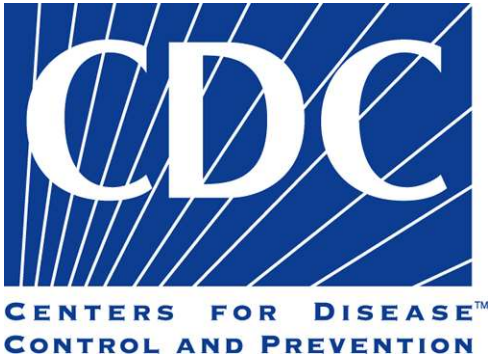


Centers for Disease Control and Prevention

NATIONAL CENTER FOR CHRONIC DISEASE PREVENTION AND HEALTH PROMOTION

Cancer Prevention and Control Programs for State, Territorial, and Tribal Organizations

CDC-RFA-DP22-2202

01/26/2022

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Part I. Overview

Applicants must go to the synopsis page of this announcement at www.grants.gov and click on the "Subscribe" button link to ensure they receive notifications of any changes to CDC-RFA-DP22-2202. 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. Notice of Funding Opportunity (NOFO) Title:

Cancer Prevention and Control Programs for State, Territorial, and Tribal Organizations

C. Announcement Type: New - Type 1:

This announcement is only for non-research activities supported by CDC. If research is proposed, the application will not be considered. For this purpose, research is defined at https://www.gpo.gov/fdsys/pkg/CFR-2007-title42-vol1/pdf/CFR-2007-title42-vol1-sec52-2.pdf. Guidance on how CDC interprets the definition of research in the context of public health can be found at https://www.hhs.gov/ohrp/regulations-and-policy/regulations/45-cfr-46/index.html (See section 45 CFR 46.102(d)).

D. Agency Notice of Funding Opportunity Number:

CDC-RFA-DP22-2202

E. Assistance Listings Number:

93.898

F. Dates:

1. Due Date for Letter of Intent (LOI):

11/27/2021
Recommended but not Required
The purpose of an LOI is to allow CDC program staff to estimate the number of and plan for the review of submitted applications.

2. Due Date for Applications:
01/26/2022
11:59 p.m. U.S. Eastern Standard Time, at www.grants.gov.

3. Due Date for Informational Conference Call:
November 18, 2021
CDC will provide three informational conference calls. Each call will provide exactly the same information therefore, applicants need only attend one call. There will not be a question and answer session on the calls. Instead, applicants are asked to submit questions to nofodp22-2202@cdc.gov

November 18, 2021 at **10:00 a.m. to 12:00 p.m. Eastern Daylight Savings Time** - For eligible applicants in the **Atlantic, Eastern, and Central time zones.** This conference call can be access ed by calling **800-593-8948.** The leader for this call is Tanya Hicks and the passcode is **1179165.**

November 18, 2021 at **3:30 p.m. to 5:30 p.m.** Eastern Daylight Savings Time –
For eligible applicants
in the **Mountain and Western time zones**. This conference call can be accessed by calling **800-593-8948.** The leader for this call is Tanya Hicks and the passcode is **1179165.**

November 18, 2021 at **7:30 p.m. to 9:30 p.m. Eastern Daylight Savings Time** -
For eligible applicants
in the **Pacific Island Jurisdictions**. This conference call can be accessed by calling **800-593-8948**. The leader for this call is Tanya Hicks and the passcode is **1179165.**

If operator assistance is needed, call 866-865-7014
and the operator will assist you in joining the call.

F. Executive Summary:

Summary Paragraph
The CDC, Division of Cancer Prevention and Control (DCPC) announces the availability of Fiscal Year 2022 funds to implement DP22-2202, a National Cancer Prevention and Control Program. This Notice of Funding Opportunity (NOFO) supports the achievement of the following cancer prevention and control goals: eliminate preventable cancers, ensure all people get the right screening at the right time for the best outcome, and support cancer survivors in a manner that allows them to live longer, healthier lives. This program takes a comprehensive, coordinated approach to achieve these goals and advance health equity. It supports breast and cervical cancer screening services, cancer control plan implementation by coalitions, and surveillance programs to monitor and report cancer burden.

These priorities will be accomplished by funding three national programs:

Program 1: National Breast and Cervical Cancer Early Detection Program (NBCCEDP) supports clinical services for women with lower incomes who are uninsured or underinsured and implementation of evidence-based interventions in the clinics that serve them.
Program 2: National Comprehensive Cancer Control Program (NCCCP) supports cancer coalition efforts that use their individual and collective resources to plan and implement evidence-based strategies as described in jurisdiction-wide cancer plans.
Program 3: National Program of Cancer Registries (NPCR) supports the implementation of a population-based core cancer registry program.

a. Eligible Applicants:
Open Competition

b. NOFO Type:
CA (Cooperative Agreement)

c. Approximate Number of Awards
198

Program 1: The National Breast and Cervical Cancer Early Detection Program (NBCCEDP) funds will be awarded up to 75 applicants to include state health departments and the District of Columbia; US Territories and Freely Associated States; Federally Recognized American Indian Tribes, Tribal Organizations, Alaska Native Organizations, and Urban Indian Organizations; or their Bona Fide Agents, for implementing a program to provide breast and cervical cancer screening services to women who are uninsured and/or underinsured and implement key evidence-based strategies to reduce structural barriers to screening within health systems.

Program 2: The National Comprehensive Cancer Control Program (NCCCP) funds will be awarded to up to 68 applicants, to include state health departments, the District of Columbia; Freely Associated States and US Affiliated Pacific Islands; US Virgin Islands: and Federally Recognized American Indian Tribes, Tribal Organizations, Alaska Native Organizations, and Urban Indian Organizations for implementing a program to support cancer coalition efforts that leverage resources to plan and implement evidence-based strategies to promote the primary prevention of cancer; support cancer early detection efforts; address the needs of cancer survivors; and promote health equity.

Program 3: The National Program of Cancer Registries (NPCR) funds will be awarded to up to 55 applicants including;
state health departments, the District of Columbia, Freely Associated States and US Affiliated Pacific Islands; US Virgin Islands: or their Bona Fide Agents for
implementing a population-based core cancer registry program.

d. Total Period of Performance Funding:
$1,100,000,000

e. Average One Year Award Amount:
$850,000

Program 1: NBCCEDP Approximately $155 million per year is available.
Program 2: NCCCP Approximately $22 million per year is available.
Program 3: NPCR Approximately $38 million per year is available.

f. Total Period of Performance Length:
5

g. Estimated Award Date:
May 24, 2022

h. Cost Sharing and / or Matching Requirements:
Yes

Program 1: NBCCEDP

Recipient financial participation is required for this program in accordance with the authorizing legislation. Section 1502(a) and (b)(1), (2), and (3) of the Public Health Services (PHS) Act, as amended, requires matching funds from non-Federal sources in an amount not less than one dollar for every three dollars of Federal funds awarded under this program. However, Title 48 of the U.S. Code 1469a (d) requires DHHS to waive matching fund requirements up to $200,000 for Guam, U.S. Virgin Islands, American Samoa and the Commonwealth of the Northern Mariana Islands, the Commonwealth of Puerto Rico, the Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau. Matching funds may be cash, in-kind or donated services or equipment. Contributions may be made directly or through donations from public or private entities. Public Law 93-638 authorizes tribal organizations contracting under the authority of Title I to use funds received under the Indian Self-Determination Act as matching funds.

Recipients may also designate as State/Tribal/Territorial/Pacific Island Jurisdiction matching funds any non-Federal amounts spent pursuant to Title XIX of the Social Security Act for the screening and case management of women for breast and cervical cancers.
Matching funds may not include: (1) payment for treatment services or the donation of treatment services; (2) services assisted or subsidized by the Federal government; or (3) the indirect or overhead costs of an organization. All costs used to satisfy the matching requirements must be documented by the applicant and will be subject to audit.

Program 2: NCCCP

Although there is no cost-sharing requirement, recipients should document and report how funds have been leveraged to increase financial and in-kind support for their NCCCP work plans and coalitions.

Program 3: NPCR

Per PHS Act (42 USC 280e-280e-4), matching funds are required for Program 3, NPCR applicants in an amount not less than 25 percent of such costs or one dollar for every three dollars of Federal funds awarded under this program; [Title 42, Chapter 6A, Subchapter II, Part M, § 280e(b)(1)]. Matching funds may be cash, in-kind, or donated services or equipment. Contributions may be made directly or through donations from public or private entities. However, Title 48 of the U.S. Code 1469a (d) requires DHHS to waive matching fund requirements for Guam, U.S. Virgin Islands, American Samoa, and the Commonwealth of the Northern Mariana Islands up to $200,000. Public Law 93-638 authorizes tribal organizations contracting under the authority of Title 1 to use funds received under the Indian Self-

Determination Act as matching funds. Non-federal financial contributions in excess of the Maintenance of Effort may be used for matching.

Part II. Full Text

A. Funding Opportunity Description

1. Background

a. Overview

Cancer is the second leading cause of death in the United States for both men and women. In 2017, more than 1.7 million people were diagnosed with cancer and 600,000 people died from this disease. Since 1990, CDC's Division of Cancer Prevention and Control (DCPC) has been committed to advancing cancer prevention nationwide for everyone through a variety of activities at the national, state, territorial, and tribal levels. The Division's overall goal is to work toward having all people free of cancer while improving health equity through prevention, screening, and health and wellness in cancer survivors. DCPC supports comprehensive cancer control, a philosophical approach that brings together partners and other organizations to collectively address a community's cancer burden in a much more impactful way than any one organization could accomplish alone. The approach relies heavily upon the willingness of organizations to work together to establish priorities for addressing the community's cancer burden and strategically present these in a coordinated cancer control plan. The plan is intended to be more than a "document on a shelf", but rather it is a blueprint for expected action that includes specific partner commitments to plan implementation. These plans prioritize primary prevention, screening and early detection and diagnosis, treatment, cancer survivorship, and palliative care. They also focus heavily on supporting a surveillance infrastructure that is critical to effective program planning and implementation, supporting clinical trials and other research efforts, and identifying specific strategies to focus on the issues that cause some people to be diagnosed with cancer more often or experience poorer health outcomes than others. The Division's primary prevention, screening, and survivorship priorities are largely addressed through comprehensive cancer control plans and implemented by 3 federally funded national programs. The National Breast and Cervical Cancer Early Detection Program (NBCCEDP), federally mandated in 1990, provides breast and cervical cancer screening, diagnostic services, and treatment referrals to women with lower incomes and who are uninsured or underinsured; the National Comprehensive Cancer Control Program (NCCCP) was established in 1998 to support the creation of coalitions and networks that develop and implement cancer control plans across the cancer continuum; and the National Program of Cancer Registries (NPCR) was federally mandated in 1992 to support the management and operations of population-based cancer surveillance systems across the United States.

This NOFO will fund eligible applicants to facilitate collaborative planning and implementation of evidence-based cancer surveillance, prevention, and control strategies in communities that improve the provision of clinical preventive services, and cancer survivorship. Ultimately, a successful implementation of the work described in this NOFO will demonstrate that by the three programs working together through partnerships, leveraging resources, coordinating efforts, consistent communication, and community involvement, we will come that much closer to health equity and "All People Free of Cancer."

b. Statutory Authorities

Program 1: The National Breast and Cervical Cancer Early Detection Program (NBCCEDP) is authorized under sections 1501-1508 and 1510 [42 U.S.C. 300k, 42 U.S.C. 300l, 42 U.S.C. 3001-1, 42 U.S.C. 300m, 42 U.S.C. 300n, 42 U.S.C. 300 n-1, 42 U.S.C. 300 n-2, 42 U.S.C. 300 n-3, 42 U.S.C. 300 n-4, 42 U.S.C. 300 n-5] of the Public Health Service Act, as amended.

Program 2: The National Comprehensive Cancer Control Program (NCCCP) is authorized under sections 317(k)(2) and (e) of the Public Health Service Act, [42 U.S.C. section247b (e) and (k)(2)], as amended.

Program 3: The National Program of Cancer Registries (NPCR) is authorized under the Public Health Service Act, Sections 399B, 399C, 399D, and 399F(a) of the Public Health Service Act (PHS Act) to the authority (Public Law 102-515), as amended

c. Healthy People 2030

Healthy People 2030: Cancer - Healthy People 2030 | health.gov
Reduce the age-adjusted annual rate of cancer mortality per 100,000 population (C-01)
Reduce the lung cancer death rate (C-02)
Increase the proportion of adults who get screened for lung cancer (C-03)
Reduce the female breast cancer death rate (C-04)
Increase the proportion of females who get screened for breast cancer (C-05)
Reduce the colorectal cancer death rate (C-06)
Increase the proportion of adults who get screened for colorectal cancer (C-07)
Reduce the prostate cancer death rate (C-08)
Increase the proportion of females who get screened for cervical cancer (C-09)
Increase the proportion of cancer survivors who are living 5 years or longer after diagnosis (C-11)
Increase quality of life for cancer survivors (C-R01)

d. Other National Public Health Priorities and Strategies

This NOFO supports strategies to increase and improve the quality of cancer screening, community-clinical linkages, and preventive services in the following national plans and guidelines:
Healthy People 2030: Cancer - Healthy People 2030 | health.gov
The Guide to Community Preventive Services: The Guide to Community Preventive Services (The Community Guide)
The National Partnership for Action to End Health Disparities: Home Page - Office of Minority Health (OMH) (hhs.gov)

e. Relevant Work

During DP17-1701, the current NOFO which ends on June 29, 2022, and over the past 30 years, substantial gains were made by increasing activities to reach and screen women with low-incomes and who are uninsured or underinsured for breast and cervical cancer; expanding state plans and coalitions to improve prevention, screening, and survivorship; and advancing the

collection and accessibility of cancer surveillance data to inform and evaluate cancer control activities.

2. CDC Project Description

a. Approach

Bold indicates period of performance outcome.

Each of the three programs (NBCCEDP, NCCCP, NPCR) in this NOFO have provided programmatic logic models below. An Integrated Programmatic Logic Model is available at https://www.cdc.gov/cancer/dcpc/about/foa-dp22-2202/

CDC-NOFO-DP22-2202 Program 1: National Breast and Cervical Cancer Early Detection Program (NBCCEDP) Logic Model

Strategies and Activities	Short-term Outcomes	Intermediate Outcomes	Long-Term Outcomes
Strategy 2: Cancer Data and Surveillance Use state and local data to identify and describe the population who is eligible for the program. Prioritize populations disproportionately burdened by breast or cervical cancer (i.e., populations of focus) for service delivery. **Strategy 3: Support Partnerships for Cancer Control and Prevention** Work with the cancer coalition, Colorectal Cancer Control Program (CRCCP), National Comprehensive Cancer Control Program (NCCCP), National Program of Cancer Registries (NPCR) and other organizations to help set breast and cervical cancer screening and health equity goals within cancer control plans. Serve on the cancer coalition. Collaborate with community-based organizations to increase screening among	**Increased access to breast and cervical cancer screening among program-eligible women, prioritizing populations of focus.** **Increased partnerships with clinics serving women with lower income.** Increased access to health/community/social services among program-eligible women through partnerships. Increased use of data to inform program planning and improvement. **Increased EBI implementation to improve screening within partner clinics.** Improved provider knowledge of breast and cervical cancer screening recommendations and diagnostic guidelines. Improved effectiveness of outreach to populations experiencing health inequities for breast and cervical cancer.	**Increased number of women receiving NBCCEDP-paid screening and follow-up services.** Increased number of women served who experience higher mortality and late-stage cancer. **Increased early detection of breast and cervical cancer.** **Increased adherence to timely diagnostic follow-up.** **Increased timely cancer treatment referral.** **Increased clinic-**	Decreased cancer incidence, morbidity, and mortality. Reduced cancer disparities.

populations of focus. Collaborate with other chronic disease and public health programs to disseminate information to women served across programs. Collaborate with other cancer programs, including other NBCCEDP-funded programs, to maximize screening access and share lessons learned. **Strategy 4: Deliver Breast and Cervical Cancer Screening** Set annual and 5-year service delivery projections for breast and cervical cancer. Establish and maintain a screening delivery system to provide breast and cervical cancer screening and diagnostic services to program-eligible women. Prioritize populations that experience higher mortality and late-stage cancer. Conduct outreach to identify program-eligible women and connect them to screening and diagnostic services in partner clinics. Engage local partners and community health workers to identify women in need of support to access services and monitor through screening completion. Provide patient navigation to women who receive NBCCEDP-paid clinical services. Provide patient navigation to women who meet some NBCCEDP eligibility requirements whose clinical services are paid by other sources (OPTIONAL).		**level breast and cervical cancer screening rates in partner screening clinics.** Increased utilization of needed health, community, and social services among program-eligible women. Decreased inequities in screening and follow-up services among populations of focus.	

Partner with organizations to link program-eligible women to other needed health, community, and social services. Establish formal partnerships with organizations that show expertise in and access to populations of focus. Collaborate with organizations with expertise in providing technical assistance to clinics. Conduct ongoing quality improvement for timely and appropriate screening and follow-up services. Collect and report minimum data element (MDE) records for all women receiving NBCCEDP-paid services.			
Strategy 4: Implement Evidence-Based Interventions Work with partner clinics that provide NBCCEDP-paid clinical services to implement evidence-based interventions (EBIs). Identify an EBI champion in each partner clinic. Provide ongoing technical assistance to support EBI implementation, adaptation, and data monitoring. Collect and report baseline and annual clinic-level data.			
Strategy 5: Program Monitoring and Evaluation Participate in CDC-led monitoring, evaluation, and dissemination efforts. Develop an evaluation plan. Evaluate processes and outcomes. Establish and maintain MDE systems to collect and report			

patient data. Monitor, report, and use MDE and clinic-level data. Submit annual evaluation reports to describe program monitoring, effectiveness, and use of findings. Share evaluation findings with appropriate partners.			

CDC-NOFO-DP22-2202 Program 2: National Comprehensive Cancer Control Program (NCCCP) Logic Model

Strategies	Short-Term Outcomes	Intermediate Outcomes	Long-term Outcomes

Strategy 1: Enhance National Program of Cancer Registries (NPCR) data quality, completeness, use, and dissemination Use data to monitor cancer risk factors, incidence, and mortality Use cancer incidence and mortality data for program planning (e.g. to revise/update cancer control plans, select program priorities, set program baseline and targets). Share data to educate policymakers, partners, and the public about the people and places that are most impacted by cancer. **Strategy 2 :** Use surveillance systems and population-based surveys to assess cancer burden and inform programmatic efforts Collaborate with internal and external partners to set and report on annual and five-year objectives Conduct policy scans to identify facilitators and barriers to cancer prevention, screening, and survivorship Use data to identify and collaborate with populations and geographic locations	**Increased use of USCS data to assess cancer burden, identify priority populations, and monitor incidence, mortality, and survival.** **Increased use of surveillance systems and population-based surveys to assess cancer risk, health behaviors, and access to preventive services** **Increased use of data to facilitate program planning and evaluation** **Improved recruitment and engagement of members from populations of focus, chronic disease programs, traditional and non-traditional public health partners within comprehensive cancer control coalitions** **Improved partnership contribution to evidenced-based interventions implemented to address cancer burden** **Improved implementation of jurisdiction-specific comprehensive cancer control plans** **Improved knowledge, awareness, and attitudes regarding evidenced based interventions and resources that aid with implementation** **Improved implementation of EBIs that address primary prevention,**	**Increased health seeking and healthy behaviors among population of focus** **Increased early detection of cancer among population of focus** **Increased number of eligible women served through the NBCCEDP** **Increased breast and cervical cancer screening rates in NBCCEDP partner clinics**	Reduced cancer risk Increased quality of life among cancer survivors Decreased cancer incidence, morbidity, and mortality Reduced cancer disparities

with the greatest burden **Strategy 3:** Support partnerships for cancer control and prevention Convene and maintain a multisectoral cancer control coalition Establish formal agreements with the cancer control coalition, partner organizations, and community members assuring their commitment to achieving NCCCP priorities/outcomes Provide staffing and support for coalition engagement **Strategy 4:** Deliver screening and implement evidence-based interventions (EBIs) Use data to implement a suite of interventions to advance program priorities that expand reach and make the greatest impact Identify short-, intermediate-, long-term strategies that complement each other and work synergistically to achieve 5-year objectives Select evidence-based interventions for strategies based on	**screening, and survivorship with fidelity** **Improved awareness, knowledge, and beliefs about cancer prevention, screening, and survivorship among priority populations** **Increased access to healthy eating and physical activity opportunities** **Increased access to cancer screening/preventive services by priority populations** **Increased reporting of high-quality program data to CDC** **Increased recipient participation in special studies**		

available research, coalition buy-in, resources for implementation, and promising program practice **Strategy 5:** Conduct program monitoring and evaluation Create a performance measurement plan to report short, intermediate, and long-term outcomes Develop and implement annual evaluation plans Use program evaluation results for program improvement by sharing results with evaluation stakeholders, revising program work plans, and revising subsequent annual evaluation plans Develop dissemination documents to share lessons learned Participate in evaluation and dissemination implementation science-driven studies to contribute to viable models for sustainable comprehensive cancer control			

CDC-NOFO-DP22-2202 Program 3: National Program of Cancer Registries (NPCR) Logic Model

*Strategies and Activities	Short-term Outcomes	Intermediate Outcomes	Long-term Outcomes
Strategy 1: Enhance NPCR data quality, completeness, use, and dissemination Maintain and enhance a population-based central cancer registry (CCR) Maintain and update legislation authorizing the registry Ensure adequate, qualified staff fill critical registry positions Provide relevant, ongoing continuing education and training to CCR staff and reporting partners Convene and maintain an advisory board Collect, format, and manage surveillance data Conduct interstate data exchange annually Implement procedures to ensure timeliness, quality, and completeness of data Maintain data confidentiality and security Perform linkages to improve data completeness and quality Create and implement innovative projects Submit data to CDC annually **Strategy 2 :** Use surveillance systems and population-based surveys to assess the cancer burden, examine health disparities, target program	Increased use of NPCR data by recipients, partners, collaborators, and researchers Achievement of data quality standards by the CCR **Successful adoption of data modernization strategies** **Improved timeliness, quality, completeness, and confidentiality of NPCR surveillance data** **Increased collaboration among chronic disease and other public health programs** Increased access to cancer screening and preventive services among populations of focus Increased knowledge about cancer prevention,	**Increased capacity, flexibility, and utility of CCR infrastructure to meet new data needs** **Increased data use for cancer prevention and control** Improved health behaviors More cancer primary prevention resources and screening available for populations of focus Increased early detection of cancer among populations of focus	Reduced cancer risk Better quality of life among cancer survivors Decreased cancer incidence, morbidity, and mortality Reduced cancer disparities Increased health equity

efforts, and inform efforts to address social determinants of health (SDOH) Use surveillance systems and population-based surveys to assess risk factors and health behaviors among populations of focus Promote and disseminate data to facilitate program planning and evaluation **Strategy 3:** Support partnerships for cancer control and prevention Engage partners to help achieve program outcomes Work with partners to facilitate access to health care for cancer screening and preventive services among populations of focus Support collaborations and partnerships across cancer, chronic disease, and other programs that increase understanding about the relationship between SDOH and cancer risk in communities Collaborate with traditional and nontraditional public health partners that address SDOH **Strategy 5:** Conduct program monitoring and evaluation Monitor and evaluate registry processes, data, and outcomes- routinely check the quality of registry data	screening, and survivorship among populations of focus **Faster reporting of high-quality program data to CDC** Increased use of evaluation findings for program improvement Increased participation in special studies		

Conduct NPCR-led and registry-led audits Participate in CDC-led special studies such as cost or surveillance studies Develop and implement program evaluation plans Evaluate innovative projects Translate and disseminate monitoring and evaluation findings			

***Please note: NPCR does not require recipients to implement DP22-2202 Strategy 4**

i. Purpose

Support three national programs working together through the state, tribe, territory, or freely-associated state's comprehensive cancer control plans, taking advantage of resources,

coordinating efforts, and community involvement to decrease cancer burden and health disparities. Achieved through the provision of breast and cervical cancer screening and diagnostic services and the implementation of evidence-based interventions, cancer coalitions and implementing cancer plan priorities at state and local levels (e.g. county, city, township), and monitoring cancer burden through surveillance.

ii. Outcomes

Program 1: NBCCEDP

Short-term:

Increased access to breast and cervical cancer screening among program-eligible women, with a focus on populations who are disproportionately affected by breast and cervical cancer.
Increased partnerships with clinics serving women with lower income.
Increased access to health/community/social services among program-eligible women through partnerships.
Increased use of data to inform program planning and improvement.
Increased sustainable EBI implementation to improve screening within partner screening clinics.
Improved provider knowledge of breast and cervical cancer screening recommendations and diagnostic guidelines
Improved effectiveness of outreach to populations experiencing health inequities for breast and cervical cancer.

Intermediate:

Increased number of women receiving NBCCEDP-paid screening and follow-up services.
Increased number of women from populations disproportionately affected by breast and cervical cancer and who experience higher mortality served through the NBCCEDP
Increased early detection of breast and cervical cancer
Increased adherence to timely diagnostic follow-up
Increased timely cancer treatment referral
Increased clinic-level breast and cervical cancer screening rates in partner screening clinics
Increased utilization of needed health, community, and social services among program-eligible women
Decreased inequities in screening and follow-up services among populations disproportionately affected by breast and cervical cancer

Long-term:

Decreased cancer incidence, morbidity, and mortality
Reduced cancer disparities

Program 2: NCCCP

Short-term

Increased data use
Increased use of United States Cancer Statistics (USCS) data to assess cancer burden, identify priority populations, and monitor incidence, mortality, and survival.
Increased use of surveillance systems and population-based surveys to assess cancer risk, health behaviors, and access to preventive services
Increased use of data to facilitate program planning and evaluation

Increased collaboration among chronic disease programs
Improved recruitment and engagement of members from priority populations , chronic disease programs, traditional and non-traditional public health partners within comprehensive cancer control coalitions
Improved partnership contribution to EBIs implemented to address cancer burden
Improved implementation of jurisdiction-specific comprehensive cancer control plans
Increased access to cancer screening/preventive services by underserved populations
Increased social, physical, and economic supports that promote healthy lifestyle behaviors that reduce cancer risk, promote screening, and support the wellness of cancer survivors
Improved built environments that shape the living and working conditions known to prevent (or protect against) cancer risk factors, promote healthy behaviors and social connectedness, and improve access to screening and other health services.
Increased chronic disease self-management and wellness programs for cancer survivors
Improved connections to health care systems and services, public health agencies, and community-based organizations to improve population health (i.e., community-clinical linkages)
Improved access to services that meet the social needs to support healthy behaviors and allow access and utilization of health care services
Increased adoption of EBIs among cancer prevention and control plannersImproved knowledge, awareness, and attitudes regarding EBIs and resources that aid with implementation
Improved implementation of EBIs that address primary prevention, screening, and survivorship with fidelity
Increased access to healthy eating and physical activity opportunities
Improved awareness, knowledge, and beliefs about cancer prevention, screening, and survivorship among priority populations
Increased reporting of high-quality program data to CDC
Increased recipient participation in special studies

Intermediate
Increased healthy behaviors among priority populations Increase in healthy behaviors that reduce cancer risk, such as sun-safety practices; reduced tobacco and alcohol use; increased physical activity and healthy eating to keep a healthy weight
Increase vaccination uptake among eligible populations to reduce HPV and Hepatitis B infection
Increased early detection of cancer among priority populations

Long-Term
Reduced cancer risk;
Reduce risk of skin cancer, tobacco-related cancers, HPV-associated cancers, and cancers in which alcohol use, physical inactivity, and poor nutrition are risk factors
Increased quality of life among cancer survivors;
Increase overall wellness (i.e. healthy days measures) as reported by cancer survivors among populations or communities experiencing a disproportionate burden of cancer risk factors and outcomes due to inequities
Improved healthy behaviors among cancer survivors, such as tobacco cessation, physical activity, nutrition, and mental health among populations or communities experiencing a disproportionate burden of cancer risk factors and poorer outcomes due to inequities
Decreased cancer incidence, morbidity, and mortality

Reduced disparities;
Reduced disparities in cancer risk factors and cancer incidence, morbidity, and mortality that are due to social, economic, and geographic inequities that cut across population characteristics, such as gender, race, ethnicity, and other characteristics, historically linked to discrimination or exclusion.
Increased number of local and state-level policies that address the root causes of health inequities, such as racism and discrimination

Program 3: NPCR

Short-term
Increased use of NPCR data by recipients, partners, collaborators, and researchers
Achievement of data quality standards by the Central Cancer Registry (CCR)
Successful adoption of data modernization strategies
Improved timeliness, quality, completeness, and confidentiality of NPCR surveillance data
Increased collaboration among chronic disease and other public health programs
Increased access to cancer screening and preventive services among populations of focus
Increased knowledge about cancer prevention, screening, and survivorship among populations of focus
Faster reporting of high-quality NPCR program data to CDC
Increased use of evaluation findings for program improvement
Increased participation in special studies

Intermediate
Increased capacity, flexibility, and utility of CCR infrastructure to meet new data needs
Increased data use for cancer prevention and control
Improved health behaviors
More primary prevention resources and screening available for populations of focus
Increased early detection of cancer among populations of focus

Long-term
Reduced cancer risk
Better quality of life among cancer survivors
Decreased cancer incidence, morbidity, and mortality
Reduced cancer disparities
Increased health equity

iii. Strategies and Activities
Each of the three programs in this NOFO will implement a unique combination of the five strategies outlined in the specific programmatic logic models as they work together to achieve combined outcomes that are grounded in their jurisdictional comprehensive cancer control plan to which all recipients will contribute and be responsible for implementing via their funded program(s) (i.e., NBCCEDP, NCCCP, and NPCR).

Program 1: NBCCEDP

Strategy 2: Use surveillance systems and population-based surveys to assess cancer burden, examine health disparities, focus program efforts, and inform efforts to address social determinants of health (SDOH).

- Use state and local level health, disease burden, and demographic data, including CCR data, as well as Geographic Information System (GIS) mapping, Small Area Health Insurance Estimates (SAHIE) data, and/or data from other sources to identify and describe the program- eligible populations in your jurisdiction. Prioritize screening and diagnostic services for populations that are disproportionately burdened by breast or cervical cancer, especially those who experience higher mortality and late stage disease.

Strategy 3: Support partnerships for cancer control and prevention.

- Work with cancer coalition partners, CRCCP, NCCCP, NPCR, and other organizations/agencies to develop and implement data-informed, equity-driven state or jurisdictional cancer control plans.
- Serve on the state or jurisdictional cancer coalition to set breast and cervical cancer screening and health equity goals in the state or jurisdictional cancer control plan. Ensure that screening goals are included as a jurisdiction-wide priority and help facilitate coalition collaborations to support implementation.
- Use the state or jurisdictional cancer control plan to inform program planning and identification of priority populations.
- Collaborate with central cancer registries to report and use cancer data for program planning.
- Collaborate with community-based organizations to increase screening among program-identified populations who are disproportionately burdened by breast and cervical cancer, especially those who experience higher mortality and late stage disease. Engage organizations who have demonstrated experience, relationships, and credibility with identified populations.
- Collaborate with other chronic disease and public health programs on activities with defined and measurable breast and cervical cancer screening outcomes. Partner to disseminate public health information and education to program-eligible women, including information on Human Papilloma Virus (HPV) immunization for their children to reduce future risk for cervical cancer.
- Collaborate with other NBCCEDP-funded programs whose service area overlaps with yours to maximize access to screening and avoid duplication in services.
- Engage with other cancer programs to share lessons learned to advance cancer prevention and program service knowledge.
- Collaborate with other programs, as appropriate, to achieve breast and cervical cancer screening outcomes and advance health equity.

Strategy 4. Deliver cancer screening and implement EBIs in primary care clinics that serve women impacted by health inequities.

- Provide breast and cervical cancer screening, diagnostic testing, and treatment referrals to women who are at or below 250% of the federal poverty level and who are uninsured or

underinsured. Prioritize populations that are disproportionately burdened by breast and cervical cancer, especially those who experience higher mortality and late stage disease.

- Ensure timely follow-up for all program-eligible women with abnormal screening and diagnostic test results.
- Ensure all program-eligible women who are diagnosed with cancer are referred to treatment.
- Identify the program-eligible population among women in your jurisdiction. Establish an eligibility determination and enrollment process; assess women for eligibility; and enroll them into the program. Recipients may have more restrictive eligibility criteria but may not expand beyond CDC's criteria as outlined in program guidance. https://www.cdc.gov/cancer/dcpc/about/foa-dp22-2202/
- Set annual and 5-year projections for the number of women who will receive screening and diagnostic services paid by the program. Recipients should increase screening at a minimum of 5% each program year.
- Establish and maintain a screening delivery system to provide breast and cervical cancer screening and diagnostic services. Include securing clinical providers; establishing clinic partnerships; establishing billing and reimbursement systems; and implementing processes to report required screening data for women served (i.e., minimum data elements [MDEs]) to CDC.
- Conduct outreach in communities to identify program-eligible women who need access to breast and cervical cancer screening and diagnostic services; connect women to services at partner clinics.
- Engage local and community-based partners and community health workers to identify women who are underserved and need support to access and complete screening; monitor and report the rate of screening completion to CDC.
- Provide patient navigation to assist women who receive NBCCEDP-paid clinical services in overcoming barriers to complete these services, and initiate cancer treatment. In addition, recipients may provide "patient navigation-only" services to women whose screening and diagnostic services are paid by other sources and who reflect NBCCEDP age and income eligibility requirements. All women enrolled in the program for clinical services must be assessed for barriers and provided patient navigation if needed according to CDC guidance. Prioritize delivery of patient navigation-only services in clinics where NBCCEDP-paid clinical services are provided. If delivering patient navigation-only services, recipients must set annual and 5-year projections; track women through screening and diagnostic services; and submit MDE records for women who complete screening and diagnostic services. Delivery of patient navigation-only services is not a required activity. These services may be implemented in addition to screening provision activities, but not in lieu of them. https://www.cdc.gov/cancer/dcpc/about/foa-dp22-2202/
- Partner with local, community-based organizations to link program-eligible women to health insurance and other needed health (e.g., diabetes, heart disease, obesity, immunization, other recommended cancer screenings) and community/social (e.g., housing, food) services to reduce barriers to breast and cervical cancer screening.

- Develop and maintain a policy requiring participating program providers to implement a tobacco screening protocol to screen every woman for tobacco use and refer women who use tobacco to comprehensive tobacco treatment programs (e.g., state tobacco quit lines).
- Track women through screening and diagnostic services and submit MDE records on all women receiving NBCCEDP-paid clinical services.
- Work with partner clinics that provide NBCCEDP-paid clinical services to implement EBIs that improve service delivery. Recipients may also partner with clinics that are not providing NBCCEDP-paid clinical services but have low breast and cervical cancer screening rates and are serving women with lower incomes. Efforts should be made to enlist these clinics as clinical providers.
- Document EBIs selected for each clinic in the workplan and evaluation plan to assess and track clinic-level screening increases and overall success of EBI implementation. The Guide to Community Preventive Services has established the following EBIs to increase breast and cervical cancer screening: client reminders, reducing structural barriers, provider assessment and feedback, provider reminder and recall systems, engaging community health workers, small media, group education, and one-on-one education. The Guide recommends use of multi-component EBIs that combine strategies which increase community demand for and access to cancer screening.
- Identify at least one individual within each partner clinic to serve as a champion for EBI implementation efforts and ensure a cancer screening policy is in place.
- Conduct quality assurance and quality improvement (QA/QI) activities that support delivery of timely and appropriate screening and diagnostic services by partnering with NBCCEDP-screening clinics to conduct a comprehensive assessment and audits of their health care delivery system. Assess the clinic's patient process flow, screening practices, validate the quality of breast and cervical cancer screening data in electronic health record (EHR) or other data systems, identify established and needed EBIs in each clinic and select appropriate interventions for implementation.
- Provide clinic partners with technical assistance (TA) to support EBI implementation, adaptation, and data monitoring, including reporting of CDC-required clinic-level data.
- Recipients are encouraged to engage organizations with appropriate expertise to assist in providing TA to clinics (e.g., expertise in clinic workflow or process mapping, assessing clinic readiness to implement EBIs, EBI adaptation and implementation, quality improvement, use of EHR data for population management, and data management).
- Engage organizations that demonstrate expertise in and access to the identified populations that are disproportionately burdened by breast and cervical cancer; ideally these organizations should be in the communities where women are being served.
- Collect and report clinic-level data on clinic characteristics, screening rates, and EBI implementation.

Strategy 5: Conduct program monitoring and evaluation to strengthen program processes and improve equitable outcomes

- Participate in CDC-led program monitoring, evaluation, and dissemination activities including periodic data quality reviews (MDEs, clinic data), quarterly program updates, annual program survey, and annual success story submissions.
- Develop an evaluation plan according to CDC guidance https://www.cdc.gov/cancer/dcpc/about/foa-dp22-2202/ and submit to CDC

within six months of award. This plan should be updated and resubmitted to CDC at the end of PY3.

- Conduct process and outcome evaluation to assess all program activities.
- Evaluate your program's activities to connect program-eligible women from the community to completed breast and cervical cancer screening at partner clinics.
- Submit an annual evaluation report to CDC summarizing program monitoring and evaluation findings, including your program's effectiveness at reaching identified populations that are disproportionately burdened by breast and cervical cancer with screening and diagnostic services that contribute to reducing cancer health disparities. Describe how findings were used for program improvement and to identify and disseminate best practices.
- Establish and maintain a patient-level data system to collect and report to CDC the required patient-level data (MDEs) https://www.cdc.gov/cancer/dcpc/about/foa-dp22-2202/ used to monitor and track screenings, outcomes, and treatment referrals for women served, according to CDC performance standards. An abbreviated MDE record must also be reported for women receiving patient navigation-only services (optional activity). For women diagnosed with cancer, link MDE records with cancer registry records to obtain cancer staging data in the MDE.
- Regularly review and use the patient-level data (MDEs) to ensure screening completion and improve the timeliness of diagnostic and treatment referrals.
- Collect and report baseline and annual clinic-level data records for clinics implementing EBIs, including clinic level screening rates, according to CDC guidance. https://www.cdc.gov/cancer/dcpc/about/foa-dp22-2202/
- Regularly review and use the clinic data, including clinic-level screening rates and EBI implementation data to monitor progress and identify areas for program improvement.
- Share monitoring and annual evaluation findings with appropriate partners, including screening providers and clinics where EBIs are implemented, to facilitate program improvement.

Program 2: NCCCP

Strategy 1: Enhance National Program of Cancer Registries (NPCR) data quality, completeness, use, and dissemination

- Use decision matrix available at https://www.cdc.gov/cancer/dcpc/about/foa-dp22-2202/ to revise or update a five-year cancer plan with goals, objectives (including baselines and targets) and strategies. NCCCP recipients are expected to work with their coalition members to select strategies that prioritize :
    - Top ten cancers for males and females (based on crude incidence and death rates).
    - Disparities in cancer outcomes among racial and ethnic groups, low-SES groups, rural or other geographically isolated communities, other population-based or geographically determined communities, and large numbers of persons at disproportionate risk for and affected by cancer.
    - Use of data to monitor cancer risk factors, incidence, and mortality. Recipients are expected to include cancer registry leadership in coalition efforts to ensure access

to data on cancer progress, trends, potential needs to reprioritize cancer, population, or geographic priorities

- Data should be provided annually that describes the reach of implemented interventions within populations and geographic areas
- Share burden data. Recipients' communication activities should include plans for sharing burden data to increase awareness among decision-makers, partners, and the public about the people and places that are most impacted by cancer and opportunities to prevent cancer.

Strategy 2: Use surveillance systems and population-based surveys to assess cancer burden and inform programmatic efforts

- Collaborate with NBCCEDP, NPCR, coalition members, health department, colleges, universities, and other partnering organizations and networks such as the Cancer Prevention and Control Research Network (CPCRN) to collect and examine data from surveillance systems and other sources such as GIS, web scraping, crowdsourced surveys, and community health needs assessments to set and report on yearly and five-year objectives for the jurisdictional cancer plan.
- Conduct environmental and policy scans to increase awareness of physical, social, and economic facilitators and/or barriers for cancer prevention, screening, and survivorship efforts.
- Coalitions should use these data to identify and work with populations and geographic locations with the greatest burden. Data should also be used to identify populations within these areas that are disproportionately affected by cancer as evidenced by race/ethnicity, urban or rural residency, age, gender, income, insurance status, education, or sexual orientation/identity. Once identified, these data should be used to guide selection of tailored interventions that can increase the likelihood that these populations of focus will benefit from the larger population wide strategies and interventions.

Strategy 3: Support partnerships for cancer control and prevention

- Applicants are required to have the infrastructure necessary to convene, manage, and sustain the activities of a multi-sectoral coalition.
- Applicants should describe the coalition within the project narrative. They should also include a table describing the coalition's involvement in supporting NCCCP priorities. An example is available at https://www.cdc.gov/cancer/dcpc/about/foa-dp22-2202/.
- Applicants should also submit a letter of support or memoranda of understanding or agreement from the coalition on the organization's letterhead, signed by coalition leadership that details how members will be involved in work plan development and implementation. This document should describe the formal arrangement and how coalition members and partners will identify and achieve short, intermediate, and long-term outcomes of this NOFO,
- After award, recipients are required to convene and maintain a multisectoral coalition that includes NBCCEDP and NPCR leadership, comprehensive cancer control subject matter experts, and influential representatives from sectors such as business, labor, civic/social, urban planners, education, health services, housing, media, public safety, and members from the populations and communities that are the focus of their cancer prevention,

screening, and survivorship strategies. Examples are available at https://www.cdc.gov/cancer/dcpc/about/foa-dp22-2202/.

- Recipients must dedicate qualified staff to support coalition recruitment, engagement, maintenance, and reporting activities. These positions should at a minimum include a:
  - Program Director (100% level of effort)
  - Program Manager of Coalition Activities (100% level of effort)
  - Policy Lead
  - Evaluator

Strategy 4: Deliver screening and implement evidence-based interventions (EBIs)

- Provide a narrative that describes the objectives, strategies, and activities, to implement and evaluate the state- or jurisdiction-wide cancer plan over the 5-year project period. Coalitions must also submit a detailed Year 1plan for implementing select cancer plan priorities for, at a minimum, Primary Prevention, Screening and Early Detection, Cancer Survivorship Strategies. Coalitions are expected to identify and implement strategies that will achieve short- (1-2 years), intermediate (3-4 years), and long-term (5 years) outcomes within three priorities:
- **Priority 1: Primary Prevention** – to reduce cancer risk factors, such as tobacco and alcohol use, physical inactivity, overweight/obesity, HPV/HBV transmission, UV exposure, and exposure to environmental carcinogens such as radon. Sample EBIs and SDOH Strategies are available at https://www.cdc.gov/cancer/dcpc/about/foa-dp22-2202/
- **Priority 2: Early Detection and Screening** – to increase access and use of screening services in accordance with the USPSTF' recommendations for breast, cervical, colorectal, lung, and/or BRCA-related cancers. In addition, applicants should also describe efforts to support the USPSTF recommendation for prostate cancer screening, i.e. informed decision-making, which helps patients consider the benefits and harms of screening to help them determine individual preferences.
- **Priority 3: Health and Wellbeing of Cancer Survivors**– to improve the health and wellbeing of cancer survivors; increase the support and well-being of their caregivers and families and increase ability of health care providers and health systems to recognize and meet survivors' needs.
- Coalitions will develop work plans that describe how their coalition will make immediate and long-term progress by implementing both population wide evidence-based interventions and strategies that address social determinants of health. Plans should account for populations that may not benefit from the population wide improvements due to characteristics such as age, disability status, gender, immigration status/national origin, race/ethnicity, sexual identity and orientation, and other characteristics, historically linked to discrimination or exclusion (Alcaraz, 2020) and identify culturally competent ways to work with selected populations of focus. Coalitions are expected to:
- Use data (NOFO Strategies 1 and 2) and the decision framework available at https://www.cdc.gov/cancer/dcpc/about/foa-dp22-2202/ to support policy, systems, and environmental interventions that will individually and collectively advance program priorities by reaching the most people possible with the greatest impact for reducing cancer risk, promoting screening, and improving the overall health of cancer survivors.

- Identify short-, intermediate-, and long-term strategies that can potentially complement each other and work synergistically to achieve the 5-year objectives. For each objective, strategies could be distinct or could build upon the strategies from the previous year.

Short-term strategies should work to reduce cancer risk factors by:

- addressing health behaviors, psychosocial factors, and psychological sequelae.
- fostering connections among health care systems and services, public health agencies, and community-based organizations to improve population health (i.e., community-clinical linkages) through enhanced navigation and community health care worker services, care coordination, tele-health and tele-mentoring, mobile screening units, home visits to increase community access to health services (e.g., HPV vaccinations) and other approaches;
- implementing changes to health care practices and systems to improve the quality, efficiency, and effectiveness of patient care, such as the use of clinical decision support tools, team-based care, standing orders; automatic patient-reminders; and/or
- addressing social needs, such as improving access to healthy, culturally acceptable, and affordable food and providing transportation to access and utilize health care services.

Intermediate-term strategies should relate to improving the built environments that shape the living and working conditions known to prevent (or protect against) cancer risk factors, promote healthy behaviors and social connectedness, and improve access to screening and other health services. Many of these strategies may cut across two or all priority areas and influence more than one of the 5-year objectives. Examples of changes in the built environments include those that address:

- neighborhood safety.
- community- and street-scale urban design.
- access to parks/greenspace/sports fields.
- food deserts.
- alcohol density (i.e., the number of alcohol outlets in each area).
- smoke free policies on prohibiting tobacco use in public places.
- availability of broadband; and/or
- availability of public transit.

Long-term strategies focus on convening and working with multi-sectoral partners and supporting community-level engagement to build the collective efficacy necessary at the local and state-level to address policies that are the root causes of health inequities. Policies may range from strengthening economic support to families to those that improve access to healthcare. Many of these strategies may cut across two or all three priorities and influence more than one of the 5-year objectives.

- Select interventions for short-, intermediate-, and long-term strategies using the following criteria:

- Availability of research demonstrating effectiveness of the intervention for reducing cancer risk and improving outcomes.
- Relevancy to the needs of the communities of focus
- Engagement of affected communities
- Multi-sectoral engagement and commitment from coalition.
- Availability of human and financial resources for implementation.
- Potential to be an innovative intervention or approach for addressing program priorities
- Evidence of successful implementation by similar public programs:
    - NCCCP Demonstration Projects that have shown to be promising (e.g., Project ECHO and Patient Navigation Interventions to Improve the Health and Wellness of Cancer Survivors in Rural Communities, Preventing Liver Cancer by Promoting Vaccination & Screening among Opioid Users)
    - Interventions highlighted in NCCCP success stories and other sources that have demonstrated measurable improvements in health outcomes, preventive care, and health behaviors, or have led to policy or environmental change that will have positive effects in the long term on health outcomes.
    - Proven interventions from other areas of health or sectors that are applicable to reducing cancer risk and improving cancer outcomes. For example, implementation of proven strategies to prevent adverse childhood experiences (ACEs) that increase likelihood for cancer risk behaviors, such as smoking and heavy drinking (CDC Vital Signs on ACEs; Sonu 2019; Holman 2019; Ports 2019).

Strategy 5: Conduct program monitoring and evaluation

Create a performance measurement plan to report short, intermediate, and long- term outcomes. Template is available at https://www.cdc.gov/cancer/dcpc/about/foa-dp22-2202/ to create a draft performance measurement plan. Specifically, performance measures should address the extent to which recipients will:

- Increase data use
- Increase collaboration among chronic disease programs
- Improve implementation of jurisdiction-specific comprehensive cancer control plans
- Increase access to cancer screening/preventive services by priority populations
- Increase adoption of EBIs among cancer prevention and control planners
- Increase reporting of high-quality program data to CDC
- Increase health seeking and healthy behaviors among priority populations
- Increase early detection of cancer among priority populations
- Establish baseline and target measures from most recent recommended data sources.
- Report on achievement of performance metrics annually

Develop and implement annual evaluation plans https://www.cdc.gov/cancer/dcpc/about/foa-dp22-2202/ to create a draft program evaluation plan.

Using the CDC Framework for Program Evaluation, develop an evaluation plan that involves processes that are useful, feasible, ethical, and accurate. The evaluation will include steps to:

- Engage partners and collaborators

- Describe the program
- Focus the evaluation
- Gather credible evidence
- Justify conclusions
- Share lessons learned

Program evaluation plans should be submitted annually and should consider an evaluation framework that acknowledges the unique context of the program. Examples of frameworks that can help facilitate the evaluation include: RE-AIM, culturally responsive evaluation, and collective impact. Plans must include:

1. Logic model
2. Evaluation questions that address:
   - Comprehensive Cancer Control plans
   - NCCCP Work Plan implementation
   - Comprehensive Cancer Control Coalition composition, roles, and contributions to program interventions
   - NCCCP interventions that address social determinants or promising practices that require rigorous evaluation to document their effectiveness
3. Evaluation planning matrix that includes information regarding how the awardee will address the evaluation questions through:
   a. Program indicators
   b. Recurring data collection methods including but not limited to abstraction of secondary data from surveillance systems or population-based surveys, document/chart review, surveys, and interviews
4. Analysis plan that describes how data collected will be analyzed using traditional qualitative, quantitative, or mixed methods. Once the program evaluation plan is implemented, evaluation findings will be shared through the dissemination of annual evaluation reports. Annual evaluation reports must include the following components:
   a. Executive summary
   b. Introduction and Background
   c. Methodology
   d. Results
   e. Summary, Conclusion, and Recommendations
   f. References and Appendices

Use program evaluation results for program improvement by sharing results with evaluation collaborators and partners, revising program work plans, and revising subsequent annual evaluation plans.

o Develop dissemination documents that are tailored to key evaluation collaborators and partners such as leadership team members, the comprehensive cancer control coalition, and program staff.

o Revise work plans with input from program implementers and CDC technical assistance team.

o Use evaluation findings and the newly revised work plan to inform annual evaluation plans.

Develop dissemination documents to share lessons learned and contribute to the body of knowledge on cancer prevention and control activities for multi-sector coalitions.

- Submit annual success stories
- Submit peer-reviewed manuscript at least once during the period of performance
- Engage in peer-peer learning by participation in webinars, conferences, or meetings

Participate in evaluation and dissemination implementation science-driven studies to contribute to viable models for sustainable comprehensive cancer control

- Submit program data via an online program monitoring and evaluation platform.
- Participate in annual surveys and interviews that assess the effectiveness of the National Comprehensive Cancer Control Program
- Upon request, submit proposals to participate in dissemination implementation science studies and demonstration projects

Program 3: NPCR

Strategy 1: Enhance National Program of Cancer Registries (NPCR) data quality, completeness, use, and dissemination

Required Activities:

Legislative Authority: Ensure that legislation supports cancer surveillance and has flexibility to meet changing data requirements and innovations in the field.

- Maintain existing law/regulations that provide legal authority for a central cancer registry as defined in Public Health Services Act Title 42, Chapter 6A, Sub-Chapter II, Part M, 280e, authorizing the National Program of Cancer Registries. https://www.cdc.gov/cancer/dcpc/about/foa-dp22-2202/ to NOFO website
- Update existing state law/regulations as needed to support criteria specified in Public Health Services Act Title 42, Chapter 6A, Sub-Chapter II, Part M, 280e specifically addressing and complying with electronic reporting, data exchange, data modernization and innovation, and data sharing and use requirements.

Administration/Operations: Maintain effective and efficient processes and high-quality staff to operate the registry

Establish or retain staff sufficient in number and expertise to manage, implement, and evaluate the central cancer registry, as well as utilize and disseminate the data. Core required staff must fill the roles of Program Director/Project Director/Principal Investigator (PD), Quality Assurance/ Quality Control Manager (QA/QC), IT Staff, and Education and Training Coordinator (ETC). The Quality Assurance/ Quality Control Manager and Education and Training Coordinator positions must be filled by qualified, experienced Certified Tumor Registrars (CTRs).

Core Required Positions:

PD	1 FTE	100%
ETC	1 FTE	100%
QA/QC	1 FTE	100%
IT	.25 FTE	25%

- Ensure policy and procedure manuals are up-to-date and staff are cross trained in key functional areas to maintain continuity of operations.
- Ensure that adequate hardware and software systems are in place to support the central cancer registry activities, including data collection, database management, interstate data exchange, data linkages, quality assurance, data analysis, and management reporting. (Provide MOU with IT department if IT staff are not embedded in program)
- Develop or utilize promising practices and tools to strengthen effective communication with data reporters to improve data quality, completeness, and timeliness.
- Implement promising processes to improve real-time reporting and improve data quality.
- Ensure the confidentiality and security of central cancer registry data through software and hardware security standards. This includes:
    1. Implemented and documented security policies and procedures
    2. Documented data release policies and procedures that include both access and disclosure of information
    3. A disaster plan that includes annual risk assessments, security audits for registry data tracked, and ongoing security training for staff and telework options. Details included on the NPCR data security pages https://www.cdc.gov/cancer/dcpc/about/foa-dp22-2202/
    4. Develop, submit, and implement a Data Management Plan that conforms with CDC requirements and guidelines. CDC DMP template and guidance for award applicants and recipients can be found through the following link https://www.cdc.gov/cancer/dcpc/about/foa-dp22-2202/

Data Collection, Content and Format: Ensure that the registry collects all reportable data in accordance with NPCR requirements.

• Conduct surveillance for all reportable cancer diagnoses and related data items according to the CDC Program Standards and Data Submission Specifications http https://www.cdc.gov/cancer/dcpc/about/foa-dp22-2202/) to NOFO Website for program standards and data submission specifications)

- Monitor central registry and facility data reporting progress throughout the year to improve data collection.

Electronic Data Exchange: Utilize and promote electronic reporting among facilities and data sources.

• Develop and implement a plan to enhance timely reporting via the expansion of electronic reporting by one or more means (e.g., Data modernization activities, EHR reporting, and ePath reporting), and through data exchanges (including interstate data exchange). The CDC NPCR Data Modernization Initiative (DMI) Strategy can be found through the following link. https://www.cdc.gov/cancer/dcpc/about/foa-dp22-2202/

Data Completeness/Timeliness/Quality: Cancer data meet NPCR completeness, timeliness and quality standards.

- Implement procedures to ensure timeliness, quality, and completeness of data in accordance with CDC data quality standards.

- Inform CDC in a timely manner if barriers to data collection processes or procedures may negatively affect compliance with CDC data quality standards or delay data submission requirements. Work with CDC to resolve and prevent future occurrence.
- Establish interstate data exchange agreements with out-of-state central cancer registries to obtain data on residents who have been diagnosed or treated outside of catchment area and perform data exchanges with them at least twice per year. Quarterly data exchange with geographically bordering central cancer registries is strongly encouraged.
- Perform linkages with external data sets to improve data completeness and quality
- Develop and promote good relationships with reporting facilities
- Develop and implement plan to monitor case reporting and completeness status
- Develop and implement procedures to effectively handle ePath volume
- Participate in the testing of Registry Plus applications to enhance functionality and timely release, which includes:
  1) Installing test versions of Registry Plus on a desktop or test server.
  2) Testing the application using test protocols provided by the Registry Plus support team.
  3) Reporting any issues related to bugs or standards.
  4) Installing revised test versions and retesting until all issues have been resolved.

Linkages: Perform linkages to improve data quality and completeness and data accessibility.

- Create and employ data linkages as described in the NPCR Program Standards and additional linkages which are necessary for registry functioning. Linkages include, but are not limited to:
  - State Vital Statistics (at a minimum, death records) annually
  - Indian Health Services Administrative records (as appropriate)
  - Social Security Administration Death Master File annually
  - National Death Index annually
  - Veterans Administration
- Perform linkages that assist in addressing other public health issues as they relate to cancer, including tobacco use, vaccination, physical activity, and obesity (e.g., behavioral risk factor data, socio-economic status (SES) data, social determinants of health (SDOH) data, including available data on intersectionality).
- The central cancer registry uses linkages to address gaps identified in data quality and completeness or to improve the utility of the data.

Data Quality Assurance and Education: Establish policies, procedures, and processes for data quality assurance that link with education and training to maintain high quality data

- Develop, implement, and maintain an education and training plan for internal staff and reporting facilities with the goal of improving CCR data quality.
- Conduct internal registry quality control and quality improvement activities by CCR staff.

- Participate in NPCR defined national data quality assurance activities including Data Quality Evaluation projects, ad hoc data evaluation, audits, and other special data quality control and improvement activities. Complete and submit the Program Evaluation Instrument (PEI) by the due date.
- Utilize available training and educational resources and program's ETC to educate staff and reporters.
- Incorporate findings and results of NPCR Data Evaluation Reports (DER), PEI and audits into educational/training plans and strategy.
- Conduct routine data quality evaluations showing continuous data quality improvement (e.g. decrease in percentage of records with unknown values)

Data Use and Data Monitoring: Use and disseminate cancer and related program data to partners, collaborators, and researchers to expand use of registry data, promote a common understanding of the state or territorial cancer burden, and inform evidence-based decision making.

- Within 12 months of the end of the diagnosis year with data that are 90% complete, the CCR produces preliminary pre-calculated data tables in an electronic data file or report of incidence rates, counts, or proportions for the diagnosis year by SEER site groups to monitor the top cancer sites within the state or territory.
- Within 24 months of the end of the diagnosis year with data that are 95% complete, the CCR, in collaboration with local cancer control programs, produces the following electronic reports:
    1. Reports on age-adjusted incidence and age-adjusted mortality rates for the diagnosis year using SEER site groups and, where applicable, stratifying by age, sex, race, ethnicity, and geographic area.
    2. Biennial reports providing data on stage and incidence by geographic area, with an emphasis on screening-amenable cancers and cancers associated with modifiable risk factors, such as tobacco use, obesity, and human papillomavirus (HPV). infection.
- The CCR ensures annual use of cancer registry data for public health and surveillance research purposes in **at least five** of the following ways:
    1. Comprehensive cancer control
    2. Detailed incidence and mortality by stage and geographic area
    3. Collaboration with cancer screening programs for breast, colorectal, or cervical cancer
    4. Health event investigations
    5. Needs assessment and program planning (e.g., Community Cancer Profiles)
    6. Program evaluation
    7. Epidemiologic studies
    8. Survivorship programs

Data Submission: Submit cancer data to CDC each year in accordance with CDC standards and requirements.

- Submit electronic data files to the NPCR Cancer Surveillance System (CSS) according to the timeframe and content established by CDC that meets the reporting requirements outlined in the NPCR-CSS Submission Specifications document.

Submitted data should meet the criteria for publication in the United States Cancer Statistics (USCS), the National Data Quality Standard, and the Advanced National Data Quality Standard. https://www.cdc.gov/cancer/dcpc/about/foa-dp22-2202/

- In appropriate data submission years, when the CCR data file meets specified data completeness and quality standards, the CCR data are included in *Cancer in Five Continents* publication.

• Participate in all CDC-created and hosted analytic datasets and web-based data query systems as outlined in the annual NPCR CSS Data Release Policy. https://www.cdc.gov/cancer/dcpc/about/foa-dp22-2202/

Innovation Projects (required, if funded for innovation project implementation)
Advanced Surveillance: As applicable and available, participate in NPCR-funded innovation projects.

- Plan, implement, and evaluate innovation projects.
- Engage cancer coalition leadership and task groups to identify potential project topics.
- Share promising practices with partners, collaborators, and cancer program recipients
- Participate in CDC sponsored special studies and pilot projects

Strategy 2: Use surveillance systems and population-based surveys to assess cancer burden, examine health disparities, target program efforts, and inform efforts to address social determinants of health (SDOH).

- Develop a data coordination plan that proposes innovative ways to utilize cancer surveillance data that can be used to improve public health in the catchment area.
- Provide cancer surveillance data in an easily accessible format and guidance on data interpretation and appropriate use.
- Analyze data for disparities and gaps and share with appropriate partners
- Support efforts to improve quality data collection on populations disproportionately affected by chronic diseases
- Promote and disseminate data to facilitate program planning and evaluation
- Promote use of surveillance data to assess risk factors and health behaviors among populations of focus affected by chronic diseases.
- Produce or participate in the production of biennial reports of incidence measures appropriate for the cancer and population (e.g., rates, counts, proportions) at geographic levels appropriate for the local population (e.g., county, city or statistical health area) for screening-amenable cancers (e.g., breast, cervix, colorectal, lung) diagnosed at late stage and cancers associated with obesity, tobacco, and human papillomavirus (HPV) infection.
- Submit final biennial cancer surveillance report to CDC and disseminate to partners as appropriate.

Strategy 3: Support partnerships for cancer control and prevention

- Support collaboration across NPCR, CDC's National Breast and Cervical Cancer Early Detection Program (NBCCEDP), CDC's National Comprehensive Cancer Control Program (NCCCP), and other chronic disease programs.
- Convene, support, and sustain partnerships and networks necessary to support implementation of cancer program priorities and activities.
- The CCR serves on the state/tribal/territory cancer coalition to develop and implement data-informed, equity-driven cancer control plans.
- The CCR establishes a working relationship with other cancer control programs, including screening programs and tobacco control programs, to assess and implement cancer control activities.
- The CCR establishes and regularly convenes an advisory committee to help build consensus, cooperation, and planning for the registry and to enhance chronic disease program coordination and collaboration.
- Use the advisory committee to develop and refine quality improvement initiatives.
- Establish and promote greater awareness and use of the cancer registry data.
- Collaborate on program planning and identification of populations of focus, based on the state or jurisdictional cancer control plan.
- Collaborate with NCCCP, CRCCP, and NBCCEDP programs on activities with defined and measurable cancer prevention or control outcomes.
- Share cancer surveillance data with NCCCP, CRCCP, and NBCCEDP programs, and other organizations/agencies as identified by the central cancer registry's advisory committee, to enable implementation of evidence-based interventions for health systems change.

See Collaboration section for more detailed information

Strategy 5: Conduct program monitoring and evaluation.

- Participate in CDC-led program monitoring, evaluation and dissemination activities including periodic data quality audits, PEI surveys, quarterly program updates, and annual success story submissions.
- Develop an evaluation plan according to CDC guidance. https://www.cdc.gov/cancer/dcpc/about/foa-dp22-2202/. This plan should be implemented and reported on annually throughout the 5-year performance period.
- Conduct process and outcome evaluation to assess all program activities and use findings to continuously improve registry operations, data quality and completeness.
- Provide an update on annual evaluation progress to CDC in the Annual Progress Report (APR). The update should summarize program monitoring and evaluation findings and describe how findings were used for registry program improvement. See Evaluation Section for details.
- Submit the NPCR Program Evaluation Instrument (PEI) as directed (this is a requirement for all CCRs).
- Participate in the NPCR Data Quality Evaluation (DQE) as requested (this is a requirement for all CCRs).

1. Collaborations

a. With other CDC programs and CDC-funded organizations:

All Programs: NBCCEDP, NCCCP, and NPCR

Successful implementation of this NOFO requires that recipients work together to maximize the effectiveness and reach of NOFO strategies and activities by building upon the unique strengths and shared goals of each of the three cancer programs. Recipients' collaborative efforts should be tied to the jurisdiction's overarching cancer plan. Leadership from each recipient should be members of the cancer coalition and be involved in the development, implementation, and updating of the cancer plan. Recipients' collaboration efforts should reflect CDC's expectation for how programs should work together to achieve NOFO outcomes. Assessment of previous collaborative efforts identified key elements of successful collaboration, to include partnerships, leveraging of resources, coordination of activities, consistent communication, and community involvement. To ensure that collaborative activities are implemented efficiently and effectively, the following standard criteria should guide recipient efforts.

Partnerships:

- Engage relevant agencies and programs to support cancer prevention and control activities.
- Ensure representation from each of the three flagship programs-NBCCEDP, CCC, and NPCR for award recipients within your jurisdiction.
- Engage and garner support from other chronic disease programs (e.g., CRCCP, WISEWOMAN, tobacco programs).
- Engage and garner support from external partners. Seek partners with varied expertise not currently represented (e.g., organizations with expertise in health equity). Expand networks to include nontraditional partners with relevant expertise.

Resources:

- Collaborate to make the best use of resources.
- Work together to maximize and ensure appropriate use of resources across programs.
- Engage community, public, and private-sector partnerships, as appropriate, to use resources in support of implementation.
- Think of resources broadly (e.g. contacts, connections, trust within the community).
- Apply innovative approaches to alleviate resource barriers.
- Use subject matter expertise (e.g., in partnership and coalition building, epidemiology and surveillance, PSE change, patient navigation, community-clinical linkages, research and evaluation, program coordination, and strategic planning) from across the flagship programs and partners to implement program activities.
- Secure additional non-federal resources to promote sustainability of program efforts.

Coordination of activities:

- Ensure program involvement is aligned with respective strengths, mandates, and priorities, and reduces duplication.
- Work together to achieve NOFO outcomes by building on the strengths of each of the flagship programs (e.g., NBCCEDP's extensive provider network, NCCC's PSE expertise,

NPCR's data).
Ensure that program roles and contributions are aligned with legislative and/or other mandates that guide program implementation.

Consistent communication:

Practice consistent, efficient, and effective communication.
Establish channels for routine, multidirectional, communication—at least monthly—between flagship programs.
Ensure ongoing communication with other chronic disease partners.

Community Involvement:

Involve and garner support from community, public, and private partners.
Engage community partners in planning, implementation, and evaluation of NOFO strategies, as appropriate.

b. With organizations not funded by CDC:

All Programs: NBCCEDP, NCCCP, and NPCR

Recipients must also work with non-funded national, regional, and local organizations to ensure NOFO success. These formal collaborations may vary based upon program, so applicants are encouraged to reference the strategies and activities sections of this NOFO and the list of organization types on the application website (DP22_2202 Website to be added). At a minimum, applicants should provide letters of support from partners that indicate the role(s) they will serve. Applicants must submit letters dated within 30 days of the application and should specifically state the organizations role and how they will help applicant achieve the goals of NOFO. If awarded, MOUs or MOAs with these partner organizations must be submitted within 90 days of receiving award.

Examples of expected collaborators include:
State Medicaid agencies, Community Health Centers,
private providers, health systems, and other relevant organizations
state- and jurisdictional-recipients of other relevant Federal programs (e.g., the Health Resources and Services Administration's State Office of Rural Health programs or Maternal and Child Health Bureau).
local public health departments (for state recipients).
local health insurers.
American Indian/Alaska Native tribal governments and/or tribally designated organizations.
non-CDC funded Community Based Organizations.
faith-based organizations.
the private sector, including chambers of commerce, large employers,
community members
organizations that influence social determinants of health (e.g., housing, transportation, healthcare access, etc.)

2. Target Populations

Program 1: NBCCEDP

The NBCCEDP's population of focus is women at or below 250% of the federal poverty level, aged-appropriate based on breast and cervical cancer screening recommendations, and who live in the applicant's geographic area (state, Federally Recognized American Indian Tribes, Tribal Organizations, Alaska Native Organizations, and Urban Indian Organizations, US Territory and Freely Associated States or service area). Applicants are required to describe their population of focus (using available data) such as race, ethnicity, gender, geography, socioeconomic status, health literacy, screening rates, and cancer incidence and mortality. Recipients must prioritize eliminating health disparities (e.g., high mortality rates and late stage disease), and achieving health equity on a jurisdictional level. Applicants must describe the health equity challenges in their jurisdiction, how they propose to address them through various strategies, and how progress will be measured. Applicants should also describe how they propose to engage these communities, influence their environments, and empower women so that screening services are accessible and culturally appropriate.

Program 2: NCCCP

Applicants are required to describe their population(s) of focus in their jurisdiction based on available data and demonstrate the extent to which they expect to reduce cancer health disparities through various strategies, including addressing the underlying social determinants of health inequities, to achieve the greatest health impact and advance health equity. Recipients are expected to take into consideration the population(s) of focus in the planning, implementation, and evaluation phases of their program. In short, recipients are expected to ensure that every person living within targeted geographic areas benefit from the relevant prevention, screening, and survivorship strategies.

Program 3: NPCR

The target audience is all residents who live in the applicant's geographic area, this includes members of tribes or tribal organizations. This program supports collection of all cancer cases in the award recipient's entire geographic catchment area (e.g., statewide). The aim of this portion of the NOFO is to ensure federal support for all statewide and established territorial cancer registries in the United States (including DC, US Virgin Islands, Freely Associated States and US Affiliated Pacific Islands).

a. Health Disparities

While all segments of society are affected by cancer, there are certain populations that are disproportionately burdened by the increased risk of cancer or by the lack of adequate healthcare options for prevention and/or treatment. Recipients should seek to achieve health equity by focusing efforts on populations disproportionately affected by cancer. Use relevant data to identify the populations and implement culturally appropriate interventions and support policy, systems, and environmental strategies to increase their access and benefits from cancer prevention, screening, referral, and survivorship services. Disproportionately burdened populations may be defined by sex, race, ethnicity, disability, sexual orientation, gender identity, geographic location, socioeconomic status, or the intersection of several of these factors that collectively impact health outcomes. Among the populations that

will benefit from this funding are those living in rural and frontier geographic areas; uninsured or underinsured persons; culturally isolated persons; incarcerated or institutionalized women; medically underserved persons; persons from minorities defined by race, religion, ethnicity, or culture, including African American, Alaska Native, American Indian, Asian American, Pacific Islander and Hispanic persons: lesbian, gay, bisexual, or transgender (LGBT) persons, and persons who have low literacy, non-English speaking language barriers, and disabilities.

Applicants must address cancer health disparities utilizing the following guidance:

- Use burden data to identify and describe populations of focus experiencing the greatest disparities.
- Allocate resources to prioritize those populations most in need based upon the data.
- Identify appropriate partners with experience working with the population of focus and expertise in addressing under-resourced communities.
- Engage communities to help identify root causes and solutions within each community.
- Identify community resources supportive of services for under-resourced communities to address i.e., housing, food instability, safety, and security needs, etc.
- Plan to assess outreach, monitor progress, and measure impact on reducing disparities.

iv. Funding Strategy

All eligible applicants may apply for one or more of the programs (NBCCEDP, NCCCP, NPCR) within this NOFO. Applicants must submit an application for each program they are seeking funding for.

Program 1: NBCCEDP

Funding will be awarded based on performance goals for the number of women projected to receive NBCCEDP-paid screening or diagnostic services each program year. Tiered funding includes support for all direct costs and allowable 10% administration costs associated with implementation of all NBCCEDP strategies and activities.
Funding amounts are divided into 5 tiers based on the number of women projected to receive NBCCEDP-paid screening or diagnostic services:

Funding by Tier		Performance Goal
Tier 1	Up to $8 million	20,000 and over
Tier 2	Up to $5.9 million	7,000-19,999
Tier 3	Up to $2.9million	3,500-6,999
Tier 4	Up to $1.9 million	1,000-3,499
Tier 5	Up to $899k	1-999

Applicants must apply for funding within a tier based on their capacity to meet the tier performance goal. Within the appropriate funding tier, applicants should not request more funding than is needed to fulfill program requirements—regardless of the maximum. These funding tiers apply to program year 1 and may be adjusted in future program years based on changes in CDC's performance goals.

Program 2: NCCCP

Each recipient will receive $250,000 in base funding to support two full-time employees (FTEs) at a 100% level of effort. It is expected that these FTEs will focus on program planning, management, coalition coordination, and reporting.

The remainder of recipients' funding will be allocated based on a combination of the following factors:

Cancer incidence and prevalence within the state, tribe, or Freely Associated States and US Affiliated Pacific Islands

Total estimated number of people that will be reached by proposed work plan's prevention, screening, and survivorship support strategies and interventions, and estimated number of people that will be reached from populations at disproportionate risk for or affected by cancer.

No more than one applicant per state, tribe, tribal organization, or Freely Associated States and US Affiliated Pacific Islands will be awarded NCCCP funds. All applicants, including those that are regional in scope or are national organizations must identify a population(s) of focus in one state, tribe, tribal organization, Freely Associated States and US Affiliated Pacific Islands, and implement all required program activities in the selected state, tribe, tribal organization, or territory

Program 3: NPCR

The NPCR funding formula will be formula-based and includes factors that impact the cost of operating a given NPCR registry (e.g., state laws and policies, underlying healthcare system structure, etc.) and the burden of cancer within the boundary of the state or Freely Associated States and US Affiliated Pacific Islands (catchment area). The legislation authorizing NPCR clearly states that its purpose is to establish a national program of cancer registries by supporting statewide cancer registries; thus, all existing statewide and well-established territorial population-based central cancer registries are eligible to apply. However, the law also stipulates that NPCR cannot replace or diminish the National Cancer Institute's Surveillance, Epidemiology, and End Results (NCI SEER) program; therefore, the funding formula will also consider funds awarded to any entity within the catchment area for core cancer surveillance operations by NCI SEER. Receipt of additional NCI SEER funds in subsequent years may result in reduced funding through this cooperative agreement, in concordance with the funding formula.

b. Evaluation and Performance Measurement

i. CDC Evaluation and Performance Strategy

All Programs: NBCCEDP, NCCCP, NCPR

Applicants must provide an evaluation and performance measurement plan that demonstrates how the recipient will fulfill the requirements described in the CDC Evaluation and Performance Measurement and Project Description sections of this NOFO. At a minimum, the plan must describe:

- How the applicant will collect the performance measures, respond to the evaluation questions, and use evaluation findings for continuous program quality improvement.
- How key program partners will participate in the evaluation and performance measurement planning processes.

- Available data sources, feasibility of collecting appropriate evaluation and performance data, and other relevant data information (e.g., performance measures proposed by the applicant)

A DMP for each collection and/or generation of public health data funded by DP22-2202 should include the following information:

- A description of the data to be collected or generated in the proposed project;
- Standards to be used for the collected or generated data;
- Mechanisms for or limitations to providing access to and sharing of the data (please include a description of provisions for the protection of privacy, confidentiality, security, intellectual property, or other rights). This section should address access to identifiable and de-identified data or justification for not making the data accessible (see below for additional information about access);
- Statement of the use of data standards that ensure all released data have appropriate documentation that describes the method of collection, what the data represent, and potential limitations for use; and
- Plans for archiving and long-term preservation of the data or an explanation why long-term preservation and access are not justified. This section should address archiving and preservation of identifiable and de-identified data (see below for additional information regarding archiving).

Please use the CDC 508 compliant DMP template provided at the following link https://www.cdc.gov/cancer/dcpc/about/foa-dp22-2202/ Applicants are to include narrative to explain DMP process in the blank space provided**.** The DMP template is also available at https://search.cdc.gov/search/?query=data%20management%20plan

Access to and Archiving of the Data

- For public use de-identified (removal of sensitive identifiable or potentially identifiable information) datasets, an accompanying data dictionary, codes, and other documentation relevant to use of the data set should be deposited in a sustainable repository to provide access to the data. Data that cannot be de-identified can be provided on request under a data use agreement.
- If data is shared through CDC's United States Cancer Statistics (USCS), and this is your only means of making data available to the public, you may indicate that in your document as your avenue for making data accessible.

Please include plans for updating the Data Management Plan (DMP) as new pertinent information becomes available, and, if applicable, throughout the lifecycle of the project. Updates to DMP should be provided in annual progress reports. For more information about CDC's policy on the DMP, see Additional Requirement – 25 | Grants | CDC

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

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

Recipients will be required to submit a more detailed Evaluation and Performance Measurement plan within the first 6 months of award, as described in the Reporting Section of this NOFO.

ii. Applicant Evaluation and Performance Measurement Plan

Applicants must provide an evaluation and performance measurement plan that demonstrates how the recipient will fulfill the requirements described in the CDC Evaluation and Performance Measurement and Project Description sections of this NOFO. At a minimum, the plan must describe:

- How the applicant will collect the performance measures, respond to the evaluation questions, and use evaluation findings for continuous program quality improvement.
- How key program partners will participate in the evaluation and performance measurement planning processes.
- Available data sources, feasibility of collecting appropriate evaluation and performance data, and other relevant data information (e.g., performance measures proposed by the applicant)
- Plans for updating the Data Management Plan (DMP) as new pertinent information becomes available. If applicable, throughout the lifecycle of the project. Updates to DMP should be provided in annual progress reports. The DMP should provide a description of the data that will be produced using these NOFO funds; access to data; data standards ensuring released data have documentation describing methods of collection, what the data represent, and data limitations; and archival and long-term data preservation plans. For more information about CDC's policy on the DMP, see https://www.cdc.gov/grants/additionalrequirements/ar-25.html.

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

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

Recipients will be required to submit a more detailed Evaluation and Performance Measurement plan, including a DMP, if applicable, within the first 6 months of award, as described in the Reporting Section of this NOFO.

Program 1: NBCCEDP

Applicants must provide an Evaluation and Performance Measurement Plan that demonstrates how they will fulfill the requirements described in the CDC Evaluation and Performance Measurement and Project Description sections of this NOFO. NBCCEDP evaluation plan guidance can be found at https://www.cdc.gov/cancer/dcpc/about/foa-dp22-2202/. Applicants should refer to and build upon evaluation questions in CDC's evaluation plan https://www.cdc.gov/cancer/dcpc/about/foa-dp22-2202/ and add any additional evaluation

questions specific to their proposed program. Outputs, short-term, intermediate, and long-term outcomes should be assessed. At a minimum, the plan must describe:

- Partners who are involved in evaluation activities and/or interest in evaluation findings.
- The program via a logic model specific to the recipient's proposed program.
- Priority areas for evaluation and specific evaluation questions that will be addressed
- Available data sources, the feasibility of collecting appropriate evaluation and performance data, and other relevant information (e.g., collecting MDEs, collecting clinic-level screening rate data, monitoring screening outcomes for women receiving patient navigation-only services, assessing extent and sustainability of EBI implementation).
- Performance measures including process measures for strategies and outcome measures for bolded outcomes. (e.g., percent of women served for breast and cervical cancer representing populations of focus, change in clinic-level screening rate, percent of women with abnormal breast cancer screening results with diagnostic follow-up within 60 days).
- Data analysis methods.
- Use of monitoring data and evaluation results for continuous quality improvement.
- How evaluation and performance measures will inform program improvement.

Recipients will be required to submit a more detailed Evaluation and Performance Measurement plan, including a Data Management Plan (DMP), if applicable, within the first six months of award, as described in the Reporting section of this NOFO. The plan should be updated annually to reflect evaluation findings, current program context, and current priorities.

Program 2: NCCCP

Recipients must provide a performance measurement plan and a formal evaluation plan that fulfill the requirements described in NCCCP Strategy 5: Conduct program monitoring and evaluation. Given that the NCCCP recipients do not generate public health data and will primarily use secondary data to evaluate their program, a DMP is not required. The recipient will submit annually a plan that describes the program's intentions evaluate its coalition, cancer control plans, and program interventions. After the first year, the program will also submit annually a report that summarizes the findings of the evaluation conducted. Applicants must submit a draft evaluation that meets the minimum requirements. Specifically, the plan must include:

- A description of program partners and consumers who will be engaged throughout the evaluation. The plan must also describe a concerted effort the program will take to ensure that partner's perspective and insight were taken into account when developing the evaluation plan.
- Logic model that serves as the visual depiction of the program, clearly outlining program resources, activities, outputs, and outcomes. The logic model should not be a duplication of the model published in the NOFO, rather it should describe how the applicant will operationalize the NOFO requirements given its unique context, capacity, and understanding of the program.
- Evaluation questions that address how CCC Plan strategy implementation, Comprehensive Cancer Control Coalition composition, roles, and contributions to

program interventions, and EBIs that address social determinants or promising practices that require rigorous evaluation to document their effectiveness

- Evaluation planning matrix that includes information regarding how the recipient will address the evaluation questions through: indicators, data collection method, and data source type.
- A description of how data will be analyzed using traditional qualitative, quantitative, or mixed methods.
- A description of how evaluation results will be shared with program implementers, partners, and consumers. In addition to this, the plan must also describe how the results will be used to inform program planning and evaluation for the next year.

Recipients will be required to submit a more detailed Evaluation and Performance Measurement plan, within the first 6 months of award, as described in the Reporting Section of this NOFO. This plan will be reviewed by subject matter experts who will submit to recipients an evaluation plan feedback report with recommendations. Recipients must revise the evaluation plan within 30 days upon receipt of the report.

Program 3: NPCR

Recipients must provide an Evaluation and Performance Measurement Plan that demonstrates how the recipeint will fulfill the requirements described in the CDC Evaluation and Performance Measurement and Project Description sections of the NOFO.
The evaluation plan should include:

- Identification of cancer registry partners and collaborators who are involved in evaluation activities and/or have interest in the evaluation findings.
- A logic model specific to the recipient's cancer registry program (can use NPCR logic model as template).
- Priority areas for evaluation and specific evaluation questions that will be addressed during the 5-year performance period.
- Available data sources, the feasibility of collecting appropriate evaluation and performance data, and other relevant information.
- Performance measures.
- Data analysis methods and plan that describes how data collected will be analyzed using traditional qualitative, quantitative, or mixed-methods.
- Use of monitoring data and evaluation results for continuous program and data quality improvement.

NPCR requires recipients to submit a mid-term evaluation plan and progress report at the year 3 midpoint. A final, comprehensive evaluation report is due in year 5. NPCR evaluation guidance and resources are available at:https://www.cdc.gov/cancer/dcpc/about/foa-dp22-2202/
Additionally, the CCR recipient is required to provide a program evaluation plan that describes clear monitoring and evaluation procedures. The plan must follow the CDC Evaluation Framework and include: (1) An overview; (2) intended use and users of evaluation results; (3) program description; (4) evaluation focus; (5) data collection plan; (6) data analysis plan; (7) evaluation timeline, and (8) dissemination plan and use of evaluation findings to make program improvements. Plan strategies, activities, and outcomes should address some of the following areas:

a. Evaluation of timeliness, quality, and completeness of data
b. Current status and improvements of electronic capture of cases
c. Submission of data in accordance with NPCR standards
d. Effective collaborations with NCCCP, NBCCEDP, and other chronic disease programs
e. Planning and implementation of data modernization strategies
f. Planning and implementation of innovation projects

Monitoring Program Progress: Required NPCR Performance Measures
Refer to the NPCR Program Standards document for a complete list of NPCR performance measures. NPCR Program Standards are available through the following link. https://www.cdc.gov/cancer/dcpc/about/foa-dp22-2202/ The performance measures outlined below are required for reporting under DP22-2202. Recipients may create additional, customized indicators or performance measures to monitor their program progress based on individual registry evaluation plan priorities and questions. Recipients will be asked to provide progress updates on customized performance measures or indicators as part of APR requirements. Recipients are required to submit progress on the following performance measures (PMs). Please see bolded short- and intermediate-term outcomes in the NPCR logic model.

NPCR short-term outcomes

1. Successful adoption of data modernization strategies

PM 8: Percentage of labs reporting data electronically using HL7 2.5.1 or other standard HL7 format (measure for e-path reporting).

Target: Increase the percentage of labs reporting data electronically in the designated HL7 format by 3% each year.

Target: Increase the percentage every year to meet the standard of 100% of hospitals reporting electronically by the end of the 5-year performance period.

PM 9: Percentage of hospitals reporting electronically to the CCR each year.

PM 10: Percentage of non-hospital facilities reporting electronically to the CCR each year.

Target: Increase the percentage every year to meet the standard of at least 80% of these facilities reporting electronically by the end of the 5-year performance period.

PM 22: CCR meets a percent completeness each year based on observed-to-expected cases (see PM 13).

Target: CCR-submitted 12-month data meets 90% completeness.

Target: CCR-submitted 24-month data meets 95% completeness.

2. Improved timeliness, quality, completeness, and confidentiality of NPCR surveillance data

PM 11: CCR creates and routinely uses management reports that monitor data reporting, completeness, and quality, attaches templates with the APR submission, and provides a brief explanation of these tools in the narrative.

PM 12: Interstate data exchange occurs at least annually between CCR and designated states or territories and quarterly (if feasible) between CCR and neighboring states.

PM 13: CCR's annual data submission adheres to the following data quality criteria for 12- and 24-month data, as measured via the data evaluation report (DER):

- There are 3% or fewer death-certificate-only cases.
- There is a 1 per 1,000 or fewer unresolved duplicate rate.
- The maximum percentage missing for critical data elements are:
  - 2% age
  - 2% sex
  - 3% race
  - 2% county
- 99% pass a CDC-prescribed set of standard edits for 12-month data, and 97% pass a CDC-prescribed set of standard edits for 24-month data.

PM 14: CCR increases case reporting by at least 2% each year for urologists, dermatologists, and gastroenterologists, as required by law, to demonstrate continuing progress and improvement by the end of the 5-year performance period.
PM 15: CCR increases case reporting by at least 2% each year for medical oncologists, radiation oncologists, and hematologists, as required by law, to demonstrate continuing progress and improvement by the end of the 5-year performance period.
PM 16: CCR performs linkage with state or territory death files at least once every year and incorporates results on vital status and cause of death into the registry database.
PM 17: CCR links with the National Death Index at least once every year and incorporates results on vital status and cause of death into the registry database.
PM 18: CCR links with the state or territory breast and cervical cancer early detection program at least once every year to identify potentially missed cases, reconcile differences between the two systems, and update appropriate data fields to capture post-linkage information.
PM 19: CCR links with the Indian Health Service (IHS) Administrative Database at least once every five years. However, CCRs within IHS Contract Health Service Delivery Area counties link their records with patient registration records from IHS at least once every year.
PM 25: Baseline and annual participation in all CDC-created analytic data sets outlined in the NPCR-CSS data release policy.

3. Increased collaboration among chronic disease and other public health programs

PM 28: Registry advisory committee meets at least twice per year to discuss CCR data reporting, quality, analysis, use, staffing, special projects, and partnerships.
PM 29: Registry advisory committee or cancer coalition develops at least one data quality improvement initiative each year.

4. Faster reporting of high-quality program data to CDC

PM 6: CCR conducts bi-weekly or monthly check-ins with reporting facilities to ensure timely reporting of cancer cases.
PM 7: CCR creates a remediation plan to address reporting challenges due to staff turnover, software issues, or other reasons for reporting delays within 60 days and shares its expectations with the reporting facility.
PM 8: Percentage of labs reporting data electronically using HL7 2.5.1 or other standard HL7 format (measure for e-path reporting).

d. Target: Increase the percentage of labs reporting data electronically in the designated HL7 format by 3% each year.

PM 9: Percentage of hospitals reporting electronically to the CCR each year.

e. Target: Increase the percentage every year to meet the standard of 100% of hospitals reporting electronically by the end of the 5-year performance period.

PM 10: Percentage of non-hospital facilities reporting electronically to the CCR each year.

f. Target: Increase the percentage every year to meet the standard of at least 80% of these facilities reporting electronically by the end of the 5-year performance period.

NPCR Intermediate-term outcomes

1. Increased capacity, flexibility, and utility of CCR infrastructure to meet new data needs

PM 2: CCR secures necessary registry management and operations staff per NPCR Manual and NOFO requirements (core required positions: PD/PI or OM, 1 FTE 100%; ETC, 1 FTE 100%; QA/QC manager, 1 FTE 100%; and IT staff, 0.25 FTE 25%).

Target: At least 75% of required CCR staff positions are filled on an annual basis.

PM 3: CCR reviews Operations Manual twice per year, updates sections as needed, and provides an update in the APR narrative.

PM 4: CCR reviews data management plan (DMP) once per year and updates as needed.

PM 5: CCR maintains a list of reporting facilities that is verified and updated once per year.

See PMs 6-10 above, which also apply to this intermediate outcome

PM 30: The CCR adopts the number of quality assurance measures required to meet Advanced National and National Data Quality Standards annually.

Target: CCR implements at least three quality assurance measures to meet Advanced National and National Data Quality Standards.

2. Increased data use for cancer prevention and control

PM 27: CCR creates a target number of cancer surveillance publications, burden reports, presentations, and data briefs and disseminates them to NPCR and other entities annually.

Target: CCR creates and disseminates at least one comprehensive cancer surveillance report that includes age-adjusted incidence rates, stage at diagnosis, and age-adjusted mortality rates for the diagnosis year using SEER site groups stratified by age, sex, race, ethnicity, and/or geographic area.

Target: CCR presents analysis findings to at least two state or territorial groups and one national group each year (NPCR counts as a national group).

Target: CCR collaborates on at least one summary surveillance report outside of cancer registry, such as environmental health, immunization, nutrition and physical activity, substance abuse (alcohol, marijuana, opioid use), HIV/AIDS, or sexually transmitted infections.

Target: CCR creates five one-page cancer surveillance data briefs each year.

c. Organizational Capacity of Recipients to Implement the Approach

Program 1: NBCCEDP

Applicants must meet the following criteria to sucessfully compete:

Demonstrate relevant expertise and sufficient staffing capacity

Demonstrate readiness to meet project requirements to successfully implement the program with a plan for long-term sustainability

Demonstrate operational experience and capacity to successfully implement activities to support the strategies outlined in the Approach section of this NOFO.

Staffing

Describe staffing capacity to effectively lead and manage the NBCCEDP.

Describe how qualified and experienced staff, including key staff, will be identified and retained to manage the program. Applicants should also submit an Organizational Chart and Curriculum Vitas showing the key staff and their assigned duties. **Applicants must name this file "CVs/Resumes" or "Organizational Charts" and upload it at www.grants.gov.**

Key staff must include:

- Program Manager, at 0.5 FTE minimum
- Data manager, at 0.5 FTE minimum
- Program evaluator, at 0.5 FTE minimum
- Medical advisor(s) with relevant expertise in breast and cervical cancer screening to serve as clinical consultant(s) throughout the five-year funding period.

Describe how cross-training among essential staff will be conducted throughout the period of performance so that key program functions are maintained during hiring freezes or vacancies.

Readiness

Describe availability of a fiscal system that tracks and monitors program expenditures, ensures the accurate and timely reimbursement for services provided by the program, and accurate and on-time reporting of expenditures.

Describe capacity and subject matter expertise to plan and implement NOFO strategies and activities.

Describe access to health systems data such as hospital, clinic, Medicaid, or health plan data to measure screening rates and screening outcomes.

Activities

Describe experience implementing a comprehensive breast and cervical cancer screening program.

Describe experience establishing new partnerships with community-based organizations, providers, health systems, organizations with health equity expertise, and other relevant organizations.

Describe experience implementing EBIs within health systems and clinics to increase breast and cervical cancer screening

Describe experience planning and implementing programs at an organizational level

Describe experience using population-level data for program planning and assessment

Describe experience implementing coordinated interventions with other chronic disease or public health programs

Program 2: NCCCP

Applicants must meet the following criteria to sucessfully compete:

Demonstrate relevant expertise and sufficient staffing capacity

Demonstrate readiness to meet project requirements to successfully implement the program with a plan for long-term sustainability

Demonstrate operational experience and capacity to successfully implement activities to support the strategies outlined in the Approach section of this NOFO.

Staffing

Describe how qualified and experienced program staff will be identified and retained to manage and sustain the cancer control plan, funded program, and coalition. Applicants should also submit an Organizational Chart and Curriculum Vitas showing the key staff and their assigned duties. **Applicants must name this file "CVs/Resumes" or "Organizational Charts" and upload it at www.grants.gov.**

Decribe the staff expertise and knowledge of community engagement strategies, policy, system, and environmental change strategies; and strategies that promote health equity.

Describe the expertise in program evaluation, particularly as it relates to facilitation of evaluation use for program improvement.

Readiness

Describe effective resource allocation to core program activities including but not limited to:

- Development and implementation of a jurisdiction-specific cancer control plan.
- Maintenance and sustainability of a multi-sectoral cancer coalition
- Provision of technical assistance and training to key program partners to ensure that program strategies are implemented as intended with maximum benefit to the community
- Proper identification, implementation, and evaluation of evidence-based strategies designed to reduce cancer risk, promote screening and early detection, and improve the health and well-being of cancer survivors.

Describe the use of disease burden to inform program strategies and community needs

Describe experience in fostering relationships with key decision makers and garnering their commitment and buy-in for program change strategies

Describe experience with effective and constitutive communication

Activities

Describe effective use of data to inform program plans

Describe effective use of a technical package (suite of evidence-based interventions) to effect change in the areas of primary prevention, screening, and survivorship.

Describe capacity to foster relationships with internal partners, the coalition, and strategic allies to achieve cancer prevention and control goals

Decribe the use of innovative and promising practices to address social determinants of health and support those who are disproportionately impacted by cancer

Describe the capacity to evaluate the program for the purpose of improving the program, sharing lessons learned, and contributing to best practices

Program 3: NPCR

Applicants must meet the following criteria to sucessfully compete:

Demonstrate relevant expertise and sufficient staffing capacity

Demonstrate readiness to meet project requirements to successfully implement the program with a plan for long-term sustainability

Demonstrate central cancer registry (CCR) operational experience and capacity to successfully implement activities in support of strategies outlined in the Approach section of this NOFO.

Staffing

Provide position descriptions with percentage of effort for required key positions, organizational chart and CVs or brief bios for all relevant leadership positions for the awardee's NPCR program. **Applicants must name this file "CVs/Resumes" or "Organizational Charts" and upload it at www.grants.gov.** The Quality Assurance/ Quality Control Manager and Education and Training Coordinator positions must be filled by qualified, experienced certified tumor registrars (CTRs).

Core Required Positions:

PD	1 FTE	100%
ETC	1 FTE	100%
QA/QC	1 FTE	100%
IT	.25 FTE	25%

Demonstrate the registry team has the qualifications, management experience, programmatic skills and technical expertise to assure adequate oversight and leadership for the cancer registry specialized functions, including: quality assurance of cancer registry data, hiring and retaining appropriate project staffing, and working with internal and external partners to promote the use and dissemination of cancer surveillance data.

Demonstrate required percent of effort (see above) for key positions for program management and dedicate staffing with sufficient workforce capacity and expertise to ensure program success, including the retention of CTRs and staff capable of providing ongoing quality control, creating the annual incidence file, data submission, and reports.

Describe processes and reports in place to monitor and track cancer data coming from various sources and effectively describe the operational processes that are implemented during the year to ensure a successful data submission to CDC.

Describe capacity of staff to communicate requirements and updates to a central cancer registry management software vendor, coordinate software conversions with the software vendor and IT staff and report software issues for problem resolution, and perform analysis of data to ensure data integrity following conversions.

Demonstrate sufficient IT and informatics support to perform software maintenance, conversions and updates as required. Provide an MOU if Software, IT and or informatics support is not embedded in CCR unit. If support is within unit describe capacity, and % of effort.

Provide position description for: CTRs; staff capable of conducting educational needs assessment and providing relevant educational support to cancer data reporters and staff at the central cancer registry; staff with subject matter expertise in cancer registry management, analysis and data dissemination; and, IT staff with skills related to functions in the cancer registry.

Readiness

Demonstrate at least 5 years of prior experience and expertise in implementing a central cancer registry program that meets NPCR quality, completeness and timeliness

requirements for data collection and submission, including reporting data that meets NPCR's National Data Quality and Advanced National Data Quality standards.
Demonstrate prior experience coordinating tumor linkages (including the state vital statistics death files and National Death Index) and data item consolidation to verify accuracy and timeliness of cancer incidence data.
Demonstrate prior experience implementing updated state-specific edit metafiles and participating in identifying, developing, and testing new or revised standard and state-specific edits.
Demonstrate prior experience participating in activities to incorporate data from new reporting sources including electronic health records(EHR) and electronic reporting initiatives such as Meaningful Use.
Describe processes utilized to electronically collect data from medical and pathology records.
Describe current hardware and software systems that are in place to support the central cancer registry activities, including data collection, database management, data linkages, quality assurance, data analysis and management reporting.
Describe ability or procedures in place to ensure confidentiality and security of central cancer registry data through software and hardware security standards.
Describe ability to conduct internal audits and/or quality checks of data collected and processed by internal staff, ability to participate in national quality assurance studies, and ability to conduct external audits of reporting sources.
Demonstrate that there is an active advisory board in place that supports the registry (provide list of advisory group members/minutes, etc.).
Demonstrate prior experience collaborating with other CDC funded cancer programs and chronic disease programs to promote accessibility to the cancer registry data and reduce cancer burden.

Activities

Describe operational processes in place to support data collection, quality control, case ascertainment, and other processes to ensure completeness and timeliness of data.
Describe specific plans, mechanisms, and requirements intended to increase use of cancer surveillance data to guide decisions, inform public health policy, assess needed changes in priority and infrastructure, improve quality and efficiency of cancer prevention and treatment efforts, and improve access to data sets across states.
Describe plans to participate in various CDC-sponsored meetings, trainings, conferences, webinars and workshops, and other relevant meetings to facilitate exchange of information and skills development with peers, CDC staff, and other subject matter experts. Describe any potential barriers to staff attendance at CDC-sponsored meetings (e.g., trainings, informational sessions, annual conferences, etc.) and plans to overcome those barriers.
Describe plans to oversee the exchange of data with other central cancer registries, including the frequency and format of such exchanges with border and non-border states.
Describe plans to develop, implement and maintain an education and training plan that meets the specific needs of the central cancer registry staff and reporters with the goal of improving data quality.

Describe plans to participate in all CDC-created analytic datasets as outlined in the annual NPCR Cancer Surveillance Systems (NPCR-CSS) Data Release Policy.
Describe capacity to implement innovative processes to improve timeliness and participate in innovative and special projects that would benefit the registry
Describe plans and capacity to electronically collect data from medical and pathology records.

d. Work Plan

All Programs: Applicants must use the designated work plan template for their program on the NOFO website https://www.cdc.gov/cancer/dcpc/about/foa-dp22-2202/ to provide a detailed work plan with SMARTIE (specific, measurable, attainable, relevant, timebound, inclusive, equitable) objectives for the first year of the 5-year period of performance and a narrative plan for subsequent years. Plans should also detail the program-specific activities that will help the applicant accomplish their objectives.
At a minimum, work plans should include:

- Proposed Objectives and Expected Outcomes
- Strategies/Activities
- Process Measures
- Responsible Position/Partner/Coalition Member/or Other Party
- Timeline and Completion Date
- Collaborators and Partners

Applicants may also get their program-specific template directly by accessing one of the following program links:

Program 1: NCCEDP https://www.cdc.gov/cancer/dcpc/about/foa-dp22-2202/
Program 2: NCCCP https://www.cdc.gov/cancer/dcpc/about/foa-dp22-2202/
Program 3: NPCR https://www.cdc.gov/cancer/dcpc/about/foa-dp22-2202/

e. CDC Monitoring and Accountability Approach

Monitoring activities include routine and ongoing communication between CDC and recipients, site visits, and recipient 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 recipient progress in achieving the desired outcomes.
- Ensuring the adequacy of recipient 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 deemed necessary to monitor the award:

- Ensuring that work plans are feasible based on the budget and consistent with the intent of the award.
- Ensuring that recipients are performing at a sufficient level to achieve outcomes within stated timeframes.
- Working with recipients 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.

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 recipients.

CDC will monitor the cooperative agreement in partnership with the awarded recipients. Monitoring milestones and performance measures ensures the mutual success of CDC and recipients in achieving the NOFO outcomes. CDC will facilitate mutual, regular, and effective communication with recipients through the Awards Management Platform (AMP), email, audio and virtual calls/meetings, and periodic site visits. Recipients and CDC staff will work together to establish a baseline for monitoring program improvement over time for each strategy. The proposed work plan will be reviewed by the project officer and evaluator and may need to be altered to better reflect program activities as outlined in the NOFO.

f. CDC Program Support to Recipients

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

CDC activities in this NOFO are as follows:

- Align programs with the division's strategic plan priorities, principles, and approaches; coordinate and facilitate consistent CDC recipient messaging, when needed; and, support and facilitate cross-program coordination and collaboration to leverage opportunities and reduce duplication, where appropriate.
- Monitor recipient progress in implementing NOFO strategies and activities in CDC-approved workplans. Review recipient progress reports and program performance and evaluation data to assess progress and areas in need of improvement; provide needed technical assistance and corrective action plans, as needed.
- Provide ongoing guidance, consultation, and technical assistance to recipients and facilitate connection to subject-matter experts to support the planning, implementation, monitoring, and evaluation of NOFO strategies and activities.
- Facilitate and support training and capacity building activities including peer-to-peer sharing to optimize effective NOFO implementation.
- Provide guidance to recipients on program-applicable Public Laws, https://www.cdc.gov/cancer/dcpc/about/foa-dp22-2202/
- Provide guidance to recipients on relevant scientific evidence, research findings, and national/state/local data; current national and public health recommendations; current clinical guidelines and recommendations; documented best practices; and peer-to-peer success stories related to the NOFO.
- Provide data to assist recipients identify vulnerable populations for program focus to reduce cancer health disparities and achieve health equity. Provide eligible population estimates for available geographic areas to inform breast and cervical cancer screening targets and other interventions. https://www.cdc.gov/cancer/dcpc/about/foa-dp22-2202.
- Manage and continually improve national program data systems (e.g., NBCCEDP clinical data; NPCR) and provide recipients with regular data monitoring feedback

reports for their use in quality assurance, program improvement, and program monitoring and evaluation.

- Develop and implement national program evaluation plans (e.g., annual recipient surveys, cost-effectiveness studies) and support recipients' development of their own high-quality evaluation plans. Conduct evaluation data analysis and report findings including publication in peer-reviewed journals.
- Develop and provide publicly available software programs for collecting, receiving, validating, processing, and analyzing data, as well as provide updated NPCR Program Standards and Manuals to recipients.

Aid dissemination of information, including success stories and evaluation results, about recipient programs to partner and public health audiences.

B. Award Information

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

2. Award Mechanism:
U58

3. Fiscal Year:
2022
Estimated Total Funding:
$1,100,000,000

4. Approximate Total Fiscal Year Funding:
$220,000,000
This amount is subject to the availability of funds.

5. Approximate Period of Performance Funding:
$1,100,000,000

6. Total Period of Performance Length:
5
year(s)

7. Expected Number of Awards:
198

Program 1: The National Breast and Cervical Cancer Early Detection Program (NBCCEDP) funds will be awarded up to 75 applicants to include state health departments and the District of Columbia; US Territories and Freely Associated States; Federally Recognized American Indian Tribes, Tribal Organizations, Alaska Native Organizations, and Urban Indian Organizations; or their Bona Fide Agents, for implementing a program to provide breast and cervical cancer screening services to women who are uninsured and/or underinsured and

implement key evidence-based strategies to reduce structural barriers to screening within health systems.

Program 2: The National Comprehensive Cancer Control Program (NCCCP) funds will be awarded to up to 68 applicants, to include state health departments, the District of Columbia; Freely Associated States and US Affiliated Pacific Islands; US Virgin Islands: and Federally Recognized American Indian Tribes, Tribal Organizations, Alaska Native Organizations, and Urban Indian Organizations for implementing a program to support cancer coalition efforts that leverage resources to plan and implement evidence-based strategies to promote the primary prevention of cancer; support cancer early detection efforts; address the needs of cancer survivors; and promote health equity.

Program 3: The National Program of Cancer Registries (NPCR) funds will be awarded to up to 55 applicants including;
state health departments, the District of Columbia, Freely Associated States and US Affiliated Pacific Islands; US Virgin Islands: or their Bona Fide Agents for
implementing a population-based core cancer registry program.

8. Approximate Average Award:

$850,000
Per Budget Period

Program 1: NBCCEDP Approximately $155 million per year is available.
Program 2: NCCCP Approximately $22 million per year is available.
Program 3: NPCR Approximately $38 million per year is available.

9. Award Ceiling:
$8,000,000
Per Budget Period

Program 1: NBCCEDP - $8,000,000 per budget period
Program 2: NCCCP - $426,000 per budget period
Program 3: NPCR - $3,000,000 per budget period

10. Award Floor:
$100,000
Per Budget Period

Program 1: NBCCEDP - $100,000 per budget period
Program 2: NCCCP - $250,000 per budget period
Program 3: NPCR- $100,000 per budget period

11. Estimated Award Date:
May 24, 2022
Throughout the project period, CDC will continue the award based on the availability of funds, the evidence of satisfactory progress by the recipient (as documented in required reports), and the determination that continued funding is in the best interest of the federal government. The

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 period of performance 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 NOFO.

All Programs: Requests for DA will be considered in years 2 – 5 of the NOFO and is dependent upon the availability of funds. The request for DA should be discussed with your Program Consultant and included in the Annual Performance Report/yearly continuation application (APR). DA is limited to payroll support of CDC's workforce development fellowship programs (e.g., the Public Health Associates Program [PHAP], Steven M. Teutsch Prevention Effectiveness [PE] Fellows, Public Health Informatics Fellows [PHIF],and Epidemic Intelligence Services [EIS] officers).

If you are successful and receive a Notice of Award, in accepting the award, you agree that the award and any activities thereunder are subject to all provisions of 45 CFR Part 75, currently in effect or implemented during the period of the award, other Department regulations and policies in effect at the time of the award, and applicable statutory provisions.

C. Eligibility Information

1. Eligible Applicants

Eligibility Category:
99 (Unrestricted (i.e., open to any type of entity above), subject to any clarification in text field entitled "Additional Information on Eligibility")

25 (Others (see text field entitled "Additional Information on Eligibility" for clarification))

Additional Eligibility Category:

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 Marianna Islands, American Samoa, Guam, the Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau

Local governments or their bona fide agents

State controlled institutions of higher education

American Indian or Alaska Native tribal governments (federally recognized or state-recognized)

American Indian or Alaska native tribally designated organizations

Other:

Private colleges and universities

2. Additional Information on Eligibility

Program 1: The National Breast and Cervical Cancer Early Detection Program (NBCCEDP) Limited Eligibility Funds will be awarded to state health departments and the District of Columbia; US Territories and Freely Associated States, Federally Recognized American Indian Tribes, Tribal Organizations, Alaska Native Organizations, and Urban Indian Organizations, or their Bona Fide Agents. Eligibility for this program is limited by statue. See https://www.govinfo.gov/content/pkg/STATUTE-104/pdf/STATUTE-104-Pg409.pdf

Program 3: The National Program of Cancer Registries (NPCR) Limited Eligibility Funds will be awarded to state health departments, the District of Columbia, Freely Associated States and US Affiliated Pacific Islands, or their Bona Fide Agents for implementing a population-based core Cancer Registry program. Eligibility for this program is limited by statute. See http://www.cdc.gov/cancer/npcr/npcrpdfs/publaw.pdf

Please note the following definitions: State (includes the District of Columbia), Territorial governments in the Commonwealth of Puerto Rico, the Virgin Islands, the Commonwealth of the Northern Marianna Islands, American Samoa, Guam, the Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau. American Indian or Alaska Native t ribal governments (federally recognized or state-recognized), American Indian or Alaska native tribal designated organizations. or their Bona Fide Agents.

3. Justification for Less than Maximum Competition

4. Cost Sharing or Matching

Cost Sharing / Matching Requirement:

Yes

Program 1: NBCCEDP

Recipient financial participation is required for this program in accordance with the authorizing legislation. Section 1502(a) and (b)(1), (2), and (3) of the Public Health Services (PHS) Act, as amended, requires matching funds from non-Federal sources in an amount not less than one dollar for every three dollars of Federal funds awarded under this program. However, Title 48 of the U.S. Code 1469a (d) requires DHHS to waive matching fund requirements up to $200,000 for Guam, U.S. Virgin Islands, American Samoa and the Commonwealth of the Northern Mariana Islands, the Commonwealth of Puerto Rico, the Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau. Matching funds may be cash, in-kind or donated services or equipment. Contributions may be made directly or through donations from public or private entities. Public Law 93-638 authorizes tribal organizations contracting under the authority of Title I to use funds received under the Indian Self-Determination Act as matching funds.

Recipients may also designate as State/Tribal/Territorial/Pacific Island Jurisdiction matching funds any non-Federal amounts spent pursuant to Title XIX of the Social Security Act for the screening and case management of women for breast and cervical cancers.
Matching funds may not include: (1) payment for treatment services or the donation of treatment services; (2) services assisted or subsidized by the Federal government; or (3) the indirect or overhead costs of an organization. All costs used to satisfy the matching requirements must be documented by the applicant and will be subject to audit.

Program 2: NCCCP

Although there is no cost-sharing requirement, recipients should document and report how funds have been leveraged to increase financial and in-kind support for their NCCCP work plans and coalitions.

Program 3: NPCR

Per PHS Act (42 USC 280e-280e-4), matching funds are required for Program 3, NPCR applicants in an amount not less than 25 percent of such costs or one dollar for every three dollars of Federal funds awarded under this program; [Title 42, Chapter 6A, Subchapter II, Part M, § 280e(b)(1)]. Matching funds may be cash, in-kind, or donated services or equipment. Contributions may be made directly or through donations from public or private entities. However, Title 48 of the U.S. Code 1469a (d) requires DHHS to waive matching fund requirements for Guam, U.S. Virgin Islands, American Samoa, and the Commonwealth of the Northern Mariana Islands up to $200,000. Public Law 93-638 authorizes tribal organizations contracting under the authority of Title 1 to use funds received under the Indian Self-Determination Act as matching funds. Non-federal financial contributions in excess of the Maintenance of Effort may be used for matching.

5. Maintenance of Effort
Program 1: NBCCEDP

Recipient financial participation is required for this program in accordance with the authorizing legislation. Section 1502(a) and (b)(1), (2), and (3) of the Public Health Services (PHS) Act, as amended, requires matching funds from non-Federal sources in an amount not less than one dollar for every three dollars of Federal funds awarded under this program. However, Title 48 of the U.S. Code 1469a (d) requires DHHS to waive matching fund requirements up to $200,000 for Guam, U.S. Virgin Islands, American Samoa and the Commonwealth of the Northern Mariana Islands, the Commonwealth of Puerto Rico, the Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau. Matching funds may be cash, in-kind or donated services or equipment. Contributions may be made directly or through donations from public or private entities. Public Law 93-638 authorizes tribal organizations contracting under the authority of Title I to use funds received under the Indian Self-Determination Act as matching funds.
Recipients may also designate as State/Tribal/Territorial/Pacific Island Jurisdiction matching funds any non-Federal amounts spent pursuant to Title XIX of the Social Security Act for the screening and case management of women for breast and cervical cancers.
Matching funds may not include: (1) payment for treatment services or the donation of treatment services; (2) services assisted or subsidized by the Federal government; or (3) the indirect or overhead costs of an organization. All costs used to satisfy the matching requirements must be documented by the applicant and will be subject to audit.

Program 2: NCCCP

Although there is no cost-sharing requirement, recipients should document and report how funds have been leveraged to increase financial and in-kind support for their NCCCP work plans and coalitions.

Program 3: NPCR

Per PHS Act (Section 399B(b) of the Public Health Service Act, 42 U.S.C. 280e(b)), matching funds are required for Program 3, NPCR applicants in an amount not less than 25 percent of such costs **or** one dollar for every three dollars of Federal funds awarded under this program; [Title 42, Chapter 6A, Subchapter II, Part M, § 280e(b)(1)]. Matching funds may be cash, in-kind, or donated services or equipment. Contributions may be made directly or through donations from public or private entities. However, Title 48 of the U.S. Code 1469a (d) requires DHHS to waive matching fund requirements for Guam, U.S. Virgin Islands, American Samoa, and the Commonwealth of the Northern Mariana Islands up to $200,000. Public Law 93-638 authorizes tribal organizations contracting under the authority of Title 1 to use funds received under the Indian Self-Determination Act as matching funds. Non-federal financial contributions in excess of the Maintenance of Effort may be used for matching.

D. Required Registrations

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. The DUNS number will be provided at no charge.

If funds are awarded to an applicant organization that includes sub-recipients, those sub-recipients 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 a recipient. 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 can require 10 or more business days, and registration must be renewed annually. Additional information about registration procedures may be found at SAM.gov and the SAM.gov Knowledge Base.

c. Grants.gov: The first step in submitting an application online is registering your organization atwww.grants.gov, the official HHS E-grant Web site. Registration information is located at the "Applicant Registration" option atwww.grants.gov.

All applicant organizations must register at www.grants.gov. The one-time registration process usually takes not more

than five days to complete. Applicants should start the registration process as early as possible.

Step	System	Requirements	Duration	Follow Up
1	Data Universal Number System (DUNS)	1. Click on http:// fedgov.dnb.com/ webform 2. Select Begin DUNS search/request process 3. Select your country or territory and follow the instructions to obtain your DUNS 9-digit # 4. Request appropriate staff member(s) to obtain DUNS number, verify & update information under DUNS number	1-2 Business Days	To confirm that you have been issued a new DUNS number check online at (http:// fedgov.dnb.com/ webform) or call 1-866-705-5711
2	System for Award Management (SAM) formerly Central Contractor Registration (CCR)	1. Retrieve organizations DUNS number 2. Go to SAM.gov and designate an E-Biz POC (note CCR username will not work in SAM and you will need to have an active SAM account before you can register on grants.gov)	3-5 Business Days but up to 2 weeks and must be renewed once a year	For SAM Customer Service Contact https://fsd.gov/ fsd-gov/ home.do Calls: 866-606-8220
3	Grants.gov	1. Set up an individual account in Grants.gov using organization new DUNS number to become an authorized organization representative (AOR) 2. Once the account is set up the E-BIZ POC will be notified via email	Same day but can take 8 weeks to be fully registered and approved in the system (note, applicants MUST obtain a DUNS number and SAM account before applying on grants.gov)	Register early! Log into grants.gov and check AOR status until it shows you have been approved

		3. Log into grants.gov using the password the E-BIZ POC received and create new password 4. This authorizes the AOR to submit applications on behalf of the organization		

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.

4. Submission Dates and Times

If the application is not submitted by the deadline published in the NOFO, it will not be processed. Office of Grants Services (OGS) 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 OGS.

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

Number Of Days from Publication 30

11/27/2021

The purpose of an LOI is to allow CDC program staff to estimate the number of and plan for the review of submitted applications.

b. Application Deadline

Number Of Days from Publication 90

01/26/2022

11:59 pm 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.

November 18, 2021

Due Date for Information Conference Call

CDC will provide three informational conference calls. Each call will provide exactly the same information therefore, applicants need only attend one call. There will not be a question and answer session on the calls. Instead, applicants are asked to submit questions to nofodp22-2202@cdc.gov

November 18, 2021 at **10:00 a.m. to 12:00 p.m. Eastern Daylight Savings Time** - For eligible applicants in the **Atlantic, Eastern, and Central time zones.** This conference call can be access

ed by calling **800-593-8948.** The leader for this call is Tanya Hicks and the passcode is **1179165.**

November 18, 2021 at **3:30 p.m. to 5:30 p.m.** Eastern Daylight Savings Time –
For eligible applicants
in the **Mountain and Western time zones**. This conference call can be accessed by calling **800-593-8948.** The leader for this call is Tanya Hicks and the passcode is **1179165.**

November 18, 2021 at **7:30 p.m. to 9:30 p.m. Eastern Daylight Savings Time** -
For eligible applicants
in the **Pacific Island Jurisdictions**. This conference call can be accessed by calling **800-593-8948**. The leader for this call is Tanya Hicks and the passcode is **1179165.**

If operator assistance is needed, call 866-865-7014
and the operator will assist you in joining the call.

5. Pre-Award Assessments

Risk Assessment Questionnaire Requirement

CDC is required to conduct pre-award risk assessments to determine the risk an applicant poses to meeting federal programmatic and administrative requirements by taking into account issues such as financial instability, insufficient management systems, non-compliance with award conditions, the charging of unallowable costs, and inexperience. The risk assessment will include an evaluation of the applicant's CDC Risk Questionnaire, located at https://www.cdc.gov/grants/documents/PPMR-G-CDC-Risk-Questionnaire.pdf, as well as a review of the applicant's history in all available systems; including OMB-designated repositories of government-wide eligibility and financial integrity systems (see 45 CFR 75.205(a)), and other sources of historical information. These systems include, but are not limited to: FAPIIS (https://www.fapiis.gov/), including past performance on federal contracts as per Duncan Hunter National Defense Authorization Act of 2009; Do Not Pay list; and System for Award Management (SAM) exclusions.

CDC requires all applicants to complete the Risk Questionnaire, OMB Control Number 0920-1132 annually. This questionnaire, which is located at https://www.cdc.gov/grants/documents/PPMR-G-CDC-Risk-Questionnaire.pdf, along with supporting documentation must be submitted with your application by the closing date of the Notice of Funding Opportunity Announcement. If your organization has completed CDC's Risk Questionnaire within the past 12 months of the closing date of this NOFO, then you must submit a copy of that questionnaire, or submit a letter signed by the authorized organization representative to include the original submission date, organization's EIN and DUNS.

When uploading supporting documentation for the Risk Questionnaire into this application package, clearly label the documents for easy identification of the type of documentation. For example, a copy of Procurement policy submitted in response to the questionnaire may be labeled using the following format: Risk Questionnaire Supporting Documents _ Procurement Policy.

Duplication of Efforts

Applicants are responsible for reporting if this application will result in programmatic, budgetary, or commitment overlap with another application or award (i.e. grant, cooperative agreement, or contract) submitted to another funding source in the same fiscal year. Programmatic overlap occurs when (1) substantially the same project is proposed in more than one application or is submitted to two or more funding sources for review and funding consideration or (2) a specific objective and the project design for accomplishing the objective are the same or closely related in two or more applications or awards, regardless of the funding source. Budgetary overlap occurs when duplicate or equivalent budgetary items (e.g., equipment, salaries) are requested in an application but already are provided by another source. Commitment overlap occurs when an individual's time commitment exceeds 100 percent, whether or not salary support is requested in the application. Overlap, whether programmatic, budgetary, or commitment of an individual's effort greater than 100 percent, is not permitted. Any overlap will be resolved by the CDC with the applicant and the PD/PI prior to award.

Report Submission: The applicant must upload the report in Grants.gov under "Other Attachment Forms." The document should be labeled: "Report on Programmatic, Budgetary, and Commitment Overlap."

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

Is a LOI:
Recommended but not Required

A Letter of Intent (LOI) is recommended but not required. The purpose of an LOI is to allow CDC program staff to estimate the number of and plan for the review of submitted applications. The LOI should include the following information:

- Name of the organization submitting the application
- Name, address, telephone number, and email address of the Principal Investigator or Project Director, or both
- Name, address, telephone number, and e-mail address of the primary contact for writing and submitting this application
- Number and title of this NOFO

Email submissions of the LOI are preferred. The subject of the email should include "LOI".

LOI must be sent via U.S. express mail, delivery service, fax, or email to:

Frances Babcock

CDC,

Address:
4770 Buford Highway

MS107-4
Atlanta, GA 30341

Telephone number: 770-488-4378

Email address: NOFODP22-2202@cdc.gov

8. Table of Contents

(There is no page limit. The table of contents is not included in the project narrative page 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

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.

A project abstract is a mandatory document. Applicants must enter the summary in the "Project Abstract Summary" text box at www.grants.gov.

10. Project Narrative

Multi-component NOFOs may have a maximum of 15 pages for the “base” (subsections of the Project Description that the components share with each other, which may include target population, inclusion, collaboration, etc.); and up to 4 additional pages per component for

Project Narrative subsections that are specific to each component.

Text should be single spaced, 12 point font, 1-inch margins, and number all pages. Page limits include work plan; content beyond specified limits may not be reviewed.

Applicants should use the federal plain language guidelines and Clear Communication Index to respond to this Notice of Funding Opportunity Announcement. Note that recipients should also use these tools when creating public communication materials supported by this NOFO. Failure to follow the guidance and format may negatively impact scoring of the application.

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 period of performance. 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 period of performance 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 period of performance. (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 address the Collaboration requirements as described in the CDC Project Description.

2. Target Populations and Health Disparities

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. The applicants must also address how they will include specific populations that can benefit from the program that is described in the Approach section. Applicants must address the Target Populations and Health Disparities requirements as described in the CDC Project Description.

c. Applicant Evaluation and Performance Measurement Plan

Applicants must provide an evaluation and performance measurement plan that demonstrates how the recipient will fulfill the requirements described in the CDC Evaluation and Performance Measurement and Project Description sections of this NOFO. At a minimum, the plan must describe:

- How applicant will collect the performance measures, respond to the evaluation questions, and use evaluation findings for continuous program quality improvement. The Paperwork Reduction Act of 1995 (PRA): Applicants are advised that any activities involving information collections (e.g., surveys, questionnaires, applications, audits, data requests, reporting, recordkeeping and disclosure requirements) from 10 or more individuals or non-Federal entities, including State and local governmental agencies, and funded or sponsored by the Federal Government are subject to review and approval by the Office of Management and Budget. For further information about CDC's requirements under PRA see https://www.cdc.gov/od/science/integrity/reducePublicBurden/.
- How key program partners will participate in the evaluation and performance measurement planning processes.

- Available data sources, feasibility of collecting appropriate evaluation and performance data, data management plan (DMP), and other relevant data information (e.g., performance measures proposed by the applicant).

Where the applicant chooses to, or is expected to, take on specific evaluation studies, they should be directed to:

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

Recipients will be required to submit a more detailed Evaluation and Performance Measurement plan (including the DMP elements) within the first 6 months of award, as described in the Reporting Section of this NOFO.

d. Organizational Capacity of Applicants to Implement the Approach

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

11. Work Plan

(Included in the Project Narrative's 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 recipient plans to carry out achieving the period of performance outcomes, strategies and activities, evaluation and performance measurement.

12. Budget Narrative

Applicants must submit an itemized budget narrative. 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 could include the cost of collecting, managing, sharing and preserving data.

Indirect costs on grants awarded to foreign organizations and foreign public entities and performed fully outside of the territorial limits of the U.S. may be paid to support the costs of

compliance with federal requirements at a fixed rate of eight percent of MTDC exclusive of tuition and related fees, direct expenditures for equipment, and subawards in excess of $25,000. Negotiated indirect costs may be paid to the American University, Beirut, and the World Health Organization.

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 NOFO 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 Marianna 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 NOFO. Proposed activities must be included in the budget narrative and must indicate which standards will be addressed.

Vital records data, including births and deaths, are used to inform public health program and policy decisions. If applicable and consistent with the cited statutory authority for this NOFO, applicant entities are encouraged to collaborate with and support their jurisdiction's vital records office (VRO) to improve vital records data timeliness, quality and access, and to advance public health goals. Recipients may, for example, use funds to support efforts to build VRO capacity through partnerships; provide technical and/or financial assistance to improve vital records timeliness, quality or access; or support vital records improvement efforts, as approved by CDC.

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 Recipients under such a plan. Applicants must name this file "Indirect Cost Rate" and upload it at www.grants.gov.

13. Pilot Program for Enhancement of Employee Whistleblowers 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 Code of Federal Regulations

(CFR) section 3.908 to the award and requires that recipients 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.

13a. Funds Tracking

Proper fiscal oversight is critical to maintaining public trust in the stewardship of federal funds. Effective October 1, 2013, a new HHS policy on subaccounts requires the CDC to set up payment subaccounts within the Payment Management System (PMS) for all new grant awards. Funds awarded in support of approved activities and drawdown instructions will be identified on the Notice of Award in a newly established PMS subaccount (P subaccount). Recipients will be required to draw down funds from award-specific accounts in the PMS. Ultimately, the subaccounts will provide recipients and CDC a more detailed and precise understanding of financial transactions. The successful applicant will be required to track funds by P-accounts/sub accounts for each project/cooperative agreement awarded.

Applicants are encouraged to demonstrate a record of fiscal responsibility and the ability to provide sufficient and effective oversight. Financial management systems must meet the requirements as described 45 CFR 75 which include, but are not limited to, the following:

- Records that identify adequately the source and application of funds for federally-funded activities.
- Effective control over, and accountability for, all funds, property, and other assets.
- Comparison of expenditures with budget amounts for each Federal award.
- Written procedures to implement payment requirements.
- Written procedures for determining cost allowability.
- Written procedures for financial reporting and monitoring.

13b. Copyright Interests Provisions

This provision is intended to ensure that the public has access to the results and accomplishments of public health activities funded by CDC. Pursuant to applicable grant regulations and CDC's Public Access Policy, Recipient agrees to submit into the National Institutes of Health (NIH) Manuscript Submission (NIHMS) system an electronic version of the final, peer-reviewed manuscript of any such work developed under this award upon acceptance for publication, to be made publicly available no later than 12 months after the official date of publication. Also at the time of submission, Recipient and/or the Recipient's submitting author must specify the date the final manuscript will be publicly accessible through PubMed Central (PMC). Recipient and/or Recipient's submitting author must also post the manuscript through PMC within twelve (12) months of the publisher's official date of final publication; however the author is strongly encouraged to make the subject manuscript available as soon as possible. The recipient must obtain prior approval from the CDC for any exception to this provision.

The author's final, peer-reviewed manuscript is defined as the final version accepted for journal publication, and includes all modifications from the publishing peer review process, and all graphics and supplemental material associated with the article. Recipient and its submitting authors working under this award are responsible for ensuring that any publishing or copyright agreements concerning submitted articles reserve adequate right to fully comply with this provision and the license reserved by CDC. The manuscript will be hosted in both PMC and the CDC Stacks institutional repository system. In progress reports for this award, recipient must identify publications subject to the CDC Public Access Policy by using the applicable NIHMS identification number for up to three (3) months after the publication date and the PubMed Central identification number (PMCID) thereafter.

13c. Data Management Plan

As identified in the Evaluation and Performance Measurement section, applications involving data collection or generation must include a Data Management Plan (DMP) as part of their evaluation and performance measurement plan unless CDC has stated that CDC will take on the responsibility of creating the DMP. The DMP describes plans for assurance of the quality of the public health data through the data's lifecycle and plans to deposit the data in a repository to preserve and to make the data accessible in a timely manner. See web link for additional information: https://www.cdc.gov/grants/additionalrequirements/ar-25.html

14. Funding Restrictions

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

- Recipients may not use funds for research.
- Recipients may not use funds for clinical care except as allowed by law.
- Recipients may use funds only for reasonable program purposes, including personnel, travel, supplies, and services.
- Generally, recipients 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 generally is not allowed, unless the CDC provides written approval to the recipient.
- 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 Additional Requirement (AR) 12 for detailed guidance on this prohibition andadditional guidance on lobbying for CDC recipients.
- 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.

Program 1: NBCCEDP

In accordance with the applicable authorizing statute **(Sections 501-1508 and 1510 of the Public Health Service Act) PL 101-354**, use of federal funds for treatment is prohibited.
In accordance with the applicable authorizing statute **(Sections 501-1508 and 1510 of the Public Health Service Act) PL 101-354**, not more than 10 percent of cooperative funds awarded may be spent annually for administrative expenses. These administrative expenses are in lieu of and replace indirect costs [Section 1504(f) of the PHS Act, as amended].

15. Other Submission Requirements

a. Electronic Submission: Applications must be submitted electronically by using the forms and instructions posted for this notice of funding opportunity atwww.grants.gov. Applicants can

complete the application package using Workspace, which allows forms to be filled out online or offline. All application attachments must be submitted using a PDF file format. Instructions and training for using Workspace can be found at www.grants.gov under the "Workspace Overview" option.

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 whenwww.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 bywww.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 NOFO. 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 Grants.gov Online User Guide.
https://www.grants.gov/help/html/help/index.htm?callingApp=custom#t=GetStarted%2FGetStarted.htm

d. Technical Difficulties: If technical difficulties are encountered at www.grants.gov, applicants should contact Customer Service atwww.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@grants.gov. Application submissions sent by e-mail or fax, or on CDs or thumb drives will not be accepted. Please note thatwww.grants.gov is managed by HHS.

e. Paper Submission: If technical difficulties are encountered at www.grants.gov, applicants should call thewww.grants.gov Contact Center at 1-800-518-4726 or e-mail them

at support@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 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 received via e-mail to the GMS/GMO listed below 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, OGS 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 1 Review

All applications will be initially reviewed for eligibility and completeness by the Office of Grants Services. Complete applications will be reviewed for responsiveness by Grants Management Officials and Program Officials. Non-responsive applications will not advance to Phase II review. Applicants will be notified that their applications did not meet eligibility and/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

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.

i. Approach **Maximum Points:** 0

Program 1: NBCCEDP Approach – Maximum Points: 40

Evaluate the extent to which the applicant:
Describes an overall strategy and activities consistent with the NOFO and logic model.

- Describes an established screening delivery system to provide breast and cervical cancer screening and diagnostic services. This should include a current network of clinical providers; established clinic partnerships; and established billing and reimbursement systems.
- Describes processes to report required screening data for women served (i.e., minimum data elements [MDEs]) to CDC.
- Uses state and local level health, disease burden, demographic and other data, as described in the NOFO, to identify and describe the program-eligible populations in the jurisdiction.
- Describes the population(s) that will be prioritized for screening and diagnostic services based on data showing the disproportionate burden of breast or cervical cancer, especially higher mortality, and late stage disease.

- Describes the health equity challenges in the jurisdiction for the identified population of focus and explains how a focus on these women will reduce cancer health disparities.
- Describes an overall strategy and activities to reduce cancer health disparities and improve health equity, including how they will engage communities to help identify root causes of low cancer screening, and how they will measure progress.
- Sets annual and 5-year projections for the number of women who will receive screening and diagnostic services paid by the program.
- Presents a work plan that is aligned with the strategies/activities, outcomes, and performance measures in the approach; describes strategies and activities that are evidence-based, achievable, and appropriate to achieve NOFO outcomes; includes specific measurable, attainable/achieveable, relevant, timebound/time based, inclusive, equitable (SMARTIE) objectives for the first year of the 5-year period of performance and a narrative plan for subsequent years.
- Provides letters of support stating how the organizations will work with the applicant to achieve NBCCEDP NOFO activities and outcomes. Letter must be dated within 30 days of the application.
- Shows that the proposed use of funds is an efficient and effective way to implement the strategies and activities and attain the outcomes throughout the period of performance.

Program 2: NCCCP Approach – Maximum Points: 30

Evaluate the extent to which the applicant:
Describes an overall strategy and activities consistent with the NOFO and logic model.

- Describes appropriate data sources for selecting and prioritizing the cancers, social determinants of health, populations, geographic areas, and settings that will be addressed.
- Presents the combination of population-wide and tailored prevention, screening, and survivorship strategies that will be used to benefit all residents within the entire state, tribe, or territory over the 5-year period of performance.
- Dscribes how they will recruit, engage, and maintain their coalition and ensure that its membership includes the sector leaders, community lay members from affected populations, and public health collaborators needed for successful planning and implementation.
- Describes potential threats to progress and how they plan to mitigate them

Program 3 - NPCR Approach Maximum Points: 35

Applicants must submit a comprehensive program description and work plan that aligns with the NPCR logic model and describes an effective approach to collect and enhance cancer surveillance data.
To what extent does the applicant:
Effectively describes a registry project management and operation of central cancer registry program.
This section should include a description of current capacity, key processes, priorities, and resources that will be used as part of ongoing program management. Does the applicant present a work plan that is aligned with the strategies/activities, outcomes, and performance measures in the approach; describes strategies and activities that are evidence-based, achievable, and appropriate to achieve NOFO outcomes. Applicant should include an organizational chart, position descriptions, CVs or brief bios for leadership staff and a plan that describes how the

personnel and consultants operate within the organization and the person(s) responsible for implementation of each activity. The required positions below should be well documented and described.

Core Required Positions:

PD	1 FTE	100%
ETC	1 FTE	100%
QA/QC	1 FTE	100%
IT	.25 FTE	25%

a. Documentation of the percentage of time each core staff member will contribute to the project and activities for which they are responsible and align with the requirements described in the NOFO activities and strategies section.

b. Documentation of the legal authority for the central cancer registry to collect and or receive cancer data.

c. Applicant describes plans for operating and managing a central cancer surveillance registry including what software the central cancer registry currently uses and what will be used over the next five years.

d. Describes an overall strategy and activities consistent with the CDC Project Description logic model, and NPCR Program Standards.

e. Describe current and future partnerships and collaborations that will assist with effective program implementation and improve data use and dissemination.

Applicants should address:

- Program collaboration with internal and external partners
- Maintaining and strengthening current legislative authority
- Data collection and content formatting
- How electronic data collection will be strengthened and expanded
- How applicant will meet data completeness and quality standards
- Current linkages and future expansion
- Data quality assurance and education/training plan for internal staff and reporters
- Data submissions
- Data use and dissemination

The applicant's work plan should align with the program description and logic model and include:

- Program outcomes
- Strategies Objectives and Activities
- Process measures
- Responsible position or party
- Partners
- Timeline/completion date

ii. Evaluation and Performance Measurement Maximum Points: 0

Program 1: NBCCEDP Evaluation and Performance Measurement – Maximum Points: 25

Applicants must provide an evaluation and performance measurement plan that will fulfill the requirements in the CDC Evaluation and Performance Measure section.
To What Extent does the applicant:

- Develop an initial evaluation and performance plan to indicate how they will assess annual and 5-year progress in implementing their proposed work plan, including program strategies, activities, and outcomes.
- Ensure that the evaluation plan follows the CDC Evaluation Framework and describes their efforts to evaluate innovative strategies and interventions, and the impact of their coalition and partnerships.
- Show/affirm 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.
- Describe 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 NOFO and for continuous program quality improvement.
- Describe how evaluation and performance measurement will contribute to developing an evidence base for programs that lack a strong effectiveness evidence base.
- Describe any evaluation studies they are to undertake.

Program 2: NCCCP Evaluation and Performance Measurement – Maximum Points: 25

Applicants must provide an evaluation and performance measurement plan that will fulfill the requirements in the CDC Evaluation and Performance Measure section.
To What Extent does the applicant:

- Present how they will develop an initial evaluation and performance plan to indicate how they will assess annual and 5-year progress in implementing their proposed work plan, including program strategies, activities, and outcomes.
- Descrribe how they will ensure that the evaluation plan follows the CDC Evaluation Framework and describes their efforts to evaluate innovative strategies and interventions, and the impact of their coalition and partnerships.

Program 3 - NPCR Evaluation and Performance Measurement Maximum Points: 25

To What Extent does the applicant:
1. Describe a clear monitoring and evaluation plan for:
   a. Status and improvements of electronic capture of cancer cases,
   b. Evaluation of registry operations processes to improve timeliness, quality, and completeness of data
   c. Submission of data in accordance to NPCR standards

2. Details capacity and intent to analyze, apply and disseminate cancer registry data, including:
   a. Ability to perform descriptive analysis of cancer counts, rates, trends, and disparities.
   b. Sources to capture data on sex, race, ethnicity, and geography

c. Production of summary reports, at least biennially
d. Policies related to access and sharing of data or analyses
e. Integration with tobacco use and cancer screening program data (e.g. NBCCEDP, CRCCP)

3. Provides names of key internal and external partners that support, or will be invited to advise, the state or territory about central cancer? registry activities (e.g., Advisory Committee) as well as utilize cancer registry data to plan and evaluate activities to improve public health and eliminate health disparities

iii. Applicant's Organizational Capacity to Implement the Approach Maximum Points: 0

Program 1: NBCCEDP Organizational Capacity-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 previous 5-year experience implementing a breast and cervical cancer screening program.
- 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 and CVs

Program 2: NCCCP Organizational Capacity – Maximum Points: 45

Evaluate the extent to which the applicant:

- Describes how they will assign and maintain full-time staff with expertise in strategic planning, partnerships, and programs
- Describes how they will educate coalition members, partners, policymakers, and the public about the most impactful cancers and the importance of ensuring that all people in all geographic locations benefit from cancer prevention, screening, and survivorship support strategies
- Describes how they will convene a coalition of influential leaders and organizations and community members from affected populations that will:
    - Provide letters of support that indicate their commitment and role(s)
    - Develop the DP22-2202 NCCCP work plan
    - Lead implementation of strategies that result in policies, systems, and improvements to social determinants of health that contribute to increased cancer prevention, screening, and support for cancer survivors, their families, caregivers, and healthcare providers

Program 3: NPCR Organizational Capacity - Maximum Points: 40

Provide a staffing plan that aligns with the work plan and includes estimated hours for each proposed activity. Evaluate the extent to which the applicant's

1. Staffing plan includes
    - Demonstrates at least 5 years of experience managing a successful cancer registry and produces data that meets NPCR submission standards.

- Describe leadership with previous experience managing programs; knowledge and experience with cancer surveillance process and quality assurance; evidence of maintaining high staff retention and partnership building/strengthening.
- Describe plans to recruit and retain Certified Tumor Registrar(s) with experience in training, providing ongoing quality control, and conducting data quality audits.
- Describe staff and plans to provide strong IT skills and demonstrated ability to manage and ensure security of large datasets, interface with software vendor and state IT departments, and support direct electronic reporting from external facilities. If staff member(s) are not imbedded within the registry, provide an MOU with IT department.
- Describe plans to participate in all CDC-created analytic datasets as outlined in the annual NPCR Cancer Surveillance Systems (NPCR-CSS) Data Release Policy.
- Describe staff and plans to analyze data and synthesize reports and presentation for dissemination to a wide variety of partners.

2, Infrastructure and experience is described to meet or exceed collection of cancer data by central cancer registry:

- To implement ongoing monitoring reports to track and improve cancer data collection.
- To provide IT and informatics resources and support for electronic data capture and timely submission, security standards, management of software installation, updates, and conversions; ability to perform data linkage and exchanges, electronic capture from medical records and pathology labs.
- Describe capacity to implement innovative processes to improve timeliness of data and participate in innovative and/or special projects that would benefit the registry
- Uphold legal authority and policies to support collection and submission of cancer data in accordance with NPCR program standards and data release policy.

3. Document prior success related to data collection, submission, and application

- Years in which program has achieved NPCR National Data Quality and Advanced National Data Quality standards for inclusion in US Cancer Statistics.
- Strategies, activities and outcomes from partnerships, collaborations, and coalition reports, publications, special studies, and presentation of data to public, policy makers, and partners (e.g., healthcare, academic, and non-profit organizations)
- Provide letters of commitment and letters of support from other cancer programs and key partners demonstrating ongoing collaborations
- Provide evidence of an established Advisory Board that supports the Central Cancer Registry

Budget Maximum Points: 0

Program 1: NBCCEDP - Maximum Points: 0

Does the budget align with the proposed work plan?
Does the budget allocation reflect focus on required NOFO strategies and activities?
Are matching funds, maintenance of effort and additional and in-kind funds provided in budget?
Does the applicant allocate no more than 10% of the budget to administrative costs?
Does the budget adhere to CDC budget guidelines?

Program 2: NCCCP – Maximum Points: 0

Does the budget include adequate funds for salary and benefits for two full-time program staff? Does the budget narrative describe how other funds will be taken advantage of by the coalition to implement, monitor, report, and evaluate work plan activities?

Program 3 -NPCR : Maximum Points: 0

Does the submitted budget align with staffing and proposed project and work plan?

c. Phase III Review

All Programs: NBCCEDP, NCCCP, NPCR

Applications will be funded in order by score and rank determined by the review panel.
No more than one applicant per state, tribe, tribal organization, or Freely Associated States and US Affiliated Pacific Islands will be awarded funds.
In addition, CDC
may fund out of rank order to ensure maximum geographic representation and inclusion of each of the programmatic populations of focus identified in the "Target Population" section of this NOFO. CDC will provide justification for any decision to fund out of rank order.

Review of risk posed by applicants.

Prior to making a Federal award, CDC is required by 31 U.S.C. 3321 and 41 U.S.C. 2313 to review information available through any OMB-designated repositories of government-wide eligibility qualification or financial integrity information as appropriate. See also suspension and debarment requirements at 2 CFR parts 180 and 376.

In accordance 41 U.S.C. 2313, CDC is required to review the non-public segment of the OMB-designated integrity and performance system accessible through SAM (currently the Federal Recipient Performance and Integrity Information System (FAPIIS)) prior to making a Federal award where the Federal share is expected to exceed the simplified acquisition threshold, defined in 41 U.S.C. 134, over the period of performance. At a minimum, the information in the system for a prior Federal award recipient must demonstrate a satisfactory record of executing programs or activities under Federal grants, cooperative agreements, or procurement awards; and integrity and business ethics. CDC may make a Federal award to a recipient who does not fully meet these standards, if it is determined that the information is not relevant to the current Federal award under consideration or there are specific conditions that can appropriately mitigate the effects of the non-Federal entity's risk in accordance with 45 CFR §75.207.

CDC's framework for evaluating the risks posed by an applicant may incorporate results of the evaluation of the applicant's eligibility or the quality of its application. If it is determined that a Federal award will be made, special conditions that correspond to the degree of risk assessed may be applied to the Federal award. The evaluation criteria is described in this Notice of Funding Opportunity.

In evaluating risks posed by applicants, CDC will use a risk-based approach and may consider any items such as the following:

(1) Financial stability;

(2) Quality of management systems and ability to meet the management standards prescribed in this part;

(3) History of performance. The applicant's record in managing Federal awards, if it is a prior recipient of Federal awards, including timeliness of compliance with applicable reporting requirements, conformance to the terms and conditions of previous Federal awards, and if applicable, the extent to which any previously awarded amounts will be expended prior to future awards;

(4) Reports and findings from audits performed under subpart F 45 CFR 75 or the reports and findings of any other available audits; and

(5) The applicant's ability to effectively implement statutory, regulatory, or other requirements imposed on non-Federal entities.

CDC must comply with the guidelines on government-wide suspension and debarment in 2 CFR part 180, and require non-Federal entities to comply with these provisions. These provisions restrict Federal awards, subawards and contracts with certain parties that are debarred, suspended or otherwise excluded from or ineligible for participation in Federal programs or activities.

2. Announcement and Anticipated Award Dates

Anticipated Announcement Date: November 1, 2021
Anticipated Award Date: May, 30, 2022

F. Award Administration Information

1. Award Notices

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

Any applicant awarded funds in response to this Notice of Funding Opportunity 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

Recipients must comply with the administrative and public policy requirements outlined in 45 CFR Part 75 and the HHS Grants Policy Statement, as appropriate.

Brief descriptions of relevant provisions are available at http://www.cdc.gov/grants/additionalrequirements/index.html#ui-id-17.

The HHS Grants Policy Statement is available at http://www.hhs.gov/sites/default/files/grants/grants/policies-regulations/hhsgps107.pdf.

The following Administrative Requirements (AR) apply to this NOFO:
AR-9: Paperwork Reduction Act Requirements

AR-10: Smoke-Free Workplace Requirements

AR-11: Healthy People 2030

AR-13: Prohibition on Use of CDC Funds for Certain Gun Control Activities

AR-14: Accounting System Requirements

AR-24: Health Insurance Portability and Accountability Act Requirements

AR-25: Data Management and Access

AR-29: Compliance with EO13513, "Federal Leadership on Reducing Text Messaging while Driving", October 1, 2009

AR-31: Research Definition

AR-34: Accessibility Provisions and Non-Discrimination Requirements
AR-37: Prohibition on certain telecommunications and video surveillance services or equipment for all awards issued on or after August 13, 2020

The full text of the Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards, 45 CFR 75, can be found at: https://www.ecfr.gov/cgi-bin/text-idx?node=pt45.1.75

Should you successfully compete for an award, recipients of federal financial assistance (FFA) from HHS must administer their programs in compliance with federal civil rights laws that prohibit discrimination on the basis of race, color, national origin, disability, age and, in some circumstances, religion, conscience, and sex (including gender identity, sexual orientation, and pregnancy).This includes taking reasonable steps to provide meaningful access to persons with limited English proficiency and providing programs that are accessible to and usable by persons with disabilities. The HHS Office for Civil Rights provides guidance on complying with civil rights laws enforced by HHS. See https://www.hhs.gov/civil-rights/for-providers/provider-obligations/index.html and https://www.hhs.gov/civil-rights/for-individuals/nondiscrimination/index.html.

- Recipients of FFA must ensure that their programs are accessible to persons with limited English proficiency. For guidance on meeting your legal obligation to take reasonable steps to ensure meaningful access to your programs or activities by limited English proficient individuals, see https://www.hhs.gov/civil-rights/for-individuals/special-topics/limited-english-proficiency/fact-sheet-guidance/index.html and https://www.lep.gov.
- For information on your specific legal obligations for serving qualified individuals with disabilities, including providing program access, reasonable modifications, and taking appropriate steps to provide effective communication, see http://www.hhs.gov/ocr/civilrights/understanding/disability/index.html.
- HHS funded health and education programs must be administered in an environment free of sexual harassment, see https://www.hhs.gov/civil-rights/for-individuals/sex-discrimination/index.html.

• For guidance on administering your project in compliance with applicable federal religious nondiscrimination laws and applicable federal conscience protection and associated anti-discrimination laws, see https://www.hhs.gov/conscience/conscience-protections/index.html and https://www.hhs.gov/conscience/religious-freedom/index.html.

3. Reporting

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

- Helps target support to recipients;
- Provides CDC with periodic data to monitor recipient progress toward meeting the Notice of Funding Opportunity outcomes and overall performance;
- Allows CDC to track performance measures and evaluation findings for continuous quality and program improvement throughout the period of performance 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 NOFO.

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 NOFO copying the CDC Project Officer.

Report	When?	Required?
Recipient Evaluation and Performance Measurement Plan, including Data Management Plan (DMP)	**Program 1 NBCCEDP and Program 2 NCCCP:** 6 months into award **Program 3 NPCR:** Due at the time of application submission; recipients will work with PCs to make any revisions. Evaluation progress summaries due annually within APR narrative. Full evaluation report due at years 3 and 5.	Yes
Annual Performance Report (APR)	**All Programs NBCCEDP, NCCCP, NPCR:** No later than 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.	NA
Federal Financial Reporting Forms	**All Programs NBCCEDP, NCCCP, NPCR:** 90 days after the end of the budget period	Yes

Final Performance and Financial Report	**All Programs NBCCEDP, NCCCP, NPCR:** 90 days after end of period of performance	Yes
Payment Management System (PMS) Reporting	**All Programs NBCCEDP, NCCCP, NPCR:** Quarterly reports due January 30; April 30; July 30; and October 30	Yes

a. Recipient Evaluation and Performance Measurement Plan (required)

With support from CDC, recipients must elaborate on their initial applicant evaluation and performance measurement plan. This plan must be no more than 20 pages; recipients must submit the plan 6 months into the award. HHS/CDC will review and approve the recipient's monitoring and evaluation plan to ensure that it is appropriate for the activities to be undertaken as part of the agreement, for compliance with the monitoring and evaluation guidance established by HHS/CDC, or other guidance otherwise applicable to this Agreement.

Recipient Evaluation and Performance Measurement Plan (required): This plan should provide additional detail on the following:

Performance Measurement

• Performance measures and targets

• The frequency that performance data are to be collected.

• How performance data will be reported.

• How quality of performance data will be assured.

• How performance measurement will yield findings to demonstrate progress towards achieving NOFO goals (e.g., reaching target populations or achieving expected outcomes).

• Dissemination channels and audiences.

• Other information requested as determined by the CDC program.

Evaluation

• The types of evaluations to be conducted (e.g. process or outcome evaluations).

• The frequency that evaluations will be conducted.

• How evaluation reports will be published on a publically available website.

• How evaluation findings will be used to ensure continuous quality and program improvement.

• How evaluation will yield findings to demonstrate the value of the NOFO (e.g., effect on improving public health outcomes, effectiveness of NOFO, cost-effectiveness or cost-benefit).

• Dissemination channels and audiences.

HHS/CDC or its designee will also undertake monitoring and evaluation of the defined activities within the agreement. The recipient must ensure reasonable access by HHS/CDC or its designee to all necessary sites, documentation, individuals and information to monitor, evaluate and verify

the appropriate implementation the activities and use of HHS/CDC funding under this Agreement.

b. Annual Performance Report (APR) (required)
The recipient must submit the APR via www.Grantsolutions.gov no later than120 days prior to the end of the budget period. This report must not exceed 45 pages excluding administrative reporting. Attachments are not allowed, but web links are allowed.

This report must include the following:

- **Performance Measures:** Recipients must report on performance measures for each budget period and update measures, if needed.
- **Evaluation Results:** Recipients must report evaluation results for the work completed to date (including findings from process or outcome evaluations).
- **Work Plan:** Recipients must update work plan each budget period to reflect any changes in period of performance outcomes, activities, timeline, etc.
- **Successes**
    - Recipients must report progress on completing activities and progress towards achieving the period of performance outcomes described in the logic model and work plan.
    - Recipients must describe any additional successes (e.g. identified through evaluation results or lessons learned) achieved in the past year.
    - Recipients must describe success stories.
- **Challenges**
    - Recipients must describe any challenges that hindered or might hinder their ability to complete the work plan activities and achieve the period of performance outcomes.
    - Recipients must describe any additional challenges (e.g., identified through evaluation results or lessons learned) encountered in the past year.
- **CDC Program Support to Recipients**
    - Recipients must describe how CDC could help them overcome challenges to complete activities in the work plan and achieving period of performance 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 recipient must submit the Annual Performance Report via https://www.grantsolutions.gov 120 days prior to the end of the budget period.

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 recipients 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 90 days after the end of the budget period through the Payment Management System (PMS). 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, recipients are required to submit a letter of explanation to OGS and include the date by which the Grants Officer will receive information.

e. Final Performance and Financial Report (required)
The Final Performance Report is due 90 days after the end of the period of performance. The Final FFR is due 90 days after the end of the period of performance and must be submitted through the Payment Management System (PMS). CDC programs must indicate that this report should not exceed 40 pages. This report covers the entire period of performance and can include information previously reported in APRs. At a minimum, this report must include the following:

- Performance Measures – Recipients must report final performance data for all process and outcome performance measures.
- Evaluation Results – Recipients must report final evaluation results for the period of performance for any evaluations conducted.
- Impact/Results/Success Stories – Recipients must use their performance measure results and their evaluation findings to describe the effects or results of the work completed over the period of performance, and can include some success stories.
- A final Data Management Plan that includes the location of the data collected during the funded period, for example, repository name and link data set(s)
- Additional forms as described in the Notice of Award (e.g., Equipment Inventory Report, Final Invention Statement).

The Final Performance Report should be component specific.

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

Federal Funding Accountability and Transparency Act of 2006 (FFATA), P.L. 109–282, as amended by section 6202 of P.L. 110–252 requires full disclosure of all entities and organizations receiving Federal funds including awards, contracts, loans, other assistance, and payments through a single publicly accessible Web site, http://www.USASpending.gov.

Compliance with this law is primarily the responsibility of the Federal agency. However, two elements of the law require information to be collected and reported by applicants: 1)

information on executive compensation when not already reported through the SAM, and 2) similar information on all sub-awards/subcontracts/consortiums over $25,000.

For the full text of the requirements under the FFATA and HHS guidelines, go to:

- https://www.gpo.gov/fdsys/pkg/PLAW-109publ282/pdf/PLAW-109publ282.pdf,
- https://www. fsrs.gov/documents /ffata_legislation_ 110_252.pdf
- http://www.hhs.gov/grants/grants/grants-policies-regulations/index.html#FFATA.

5. Reporting of Foreign Taxes (International/Foreign projects only)

A. Valued Added Tax (VAT) and Customs Duties – Customs and import duties, consular fees, customs surtax, valued added taxes, and other related charges are hereby authorized as an allowable cost for costs incurred for non-host governmental entities operating where no applicable tax exemption exists. This waiver does not apply to countries where a bilateral agreement (or similar legal document) is already in place providing applicable tax exemptions and it is not applicable to Ministries of Health. Successful applicants will receive information on VAT requirements via their Notice of Award.

B. The U.S. Department of State requires that agencies collect and report information on the amount of taxes assessed, reimbursed and not reimbursed by a foreign government against commodities financed with funds appropriated by the U.S. Department of State, Foreign Operations and Related Programs Appropriations Act (SFOAA) ("United States foreign assistance funds"). Outlined below are the specifics of this requirement:

1) Annual Report: The recipient must submit a report on or before November 16 for each foreign country on the amount of foreign taxes charged, as of September 30 of the same year, by a foreign government on commodity purchase transactions valued at 500 USD or more financed with United States foreign assistance funds under this grant during the prior United States fiscal year (October 1 – September 30), and the amount reimbursed and unreimbursed by the foreign government. [Reports are required even if the recipient did not pay any taxes during the reporting period.]

2) Quarterly Report: The recipient must quarterly submit a report on the amount of foreign taxes charged by a foreign government on commodity purchase transactions valued at 500 USD or more financed with United States foreign assistance funds under this grant. This report shall be submitted no later than two weeks following the end of each quarter: April 15, July 15, October 15 and January 15.

3) Terms: For purposes of this clause:
"Commodity" means any material, article, supplies, goods, or equipment;
"Foreign government" includes any foreign government entity;
"Foreign taxes" means value-added taxes and custom duties assessed by a foreign government on a commodity. It does not include foreign sales taxes.

4) Where: Submit the reports to the Director and Deputy Director of the CDC office in the country(ies) in which you are carrying out the activities associated with this cooperative

agreement. In countries where there is no CDC office, send reports to VATreporting@cdc.gov.

5) Contents of Reports: The reports must contain:

a. recipient name;
b. contact name with phone, fax, and e-mail;
c. agreement number(s) if reporting by agreement(s);
d. reporting period;
e. amount of foreign taxes assessed by each foreign government;
f. amount of any foreign taxes reimbursed by each foreign government;
g. amount of foreign taxes unreimbursed by each foreign government.

6) Subagreements. The recipient must include this reporting requirement in all applicable subgrants and other subagreements.

6. Termination

CDC may impose other enforcement actions in accordance with 45 CFR 75.371- Remedies for Noncompliance, as appropriate.

The Federal award may be terminated in whole or in part as follows:

(1) By the HHS awarding agency or pass-through entity, if the non-Federal entity fails to comply with the terms and conditions of the award;

(2) By the HHS awarding agency or pass-through entity for cause;

(3) By the HHS awarding agency or pass-through entity with the consent of the non-Federal entity, in which case the two parties must agree upon the termination conditions, including the effective date and, in the case of partial termination, the portion to be terminated; or

(4) By the non-Federal entity upon sending to the HHS awarding agency or pass-through entity written notification setting forth the reasons for such termination, the effective date, and, in the case of partial termination, the portion to be terminated. However, if the HHS awarding agency or pass-through entity determines in the case of partial termination that the reduced or modified portion of the Federal award or subaward will not accomplish the purposes for which the Federal award was made, the HHS awarding agency or pass-through entity may terminate the Federal award in its entirety.

G. Agency Contacts

CDC encourages inquiries concerning this NOFO.

Program Office Contact

For programmatic technical assistance, contact:

First Name:
Frances

Last Name:
Babcock
Project Officer
Department of Health and Human Services
Centers for Disease Control and Prevention

Address:
4770 Buford Highway
MS107-4
Atlanta, GA 30341

Telephone:
770-488-4378

Email:
NOFODP22-2202@cdc.gov

Grants Management Office Information

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

First Name:
Pamela

Last Name:
Render
Grants Management Specialist
Department of Health and Human Services
Office of Grants Services

Address:
2939 Brandywine Road
Atlanta, Georgia 30341

Telephone:
770-488-2712

Email:
plr3@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.

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
- Report on Programmatic, Budgetary and Commitment Overlap
- Table of Contents for Entire Submission

For international NOFOs:

- SF424
- SF424A
- Funding Preference Deliverables

Optional attachments, as determined by CDC programs:
Resumes / CVs

Position descriptions

Organization Charts

Indirect Cost Rate, if applicable

Bona Fide Agent status documentation, if applicable

Memorandum of Understanding (MOU)

Memorandum of Agreement (MOA)

Non-profit organization IRS status forms, if applicable

Letters of Support

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 75 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 NOFO; recipients must comply with the ARs listed in the NOFO. To view brief descriptions of relevant provisions, see http:// www.cdc.gov/ grants/ additional requirements/ index.html. Note that 2 CFR 200 supersedes the administrative requirements (A-110 & A-102), cost principles (A-21, A-87 & A-122) and audit requirements (A-50, A-89 & A-133).

Approved but Unfunded: Approved but unfunded refers to applications recommended for approval during the objective review process; however, they were not recommended for funding by the program office and/or the grants management office.

Assistance Listings: 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.

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

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 period of performance. 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.

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 recipients. It may include the value of allowable third-party, in-kind contributions, as well as expenditures by the recipient.

Direct Assistance: A financial assistance mechanism, which must be specifically authorized by statute, whereby goods or services are provided to recipients in lieu of cash. DA generally involves the assignment of federal personnel or the provision of equipment or supplies, such as vaccines. DA is primarily used to support payroll and travel expenses of CDC employees assigned to state, tribal, local, and territorial (STLT) health agencies that are recipients of grants and cooperative agreements. Most legislative authorities that provide financial assistance to STLT health agencies allow for the use of DA. http:// www.cdc.gov /grants/additionalrequirements /index.html.

DUNS: The Dun and Bradstreet (D&B) Data Universal Numbering System (DUNS) number is a nine-digit number assigned by Dun and Bradstreet Information Services. When applying for Federal awards or cooperative agreements, all applicant organizations must obtain a DUNS number as the Universal Identifier. DUNS number assignment is free. If requested by telephone, a DUNS number will be provided immediately at no charge. If requested via the Internet, obtaining a DUNS number may take one to two days at no charge. If an organization does not know its DUNS number or needs to register for one, visit Dun & Bradstreet at http://fedgov.dnb.com/ webform/displayHomePage.do.

Evaluation (program evaluation): The systematic collection of information about the activities, characteristics, and outcomes of programs (which may include interventions, policies, and

specific projects) to make judgments about that program, improve program effectiveness, and/or inform decisions about future program development.

Evaluation Plan: A written document describing the overall approach that will be used to guide an evaluation, including why the evaluation is being conducted, how the findings will likely be used, and the design and data collection sources and methods. The plan specifies what will be done, how it will be done, who will do it, and when it will be done. The NOFO evaluation plan is used to describe how the recipient and/or CDC will determine whether activities are implemented appropriately and outcomes are achieved.

Federal Funding Accountability and Transparency Act of 2006 (FFATA): Requires that information about federal awards, including awards, contracts, loans, and other assistance and payments, be available to the public on a single website at www.USAspending.gov.

Fiscal Year: The year for which budget dollars are allocated annually. The federal fiscal year starts October 1 and ends September 30.

Grant: A legal instrument used by the federal government to transfer anything of value to a recipient for public support or stimulation authorized by statute. Financial assistance may be money or property. The definition does not include a federal procurement subject to the Federal Acquisition Regulation; technical assistance (which provides services instead of money); or assistance in the form of revenue sharing, loans, loan guarantees, interest subsidies, insurance, or direct payments of any kind to a person or persons. The main difference between a grant and a cooperative agreement is that in a grant there is no anticipated substantial programmatic involvement by the federal government under the award.

Grants.gov: A "storefront" web portal for electronic data collection (forms and reports) for federal grant-making agencies at www.grants.gov.

Grants Management Officer (GMO): The individual designated to serve as the HHS official responsible for the business management aspects of a particular grant(s) or cooperative agreement(s). The GMO serves as the counterpart to the business officer of the recipient organization. In this capacity, the GMO is responsible for all business management matters associated with the review, negotiation, award, and administration of grants and interprets grants administration policies and provisions. The GMO works closely with the program or project officer who is responsible for the scientific, technical, and programmatic aspects of the grant.

Grants Management Specialist (GMS): A federal staff member who oversees the business and other non-programmatic aspects of one or more grants and/or cooperative agreements. These activities include, but are not limited to, evaluating grant applications for administrative content and compliance with regulations and guidelines, negotiating grants, providing consultation and technical assistance to recipients, post-award administration and closing out grants.

Health Disparities: Differences in health outcomes and their determinants among segments of the population as defined by social, demographic, environmental, or geographic category.

Health Equity: Striving for the highest possible standard of health for all people and giving special attention to the needs of those at greatest risk of poor health, based on social conditions.
Health Inequities: Systematic, unfair, and avoidable differences in health outcomes and their

determinants between segments of the population, such as by socioeconomic status (SES), demographics, or geography.

Healthy People 2030: National health objectives aimed at improving the health of all Americans by encouraging collaboration across sectors, guiding people toward making informed health decisions, and measuring the effects of prevention activities.

Inclusion: Both the meaningful involvement of a community's members in all stages of the program process and the maximum involvement of the target population that the intervention will benefit. Inclusion ensures that the views, perspectives, and needs of affected communities, care providers, and key partners are considered.

Indirect Costs: Costs that are incurred for common or joint objectives and not readily and specifically identifiable with a particular sponsored project, program, or activity; nevertheless, these costs are necessary to the operations of the organization. For example, the costs of operating and maintaining facilities, depreciation, and administrative salaries generally are considered indirect costs.

Letter of Intent (LOI): A preliminary, non-binding indication of an organization's intent to submit an application.

Lobbying: Direct lobbying includes any attempt to influence legislation, appropriations, regulations, administrative actions, executive orders (legislation or other orders), or other similar deliberations at any level of government through communication that directly expresses a view on proposed or pending legislation or other orders, and which is directed to staff members or other employees of a legislative body, government officials, or employees who participate in formulating legislation or other orders. Grass roots lobbying includes efforts directed at inducing or encouraging members of the public to contact their elected representatives at the federal, state, or local levels to urge support of, or opposition to, proposed or pending legislative proposals.

Logic Model: A visual representation showing the sequence of related events connecting the activities of a program with the programs' desired outcomes and results.

Maintenance of Effort: A requirement contained in authorizing legislation, or applicable regulations that a recipient must agree to contribute and maintain a specified level of financial effort from its own resources or other non-government sources to be eligible to receive federal grant funds. This requirement is typically given in terms of meeting a previous base-year dollar amount. Memorandum of Understanding (MOU) or Memorandum of Agreement**(MOA):** Document that describes a bilateral or multilateral agreement between parties expressing a convergence of will between the parties, indicating an intended common line of action. It is often used in cases where the parties either do not imply a legal commitment or cannot create a legally enforceable agreement.

Nonprofit Organization: Any corporation, trust, association, cooperative, or other organization that is operated primarily for scientific, educational, service, charitable, or similar purposes in the public interest; is not organized for profit; and uses net proceeds to maintain, improve, or expand the operations of the organization. Nonprofit organizations include institutions of higher educations, hospitals, and tribal organizations (that is, Indian entities other than federally recognized Indian tribal governments).

Notice of Award (NoA): The official document, signed (or the electronic equivalent of signature) by a Grants Management Officer that: (1) notifies the recipient of the award of a grant; (2) contains or references all the terms and conditions of the grant and Federal funding limits and obligations; and (3) provides the documentary basis for recording the obligation of Federal funds in the HHS accounting system.

Objective Review: A process that involves the thorough and consistent examination of applications based on an unbiased evaluation of scientific or technical merit or other relevant aspects of the proposal. The review is intended to provide advice to the persons responsible for making award decisions.

Outcome: The results of program operations or activities; the effects triggered by the program. For example, increased knowledge, changed attitudes or beliefs, reduced tobacco use, reduced morbidity and mortality.

Performance Measurement: The ongoing monitoring and reporting of program accomplishments, particularly progress toward pre-established goals, typically conducted by program or agency management. Performance measurement may address the type or level of program activities conducted (process), the direct products and services delivered by a program (outputs), or the results of those products and services (outcomes). A "program" may be any activity, project, function, or policy that has an identifiable purpose or set of objectives.

Period of performance –formerly known as the project period - : The time during which the recipient may incur obligations to carry out the work authorized under the Federal award. The start and end dates of the period of performance must be included in the Federal award.

Period of Performance Outcome: An outcome that will occur by the end of the NOFO's funding period

Plain Writing Act of 2010: The Plain Writing Act of 2010 requires that federal agencies use clear communication that the public can understand and use. NOFOs must be written in clear, consistent language so that any reader can understand expectations and intended outcomes of the funded program. CDC programs should use NOFO plain writing tips when writing NOFOs. **Program Strategies:** Strategies are groupings of related activities, usually expressed as general headers (e.g., Partnerships, Assessment, Policy) or as brief statements (e.g., Form partnerships, Conduct assessments, Formulate policies).

Program Official: Person responsible for developing the NOFO; can be either a project officer, program manager, branch chief, division leader, policy official, center leader, or similar staff member.

Public Health Accreditation Board (PHAB): A nonprofit organization that works to promote and protect the health of the public by advancing the quality and performance of public health departments in the U.S. through national public health department accreditation http://www.phaboard.org.

Social Determinants of Health: Conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

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.

System for Award Management (SAM): The primary vendor database for the U.S. federal government. SAM validates applicant information and electronically shares secure and encrypted data with federal agencies' finance offices to facilitate paperless payments through Electronic Funds Transfer (EFT). SAM stores organizational information, allowing www.grants.gov to verify identity and pre-fill organizational information on grant applications.

Technical Assistance: Advice, assistance, or training pertaining to program development, implementation, maintenance, or evaluation that is provided by the funding agency.

Work Plan: The summary of period of performance 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.