for awardees and teams.

- Participate in a national media campaign strategy and coordinate with local implementation of media interventions that will foster effective and hard-hitting prevention and wellness messages and advertisements that will complement and reinforce state and community activities.

- Maintain an electronic community health web portal and other mechanisms for information sharing among awardees that includes a web-site and web-board.

- Record best practices and community experiences for dissemination to existing awardees and other communities for replication of successful interventions.

- Fund national experts to provide programmatic support in implementing the prescribed set of evidence-based MAPPS strategies and the selected interventions.

- Provide project monitoring that includes the analysis of performance measures and the consistency of measurement and comparability of Recovery Act reporting measures and CHANGE tool data.

- Coordinate with other Federal agencies and existing place-based revitalization and reform projects funded by the US Government, including community development and livability efforts and activities funded by the Recovery Act.

- In addition to community evaluation efforts, HHS has allocated $39.5 million to support evaluation of community efforts through community and state level risk factor surveillance, case studies in funded communities and states, cost tracking, and modeling. Behavioral outcomes will be tracked using existing BRFSS and YRBSS tools, and the CDC CHANGE Tool data collected in funded communities. CDC will utilize data from BRFSS, YRBSS, and modeling techniques to monitor behavior

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

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

II. Award Information

Type of Award: Cooperative Agreement.

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

Award Mechanism: U58

Fiscal Year Funds: 2009-2010 Recovery Act

Approximate Current Fiscal Year Funding: $373 million

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

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

Illustrative ranges are:

Category A: Obesity/Physical Activity/Nutrition

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

Category B: Tobacco Prevention and Control

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

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

Anticipated Award Date: February 26, 2010

Budget Period Length: 24 months

Project Period Length: 24 months

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

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.

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

III. Eligibility Information

III.1. Eligible Applicants

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

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

- Federally recognized Tribal Governments, Regional Area Indian Health Boards, Urban Indian organizations, and Inter-Tribal Councils as designated by the Principal Tribal elected official or chief executive officer will serve as the lead/fiduciary agency for **Tribal Community** applications.
- An official state health department (or its bona fide agent), or its equivalent, as designated by the Governor, is to serve as the lead/fiduciary agency for **Small City and Rural Community** applications. For this announcement, 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. The term "small city" is defined as a local health department that serves a jurisdiction with a population between 50,000 – 500,000 people. The term "rural area" is defined as a local health department that serves a jurisdiction with a population of 50,000 people and below.

III.2. Cost Sharing To Promote Sustainability

There is no match requirement for this program. However, leveraging other resources and related on-going efforts to promote sustainability is encouraged. Examples include foundation funding, other US government funding sources including the Recovery Act, and state appropriations. (See Attachment B)

III.3. Other

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

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

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

Applicants are required to submit a Letter of Intent (LOI) to be eligible to apply for this program. Failure to submit a LOI will result in non-responsiveness and the applicant will be prohibited from applying. See Sections IV.2, IV.3, and IV.6 of this announcement for more information on LOI submission. The LOI must identify the type of applicant and the risk factor area to be addressed. If an applicant wishes to apply for both tobacco and obesity/ physical activity/ nutrition funding, one LOI can be submitted to indicate that intention.

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.

Special Requirements:

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

- Late applications will be considered non-responsive. See section "IV.3. Submission Dates and Times" for more information on deadlines.

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

IV. Application and Submission Information

IV.1. Address to Request Application Package

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

Electronic Submission:

CDC strongly encourages the applicant to submit the application electronically by utilizing the forms and instructions posted for this announcement on www.Grants.gov, the official Federal agency wide E-grant Web site. Only applicants who apply on-line are permitted to forego paper copy submission of all application forms.

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

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

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

IV.2. Content and Form of Submission

Letter of Intent (LOI):

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

- Program announcement title and number;

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

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.

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

Although the LOI will not be scored as part of the application process, submission of the LOI is considered the submission of a formal application and the applicant will be subject to lobbying restrictions highlighted in section VIII. "Recovery Act Lobbying Restrictions." Applicants will be notified by email upon receipt of the LOI by CDC.

Application:

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

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

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

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

- Maximum number of pages: 30. If your narrative exceeds the page limit, only the first pages which are within the page limit will be reviewed.
- Font size: 12 point unreduced, Times New Roman
- Double spaced
- Paper size: 8.5 by 11 inches

- Page margin size: One inch
- Number all narrative pages; not to exceed the maximum number of pages.

The narrative should address activities to be conducted over the entire project period for either Category A or Category B and must include the following items in the order listed:

I. Program Infrastructure and Fiscal Management

A. Identify required staff, qualifications, and responsibilities.

B. For state-coordinated small city and rural areas, state health departments need to identify staff, qualifications, and responsibilities for the state-community management team. Describe plans for programmatic support to the funded communities.

C. Describe financial management systems that are in place to fulfill the Recovery Act reporting requirements outlined in section VI.3. Reporting Requirements under "Recovery Act-Specific Reporting Requirements."

D. Describe how proposed efforts will be sustained after Recovery Act funding has ceased.

II. Leadership Team and Coalitions

A. Identify potential members of the Leadership Team, including letters of support that detail their commitment to advancing the broad-based policy changes selected from the menu of evidence-based MAPPS strategies or other proposed interventions (letters of support can be included as part of the Appendices).

B. Provide a description of the existing community coalition or coalitions, including the types of groups represented (membership lists can be included as part of the Appendices). Describe the past successes of the existing coalition(s) working with community leaders in advancing broad-based policy, systems, and environmental change strategies.

C. Include a letter of support from the mayor, county executive, tribal leader, or other equivalent government official that demonstrates their commitment to supporting the CPPW Initiative and the reporting requirements as highlighted in this FOA (letter of support can be included as part of the Appendices).

D. Include list of other Federal ARRA collaborations.

III. Intervention Area and Populations of Need

A. Describe the jurisdiction of the health department (intervention area) including a thorough description of the exact population size and location of the populations to be served.

B. Include local data (where available), that provides the population size; substantiates the existing burden and/or disparities of chronic diseases and conditions; substantiates existing health risk behaviors and risk factors related to chronic diseases; and describes assets and barriers to successful program implementation, including an understanding of the policy, systems, and environmental policies in the community. Ensure that these data highlight geographic areas and populations of high need, which may include racial and ethnic minorities, low-income persons, the medically underserved, persons with

disabilities, persons affected by mental illness, or persons affected by substance abuse.

IV. Selection of Risk Factors and Interventions

A. Clearly indicate which risk factors will be addressed: tobacco or obesity/ physical activity/ nutrition. If selecting both, please provide separate descriptions of how each risk factor will be addressed.

B. Identify intervention strategies across the five evidence-based MAPPS strategies, provide a justification of why these interventions were selected including an assessment of the current needs and assets in the community related to tobacco or obesity/physical activity/nutrition, and indicate plans for sustainability and leveraging resources. Identify how the applicant has addressed priority interventions (tobacco smoke free policies and evidence-based pricing strategies OR removing/limiting availability of unhealthy food and beverages).

C. If proposing an intervention not included in the prescribed menu of interventions, provide a justification for the choice of the intervention (e.g. identified need or opportunity) and demonstrate that it has the potential for broad reach and impact not achievable with a listed intervention.

D. Explain how the intervention strategies will impact the entire jurisdiction of the health department and how they have the potential for broad reach and impact. Ensure that the selection of interventions takes into account the gaps and opportunities that exist in the community.

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

F. Provide examples of how the awardee will interact with the state health department, national experts, foundations and CDC on the implementation of selected interventions.

V. Evaluation to Monitor/Measure Progress

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

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

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

D. For those communities engaged in biometric data collection and who wish to improve their efforts, describe current approach (e.g. target audience including which school-age populations (which ages/grades), method of data collection,

frequency of data collection, and evidence of validity and reliability of data collected) as well as plans for upgrading the current approach with these funds. All applicants should describe any current activities to collect these data in school-age populations.

VI. Community Programmatic Support Needs

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

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

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

- Curricula Vitae, Resumés, Organizational Charts, Letters of Support, Membership Lists, and Indirect Cost Agreement.
- Community Action Plan that includes the selected evidence-based MAPPS strategies; describes key activities; identifies anticipated policy outcomes; and includes SMART Objectives (Specific, Measurable, Achievable, Relevant, Time-Framed) for each intervention.

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

- "807_(state two letter abbreviation)_(document name)"

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

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

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

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

IV.3. Submission Dates and Times

Letter of Intent (LOI) Deadline Date: October 30, 2009 (EDT)

Application Deadline Date: December 1, 2009 (EST)

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

Applications must be submitted electronically at www.Grants.gov. Applications completed on-line through Grants.gov are considered formally submitted when the applicant organization's

Authorizing Organization Representative (AOR) electronically submits the application to www.Grants.gov. Electronic applications will be considered as having met the deadline if the application has been successfully submitted electronically by the applicant organization's AOR to Grants.gov on or before the deadline date and time.

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

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

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

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

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

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

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

IV.4. Intergovernmental Review of Applications

Executive Order 12372 does not apply to this program.

IV.5. Funding Restrictions

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

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

If requesting indirect costs in the budget, a copy of the indirect cost rate agreement is required. If the indirect cost rate is a provisional rate, the agreement should be less than 12 months of age.

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

The recommended guidance for completing a detailed justified 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 the LOI by express mail, delivery service, fax, or E-mail to:

Tracey Sims, Grants Management Specialist
Procurement and Grants Office
Centers for Disease Control and Prevention
2920 Brandywine Road, MS E-09
Atlanta, GA 30341
Phone Number: 770-488-2739
Fax Number: 770-488-2677
E- mail: atu9@cdc.gov

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

Adrienne S. Brown, Public Health Analyst
Division of Adult and Community Health

National Center for Chronic Disease Prevention and Health Promotion
Centers for Disease Control and Prevention
3005 Chamblee-Tucker Road, Mailstop K-45
Atlanta, GA 30341
Fax: (770) 488-5964

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

Application Submission Address:

Electronic Submission:

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

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

V. Application Review Information

V.1. Criteria

The application will be evaluated against the following criteria:

Application will be scored on the extent to which the proposed plan provides a robust combination of interventions with broad reach, and provides evidence that this plan is likely to produce the long term outcomes of this initiative. The applicant should provide evidence that performance measures will be achieved during the annual project years or cooperative agreement project period, as appropriate, in each of the following areas (points indicate the weight of each criterion):

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

1. Applicants

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

i. Is the lead/fiduciary agency clearly identified? (2 pts) / **(2 pts)**

ii. Does the lead/fiduciary agency exhibit the capacity to ensure accountability for expenditures in relationship to performance of all key partners and Recovery Act requirements? (4 pts)/ **(3 pts)**

iii. How well does the applicant provide evidence of the ability to implement funding for this program in the time required? (2 pts) / **(2 pts)**

iv. Does the applicant identify the required staff for the program, including the provision of resumés or CVs? How well does the applicant identify ways in which to engage the required skill sets to fulfill the CPPW benchmarks? (3 pts) / **(2 pts)**

v. Does the applicant provide letters of support from government leaders (e.g. the mayor, the Governor, or Tribal Council Leader) indicating support for the CPPW Initiative? (3 pts) / **(2 pts)**

vi. Does the applicant describe clearly defined roles and abilities of project staff, especially related to policy-related efforts, and an appropriate percent of time each is committing to the project? (4 pts) / **(3 pts)**

vii. Does the applicant demonstrate staff experience with policy making and briefing political leaders and policy makers? (2 pts) / (2 pts)

viii. For state-coordinated small city and rural community applicants, how well does the state health department describe their State-Community Management Team, including participation from the funded communities, the state health department's collaborative FOA designated Healthy Communities coordinator, the state education agency, the state planning agency (where applicable), and the state tobacco or obesity/physical activity/nutrition coordinator (where applicable), and the Office of Rural Health (where applicable). **(2 pts)**

ix. For state-coordinated small city and rural community applicants, how well does the state health department describe their plans to provide programmatic support to the funded communities in their state? **(2 pts)**

B. Leadership team and community coalitions (25 points)

i. Is the leadership team identified and defined to the extent that they will actively participate in overseeing the strategic direction of project activities, be responsible for enacting the selected policy changes selected from the prescribed set of interventions, establish and maintain an organizational structure and governance for the community coalition or coalitions, and participate in project-related local and national meetings? What roles will they play in meeting the purpose of the Initiative? (4 pts)

ii. Do members of the leadership team represent the leadership of the organizations or institutions that they represent? (2 pts)

iii. Do the members of the leadership team demonstrate a high-level commitment to the CPPW Initiative, including a commitment of time and other resources? (3 pts)

iv. Does the applicant have an established community coalition that is inclusive of key partners, and related coalitions? Does the applicant include a list of current members, meeting minutes, or a memorandum of understanding? (5 pts)

v. How well does the applicant describe the capacity of the existing coalition in terms of leadership, expertise, community representation, collaborative experience/abilities, and agency representation? (3 pts)

vi. Have members of the existing coalition successfully worked together and in collaboration with community leaders to implement broad-based policy, systems, and environmental change initiatives? Does the applicant provide examples of past successes? (5 pts)

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

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

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

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

iii. Are data provided that substantiate the existing burden and/or disparities of chronic diseases, conditions, existing health behaviors, and risk factors in the jurisdiction and populations to be served? (2 pts)

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

v. Does the applicant clearly articulate which risk factors they will address: tobacco or obesity/physical activity/nutrition? Has the applicant selected from the prescribed set of MAPPS evidence-based strategies and the appropriate mix of interventions? (2 pts)

vi. How well does the applicant justify the selected of interventions? Does the justification reflect the assets and needs of the community, the decision to include or to not include the required interventions, and the potential for broad reach and impact consistent with the short and long-term goals of the initiative? (4 pts)

vii. Does the two -year community action plan describe an overall integrated strategy that identifies the selected interventions; describes key activities; describes milestones and timelines on achieving intervention implementation; identifies anticipated policy outcomes; and includes SMART Objectives (Specific, Measurable, Achievable, Relevant, Time-Framed) for each intervention? (5 pts)

viii. Does the applicant describe realistic plans to coordinate proposed activities with state- and community-level programs to prevent and control chronic disease? (2 pts)

ix. Do the intervention strategies build on and complement, but not duplicate, existing programs and the potential synergy created through multiple interventions? (2 pts)

x. Does the applicant clearly articulate how the activities and interventions highlighted in the CAP will be sustained after Recovery Act spending is complete? Does the applicant provide evidence of leveraging other resources in the community (e.g. foundations, state funding, private sector funds, etc.)? (4 pts)

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

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

i. Does the applicant indicate that they will collect Recovery Act performance measures in the required format and according to the required schedule? (Highlighted in section VI.3. Reporting Requirements under "Recovery Act-Specific Reporting Requirements"). (5 pts)

ii. Does the applicant describe plans to collaborate fully in external, independently coordinated evaluation activities to evaluate the overall impact of the initiative, especially the national evaluation activities? (3 pts)

iii. How well does the applicant describe the overall plan to evaluate the initiative at the community level? (3 pts)

iv. Does the applicant describe a detailed plan to collect YRBSS data according to standard YRBSS protocol, including the identification of a YRBSS lead who will attend a 3-day YRBSS training in August 2010 and methods for collecting the data? (4 pts)

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

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

E. Programmatic Support Needs (5 points)

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

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

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

F. Budget (not scored)

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

V.2. Review and Selection Process

Applications will be reviewed for responsiveness by the Procurement and Grants Office (PGO) and the National Center for Chronic Disease Prevention and Health Promotion. Applications that are non-responsive to the eligibility criteria will not advance through the review process. Applicants will be notified the application did not meet submission requirements.

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

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

In addition, funding decisions may be made to ensure:

- Representation of tobacco and obesity/physical activity/nutrition across communities, including a varied type of interventions and evidence-based strategies.
- Geographic distribution of The Communities Putting Prevention to Work Initiative nationwide.

- Inclusion of communities of varying sizes, including rural, suburban, and urban communities.
- Inclusion of populations disproportionately affected by chronic disease and associated risk factors.

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

VI. Award Administration Information

VI.1. Award Notices

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

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

VI.2. Administrative and National Policy Requirements

- Successful applicants must comply with the administrative requirements outlined in 45 CFR Part 74 and Part 92, as appropriate. The following additional requirements apply to this project:
- AR-9 Paperwork Reduction Act Requirements
- AR-10 Smoke-Free Workplace Requirements

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

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

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

For more information on the Code of Federal Regulations, see the National Archives and Records Administration at the following Internet address:
http://www.access.gpo.gov/nara/cfr/cfr-table-search.html

VI.3. Reporting Requirements

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

Outcome Measures

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

Output Measures

- Measure: Rating (on 1-5 scale) of progress implementing each of the chosen strategies in [specific focus area: physical activity and nutrition or tobacco]
- Reporting: CHANGE Tool progress module
- Frequency: Semi-annually. Awardee will report to CDC; CDC will compile into average scores for aggregate reporting. For awardees who have failed to meet benchmarks in Year 1, reporting of some elements of the CHANGE tool will be required quarterly.

- Measure: Score (green, yellow, red) on quarterly implementation scorecard during the first year of implementation.
- Reporting: Awardee progress reporting “benchmark” scorecard
- Frequency: Quarterly report by awardee to Project Officer

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

Recovery Act-Specific Reporting Requirements

1. Other Standard Terms and Conditions

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

2. Quarterly Benchmarks

Awardees are required to meet quarterly benchmarks in the first year of implementation, located in Attachment A. During year 1, at the end of each quarter, the awardee will receive a score card that indicates the percentage of benchmarks being met (100%-70% of benchmarks = green; 70%-50% of benchmarks = yellow; less than 50% of benchmarks = red). Leadership within CDC will be made aware of those awardees that are scoring in the yellow and red. Quarterly scores resulting in a red designation will result in an immediate on-site meeting with CDC staff, community leadership and selected national experts to establish an emergency plan for overcoming barriers to success. Depending on the type of community, state and/or local government leaders (e.g. the Governor, Mayor, or Tribal Council leader) will also be informed. Awardees within the red scorecard category will be asked to submit a performance improvement plan, and teams of experts will be available to provide intensive programmatic support and to verify progress. In

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

3. Recovery Act-Specific Requirements

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

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

a. The total amount of Recovery Act funds under this award;
b. The amount of Recovery Act funds received under this award that were obligated and expended to projects or activities;
c. The amount of unobligated award balances;
d. A detailed list of all projects or activities for which Recovery Act funds under this award were obligated and expended, including
    - The name of the project or activity;

- A description of the project or activity;
- An evaluation of the completion status of the project or activity;
- An estimate of the number of jobs created and the number of jobs retained by the project or activity (see OMB Guidance M-09-21, June 22, 2009) and;
- For infrastructure investments made by State and local governments, the purpose, total cost, and rationale of the agency for funding the infrastructure investment with funds made available under this Act, and the name of the person to contact at the agency if there are concerns with the infrastructure investment.

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

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

- The name of the entity receiving the sub-award;
- The amount of the sub-award;
- The transaction type;
- The North American Industry Classification System code or Catalog of Federal Domestic Assistance (CFDA) number;
- Program source;
- An award title descriptive of the purpose of each funding action;
- The location of the entity receiving the award;

- The primary location of performance under the award, including the city, State, congressional district, and county.
- A unique identifier of the entity receiving the award and of the parent entity of the recipient, should the entity be owned by another entity;
- The date the sub-award was issued;
- The term of the sub-award (start/end dates);
- The scope/activities of the sub-award;
- The amount of the total sub-award that has been obligated or disbursed by the sub-recipient; and
- The amount of the total sub-award that remains unobligated by the sub-recipient.

f. All sub-awards less than $25,000 or to individuals may be reported in the aggregate, as prescribed by HHS.

g. Recipients must account for each Recovery Act award and sub-award (sub-grant and sub-contract) separately. Recipients will draw down Recovery Act funds on an award-specific basis. Pooling of Recovery Act award funds with other funds for drawdown or other purposes is not permitted.

h. Recipients must account for each Recovery Act award separately by referencing the assigned CFDA number for each award.

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

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

Recipients may not use any funds obligated under this award for the construction, alteration, maintenance, or repair of a public building or public work unless all of the iron, steel, and manufactured goods used in the project are produced in the United States unless HHS waives the application of this provision. (Recovery Act Sec. 1605)

5. Wage Rate Requirements

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

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

6. Preference for Quick Start Activities (Recovery Act)

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

7. Limit on Funds (Recovery Act)

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

8. Disclosure of Fraud or Misconduct

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

9. Recovery Act: One-Time Funding

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

10. Schedule of Expenditures of Federal Awards

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

11. Responsibilities for Informing Sub-recipients

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

12. Reporting Jobs Creation

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

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

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

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

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

VII. Agency Contacts

CDC encourages inquiries concerning this announcement.

For general questions, contact:

Technical Information Management Section
Department of Health and Human Services
CDC Procurement and Grants Office
2920 Brandywine Road, MS E-14
Atlanta, GA 30341
Telephone: 770-488-2700

For programmatic assistance:

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

If you need further assistance, contact:

Adrienne S. Brown, Public Health Analyst
Division of Adult and Community Health
National Center for Chronic Disease Prevention and Health Promotion
Centers for Disease Control and Prevention

3005 Chamblee-Tucker Road, Mailstop K-45

Atlanta, GA 30341

E-mail: CPPW@cdc.gov

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

Tracey Sims

Procurement and Grants Office

Centers for Disease Control and Prevention

2920 Brandywine Road, MS E-09

Atlanta, GA 30341

E- mail: atu9@cdc.gov

Phone Number: 770-488-2739

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

VIII. Recovery Act Lobbying Restrictions

This funding announcement is subject to restrictions on oral conversations during the period of time commencing with the submission of a formal application[*] by an individual or entity and ending with the award of the competitive funds. Federal officials may not participate in oral communications initiated by any person or entity concerning a pending application for a Recovery Act competitive grant or other competitive form of Federal financial assistance,

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

whether or not the initiating party is a federally registered lobbyist. This restriction applies unless:

(i) the communication is purely logistical;

(ii) the communication is made at a widely attended gathering;

(iii) the communication is to or from a Federal agency official and another Federal Government employee;

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

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

For additional information see http://www.whitehouse.gov/omb/assets/memoranda_fy2009/m09-24.pdf .

VIII. Other Information

Other CDC funding opportunity announcements can be found on the CDC Web site, Internet address: http://www.cdc.gov/od/pgo/funding/FOAs.htm.

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

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

1. Organizational/Institutional Registration in the eRA Commons

- To find out if an organization is already eRA Commons-registered, see the "List of Grantee Organizations Registered in eRA Commons."
- Direct questions regarding the eRA Commons registration to:

  eRA Commons Help Desk

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

  TTY: 301-451-5939

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

  Email commons@od.nih.gov

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

- The individual designated as the PD/PI on the application must also be registered in the eRA Commons. It is not necessary for PDs/PIs to register with Grants.gov.
- The PD/PI must hold a PD/PI account in the eRA Commons and must be affiliated with the applicant organization. This account cannot have any other role attached to it other than the PD/PI.
- This registration/affiliation must be done by the Authorized Organization Representative/Signing Official (AOR/SO) or their designee who is already registered in the eRA Commons.

- Both the PD/PI and AOR/SO need separate accounts in the eRA Commons since both hold different roles for authorization and to view the application process.

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

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

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

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

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

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

US Department of Transportation

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

US Department of Agriculture

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

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

US Department of Interior

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

US Department of Education

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

Environmental Protection Agency

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

US Department of Housing and Urban Development

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

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

US Federal Emergency Management Administration

- Emergency Food and Shelter Program

US Department of Health and Human Services

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

Attachment C: MAPPS Interventions for Communities Putting Prevention to Work

Five evidence-based MAPPS strategies, when combined, can have a profound influence on improving health behaviors by changing community environments: Media, Access, Point of decision information, Price, and Social support/services. Communities will take evidence-based action in each of these areas, choosing from the actions listed in the table. Each community will address all 5 strategies for each risk factor area. These actions will change policy and environment in schools and communities, including in worksites and businesses, health care settings, faith-based communities, and other places where people live, work and play.

	Tobacco	Nutrition	Physical Activity
Media	• Media and advertising restrictions consistent with federal law (k) • Hard hitting counter-advertising (l-n) • Ban brand-name sponsorships (o) • Ban branded promotional items and prizes (p)	• Media and advertising restrictions consistent with federal law (38-44) • Promote healthy food/drink choices (42, 43, 45) • Counter-advertising for unhealthy choices (46)	• Promote increased physical activity (i, ii, vi, ix, xxix-xxx) • Promote use of public transit (i, ii, vi, ix, xxix-xxx) • Promote active transportation (bicycling and walking for commuting and leisure activities) (i, ii, vi, ix, xxix-xxx) • Counter-advertising for screen time (i, ii, vi, ix, xxix-xxx)
Access	• Usage bans (i.e. 100% smoke-free policies or 100% tobacco-free policies) (f, g, v) • Usage bans (tobacco-free school campuses) (e-g, h-j) • Zoning restrictions (e-g) • Restrict sales (e.g. internet; sales to minors; stores/events w/o tobacco) (e-g) • Ban self-service displays & vending (e-g)	• Healthy food/drink availability (e.g., incentives to food retailers to locate/offer healthier choices in underserved areas, healthier choices in child care, schools, worksites) (7-9, 10-21, 63-68, 76-82) • Limit unhealthy food/drink availability (whole milk, sugar sweetened beverages, high-fat snacks) (17, 22-25, 69-73) • Reduce density of fast food establishments (15, 26) • Eliminate transfat through purchasing actions, labeling initiatives, restaurant standards (29-31) • Reduce sodium through purchasing actions, labeling initiatives, restaurant standards (32-34) • Procurement policies and	• Safe, attractive accessible places for activity (i.e., access to outdoor recreation facilities, enhance bicycling and walking infrastructure, place schools within residential areas, increase access to and coverage area of public transportation, mixed use development, reduce community design that lends to increased injuries) (xxxix – xli) • City planning, zoning and transportation (e.g., planning to include the provision of sidewalks, parks, mixed use, parks with adequate crime prevention measures, and Health Impact Assessments) (ii,iii,iv,v,viii,ix) • Require daily quality PE in schools (xvi – xxiii) • Require daily physical

		practices (8, 9, 13, 14, 35, 36) • Farm to institution, including schools, worksites, hospitals, and other community institutions (35, 36, 37)	activity in afterschool/childcare settings (i, ii, iii, v, viii, ix, xxiv-xxvii) • Restrict screen time (afterschool, daycare) (x, xi, xii, xiii, xiv)
Point of Purchase/ Promotion	• Restrict point of purchase advertising (q) • Product placement (q)	• Signage for healthy vs. less healthy items (8, 9, 47, 48, 74-75) • Product placement & attractiveness (8, 9, 47, 48, 49, 74-75) • Menu labeling (50-53)	• Signage for neighborhood destinations in walkable/mixed-use areas (library, park, shops, etc) (ii, iii, iv, ix, xlxiii) • Signage for public transportation, bike lanes/boulevards (ii, iii, iv, ix, xlxii, xlxiii)
Price	• Use evidence-based pricing strategies to discourage tobacco use (a-c) • Ban free samples and price discounts (d)	• Changing relative prices of healthy vs. unhealthy items (e.g. through bulk purchase/procurement/ competitive pricing) (5-9, 60-62)	• Reduced price for park/facility use (xxxvi – xxxviii) • Incentives for active transit (xxxvii, xxxviii) • Subsidized memberships to recreational facilities (ii, iii, viii,ix)
Social Support & Services	• Quitline and other cessation services (r-t)	• Support breastfeeding through policy change and maternity care practices (54-59)	• Safe routes to school (vii, xv, xxxi-xxxv) • Workplace, faith, park, neighborhood activity groups (e.g., walking hiking, biking) (ii, iii, viii, ix)

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