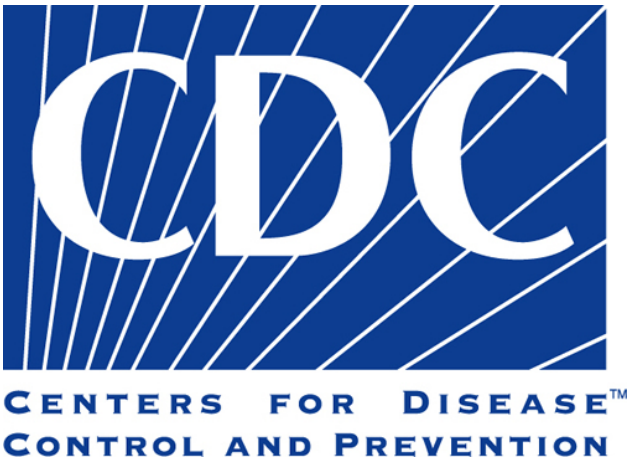


Centers for Disease Control and Prevention

NATIONAL CENTER FOR CHRONIC DISEASE PREVENTION AND HEALTH PROMOTION

A Strategic Approach to Advancing Health Equity for Priority Populations with or at Risk for Diabetes

CDC-RFA-DP-23-0020

03/07/2023

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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-DP-23-0020. 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:

A Strategic Approach to Advancing Health Equity for Priority Populations with or at Risk for Diabetes

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-DP-23-0020

E. Assistance Listings Number:

93.988

F. Dates:

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

The LOI date will generate once the Synopsis is published if Days or a Date are entered. Recommended but not Required

01/20/2023, 11:59 PM U.S. Eastern Standard Time

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

LOI must be sent via email to:
Pat Schumacher
DP2320NOFO@cdc.gov

2. Due Date for Applications:
03/07/2023
11:59 p.m. U.S. Eastern Standard Time, at www.grants.gov.

3. Due Date for Informational Conference Call
Date: 01/13/2023
Time: 02:00-3:30 PM U.S Eastern Time (US and Canada)
Topic: DP23-0020 Informational Conference Call

Please email DP2320NOFO@cdc.gov to register in advance for this webinar. Details for accessing the webinar will be posted on or before January 12, 2023, at the website referenced below. (Pre-registration is optional.)

The Informational Conference Call will be recorded and added to the DP23-0020 Information Webpage https://www.cdc.gov/diabetes/funding-opportunity/NOFO-CDC-RFA-DP23-0020.html.

F. Executive Summary:

Summary Paragraph
This NOFO seeks to decrease risk for type 2 diabetes among adults with prediabetes and improve self-care practices, quality of care, and early detection of complications among people with diabetes. Additionally, this NOFO will support implementation of evidence-based, family-centered childhood obesity interventions as a type 2 diabetes risk reduction strategy. The NOFO includes 3 components. Applicants may apply for only 1. **Components A and B** focus on a menu of strategies to decrease risk for type 2 diabetes among adults at high risk; improve self-care practices, quality of care, and early detection of complications among priority populations with diabetes; and support implementation of family-centered childhood obesity interventions to reduce risk for type 2 diabetes. **Component A** will fund 51 organizations physically located in each of the 50 states and the District of Columbia to achieve state/district-wide reach. **Component B** will fund up to 22 organizations to work in US counties identified as "high need" based on diabetes burden and social vulnerability; applicants' work must reach a population ≥ 350,000 across one or more of these counties, in partnership with local organizations. **Component C** will fund 3-4 multisectoral partnership networks to simultaneously and collaboratively address 4 aspects of work proven necessary to scale and sustain the National Diabetes Prevention Program to better engage, enroll, and retain large numbers of participants.

a. Eligible Applicants:
Open Competition

b. NOFO Type:

CA (Cooperative Agreement)

c. Approximate Number of Awards

77
Component A: 51 awards
Component B: up to 22 awards
Component C: up to 4 awards

d. Total Period of Performance Funding:

$411,000,000

e. Average One Year Award Amount:

$1,067,532
Component A: award range of $850,000-$1,250,000
Component B: award range of $750,000-$1,100,000
Component C: award range of $2,500,000-$3,300,000

f. Total Period of Performance Length:

5 year(s)

g. Estimated Award Date:

May 30, 2023

h. Cost Sharing and / or Matching Requirements:

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

Part II. Full Text

A. Funding Opportunity Description

1. Background

a. Overview

Diabetes is the 8th leading cause of death in the US, the number one cause of kidney failure, lower-limb amputations, and adult-onset blindness, and is a leading cause of heart disease and stroke. More than 37 million people in the US have diabetes. Medical costs and lost work/wages for people with diabetes total $327 billion yearly. Age-adjusted data for 2018–2019 indicated that, for both men and women, prevalence of diagnosed diabetes was highest among American Indian and Alaska Native adults (14.5%), followed by non-Hispanic Black (12.1%), Hispanic (11.8%), non-Hispanic Asian (9.5%), and non-Hispanic White adults (7.4%). Prevalence varied significantly by education level, which is an indicator of socioeconomic status. Of adults with less than a high school education, 13.4% had diagnosed diabetes versus 9.2% of those with a high school education and 7.1% of those with more than a high school education. Adults with family income below the federal poverty level had the highest prevalence for both men (13.7%) and women (14.4%). Additionally, 96 million US adults have prediabetes, and more than 8 in 10 of them don't know they have it.

This NOFO seeks to decrease risk for type 2 diabetes among adults with prediabetes and

improve self-care practices, quality of care, and early detection of complications among people with diabetes. Additionally, this NOFO will support implementation of evidence-based, family-centered childhood obesity interventions as a type 2 diabetes risk reduction strategy. **All work supported under this NOFO will focus on reducing health disparities for priority populations, defined as those who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion.**

A menu of strategies related to diabetes management, type 2 diabetes prevention, and childhood obesity management is provided. Strategies are based on interventions grounded in scientific and practice-based evidence. These include 1) diabetes self-management education and support (DSMES), which improves health outcomes and quality of life and is cost effective; 2) the National Diabetes Prevention Program (National DPP), which supports a lifestyle intervention founded on the science of the DPP research study that confirmed type 2 diabetes can be prevented in adults at high risk; and 3) four family-centered weight management interventions for children proven effective in low-income populations. Other strategies are aligned with recommendations in the 2021 National Clinical Care Commission Report to Congress on preventing and controlling diabetes and its complications.

The NOFO includes 3 components. Applicants may apply for only 1. **Component A** will fund 51 organizations (1 located in each state and the District of Columbia) to achieve state/district-wide reach on at least 6 strategies selected from the menu. **Component B** will fund up to 22 organizations to work in US counties identified as "high need" based on diabetes burden and social vulnerability to work on at least 4 strategies from the menu; applicants must reach a population ≥ 350,000 across one or more of these counties. **Component C** will fund up to 4 multisectoral partnership networks to collaboratively address 4 aspects of work proven necessary to scale and sustain the National DPP to engage, enroll, and retain large numbers of participants.

b. Statutory Authorities

Section 301(a) of the Public Health Service Act (PHS Act) [42] U.S.C. Section 241(a) 93.426 and Title IV Section 4002 of the Affordable Care Act 42 U.S.C. 300u-11, Prevention and Public Health Fund

c. Healthy People 2030

Diabetes Management/Prevention of Complications

- D-06: Increase the proportion of people with diabetes who get formal diabetes education.
- D-03: Reduce the proportion of adults with diabetes who have an A1c value > 9 percent.
- V-04: Reduce vision loss from diabetic retinopathy.
- CKD-01: Reduce the proportion of adults with chronic kidney disease (CKD).
- CKD-02: Increase the proportion of adults with CKD who know they have it.

Type 2 Diabetes Prevention

- D-02: Reduce the proportion of adults who don't know they have prediabetes.

- D-D01: Increase the proportion of eligible people completing CDC-recognized type 2 diabetes prevention programs.
- D-01: Reduce the number of diabetes cases diagnosed yearly

d. Other National Public Health Priorities and Strategies
National Diabetes Prevention Program

Diabetes Self-Management Education and Support (DSMES): https://doi.org/10.2337/dci20-0023; CDC DSMES Toolkit

CDC National Center for Chronic Disease Prevention and Health Promotion's Social Determinants of Health (SDOH) Framework

National Strategy on Hunger, Nutrition, and Health

e. Relevant Work
This NOFO builds on the accomplishments and lessons learned of CDC-RFA-DP18-1815, CDC-RFA-DP18-1817, and CDC-RFA-DP17-1705; more information is available at:

- CDC-RFA-DP18-1815
- CDC-RFA-DP18-1817
- CDC-RFA-DP17-1705
- Evaluation Resources

This NOFO is associated with a companion NOFO: *A Strategic Approach to Advancing Health Equity for Priority Populations with or at Risk for Diabetes: Subject Matter Expertise, Training, and Technical Assistance.*

2. CDC Project Description

a. Approach

Bold indicates period of performance outcome.

CDC-RFA-*DP-23-0020* Logic Model: A Strategic Approach to Advancing Health Equity for Priority Populations with or at Risk for Diabetes

LOGIC MODEL: COMPONENTS A & B
Bold indicates period of performance outcome

Strategies & Activities	Short-Term Outcomes	Intermediate Outcomes	Long-Term Outcomes
I. Evidence-based Approaches to Diabetes Management: 1) Improve access, appropriateness, and feasibility of diabetes	**Increase in the number of organizations implementing evidence-based**	**Increased participation in evidence-based community behavioral**	Decrease in the proportion of people with diabetes with an A1C > 9% (I, III)

elf-management education and support services 2) Expand coverage of recognized-accredited DSMES services 3) Prevent diabetes complications through early detection 4) Improve acceptability and quality of diabetes care for priority populations **II. Evidence-based Approaches to Type 2 Diabetes Prevention and Risk Reduction:** 5) Increase enrollment and retention of priority populations in the National Diabetes Prevention Program (National DPP) lifestyle intervention and the Medicare Diabetes Prevention Program, 6) Expand availability of National DPP lifestyle intervention as covered health benefit 7) Establish/expand National DPP Umbrella Hub Arrangements 8) Implement, spread, and sustain one of 4 evidence-based, family-centered childhood obesity interventions **III. Policy & Systems-Level Support for Diabetes Management and Type 2 Diabetes Prevention**: 9) Increase and sustain DSMES and National DPP delivery sites within pharmacy networks and	**community behavioral change programs (I, II)** **Increased adaptation/ tailoring of effective programs for priority populations (I, II)** **Increased # of patients screened and referred to community resources (i.e., health/mental health resources) (III)** **Increased SDOH screenings in clinical settings (III)**	**change programs (I, II)** Improved self-management of chronic disease(s) **Increased multi-directional communication between clinical and community resources (III)** Increased patient contact with CHWs or health care extenders (III) Increased proportion of the population receiving the health care services they need and want (III)	Increased number of program completers served by CDC-recognized National DPP delivery organizations who reduce their risk for type 2 diabetes (II, III) Decrease in percent of the 95th percentile body mass index (BMI) and percent of median BMI in children, improvement in pediatric quality of life, and decrease in BMI among caregivers (II)

chain pharmacies 10) Support development of multidirectional e-referral systems 11) Design and test innovative payment models that bundle National DPP and/or DSMES with other programs and services addressing social needs 12) Build infrastructure to improve sustainability of Community Health Workers (CHWs) 13) Improve capacity of the diabetes workforce to address social determinants of health (SDOH)-related barriers			

LOGIC MODEL: COMPONENT C
Use of Multisectoral Partner Networks to Scale and Sustain the National DPP to Reach Priority Populations

Strategies	**Short-term Outcomes**	**Intermediate Outcomes**	**Long-Term Outcomes**
1. **Administrative Infrastructure**: Serve as the hub for the multisectoral National DPP partner network and manage its administrative infrastructure	**Increase in clinical and community-based organization (CBO) partners' capacity to institutionalize participant referral processes, with an emphasis on increasing priority population reach**	**Increase use of existing or newly designed coverage benefits to cover costs of program delivery and program supports for priority populations**	**Increase multisectoral partnership networks with the capacity to activate all levers of the National DPP and reach priority populations** **Increase**
2. **Participant Referral Processes**: Work with and fund clinical and community partners to institutionalize participant referral processes, with an			

emphasis on reaching priority populations specified in the enrollment goal and implementing the American Medical Association-sponsored prediabetes quality measures	**via SDOH programs and/or services** **Increase systems that monitor the outcome of participant referrals to identify clinical and community-based referral processes that maximize enrollment of priority populations**		**enrollment and retention of priority populations in the National DPP lifestyle intervention**
3. **Program Delivery and Participant Support**: Work with delivery partners to establish a network of both in-person and virtual CDC-recognized program delivery organizations and standardize procedures for participant support via SDOH programs and/or services			
4. **Payment/Coverage**: Work with payer and employer partners to implement existing coverage policies and test new coverage policies within the network			

i. Purpose

This NOFO will support evidence-based diabetes management and type 2 diabetes prevention and risk mitigation strategies, with an emphasis on reducing health disparities for priority populations.

ii. Outcomes

Component A & B outcomes include:

- **Increase in the number of organizations implementing evidence-based community behavioral change programs**
- **Increased adaptation/tailoring of effective programs for priority populations**
- **Increase in the # of patients screened and referred to community resources (i.e., health/mental health resources)**
- **Increased SDOH screenings in clinical settings**

- **Increased participation in evidence-based community behavioral change programs**
- **Increased multi-directional communication between clinical and community resources**

Component C outcomes include:

- **Increase in clinical and CBO partners' capacity to institutionalize participant referral processes, with an emphasis on increasing priority population reach via SDOH programs and/or services**
- **Increase in systems that monitor the outcome of participant referrals to identify clinical and community-based referral processes that maximize enrollment of priority populations**
- **Increase in use of existing or newly designed coverage benefits to cover costs of program delivery and program supports for priority populations**
- **Increase in multisectoral partnership networks with the capacity to activate all levers of the National DPP and reach priority populations**
- **Increase in enrollment and retention of priority populations in the National DPP lifestyle intervention**

iii. Strategies and Activities
Applicants will **apply for one of the following components**.

Component A applicants will select a minimum of 6 of the 13 strategies from the "Components A and B: Menu of Strategies" section below and must include strategy 1 and/or strategy 5 among their selections. Applicants should choose the strategies they are best equipped to implement and achieve significant progress on based on their organization's mission, capacity, expertise, partner connections, and related factors.

Component B applicants will select a minimum of 4 of the 13 strategies from the "Components A and B: Menu of Strategies" section below and must include strategy 1 and/or strategy 5 among their selections. Applicants should choose the strategies they are best equipped to implement and achieve significant progress on based on their organization's mission, capacity, expertise, partner connections, and related factors.

Component C applicants will work on all 4 strategies from the "Component C Strategies" section below.

Component A and B Strategies

Evidence-based Approaches to Diabetes Management

1. Strengthen self-care practices by improving access, appropriateness, and feasibility of diabetes self-management education and support (DSMES) services for priority populations

Applicants selecting this strategy will work on both of the following:

a. Increase access to and participation in American Diabetes Association (ADA)-recognized and Association of Diabetes Care and Education Specialists (ADCES)-accredited DSMES services among priority populations with diabetes. (Examples of activities might include establishing and promoting referrals from clinical and community sources, designing and deploying various marketing strategies, supporting DSMES delivery organizations in scheduling sessions at times and in locations and languages appropriate for the priority population(s) served, identifying approaches to decrease high co-payments and other barriers to program access, supporting DSMES delivery organizations in obtaining reimbursement for services, tailoring delivery approaches and materials to better engage and support priority populations, improving options for transportation and childcare where needed, and other effective approaches.) More information on ADA-recognized and ADCES-accredited DSMES services is available on the CDC DSMES Toolkit. Information and examples of ways in which underserved populations can be engaged in DSMES services is available in the Implementing and Evaluating DSMES Programs for Underserved Populations/Communities Guide.
b. Increase access to and participation in complementary diabetes support programs and services. (A list of research-tested and practice-tested diabetes support programs/services is available at https://professional.diabetes.org/content-page/diabetes-support-directory). Diabetes support programs and services help people with diabetes implement self-management behaviors and address challenges that occur in day-to-day life. Note: DSMES service providers and specialized educators often provide both education and support. However, ongoing support from the primary health care team and the community are necessary to maximize implementation of self-management skills.

2. Expand availability of ADA-recognized and ADCES-accredited DSMES services as a covered health benefit for Medicaid beneficiaries and employees with diabetes

Applicants selecting this strategy will support efforts to establish new or strengthen existing Medicaid and/or employer health benefit coverage for ADA-recognized and ADCES-accredited DSMES services. If working with employers, applicants should focus on those with a significant number of employees representative of the priority populations selected. (More information on coverage and reimbursement for DSMES services is available on the CDC DSMES Toolkit.

3. Prevent diabetes complications for priority populations through early detection.

Applicants selecting this strategy will work on both of the following:

a. Increase diabetic retinopathy screening in priority populations with diabetes.
b. Improve early detection of chronic kidney disease (CKD) in priority populations with diabetes.

4. Improve acceptability and quality of care for priority populations with diabetes

Applicants selecting this strategy will work on both of the following:

a. Increase adoption or enhancement of team-based care for people with diabetes supported by sustainable payment models – to include Pharmacists, Community Health Workers (CHWs), behavioral health professionals, and other culturally competent personnel (e.g., Registered Dietitians, Patient Navigators, others) – as critical members of the care team.
b. Increase adoption and use of clinical systems and care practices (e.g., health information technology (HIT)/electronic health records (EHRs), clinical decision support tools, learning collaboratives) to improve quality of care and resulting health outcomes for people with diabetes in alignment with the 2022 ADA Medical Standards of Care in Diabetes.

Evidence-based Approaches to Type 2 Diabetes Prevention and Risk Reduction

5. Increase enrollment and retention of priority populations in the National Diabetes Prevention Program (National DPP) lifestyle intervention and the MDPP by improving access, appropriateness, and feasibility of the programs

Applicants selecting this strategy will increase enrollment and retention of priority populations in the National DPP lifestyle intervention and the Medicare Diabetes Prevention Program by improving awareness and appeal of the program, access to and appropriateness of classes, ease of enrollment, and relevant participant support. (Examples of activities might include establishing and promoting referrals from clinical and community sources, designing and deploying various marketing strategies, supporting program delivery organizations in scheduling classes at times and in locations and languages appropriate for the priority population(s) served, identifying approaches to decrease out-of-pocket costs and other barriers to program access, tailoring delivery approaches and materials to better engage and support priority populations, improving options for transportation and childcare where needed, and other effective approaches.) More information on the National Diabetes Prevention Program is available on the National DPP website and the National DPP Customer Service Center.

6. Expand availability of the National DPP lifestyle intervention as a covered health benefit for Medicaid beneficiaries and/or employees and covered dependents **at high risk for type 2 diabetes**

Applicants selecting this strategy will support efforts to establish or strengthen Medicaid and/or employer health benefit coverage for the National DPP lifestyle intervention. (More information on Medicaid and employer coverage for the National DPP lifestyle intervention is available on the National DPP Coverage Toolkit.

7. Improve sustainability of CDC-recognized National DPP delivery organizations serving priority populations by establishing or expanding National DPP Umbrella Hub Arrangements

Applicants selecting this strategy will establish new National DPP Umbrella Hub Arrangements that enable more organizations to successfully offer and obtain reimbursement for the National DPP lifestyle intervention. (More information on Umbrella Hub Arrangements is available on the National DPP Coverage Toolkit.)

8. Implement, spread, and sustain one of the following evidence-based, family-centered childhood obesity interventions:

- **Mind, Exercise, Nutrition…Do It! (MEND) – community-based**
- **Family Based Behavioral Therapy – primary care/clinic-based**
- **Bright Bodies – hybrid (clinic/community-based)**
- **Healthy Weight and Your Child – YMCA-based**

These interventions offer 26 or more hours of contact time, are packaged for immediate use, and have implementation and training supports available (e.g., provider/health system onboarding, facilitated interventionist on-demand and/or live training, and program materials). For applicant organizations that do not currently own or deliver these interventions, year 1 of the cooperative agreement will be a planning year; selection of the most appropriate intervention to implement will be part of the planning process. Applicants who do own or currently deliver one or more of these interventions will expand implementation of the intervention in year 1.

Policy & Systems-level Support for Diabetes Management and/or Type 2 Diabetes Prevention

9. Increase and sustain DSMES and National DPP delivery sites within pharmacy networks and chain pharmacies to improve reach to priority populations

Applicants selecting this strategy will increase and sustain pharmacy-based DSMES and National DPP delivery sites by working with pharmacy networks (e.g., Community Pharmacy Enhanced Services Networks [CPESN], state pharmacy associations, and chain pharmacies.) Examples of activities might include involving pharmacy networks/chains in umbrella hub arrangements, strengthening billing systems and processes, and implementing electronic systems that enable exchange of information between pharmacies and primary care sites.

10. Support the development of multi-directional e-referral systems that support electronic exchange of information between health care and CBOs, including:

a. CDC-recognized organizations offering the National DPP lifestyle intervention and/or
b. ADA-recognized/ADCES-accredited DSMES services and/or diabetes support programs or services in the community and
c. Community programs/services that address SDOH or meet social needs

Applicants selecting this strategy will work on items a) and/or b) above **and** item c).

11. Design and test innovative payment models that bundle the National DPP lifestyle intervention and/or DSMES with other programs and services that address relevant health or social needs of priority populations

Applicants selecting this strategy will design and test innovative models that bundle the National DPP lifestyle intervention and/or DSMES with other programs and services that address other relevant health or social needs. These models should 1) improve access to and participation in the National DPP lifestyle intervention and/or DSMES by decreasing identified barriers related

to the SDOH and other factors impacting priority populations and 2) allow for streamlined reimbursement for National DPP/DSMES program delivery organizations. (Example: The North Carolina Medicaid Healthy Opportunities Pilots aim to test and evaluate the impact of providing select evidence-based, non-medical interventions—including the National DPP lifestyle intervention—related to health, housing, food, transportation, and interpersonal safety for high-needs Medicaid beneficiaries.)

12. Improve the sustainability of Community Health Workers (CHWs) by building or strengthening a supportive infrastructure to expand their involvement in evidence-based diabetes prevention and management programs and services

Applicants selecting this strategy will work to develop the infrastructure necessary to promote long-term sustainability and sustainable financing for CHWs to expand/enhance their involvement in evidence-based diabetes management and prevention programs and services. Infrastructure includes:

a. Awareness: Increase awareness of the competencies, roles, and skills of CHWs as a workforce and their effectiveness in evidence-based interventions like the National DPP lifestyle intervention and DSMES services.
b. Availability: Increase availability of CHWs who are fully integrated in delivery of the National DPP lifestyle intervention and DSMES services.
c. Workforce Development: Develop training and career ladders that build on CHW values, expertise, and collective vision of their roles in communities and systems; eliminate barriers that influence CHW access to relevant training/career ladders and involve CHWs in their development; and support mentoring within the CHW profession.
d. Financing/Coverage: Increase public and private payer and employer coverage of services provided by CHWs. Advance financing options that prioritize broad CHW roles, including work addressing the SDOH and racial equity in Medicaid and beyond.
e. Policy Change: Establish policies and practices to define and promote CHW-led research agendas and projects, involving CHWs in the process.
f. CHW Networks: Support CHW networks to strengthen and expand their capacity for training, policy development, promotion of the CHW profession, and mentoring.
g. Data Collection: Support relevant data collection at the employer, state, and national level to assess and document progress and determine additional needs/gaps.
h. Best Practices: Develop, disseminate, and promote CHW-led best practices.

13. Improve the capacity of the diabetes workforce to address factors related to the SDOH that impact health outcomes for priority populations with and at risk for diabetes

Applicants selecting this strategy will work to improve the capacity of the diabetes prevention and care workforce (e.g., National DPP Lifestyle Coaches, Diabetes Care and Education Specialists, CHWs, Pharmacists, Registered Dietitians, Physicians and other medical or behavioral health professionals) to better assess and address factors related to the SDOH that impact the ability of people with and at risk for diabetes to successfully access and engage in evidence-based care and services.

Component C Strategies

Use of Multisectoral Partner Networks to Scale and Sustain the National DPP to Reach Priority Populations

Component C applicants will serve as a hub (backbone) organization supporting a National DPP partner network and will be required to convene and fund partners from across sectors, to include payers (e.g., employers, public or private insurers); CDC-recognized National DPP delivery organizations; health care organizations; CBOs or other groups with demonstrated experience reaching and engaging the priority populations of focus; and other partners as needed.

1. Administrative Infrastructure: Serve as the hub for the partner network and manage its administrative infrastructure, including:

a. Developing a business plan tied to the required enrollment goal and demonstrating how the enrollment goal includes priority populations relative to their overall population in the network geographic area.
b. Developing a plan for convening partners, awarding partner funding, and maintaining accountability for partner contributions to the shared enrollment goal.
c. Developing a marketing plan to reach ten times the number of eligible people specified in the enrollment goal and providing tested marketing and enrollment strategies to the delivery network.

2. Participant Referral Processes: Work with and fund clinical and community partners with specialized expertise reaching one or more priority populations to institutionalize participant referral processes, which includes all of the following:

a. Working with clinical partners to ensure that the referral process includes use of electronic registries, standing orders (algorithms), clinical care teams, and shared decision making. Ideally, the referral process should include a link to a health information exchange or similar system to facilitate the exchange of information between health care systems and CDC-recognized organizations.
b. Ensuring that priority populations are reached by implementing one or more of the following: use of patient navigators/CHWs, inclusion of program offerings on a social needs network, and/or working with other state or local program locators to include culturally tailored content.
c. Working with clinical partners to test the American Medical Association-sponsored prediabetes quality measures addressing prediabetes screening, referral, and outcomes and providing incentives comparable to those for other accepted quality measures.

3. Program Delivery and Participant Support: Work with delivery partners to establish a network of both in-person and virtual CDC-recognized program delivery organizations and standardize procedures for participant support, including:

a. Ensuring that the network has the capacity to meet the 1,000 enrollment goal in year 1 and the 10,000 enrollment goal by year 5. [Example: In a geographic area with 500,000 adults, ~30% (150,000) may have prediabetes. Assuming 10% (15,000) of these people are ready to enroll, the recipient would need to work with partners to enroll 10,000 to meet the goal for the 5-year performance period. If we assume cohorts of ~20 participants, the CDC-recognized organizations participating in the network would need to run at least 50 cohorts in the first year (and 500 cohorts by year 5)].
b. Ensuring that the network has the capacity to reach the required percentage of priority population participants by including federally qualified health centers (FQHCs), local health departments, CBOs and/or other organizations that serve priority populations; accounting for the technology needs of priority populations to participate in virtual offerings; and providing culturally tailored curricula where needed.
c. Establishing a process for assessing and helping to address the SDOH-related needs of priority population participants, including referral to social needs networks.
d. Providing ongoing support to optimize program delivery, including data management and billing systems, other technology upgrades, and workforce development opportunities.

CDC recommends that ~35% of total funding be allocated to National DPP delivery partners and that ~15% of these funds be used to help alleviate SDOH-related barriers impacting participants' access to and successful participation in the program.

4. Payment/Coverage: Work with payer and employer partners to implement existing coverage policies and test new coverage policies within the network, including:

a. Working with one or more payers or employers to incorporate coverage of the National DPP lifestyle intervention in all value-based payment contracts, either alone or as part of a bundled package of services, and partner with payers and employers to promote uptake of the benefit by all eligible participants. (Note that funding provided for Component C cannot be used to cover program delivery costs; those costs should be covered by participating payers such as Medicare, Medicaid, employers, and commercial health plans.)
b. Supporting all organizations in the delivery network in becoming MDPP suppliers and/or Medicaid providers (where applicable).
c. Working with payers and employers to test new coverage policies, reimbursement schedules, and payment options, such as alternate methods for risk sharing, increasing rates to cover SDOH-related needs commensurate with improved outcomes, using performance benchmarks other than weight loss, and developing alternatives to traditional claims-based processing for reimbursement.

1. Collaborations

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

All recipients, regardless of the component they apply for, are encouraged to collaborate with other related CDC-funded programs that have a role in achieving the NOFO outcomes for the strategies selected. Collaborations may center on shared goals related to health equity or addressing SDOH-related barriers impacting access to and participation in evidence-based

diabetes/chronic disease prevention or management programs and services. Collaborations may also be based on shared data; partners; intervention settings/locations; marketing approaches/messages; electronic health records or other electronic clinical decision support systems; or shared efforts to reach and engage priority populations of focus.

Recipients funded under one NOFO component will be expected to work closely with applicants funded under the other components, particularly those working in similar geographic areas or with the same priority populations of focus.

b. With organizations not funded by CDC:
Collaboration with partners is critical for all components of this NOFO. Requirements vary by component. **All applicants should collaborate with organizations that have a role or shared investment in the selected NOFO strategies and outcomes**. This includes collaborations centered on shared goals related to health equity or reducing SDOH-related barriers that impact access to and successful participation in the NOFO's evidence-based programs and services. Other potential examples include work with public and private employers; federally qualified health centers/rural health centers/community health centers; non-profit agencies; other federal, state, or local government programs (e.g., State Medicaid Agency, State Employee Benefit Agency, etc.); CBOs; tribes or tribal organizations; professional associations (state medical society, other medical specialty associations, etc.); quality improvement organizations; ADA-recognized and ADCES-accredited diabetes self-management education and support programs; local/regional ADA or ADCES chapters; CDC-recognized organizations delivering the National DPP lifestyle intervention, and others. In addition, please see the component-specific requirements below.

Component A applicants should clearly describe in the project abstract their organization's ability to serve all populations and communities within the state they are proposing to work in. Component A applicants should collaborate with organizations that have experience/expertise reaching the selected priority populations of focus and addressing system or population-level needs related to the SDOH to help those populations successfully engage in the diabetes management and prevention programs/services described in this NOFO. Component A applicants that are not a state or District of Columbia health department should describe how they will collaborate with the state or district health department to assist in achieving statewide reach and to leverage existing partnerships and expertise. Component A applicants should also describe established working relationships with key national, state, or local partner organizations relevant to the selected strategies and include a description of outcomes or key accomplishments resulting from these partnerships (e.g., reports, publications, resource documents, tools, policy change, health impact). Letters of collaboration (maximum of 5) are required from key partners that will be involved in implementing the selected strategies. **At least one of the letters should be from a partner with experience engaging/enrolling priority populations in DSMES and/or the National DPP lifestyle intervention**. The letters should 1) summarize any prior work/accomplishments achieved with each partner (if applicable); 2) include a brief description of the work that will be accomplished by each partner, referencing back to the NOFO strategies; 3) specify the geographic area the partner will work in; and 4) discuss the partner's role in reaching priority populations and/or reducing health disparities in that area (if applicable) in

connection with work on the NOFO strategies selected. Applicants must name each letter of collaboration (LOC1_organization name, LOC2_organization name, etc.) and upload them as PDF files on www.grants.gov as part of the application.

Component B applicants must collaborate with Community Based Organizations (CBOs) in their selected "high need" counties that have experience/expertise reaching the selected priority populations of focus and helping to eliminate SDOH-related barriers that hinder those populations from successfully engaging in the diabetes management and prevention programs/services described in this NOFO. Letters of collaboration from up to 5 of these CBO partners are required as part of the application. **At least one of the letters should be from a partner with experience engaging/enrolling priority populations in DSMES and/or the National DPP lifestyle intervention.** The letters should 1) summarize any prior work/accomplishments achieved with each partner (if applicable); 2) include a brief description of the work that will be accomplished by each partner, referencing back to the NOFO strategies; 3) specify the geographic area the partner will work in; and 4) discuss the partner's role in reaching priority populations and/or reducing health disparities in that area in connection with work on the NOFO strategies selected. Applicants must name each letter of collaboration (LOC1_organization name, LOC2_organization name, etc.) and upload it as a PDF file on www.grants.gov as part of the application.

Component C applicants will serve as a hub (backbone) organization supporting a National DPP partner network and will be **required to convene and fund partners from across sectors, to include payers (e.g., employers, public or private insurers), CDC-recognized National DPP delivery organizations, health care organizations, CBOs or other groups with demonstrated experience reaching and engaging the priority populations of focus, and other partners as needed**. Component C applicants are required to submit letters of collaboration from one organization in each of these categories, for a maximum of 5 letters: 1) a payer/employer covering the National DPP lifestyle intervention as a health or wellness benefit, 2) a clinical partner with an established system to refer eligible patients to a CDC-recognized organization offering the National DPP lifestyle intervention, 3) a CBO with specific experience enrolling one or more priority populations in the National DPP lifestyle intervention, 4) an organization with experience addressing health equity and SDOH-related issues, and 5) a CDC-recognized National DPP delivery organization with claims submission experience. Letters should include a brief description of the work that will be accomplished by each partner, referencing back to the NOFO strategies. Applicants must name each letter of collaboration (LOC1_organization name, LOC2_organization name, etc.) and upload it as a PDF file on www.grants.gov as part of the application.

2. Target Populations

Component A applicants should focus on priority populations*, as defined in the Overview section of this NOFO and in the Glossary.

- Applicants' work, in total, under Component A should achieve statewide reach (district-wide reach in D.C.).
- Applicants' work in the selected strategies should aim to reduce health disparities for priority populations. Applicants should identify the priority population(s) they will focus on and describe the rationale for selecting those population(s) considering the following

factors: disproportionate incidence, prevalence, or severity of diabetes disease burden and/or social vulnerability.

- Applicants should describe any prior experience working with their selected populations and/or involvement and support from these groups for the work proposed.
- For each strategy selected, applicants should describe how they will tailor their activities and approaches to reach, engage, and support the priority population(s) selected.

Component B applicants should focus on priority populations, as defined in the Overview section of this NOFO and in the Glossary.

- Applicants' work, in total, should reach a population greater than or equal to 350,000 across one or more of the"high need" counties on the list available at https://www.cdc.gov/diabetes/funding-opportunity/NOFO-CDC-RFA-DP23-0020.html.

- Applicants should identify the "high need" counties they will work in and the priority population(s) they will focus on. Applicants should describe their rationale for selecting those counties/population(s) and describe any prior experience working in those areas and with the selected populations using participatory approaches and/or involvement and support from these groups for the work proposed.
- For each strategy selected, applicants should describe how they will tailor their activities and approaches to reach, engage, and support the priority population(s) selected.
- Applicants should also describe how they will establish or enhance partnerships with CBOs in their selected "high need" counties that have experience and expertise engaging the priority populations they wish to reach.

Component C applicants should focus National DPP participant enrollment on priority populations (primary focus) as well as the general eligible population within the targeted service area.

- Applicants should define the geographic area(s) they will work in and identify their priority population(s) of focus. Applicants must work in a geographic area(s) with a population large enough to make it feasible to enroll the required 1,000 participants in year 1 and 10,000 participants by the end of the performance period, estimating that, for every 100 people with prediabetes or at high risk for type 2 diabetes reached, ~10 will be ready to enroll in the program. [Example: In a geographic area with 500,000 adults, ~30% (150,000) may have prediabetes. Assuming 10% (15,000) of these people are ready to enroll, the applicant would need to work with partners to enroll 10,000 to meet the goal for the 5-year performance period. If we assume cohorts of ~20 participants, the CDC-recognized organizations participating in the network would need to run at least 50 cohorts in the first year (and 500 cohorts by year 5)].

- To aid in reaching priority populations of focus, applicants are encouraged to partner with CBOs and health care organizations serving these populations (e.g., FQHCs, community health centers, others) and to support CDC-recognized organizations in becoming Medicaid providers if working in states where Medicaid coverage for the National DPP lifestyle intervention is available.

*The following resources are available to assist in identifying priority populations: US Diabetes Surveillance System—home page; US Diabetes Surveillance System—SDOH module. This NOFO, including funding, eligibility, and populations of focus, is not limited based on, and does not discriminate on the basis of race, color, national origin, disability, age, sex (including gender identity, sexual orientation, and pregnancy), or other constitutionally protected statuses.

a. Health Disparities

This NOFO seeks to address health disparities by reducing SDOH-related barriers impacting priority populations' successful access to and participation in evidence-based diabetes management and type 2 diabetes programs and services.

Component A applicants should describe how they will tailor their activities and approaches to reach, engage, and support the priority population(s) selected and to reduce health disparities for these populations. CDC recommends that applicants allocate between 10-20% of total funding requested for Component A (minimum of 10%) in their proposed budgets to address system or population-level needs related to the SDOH that support the priority population(s) engaged in the selected program strategies. Some examples of SDOH-related system or population-level approaches to support the priority population(s) engaged in selected program strategies include work to increase available greenspace and safe places to exercise; address policies and other supports to improve access to healthy food—particularly in food deserts—or decrease intake of unhealthy food; and collaborate or leverage existing work with agencies and offices responsible for urban planning, transportation, housing, and other relevant programs or services to create environments that support health and healthy lifestyles.

Component B applicants should describe how they will work in US counties identified as "high need" based on diabetes disease burden and social vulnerability. (A list of counties that meet these criteria, along with their populations, is available at: https://www.cdc.gov/diabetes/funding-opportunity/NOFO-CDC-RFA-DP23-0020.html .) Applicants are encouraged to seek involvement and support from priority populations of focus for the work proposed. For each strategy selected, applicants should describe how they will tailor their activities and approaches to reach, engage, and support the priority population(s) selected. Component B applicants must establish partnerships with CBOs in their selected "high need" counties that have experience and expertise engaging the priority populations they wish to reach. CDC recommends that applicants submit a proposed budget that sub-awards a minimum of 30% of total funding to their CBO partners to support implementation of the strategies selected and to help eliminate SDOH-related barriers to recruitment, enrollment, and retention of priority populations in the evidence-based diabetes prevention and management programs/services selected.

Component C applicants should describe how they will focus on priority populations (primary focus) as well as the general eligible population to significantly increase enrollment in the National DPP lifestyle intervention through operationalization of a multisectoral partner network. CDC recommends that ~35% of total funding awarded be used for program delivery, with ~15% of that amount dedicated to meeting the SDOH-related needs of priority populations that impact National DPP participant enrollment and retention.

iv. Funding Strategy

This NOFO will fund up to 77 recipients annually for a period of 5 years. There are 3 components in this NOFO; applicants may apply for only 1 of the 3.

Component A award amounts will be based on CDC-defined disease burden (USDSS data), population (US Census 2021) and social vulnerability (CDC/ATSDR data). A funding table ("Component A Funding Table") by state/district is available at: https://www.cdc.gov/diabetes/funding-opportunity/NOFO-CDC-RFA-DP23-0020.html

Component B award amounts will be based on **"high need" counties** defined by CDC using a formula based on disproportionate diabetes burden (diabetes prevalence > 8.4% and incidence > 9.6 per 1,000 people), a disproportionate number of persons at risk for type 2 diabetes (obesity prevalence > 28.3%), and a disproportionate level of social needs as defined by a social vulnerability index of > 0.5. A list of counties meeting these criteria is available at: https://www.cdc.gov/diabetes/funding-opportunity/NOFO-CDC-RFA-DP23-0020.html.

Component C

Award range: $2,500,000-$3,300,000

Award amounts for Component C are based on information and insights from previous work with partner organizations on the National DPP. They are informed by estimates of average program delivery costs coupled with additional funds to help address SDOH-related barriers to access impacting the priority populations of focus in this NOFO.

*This program notice is subject to the appropriation of funds and contingent upon the availability of funds for this purpose. If future fiscal year appropriations or other statutes fail to authorize this activity, final award amounts may be less than requested or awards will not be made. Funding availability in subsequent fiscal years is subject to the availability of appropriated funds.

b. Evaluation and Performance Measurement

i. CDC Evaluation and Performance Strategy

CDC Evaluation and Performance Measurement Strategy
The evaluation and performance measurement strategy will help demonstrate program accomplishments and strengthen the evidence for strategy implementation. It will also assist in determining whether the identified strategies and associated activities can be implemented at various levels (i.e., state, sub-population, etc.) within a state, community, or organization.

Program evaluation and performance measurement activities will include the collection and analysis of program implementation and performance data submitted by recipients and tracking of key performance outputs and outcome indicators. Additional information will be gathered through the review of performance reports, conference calls, and site visits. During the period of performance, CDC may partner with recipients on evaluation activities.

Data collected are used for program monitoring, evaluation, and improvement. Recipients will collect the required quantitative and qualitative data using CDC-approved applications (software)

and submit to CDC according to an established schedule and via CDC-approved systems. Data will be reviewed by CDC to identify challenges experienced by recipients, capacity building assistance needs, and possible solutions needed to improve overall project performance.

CDC, with input from recipients, will produce reports on project accomplishments, annual evaluation reports, strategy and recipient profiles, and other monitoring and evaluation dissemination materials. Findings may also be reported for policy requests, at national conferences, online, in peer-reviewed journals, and in other public forums. Recipients will be expected to demonstrate measurable progress toward achieving the intended short and intermediate term outcomes depicted in the logic model. For each of the NOFO's program strategies, a list of short, intermediate, and long-term performance measures (indicators) is presented in the Strategy and Performance Measure Table. CDC will work with recipients to finalize their detailed Evaluation and Performance Management Plans (EPMPs), including a Data Management Plan (DMP), in accordance with CDC program guidance.

Throughout the five-year period, CDC will work individually and collectively with recipients to track the implementation of recipient strategies and activities and assess progress on achieving the 5-year NOFO outcomes. CDC will use an evaluation approach that consists of (1) ongoing monitoring and evaluation through the collection and reporting of performance measures, (2) a CDC-led national evaluation, and (3) recipient-led evaluations.

Component A:
Both the process and outcome evaluation for Component A will seek to answer the following overarching evaluation questions in five core evaluation areas:

1. Approach: To what extent has the recipient's implementation approach resulted in achieving the desired outcomes?
2. Efficiency: To what extent has the NOFO affected efficiencies with regard to infrastructure, management, partners, and financial resources?
3. Effectiveness: To what extent has the recipient increased the reach of program strategies to prevent and manage type 2 diabetes?

- To what extent has implementation of program strategies led to improved health outcomes among the identified priority population(s)?
- What factors were associated with effective implementation of program strategies?

4. Sustainability: To what extent can the strategies implemented be sustained after the NOFO ends?
5. Impact: To what extent have the strategies implemented contributed to a measurable change in health, behavior, or environment in a defined community, population, organization, or system?

For Component A, CDC will conduct a national evaluation that will include a Rapid Evaluation of selected DSMES sites, National DPP sites, and (potentially) other diabetes-related interventions and Case Study Analysis of innovative practices identified during the rapid evaluation process.

Component B:

For Component B, CDC will conduct a national evaluation that will include Emerging Practice Assessments of innovative practices identified during analysis of evaluation and performance measure reporting. The assessment aims to build practice-based evidence in support of community-level SDOH interventions used to improve access to the diabetes management and prevention programs and services included in this NOFO.
Both the process and outcome evaluation will seek to answer the following overarching evaluation questions in three areas:

1. Approach: To what extent has the recipient's implementation approach resulted in achieving the desired outcomes?
2. Effectiveness:
    - To what extent has the recipient increased the reach of program strategies to prevent and manage type 2 diabetes?
    - To what extent has implementation of program strategies led to improved health outcomes among the identified priority population(s)?
    - What factors were associated with effective implementation of program strategies?
3. Impact: To what extent have the strategies implemented contributed to a measurable change in health, behavior, or environment in a defined community or population?

Component C:
For Component C, CDC will conduct a cross-site evaluation of funded networks in years 4 and 5. The national evaluation team will utilize various data collection methods, including virtual key informant interviews and in-person site visits with recipients and partners, to assess the effectiveness of the network model and the collective impact of the individual strategies implemented.
Both the process and outcome evaluation will seek to answer the following overarching evaluation questions in five evaluation core areas:

1. Approach: To what extent has the recipient's implementation of a multisectoral partnership network model resulted in achieving the desired outcomes?
2. Efficiency: To what extent has the NOFO affected efficiencies regarding the network infrastructure, management, partners, and financial resources?
3. Effectiveness: To what extent has the recipient's implementation of a network model increased the reach of the National DPP lifestyle intervention?
    - To what extent has implementation of program strategies led to improved health outcomes among the identified priority population(s)?
    - What factors were associated with effective implementation of program strategies using the network model?
4. Sustainability: To what extent can the strategies implemented using a network model be sustained after the NOFO ends? What changes occurred in the network over time, and what factors facilitated growth and success?

5. Impact: To what extent is the recipient-implemented network contributing to a measurable change in health, behavior, or environment in a defined community, population, organization, or system?

All Components:
Performance measures developed for this program correspond to the strategies and outcomes described in the logic model. Performance measures recipients will be responsible for collecting and reporting on are noted in the Strategy and Performance Measure Table in this section. Component A and B recipients will report on the short, intermediate, and long-term performance measures that align with the specific strategies they choose to work on. Component C recipients will report on all measures listed in the Component C section of the Strategy and Performance Measure Table. CDC will work with recipients on operationalizing and further defining each performance measure, and guidance will be provided prior with the first year of reporting. Performance measures will be reported annually to CDC, and CDC will manage and analyze the data to assess recipient program improvements, respond to broader technical assistance needs, and report to stakeholders.

CDC will analyze performance measure data annually and develop aggregate performance measure reports to be disseminated to recipients and other key stakeholders, including federal partners, other funded and non-funded partners, and policy makers, as appropriate. These aggregate findings may also be presented during site visits and recipient meetings. In addition to performance measure data reported by recipients, CDC will track specific intermediate outcome measures and other short and long-term measures listed on the Strategy and Performance Measure Table that are relevant to the program through national datasets or CDC- and recipient-led evaluation activities.

CDC will lead the design, data collection, analysis, and reporting for the national evaluation. Recipients will participate in evaluation activities such as surveys, interviews, case studies, and other data collection efforts. An appropriate level of guidance and support will be provided to the recipients to ensure their effective participation in the CDC-led evaluation. CDC will use findings from these evaluation efforts to refine its technical assistance and, in turn, maximize and sustain program outcomes.

CDC will assist recipients in developing and implementing evaluation plans that are useful for program improvement and for the overall evaluation of the program. For all components of the evaluation, CDC and recipients will only collect data that will be analyzed and used.

CDC will provide recipients with performance measure reporting templates and, potentially, with evaluation plan reporting templates. CDC will provide evaluation technical assistance and ongoing evaluation guidance on recipient-led evaluation and performance measures. Evaluation technical assistance will be provided using a tiered approach to ensure that the tools and services provided best meet the needs of the recipients. All information will be stored using a secure system. All evaluation findings produced by CDC and recipients, where appropriate, will contribute to: (1) continuous improvement of quality and effectiveness of program strategies; (2) the evidence base; (3) documentation and sharing of lessons learned to support replication and scaling of these program strategies; and/or (4) future funding opportunities supported by CDC.

The data collected by CDC for performance measurement and evaluation are directly related to the implementation of the strategies and/or the desired outcomes indicated in the logic model. The data collected for this NOFO for performance measurement and national evaluation do not include any personally identifiable information. Data being collected are strictly related to the implementation of the NOFO strategies and shall be used for assessing and reporting progress and for other pertinent program improvement actions. All performance measure data will be stored using a secure data system. Recipients will report their performance measure data annually and will only have access to their data. Over the 5-year performance period, data will be secured with limited access to authorized CDC program and evaluation staff to the extent allowed under applicable Federal law. CDC will aggregate data across all recipients to publish annual and summative reports.

Performance measures for each strategy (reported based on the strategies selected) are described in the Strategy and Performance Measure Table. The table aligns with the logic model and shows the alignment between the overarching focus areas, specific strategies, outcomes, and performance measures.

Applicants must include a Data Management Plan (DMP) that includes, but is not limited to, the type of data that will be collected, procedures for collecting the data, how data will be stored, procedures for providing access to the data, provisions for maintaining data privacy, confidentiality, and data security. If all of these items cannot be addressed comprehensively, applicants should include a DMP that is as complete as possible.

Components A & B: Strategy & Performance Measure Table			
Evidence-based Approaches to Diabetes Management Strategies	**Short-term Performance Measures** (Applicants will ONLY report on short-term measures for the strategies selected)	**Intermediate Performance Measures** (Applicants will ONLY report on intermediate measures for the strategies selected)	**Long-term Performance Measures** (Applicants will ONLY report on long-term measures for the strategies selected)
1. Strengthen self-care practices by improving access, appropriateness, and feasibility of diabetes self-management education and support (DSMES) services for priority populations	# of new ADA-recognized or ADCES-accredited DSMES services established # of new diabetes support programs or services established	# of people with diabetes (total # and # from priority populations) participating in recognized/ accredited DSMES	Proportion of people with diabetes with an A1C > 9% (decrease desired in this measure)

	# of existing ADA-recognized or ADCES-accredited DSMES services and diabetes support programs that have tailored their programs or recruitment strategies to increase participation of priority populations	services # of people with diabetes (total # and # from priority populations) participating in diabetes support programs/ services	
2. Expand availability of ADA-recognized and ADCES-accredited DSMES services as a covered health benefit for Medicaid beneficiaries and employees with diabetes	# of state Medicaid programs and/or employers working to establish new health benefit coverage for DSMES or strengthen existing coverage	# of Medicaid beneficiaries and/or employees covered	
3. Prevent diabetes complications for priority populations through early detection	# of health care organizations working with the recipient to a) increase diabetic retinopathy screening and b) improve early detection of CKD in priority populations with diabetes	# and % of patients with diabetes who have received the diabetic retinopathy and CKD screening tests in these health care organizations	
4. Improve acceptability and quality of care for priority populations with diabetes	# of health care organizations that have adopted or enhanced a) team-based care supported by sustainable payment models and b) clinical systems and care practices to improve health outcomes for people with diabetes	# of people with diabetes served by health care organizations that have adopted or enhanced a) team-based care supported by sustainable payment models and b) clinical systems and care practices to improve health outcomes for	

		people with diabetes	
Evidence-based Approaches to Type 2 Diabetes Prevention and Risk Reduction Strategies	**Short-term Performance Measures**	**Intermediate Performance Measures**	**Long-term Performance Measures**
5. Increase enrollment and retention of priority populations in the National Diabetes Prevention Program (National DPP) lifestyle intervention and the MDPP by improving access, appropriateness, and feasibility of the programs	# of participants (total # and # from priority populations) enrolled by CDC-recognized National DPP delivery organizations	# of participants (total # and # from priority populations) retained* by CDC-recognized National DPP delivery organizations	# of program completers* (total # and # from priority populations) served by CDC-recognized National DPP delivery organizations who reduce their risk for type 2 diabetes
6. Expand availability of the National DPP lifestyle intervention as a covered health benefit for Medicaid beneficiaries and/or employees and covered dependents at high risk for type 2 diabetes	# of state Medicaid programs and/or employers working to establish new health benefit coverage for the National DPP lifestyle intervention or strengthen existing coverage	# of Medicaid beneficiaries and/or employees covered	
7. Improve sustainability of CDC-recognized National DPP delivery organizations serving priority populations by establishing or expanding National DPP Umbrella Hub Arrangements	# of program participants enrolled by CDC-recognized National DPP delivery organizations participating in Umbrella Hub Arrangements established through the recipient's work	# of program participants enrolled by CDC-recognized National DPP delivery organizations participating in Umbrella Hub Arrangements for whom claims are	

		submitted to payers	
8. **Implement, spread, and sustain one of the following evidence-based, family-centered childhood obesity interventions:** • **Mind, Exercise, Nutrition…Do It! (MEND)** • **Family Based Behavioral Therapy** • **Bright Bodies** • **Healthy Weight and Your Child**	# of organizations offering the intervention	# of children, other family members, and participants from underserved areas or historically socially disadvantaged populations enrolled in the intervention	Children: Decrease in percent of the 95th percentile body mass index (BMI), percent of median body mass index (BMI), and improvement in pediatric quality of life Caregivers: Decrease in BMI
Policy & Systems-level Support for Diabetes Management and/or Type 2 Diabetes Prevention Strategies	**Short-term Performance Measures**	**Intermediate Performance Measures**	**Long-term Performance Measures**
9. Increase and sustain DSMES and National DPP delivery sites within pharmacy networks and chain pharmacies to improve reach to priority populations	# of pharmacies and pharmacists offering DSMES services and/or the National DPP lifestyle intervention for priority populations	# of pharmacy locations offering DSMES services and/or the National DPP lifestyle intervention that operate within a billing-capable network # of pharmacy locations offering DSMES services and/or the National DPP lifestyle intervention that are receiving	Proportion of people with diabetes with an A1C > 9% (decrease desired in this measure) # of program completers (total # and # from priority populations) served by CDC-recognized National DPP delivery organizations who reduce their risk for

		patient referrals from health care organizations for individuals with or at risk for diabetes through a bidirectional e-referral system	type 2 diabetes**
10. Support the development of multi-directional e-referral systems that support electronic exchange of information between health care and CBOs, including: a. **CDC-recognized organizations offering the National DPP lifestyle intervention and/or** b. **ADA-recognized/ADCES-accredited DSMES services and/or diabetes support programs or services in the community <u>and</u>** c. **Community programs/services that address SDOH or meet social needs**	# and types of new multi-directional e-referral systems established # of health care organizations using these multi-directional referral systems to exchange information with a) CDC-recognized organizations offering the National DPP lifestyle intervention and/or b) DSMES or diabetes support services **and** c) community programs/services that address SDOH or meet social needs; and the total # of patients served within these health care organizations	# of participants (total # and # from priority populations) enrolled by CDC-recognized National DPP delivery organizations # of people with diabetes (total # and # from priority populations) participating in DSMES services offered by an ADA-recognized or ADCES-accredited organization # of people with diabetes (total # and # from priority populations) participating in diabetes support programs/	
11. Design and test innovative payment models that bundle the National DPP lifestyle intervention and/or DSMES with other programs and services that address relevant	# and types of models implemented that bundle the National DPP lifestyle intervention and/or DSMES with other		

health or social needs of priority populations	programs and services that address relevant health or social needs of priority populations	services	
12. Improve the sustainability of Community Health Workers (CHWs) by building or strengthening a supportive infrastructure to expand their involvement in evidence-based diabetes prevention and management programs and services	# of CHWs in the workforce who: i. are supported by and involved in shaping a recognized definition of CHW scope of practice ii. have access to workforce development training and career ladders iii. are fully integrated into diabetes care teams, DSMES/diabetes support programs, and National DPP lifestyle intervention delivery organizations and making or facilitating referrals for people with or at risk for diabetes to these services iv. are reimbursed for their services through public and private insurer and employer payment mechanisms (includes both general funding and insurance company payments)		
13. Improve the capacity of the diabetes workforce to address factors related to the SDOH that impact health outcomes for priority populations with and at risk for diabetes	# and type of staff trained on SDOH strategies and training type		

* Based on CDC's Diabetes Prevention Recognition Program (DPRP) Standards, participants who are retained in the National DPP lifestyle intervention (i.e., program completers) are defined as those who attended 8+ sessions in the first six months and whose total time in the program is 9 or more full months.
**The CDC DPRP Standards define reduced risk for type 2 diabetes as program completers who achieve any one of the following outcomes: 1) at least 5% weight loss 12 months after the participant cohort began, or 2) at least 4% weight loss and at least 150 minutes/week on average of physical activity 12 months after the cohort began, or 3) a 0.2% reduction in HbA1C.

Component C: Strategy & Performance Measure Table			
Use of a Funded Multisectoral Partner Network to Scale and Sustain the National DPP to Reach Priority Populations **Strategies** (Component C applicants will work on ALL strategies)	**Short-term Performance Measures** (Applicants will report on ALL measures)	**Intermediate Performance Measures** (Applicants will report on ALL measures)	**Long-term Performance Measures** (Applicants will report on all measures)
1. <u>Administrative Infrastructure</u>: Serve as the hub for the partner network and manage its administrative infrastructure	# of people (total # and # from priority populations) specified in the enrollment goal reached through tested marketing strategies supported by the partner network	# of participants (total # and # from priority populations) enrolled by CDC-recognized National DPP delivery organizations participating in the network	# of program completers* (total # and # from priority populations) served by CDC-recognized National DPP delivery organizations participating in the network who reduce their risk for type 2 diabetes
2. <u>Participant Referral Processes</u>: Work with and fund clinical and community partners with specialized expertise reaching one or more priority	# of people at risk for type 2 diabetes (total # and # from priority populations) referred to a CDC-recognized organization participating in the network	# of people (total # and # from priority populations) referred to a CDC-recognized organization participating in the network who enroll in the National DPP	

populations to institutionalize participant referral processes		lifestyle intervention # of health care organizations implementing the AMA-sponsored prediabetes quality measures	
3. <u>Program Delivery and Participant Support</u>: Work with delivery partners to establish a network of both in-person and virtual CDC-recognized program delivery organizations and standardize procedures for participant support	# of National DPP Lifestyle Coaches that received training on working with priority populations, including assessing and addressing social needs # of people (total # and # from priority populations) enrolled by CDC-recognized organizations participating in the network who are **assessed** for SDOH-related needs # of people (total # and # from priority populations) enrolled by CDC-recognized organizations participating in the network who **receive services** to meet SDOH-related needs organizations participating in the network	# of participants (total # and # from priority populations) assessed for SDOH-related needs who are **retained*** by CDC-recognized organizations participating in the network	
4. <u>Payment/Coverage</u>: Work with payer and employer partners to implement existing coverage policies and test new coverage policies within the network	# of public or private payers or employers including the National DPP lifestyle intervention as a covered health benefit # and types of new coverage, payment, or risk sharing models implemented for the National DPP lifestyle intervention	# of participants (total # and # from priority populations) enrolled by CDC-recognized organizations in the network that are receiving reimbursement from a public or private payer or employer	

* Based on CDC's Diabetes Prevention Recognition Program (DPRP) Standards, participants who are retained in the National DPP lifestyle intervention (i.e., program completers) are defined

as those who attended 8+ sessions in the first six months and whose total time in the program is 9 or more full months.
**The CDC DPRP Standards define reduced risk for type 2 diabetes as program completers who achieve any one of the following outcomes: 1) at least 5% weight loss 12 months after the participant cohort began, or 2) at least 4% weight loss and at least 150 minutes/week on average of physical activity 12 months after the cohort began, or 3) a 0.2% reduction in HbA1C.

Post-Award
With support from CDC, recipients will be required to submit a more detailed Evaluation and Performance Measurement Plan (EPMP), including a DMP, within the first 6 months of receiving the award, as described in the Reporting Section of this NOFO. CDC will review and provide input on the recipient's monitoring and evaluation plan to ensure that it is appropriate for the activities to be undertaken as part of the agreement and for compliance with the monitoring and evaluation guidance established by CDC or other guidance otherwise applicable to this cooperative agreement.

In addition to the EPMP, recipients are required to submit a plan for Performance Measurement Data Collection and Use. A detailed plan for Performance Measurement Data Collection and Use will be due within 6 months of receiving the award. CDC will provide additional templates and guidance for developing the Performance Measurement Data Collection and Use plan.

Recipients should review the published Performance Measure Definitions Guidance in-depth before finalizing this plan to gain an understanding of the purpose of each measure, the values to be reported, as well as the supporting qualitative information to be reported and attachments to be submitted with the report. The Performance Measure Definitions Guidance will be developed by CDC in year 1 of the performance period and made available for recipients' use. Any anticipated issue with data collection should be highlighted in the plan, along with options to remedy it. Additionally, the plan should address how the information generated by the performance measures will be used for program improvement by the recipient.

The following section describes evaluation activities and deliverables for recipients funded under Components A, B and C.

Component A:
Each funded Component A recipient will be required to rigorously evaluate 3 of the 6 strategies selected for implementation using a multi-year approach. One of the 3 strategies selected to evaluate should be strategy 1 or 5 (or both). Recipients will complete an Evaluation Performance and Measurement Plan based on CDC guidance. The recipient will also submit an annual Evaluation Report and Performance Measure Report. Additionally, each year the recipient will submit a summary report focusing on one of the 5 core evaluation areas described in the CDC Evaluation and Performance Measurement Strategy, Component A section. In year 5, recipients will be required to submit health impact statements for each strategy selected for evaluation in lieu of evaluation reports.

Component B:
Each funded Component B recipient will be required to rigorously evaluate 2 of the 4 strategies

selected using a multi-year evaluation approach. One of the 2 strategies selected to evaluate should be strategy 1 or 5 (or both). Recipients will complete an Evaluation Performance and Measurement Plan based on CDC guidance. The recipient will also submit an annual Evaluation Report and Performance Measure Report. Additionally, the recipient will submit a summary report focusing on one of the 3 core evaluation areas described under the CDC Evaluation and Performance Measurement Strategy, Component B section. In year 5, recipients will be required to submit health impact statements for each strategy selected for evaluation in lieu of evaluation reports.

Component C:
Each funded Component C recipient will be required to rigorously evaluate all 4 required strategies using a multi-year evaluation approach. Recipients will complete an Evaluation Performance and Measurement Plan based on CDC guidance. The recipient will also submit an annual Evaluation Report and Performance Measure Report. Additionally, the recipient will submit a summary report focusing on one of the 5 core evaluation areas described under the CDC Evaluation and Performance Measurement Strategy, Component C section. In year 5, recipients will be required to submit a health impact statement in lieu of an evaluation report.

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/additional-requirements/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.

Evaluation plans should:

- Describe data collection approaches, measures, and data sources.
- Align each evaluation question with the approach, instruments/data sources, and timeline.
- Propose analyses for at least two time points (baseline and follow-up) and assess program impact on priority populations.
- Describe the amount of the award allocated to evaluation.
- Describe how applicants will work with professional evaluators (either internal or external) to meet the evaluation and performance measurement requirements.

Applicants are encouraged to work with professional evaluators (either internal or external) to meet the evaluation and performance reporting requirements of this NOFO. Therefore, applicants should allocate adequate funding to support evaluation and performance monitoring considering both development and implementation costs. For information on developing an evaluation plan, please refer to the CDC Framework for Program Evaluation in Public Health.

c. Organizational Capacity of Recipients to Implement the Approach

Applicants must describe their organizational capacity to carry out the strategies for the component they apply for, either Component A, B, or C. Applicants should choose the strategies they are best equipped to implement and evaluate, based on the organizational capacity criteria described here.

All applicants should describe their capacity to work on the component and strategies they select, to include:

- A description of prior experience and accomplishments working and providing technical assistance on the selected strategies.
- A description of methods that will be used to collect and monitor data to document progress.
- A staffing plan that demonstrates the applicant has access to staff or contractors/consultants with relevant subject matter expertise to lead work on the selected strategies (e.g., project manager, health equity lead, project manager, diabetes subject matter expert, evaluator). The staffing plan should be named Staffing Plan_organization name and uploaded as a PDF file on www.grants.gov as part of the application. At a minimum, the staffing plan should include:
    - A description of a staff member to lead the project. This individual should have previous experience with grants administration; program planning and implementation; partnership development; and staff/contractor supervision/oversight.
    - A description of how relevant diabetes management/prevention expertise will be accessed.
    - A description of staff who will have the day-to-day responsibility for key tasks such as leadership of work on selected strategies; monitoring of the project's ongoing

progress; preparation of reports; program evaluation; and communication with partners and CDC.

- Ability to manage the required procurement efforts, including the ability to write and award contracts efficiently, in accordance with applicable grants regulations and in a reasonable timeframe.

In addition, applicants should address the following component-specific organizational capacity criteria:

Applicants for Component A should:

- Document the organization's permanent, physical address, which must be located in the state the applicant is proposing to serve (or in the District of Columbia if proposing to serve that area) – **(required in the abstract).**
- Clearly state whether your organization has the capability to serve all populations and communities within the state you are proposing to work in – **(required in the abstract)**.
- Describe any prior experience working with the selected populations using participatory approaches or involvement and support from these groups for the work proposed.
- Describe how they will tailor work/approaches to reach priority populations and enable them to be successful in accessing and participating in the diabetes-related programs/services addressed in this NOFO (in the work plan and accompanying narrative).
- Describe plans to address system or population-level needs related to the SDOH that support the priority population(s) engaged in the selected program strategies. (CDC recommends that Component A applicants allocate between 10-20% of total funding requested for Component A [minimum of 10%] to address system or population-level needs related to the SDOH that support the priority population(s) engaged in the selected program strategies.)
- Describe their capacity to evaluate work on the selected strategies and monitor/submit data on the required performance measures. (CDC recommends that Component A applicants allocate adequate funding to support evaluation and performance monitoring efforts.)
- Describe established working relationships with key national, state, or local partner organizations relevant to the selected strategies, and include a description of outcomes or key accomplishments resulting from these partnerships (e.g., reports, publications, resource documents, tools, policy change, health impact). [Partners may include groups such as state Medicaid agencies; state employee benefit agencies; CBOs; tribes or tribal organizations; professional associations (state medical society, other medical specialty associations, etc.); quality improvement organizations; ADA-recognized and ADCES-accredited DSMES services; local/regional ADA or ADCES chapters; CDC-recognized organizations delivering the National DPP lifestyle intervention, and others.]
- Describe how they will collaborate with organizations that have experience/expertise in:
    - Reaching the selected priority populations.
    - Addressing system or population-level need related to SDOH.

- Assisting the priority populations of focus in successfully engaging in the program strategies selected.
- Note: Non-state or District of Columbia health department applicants should describe how they will collaborate with the state or district health department to achieve statewide or district-wide reach and leverage existing partnerships and expertise.

- Include required letters of collaboration (maximum of 5) from key partner organizations that will be involved in implementing the selected strategies. At least one of the letters should be from a partner with experience engaging/enrolling priority populations in DSMES and/or the National DPP lifestyle intervention. The letters should 1) summarize any prior work/accomplishments achieved with each partner (if applicable); 2) include a brief description of the work that will be accomplished by each partner, referencing back to the NOFO strategies; 3) specify the geographic area the partner will work in; and 4) discuss the partner's role in reaching priority populations and/or reducing health disparities in that area (if applicable) in connection with work on the NOFO strategies selected. Applicants must name each letter of collaboration (LOC1_organization name, LOC2_organization name, etc.) and upload it as a PDF file on www.grants.gov as part of the application.

Component B:
List the specific "high need" counties the applicant will work in along with the populations of those counties (from the list provided at:– https://www.cdc.gov/diabetes/funding-opportunity/NOFO-CDC-RFA-DP23-0020.html – **(required in the abstract).** Describe any prior experience working in these counties.

- Describe how the applicants' work, in total, will reach a population greater than or equal to 350,000 across one or more of the "high need" counties selected – **(required in the abstract)**.
- Describe any prior experience working with the selected populations using participatory approaches or involvement and support from these groups for the work proposed.
- Describe prior experience addressing relevant health disparities among populations disproportionately impacted by disease burden and social vulnerability.
- Describe ability to tailor work/approaches to reach priority populations and enable them to be successful in accessing and participating in health-related programs/services (in the work plan and accompanying narrative).
- Provide documentation of established partnerships with CBOs in the selected counties that have experience and expertise engaging the priority populations selected, as evidenced by signed letters of collaboration from up to 5 of these CBO partners. At least one of the letters should be from a partner with experience engaging/enrolling priority populations in DSMES and/or the National DPP lifestyle intervention. The letters should 1) summarize any prior work/accomplishments achieved with each partner (if applicable); 2) include a brief description of the work that will be accomplished by each partner, referencing back to the NOFO strategies; 3) specify the geographic area the partner will work in; and 4) discuss the partner's role in reaching priority populations and/or reducing health disparities in that area in connection with work on the NOFO strategies selected. Applicants must name each letter of collaboration

(LOC1_organization name, LOC2_organization name, etc.) and upload it as a PDF file on www.grants.gov as part of the application.)

- Describe plans to fund and support CBO partners to assist them in implementing the strategies selected and help eliminate SDOH-related barriers to recruitment, enrollment, and retention of priority populations in the evidence-based diabetes prevention/management programs described. (CDC recommends that Component B applicants sub-award a minimum of 30% of total funding to their CBO partners for this purpose.)
- Describe their capacity to evaluate work on the selected strategies and monitor/submit data on the required performance measures. (CDC recommends that Component B applicants allocate adequate funding to support evaluation and performance monitoring efforts.)

Component C:

- Describe prior experience convening and managing a network of partners from across multiple sectors to expand and increase participant enrollment in the National DPP lifestyle intervention, including, at a minimum: public or private payers and employers, health care organizations, CDC-recognized National DPP delivery organizations, and CBOs or other groups with demonstrated experience reaching and engaging priority populations in the geographic area covered by the network.
- Provide a clear and concise narrative description of how they will implement all four of the strategies described in the Component C section of the strategy list to achieve the performance measure targets and 5-year outcomes.
- Describe the specific role(s) network partners will play in implementing the required strategies and activities and achieving progress on the performance measures, with emphasis on how the network will screen, test, and refer sufficient numbers of both general and priority population participants to reach the enrollment targets; how the network will recruit sufficient numbers and types of partners to serve the enrolled participants; and how the network will ensure that health benefit coverage is provided for enrolled participants.
- Describe how they will administer and support the network, including the process for developing a business plan, allocating funding to network partners, and ensuring accountability of network partners for meeting the enrollment targets.
- Describe the geographic area the applicant will work in, including a description of how the participant enrollment goal will be achieved within that geographic area. Recipients will be expected to enroll 1,000 eligible participants in year 1, followed by graduated yearly increases for a total of 10,000 (minimum) by the end of the period of performance. Example:
    - YR 1: 1,000
    - YR 2: 1,500
    - YR 3: 2,000
    - YR 4: 2,500
    - YR 5: 3,000

Applicants must describe their plans to work in a geographic area(s) with a population large enough to make it feasible to enroll the numbers stated above, estimating that, for every 100

people with prediabetes or at high risk for type 2 diabetes reached, ~10 will be ready to enroll in the program. (*Example: In a geographic area with 500,000 adults, ~30% (150,000) may have prediabetes. Assuming 10% (15,000) of these people are ready to enroll, the recipient would need to work with partners to enroll 10,000 to meet the goal for the 5-year performance period. If we assume cohorts of ~20 participants, the CDC-recognized organizations participating in the network would need to run at least 50 cohorts in the first year (and 500 cohorts by year 5).*

- Describe a feasible plan to allocate funding and provide support for program delivery, including plans to help address the SDOH-related needs of priority populations that can negatively impact National DPP participant enrollment and retention. (CDC recommends that ~35% of total funding awarded be used for program delivery, with ~15% of that amount dedicated to meeting the SDOH-related needs of priority populations that impact National DPP participant enrollment and retention.)
- Describe, in the project narrative, any prior experience reaching and engaging priority populations, including specific efforts to address SDOH/barriers to participation in the network area and the resulting accomplishments/impact of those efforts.*
- Describe existing capacity to submit claims to public (Medicare, Medicaid) and/or private (commercial health plans, employers) payers for the National DPP lifestyle intervention.
- Describe their capacity to evaluate work on the selected strategies and monitor/submit data on the required performance measures. (CDC recommends that Component C applicants allocate adequate funding to support evaluation and performance monitoring efforts.)
- Provide letters of collaboration (maximum of 5) from one organization in each of these categories: 1) a payer/employer covering the National DPP lifestyle intervention as a health or wellness benefit, 2) a clinical partner with an established system to refer eligible patients to a CDC-recognized organization offering the National DPP lifestyle intervention, 3) a CBO with specific experience enrolling one or more priority populations in the National DPP lifestyle intervention, 4) an organization with experience addressing health equity and SDOH-related issues, and 5) a CDC-recognized National DPP delivery organization with claims submission experience. Letters should include a brief description of the work that will be accomplished by each partner, referencing back to the NOFO strategies. Applicants must name each letter of collaboration (LOC1_organization name, LOC2_organization name, etc.) and upload it as a PDF file on www.grants.gov as part of the application.

* For Component C, applicants will present a feasible plan to meet at least 50% of the enrollment goal for year 1 (minimum of 1,000 people) by reaching and enrolling eligible priority populations.

d. Work Plan

Applicants should complete a work plan, to include the information described below. For convenience, a Word version of the work plan is available for download at: https://www.cdc.gov/diabetes/funding-opportunity/NOFO-CDC-RFA-DP23-0020.html .

In addition to the work plan, applicants should provide a brief narrative description of their proposed work on the selected strategies as part of the Project Narrative section of the application.

Work Plan

A Strategic Approach to Advancing Health Equity for Priority Populations with or at Risk for Diabetes (CDC-RFA-DP23-0020)

Instructions: *Applicants may use the below template to complete their Year 1 Work Plans. For the menu of strategies, and for more detailed instruction, refer to the CDC-RFA-DP23-0020 notice of funding opportunity (NOFO).* ***The final work plan should be saved as "Work Plan_Applicant Organization Name" and uploaded as a PDF****.*
Italicized text represents instructions for completing the Work Plan template. Applicants may remove this text as necessary.

Strategies and Supporting Information: ***Use the table below to complete your work plan for the NOFO strategies you choose to work on.***

Use the table below to complete your work plan for the NOFO strategies you choose to work on.

- ***Component A*** *applicants must select a minimum of 6 of the evidence-based diabetes management, type 2 diabetes prevention, and/or policy and systems level support strategies listed in the NOFO strategy list, including at least one of the following*:
    - Strategy 1: Strengthen self-care practices through improving access, appropriateness, and/or feasibility of diabetes self-management education and support (DSMES) services
    - Strategy 5: Increasing enrollment and retention in the National DPP lifestyle intervention by improving access, appropriateness, and/or feasibility of the program
- ***Component B*** *applicants must select a minimum of 4 of the evidence-based diabetes management, type 2 diabetes prevention, and/or policy and systems level support strategies, listed in the NOFO strategy list, including at least one of the following*:
    - Strategy 1: Strengthen self-care practices through improving access, appropriateness, and/or feasibility of diabetes self-management education and support (DSMES) services
    - Strategy 5: Increasing enrollment and retention in the National DPP lifestyle intervention by improving access, appropriateness, and/or feasibility of the program
- ***Component C*** *applicants must select all 4 strategies listed in the Component C section of the NOFO strategy list.*

Applicant Name: ***Enter your organization's name in the box below.***

Component: ***Identify the NOFO Component you are applying for and enter it into the box below. (Select only one.)***

- Component A: Statewide Evidence-based Approaches to Diabetes Management and Type 2 Diabetes Prevention
- Component B: Local Evidence-based Approaches to Diabetes Management and Type 2 Diabetes Prevention
- Component C: Using Multisectoral Partner Networks to Scale and Sustain the National Diabetes Prevention Program to Reach Priority Populations

INSTRUCTIONS: *Copy/paste the first strategy you select into the work plan template below and fill in the requested information. Repeat for all additional strategies you select. You may* ***replicate the blank table as many times as needed to complete your work plan for all selected strategies****.*

Writing SMARTIE Objectives: *SMARTIE objectives are "Specific," "Measurable," "Attainable," "Relevant," "Time-based," "Inclusive," and "Equitable." Include supporting activities that describe the work you will do to achieve each SMARTIE objective. Additional information on writing SMARTIE objectives is available at:* https://www.cdc.gov/diabetes/funding-opportunity/NOFO-CDC-RFA-DP23-0020.html.

[Enter First Selected Strategy Here]

SMARTIE Objectives and Supporting Activities	Lead Personnel Assigned	Contributing Partners	Key Contracts & Consultants	Start Quarter	End Quarter
Objective 1					
Objective 2					
Objective 3					
Objective 4					
Objective 5					
Etc.					

Short Term Measure(s): *Populate the table below with the short-term performance measure(s) that correspond to this strategy. To see which short-term measures correspond to each strategy, refer to the NOFO Strategy and Performance Measure Table. Use the Notes section to provide additional information/context for the values reported and describe any barriers to reporting values, with a timeline to update missing values.*

Short-term Measure Description (copy from the Strategy and Performance Measure Table in the NOFO)	**Baseline Value**	**Year 1 Target Value**	**Data Source**	**Notes**

Setting: *Indicate the setting(s) for this strategy from the following list:* state government, community-based organizations, faith-based organizations, federally qualified health centers, other health care organizations, U.S. Department of Housing and Urban Development (HUD) affordable housing communities, Other—please describe

Priority Population(s) of Focus: *Indicate the priority populations of focus for this strategy from each row in the below table by deleting those choices in the Options column that do not apply and/or adding additional options. If this strategy does not have a specific population of focus, delete the table below and write "General" in this space.*

Population of Focus	**Options**
Age	*Children, Teens, Adults {18-24}, Adults {25-39}, Adults {40-49}, Adults {50-64}, Adults {65 & Older}*
Ethnicity	*Hispanic or Latino, Not Hispanic or Latino*
Race	*African American or Black, American Indian or Alaska Native, Asian Indian, Chinese, Filipino, Japanese, Korean, Vietnamese, Other Asian {Specify}, Native Hawaiian or Other Pacific Islander, Guamanian or Chamorro, Samoan, White, Other {Specify}*
Gender or Gender Identity	*Female, Male, Transgender, Non-Binary, Two-Spirit, Other {Specify}*
Sexual Orientation	*Gay or Lesbian, Straight (Heterosexual), Bisexual, Two-Spirit, Other {Specify}*
Socioeconomic Status	*Specify*
Geographic Location	*Rural, Urban, Frontier*

Cognitive, Sensory, or Physical Disability	*Specify*
Mental Health	*Specify*
Religion	*Specify*
Other characteristics historically linked to discrimination or exclusion	*Specify*
Other Populations	*Specify*

Work Plan: Years 2-5

Provide a general summary of work plan objectives proposed for years 2-5 of the cooperative agreement (maximum one page narrative). This summary should describe how work in years 2-5 will build on the year 1 objectives/activities and ultimately result in accomplishment of NOFO outcomes.

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.

The proposed work plan and performance measure targets will be reviewed annually by CDC Project Officers and Evaluators and may need to be altered to better align with or achieve progress on the program strategies outlined in the NOFO. Project Officers and Evaluators will meet regularly with recipients to:

- Ensure that proposed activities and deliverables are on track for completion.
- Assist recipients in revising work plan activities or performance measure targets based on achievement of objectives and/or budget changes.
- Host webinars, peer learning opportunities, and other meetings/trainings associated with the NOFO strategies.
- Provide tools/resources aligned with program activities and NOFO outcomes, implementation, and evaluation support.

CDC will analyze performance measure data to review progress and identify technical assistance needs for all NOFO strategies on an annual basis. Performance measure data will be triangulated with other internal and external data sources to determine progress and impact at the national level. Findings from the annual analysis of performance measure data will be used to identify program improvement and broader technical assistance needs and to report to stakeholders. CDC will develop annual, aggregate performance measure reports to be disseminated to recipients and other key stakeholders, including federal partners, other funded and non-funded partners, and policy makers as appropriate. These aggregate findings may also be presented during site visits and recipient meetings. In addition to performance measures reported by recipients, CDC will track specific intermediate outcome measures and other short and long-term measures (as indicated in the Strategy and Performance Measure Table in this NOFO) that are relevant to the program through national datasets or national evaluation activities.

A national evaluation will be conducted by CDC to answer questions regarding the effectiveness, sustainability, and impact of the approaches and activities implemented by recipients for Components A and C, and effectiveness and impact for Component B. The specific questions in each area will be updated annually based on findings from performance measure data as well as other lessons learned throughout the year. Recipients will participate in data collection activities for the CDC-led national evaluation. CDC guidance will be provided to the recipients to ensure effective participation in the CDC-led national evaluation. All evaluation findings produced by CDC and recipients, where appropriate, will contribute to: (1) continuous improvement of quality and effectiveness of program strategies; (2) the evidence base; (3) documentation and sharing of lessons learned to support replication and scaling of these program strategies; and/or (4) future funding opportunities supported by CDC.

f. CDC Program Support to Recipients

CDC will work in partnership with recipients to ensure the success of the cooperative agreement by:

- Supporting recipients in implementing cooperative agreement requirements and meeting program outcomes;
- Assisting recipients in advancing program activities to achieve project outcomes;
- Providing scientific subject matter expertise and resources in support of the selected strategies;
- Collaborating with recipients to develop and implement evaluation plans that align with CDC evaluation activities;
- Providing technical assistance on recipients' evaluation and performance measurement plans;
- Providing technical assistance to define and operationalize performance measures;
- Using webinars and other social media for recipients and CDC to communicate and share tools and resources; and
- Translating and disseminating lessons learned through publications, meetings, and other means on promising and best practices to expand the evidence base.

In addition, CDC will fund a recipient organization under a companion NOFO, CDC-RFA-DP23-0021, *A Strategic Approach to Advancing Health Equity for Priority Populations with or at Risk for Diabetes—Subject Matter Expertise, Training, and Technical Assistance*. This recipient organization will work closely with CDC to:

- Provide supplemental technical support through a network of partners and subject matter experts;
- Establish peer learning communities to facilitate the sharing of information among recipients;
- Provide professional development and training opportunities for the purpose of sharing the latest science, best practices, success stories, and program models;
- Develop guidance documents and other resources to ensure relevant knowledge and skills to implement evidence-based approaches to diabetes management and type 2 diabetes prevention and risk reduction in priority populations; and
- Host a meeting/training during the first year of the period of performance and later in the period of performance (for a total of 2 meetings/trainings for recipients).

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:
2023
Estimated Total Funding:
$411,000,000

4. Approximate Total Fiscal Year Funding:
$82,200,000
This amount is subject to the availability of funds.

5. Approximate Period of Performance Funding:
$411,000,000

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

7. Expected Number of Awards:
77
Component A: 51 awards
Component B: up to 22 awards
Component C: up to 4 awards

8. Approximate Average Award:

$1,067,532
Per Budget Period

Component A: award range of $850,000-$1,250,000
Component B: award range of $750,000-$1,100,000
Component C: award range of $2,500,000-$3,300,000

9. Award Ceiling:
$3,300,000
Per Budget Period

This NOFO will fund up to 77 recipients annually for a period of 5 years.
Annual funding for the NOFO components is:
Component A- award ceiling -$1,250,000
Component B- award ceiling of $1,100,000
Component C- award ceiling of $3,300,000

10. Award Floor:
$750,000
Per Budget Period

Component A - award floor of $850,000
Component B - award floor of $750,000
Component C - award floor of $2,500,000

11. Estimated Award Date:

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 not available through this NOFO.

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:
00 (State governments)

01 (County governments)

02 (City or township governments)

04 (Special district governments)

05 (Independent school districts)

06 (Public and State controlled institutions of higher education)

07 (Native American tribal governments (Federally recognized))

08 (Public housing authorities/Indian housing authorities)

11 (Native American tribal organizations (other than Federally recognized tribal governments))

12 (Nonprofits having a 501(c)(3) status with the IRS, other than institutions of higher education)

13 (Nonprofits without 501(c)(3) status with the IRS, other than institutions of higher education)

20 (Private institutions of higher education)

22 (For profit organizations other than small businesses)

23 (Small businesses)

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

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

Additional Eligibility Category:

Government Organizations:

State (includes the District of Columbia)

Local governments or their bona fide agents

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

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

Community-based organizations

Faith-based organizations

2. Additional Information on Eligibility

The NOFO contains 3 components: A, B, and C. Applicants may apply for only 1 component. Applications will be considered non-responsive and will receive no further review if the following criteria are not met:

1. **All applicants** must identify the component they are applying for in the project abstract. If the applicant does not identify the component in the project abstract, the application will be deemed non-responsive. If an applicant applies for more than 1 component, both applications will be considered non-responsive.
2. **All applications** must contain a Table of contents, a Project Abstract, a Project Narrative (including work plan), and a Budget Narrative. Applications submitted without these documents will be considered non-responsive.

Component A Applicants: Must be physically located in the state or district they are proposing to serve. Applicants must identify the state or district they are proposing to serve along with their physical address in the project abstract. If this information is not identified in the project abstract, the application will be deemed non-responsive and will not receive further review.

Component B Applicants: Applicants' proposed work must be in one or more of the "high need" counties identified on the list available at: https://www.cdc.gov/diabetes/funding-opportunity/NOFO-CDC-RFA-DP23-0020.html.that, together, comprise a population of at least

350,000* people. Applicants must identify the high-need county(s)* and population(s) from the provided list in the project abstract. If this information is not identified in the project abstract, the application will be deemed non-responsive and will not receive further review.

**Note that 350,000 people was determined to be a minimum reach for work in Component B, given the projected award amounts and the estimated number of people with and at risk for diabetes who will need to be reached in order to achieve substantive participation in the National DPP lifestyle intervention, DSMES, and related programs/services addressed in the NOFO strategies. **"High need" counties were defined by CDC using a formula based on disproportionate diabetes burden (diabetes prevalence > 8.4% and incidence > 9.6 per 1,000 people), a disproportionate number of persons at risk for type 2 diabetes (obesity prevalence > 28.3%), and a disproportionate level of social needs as defined by a social vulnerability index of > 0.5.).*

3. Justification for Less than Maximum Competition

N/A

4. Cost Sharing or Matching

Cost Sharing / Matching Requirement:

No

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

5. Maintenance of Effort

Maintenance of effort is not required for this program.

D. Required Registrations

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.

PLEASE NOTE: Effective April 4, 2022, applicants must have a Unique Entity Identifier (UEI) at the time of application submission (SF-424, field 8c). The UEI is generated as part of SAM.gov registration. Current SAM.gov registrants have already been assigned their UEI and can view it in SAM.gov and Grants.gov. Additional information is available on the GSA website, SAM.gov, and Grants.gov- Finding the UEI.

a. Unique Entity Identifier (UEI):

All applicant organizations must obtain a Unique Entity Identifier (UEI) number by registering in SAM.gov prior to submitting an application. A UEI number is a unique twelve-digit identification number assigned to the registering organization.

If funds are awarded to an applicant organization that includes sub-recipients, those sub-recipients must provide their UEI 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 and a Unique Entity Identifier (UEI). 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	System for Award Management (SAM)	1. Go to SAM.gov and designate an E-Biz POC (You will need to have an active SAM account before you can register on grants.gov). The UEI is generated as part of your registration.	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
2	Grants.gov	1. Set up an individual account in Grants.gov using organization's new UEI number to become an Authorized Organization Representative (AOR) 2. Once the account is set up the E-BIZ POC will be notified via email 3. Log into grants.gov using the password the E-BIZ POC received and create new password	It takes one day (after you enter the EBiz POC name and EBiz POC email in SAM) to receive a UEI (SAM) which will allow you to register with Grants.gov and apply for federal funding.	Register early! Applicants can register within minutes.

		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)

Due Date for Letter Of Intent 01/20/2023

The LOI date will generate once the Synopsis is published if Days or a Date are entered.
01/20/2023, 11:59 PM U.S. Eastern Standard Time

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

LOI must be sent via email to:
Pat Schumacher
DP2320NOFO@cdc.gov

b. Application Deadline

Due Date for Applications 03/07/2023

03/07/2023
11:59 pm U.S. Eastern 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.

Due Date for Informational Conference Call
Date: 01/13/2023
Time: 02:00-3:30 PM U.S Eastern Time (US and Canada)
Topic: DP23-0020 Informational Conference Call

Please email DP2320NOFO@cdc.gov to register in advance for this webinar. Details for accessing the webinar will be posted on or before January 12, 2023, at the website referenced below. (Pre-registration is optional.)

The Informational Conference Call will be recorded and added to the DP23-0020 Information Webpage https://www.cdc.gov/diabetes/funding-opportunity/NOFO-CDC-RFA-DP23-0020.html.

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 UEI.

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
The purpose of a Letter of Intent (LOI) is to allow CDC to estimate the number of and plan for the review of submitted applications. LOIs are not required as part of the application for this NOFO. Non-submission will not impact the review of applications.

LOIs are due on 1/20/2023.

The LOIs must include the applicant's name and organizational type, the component (Component A, B, or C) the applicant will apply for, and the geographical area of focus. For example:

- Agency ABC is a state health department.
- Agency ABC will apply for Component A.
- The proposed area of focus is State X.

Or

- Agency ABC is a 501 (c) 3 organization.
- Agency ABC will apply for Component B.
- The proposed areas of focus are County X, County Y, and County Z, for a total population reach of 400,000 people.

Letters of Intent must be sent via email to:
Pat Schumacher
Chief, Program Implementation Branch
Division of Diabetes Translation
CDC, National Center for Chronic Disease Prevention and Health Promotion
Email address for LOI: DP2320NOFO@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.

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.

The budget should follow the *CDC's* budget preparation guidelines at: https://www.cdc.gov/grants/applying/application-resources.html).

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/additional-requirements/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.

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 via email.

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:** 40

COMPONENT A

Background, Purpose, and Outcomes

Evaluate the extent to which the applicant:

- Describes specifically how they will address the public health problem described in the NOFO, with emphasis on how they will achieve statewide reach, inclusive of all populations and communities in the state. **(5 points)**

Target Populations and Health Disparities

Evaluate the extent to which the applicant:

- Describes how the priority population(s) of focus were identified and the rationale for selecting those population(s), considering the following factors: disproportionate incidence, prevalence, or severity of diabetes disease burden and/or social vulnerability. **(3 points)**

Collaborations

Evaluate the extent to which the applicant:

- Describes how they will collaborate with organizations that have experience/expertise in: **(6 points)**
    - Reaching the selected priority populations.
    - Addressing system or population-level needs related to the SDOH.
    - Assisting the priority populations of focus in successfully engaging in the diabetes programs/services in the selected strategies.
    - (Non-state or District of Columbia health department applicants should describe how they will collaborate with the state or district health department to achieve statewide or district-wide reach and leverage existing partnerships and expertise.)
- Provides a maximum of 5 letters of collaboration from key partners that will be involved in implementing the selected strategies. At least one of the letters should be from a partner with experience engaging/enrolling priority populations in DSMES and/or the National DPP lifestyle intervention. The letters should 1) summarize any prior work/accomplishments achieved with each partner (if applicable); 2) include a brief description of the work that will be accomplished by each partner, referencing back to the NOFO strategies; 3) specify the geographic area the partner will work in; and 4)

discuss the partner's role in reaching priority populations and/or reducing health disparities in that area (if applicable) in connection with work on the NOFO strategies selected. **(6 points)**

Strategies and Activities
Evaluate the extent to which the applicant:

- Provides a clear and concise narrative description of how they will implement at least 6 of the strategies described in the Component A section of the strategy list to achieve the performance measure targets and 5-year outcomes. This includes the required implementation of strategy 1 and/or strategy 5. **(6 points)**

Work Plan
Evaluate the extent to which the applicant:

- Presents a work plan that describes the strategies selected and the objectives/activities and short-term performance measure baselines, targets, and data sources in alignment with NOFO outcomes. The work plan should: **(6 points)**
    - Include specific measurable, attainable/achievable, relevant, timebound/time based, inclusive, equitable (SMARTIE) objectives for each strategy for the first year and supporting activities that describe the work that will be done to achieve each objective.
    - Specify the setting(s) and population(s) of focus, and collaborative partners for work under each strategy.
- Describes how they will tailor work/approaches to reach priority populations and enable them to be successful in accessing and participating in the diabetes-related programs/services addressed in this NOFO. **(5 points)**
- Provides a narrative summary of activities planned for each strategy in years 2-5. This summary should describe how work in years 2-5 will build on the year 1 objectives/activities and ultimately result in accomplishment of NOFO outcomes. **(3 points)**

ii. Evaluation and Performance Measurement **Maximum Points:** 25

COMPONENT A
Evaluate the extent to which the applicant:

- Indicates how key evaluation questions, posed by CDC, will be addressed as they relate to the overall evaluation plan. **(5 points)**
- Describes an evaluation design that is appropriate for the proposed strategies and is rigorous enough to determine whether activities have contributed to health and other outcomes. **(6 points)**
- Describes data collection processes and data sources that are feasible and align with the evaluation design. **(5 points)**
- Describes how a a percentage of total funding will be used to provide adequate staffing and technical support for monitoring and evaluation. **(3 points)**

- Describes how evaluation findings will be used for continuous program and quality improvement. **(3 points)**
- Describes how the evaluation will add to the evidence base for selected strategies. **(3 points)**
- Includes a preliminary Data Management Plan (DMP) describing, at a minimum, required information as outlined in the NOFO. **(not scored)**

iii. Applicant's Organizational Capacity to Implement the Approach **Maximum Points:** 35

COMPONENT A

Evaluate the extent to which the applicant:

- Describes prior experience and accomplishments working with and providing technical assistance on the selected strategies, with emphasis on the National Diabetes Prevention Program (National DPP) and/or diabetes self-management education and support (DSMES). Describes ability to collect and monitor data to document progress on selected strategies. **(12 points)**
- Describes any prior experience working with the selected populations using participatory approaches or involvement and support from these groups for the work proposed. **(3 points)**
- Describes experience achieving statewide reach in previous work. **(3 points)**
- Provides a staffing plan that demonstrates the applicant has access to staff or contractors/consultants with relevant subject matter expertise to lead work on the selected strategies (e.g., project manager, health equity lead, diabetes subject matter expert, evaluator). The staffing plan should include the following: **(6 points)**
    - A description of a staff member to lead the project. This individual should have previous experience with grants administration; program planning and implementation; partnership development; and staff/contractor supervision/oversight.
    - A description of how diabetes management/prevention expertise will be accessed.
    - A description of staff who will have the day-to-day responsibility for key tasks such as leadership of work on selected strategies; monitoring of the project's ongoing progress; preparation of reports; program evaluation; and communication with partners and CDC.
- Describes their ability to manage the required procurement efforts, including the ability to write and award contracts efficiently, in accordance with applicable grants regulations and in a reasonable timeframe. **(3 points)**
- Demonstrates readiness to implement the evidence-based strategies in this NOFO by: **(8 points)**
    - Describing established working relationships with key national, state, or local partner organizations relevant to selected strategies, and including a description of outcomes or key accomplishments resulting from these partnerships (e.g., reports, publications, resource documents, tools, policy change, health impact). [Partners may include groups such as state Medicaid agencies; state

employee benefit agencies; CBOs; tribes or tribal organizations; professional associations (state medical society, other medical specialty associations, etc.); quality improvement organizations; ADA-recognized and ADCES-accredited DSMES services; local/regional ADA or ADCES chapters; CDC-recognized organizations delivering the National DPP lifestyle intervention, and others.]

Budget **Maximum Points:** 0

COMPONENT A

- Evaluate the extent to which the proposed budget is reasonable and consistent with the stated objectives and planned program activities. Although not scored, applicants must ensure their proposed budget aligns with their proposed work plan and NOFO objectives.

i. Approach **Maximum Points:** 40

COMPONENT B

Background, Purpose, and Outcomes

Evaluate the extent to which the applicant:

- Describes specifically how they will address the public health problem described in the NOFO in the "high need" counties selected. **(4 points)**

Target Populations and Health Disparities

Evaluate the extent to which the applicant:

- Clearly identifies the priority population(s) they will focus on and the rationale for selecting those population(s), considering the following factors: disproportionate incidence, prevalence, or severity of diabetes disease burden and/or social vulnerability. **(3 points)**

Collaborations

Evaluate the extent to which the applicant:

- Describes how they will 1) establish partnerships with CBOs in the selected "high need" counties that have experience and expertise engaging the priority populations they wish to reach and 2) how funds will be used to support the CBO partners in implementing the selected strategies and helping eliminate SDOH-related barriers to recruitment, enrollment, and retention of priority populations in the diabetes prevention/management programs and services included in this NOFO. **(7 points)**
- Provides a maximum of 5 letters of collaboration from CBO partners with experience/expertise reaching the priority populations of focus and helping to eliminate SDOH-related barriers that hinder those populations from successfully engaging in the diabetes management and prevention programs/services described in this NOFO. At least one of the letters should be from a partner with experience engaging/enrolling priority populations in DSMES and/or the National DPP lifestyle intervention. The letters should 1) summarize any prior work/accomplishments achieved with each partner (if applicable); 2) include a brief description of the work that will be accomplished by each

partner, referencing back to the NOFO strategies; 3) specify the geographic area the partner will work in; and 4) discuss the partner's role in reaching priority populations and/or reducing health disparities in that area in connection with work on the NOFO strategies selected. **(6 points)**

Strategies and Activities
Evaluate the extent to which the applicant:

- Provides a clear and concise narrative description of how they will implement at least 4 of the strategies described in the Component B section of the strategy list to achieve the performance measure targets and 5-year outcomes. This includes the required implementation of strategy 1 and/or strategy 5. **(6 points)**

Work Plan
Evaluate the extent to which the applicant:

- Presents a work plan that describes the strategies selected and the objectives/activities, and short-term performance measure baselines, targets, and data sources in alignment with NOFO outcomes. The work plan should: **(6 points)**
    - Include specific measurable, attainable/achievable, relevant, timebound/time based, inclusive, equitable (SMARTIE) objectives for each strategy for the first year and supporting activities that describe the work that will be done to achieve each objective.
    - Specify the setting(s) and population(s) of focus, and collaborative partners for work under each strategy.
- Describes how they will tailor work/approaches to reach priority populations and enable them to be successful in accessing and participating in the diabetes-related programs/services addressed in this NOFO. **(5 points)**
- Provides a narrative summary of activities planned for each strategy for years 2-5. This summary should describe how work in years 2-5 will build on the year 1 objectives/activities and ultimately result in accomplishment of NOFO outcomes. **(3 points)**

ii. Evaluation and Performance Measurement **Maximum Points:** 25
COMPONENT B
Evaluate the extent to which the applicant:

- Indicates how key evaluation questions, posed by CDC, will be addressed as they relate to the overall evaluation plan. **(5 points)**
- Describes an evaluation design that is appropriate for the proposed strategies and is rigorous enough to determine whether activities have contributed to health and other outcomes. **(6 points)**
- Describes data collection processes and data sources that are feasible and align with the evaluation design. **(5 points)**
- Describes how a percentage of total funding will be used to provide adequate staffing and technical support for monitoring and evaluation. **(3 points)**

- Describes how evaluation findings will be used for continuous program and quality improvement. **(3 points)**
- Describes how the evaluation will add to the evidence base for selected strategies. **(3 points)**
- Includes a preliminary Data Management Plan (DMP) describing, at a minimum, required information as outlined in the NOFO. **(not scored)**

iii. Applicant's Organizational Capacity to Implement the Approach **Maximum Points:** 35

COMPONENT B

Evaluate the extent to which the applicant:

- Describes prior experience and accomplishments working and providing technical assistance on the selected strategies, with emphasis on the National Diabetes Prevention Program (National DPP) and/or diabetes self-management education and support (DSMES). Describes ability to collect and monitor data to document progress on selected strategies. **(12 points)**
- Describes prior experience working in the "high need" countiesselected. **(3 points)**
- Clearly describes any prior experience working with the selected populations using participatory approaches or involvement and support from these groups for the work proposed. **(3 points)**
- Provides a staffing plan that demonstrates the applicant has access to staff or contractors/consultants with relevant subject matter expertise to lead work on the selected strategies (e.g., health equity lead, project manager, diabetes subject matter expert, evaluator). The staffing plan should include the following: **(6 points)**
    - A description of a staff member to lead the project. This individual should have previous experience with grants administration; program planning and implementation; partnership development; and staff/contractor supervision/oversight.
    - A description of how diabetes management/prevention expertise will be accessed.
    - A description of staff who will have the day-to-day responsibility for key tasks such as the leadership of work on selected strategies; monitoring of the project's ongoing progress; preparation of reports; program evaluation; and communication with partners and CDC.
- Describes their ability to manage the required procurement efforts, including the ability to write and award contracts efficiently, in accordance with applicable grants regulations and in a reasonable timeframe. **(3 points)**
- Describes prior experience addressing relevant health disparities among populations disproportionately impacted by disease burden and social vulnerability. **(8 points)**

Budget **Maximum Points:** 0

COMPONENT B

- Evaluate the extent to which the proposed budget is reasonable and consistent with the stated objectives and planned program activities. Although not scored, applicants must ensure their proposed budget aligns with their proposed work plan and NOFO objectives.

i. Approach **Maximum Points:** 40

COMPONENT C

Background, Purpose, and Outcomes

The extent to which the applicant:

- Describes specifically how they will address the public health problem described in the NOFO through the network model to positively impact the problem (achieve a significant increase in National DPP enrollment). **(3 points)**

Target Populations and Health Disparities

- Describes how the priority population(s) of focus were identified in the network and the rationale for selecting those population(s), considering the following factors: disproportionate incidence, prevalence, or severity of diabetes disease burden and/or social vulnerability. **(3 points)**
- Presents a feasible plan to address system or population-level needs related to the SDOH that impact priority populations' successful participation in the National DPP lifestyle intervention and ensures that priority populations comprise at least half of the 1,000 enrollment goal for year 1. **(3 points)**

Collaborations

- Describes the applicant's prior experience convening partners from across multiple sectors, including, at a minimum: public or private payers and employers, health care organizations, CDC-recognized National DPP delivery organizations, and CBOs or other groups with demonstrated experience reaching and engaging priority populations in the geographic area covered by the network. **(7 points)**
- Includes letters of collaboration from one partner organization in each of these categories: 1) a payer/employer covering the National DPP lifestyle intervention as a health or wellness benefit, 2) a clinical partner with an established system to refer eligible patients to a CDC-recognized organization offering the National DPP lifestyle intervention, 3) a CBO with specific experience enrolling one or more priority populations in the National DPP lifestyle intervention, 4) an organization with experience addressing health equity and SDOH-related issues, and 5) a CDC-recognized National DPP delivery organization with claims submission experience. Letters should include a brief description of the work that will be accomplished by each partner, referencing back to the NOFO strategies. **(9 points)**

Strategies and Activities

The extent to which the applicant:

- Provides a clear and concise narrative description of how they will implement all four of the strategies described in the Component C strategy list to achieve the performance measure targets and 5-year outcomes, with emphasis on how they will scale the National DPP lifestyle intervention through the network to reach the required enrollment targets. **(3 points)**
- Provides 1) a description of how they will administer and support the network, including the process for allocating funding to network partners and ensuring accountability of network partners for the enrollment targets and 2) a plan showing: **(5 points)**
    - How the network will screen, test, and refer sufficient numbers of both general and priority population participants to reach the enrollment targets.
    - How the network will recruit sufficient numbers and types of partners to serve the enrolled participants.
    - How the network will ensure that health benefit coverage is provided for enrolled participants.

Work Plan

Evaluate the extent to which the applicant:

- Presents a work plan that describes the strategies selected and the objectives/activities, and short-term performance measure baselines, targets, and data sources in alignment with NOFO outcomes. The work plan should: **(4 points)**
    - Include specific measurable, attainable/achievable, relevant, timebound/time based, inclusive, equitable (SMARTIE) objectives for each strategy for the first year and supporting activities that describe the work that will be done to achieve each objective.
    - Specify the setting(s) and population(s) of focus, and collaborative partners for work under each strategy.
- Provides a narrative summary of activities planned for each strategy for years 2-5. This summary should describe how work in years 2-5 will build on the year 1 objectives/activities and ultimately result in accomplishment of NOFO outcomes. **(3 points)**

ii. Evaluation and Performance Measurement **Maximum Points:** 25

COMPONENT C

Evaluate the extent to which the applicant:

- Indicates how key evaluation questions, posed by CDC, will be addressed as they relate to the overall evaluation plan. **(5 points)**
- Describes an evaluation design that is appropriate for the proposed strategies and is rigorous enough to determine whether activities have contributed to health and other outcomes. **(6 points)**
- Describes data collection processes and data sources that are feasible and align with the evaluation design. **(5 points)**
- Describes how a percentage of total funding will be used to provide adequate staffing and technical support for monitoring and evaluation. **(3 points)**

- Describes how evaluation findings will be used for continuous program and quality improvement. **(3 points)**
- Describes how the evaluation will add to the evidence base for selected strategies. **(3 points)**
- Includes a preliminary Data Management Plan (DMP) describing, at a minimum, required information as outlined in the NOFO. **(not scored)**

iii. Applicant's Organizational Capacity to Implement the Approach **Maximum Points:** 35

COMPONENT C

Evaluate the extent to which the applicant:

- Describes prior experience convening and managing a cross-sectoral partner network focused on expanding and increasing participant enrollment the National DPP lifestyle intervention. Describes ability to collect and monitor data to document progress. **(10 points)**
- Demonstrates prior experience reaching and engaging priority populations, including documentation of previous efforts to address SDOH/barriers to participation in the network area and the resulting accomplishments/impact of those efforts. **(10 points)**
- Describes a process for developing a business plan that addresses: the number and type of network partners needed, the funding allocations, and the accountability mechanisms. **(4 points)**
- Describes the geographic area the applicant will work in, including a description of how the participant enrollment goal (1,000 participants in year 1 and 10,000 by the end of the performance period) will be met. **(3 points)**
- Provides a staffing plan that demonstrates the applicant has access to staff or contractors/consultants with relevant subject matter expertise to lead work on the selected strategies (e.g., project manager, health equity lead, diabetes subject matter expert, evaluator). The staffing plan should include the following: **(5 points)**
    - A description of a staff member to lead the project. This individual should have previous experience with grants administration; program planning and implementation; partnership development; and staff/contractor supervision/oversight.
    - A description of how expertise in all aspects of scaling and sustaining the National DPP lifestyle intervention will be provided by network partners or other specialists.
    - A description of staff who will have the day-to-day responsibility for key tasks such as the operation of the network; monitoring of the network's ongoing progress; preparation of reports; program evaluation; and communication with network partners and CDC.
- Describes their ability to manage the required procurement efforts, including the ability to write and award contracts efficiently, in accordance with applicable grants regulations and in a reasonable timeframe **(3 points)**

Budget **Maximum Points:** 0

COMPONENT C

- Evaluate the extent to which the proposed budget is reasonable and consistent with the stated objectives and planned program activities. Although not scored, applicants must ensure their proposed budget aligns with their proposed work plan and NOFO objectives.

c. Phase III Review

All eligible applications will be reviewed and scored in accordance with the "Phase II Review" criteria above. Applications for each component (Components A, B, and C) will be reviewed separately. The CDC program will use a separate rank- order list for each component. The following factors may influence funding decisions:

- **Component A**: To ensure maximum US coverage in Component A, no more than one application per state and in the District of Columbia will be funded. If multiple applicants from the same state/D.C. apply under Component A, the highest scoring applicant from that state/D.C will be considered for funding. CDC may not fund an applicant if it is determined they do have state/district-wide reach, which may result in funding out of rank order.
- **Component B:** Applicants may be funded out of rank order in Component B to achieve the greatest geographic diversity across the "high-need" counties identified on the list available at: "high need" counties and diversity across the priority populations of focus. CDC may not fund an applicant if it is determined they are not proposing work in the "high need" counties provided to reach at least 350,000 people, which may result in funding out of rank order.
- **Component C**: Applicants may be funded out of rank order to avoid the duplication of effort that could arise with more than one National DPP multisectoral partner network operating in the same geographic area.

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

Announcement date: January 6, 2023
Informational conference call: January 13, 2023
Letters of intent due: January 20, 2023
Application submission due date: March 7, 2023
Anticipated award date: May 30, 2023
Anticipated start date: June 30, 2023

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 annual 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.

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 https://www.cdc.gov/grants/additional-requirements/index.html.

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 project:

- *AR-1: Human Subjects Requirements*
- *AR-9: Paperwork Reduction Act Requirements*
- *AR-10: Smoke-Free Workplace Requirements*
- *AR-11: Healthy People 2030*
- *AR-12: Lobbying Restrictions*
- *AR-13: Prohibition on Use of CDC Funds for Certain Gun Control Activities*
- *AR-14: Accounting System Requirements*
- *AR-16: Security Clearance Requirement*
- *AR-21: Small, Minority, And Women-owned Business*
- *AR-24: Health Insurance Portability and Accountability Act Requirements*
- *AR-25: Data Management and Access*
- *AR-26: National Historic Preservation Act of 1966*
- *AR-29: Compliance with EO13513, "Federal Leadership on Reducing Text Messaging while Driving", October 1, 2009*
- *AR-30: Information Letter 10-006, - Compliance with Section 508 of the Rehabilitation Act of 1973*
- *AR-31: Research Definition*
- *AR-32: Enacted General Provisions*

- *AR-33: United States Government Policy for Institutional Oversight of Life Sciences Dual Use Research of Concern*
- *AR-37: Prohibition on certain telecommunications and video surveillance services or equipment for all awards issued on or after August 13, 2020*

Organization-specific ARs:

1. *AR-8: Public Health System Reporting Requirements*
2. *AR-23: Compliance with 45 CFR Part 87*

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 will be required to complete an HHS Assurance of Compliance form (HHS 690) in which you agree, as a condition of receiving the grant, to administer your programs in compliance with federal civil rights laws that prohibit discrimination on the basis of race, color, national origin, age, sex and disability, and agreeing to comply with federal conscience laws, where applicable. This includes ensuring that entities take meaningful steps to provide meaningful access to persons with limited English proficiency; and ensuring effective communication with persons with disabilities. Where applicable, Title XI and Section 1557 prohibit discrimination on the basis of sexual orientation, and gender identity. 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.

- 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 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)	6 months into award	Yes
Annual Performance Report (APR)	No later than 120 days before end of budget period. Serves as yearly continuation application.	Yes
Data on Performance Measures	CDC program determines.	Yes
Federal Financial Reporting Forms	90 days after the end of the budget period	Yes
Final Performance and Financial Report	90 days after end of period of performance	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 publicly 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).

No additional requirements.

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:
Pat

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

Address:
National Center for Chronic Disease Prevention and Health Promotion
Division of Diabetes Translation

Telephone:

Email:
DP2320NOFO@cdc.gov

Grants Management Office Information

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

First Name:
Stephanie

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

Address:

CDC, Office of Financial Resources (OFR)
Branch 5 Supporting Chronic Diseases and Injury Prevention

Telephone:

Email:
fzv6@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

Letters of Support

Organization Charts

Indirect Cost Rate, if applicable

Memorandum of Agreement (MOA)

Memorandum of Understanding (MOU)

Bona Fide Agent status documentation, if applicable

The Work Plan, Staffing Plan and Letters of Collaboration attachments are not counted towards the 25-page limit.

Please note that *Letters of Support* refers to the *Letters of Collaboration* described under *Collaborations* in the *CDC Project Description* section. Applicants should include the required letters of collaboration for the component they are applying for and a staffing plan, as described in the Organizational Capacity section of this NOFO. Letters of collaboration should be named as follows: LOC1_organization name, LOC2_organization name, etc., and uploaded as PDF files on www.grants.gov as part of the application.

The staffing plan should be named Staffing Plan_organization name and uploaded as a PDF file on www.grants.gov as part of the application.

The work plan should be named "Work Plan_Applicant Organization Name" and uploaded as a PDF on www.grants.gov as part of the application.

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 https://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 collection of federal programs, projects, services, and activities that provide assistance or benefits to the American public.

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. https://www.cdc.gov/grants/additional-requirements/index.html.

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.

UEI: The Unique Entity Identifier (UEI) number is a twelve-digit number assigned by SAM.gov. When applying for Federal awards or cooperative agreements, all applicant organizations must obtain a UEI number as the Universal Identifier. UEI number assignment is free. If an organization does not know its UEI number or needs to register for one, visit www.sam.gov.

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.

Priority populations are defined as those who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion. Refer to the CDC National Center for Chronic Disease Prevention and Health Promotion's

Health Equity Guiding Principles for Inclusive Communication for guidance on addressing all people inclusively and respectfully.

Social Determinants of Health (SDOH)— The non-medical factors that influence health outcomes. The conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. These forces (e.g., racism, climate) and systems include economic policies and systems, development agendas, social norms, social policies, and political systems. More information on SDOH and the CDC National Center for Chronic Disease Prevention and Health Promotion's SDOH Framework can be found at https://www.cdc.gov/chronicdisease/programs-impact/sdoh.htm.

Social Vulnerability refers to the resilience of communities (the ability to survive and thrive) when confronted by external stresses on human health.
https://www.atsdr.cdc.gov/placeandhealth/svi/at-a-glance_svi.html