



Centers for Disease Control and Prevention

National Center for Chronic Disease Prevention and Health Promotion

Organized Approaches to Increase Colorectal Cancer Screening ***AMENDMENT TO FAQs- Changes to
Question and Answer 14***

CDC-RFA-DP15-1502

Application Due Date: 04/14/2015

Organized Approaches to Increase Colorectal Cancer Screening ***AMENDMENT TO FAQs- Changes to
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TABLE OF CONTENTS

[Part I. Overview Information](#)

- A. Federal Agency Name
- B. Funding Opportunity Title
- C. Announcement Type
- D. Agency Funding Opportunity Number
- E. Catalog of Federal Domestic Assistance (CFDA) Number
- F. Dates
- G. Executive Summary

[Part II. Full Text](#)

- A. [Funding Opportunity Description](#)
- B. [Award Information](#)
- C. [Eligibility Information](#)
- D. [Required Registrations](#)
- E. [Review and Selection Process](#)
- F. [Award Administration Information](#)
- G. [Agency Contacts](#)
- H. [Other Information](#)
- I. [Glossary](#)

Part I. Overview Information

Applicants must go to the synopsis page of this announcement at www.grants.gov and click on the "Send Me Change Notifications Emails" link to ensure they receive notifications of any changes to CDC-RFA-DP15-1502. Applicants also must provide an e-mail address to www.grants.gov to receive notifications of changes.

A. Federal Agency Name:

Centers for Disease Control and Prevention (CDC)

B. Funding Opportunity Title:

Organized Approaches to Increase Colorectal Cancer Screening ***AMENDMENT TO FAQs- Changes to Question and Answer 14***

C. Announcement Type: New - Type 1

This announcement is only for non-research domestic activities supported by CDC. If research is proposed, the application will not be considered Research for this purpose is defined at <http://www.cdc.gov/od/science/integrity/docs/cdc-policy-distinguishing-public-health-research-nonresearch.pdf>.

D. Agency Funding Opportunity Number:

CDC-RFA-DP15-1502

E. Catalog of Federal Domestic Assistance (CFDA) Number:

93.800

F. Dates:

- | | |
|---|--|
| 1. Due Date for Letter of Intent (LOI): | 03/06/2015 |
| 2. Due Date for Applications: | 04/14/2015 , 11:59 p.m. U.S. Eastern Standard Time, at www.grants.gov . |
| 3. Date for Informational Conference Call: | 03/03/2015 |

Informational Conference Calls for Potential Applicants: CDC will conduct two (2) informational conference calls for interested applicants on **March 3, 2015** at **11:00 AM and 3:00 PM U.S. Eastern Standard Time**. The calls will last no longer than an hour and a half.

Conference call lines are limited, so we encourage those who can to call in from one location.

Call-in information:

Toll Number: 1-517-968-2548

Toll-free Number: 1-866-510-1407

Participant Passcode: 80681704

G. Executive Summary:

1. Summary Paragraph:

This five-year funding opportunity offers support to implement DP15-1502, Organized Approaches to Increase Colorectal Cancer Screening for a five-year period. The program's purpose is to increase colorectal cancer (CRC) screening rates among an applicant-defined target population of persons 50-75 years of age within a partner health system, defined geographical areas, or disparate populations. This program has two components: 1) implement evidence-based interventions (EBIs) and other strategies in partnership with health systems to institute organized screening programs and 2) provide direct screening and follow-up services for a limited number of individuals aged 50-64 in the Program's Priority Population (PPP) who are asymptomatic, at average risk for CRC, have inadequate or no health insurance for CRC screening, and are

low-income.

Component 1: Health Systems Change to Increase and Improve Colorectal Cancer Screening

(Required). To increase capacity and support organized CRC screening, awardees must partner with health systems, such as federally qualified health centers (FQHCs), academic health care systems, health plan clinic networks, Medicaid, Medicare, and insurance plans that serve the applicant-defined target population to: a) implement EBIs (e.g., reminder systems) identified in The Community Guide to increase CRC screening and b) measure outcomes for evaluation. Supporting strategies such as small media, patient navigation, clinical-community linkages, and health information technology are secondary. The applicant-defined target population should have CRC screening rates lower than the state or national overall screening rates.

Component 2: CRC Screening Delivery to Improve Access to the Underserved (Optional):

Awardees must use an active, existing organized screening provision program to provide CRC screening and diagnostic follow-up services for the Program's Priority Population. CDC funding may only be used to pay for services for individuals with inadequate or no health insurance. Only funded Component 1 applications will be considered for Component 2 funding.

a. Eligible Applicants:	Limited
b. FOA Type:	Cooperative Agreement
c. Approximate Number of Awards:	35
Approximately thirty (30) Component 1 awards will be made.	
Approximately five (5) Component 2 awards will be made.	
d. Total Project Period Funding:	\$114,000,000
e. Average One Year Award Amount:	\$0
The approximate average award for Component 1 will be \$500,000 per budget period.	
The approximate average award for Component 2 will be \$750,000 per budget period.	
f. Number of Years of Award:	5
g. Estimated Award Date:	06/30/2015
h. Cost Sharing and / or Matching Requirements:	N

Cost sharing or matching funds are not required for this program. Although no statutory matching requirement for this FOA exists, leveraging other resources and related ongoing efforts to promote sustainability is strongly encouraged.

Part II. Full Text

A. Funding Opportunity Description

1. Background

a. Overview

Colorectal cancer (CRC) is the second leading cause of death from cancer in the United States. There is substantial evidence that screening for CRC reduces incidence of and death from the disease. Screening for CRC can both detect disease early when treatment is more effective and prevent cancer by finding and removing precancerous polyps. Of individuals diagnosed with early stage CRC, more than 90% live five or more years.

The U.S. Preventive Services Task Force recommends screening average risk adults aged 50-75 years for colorectal cancer with either: 1) fecal occult blood test (FOBT) or fecal immunochemical test (FIT) annually,

2) colonoscopy every 10 years, or 3) flexible sigmoidoscopy every 5 years with FOBT or FIT every 3 years. Despite strong evidence to support CRC screening, currently, only 65% of adults report being up-to-date with CRC screening, with more than 22 million age eligible adults estimated to be untested. Individuals who don't live in a city, Hispanics, adults aged 50-64, men, American Indians/Alaska Natives, and people with lower education and income are less likely to be screened. Lower rates of screening directly contribute to disparities in CRC morbidity and mortality. To reduce CRC morbidity, mortality, and associated costs, use of CRC screening tests must be increased among age-eligible adults with the lowest CRC screening rates.

Traditionally, lack of insurance has been a key barrier to cancer screening for adults. Implementation of the Affordable Care Act provides opportunities to increase participation in CRC screening and instituting the National Prevention Strategy framework can ensure that screening is more widespread and equitable. However, many people who currently have health insurance and regular access to medical care are not screened. Barriers, such as lack of knowledge, not receiving a provider's recommendation to be screened, and, transportation can hinder participation in screening.

To reach ambitious national CRC screening goals proposed by Healthy People 2020, the National Prevention Strategy, and other initiatives such as "80% by 2018," systematic approaches are needed. The Guide to Community Preventive Services (*The Community Guide*) has identified effective evidence-based interventions (EBIs) that address many barriers to CRC screening. These interventions include patient and provider reminder systems, reducing structural barriers, and provider assessment and feedback. Other promising strategies include patient navigation to assist people with completing the screening process. Public health can play an important role in increasing CRC screening rates by partnering with health systems to implement these interventions to maximize impact.

Further increases in CRC screening rates could also be achieved with more organized approaches to screening. Currently, individuals who visit a provider regularly are more likely to be screened, as screening is often offered during visits to the provider for other reasons; this is opportunistic screening. In contrast, organized screening is an explicit policy with defined age categories, method, and interval for screening in a defined target population with a defined implementation and quality assurance structure, and tracking of cancer in the population. Organized screening programs have the potential to systematically reach an entire population eligible and due for CRC screening.

To address barriers to CRC screening, this program will support public health and health systems partnerships to implement EBIs recommended by *The Community Guide* and additional strategies to increase and improve the quality of CRC screening and to support the adoption of organized screening systems. Using combinations of these rigorously tested, cost-effective, and scalable EBIs along with reliable sources of data to target populations and health systems with the greatest need, this FOA's comprehensive approach is intended to increase high-quality CRC screening. The proposed strategies and activities should complement not supplant private or public insurance.

b. Statutory Authorities

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

c. Healthy People 2020

Activities in the proposed FOA are directly related to the Healthy People 2020 Cancer (HP-C) Focus Area: a) Reduce the age-adjusted annual rate of cancer mortality per 100,000 population; b) Reduce the colorectal cancer death rate (HP-C5); c) Increase the proportion of adults who receive a colorectal cancer screening based on current guidelines (HP-C16); and d) Increase the proportion of adults who were counseled by their providers about colorectal cancer screening (HP-C18.3).

d. Other National Public Health Priorities and Strategies

This program supports strategies to increase and improve the quality of colorectal cancer screening, community-clinical linkages, and preventive services in the following national plans and guidelines:

The Guide to Community Preventive Services: <http://www.thecommunityguide.org>

The National Partnership for Action to End Health Disparities: <http://minorityhealth.hhs.gov/npa/>

The National Prevention Strategy: <http://www.healthcare.gov/prevention/nphpphc/strategy/report.pdf>

The National Quality Strategy: <http://www.ahrq.gov/workingforquality/>

e. Relevant Work

National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP) Domains This FOA primarily relates to two (bolded below) of the four NCCDPHP domains of action to transform the nation's health and support Americans to take charge of their own health: 1) epidemiology and surveillance, 2) environmental approaches that promote health and support and reinforce healthful behaviors, **3) health system interventions to improve the effective delivery and use of clinical and other preventive services, and 4) strategies to improve community-clinical linkages.**

The Colorectal Cancer Control Program (CRCCP): In 2009 CDC began implementing the CRCCP across 29 grantees. The program's primary goal is to increase CRC screening rates in the funded states and tribes. Grantees focused on using evidence-based strategies from The Guide to Community Preventive Services (*The Community Guide*) to increase population-level CRC screening. Grantees also used a portion of their funding to provide direct screening services to average risk, low-income, uninsured, and underinsured individuals.

80% by 2018 Initiative: A significant new effort to support increasing CRC screening is the 80% by 2018 Initiative started by the National Colorectal Cancer Round Table in partnership with CDC. The initiative leverages resources across a wide variety of organizations and agencies to increase the proportion of the population screened for CRC, with the goal of reaching an 80% screening rate by 2018: <http://nc crt.org/about/80-percent-by-2018/>.

2. CDC Project Description

a. Approach

The two CRCCP logic models illustrate how the two components of the FOA will accomplish outcomes.

CDC-RFA DP15-1502 Logic Model – Component 1			
Grantee Strategies and Activities	Short-Term Outcomes	Intermediate Outcomes	Long-Term Outcomes
Partnerships and Program Coordination - Establish formal agreements (e.g., MOUs or contracts with health systems, CBOs) - Collaborate with chronic disease programs to increase CRC cancer screening Priority Evidence-based Strategies Implement: - Patient reminder systems* - Provider reminder systems* - Provider assessment and feedback systems* - Reduce structural barriers* Supportive Activities Implement: - Small media* - Patient navigation Community-Clinical Linkages - Conduct targeted outreach to priority populations - Utilize community-based health workers (CHWs) - Implement workplace interventions - Facilitate linkage to medical home Professional Development Training - Promote USPSTF guidelines for CRC screening - Promote USMSTF surveillance guidelines - Promote EBIs and QA/QI practices Information Technology - Support utilization of EMRs to implement EBIs and performance monitoring (e.g., GPRA, UDS, HEDIS) Program Monitoring and Evaluation, including assessing changes in screening rates for a defined population	Established partnerships that support increased CRC screening* Multiple EBIs implemented within health systems, insurers, others* Access to CRC screening for priority populations* Appropriate provider recommendations for patients to receive CRC screening* Knowledge about the need for CRC screening among priority populations* Reduced barriers to CRC screening* Adherence to USPSTF and USMSTF CRC screening guidelines* Provider knowledge of CRC screening quality standards* Measurement and use of health system data* Increased high quality screening among defined patient populations* Increased adherence to timely, diagnostic colonoscopy* Increased rescreening among defined patient populations*	Population level 80% CRC screening by 2018 Increased CRC prevention via polypectomy Decreased disparities in CRC screening Increased detection of early-stage CRC Increased timely CRC treatment initiation	Decreased disparities in CRC incidence and mortality Decreased CRC incidence and mortality

* Strategies recommended by *Guide to Community Preventive Services for increasing colorectal cancer screening* by FOBT (<http://www.thecommunityguide.org/cancer/index.html>)

CDC-RFA DP15-1502 Logic Model – Component 2			
Grantee Strategies and Activities	Short-Term Outcomes	Intermediate Outcomes	Long-Term Outcomes
Program Management • Convene medical advisor(s) • Establish/maintain contract(s) with providers • Maintain data management and billing systems CRC Screening, Diagnostics, Patient Navigation, and other Support Services • Integrate screening with other clinical services • Provide quality, appropriate screening and surveillance to average risk populations • Provide timely follow-up of abnormal screens • Implement patient navigation • Facilitate access to diagnostic services and cancer treatment Data Management and Utilization for Recruitment and Quality Assurance/Quality Improvement • Identification of priority populations • In-reach to patients in existing health care systems • Clinical data collection and tracking • Monitoring and Evaluation	Increased high quality screening among CRCCP clients* Increased adherence to timely, diagnostic colonoscopy* Increased rescreening among CRCCP clients*	Increased CRC prevention via polypectomy Decreased disparities in CRC screening Increased detection of early-stage CRC Increased timely CRC treatment initiation	Population level 80% CRC screening by 2018 Decreased disparities in CRC incidence and mortality Decreased CRC incidence and mortality
*Project period outcomes expected to be measured and achieved among CRCCP clients			

i. Purpose

To increase CRC screening and follow-up rates, awardee activities that may be funded include, but are not limited to: formally partnering with an FQHC to implement a provider-oriented intervention such as provider reminders, formally partnering with a state primary care association to create or modify FQHC operational models, or formally partnering with an insurer to implement client-oriented EBIs such as client reminders.

ii. Outcomes

Note: Only the five-year project period outcomes are listed below. Their accomplishment will contribute to achievement of the intermediate and long-term outcomes beyond the five-year project period.

Component 1 Outcomes

Short-term outcomes of this program are:

Outcome 1: Increased formal partnerships that support increased screening.

Outcome 2: Improved adoption of multiple evidence-based interventions within health care systems, insurers, and others.

Outcome 3: New organizational policies and systems change in partner health systems as well as community-clinical linkages that support improved access to CRC screening.

Outcome 4: Increased appropriate provider recommendations for patients to be screened for CRC.

Outcome 5: Increased knowledge about the need for CRC screening among priority populations.

Outcome 6: Reduced barriers to CRC screening.

Outcome 7: Increased provider adherence to USPSTF and USMSTF guidelines for CRC screening and surveillance.

Outcome 8: Increased provider knowledge of CRC screening quality standards.

Outcome 9: Improved measurement and use of health systems data.

Outcome 10: Increased rates of high-quality screening among defined patient population (e.g., annual fecal test rescreening rate, adequate test prep for colonoscopy).

Outcome 11: Increased adherence to timely diagnostic colonoscopy.

Outcome 12. Increased rescreening among defined patient populations.

Component 2 Outcomes

Short-term outcomes of this program are:

Outcome 1: Increased high-quality screening among defined patient population (i.e., fecal return rate, annual fecal test rescreening rate, and adequate test prep for colonoscopy).

Outcome 2: Increased adherence to timely, diagnostic colonoscopy.

Outcome 3. Increased rescreening among CRCCP clients.

iii. Strategies and Activities

Component 1

Applicants must propose activities for **Partnerships and Program Coordination** and **Priority Evidence-based Interventions**, respectively, as outlined in the logic model for Component 1:

1) Partnerships and Program Coordination

Health systems partners can include, but are not limited to: FQHCs, other publicly funded entities that provide primary care services, health care plans, health care networks, hospitals, non-profit organizations, primary care associations, insurers, regional medical associations, and professional organizations. Applicants are *required* to collaborate with a health systems partner to implement the applicant's proposed strategies and activities.

1. Identify health systems partners that serve the applicant-defined target population.
2. Strengthen existing or establish new formal strategic partnerships and collaborations with health systems partners that serve the applicant-defined target population to help facilitate implementation of EBIs to increase CRC screening and ensure quality screening. Secure a written agreement to work collaboratively to implement two or more priority EBI(s) ~~and one or more supporting strategies~~ described in the attached logic model.
3. Identify and describe a defined target population(s) based on data presenting need; populations with an age range of 50-75 years with CRC screening rates lower than the state or national overall screening rate or known screening rates for that population.
4. Assess the health system partners' organizational data, current infrastructure, processes, procedures, and other relevant data to inform the intervention plan (e.g., a patient reminder system exists but is not

used by all staff.) This assessment and the interventions selected should be done in partnership with health systems partner(s); the intent is to increase and improve CRC screening within the partners' health system.

5. Determine a final, accurate baseline for CRC screening within the defined target population if preliminary data are used in the application for funding).
6. Develop an implementation plan that includes evaluation measures and data sources.
7. Monitor and evaluate project progress.
8. Provide a plan to formally evaluate the process and outcomes of partnerships and partnership activities.

2) **Priority Evidence-based Interventions**

Applicants must propose at least two of the four Priority Evidence-Based Interventions described below to conduct collaboratively with partner health systems. In selecting and implementing EBIs to increase CRC screening, applicants should strive to develop a comprehensive strategy, which may include multiple interventions to address the needs of the applicant-defined target population. Applicants should choose EBIs that are well matched to the culture, needs, and capabilities target population(s). In setting priorities for EBIs to meet work plan objectives, recommendations, research-tested intervention program(s) (RTIPs) and other evidence provided in the *Community Guide* should be considered along with such local information as resource availability, administrative structures, and the cultural, economic, social, and regulatory environments of organizations and practitioners.

To conduct activities for the four Priority Evidence-Based Interventions, applicants will:

1. Determine a final, accurate baseline CRC screening rate within the selected applicant-defined target population if preliminary data are used in the application for funding
2. Implement two or more of the following four *Community Guide*-recommended interventions within partner health systems:
 - **Provider Assessment and Feedback** - Provider assessment and feedback interventions evaluate provider performance in delivering or offering screening to clients (assessment) and present providers with information about their performance in providing screening services (feedback).
 - **Provider Reminders** - Reminders inform health care providers it is time for a client's cancer screening test (called a "reminder") or that a client is overdue for screening (called a "recall").
 - **Client Reminders** - Client reminders are written (letter, postcard, e-mail) or telephone messages (including automated messages) advising people that they are due for screening. These interventions can be untailored to reach the overall target population or tailored with the intent to reach one specific person, based on characteristics unique to that person, related to the outcome of interest, and derived from an individual assessment.
 - **Reducing Structural Barriers** - Structural barriers are non-economic burdens or obstacles that make it difficult for people to access cancer screening (e.g., inconvenient clinic hours).
1. Pair small media, considered a secondary EBI for purposes of this FOA, with any of the four priority EBIs above. Small media may not be used as a stand-alone activity. Applicants should propose to use existing high-quality materials, such as Screen for Life and Make It Your Own (MIYO) tested CRC messages. If adequate small media do not exist for the applicant-defined target population, awardees must obtain CDC approval to develop new materials.
2. Patient navigation may be used to help clients overcome barriers and support adherence to screening, diagnostics, and initiation of cancer treatment.
3. Describe the rationale for selection of the proposed EBIs and describe any adaptations made to RTIPs.
4. Describe a comprehensive plan for how each selected EBI will be implemented, including how data will be used to evaluate intervention impact.
5. Conduct evaluation to measure progress toward meeting short-term, intermediate, and long-term outcomes.

3) **Community-Clinical Linkages**

1. Facilitate collaboration between health systems and community-based organizations that serve the target population (e.g., utilize Community Health Workers for targeted outreach to reach priority populations and provide education and support to link them to primary health care/medical home).
2. Facilitate a formal partnership with a worksite that employs members of the target population to influence adoption of a corporate policy that encourages CRC screening among employees by removing structural barriers that may prevent screening.
3. Implement a community-based program such as, but not limited to, a Flu-FIT/Flu-FOBT program.

4) Professional Development Training

1. Promote adherence to USPSTF guidelines for CRC screening.
2. Promote USMSTF surveillance guidelines.
3. Promote CRC screening quality assurance/quality improvement practices.

5) Health Information Technology

Awardees may consider assisting partner health systems and stakeholders to develop new or expanded tools and procedures that facilitate the regular and ongoing use of data, including state cancer registry data, health system electronic health record data, other relevant data to:

1. Collect and report relevant data (e.g., baseline and post-intervention CRC screening numbers).
2. Implement EBIs to ensure patients receive CRC screening.
3. Monitor quality (e.g., timeliness) and clinical outcomes.
4. Enhance current clinical decision support, electronic health record/information technology and financial management systems to identify, screen, and follow up on persons due for CRC screening.
5. Use data to routinely conduct quality improvement activities.
6. Provide ongoing feedback regarding progress toward meeting project goals.
7. Assist in adopting strategies to improve the exchange of electronic data across organizational and jurisdictional boundaries.
8. Address legal, ethical, and security and confidentiality issues related to data sharing (only de-identified data will be shared with CDC).

6) Program Monitoring and Evaluation

Program monitoring and evaluation allows the awardee and CDC to track progress and measure outcomes of awardees' efforts. Awardees must:

1. Propose work plan objectives and activities that clearly relate to the relevant short and intermediate-term outcomes specified in the logic model.
2. Conduct process evaluation to monitor implementation of all program activities. Monitoring implementation can serve as an early detection system to identify implementation problems allowing for mid-course corrections.
3. Demonstrate achievement of work plan outcomes noted in the logic model as short-term outcomes (e.g., increased high quality screening among defined patient populations, increased adherence to timely, diagnostic colonoscopy, increased re-screening among defined patient populations).
4. Provide baseline data for these outcomes prior to implementation of activities specified in the work plan followed by annual reporting of data for these outcomes.

Organized Approaches to Colorectal Cancer Screening Required and Supporting Logic Model Strategies	
REQUIRED Strategies Applicants MUST:	SUPPORTING Strategies Applicants Can Also CHOOSE to:

1.	Partner with at least one health system to select an appropriate intervention and describe preliminary data	1.	Conduct the Secondary Evidence-based Intervention, small media (not a standalone intervention)
2.	Conduct at least two or more Priority Evidence-based Interventions • Patient reminder systems • Provider reminder systems • Provider feedback and assessment • Reducing structural barriers	2.	Facilitate Professional Development Training
		3.	Patient Navigation
		4.	Enhance Community-Clinical Linkages
		5.	Utilize Health Informatics s

Component 2: CRC Screening Delivery (Optional)

Applicants must propose activities from the following strategies as outlined in the Logic Model for Component 2:

1) Program Management

1. Convene medical advisor(s). Convene a medical advisory board (MAB) to provide oversight of the quality of screening services delivered throughout the five year funding period. MAB membership should reflect relevant expertise to CRC screening (e.g., primary care physicians, endoscopists, oncologists, pathologists, radiologists, nurses, patient navigators).
2. Establish any necessary contract(s), grants, or memoranda of agreements with program partners (e.g., health care providers) in a timely manner to assure service delivery. Ensure non-CDC resources (e.g., private funds or other public funding) are in place to support treatment for persons diagnosed with cancer through the program and those experiencing medical complications from screening and diagnostic procedures.
3. Maintain data management and billing systems to track costs and ensure proper billing and payment for services delivered.

2) CRC Screening, Diagnostics, Patient Navigation, and other Support Services

1. Provide CRC screening and diagnostic follow-up services for the program priority population. The Program Priority Population is defined as persons ages 50-64, asymptomatic and at average risk for CRC, with inadequate or no health insurance for CRC screening, and are low-income, at or below 250% of the FPG. Awardees may define a demographic sub-population(s) of the program priority population for emphasized screening efforts. Awardees must assure appropriate medical referral for clinically ineligible patients.
2. Collaborate with health systems that serve the priority population to assure that patients are currently enrolled with a primary care provider prior to receiving services through this program.
3. Select CRC screening tests with two important caveats: 1) awardees can only offer screening tests for which test availability has been assessed (e.g., there is adequate endoscopic capacity and workforce to implement a large-scale intervention to increase colonoscopy), and capacity and effectiveness has been demonstrated; and 2) awardees can only offer screening tests recommended by the U.S. Preventive Services Task Force (<http://www.ahrq.gov/clinic/uspstf08/colocancer/colors.htm>) and approved by CDC for reimbursement.
4. Establish and document a process to assess each participant's eligibility, including determining if the participant has other forms of insurance to pay for CRC screening.
5. Establish realistic, annual screening projections for the five-year program period taking into consideration the size of the eligible population and previous experience providing CRC screening services.

6. Ensure patients scheduled for endoscopy (e.g., colonoscopy, flexible sigmoidoscopy) are clinically evaluated prior to the procedure.
7. Utilize a patient tracking and reminder system to support screening adherence, the provision of appropriate and timely follow-up of all abnormal screening results, and rescreening.
8. Establish patient support or patient navigation services to assist patients through the screening and diagnostic testing process and facilitate access to medical care for persons identified with cancer. Develop a plan and identify resources (e.g., financial, in-kind) to provide treatment for patients who incur an unanticipated medical complication from services provided by the program or are diagnosed with cancer through the program. CDC funds cannot be used for the treatment of complications resulting from screening or for diagnosed cancer.
9. Integrate screening and diagnostic follow-up services, when and where appropriate, with existing CRC screening programs, the National Breast and Cervical Cancer Early Detection Program, other appropriate chronic disease programs that deliver clinical preventive services, and with health systems partners to improve the effectiveness and efficiency of public health programs and services.
10. Deliver screening services within 60 days of award, upon approval by CDC.

3) Data Management and Utilization for Recruitment and Quality Assurance/Quality Improvement

1. Use or adapt a pre-existing data collection system to collect and report patient-level clinical data to CDC. These data will include information on patient demographics, screening and diagnostic services provided, and clinical outcomes related to this program. Awardees will be required to submit these clinical data to CDC semi-annually. A standardized clinical data set developed by CDC will be used to monitor program quality and progress. The list of current data elements can be found at http://www.cdc.gov/cancer/colorectal/pdf/CCDE_Data_DefinitiontableOMB_T.pdf.
2. Use clinical data to support on-going monitoring of the quality, timeliness, and appropriateness of services provided by the program and adhere to current standards related to data-sharing, data security, and patient confidentiality. All data submitted to CDC must be de-identified. Awardees are required to submit these data on all persons who are screened through this program supported by CDC funds.
3. Demonstrate achievement of work plan outcomes noted in the logic model as short-term outcomes (e.g., high quality screening among defined patient population, adherence to timely diagnostic colonoscopy, re-screening among defined patient funded externally to populations).
4. In collaboration with the state or territorial central cancer registry, collect and report information regarding the first course of treatment for any persons diagnosed with colorectal cancer (i.e., treatment above and beyond polypectomy performed during colonoscopy such as chemotherapy).
5. Use standards, systems, policies, and procedures to maintain high-quality services, including tracking and follow-up systems to assure appropriate and timely follow-up of all abnormal screening results and diagnoses of cancer.

1.Collaborations

Collaborations with CDC-funded programs and other organizations external to CDC are strongly encouraged but are not required. If the applicant plans to collaborate with any CDC-funded program or other organizations external to CDC, applicants are strongly encouraged to provide an MOA/MOU or letter of intent (LOI) describing the proposed collaboration. Applicants should describe how they will collaborate with CDC-funded programs as well as programs CDC to implement the program strategies outlined in this FOA, if applicable. These types of collaborations allow for more efficient use of existing resources. Awardees may establish, build, and/or maintain collaborative relationships that will support the implementation of the proposed program. Name the file "Collaborations" and upload it as a PDF at www.grants.gov.

a. With CDC-funded programs:

Component 1 and Component 2: Awardees are encouraged to collaborate with CDC-funded programs if any are currently funded in the applicant's state, county, city, Tribe, or territory to enhance cancer prevention and control efforts and support the delivery of clinical preventive services. State- and local-level CDC-funded chronic disease programs may include the National Breast and Cervical Cancer Early Detection Program, National Comprehensive Cancer Control Program, National Program of Cancer Registries, Heart Disease and Stroke Prevention Program, Diabetes Program, and WISEWOMAN Program.

b. With organizations external to CDC:

Component 1 and Component 2: Applicants are encouraged to establish or strengthen existing partnerships and to maintain strategic partnerships and collaborations with organizations that have a role in helping to achieve the FOA outcomes and proposed activities. Applicants should consider strategic partnerships with the following types of organizations: Federal agencies (e.g., Health Resources Services Administration, specifically, FQHCs; Centers for Medicaid and Medicare Services, CMS; Indian Health Service, IHS; American Indian/Alaska Native tribal governments and/or tribally designated organizations; primary care associations; professional organizations; businesses; not-for-profit organizations, such as the American Cancer Society; the National Association of Community Health Centers; community-based organizations; for-profit organizations; community health centers; clinics and hospitals; non-governmental organizations; State and local governments; community advocates, community members; and other stakeholders that may have a vested interest in increasing colorectal cancer screening.

2. Target Populations

As described in the Overview, only 65% of adults report being up-to-date with CRC screening, with more than 22 million age eligible adults estimated to be untested. Moreover, considerable and persistent gaps between the healthiest people and the least healthy continue to exist. With its focus on gathering data on disparities and the application of EBIs to achieve health equity, this program can help to eliminate health disparities within targeted populations. Applicants are expected to target disparate populations known to have lower screening rates (e.g., individuals with low income, persons who do not live in a city, Hispanics).

Component 1:

Applicants have the flexibility to define their target population (applicant-defined target population). However, applicant-defined target populations should be within the age range of 50-75 years and special effort should be taken to focus on populations that are asymptomatic, low-income, uninsured, underinsured, racial and ethnic groups disproportionately affected, and/or geographically challenged. Applicants should use the most relevant, accurate data available to identify and address target populations that are disproportionately affected by CRC and have low screening rates. In addition to identifying populations at greatest risk, applicants should also strive to achieve the greatest health impact. For example, given the opportunity to target two similar disproportionately affected target populations with 1,000 and 10,000 eligible individuals, respectively, strong consideration should be given to focus on the larger population where the potential to reduce health disparities is greater.

Component 2:

The Program Priority Population for CRC screening delivery is persons aged 50-64, asymptomatic and at average risk for CRC, with inadequate or no health insurance for CRC screening, and who are low-income, at or below 250% of the FPG. Awardees may define a demographic sub-population(s) of the program priority population for emphasized screening efforts.

a. Inclusion

N/A

iv. Funding Strategy (for multi-component FOAs only)

Funding for Component 1 annual awards will range from \$350,000 to \$800,000.

Funding for Component 2 annual awards will range from \$500,000 to \$1,000,000.

Only Component 1 awardees are eligible to receive Component 2 awards.

Component 1 applications will be funded in order by score and rank as determined by an objective review panel process.

Component 2 funding will be determined by the score and ranking from both the Component 1 and Component 2 objective review panels. Therefore, funding decisions may be made out of rank order for Component 2.

In addition, the following factors may affect funding decisions: geographic diversity, priority populations or strategies and activities not proposed by higher ranking applicants, proposals that maximize the population served or the impact of federal funding.

b. Evaluation and Performance Measurement

i. CDC Evaluation and Performance Measurement Strategy

Awardee evaluation and performance measurement will demonstrate achievement of the work plan outcomes and show effective implementation of the strategies within a partner health system. Evaluation findings will be used by awardees and CDC to ensure continuous program and system improvement and assess the extent to which the strategies impact screening and diagnostic services among the target and priority populations identified by the awardee.

The CDC strategy for monitoring and evaluating program and awardee performance will include several activities, spanning both process and outcome evaluation and will be consistent with the logic model and approach described previously. The CDC strategy will include monitoring and evaluation for the overall project as well as for individual awardees.

CDC will monitor intermediate outcomes noted in the logic model, including state-level CRC screening rates bi-annually using data from the Behavioral Risk Factor Surveillance Survey (BRFSS) and detection of early stage CRC using state-and national-level surveillance data from cancer registries.

CDC will monitor long-term outcomes noted in the logic model, including CRC incidence and mortality, using state- and national-level surveillance data.

CDC will provide guidance and technical assistance to awardees on required data collection and reporting, including measurement of required outcomes.

ii. Applicant Evaluation and Performance Measurement Plan

Component 1

Evaluation and performance measurement results will be used by awardees and CDC to ensure continuous program and system improvement and to assess the extent to which implemented strategies impact CRC screening, diagnostic, and rescreening services among applicant-defined target population(s) identified by awardees.

Component 2

Evaluation and performance measurement results will be used by awardees and CDC to ensure continuous program and system improvement and to assess the extent to which implemented strategies impact CRC

screening, diagnostic, and rescreening services among Program Priority Population(s) identified by awardees.

Awardee evaluation and performance measurement will demonstrate achievement of the work plan outcomes and show effective implementation of the strategies within a health system. An awardee evaluation and performance measurement plan will be comprised of two parts: monitoring program implementation and measurement of short-term outcomes.

1. **Monitoring program implementation** – Awardees will track progress in implementing program activities specified in work plans. Awardees may use process evaluation methods (e.g., ongoing performance monitoring) to track implementation efforts. For example, implementation of patient navigation could be monitored by tracking the number of patients navigated per navigator, the average of number of contacts between a navigator and a patient, and the percentage of navigated patients who complete screening. Similarly, implementation of a provider reminder system could be monitored by tracking the percentage of patients due for screening that actually receive a FOBT kit or colonoscopy referral. Process evaluation data should be used to document implementation efforts, including identification of implementation challenges and successes, and inform program improvement.
2. **Measurement of short-term outcomes** – Awardees will measure short-term outcomes specified in the logic models and related to increasing screening rates among defined populations, increased adherence to timely, diagnostic colonoscopy, and increased rescreening among defined patient populations within specified health system(s). Awardees must provide aggregate baseline data for these outcomes for *each* health system where implementation is planned followed by annual reporting of aggregate data for these outcomes for each health system.

Awardee Evaluation and Performance Measurement plans should:

- Describe how key health system partners or other partners will be engaged in the evaluation and performance measurement planning processes.
- Describe the type of evaluations planned (i.e., process or outcome).
- Describe key evaluation questions to be answered.
- Describe potentially available data sources.
- Describe how data will be analyzed and reported.
- Describe how an increase in CRC screening rates in the target population will be measured (include how the denominator, or target population, and numerator, or the number of the target population that has been screened, will be determined).
- Describe how data quality will be ensured.

Describe how evaluation findings will be used for continuous program and quality improvement.

Describe how evaluation and performance measurement will contribute to our understanding of the advantages and challenges of working collaboratively with health system partners to achieve stated outcomes.

c. Organizational Capacity of Awardees to Execute the Approach

Component 1 and Component 2

Applicants must describe their organizational capacity to carry out the strategies outlined in each of the components an applicant applies for. Applicants should address infrastructure, workforce capacity and competence, expertise and experience related to all program focus areas, and information and data systems to implement the award. Applicants must provide evidence of program management/staffing plans, performance measurement, evaluation, financial reporting, management of travel requirements, and workforce development and training.

Applicants should include a detailed description of their experience, with particular focus on any collaborative work with health systems partners; program management components; readiness to establish working agreements; and a plan for long-term sustainability of the project. If available, letters of commitment, MOAs, and MOUs with health partner system(s) should be included.

Flexibility will be allowed to enable applicants to implement FOA requirements based on their own organizational design and approach, unless otherwise required by statute.

Component 1

Applicants for Component 1 must also demonstrate capacity to implement relevant strategies and activities by providing a detailed description of:

- Established or newly built partnerships with health systems and other relevant organizations.
- Experience implementing or facilitating systems level change within health systems or other organizations.
- Proven ability to collect data at a population level and health systems level and use data to demonstrate impact.
- Experience implementing coordinated interventions across 2 or more categorical programs.
- Experience with planning and implementing programs at a systems level.
- Subject matter expertise to plan and implement strategies.
- Access to health systems data, including, for example, Medicaid data or health plan performance data.

Component 2

Applicants must demonstrate their existing and future capacity to successfully deliver colorectal screening and diagnostic services to meet the following program requirements:

1. Identify and maintain staff to manage the program. Applicants should submit an Organizational Chart showing the core staff and their assigned duties. As appropriate, integrate program management functions with existing CRC screening programs and/or other cancer screening or chronic disease programs. Core staff must include persons to:
 - Manage the program, no more than a 0.5 FTE paid with CDC funds
 - Fulfill data management functions, no more than a 0.5 FTE paid with CDC funds
 - Provide clinical consultation
 - Secure at least one medical advisor with relevant expertise to CRC screening to provide oversight of the quality of screening services delivered throughout the five-year funding period.
 - Establish any necessary contract(s), grants, or memoranda of agreements with program partners (e.g., health care providers) in a timely manner to assure service delivery.
 - Use a fiscal system that tracks and monitors program expenditures and ensures the accurate and timely reimbursement for services provided by the program.

d. Work Plan

The CRCCP logic models illustrate how the two components of the FOA will accomplish outcomes.

Applicants must provide a detailed work plan for the first year of the project period and a high level plan in narrative form for subsequent years in support of FOA outcomes. Activities must be in alignment with the proposed outcomes and the chosen program strategies and must include those activities the applicant selects as priority, based on the cited evidence, for the first year of the project. CDC will provide feedback and technical assistance to awardees to finalize the work plan post-award.

The work plan must, at a minimum, include:

- Activities directly related to implementation of evidence-based strategies to reach segments of the target and priority populations.
- A description of intended outcomes for the five-year project period.
- A description of strategies to be used in the first year of the project period.
- Objectives (including measures of effectiveness to assess progress and accomplishment)
- Activities for the first year of the project period.

- A description of how the applicant will monitor and report progress on the short-term performance measures and as many of the intermediate and long-term measures as feasible for the EBIs and/or strategies selected.
- Applicants should use the template provided to document their detailed work plan for Year 1 of the award and provide a general summary of work plan activities for Years 2-5 in narrative form.

Component 1

The Component 1 work plan must also include:

- A logic model or equivalent that graphically displays the specific conditions, inputs, strategies, outputs, and intended outcomes for the five-year period that have been selected from the Component 1 logic model in the Approach section of this FOA. The applicant's logic model should only include the strategies, interventions, and short-term, intermediate, and long-term outcomes the applicant proposes to implement and achieve during the five year-year period. The applicant should not propose additional activities and outcomes not included in the Component 1 logic model in the Approach section of this FOA.

Component 2

The Component 2 work plan must also include:

- Specific strategies, interventions, and short-term, intermediate, and long-term outcomes from the applicant's CRC Screening Delivery to Improve Access to the Underserved Logic Model.
- Activities directly related to implementation of strategies to the Program Priority Population. Include an estimate of the number of people in the priority population that will be screened for CRC through the program.
- A complete narrative description of the process proposed to identify, locate, screen, follow-up, and re-screen the Program Priority Population.

e. CDC Monitoring and Accountability Approach

Monitoring activities include routine and ongoing communication between CDC and awardees, site visits, and awardee reporting (including work plans, performance, and financial reporting). Consistent with applicable grants regulations and policies, CDC expects the following to be included in post-award monitoring for grants and cooperative agreements:

- Tracking awardee progress in achieving the desired outcomes.
- Ensuring the adequacy of awardee systems that underlie and generate data reports.
- Creating an environment that fosters integrity in program performance and results.

Monitoring may also include the following activities:

- Ensuring that work plans are feasible based on the budget and consistent with the intent of the award.
- Ensuring that awardees are performing at a sufficient level to achieve outcomes within stated timeframes.
- Working with awardees on adjusting the work plan based on achievement of outcomes, evaluation results and changing budgets.
- Monitoring performance measures (both programmatic and financial) to assure satisfactory performance levels.

Other activities deemed necessary to monitor the award, if applicable.

These activities may include monitoring and reporting activities that assist grants management staff (e.g., grants management officers and specialists, and project officers) in the identification, notification, and management of high-risk grantees.

All of the activities above may occur during the five-year project period.

f. CDC Program Support to Awardees (THIS SECTION APPLIES ONLY TO COOPERATIVE AGREEMENTS)

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

1. Collaborate to ensure coordination and implementation of strategies to increase and improve the quality of CRC screening.
2. Provide guidance and coordination to awardees to improve the quality and effectiveness of work plans, monitoring and evaluation plans, products and services, and collaborative activities with other organizations.
3. Collaborate to compile and publish accomplishments, performance criteria, and lessons learned during the project period.
4. Collaborate, as appropriate, in assessing progress toward meeting strategic and operational goals and objectives and in establishing measurement and accountability systems for documenting outcomes.
5. Convene an in-person or teleconference meeting of all new grantees at program initiation.
6. Provide priority population estimates for geographic units that are available. Estimates are currently available at the state level. Provide program policies and guidelines.
7. Interpret current scientific literature and national colorectal cancer screening guidelines.
8. Develop regular data monitoring feed-back reports based on clinical data submissions to support data use for quality assurance, program improvement, and program evaluation.
9. Support data linkage with the awardee's state, territorial, or tribal cancer registry data.
10. Conduct site visits as needed.
11. Participate in national-level colorectal cancer efforts and convey relevant public health practice recommendations and opportunities.
12. Disseminate information, including evaluation results, about awardees' program efforts to the public and public health audiences. When appropriate, evaluation findings will be described for individual awardees by name.

B. Award Information

1. Funding Instrument Type: Cooperative Agreement
CDC's substantial involvement in this program appears in the CDC Program Support to Awardees Section.

2. Award Mechanism:

3. Fiscal Year: 2015
Estimated Total Funding: \$22,800,000

4. Approximate Total Fiscal Year Funding: \$22,800,000

5. Approximate Project Period Funding: \$114,000,000

6. Total Project Period Length: 5 year(s)

7. Expected Number of Awards: 35

Approximately thirty (30) Component 1 awards will be made.

Approximately five (5) Component 2 awards will be made.

8. Approximate Average Award: \$0 Per Budget Period

The approximate average award for Component 1 will be \$500,000 per budget period.

The approximate average award for Component 2 will be \$750,000 per budget period.

9. Award Ceiling: \$1,800,000 Per Budget Period

The award ceiling for applicants funded for both Component 1 and Component 2 is \$1,800,000 per budget period.

10. Award Floor: \$350,000 Per Budget Period

11. Estimated Award Date: 06/30/2015

Throughout the project period, CDC will continue the award based on the availability of funds, the evidence of satisfactory progress by the awardee (as documented in required reports), and the determination that continued funding is in the best interest of the federal government. The total number of years for which federal support has been approved (project period) will be shown in the "Notice of Award." This information does not constitute a commitment by the federal government to fund the entire period. The total project period comprises the initial competitive segment and any subsequent non-competitive continuation award(s).

12. Budget Period Length: 12 month(s)

13. Direct Assistance

Direct Assistance (DA) is available through this FOA.

Consistent with the cited authority for this announcement, direct assistance may be available in the form of equipment, supplies and materials, and/or federal personnel. If DA is provided as a part of your award, CDC will reduce the financial assistance award amount provided directly to you as a part of your award. The amount by which your award is reduced will be used to provide DA; the funding shall be deemed part of the award and as having been paid to you, the awardee.

C. Eligibility Information

1. Eligible Applicants

Eligibility Category: State governments
Public and State controlled institutions of higher education
Native American tribal governments (Federally recognized)
Private institutions of higher education

Government Organizations:

State (includes the District of Columbia)
Territorial governments or their bona fide agents in the Commonwealth of Puerto Rico, the Virgin Islands, the Commonwealth of the Northern Mariana Islands, American Samoa, Guam, the Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau.
State controlled institutions of higher education
American Indian or Alaska Native tribal governments (federally recognized or state-recognized)

Non-government Organizations:

American Indian or Alaska native tribally designated organizations

Other:

Private colleges and universities

2. Additional Information on Eligibility

State health departments or their bona fide agents are also eligible.

Eligibility criteria are the same for Component 1 and Component 2.

The award ceiling for this FOA is \$1,800,000. CDC will consider any application requesting an award higher than this amount as non-responsive and it will receive no further review. If a pre-application is required, then specify here and include it in the special eligibility requirements section. (<http://www.hhs.gov/asfr/ogapa/aboutog/hhsgps107.pdf>)

3. Justification for Less than Maximum Competition

Component 1 and Component 2:

Eligibility for Component 1 and Component 2 is limited to state health departments or their bona fide agents, tribes, tribal organizations, territories, state-controlled institutions of higher learning, and private colleges and universities because these entities have critical experience and infrastructure necessary to most effectively and efficiently address and improve systems-level approaches to increase colorectal cancer screening within health systems, such as Federally Qualified Health Centers.

Colorectal cancer is a major cause of morbidity and mortality in the U.S. and more work is needed to decrease the number of new cancer cases and the number of cancer cases diagnosed at a late stage. State health agencies, tribes, tribal organizations, territories, state-controlled institutions of higher learning, and private colleges and universities are in a unique position to support implementation of cancer prevention strategies at the local and health systems level that may have a large impact on the burden of cancer by changing the context in which an individual makes health decisions. Partnering with health systems, as required in this FOA, requires extensive experience partnering with health systems, convening stakeholders, assessing epidemiologic data, and preparing and implementing formal plans to reduce the incidence and burden of CRC.

Working with funded state health agencies, tribes, tribal organizations, territories, state-controlled institutions of higher learning, and private colleges and universities, the CDC has also developed a national data system to ensure timely follow-up and treatment of patients with abnormal screening test results. Through the Integrating Colorectal Cancer Screening within Chronic Disease Programs (DP09-903 and DP14-1414), grantees have been required to fund clinical providers to collect and report state-based, standardized data to the Colorectal Cancer Control Data Elements registries. This CRC registry is the only system of its kind that collects information to monitor attainment of CRC screening quality. This highly-organized public health approach is necessary to maximize the program's impact and to advance colorectal cancer prevention and control efforts. Only state health departments or their bona fide agents, tribes, tribal organizations, territories, state-controlled institutions of higher learning, and private colleges and universities have the capacity to implement this kind of specialized reporting and registry maintenance.

Applicants qualified to perform the activities in this FOA should have extensive knowledge of public health and experience working closely with health systems, such as Federally Qualified Health Centers and Medicaid, to identify, plan, and implement evidence-based intervention to increase colorectal cancer screening, with a particular emphasis on populations that experience colorectal cancer disparities. State health departments, tribes, tribal governments, state-controlled institutions of higher learning, and private colleges and universities have received federal and state funding to undertake similar efforts through

funding opportunity announcements DP09-903 and DP1414, making them uniquely qualified to accomplish the tasks set out in this current FOA. Qualified applicants must also have experience planning and implementing cancer control and prevention initiatives, such as patient navigation programs, to enhance community-clinical linkages to increase colorectal cancer screening. Moreover, qualified applicants must have experience utilizing surveillance data on colorectal cancer screening (for their entire state, tribe, territory or jurisdiction, university healthcare system) to identify disparate populations and developing targeted outreach programs to engage the most difficult-to-reach.

Component 2:

In addition to the specialized experience described above, eligibility for Component 2 is limited to applicants that have demonstrable ability to provide CRC screening, diagnostic, and follow-up services to individuals within three months of funding as evidenced by an active, existing CRC screening program.

Based on past experience, grantees have needed up to three years to develop a fully functioning CRC screening program. Given limited funding for actual CRC screening, it is imperative that scarce resources be limited to entities with existing capacity to screen to ensure the largest number of uninsured, underinsured, and age-eligible individuals receive services.

This proposed project will assess nationwide capacity to enhance colorectal cancer screening activities by supporting the implementation and evaluation of EBIs and community-clinical linkage strategies to ultimately increase colorectal cancer screening.

No special documentation is needed to establish eligibility.

This FOA follows DP09-903 and DP14-1414, both of which limited eligibility to health departments and their bona fide agents, tribes, and tribal organizations. These FOAs specifically sought to enhance the colorectal cancer screening capacity of the limited eligibility entities described above. While this approach has proven to be a successful approach for identifying and setting specific program expectations in the midst of evolving environmental challenges and opportunities, this FOA expands eligibility to include state-controlled institutions of higher education as well as private colleges and universities.

4. Cost Sharing or Matching

Cost Sharing / Matching No
Requirement:

Cost sharing or matching funds are not required for this program. Although no statutory matching requirement for this FOA exists, leveraging other resources and related ongoing efforts to promote sustainability is strongly encouraged.

5. Maintenance of Effort

Maintenance of effort is not required for this program.

D. Required Registrations

Additional materials that may be helpful to applicants: <http://www.cdc.gov/od/pgo/funding/docs/FinancialReferenceGuide.pdf>.

1. Required Registrations

An organization must be registered at the three following locations before it can submit an application for funding at www.grants.gov.

a. Data Universal Numbering System: All applicant organizations must obtain a Data Universal Numbering System (DUNS) number. A DUNS number is a unique nine-digit identification number provided by Dun & Bradstreet (D&B). It will be used as the Universal Identifier when applying for

federal awards or cooperative agreements.

The applicant organization may request a DUNS number by telephone at 1-866-705-5711 (toll free) or Internet at [http:// fedgov.dnb.com/webform/displayHomePage.do](http://fedgov.dnb.com/webform/displayHomePage.do). The DUNS number will be provided at no charge. If funds are awarded to an applicant organization that includes sub-awardees, those sub-awardees must provide their DUNS numbers before accepting any funds.

b. System for Award Management (SAM): The SAM is the primary registrant database for the federal government and the repository into which an entity must submit information required to conduct business as an awardee. All applicant organizations must register with SAM, and will be assigned a SAM number. All information relevant to the SAM number must be current at all times during which the applicant has an application under consideration for funding by CDC. If an award is made, the SAM information must be maintained until a final financial report is submitted or the final payment is received, whichever is later. The SAM registration process usually requires not more than five business days, and registration must be renewed annually. Additional information about registration procedures may be found at www.SAM.gov.

c. Grants.gov: The first step in submitting an application online is registering your organization through www.grants.gov, the official HHS E-grant website. Registration information is located at the "Get Registered" option at www.grants.gov.

All applicant organizations must register with www.grants.gov. The one-time registration process usually takes not more than five days to complete. Applicants must start the registration process as early as possible.

2. Request Application Package

Applicants may access the application package at www.grants.gov.

3. Application Package

Applicants must download the SF-424, Application for Federal Assistance, package associated with this funding opportunity at www.grants.gov. If Internet access is not available, or if the online forms cannot be accessed, applicants may call the CDC PGO staff at 770-488-2700 or e-mail PGO PGOTIM@cdc.gov for assistance. Persons with hearing loss may access CDC telecommunications at TTY 1-888-232-6348.

4. Submission Dates and Times

If the application is not submitted by the deadline published in the FOA, it will not be processed. PGO personnel will notify the applicant that their application did not meet the deadline. The applicant must receive pre-approval to submit a paper application (see Other Submission Requirements section for additional details). If the applicant is authorized to submit a paper application, it must be received by the deadline provided by PGO.

a. Letter of Intent Deadline (must be emailed or postmarked by)

Due Date for Letter of Intent: **03/06/2015**

b. Application Deadline

Due Date for Applications: **04/14/2015**, 11:59 p.m. U.S. Eastern Standard Time, at www.grants.gov. If Grants.gov is inoperable and cannot receive applications, and circumstances preclude advance notification of an extension, then applications must be submitted by the first business day on which grants.gov operations resume.

Date for Informational Conference Call: 03/03/2015

Informational Conference Calls for Potential Applicants: CDC will conduct two (2) informational conference calls for interested applicants on **March 3, 2015 at 11:00 AM and 3:00 PM U.S. Eastern Standard Time**. The calls will last no longer than an hour and a half.

Conference call lines are limited, so we encourage those who can to call in from one location.

Call-in information:

Toll Number: 1-517-968-2548

Toll-free Number: 1-866-510-1407

Participant Passcode: 80681704

5. CDC Assurances and Certifications

All applicants are required to sign and submit “Assurances and Certifications” documents indicated at <http://www.cdc.gov/grants/interestedinapplying/applicationprocess.html>.

- Complete the applicable assurances and certifications on an annual basis, name the file “Assurances and Certifications” and upload it as a PDF file at www.grants.gov
- Complete the applicable assurances and certifications and submit them directly to CDC on an annual basis at [http://wwwn.cdc.gov/grantassurances/\(S\(mj444mxct51lnrv1hljjimaa\)\)/Homepage.aspx](http://wwwn.cdc.gov/grantassurances/(S(mj444mxct51lnrv1hljjimaa))/Homepage.aspx)

Assurances and certifications submitted directly to CDC will be kept on file for one year and will apply to all applications submitted to CDC by the applicant within one year of the submission date.

6. Content and Form of Application Submission

Applicants are required to include all of the following documents with their application package at www.grants.gov.

7. Letter of Intent

A letter of intent (LOI) is requested but optional for this FOA.

CDC urges you to submit an LOI before you send in your application. The purpose of this letter is to inform CDC that your organization is interested in applying for funding under DP15-1502. Although a letter of intent is not required, it is highly recommended because this information will assist CDC in planning for the review process.

There are two components of this FOA. Please submit **one** Letter of Intent (LOI) indicating which component or components you are applying for.

The LOI should be submitted on organizational letterhead and include the following information:

- Number and title of this funding opportunity
- Descriptive title of proposed project
- Name, address, and telephone number of the Principal Investigator/Project Director
- Participating institutions
- Maximum number of pages: 1
- Font size: 12-point unredacted, Times New Roman
- Single spaced
- Paper size: 8.5 by 11 inches
- Page margin size: one inch
- Printed only on one side of page
- Written in plain language, avoiding jargon

Submit your Letter(s) of Intent to:

Attention: Tanya Hicks – CDC-RFA- DP15-1502

Department of Health and Human Services
CDC Division of Cancer Prevention and Control Program Services Branch
Building 107, Room 4219.1
4770 Buford Highway, N.E., MS F-76
Atlanta, GA 30341
Phone: 770-488-4326

Email: THicks@cdc.gov

Overnight delivery address:

CDC/DCPC/Warehouse for Tanya Hicks
3719 North Peachtree, MS F-76
Chamblee Bldg. 107, 4th Floor
Chamblee, GA 30341

8. Table of Contents

(No page limit and not included in Project Narrative limit): The applicant must provide, as a separate attachment, the "Table of Contents" for the entire submission package.

Provide a detailed table of contents for the entire submission package that includes all of the documents in the application and headings in the "Project Narrative" section. Name the file "Table of Contents" and upload it as a PDF file under "Other Attachment Forms" at www.grants.gov.

9. Project Abstract Summary

(Maximum 1 page)

A project abstract is included on the mandatory documents list and must be submitted at www.grants.gov. The project abstract must be a self-contained, brief summary of the proposed project including the purpose and outcomes. This summary must not include any proprietary or confidential information. Applicants must enter the summary in the "Project Abstract Summary" text box at www.grants.gov.

10. Project Narrative

(Maximum of 20 pages, single spaced, Calibri 12 point, 1-inch margins, number all pages. Content beyond 20 pages will not be considered. The 20 page limit includes the work plan. For a multi-component FOA, maximum page limit is 25.)

The Project Narrative must include all of the bolded headings shown in this section. The Project Narrative must be succinct, self-explanatory, and in the order outlined in this section. It must address outcomes and activities to be conducted over the entire project period as identified in the CDC Project Description section. Applicants must submit a Project Narrative with the application forms. Applicants must name this file "Project Narrative" and upload it at www.grants.gov.

a. Background

Applicants must provide a description of relevant background information that includes the context of the problem (See CDC Background).

b. Approach

i. Purpose

Applicants must describe in 2-3 sentences specifically how their application will address the problem as described in the CDC Background section.

ii. Outcomes

Applicants must clearly identify the outcomes they expect to achieve by the end of the project period. Outcomes are the results that the program intends to achieve. All outcomes must indicate the intended direction of change (e.g., increase, decrease, maintain). (See the logic model in the Approach section of the CDC Project Description.)

iii. Strategies and Activities

Applicants must provide a clear and concise description of the strategies and activities they will use to achieve the project period outcomes. Applicants must select existing evidence-based strategies that meet their needs, or describe in the Applicant Evaluation and Performance Measurement Plan, how these strategies will be evaluated over the course of the project period. (See CDC Project Description: Strategies and Activities section.)

1. Collaborations

Applicants must describe how they will collaborate with programs and organizations either internal or external to CDC.

Applicants must select interventions from the four Priority EBIs to increase CRC screening recommended by The *Community Guide*. Applicants must meet the requirements listed in the collaboration section of the Project Description.

Guidelines for MOUs, MOAs, and Letters of Commitment

The purpose of each MOU, MOA, or Letter of Commitment is to clearly define the mutual goal and the working relationship and to outline the responsibilities of the applicant and the participating health system partner or other entity to conduct work directly funded by this FOA. At minimum, the MOU/MOA/Letter of Commitment must definitively state a commitment to participate for the entire length of the proposed project, subject to the success of the application and receipt of a Notice of Award.

The MOU/MOA/Letter of Commitment must include:

- An effective date range that spans the proposed length of the proposed project, subject to availability of funds, satisfactory progress of the awardee, and a determination that continued funding would be in the best interest of the federal government.
- Commitment of the participating partner health system and other entity to work with the applicant and other collaborative partners to address program requirements.
- Commitment to jointly assess the needs and existing capacity to effectively conduct CRC screening, plan and implement EBI interventions, monitor implementation progress, and, evaluate outcomes in the partner's health system.
- Commitment of the applicant will work with the partner and other collaborative partners to address project requirements, including the designation of a point of contact within the applicant organization and the partner health system with authority to make program-related decisions and dedicated to the implementation of the proposed applicant activities.
- Overview of the mutual goals and the plan to collaboratively select EBIs and implement project activities for grant funding.
- Commitment of both parties to participate in required data reporting and evaluation activities including those led by CDC.
- Counter-signatures for both parties by authorized representatives.

Applications with signed MOUs/MOAs/Letters of Commitment that contain the information listed above will receive higher scores than those that do not. Applicants unable to obtain MOUs/MOAs, must file letters of support from partners, name the file "Letters of Commitment," and upload it as a PDF file at www.grants.gov.

2. Target Populations

Applicants must describe the specific target population(s) in their jurisdiction and explain how such a target will achieve the goals of the award and/or alleviate health disparities. Refer back to the CDC Project Description section – Approach: Target Population.

Component 1: Applicant-defined Target Populations: Applicants are strongly encouraged to focus the majority of their activities on target populations that include asymptomatic persons 50–75 years, men, Hispanics, and American Indian/Alaska Natives. Additional target populations may be prioritized according to the applicant’s data. Applicants should work with partners that are within and serve areas and communities disproportionately affected. Refer back to the CDC Project Description section – Approach: Target Population.

Component 2: Program Priority Populations: Applicants are strongly encouraged to focus the majority of their activities on a Program Priority Population of asymptomatic persons 50–64 years who are low-income, uninsured, and underinsured. Additional target populations may be prioritized according to the applicant’s data. Applicants should work with service delivery sites and partners that are within and serve geographic areas and communities disproportionately affected. Refer back to the CDC Project Description section – Approach: Target Population.

c. Applicant Evaluation and Performance Measurement Plan

Applicants must provide an overall evaluation and performance measurement plan that is consistent with the CDC Evaluation and Performance Measurement Strategy section of the CDC Project Description of this FOA. Data collected must be used for ongoing monitoring of the award to evaluate its effectiveness, and for continuous program improvement.

The plan must:

- Affirm the ability to collect the performance measures and respond to the evaluation questions specified in the CDC strategy. (For guidance regarding the Paperwork Reduction Act, please visit <http://www.hhs.gov/ocio/policy/collection/infocollectfaq.html>)
- Describe how key program partners will participate in the evaluation and performance measurement planning processes.
- Describe how evaluation findings will be used for continuous program quality improvement.

Where the applicant chooses to, or is expected to, take on specific evaluation studies:

- Describe the type of evaluation(s) (i.e., process, outcome, or both) to be conducted.
- Describe key evaluation questions to be addressed by these evaluations.
- Describe other information relevant to the evaluation (e.g., measures, data sources)

CDC will have substantial involvement.

Awardees will be required to submit a more detailed evaluation and performance measurement plan within the first 6 months of the project, as outlined in the reporting section of the FOA.

d. Organizational Capacity of Applicants to Implement the Approach

Applicant must address the organizational capacity requirements as described in the CDC Project Description.

11. Work Plan

(Included in the Project Narrative's 20 page limit)

Applicants must prepare a work plan consistent with the CDC Project Description Work Plan section. The work plan integrates and delineates more specifically how the awardee plans to carry out achieving the project period outcomes, strategies and activities, evaluation and performance measurement.

Applicants must name this file "Work Plan" and upload it as a PDF file at www.grants.gov.

Provide a detailed work plan for the proposed budget period and project period in support of FOA outcomes. Activities must be in alignment with the proposed objectives and the chosen program strategies and must include those activities the applicant selects as priority, based on the cited evidence, for the first year of the project. CDC will provide feedback and technical assistance to awardees to finalize the work plan post-award.

The work plan must, at a minimum, include:

- A logic model or equivalent that graphically displays the conditions, inputs, strategies, outputs, and intended outcomes for the five-year period.
- Activities directly related to implementation of evidence-based strategies to reach segments of the target and priority populations.
- A description of intended outcomes for the five-year project period.
- A description of strategies to be used in the first year of the project period.
- Objectives (including measures of effectiveness to assess progress and accomplishment)
- Activities for the first year of the project period.
- A description of how the applicant will monitor and report progress on the short-term performance measures and as many of the intermediate and long-term measures as feasible for the EBIs and/or strategies selected.

Applicants should use the template provided to document their detailed work plan for Year 1 of the award and provide a general summary of work plan activities for Years 2-5 in narrative form.

Component 1

The Component 1 work plan must also include:

- Specific strategies, interventions, and short-term, intermediate, and long-term outcomes from the applicant's CRC Logic Model included in the FOA.

Component 2

The Component 2 work plan must also include:

- Specific strategies, interventions, and short-term, intermediate, and long-term outcomes from the applicant's CRC Screening Delivery to Improve Access to the Underserved Logic Model.
- Activities directly related to implementation of strategies to the Program Priority Population. Include an estimate of the number of people in the priority population that will be screened for CRC through the program.
- A complete narrative description of the process proposed to identify, locate, screen, follow-up, and re-screen the Program Priority Population.

12. Budget Narrative

Applicants must submit an itemized budget narrative, which may be scored as part of the Organizational Capacity of Awardees to Execute the Approach. When developing the budget narrative, applicants must consider whether the proposed budget is reasonable and consistent with the purpose, outcomes, and program strategy outlined in the project narrative. The budget must include:

- Salaries and wages

- Fringe benefits
- Consultant costs
- Equipment
- Supplies
- Travel
- Other categories
- Contractual costs
- Total Direct costs
- Total Indirect costs

Indirect costs will not be reimbursed under grants to foreign organizations, international organizations, and foreign components of grants to domestic organizations (does not affect indirect cost reimbursement to the domestic entity for domestic activities). The CDC will not reimburse indirect costs unless the recipient has an indirect cost rate covering the applicable activities and period.

For guidance on completing a detailed budget, see Budget Preparation Guidelines at: <http://www.cdc.gov/grants/interestedinapplying/applicationresources.html> .

If applicable and consistent with the cited statutory authority for this announcement, applicant entities may use funds for activities as they relate to the intent of this FOA to meet national standards or seek health department accreditation through the Public Health Accreditation Board (see: <http://www.phaboard.org>). Applicant entities to whom this provision applies include state, local, territorial governments (including the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, the Commonwealth of the Northern Mariana Islands, American Samoa, Guam, the Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau), or their bona fide agents, political subdivisions of states (in consultation with states), federally recognized or state-recognized American Indian or Alaska Native tribal governments, and American Indian or Alaska Native tribally designated organizations. Activities include those that enable a public health organization to deliver public health services such as activities that ensure a capable and qualified workforce, up-to-date information systems, and the capability to assess and respond to public health needs. Use of these funds must focus on achieving a minimum of one national standard that supports the intent of the FOA. Proposed activities must be included in the budget narrative and must indicate which standards will be addressed.

Applicants must name this file “Budget Narrative” and upload it as a PDF file at www.grants.gov. If requesting indirect costs in the budget, a copy of the indirect cost-rate agreement is required. If the indirect costs are requested, include a copy of the current negotiated federal indirect cost rate agreement or a cost allocation plan approval letter for those Grantees under such a plan. Applicants must name this file “Indirect Cost Rate” and upload it at www.grants.gov.

Applicants applying for funding for Component 1 and Component 2 must submit a separate line item budget and budget narrative justification for each component. They should be uploaded in grants.gov as a single document.

The itemized budget narrative will not be scored as part of the Organizational Capacity of Awardees to Execute the Approach.

Participation of all awardees in CDC sponsored training, workshops, or meetings is essential to the effective implementation of this program. Travel funds should be budgeted for the following meetings:

- Two persons to Atlanta, Georgia to participate in a reverse site visit to discuss program implementation progress and for consultation and technical assistance (two days, one trip per year.)

- One additional two-person trip to Atlanta, or other destinations, to attend or assist with national workgroups, task forces, or committees (one to three days.)

13. Tobacco and Nutrition Policies

Awardees are encouraged to implement tobacco and nutrition policies.

Unless otherwise explicitly permitted under the terms of a specific CDC award, no funds associated with this FOA may be used to implement the optional policies, and no applicants will be evaluated or scored on whether they choose to implement these optional policies.

CDC supports implementing evidence-based programs and policies to reduce tobacco use and secondhand smoke exposure, and to promote healthy nutrition. CDC encourages all awardees to implement the following optional recommended evidence-based tobacco and nutrition policies within their own organizations. The tobacco policies build upon the current federal commitment to reduce exposure to secondhand smoke, specifically The Pro-Children Act, 20 U.S.C. 7181-7184, that prohibits smoking in certain facilities that receive federal funds in which education, library, day care, health care, or early childhood development services are provided to children.

Tobacco Policies:

1. Tobacco-free indoors: Use of any tobacco products (including smokeless tobacco) or electronic cigarettes is not allowed in any indoor facilities under the control of the awardee.
2. Tobacco-free indoors and in adjacent outdoor areas: Use of any tobacco products or electronic cigarettes is not allowed in any indoor facilities, within 50 feet of doorways and air intake ducts, and in courtyards under the control of the awardee.
3. Tobacco-free campus: Use of any tobacco products or electronic cigarettes is not allowed in any indoor facilities or anywhere on grounds or in outdoor space under the control of the awardee.

Nutrition Policies:

1. Healthy food-service guidelines must, at a minimum, align with HHS and General Services Administration Health and Sustainability Guidelines for Federal Concessions and Vending Operations. These guidelines apply to cafeterias, snack bars, and vending machines in any facility under the control of the awardee and in accordance with contractual obligations for these services (see: [http://www.gsa.gov/graphics/pbs/Guidelines for Federal Concessions and Vending Operations.pdf](http://www.gsa.gov/graphics/pbs/Guidelines%20for%20Federal%20Concessions%20and%20Vending%20Operations.pdf)).
2. Resources that provide guidance for healthy eating and tobacco-free workplaces are:

<http://www.cdc.gov/nccdphp/dnpao/hwi/toolkits/tobacco/index.htm>

<http://www.thecommunityguide.org/tobacco/index.html>

<http://www.cdc.gov/obesity/strategies/food-serv-guide.html>

14. Health Insurance Marketplaces

A healthier country is one in which Americans are able to access the care they need to prevent the onset of disease and manage disease when it is present. The Affordable Care Act, the health care law of 2010, creates new Health Insurance Marketplaces, also known as Exchanges, to offer millions of Americans affordable health insurance coverage. In addition, the law helps make prevention affordable and accessible for Americans by requiring health plans to cover certain recommended preventive services without cost sharing. Outreach efforts will help families and communities understand these new options and provide eligible individuals the assistance they need to secure and retain coverage as smoothly as possible. For more information on the Marketplaces and the health care law, visit: www.HealthCare.gov.

15. Intergovernmental Review

Executive Order 12372 does not apply to this program.

16. Pilot Program for Enhancement of Employee Whistleblower Protections

Pilot Program for Enhancement of Employee Whistleblower Protections: All applicants will be subject to a term and condition that applies the terms of 48 CFR section 3.908 to the award and requires that grantees inform their employees in writing (in the predominant native language of the workforce) of employee whistleblower rights and protections under 41 U.S.C. 4712.

17. Funding Restrictions

Restrictions that must be considered while planning the programs and writing the budget are:

- Awardees may not use funds for research.
- Awardees may not use funds for clinical care.
- Awardees may use funds only for reasonable program purposes, including personnel, travel, supplies, and services.
- Generally, awardees may not use funds to purchase furniture or equipment. Any such proposed spending must be clearly identified in the budget.
- Reimbursement of pre-award costs is not allowed.
- Other than for normal and recognized executive-legislative relationships, no funds may be used for:
 - publicity or propaganda purposes, for the preparation, distribution, or use of any material designed to support or defeat the enactment of legislation before any legislative body
 - the salary or expenses of any grant or contract recipient, or agent acting for such recipient, related to any activity designed to influence the enactment of legislation, appropriations, regulation, administrative action, or Executive order proposed or pending before any legislative body
- See <http://www.cdc.gov/grants/additionalrequirements/index.html#ar12> for detailed guidance on this prohibition and <http://www.cdc.gov/od/pgo/funding/grants/Anti-LobbyingRestrictionsforCDCGranteesJuly2012.pdf>.
- The direct and primary recipient in a cooperative agreement program must perform a substantial role in carrying out project outcomes and not merely serve as a conduit for an award to another party or provider who is ineligible.
- For the purposes of this FOA, "clinical care" refers to treatment services.

18. Other Submission Requirements

a. Electronic Submission: Applications must be submitted electronically at www.grants.gov. The application package can be downloaded at www.grants.gov. Applicants can complete the application package off-line and submit the application by uploading it at www.grants.gov. All application attachments must be submitted using a PDF file format. Directions for creating PDF files can be found at www.grants.gov. File formats other than PDF may not be readable by PGO Technical Information Management Section (TIMS) staff.

Applications must be submitted electronically by using the forms and instructions posted for this funding opportunity at www.grants.gov.

If Internet access is not available or if the forms cannot be accessed online, applicants may contact the PGO TIMS staff at 770- 488-2700 or by e-mail at pgotim@cdc.gov, Monday through Friday, 7:30 a.m.–4:30 p.m., except federal holidays. Electronic applications will be considered successful if they are available to PGO TIMS staff for processing from www.grants.gov on the deadline date.

b. Tracking Number: Applications submitted through www.grants.gov are time/date stamped

electronically and assigned a tracking number. The applicant's Authorized Organization Representative (AOR) will be sent an e-mail notice of receipt when www.grants.gov receives the application. The tracking number documents that the application has been submitted and initiates the required electronic validation process before the application is made available to CDC.

c. Validation Process: Application submission is not concluded until the validation process is completed successfully. After the application package is submitted, the applicant will receive a "submission receipt" e-mail generated by www.grants.gov. A second e-mail message to applicants will then be generated by www.grants.gov that will either validate or reject the submitted application package. This validation process may take as long as two business days. Applicants are strongly encouraged to check the status of their application to ensure that submission of their package has been completed and no submission errors have occurred. Applicants also are strongly encouraged to allocate ample time for filing to guarantee that their application can be submitted and validated by the deadline published in the FOA. Non-validated applications will not be accepted after the published application deadline date.

If you do not receive a "validation" e-mail within two business days of application submission, please contact www.grants.gov. For instructions on how to track your application, refer to the e-mail message generated at the time of application submission or the Applicant User Guide, Version 1.1, page 102.

<http://www.grants.gov/documents/19/18243/GrantsgovApplicantUserGuide.pdf/ce754626-c2aa-44bc-b701-30a75bf428c8>

d. Technical Difficulties: If technical difficulties are encountered at www.grants.gov, applicants should contact Customer Service at www.grants.gov. The www.grants.gov Contact Center is available 24 hours a day, 7 days a week, except federal holidays. The Contact Center is available by phone at 1-800-518-4726 or by e-mail at support@www.grants.gov. Application submissions sent by e-mail or fax, or on CDs or thumb drives will not be accepted. Please note that www.grants.gov is managed by HHS.

e. Paper Submission: If technical difficulties are encountered at www.grants.gov, applicants should call the www.grants.gov Contact Center at 1-800-518-4726 or e-mail them at support@www.grants.gov for assistance. After consulting with the Contact Center, if the technical difficulties remain unresolved and electronic submission is not possible, applicants may e-mail or call CDC GMO/GMS, before the deadline, and request permission to submit a paper application. Such requests are handled on a case-by-case basis.

An applicant's request for permission to submit a paper application must:

1. Include the www.grants.gov case number assigned to the inquiry
2. Describe the difficulties that prevent electronic submission and the efforts taken with the www.grants.gov Contact Center to submit electronically; and
3. Be postmarked at least three calendar days before the application deadline. Paper applications submitted without prior approval will not be considered. If a paper application is authorized, PGO will advise the applicant of specific instructions for submitting the application (e.g., original and two hard copies of the application by U.S. mail or express delivery service).

E. Review and Selection Process

1. Review and Selection Process: Applications will be reviewed in three phases.

a. Phase I Review

All applications will be reviewed initially for completeness by CDC PGO staff and will be reviewed jointly for eligibility by the CDC NCCDPHP and PGO. Incomplete applications and applications that do not meet the eligibility criteria will not advance to Phase II review. Applicants will be notified that their applications did not meet eligibility or published submission requirements.

b. Phase II Review

A review panel will evaluate complete, eligible applications in accordance with the criteria below.

- i. Approach
- ii. Evaluation and Performance Measurement
- iii. Applicant’s Organizational Capacity to Implement the Approach

i. Approach

Maximum Points: 40

Evaluate the extent to which the applicant:

- Presents outcomes that are consistent with the project period outcomes described in the CDC Project Description and logic model.
- Describes an overall strategy and activities consistent with the CDC Project Description and logic model.
- Describes strategies and activities that are achievable, appropriate to achieve the outcomes of the project, and evidence-based (to the degree practicable).
- Shows that the proposed use of funds is an efficient and effective way to implement the strategies and activities and attain the project period outcomes.
- Presents a work plan that is aligned with the strategies/activities, outcomes, and performance measures in the approach and is consistent with the content and format proposed by CDC.

ii. Applicants Organizational Capacity to Implement the Approach

Maximum Points: 35

Evaluate the extent to which the applicant:

- Demonstrates relevant experience and capacity (management, administrative, and technical) to implement the activities and achieve the project outcomes.
- Demonstrates experience and capacity to implement the evaluation plan.
- Provides a staffing plan and project management structure that will be sufficient to achieve the project outcomes and which clearly defines staff roles. Provides an organizational chart.
- Budget: When scoring budgets, CDC programs must assess whether the budget aligns with the proposed work plan. For additional guidance, check with the CIO extramural program office, GMO, or GMS.

iii. Evaluation and Performance Management

Maximum Points: 25

Evaluate the extent to which the applicant:

- Shows/affirms the ability to collect data on the process and outcome performance measures specified by CDC in the project description and presented by the applicant in their approach.
- Describes clear monitoring and evaluation procedures and how evaluation and performance measurement will be incorporated into planning, implementation, and reporting of project activities.
- Describes how performance measurement and evaluation findings will be reported, and used to demonstrate the outcomes of the FOA and for continuous program quality improvement.
- Describes how evaluation and performance measurement will contribute to developing an evidence base for programs that lack a strong effectiveness evidence base.
- Describes any evaluation studies they are to undertake. Describe in sufficient detail to identify the

key evaluation questions, and data sources and analysis methods.

Not more than thirty days after the Phase II review is completed, applicants will be notified electronically if their application does not meet eligibility or published submission requirements.

c. Phase III Review

All applications will be objectively reviewed.

Component 1

Applications for Component 1 funding only will be objectively reviewed separately from applications for both components.

Component 1 and Component 2

Applications for Component 1 and Component 2 will be objectively reviewed separately from applications for Component 1 only. Final funding determinations will be based on application scores and rank from the objective reviews. The following factors may also affect the funding decision: geographic diversity, priority populations or strategies and activities not proposed by higher ranking applicants, projects that maximize the population served or impact of federal funding.

~~Component 1~~

~~Final funding determinations will be based on application scores from the Component 1 and Component 2 objective reviews. All stand-alone Component 2 applications will be objectively reviewed, scored, and ranked. Final funding determinations will be based on Component 1 application objective reviews. The following factors may also affect the funding decision: geographic diversity, priority populations or strategies and activities not proposed by higher ranking applicants, projects that maximize the population served or impact of federal funding.~~

~~Component 2:~~

~~Only successful Component 1 applicants in Phase II that are selected for an award and that also apply for Component 2 will be eligible for consideration for Component 2 awards. All stand-alone Component 2 applications will be objectively reviewed, scored, and ranked. Final funding determinations will be based on application scores from the Component 1 and Component 2 objective reviews.~~

~~To be eligible for consideration for Component 2 awards, applications must be selected for a Component 1 award and be scored/ranked among the very top applications during the objective review process. Applications that are scored/ranked among the top of applications but do not score/rank high enough to receive a Component 2 award, will still be highly considered for Component 1 award.~~

2. Announcement and Anticipated Award Dates

Announcement date: January 15, 2015

Anticipated award date: June 1, 2015

F. Award Administration Information

1. Award Notices

Awardees will receive an electronic copy of the Notice of Award (NOA) from CDC PGO. The NOA shall be the only binding, authorizing document between the awardee and CDC. The NOA will be signed by an authorized GMO and emailed to the Awardee Business Officer listed in application and the Program Director.

Any applicant awarded funds in response to this FOA will be subject to the DUNS, SAM Registration, and Federal Funding Accountability And Transparency Act Of 2006 (FFATA) requirements.

Unsuccessful applicants will receive notification of these results by e-mail with delivery receipt or by U.S. mail.

2. Administrative and National Policy Requirements

Awardees must comply with the administrative and public policy requirements outlined in 45 C.F.R. Part 74 or Part 92 and the HHS Grants Policy Statement, as appropriate.

Brief descriptions of relevant provisions are available

at <http://www.cdc.gov/grants/additionalrequirements/index.html>

The HHS Grants Policy Statement is available at <http://www.hhs.gov/asfr/ogapa/aboutog/hhsgps107.pdf>.

*Note that 2 CFR 200 will supersede the administrative requirements (A-110 & A-102), cost principles (A-21, A-87 & A-122) and audit requirements (A-50, A-89 & A-133).

For more information on the C.F.R. visit <http://www.ecfr.gov/cgi-bin/ECFR?page=browse>.

3. Reporting

Reporting provides continuous program monitoring and identifies successes and challenges that awardees encounter throughout the project period. Also, reporting is a requirement for awardees who want to apply for yearly continuation of funding. Reporting helps CDC and awardees because it:

- Helps target support to awardees;
- Provides CDC with periodic data to monitor awardee progress toward meeting the FOA outcomes and overall performance;
- Allows CDC to track performance measures and evaluation findings for continuous quality and program improvement throughout the project period and to determine applicability of evidence-based approaches to different populations, settings, and contexts; and
- Enables CDC to assess the overall effectiveness and influence of the FOA.

The table below summarizes required and optional reports. All required reports must be sent electronically to GMS listed in the “Agency Contacts” section of the FOA copying the CDC Project Officer.

Report	When?	Required?
Awardee Evaluation and Performance Measurement Plan	6 months into award	Yes
Annual Performance Report (APR)	120 days before end of budget period. Serves as yearly continuation application.	Yes
Data on Performance Measures	CDC program determines. Only if program wants more frequent performance measure reporting than annually in APR.	No
Federal Financial Reporting Forms	90 days after end of calendar quarter in which budget period ends	Yes

Final Performance and Financial Report	90 days after end of project period.	Yes
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a. Awardee Evaluation and Performance Measurement Plan (required)

With support from CDC, awardees must elaborate on their initial applicant evaluation and performance measurement plan. This plan must be no more than 20 pages; awardees must submit the plan 6 months into the award.

This plan should provide additional detail on the following:

- The frequency that evaluation and performance data are to be collected.
- How data will be reported.
- How evaluation findings will be used for continuous quality and program improvement.
- How evaluation and performance measurement will yield findings to demonstrate the value of the FOA (e.g., improved public health outcomes, effectiveness of FOA, cost-effectiveness or cost benefit).
- Dissemination channels and audiences.
- Other information requested as determined by the CDC program.

b. Annual Performance Report (APR) (required)

The awardee must submit the APR via www.grants.gov 120 days before the end of the budget period. This report must not exceed 45 pages excluding administrative reporting. Attachments are not allowed, but weblinks are allowed.

This report must include the following:

- **Performance Measures:** Awardees must report on performance measures for each budget period and update measures, if needed.
- **Evaluation Results:** Awardees must report evaluation results for the work completed to date (including findings from process or outcome evaluations).
- **Work Plan:** Awardees must update work plan each budget period to reflect any changes in project period outcomes, activities, timeline, etc.
- **Successes**
 - Awardees must report progress on completing activities and progress towards achieving the project period outcomes described in the logic model and work plan.
 - Awardees must describe any additional successes (e.g. identified through evaluation results or lessons learned) achieved in the past year.
 - Awardees must describe success stories.
- **Challenges**
 - Awardees must describe any challenges that hindered or might hinder their ability to complete the work plan activities and achieve the project period outcomes.
 - Awardees must describe any additional challenges (e.g., identified through evaluation results or lessons learned) encountered in the past year.
- **CDC Program Support to Awardees**
 - Awardees must describe how CDC could help them overcome challenges to complete activities in the work plan and achieving project period outcomes.
- **Administrative Reporting** (No page limit)

- SF-424A Budget Information-Non-Construction Programs.
- Budget Narrative – Must use the format outlined in "Content and Form of Application Submission, Budget Narrative" section.
- Indirect Cost Rate Agreement.

The carryover request must:

- Express a bona fide need for permission to use an unobligated balance;
- Include a signed, dated, and accurate Federal Financial Report (FFR) for the budget period from which funds will be transferred (as much as 75% of unobligated balances);
- and Include a list of proposed activities, an itemized budget, and a narrative justification for those activities.

The awardee must submit the Annual Performance Report via www.grants.gov 120 days before the end of the budget period.

CDC will have substantial involvement.

c. Performance Measure Reporting (optional)

CDC programs may require more frequent reporting of performance measures than annually in the APR. If this is the case, CDC programs must specify reporting frequency, data fields, and format for awardees at the beginning of the award period.

d. Federal Financial Reporting (FFR) (required)

The annual FFR form (SF-425) is required and must be submitted through eRA Commons 90 days after the end of the calendar quarter in which the budget period ends. The report must include only those funds authorized and disbursed during the timeframe covered by the report. The final FFR must indicate the exact balance of unobligated funds, and may not reflect any unliquidated obligations. There must be no discrepancies between the final FFR expenditure data and the Payment Management System's (PMS) cash transaction data. Failure to submit the required information by the due date may adversely affect the future funding of the project. If the information cannot be provided by the due date, awardees are required to submit a letter of explanation to PGO and include the date by which the Grants Officer will receive information.

Effective October 1, 2012, CDC grantees are required to submit their upcoming FFR (SF 425) electronically through eRA Commons. Per Federal Register Notice published Monday, June 11, 2012. <http://www.gpo.gov/fdsys/pkg/FR-2012-06-11/pdf/2012-14049.pdf>

e. Final Performance and Financial Report (required)

This report is due 90 days after the end of the project period. CDC programs must indicate that this report should not exceed 40 pages. This report covers the entire project period and can include information previously reported in APRs. At a minimum, this report must include the following:

- Performance Measures – Awardees must report final performance data for all process and outcome performance measures.
- Evaluation Results – Awardees must report final evaluation results for the project period for any evaluations conducted.
- Impact/Results/Success Stories – Awardees must use their performance measure results and their evaluation findings to describe the effects or results of the work completed over the project period, and can include some success stories.
- Additional forms as described in the Notice of Award (e.g., Equipment Inventory Report, Final

Invention Statement).

4. Federal Funding Accountability and Transparency Act of 2006 (FFATA)

The FFATA and Public Law 109-282, which amends the FFATA, require full disclosure of all entities and organizations that receive federal funds including awards, contracts, loans, other assistance, and payments. This information must be submitted through the single, publicly accessible website, www.USASpending.gov.

Compliance with these mandates is primarily the responsibility of the federal agency. However, two elements of these mandates require information to be collected and reported by applicants: 1) information on executive compensation when not already reported through SAM; and 2) similar information on all sub-awards, subcontracts, or consortiums for greater than \$25,000. For the full text of these requirements, see: <http://www.gpo.gov/fdsys/browse/collection.action?collectionCode=BILLS>.

G. Agency Contacts

CDC encourages inquiries concerning this FOA.

Program Office Contact

For programmatic technical assistance, contact:

Tanya Hicks, Project Officer
Department of Health and Human Services
Centers for Disease Control and Prevention
Telephone: (770) 488-4326
Email: THicks@cdc.gov

Grants Staff Contact

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

Veronica Davis, Grants Management Specialist
Department of Health and Human Services
CDC Procurement and Grants Office
2920 Brandywine Rd, MS E-09
Atlanta, GA 30341
Telephone: (770) 488-2743
Email: VAD4@cdc.gov

For assistance with **submission difficulties related to** www.grants.gov, contact the Contact Center by phone at 1-800-518-4726.

Hours of Operation: 24 hours a day, 7 days a week, except on federal holidays.

For all other **submission** 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

E-mail: pgotim@cdc.gov

CDC Telecommunications for persons with hearing loss is available at: TTY 1-888-232-6348.

H. Other Information

Following is a list of acceptable attachments **applicants** can upload as PDF files as part of their application at www.grants.gov. Applicants may not attach documents other than those listed; if other documents are attached, applications will not be reviewed.

- Project Abstract
- Project Narrative
- Budget Narrative
- CDC Assurances and Certifications
- Table of Contents for Entire Submission

Optional attachments, as determined by CDC programs

- Resumes/CVs
- Position descriptions
- Letters of Support
- Organizational Charts
- Non-profit organization IRS status forms, if applicable
- Indirect Cost Rate , if applicable
- Memorandum of Agreement (MOA)
- Memorandum of Understanding (MOU)
- Bona Fide Agent status documentation, if applicable

<http://www.cdc.gov/chronicdisease/>

Optional attachments:

- Project logic model

I. Glossary

Activities: The actual events or actions that take place as a part of the program.

Administrative and National Policy Requirements, Additional Requirements (ARs): Administrative requirements found in 45 CFR Part 74 and Part 92 and other requirements mandated by statute or CDC policy. All ARs are listed in the Template for CDC programs. CDC programs must indicate which ARs are relevant to the FOA; awardees must comply with the ARs listed in the FOA. To view brief descriptions of relevant provisions, see <http://www.cdc.gov/grants/additionalrequirements/index.html>

. Note that 2 CFR 200 will supersede the administrative requirements (A-110 & A-102), cost principles (A-21, A-87 & A-122) and audit requirements (A-50, A-89 & A-133).

Award: Financial assistance that provides support or stimulation to accomplish a public purpose. Awards include grants and other agreements (e.g., cooperative agreements) in the form of money, or property in lieu of money, by the federal government to an eligible applicant.

Budget Period or Budget Year: The duration of each individual funding period within the project period. Traditionally, budget periods are 12 months or 1 year.

Carryover: Unobligated federal funds remaining at the end of any budget period that, with the approval of the GMO or under an automatic authority, may be carried over to another budget period to cover allowable costs of that budget period either as an offset or additional authorization. Obligated but liquidated funds are not considered carryover.

Catalog of Federal Domestic Assistance (CFDA): A government-wide compendium published by the General Services Administration (available on-line in searchable format as well as in printable format as a .pdf file) that describes domestic assistance programs administered by the Federal Government.

CFDA Number: A unique number assigned to each program and FOA throughout its lifecycle that enables data and funding tracking and transparency.

CDC Assurances and Certifications: Standard government-wide grant application forms.

Competing Continuation Award: A financial assistance mechanism that adds funds to a grant and adds one or more budget periods to the previously established project period (i.e., extends the “life” of the award).

Continuous Quality Improvement: A system that seeks to improve the provision of services with an emphasis on future results.

Contracts: An award instrument used to acquire (by purchase, lease, or barter) property or services for the direct benefit or use of the Federal Government.

Cooperative Agreement: A financial assistance award with the same kind of interagency relationship as a grant except that it provides for substantial involvement by the federal agency funding the award. Substantial involvement means that the recipient can expect federal programmatic collaboration or participation in carrying out the effort under the award.

Cost Sharing or Matching: Refers to program costs not borne by the Federal Government but by the awardees. It may include the value of allowable third-party, in-kind contributions, as well as expenditures by the awardee.

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Statute: An act of the legislature; a particular law enacted and established by the will of the legislative department of government, expressed with the requisite formalities. In foreign or civil law any particular municipal law or usage, though resting for its authority on judicial decisions, or the practice of nations.

Statutory Authority: Authority provided by legal statute that establishes a federal financial assistance program or award.

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Work Plan: The summary of project period outcomes, strategies and activities, personnel and/or partners who will complete the activities, and the timeline for completion. The work plan will outline the details of all necessary activities that will be supported through the approved budget.

Activities: The actual events or actions that take place as a part of the program.

Administrative and National Policy Requirements, Additional Requirements

(ARs): Administrative requirements found in 45 CFR Part 74 and Part 92 and other requirements mandated by statute or CDC policy. All ARs are listed in the Template for CDC programs. CDC programs must indicate which ARs are relevant to the FOA; awardees must comply with the ARs listed in the FOA. To view brief descriptions of relevant provisions, see http://www.cdc.gov/od/pgo/funding/grants/additional_req.shtm. Note that 2 CFR 200 will supersede the administrative requirements (A-110 & A-102), cost principles (A-21, A-87 & A-122) and audit requirements (A-50, A-89 & A-133).

Award: Financial assistance that provides support or stimulation to accomplish a public purpose. Awards include grants and other agreements (e.g., cooperative agreements) in the form of money, or property in lieu of money, by the federal government to an eligible applicant.

Budget Period or Budget Year: The duration of each individual funding period within the project period. Traditionally, budget periods are 12 months or 1 year.

Carryover: Unobligated federal funds remaining at the end of any budget period that, with the approval of the GMO or under an automatic authority, may be carried over to another budget period to cover allowable costs of that budget period either as an offset or additional authorization. Obligated but liquidated funds are not considered carryover.

Catalog of Federal Domestic Assistance (CFDA): A government-wide compendium published by the General Services Administration (available on-line in searchable format as well as in printable format as a .pdf file) that describes domestic assistance programs administered by the Federal Government.

CFDA Number: A unique number assigned to each program and FOA throughout its lifecycle

that enables data and funding tracking and transparency.

CDC Assurances and Certifications: Standard government-wide grant application forms.

Competing Continuation Award: A financial assistance mechanism that adds funds to a grant and adds one or more budget periods to the previously established project period (i.e., extends the “life” of the award).

Continuous Quality Improvement: A system that seeks to improve the provision of services with an emphasis on future results.

Contracts: An award instrument used to acquire (by purchase, lease, or barter) property or services for the direct benefit or use of the Federal Government.

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Applicant-defined Target Population: A population selected by the awardee using current, accurate data. The awardee should pay special attention to ensure the applicant-defined target population represents at least one disparate group.

Client Reminders: Client (patient) reminders are written, electronic or telephone messages advising people that they are due for cancer screening.

Community Guide: See [The] Guide to Community Preventive Services below.

Federally Qualified Health Centers (FQHCs): Include all organizations receiving grants under Section 330 of the Public Health Service Act (PHS). FQHCs must serve an underserved area or population, offer a sliding fee scale, provide comprehensive services, have an ongoing quality assurance program, and have a governing board of directors.

[The] Guide to Community Preventive Services: A free resource for evidence-based recommendations and findings from The Community Preventive Services Task Force, an independent, nonfederal, volunteer body of public health and prevention experts at: www.thecommunityguide.org/.

Health Systems: All the organizations, institutions, and resources that are devoted to producing health actions. This definition includes the full range of players engaged in the provision and financing of health services including the public, nonprofit, and for-profit private sectors, as well as international and bilateral donors, foundations, and voluntary organizations involved in funding or implementing health activities.

Partner Health Systems: Health systems that an awardee has entered in a formal agreement with to collaboratively implement CRC screening EBIs recommended by The Community Guide (e.g., provider reminders in a clinic system).

Program Priority Population: (Component 2 only): Persons ages 50-64, asymptomatic and at average risk for CRC, with inadequate or no health insurance for CRC screening, and with income at or below 250% of the Federal Poverty Guidelines (FPG).

Provider Assessment and Feedback: Provider assessment and feedback interventions evaluate provider performance (assessment) in delivering cancer screening to clients and then present providers with information about their performance (feedback), sometimes comparing it with a goal or standard.

Provider Reminders: A provider reminder is used to inform a health care provider that a specific client is due or overdue for a cancer screening test. The reminder to a provider can be made in different ways such as in client charts, in client electronic medical records, or by e-mail.

Reducing Structural Barriers: Structural barriers are non-economic obstacles that make it difficult for people to access cancer screening (e.g., inconvenient hours or days of clinical service, transportation costs, unpaid sick leave). Interventions are designed to reduce these barriers in order to facilitate access to cancer screening services.

Small Media: Small media include videos and printed materials such as letters, brochures, and newsletters that can be used to inform and motivate people to be screened for cancer. Small media materials can provide information tailored to specific individuals or targeted to general audiences.