**Centers for Disease Control and Prevention**

National Center for Chronic Disease Prevention and Health Promotion

National and State Tobacco Control Program
CDC-RFA-DP20-2001
Application Due Date: 04/13/2020

National and State Tobacco Control Program
CDC-RFA-DP20-2001
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## Part I. Overview Information

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-DP20-2001. 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) / Agency for Toxic Substances and Disease Registry (ATSDR)

**B. Notice of Funding Opportunity (NOFO) Title:**

National and State Tobacco Control Program

**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-DP20-2001

**E. Assistance Listings (CFDA) Number:**

93.387

**F. Dates:**

| | |
|---|---|
| **1. Due Date for Letter of Intent (LOI):** | **N/A** |
| **2. Due Date for Applications:** | **04/13/2020**, 11:59 p.m. U.S. Eastern Standard Time, at www.grants.gov. |

Modification to the NOFO due date. Applications are due on 4/13/2020.

**3. Date for Informational Conference Call:**

Information Conference Call #1: Wednesday, February 12, 2020, 3:00 – 4:00 U.S. Eastern Standard Time

Information Call Number: 1-866-803-2146

Passcode: 19609609#

Link: https://adobeconnect.cdc.gov/rr1ym55lt24e/

Information Conference Call #2 Thursday, February 13, 2020, 11:00 – 12:00 U.S. Eastern Standard Time

Information Call Number: 1-866-803-2146

Passcode: 19609609#

Link: https://adobeconnect.cdc.gov/rr1ym55lt24e/

A list of Frequently Asked Questions is available at

https://www.cdc.gov/tobacco/about/foa/national-state-tobacco-control-program/index.html

## G. Executive Summary:

### 1. Summary Paragraph:

CDC's Office on Smoking and Health (OSH) announces the availability of funds to implement DP20-2001, *National and State Tobacco Control Program*. This Notice of Funding Opportunity (NOFO) supports the achievement of four National Tobacco Control Program (NTCP) goals to 1) Prevent initiation of commercial tobacco use among youth and young adults; 2) Eliminate exposure to secondhand smoke (SHS); 3) Promote quitting among adults and youth; and 4) Identify and eliminate tobacco-related disparities. Achievement of these goals will reduce chronic disease morbidity, mortality, and disability related to commercial tobacco use and dependence and SHS exposure in the United States. These goals will be accomplished by funding two components:

1. **National Tobacco Control Program (State Based):** Approximately $67 million per year to fund 51 applicants.
2. **Commercial Tobacco Use and Dependence Treatment Support System:** Approximately $16 million per year to fund 53 applicants to ensure quitline capacity during a national media campaign.

*When CDC references tobacco, the reference is for commercial tobacco and not the sacred and traditional use of tobacco by some American Indian communities.

**a. Eligible Applicants:** Limited
**b. NOFO Type:** Cooperative Agreement
**c. Approximate Number of Awards:** 53

**d. Total Period of Performance Funding:** $403,000,000

Component 1: National Tobacco Control Program (State Based): $326,000,000

Component 2: Commercial Tobacco Use and Dependence Treatment Support System: $77,000,000

Year 1 budget period is 10 months.

**e. Average One Year Award Amount:** $1,600,000

Component 1: National Tobacco Control Program (State Based): $1,300,000

Component 2: Commercial Tobacco Use and Dependence Treatment Support System: $300,000

Year 1 budget period is 10 months; therefore, the average award is lower than the anticipated amount for subsequent 12-month budget periods.

**f. Total Period of Performance Length:** 5
**g. Estimated Award Date:** 05/28/2020

**h. Cost Sharing and / or Matching Requirements:** N

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

## Part II. Full Text

## A. Funding Opportunity Description

## Part II. Full Text

### 1. Background

**a. Overview**

CDC's Office on Smoking and Health seeks to build on the successes of previously funded work to expand evidence-based, culturally appropriate policy, systems, and environmental (PSE) strategies and activities to address the National Tobacco Control Program (NTCP) four national goals: 1) Prevent initiation of tobacco use (including emerging products and e-cigarettes) among youth and young adults; 2) Promote quitting among adults and youth; 3) Eliminate exposure to secondhand smoke (SHS); and 4) Identify and eliminate tobacco-related disparities among population groups. The most effective strategies for tobacco control are population-based PSE approaches that contribute to changes in social norms and behaviors related to tobacco use and dependence and SHS exposure. In order to have the greatest population impact, these evidence-based PSE strategies must be sustained for a sufficient amount of time at the appropriate intensity and have the greatest span (economic, regulatory, and comprehensive) and reach.

**Tobacco Burden:** Tobacco use and dependence remains the leading preventable cause of death and disease in the United States resulting in more deaths annually than HIV/AIDS, alcohol use, cocaine use, heroin use, homicides, suicides, motor vehicle crashes, and fires combined. Each year, approximately 480,000 people die from smoking, including more than 41,000 from SHS related deaths. Cigarette smoking and other tobacco use and dependence causes cardiovascular disease, multiple types of cancer, pulmonary disease, diabetes, eye disease, adverse reproductive outcomes, and the exacerbation of other chronic health conditions. Though progress has been made in reducing cigarette smoking among our nation's youth and young adults, the tobacco product landscape continues to evolve to include a variety of tobacco products, including e-cigarettes. In 2018, more than 3.6 million U.S. youth, that is 1 in 5 high school students and 1 in 20 middle school students, currently use e-cigarettes. E-cigarette use has become an epidemic among our nation's youth and young adults.

**Health Disparities:** Despite tobacco use and dependence reduction among the general population, tobacco use and dependence and SHS exposure is still higher among some population groups, including: African Americans; American Indians/Alaska Natives; Asian Americans, Pacific Islanders, and Native Hawaiians; Hispanic/Latinos; lesbian, gay, bisexual, transgender, and queer (LGBTQ) individuals; people of low socioeconomic status; people living with a disability; individuals with behavioral health conditions (including mental health conditions and substance use disorders); and by individuals living in different geographic regions.

**Quit Support Services**: Approximately 70 percent of adults who smoke cigarettes want to quit

and more than 50 percent of people try to quit each year. One of the most accessible treatment resources that can efficiently reach people who smoke is a tobacco use and dependence quitline. Quitlines increase quit rates among individuals who use tobacco and are trying to quit, reach a large number of people who smoke, and are effective among diverse and low-income populations. Advances in new digital-based quit support services (e.g., texting, web, chat, apps) show great promise in expanding the reach of tobacco use and dependence treatment systems.

Eligible applicants may apply for one or more components and may only submit a single application for this funding announcement. Each component must be labeled "**Component 1**" and "**Component 2.**"

**b. Statutory Authorities**

This program is authorized under section 317(k)(2)(e) of the *Public Health Service Act*, 42 U.S.C. §247b(k)(2)(e), *Comprehensive Smoking Education Act of 1984* 15 U.S.C.§1341*,* and *Comprehensive Smokeless Tobacco Health Education Act of 1986,* 15 U.S.C. § 4401.

**c. Healthy People 2030**

This funding opportunity supports Healthy People 2030 objectives in the topic area of Tobacco Use (TU). For specific objectives within the topic areas, please visit www.HealthyPeople.gov.

**d. Other National Public Health Priorities and Strategies**

This NOFO supports Government Performance Results Modernization Act (GPRA) Long-term Objective 4.6: Reduce Death and Disability Due to Tobacco, and the following measures:

- 4.6.2a Reduce the annual adult per-capita combustible tobacco consumption in the United States. (Intermediate Outcome)
- 4.6.3 Reduce the proportion of adults (aged 18 years and over) who are current cigarette smokers. (Intermediate Outcome)
- 4.6.4 Increase proportion of the U.S. population that is covered by comprehensive state and/or local laws making workplaces, restaurants, and bars 100% smoke-free (no smoking allowed, no exceptions)*. (Intermediate Outcome)
- 4.6.5a Reduce the proportion of adolescents grades 6 through 12 who are current users of any tobacco product. (Outcome measure)
- 4.6.8 Increase the proportion of every cigarette smokers aged 18 years or older who are former cigarette smokers. (quit ratio) (outcome)

In addition, this program supports the following national initiatives and strategic plans:

- The National Prevention Council's National Prevention Strategy - America's Plan for Better Health (Tobacco-Free Living) http://www.ldh.la.gov/assets/docs/GovCouncil/MinHealth/NationalPreventionStrategyJune2011.pdf.
- U.S. Department of Health & Human Services's (HHS) Strategic Plan (Objective 2.1: Empower people to make informed choices for healthier living, and the following performance measure: Reduce the annual adult per capita combustible tobacco consumption in the United States). https://www.hhs.gov/about/strategic-plan/overview

/index.html#strategic-plan.

*Note that all activities funded under this NOFO must be in compliance with applicable anti-lobbying provisions. See Section 17, Funding Restrictions for further detail and links to applicable guidance.

**e. Relevant Work**

This NOFO continues to support ongoing efforts since 1999 to build state health department infrastructure and capacity to implement comprehensive tobacco control programs. The funding opportunity builds upon the following past NOFOs:

- *Tobacco Use Prevention: Public Health Approaches for Ensuring Quitline Capacity* (CDC-RFA-DP14-1410).
- *National State-Based Tobacco Control Programs* (CDC-RFA-DP15-1509).

## 2. CDC Project Description

**a. Approach**

**Bold** indicates period of performance outcome.

CDC-RFA-20-2001 Logic Model: National and State Tobacco Control Program

**Inputs: CDC funding, training, technical assistance, and consultation on evidence-based strategies and activities, surveillance and epidemiology, and program evaluation**

| Evidence-Based Strategies and Activities | Short-Term Outcomes | Intermediate Outcomes | Long-Term Outcomes |
|---|---|---|---|
| **Component 1: National Tobacco Control Program (State Based)** | | | |
| State and Community Interventions<br>Engage communities, partners, and coalitions, and community-based organizations to strengthen capacity, and to coordinate and collaborate across programs, agencies, and stakeholder groups<br>Inform and educate leaders, decision makers and the public<br>Implement evidence-based, culturally | Increased public-private partnerships addressing tobacco control, tobacco-related disparities, and health equity<br>Increased public and decision-maker awareness and knowledge of the dangers of tobacco use, effective tobacco control interventions, and social norm change | **Decreased exposure to tobacco marketing and access to tobacco products****<br>Decreased youth susceptibility to experimentation with tobacco products, including e-cigarettes and other emerging tobacco products<br>**Increased implementation of tobacco control** | **Decreased initiation of tobacco use among youth and young adults**<br>**Decreased exposure to SHS**<br>**Decreased tobacco use and dependence among adults and youth**<br>**Decreased tobacco-** |

| | | | |
|---|---|---|---|
| appropriate state/ community interventions to prevent tobacco use, reduce SHS exposure, promote quitting, and reduce tobacco related disparities<br><br>Mass-Reach Health Communications Interventions<br><br>Plan, implement, and evaluate communications interventions, and support media engagement efforts<br><br>Expand, leverage, and localize CDC media campaigns and resources<br><br>Tobacco Use and Dependence Treatment Interventions<br><br>Promote health systems change, including referrals to state quitlines<br><br>Educate private and public insurers and employers on the benefits of barrier-free coverage and treatments<br><br>Promote use of covered tobacco use dependence treatments to increase use | Increased evidence-based strategies and activities to decrease access to tobacco products, reduce exposure to SHS, promote quitting, and reduce tobacco-related disparities<br><br>**Increased health communication interventions and messages to reach the general population and populations experiencing tobacco-related disparities****<br><br>**Increased health care system changes to promote and support tobacco use and dependence treatment****<br><br>**Increased access to and awareness of barrier-free coverage of evidence-based tobacco use and dependence treatments****<br><br>Increased capacity to collect, analyze, and disseminate data related to tobacco-related disparities and health equity | **policies, including comprehensive smokefree policies***<br><br>Increased price of tobacco products<br><br>Increased use of evidence-based quit support services<br><br>Increased quit attempts and attempts using evidence-based tobacco use and dependence treatment services<br><br>Increased successful cessation among people who use tobacco<br><br>**Increased implementation and reach of evidence-based, culturally appropriate strategies and activities to reduce tobacco-related disparities***<br><br>Increased development of innovative and/or promising practices that contribute to the tobacco control evidence-base | **related disparities** |

| | | | |
|---|---|---|---|
| Surveillance and Evaluation<br>Maintain and enhance systems to collect, evaluate, analyze, and disseminate state and community-specific data<br>Use surveillance and evaluation data to inform public health action, and evaluate progress in reducing tobacco use and tobacco-related disparities<br>_____<br>Infrastructure, Administration and Management<br>Develop and maintain an infrastructure aligned with the five core components of the Component Model of Infrastructure<br>Award and monitor sub recipient contracts and grants, and provide training and technical assistance<br>Develop and maintain a fiscal management system | Increased or maintained infrastructure and capacity to support a state-based tobacco control program | | |

| Component 2: Commercial Tobacco Use and Dependence Treatment Support System | | | |
|---|---|---|---|
| **Evidence-Based Strategies and Activities** | **Short-Term Outcomes** | **Intermediate Outcomes** | **Long-Term Outcomes** |
| Improve quitline infrastructure to streamline intake, enhance services, absorb increases in demand, and accept e-referrals<br>———<br>Enhance quitline sustainability by increasing partnerships to diversify funding and working with private/public insurers and employers to provide or reimburse the cost of barrier-free quit support services<br>———<br>Expand implementation and reach of evidence-based tobacco use dependence treatment services, including quitline services<br>———<br>Conduct assessments of tobacco use and dependence disparities and develop an action plan to address identified disparities; transfer calls to culturally appropriate quitlines (Asian Smokers' Quitline, 1-855-DEJELO-YA, 1-855-QUIT-VET) | **Optimized quitline intake****<br><br>Increased public and private partnerships to ensure availability of high quality quit support services, including the quitline<br><br>Increased quitline funding from diverse sources for tobacco use and dependence treatment resources<br><br>Increased availability of culturally appropriate evidence-based quit support services, such as the quitline and the use of digital-based technologies, such as texting, apps, web, and chat<br><br>**Increased awareness of quit support services among people who use tobacco ****<br><br>Increased quitline referrals from health systems that serve populations experiencing tobacco | **Increased number of insurers and employers that provide or reimburse for tobacco use and dependence treatment services, including the quitline****<br><br>**Increase use and reach of evidence-based quit support services, including the quitline, and use of digital technologies, such as texting, apps, and chat.***<br><br>Increased quit attempts and attempts using evidence-based tobacco use and dependence treatment services<br><br>Increased successful cessation among people who use tobacco<br><br>**Decreased disparities in the use of quit support services/treatments among populations experiencing tobacco-related disparities*** | **Decreased tobacco use and dependence among adults and youth**<br><br>**Decreased disparities in tobacco cessation and tobacco use and dependence** |

| | | | |
|---|---|---|---|
| Conduct strategic efforts to increase awareness of quit support services to providers, tobacco users, and populations experiencing tobacco-related disparities (e.g., Medicaid) using culturally-appropriate protocols, channels, and messages to increase quitlines use and referrals<br><br>Evaluate quit support services and monitor the reach of services delivered, including digital-based technologies, and submit data to the National Quitline Data Warehouse | use and dependence disparities (i.e., Medicaid)<br><br>Increased intention to quit | | |

*The recipient is required to report on all Tier 1 performance outcomes.

** For Tier 2 performance outcomes, the recipient will report only on the performance outcomes for strategies and activities implemented by the recipient that are intended to achieve the related outcome.

**i. Purpose**

Recipients will be funded to implement evidence-based PSE strategies and activities to 1) Prevent initiation of tobacco use (including emerging products and e-cigarettes) among youth and young adults; 2) Promote quitting among adults and youth; 3) Eliminate exposure to SHS; and 4) Identify and eliminate tobacco-related disparities among population groups.

**ii. Outcomes**

Recipients are expected to implement activities that will impact relevant short-term, intermediate, and long-term outcomes within five years or earlier. The specific short-, intermediate-, and long-term outcomes should be tailored to the work plan priorities and strategies. Data for long-term outcomes are measured by CDC.

**Component 1: National Tobacco Control Program (State Based)**

**Short Term**

- Increased health communication interventions and messages to reach the general population and populations experiencing tobacco-related disparities**
- Increased health care system changes to promote and support tobacco use and dependence treatment services**
- Increased access to and awareness of barrier-free coverage of evidence-based tobacco use and dependence treatment**

**Intermediate**

- Decreased exposure to tobacco marketing and access to tobacco products, including e-cigarettes and other emerging tobacco products**
- Increased implementation of tobacco control policies, including comprehensive smokefree policies*
- Increased implementation and reach of evidence-based, culturally appropriate strategies and activities to reduce tobacco-related disparities*

**Long Term**

- Decreased initiation of tobacco use among youth and young adults
- Decreased exposure to secondhand smoke
- Decreased tobacco use and dependence among adults and youth
- Decreased tobacco-related disparities

**Component 2: Commercial Tobacco Use and Dependence Treatment Support System**

**Short Term**

- Optimized quitline intake**
- Increased awareness and use of quit support services among people who use tobacco**

**Intermediate**

- Increased number of insurers and employers that provide or reimburse for evidence-based tobacco use and dependence treatment services, including quitline services**
- Increased use and reach of evidence-based quit support services, including the quitline, and use of digital technologies, such as texting, apps, and chat*
- Decreased disparities in the use of quit support services/treatments, including the quitline, among populations experiencing tobacco-related disparities*

**Long Term**

- Decreased tobacco use and dependence prevalence and consumption
- Decreased disparities in tobacco cessation and tobacco use and dependence

*The recipient is required to report on all Tier 1 performance outcomes.

** For Tier 2 performance outcomes, the recipient will report only on the performance outcomes for strategies and activities implemented by the recipient that are intended to achieve the related outcome.

**iii. Strategies and Activities**

Evidence-based, state tobacco control programs that are comprehensive, sustained, and accountable have been shown to reduce smoking prevalence as well as tobacco-related diseases and deaths. According to CDC's *Best Practice - 2014*, a comprehensive statewide tobacco control program is a coordinated effort that includes:

- Eliminating exposure to secondhand smoke.
- Promoting cessation and assist tobacco users to quit.
- Preventing initiation of tobacco use.

CDC funding is designed to support and leverage statewide tobacco control funding for evidence-based strategies and activities. CDC recognizes the funding in this NOFO is not adequate for a fully comprehensive tobacco control program to meet CDC's Best Practices - 2014 . Therefore, recipients should plan strategically to prioritize strategies and activities based on the total funding available for tobacco control. For Component 1, recipients are required to implement activities across all five components of a comprehensive tobacco control program as outlined in Best Practices - 2014, but have flexibility in prioritizing evidence-based strategies and activities based on available funding. CDC expects recipients to focus on the State and Community Interventions component in Component 1 and implement policy, systems, and environmental (PSE) strategies and activities that provide an opportunity for all people to live a healthy, tobacco-free life. Applications are expected to ensure that the selected evidence-based strategies and activities are equitable in order to eliminate tobacco-related disparities.

**Component 1: National Tobacco Control Program (State Based)**

**State and Community Interventions:** Recipients will select evidence-based strategies and activities that support a comprehensive statewide tobacco control program that coordinates community-level interventions.

- Establish a statewide program that supports and/or facilitates tobacco prevention and control partnerships and coalition development, as well as links to other related partnerships and coalitions (e.g., cancer control, cardiovascular disease, diabetes, asthma, oral health).
- Establish a strategic plan for comprehensive tobacco control with appropriate partners at the state and community levels.
- Collaborate with state and community coalitions for program planning and identification of populations most affected by tobacco use and dependence and secondhand smoke exposure.
- Collaborate with partners to implement and evaluate culturally-appropriate, evidence-based strategies and activities to reduce tobacco-related disparities in the state and communities.
- Identify benchmarks for closing gaps for disparate populations and improving health equity.
- Collaborate with CDC's funded national networks, Networking2Save, to enhance training and implementation of evidence-based strategies among specific populations affected by tobacco-related disparities.
- Educate state leaders, decision makers, and the public about the burden of tobacco use and dependence and evidence-based strategies to equitably reduce this burden.
- Engage stakeholders and partners on approaches, such as message development and messengers, to reach populations most impacted by tobacco use and dependence and secondhand smoke exposure.
- Collect, disseminate, and analyze state and community-specific data.
- Sponsor community, regional, and statewide trainings, conferences, and technical assistance on best practices for effective tobacco use and dependence prevention and treatment programs.
- Monitor and share tobacco marketing information to inform discussion among partners, decision makers, and other stakeholders at the state and community level.
- Support new ways of implementing evidence-based PSE strategies and activities that address unique characteristics of the communities.
- Provide support to community-based organizations to strengthen the capacity of these groups to positively influence social norms regarding tobacco use and dependence.
- Build relationships among multiple sectors of the community, such as housing, education, business, and planning.
- Empower community agencies to build coalitions and partnerships that facilitate sociodemographic and multi-disciplinary diversity among local governments, voluntary and civic organizations, and community-based organizations.
- Collaborate with partners and other programs to implement evidence-based strategies and activities; build and sustain capacity through technical assistance and training.
- Support community strategies and activities to educate the public and media, not only about the health effects of tobacco use and dependence and exposure to secondhand

smoke, but also about available quit support services.

- Promote public discussion among partners, decision makers, and other stakeholders about tobacco-related health issues and pro-tobacco influences.
- Establish community strategic plans of action that are consistent with developed comprehensive state tobacco control plans.
- Ensure that funded local lead agency measures and evaluates social norm change outcomes (e.g., policy implementation, increased compliance) resulting from their strategies and activities.
- Ensure that funded partners from various entities work together collaboratively.
- Collaborate with behavioral health systems to create tobacco-free campuses, increase tobacco use and dependence screening, and provide tobacco use and dependence treatment assistance to clients.
- Engage and educate parents, teachers, administrators, professionals and others who influence youth and young adults about the rapidly evolving tobacco product landscape, the harms of tobacco use and dependence, and the benefits of prevention interventions.
- Collaborate with partners to develop a coordinated response to the rapidly increasing use and dependence of emerging tobacco products by youth and young adults.

The recipient **must** address the **three** (3) population-specific requirements outlined below. **In the work plan, the recipient is required to include objectives, strategies, and activities for each population-specific requirement.**

**1. Statewide Disparities Requirement**

**Required:** Recipients will develop strategies and activities to address populations with behavioral health conditions or low socioeconomic status (SES).

Approximately 1 in 4 (or 25%) of United States adults have some form of behavioral health condition, and these adults consume almost 40% of all cigarettes smoked by adults. To encourage tobacco use cessation among individuals with behavioral health conditions, recipients should work with the behavioral health systems, providers, hospitals, outpatient facilities, residential facilities, and recovery residences, to create tobacco-free campuses, increase tobacco use and dependence screening, and provide tobacco use and dependence treatment assistance to clients. According to *Morbidity and Mortality Weekly Report,* Tobacco Cessation Interventions and Smoke-Free Policies in Mental Health and Substance Abuse Treatment Facilities ;- United States, 2016 (MMWR 2018), full integration of tobacco use and dependence treatment interventions, coupled with implementation of tobacco-free campus policies in behavioral health treatment settings, could decrease tobacco use and dependence and tobacco-related disease and improve health outcomes among individuals with behavioral health conditions.

**Recipients are required to work with behavioral health systems unless the state's data meets or exceeds the following national average as reported in the MMWR 2018**

**National Average**

| | **Mental Health Facilities** | **Substance Use Facilities** |
|---|---|---|
| **Percent** | 49% | 64% |

| | | |
|---|---|---|
| **screening for tobacco use** | | |
| **Percent of smokefree campuses** | 49% | 35% |

**If a state's mental health and substance use facilities meets or exceeds the national average above,** then the recipient can choose to continue working with the behavioral health population or work with the low SES population and the state Medicaid program to decrease tobacco use and dependence and exposure to secondhand smoke.**

Proxy measures for low SES include: level of educational attainment, employment status, and United States federal poverty level. Individuals experiencing low SES have a much higher prevalence of cigarette smoking and other tobacco products use and are less likely to successfully quit and more likely not to have access to affordable cessation support. Recipients who choose to work with the low SES population should consider the following:

- Improve understanding of comprehensive tobacco use and dependence treatment coverage with Medicaid recipients and health care providers.
- Promote health systems changes in Federally Qualified Health Centers and other state-funded and non-profit health centers.
- Collaborate with low-income multi-unit housing to implement smokefree policies and promote quit support resources.
- Work with social service agencies to increase access to quit support services.

**NOTE: The following states meet or exceed the national average: Alaska, Connecticut, Indiana, Maine, New Hampshire, New York, Oklahoma, Oregon, Utah, and Wyoming.

**2. Community-Based Disparities Requirement**

Community-based PSE strategies and activities use a community-led approach to address populations that are disparately affected by tobacco use and dependence and secondhand smoke (SHS) exposure in a specific community within the state. A community within the state could be defined as a city, county, parish, or jurisdiction/sub-jurisdiction. The recipient is required to work with a selected population within a community.

*Best Practices - 2014* recommends that funds be awarded directly to local lead agencies (e.g., community-based organizations, local health departments, federally-recognized American Indian Tribe/Alaska Native Villages) that serve specific populations, in order to implement evidence-based programs and activities targeted to that population. All recipients must direct funds from their Component 1 award or state dollars to fund one local lead agency to implement tobacco control strategies and activities in a community. The local lead agency must have a demonstrated track record of successfully working with the selected population affected by tobacco-related disparities and demonstrate impact/improvement in at least one social determinants of health. Examples include the following:

- Access to health care services.
- Access to social support services.

- Safe housing.
- Access to healthy food options.
- Access to transportation.
- Job opportunities.
- Active living opportunities.
- Public safety.

The applicant is required to use data to select one of the following populations that is disparately affected by tobacco use and dependence and SHS exposure.

- African Americans.
- American Indians/Alaska Natives.
- Asian Americans, Native Hawaiians, or Pacific Islanders.
- Geographic regions.
- Hispanic/Latinos.
- Lesbian, Gay, Bisexual, Transgender, and Queer.
- Individuals with low socioeconomic status.
- Individuals with behavioral health conditions.
- Individuals living with a disability.
- Individuals with military/veteran status.

The applicant is required to complete the following:

- Identify the population that is disparately affected by tobacco use and dependence and SHS exposure and provide the following:
    - Provide justification for selecting the population group for targeted evidence-based programs and activities.
    - Adult smoking prevalence for the selected population group.
- Include in the application a draft request for proposal (RFP) or cooperative agreement to fund at least one local lead agency to implement tobacco control strategies and activities.
- Discuss how the recipient will recruit and select individuals that understand the unique cultural differences of the selected population for an advising group within the first three months to assist with selecting the community.

In the Year 1 work plan, the applicant will develop strategies and activities to address activities listed in the Required Activities table below.

**Required Activities**

| Year | Activities |
|---|---|
| Year 1 | During the first three (3) months of the award, the recipient will recruit and select individuals that understand the unique cultural differences of the selected population to assist with selecting the community. The recipient should budget for one staff member to implement Year 1 activities.<br><br>**Recipient** and **two individuals that understand the unique cultural differences of the selected population** will attend one training. |

- Budget for three staff and two individuals that understand the unique cultural differences of the selected population to travel to Atlanta for training.

During the first six (6) months of the award, the recipient will complete the following activities:

- Select the community.
- Award a local lead agency with a cooperative agreement or grant.
- Recruit community stakeholders.
- Develop a memorandum of understanding (MOU) or memorandum of agreement (MOA) to be signed by the coalition.

During Year 1, the recipient will collaborate with the local lead agency to develop and implement culturally appropriate policy, systems, and environmental (PSE) strategies and activities and will complete the following:

- Develop a coalition or engage a current coalition. The coalition must include representatives from the following groups:
    - Community stakeholders.
    - Community leaders.
    - Local public health.
    - Multi-disciplinary and diverse community partners - e.g., health care systems, housing, businesses, faith-based organizations, and education.

- Provide results from a community health needs assessment that provides specific information about the community and selected population. The needs assessment should have been completed within the last five (5) years and should include demographic characteristics, health status, community profile, existing tobacco control policies, and available health care systems. Data sources used to define and describe the selected population must be cited. Examples of data sources include:
    - County Health Rankings https://www.countyhealthrankings.org/.
    - City Health Dashboard https://www.cityhealthdashboard.com/.
    - Census https://www.census.gov/.
    - Census Factfinder https://factfinder.census.gov/faces/nav/jsf/pages/index.xhtml#.
    - Community Commons https://www.communitycommons.org/.

- Collaborate with the local lead agency, coalition, and community stakeholders to develop the following:
    - A five-year strategic plan.
    - Detailed work plans and culturally appropriate policy, systems, and environmental (PSE) strategies and activities which seek to

| | |
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| | improve health equity.<br><br>• Establish a baseline for the selected population.<br>• Collaborate with CDC to determine the minimum number of people within the selected population that will be reached by the PSE strategies and activities.<br>• Obtain one (1) letter of support from the local lead agency that includes a description of their role in support of the proposed project and submit to CDC.<br><br>In collaboration with the local lead agency, coalition, and community stakeholders, the recipient will complete the following activities:<br><br>• Build new relationships and strengthen current relationships.<br>• Engage the community leaders, stakeholders, organizations.<br>• Provide training opportunities.<br>• Conduct data collection.<br>• Conduct a joint readiness assessment.* |
| Years 2 - 4 | The recipient and local lead agency will complete the following activities:<br><br>• Establish objectives.<br>• Implement strategies and activities and adjust action plans as appropriate.<br>• Conduct an additional readiness assessment to identify barriers to success. |
| Year 5 | The recipient and local lead agency will complete the following activities:<br><br>• Conduct data collection.<br>• Evaluate and develop a best practices document/publication based on lessons learned. |

*CDC will provide technical assistance for conducting a readiness assessment.

### 3. Statewide Prevention of Initiation to Emerging Tobacco Products, Including E-cigarettes, for Youth and Young Adults Requirement

Recipients are expected to support and implement programs and policies and collaborate with organizations, health care systems, and networks that encourage and support youth and young adults to make behavior choices consistent with tobacco-free norms. CDC expects recipients to focus on the State and Community Interventions component and implement PSE strategies and activities that provide the opportunity for all people to live a healthy, tobacco-free life. Recipients are expected to ensure that the selected evidence-based strategies and activities are equitable in order to eliminate tobacco-related disparities.

**Required Activities**

| Comprehensive Tobacco Control Program | Activities |
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| Components | |
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| **State and Community Interventions** | The available funding level is appropriate for statewide interventions that include the strategies/activities listed below. Even though community-based work is important in tobacco control and prevention, there is not sufficient funding to require funding to the local communities.<br><br>The recipients is required to complete the following statewide activities:<br><br>• Implement the minimum age of purchase of any tobacco products, including e-cigarettes, to 21 years old.<br>• Educate stakeholders and decision makers on evidence-based, population-level strategies to reduce emerging tobacco products use, including e-cigarettes, among youth and young adults, for example:<br>  ○ Add e-cigarettes to smokefree indoor air policies in school/college/university policies as well as community and state policies.<br>  ○ Restrict access to emerging tobacco products in retail settings.<br>  ○ License tobacco retailers.<br>  ○ Add e-cigarettes to tobacco product price policies.<br>  ○ Develop state and community-based educational initiatives targeting youth and young adults.<br>  ○ Decrease exposure to marketing that appeals to youth and young adults.<br>  ○ Reduce access to menthol and other flavored tobacco products.<br>  ○ Decrease access to online sales of e-cigarettes and emerging tobacco products.<br>• Engage parents, teachers, education professionals, coaches, and other stakeholders who influence youth and young adults about the rapidly evolving tobacco product landscape, the harms of use, and the benefits of prevention interventions.<br>• Partner with community-based programs or organizations to:<br>  ○ Conduct education outreach to prevent initiation of e-cigarettes and other emerging products among youth and young adults, for example:<br>  ▪ Community-based youth organizations.<br>  ▪ Youth sports organizations.<br>  ▪ School clubs and organizations.<br>  ▪ Youth military organizations (e.g., |

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| | ROTC).<br>▪ Organizations that reach at-risk youth and young adults particularly in low SES populations.<br>• Engage youth to educate other youth and communities on the dangers of tobacco use and dependence, including e-cigarettes.<br>• Recruit and engage partners to reach at-risk youth and young adults impacted by tobacco-related disparities in communities, schools, worksites, and colleges and universities.<br>• Conduct surveillance activities that focus on emerging tobacco products among youth and young adults.<br>• Engage pediatricians, OB/GYNs, school nurses, social workers, and other health care providers in strengthening their own health care systems through the integration of child and family centered tobacco control initiatives to address the initiation of emerging tobacco products, including e-cigarettes.<br>• Collaborate with pediatricians and other health professionals to create culturally safe medical practices including integrating child and family communication strategies and evidence-based screening tools for tobacco use and dependence among child and family.<br>• Collaborate with school nurses to screen for tobacco use and dependence when interacting with students and provide age-appropriate educational information.<br>• Collaborate with dentists, dental hygienists, and orthodontists to screen for tobacco use and dependence, including e-cigarettes, and educate when interacting with youth and young adults.<br>• Collaborate with behavioral health professionals to screen for tobacco use and dependence, including e-cigarettes, and educate when interacting with youth and young adults. |
| **Mass-Reach Health Communication Interventions** | An effective statewide, mass-reach health communication intervention delivers strategic, culturally appropriate, and high-impact messages through sustained and adequately funded education campaigns that are integrated into the state's comprehensive tobacco control program. For an effective paid education campaign, adequate funding is needed to ensure that advertisements reach 75% to 85% of the target audience each quarter of the year, with a minimum average per quarter of 1,200 gross rating points (GRPs) during the introduction of a campaign and a minimum average of 800 GRPs per quarter thereafter. To |

effectively develop and implement paid media, earned media, social media, please review *Best Practices User Guide: Health Communications* at https://www.cdc.gov/tobacco/stateandcommunity/bp-health-communications/index.htm.

The funding level is not sufficient to fully fund a comprehensive youth and young adult media intervention. Therefore, recipients should focus on earned media efforts to reach youth and young adult stakeholders, expand upon and/or complement existing paid media efforts at the national level focusing on emerging tobacco products, including e-cigarettes, and should consider existing creative materials to reduce paid media cost. Examples include:

- Earned media includes news stories, letters to the editor, editorials, media interviews, and public service announcement (PSA) distribution and outreach to encourage broadcast/publication.
- Social media includes YouTube, Instagram, Facebook, and Twitter. Examples include:
  - CDC's Media Campaign Resource Center.
  - Truth Initiative social media posts, gifs and still images.
- Paid media includes ads on television, radio, in print, posters, and digital advertising. Examples include:
  - Truth Initiative ads:
    - "Sweet Clouds"
    - "Burn Through"
    - "Making Menthol Black"
    - "Power in Numbers"
  - CDC's Media Campaign Resource Center.

Recipients should leverage existing educational resources and effective messages, in lieu of a new education media campaign, to reach youth and young adults directly or indirectly. Existing evidence-based resources and messaging include:

- CDC Office on Smoking and Health (CDC/OSH) E-Cigarettes Resources:
  - Facts, fact sheets, and youth specific information at https://www.cdc.gov/tobacco/basic_information/e-cigarettes/about-e-cigarettes.html.
  - Know the Risks: A Youth Guide to E-cigarettes Presentation.
  - E-Cigarettes and Youth Toolkit for Partners: How You can Help End the Epidemic.
  - Youth communication materials:

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| | ▪ One Brain radio PSA.<br>▪ *It's Not Like You Can Buy A New Brain* (Vending Machine) print ad.<br>▪ Protecting Young People from E-cigarettes digital and social media images.<br>• FDA e-cigarette prevention posters, available for download at FDA Exchange Lab.<br>• Office of the Surgeon General youth materials:<br>  ○ *It's a Fact* radio PSA.<br>  ○ Any Volunteers' video PSA.<br>  ○ *E-Cigarettes Risky for Youth* digital and social media images.<br>  ○ E-Cigarettes, Nicotine, and Brain Development social media image. |
| **Tobacco Use and Dependence Treatment Interventions** | The funding level is not sufficient to fully fund a comprehensive youth and young adult tobacco use and dependence treatment intervention. Therefore, recipients should focus on the following:<br><br>• Identify and develop cessation strategies that are appropriate for youth and young adults. |
| **Surveillance and Evaluation** | The level of available funding is not sufficient for a fully comprehensive evaluation or surveillance activities, including measuring local youth behavior. The following activities are required for the current level of funding available:<br><br>• Conduct state youth tobacco survey or state youth risk behavior survey.<br>• Conduct surveillance activities that focus on emerging tobacco products among youth and young adults, including those that are at greatest risk for tobacco-related disparities based on sociodemographic factors and social determinants of health.<br>• Develop and implement a plan for sharing data with community members, stakeholders, and decision makers.<br>• Monitor changes in the tobacco product use and market environment, including emerging products and e-cigarettes.<br>• Communicate evaluation findings and lessons learned using data visualization to stakeholders.<br>• Submit a minimum of one impact statement during each project year. |
| **Infrastructure,** | The recipient is required to staff a full-time person to manage the |

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| **Administration, and Management** | youth and young adult activities. Additionally, the recipient must ensure a program evaluator is available. The recipient should complete the following:<br><br>• Leverage existing, expand, and establish new partnerships with the state education system, health care organizations, military bases, and other youth organizations to prevent initiation of e-cigarettes and other emerging products among youth and young adults.<br>• Demonstrate staff capacity and expertise to manage and implement proposed youth and young adult activities to prevent initiation of emerging tobacco products. |

**Mass-Reach Health Communication Interventions:** Mass-reach health communication refers to the various means by which public health information reaches large numbers of people. Recipients will select evidence-based strategies and activities that are strategic, culturally appropriate, and contain high-impact messages.

- Deliver evidence-based, strategic, culturally-appropriate, high-impact messages through sustained and adequately funded health communication campaigns and countermarketing strategies.
- Use hard-hitting messaging that elicits negative emotions to raise awareness; educate the public and decision makers; promote tobacco use and dependence treatment services; increase prevention; increase protection from secondhand smoke; and address the impact of tobacco use and dependence on others.
- Use a broad range of strategies such as paid media, social media, earned media, and program communications to effectively reach target audiences with paid television, radio, billboard, print, websites, digital, and social media (e.g. Facebook and Twitter) as appropriate.
- Ensure countermarketing and other media campaigns have sufficient reach, frequency, and duration.
- Conduct formative, process, and outcome evaluation of health communications interventions, including with population groups experiencing tobacco-related disparities.
- Support and leverage CDC's national tobacco education campaigns and *Surgeon General Reports* about tobacco use and dependence at the state and community level.
- Review and consider effective CDC-licensed advertisements and campaigns located in the CDC's Media Campaign Resource Center (MCRC) previously created by other states and partners.
- Develop a health communications plan consistent with CDC's Best Practices User Guide: Health Communications.
- Identify benchmarks for closing gaps for population groups experiencing tobacco-related disparities and improving health equity.

**Tobacco Use and Dependence Treatment Interventions:** Health system changes that integrate

treatment for tobacco use and dependence into routine clinical care, barrier-free cessation insurance coverage, and state quit support services, including the quitline play a key role in connecting people who use tobacco to proven cessation treatments. Recipients will select evidence-based strategies and activities that support promoting health systems change, expanding insurance coverage and utilization of proven tobacco use and dependence treatments, and supporting statewide evidence-based quit support services, including use of the quitline and digital-based technologies, such as texting, apps, web, and chat.

- Sustain or improve existing evidence-based state quit services, including the quitline that increase quit attempts and successful cessation among adults and young people.
- Educate private and public insurers and employers about the benefits of barrier-free coverage of evidence-based tobacco use and dependence treatments.
- Collaborate with health care systems, including medical and dental providers, to integrate tobacco use and dependence treatment into their workflows and leverage referral to the quitlines through electronic health records.
- Provide technical assistance to health care systems to help implement system changes that 1) prompt providers to identify patients who use tobacco products; 2) provide these patients with brief advice and assistance; and 3) refer them to the state quitline or community-based quit support services.
- Expand efforts to promote the use of the quit support services, including the quitline and expand its reach, including among populations most affected by tobacco use and dependence and secondhand smoke exposure.
- Inform and educate private and public health systems, including medical and dental providers; health insurers; and employers about how quitting tobacco use reduces tobacco-related disease and death, and health care costs.
- Address and/or reduce barriers in order to provide seamless language services and promotion of existing culturally and linguistically appropriate federal resources such as the Spanish Quitline Portal 1-855-DEJELO-YA (1-855-335-3569), the National Asian Language Tobacco Use and Dependence Treatment Support System, and 1-855-QUIT-VET.
- Increase collaborations with health systems and medical and dental providers.
- Maintain participation with CDC-funded North American Quitline Consortium to stay up-to-date on evidence-based quitline services.
- Collect the Minimum Data Set, as defined by the North American Quitline Consortium.
- Participate in the CDC, OSH, National Quitline Data Warehouse (NQDW) (i.e., quarterly reporting of intake data on quitline callers and information on services provided through the NQDW Online Services Survey.
- Participate in continuing education activities related to quitline operations and evaluation.
- Evaluate the state quitline.
- Identify benchmarks for closing gaps for population groups experiencing tobacco-related disparities and improving health equity.

**Surveillance and Evaluation:** Recipients will select evidence-based strategies and activities that monitor and document key short-term, intermediate, and long-term outcomes within populations. Recipients must have access to surveillance systems, including Behavioral Risk Factor Surveillance System (BRFSS) and Adult or Youth Tobacco Surveys (YTS/YRBS). The

data can be used to inform program and policy direction, demonstrate program effectiveness, ensure accountability to those with fiscal oversight, and engage stakeholders.

Publicly financed programs need accountability, demonstrate effectiveness, and have access to timely data that can be used for program improvement and decision making. Therefore, a critical infrastructural component of any comprehensive tobacco control program is a surveillance and evaluation system that can monitor and document outcomes and provide direction for future activities. To accomplish this, *Best Practices - 2014* recommends that 10% of total annual tobacco control program funds be allocated for surveillance and evaluation.

- Direct a minimum of **10%** of funding to implement evaluation activities.
- Establish a surveillance and evaluation system to monitor and document key short-term, intermediate, and long-term outcomes within and across populations groups.
- Collect data on tobacco use and dependence behaviors and other key risk factors and health outcomes using surveillance systems, such as BRFSS, Youth Risk Behavior Surveillance System (YRBSS), Pregnancy Risk Assessment Monitoring System (PRAMS), and the Adult or Youth Tobacco Surveys (ATS/YTS).
- Work in partnership with universities, Prevention Research Centers (PRCs), and other research institutions as appropriate to tap into existing expertise in surveillance and evaluation.
- Develop and implement a written evaluation plan for the tobacco control program.
- Conduct evaluations designed to inform and engage diverse stakeholders, and members of the population groups affected by tobacco-related disparities, including planning, implementation, interpretation, dissemination, and use of results.
- Develop key questions to be answered by the evaluation of the program.
- Conduct evaluation activities consistent with CDC's Framework for Evaluation.
- Identify credible evidence and verify its accuracy and appropriateness with stakeholders.
- Use surveillance data to monitor programmatic state and community progress toward program objectives.
- Develop and submit a minimum of one impact statement during each project year.
- Communicate evaluation findings and lessons learned using data visualization to stakeholders.
- Identify benchmarks for closing gaps for population groups experiencing tobacco-related disparities and improving health equity.

**Infrastructure, Administration and Management:** Recipients must be capable to readily implement this program upon receipt of this award. To ensure that recipients are able to execute NOFO requirements and meet period of performance outcomes, recipients must demonstrate readiness, experience, and capacity in the following areas.

- **Networked Partnerships** are relationships between the statewide tobacco control program (TCP) and individual and organizational stakeholders. These partnerships occur at all levels, national, state, community, and are characterized by diversity and coordinated efforts toward common goals. Networked partnerships should extend the reach of the TCP, build program champions, and contribute to program sustainability.
    - The TCP should maintain active strategic partnerships and establish

communication systems at the state and community level to support the achievement of the four NTCP goals. Partnerships may include the following:

- Local health departments.
- State and community coalitions.
- Voluntary health organizations.
- American Indian Tribes/Alaska Native Villages.
- Urban Indian Organization and other tribal organizations.
- Organizational members of the Funders Alliance for state-based TCPs.
- Organizations serving populations most affected by tobacco use and dependence, exposure to SHS, and tobacco-related diseases.
- Heath care systems and providers (medical and dental).
- Educational institutions.
- Housing and education authorities.
- Private and business sector.
- Community-based organizations.
- Faith-based organizations.
- Third-party payers.
- Youth-focused organizations.

- **Multi-level Leadership** refers to individuals, not partnerships, who provide direction to the TCP and the processes by which program direction is provided. Leaders and leadership processes occur at multiple levels - above, below, within, and lateral to the program. Recipients should complete the following activities:
    - Identify and nurture leaders and champions who support the state's comprehensive tobacco control and prevention program at all levels, including within the state and local health departments, boards of health, partners and other chronic disease areas, community-based organizations, and decision makers.
    - Focus on developing the knowledge and skill level for all tobacco control staff.
    - Develop plans to train new program managers; finalize and implement within one month of the award.

- **Engaged Data** are data that are identified, collected, and/or analyzed in a way to promote program action. The recipient should use data visualization, as appropriate, and complete the following activities:
    - Collect, analyze, and use data in collaboration with multiple stakeholders for the purposes of program planning, implementing, and evaluating.
    - Use data to engage staff, leadership, partners, decision makers, and community programs to promote action.
    - Promote public health goals with data.
    - Share data and experiences to facilitate dissemination of activities and strategies.
    - Identify benchmarks for closing gaps for disparate populations and improving health equity.

- **Managed Resources** are funding and staff. Managed "funding" refers to leveraging funds from diverse sources and using those funds to meet the program's goals and objectives. Managed "staff" refers to recruiting diverse staff with the skills and knowledge to plan, implement, and evaluate the program's goals and objectives. This includes continuously

updating staff skills and knowledge to incorporate emerging research and address new challenges. The recipient should complete the following:

- Ensure that adequate number of diverse and qualified staff and partners are available to effectively implement the tobacco control program. To administer the tobacco control program, the applicant is required to have the following:
  - **One full-time program manager.**
  - **One full-time tobacco use and dependence treatment coordinator.**
  - **One full-time person to manage the youth and young adult activities.**
- Include a program evaluator or have access to evaluation staff to conduct required evaluation activities. In addition to the required staff, ideal staffing levels include a policy coordinator, communication specialist, surveillance staff, fiscal management systems staff, grants manager, and administrative staff.
- Implement a training and technical assistance process to address the needs of funded partners, local health departments, community organizations, and state and community coalitions.

- **Responsive Plans/Planning** occurs in collaboration with partners. Recipients will submit plans that are dynamic and evolve in response to contextual influences, such as changes in scientific evidence, priorities, funding levels, emerging products, and external support. Within six (6) months of the award, recipients will submit the following plans:
  - **Comprehensive State Tobacco Control and Sustainability Plan**: Recipients will submit a five-year comprehensive state tobacco control and sustainability plan that aligns with or builds upon two statewide plans: 1) chronic disease and health promotion and 2) behavioral health. This plan should span the proposed funding cycle and include active participation from a multi-disciplinary diversity group of stakeholders. It should include the overall goals, objectives, and evidence-based interventions and strategies for tobacco control. The plan should include how the state will maintain or increase funding for the comprehensive state tobacco control program and sustain program accomplishments.
  - **Health Communications Plan:** Recipients will submit a health communications plan to educate leaders, decision makers, and the public about the dangers of tobacco use and dependence, the dangers of exposure to SHS, youth and e-cigarette epidemic, and available quit support and resources.
  - **Evaluation Plan:** Applicants will submit draft evaluation questions for Component 1 and Component 2 within the application. Recipients will submit a five-year evaluation plan that builds upon the prior tobacco-related evaluation efforts and lessons learned. The evaluation plan should align with CDC national evaluation's efforts and state department of health's priorities based on guidance provided by CDC.

**Component 2: Commercial Tobacco Use and Dependence Treatment Support System**

The State Tobacco Use and Dependence Treatment Support System strategies are based on 1) CDC's *Best Practices for Comprehensive Tobacco Control Programs 2014*; 2) The Guide to Community Preventive Services; 3) the 2008 Public Health Service Clinical Practice Guideline on *Treating Tobacco Use and Dependence*; 4) the 2019 Surgeon General's Report on smoking cessation; and 5) the 2015 U.S. Preventive Services Task Force recommendation on tobacco use

and dependence cessation interventions for adults. CDC's strategy includes a population-based approach designed to produce durable changes in environments, health systems, and social norms that motivate people who use tobacco products to quit and make it easier for them to succeed in quitting. State and territorial quitlines are an important aspect of state cessation services and are available in all 50 states, the District of Columbia, Puerto Rico, and Guam. People anywhere in the United States can call their state quitline by dialing 1-800-QUIT-NOW.

For this NOFO, recipients ***must*** address all of the following required activities:

**Improve Quitine Infrastructure to Streamline Intake, Enhance Services, Absorb Increases in Demand, and accept E-referrals:** Recipients will ensure that adequate infrastructure exists to meet increased quitline demand, including demand generated by national media campaigns, such as CDC's *Tips From Former Smokers®*. The infrastructure should be adequate to ensure that all callers to the quitline during national media campaigns are offered, at a minimum, at least one coaching call, either immediately upon calling or by being re-contacted within 24 hours. Adequate infrastructure includes the following.

- Sufficient diverse staff to support state quitline and tobacco use and dependence quit support strategies and activities.
- Ongoing training to ensure counselors are culturally competent to meet the needs of diverse populations.
- Partnerships and established communication systems that support state quitlines and quit support strategies and activities.
- Use of data, including data visualization, for the purposes of tobacco cessation treatment program planning, implementation, and evaluation to ensure that objectives are achieved.
- Managed resources, including adequate diverse staff and partners, communication, and administrative support to execute the work plan and the cooperative agreement.
- Enhance intake and triage processes.
- Development and/or maintenance of quitline capacity to accept e-referrals.To address the anticipated increase in calls resulting from national media campaigns, recipients should ensure the following:
    - Each call is answered live or by a caller-friendly Interactive Voice Response (IVR) system that provides information and access to automated or live services.
    - Eighty percent (80%) of calls during airing of federal campaigns are answered within 30 seconds.
    - Adequate hours of quitline service to respond to callers during periods when tobacco education media campaigns are on air.
    - Sufficient capacity to provide Spanish language quitline coaching and services to all Spanish-speaking callers.
    - Callers should be provided with quit tips and encouragement to assist with quit attempts. This includes addressing barriers to successful quitting, helping callers make a plan and set a quit date, and providing support around staying quit.
    - The quitline should be able to meet the demand generated by promotions incorporated in national tobacco educations, such as *Tips®* nicotine replacement therapy (NRT) promotions.
    - Callers should be referred to resources to assist them with quitting based on eligibility, including information on how to access medications through their

health insurance.

Emphasis should be placed on serving *all* callers rather than providing more intensive services to fewer callers. If necessary, recipients should collaborate with CDC to link callers to back-up federal counseling during CDC's national tobacco education campaign. Recipients are encouraged to leverage national tobacco education media campaigns to increase annual call volumes, rather than as a substitute for conducting their own cessation and quitline outreach and promotion activities.

**Enhance Quitline Sustainability by Increasing Partnerships to Diversify Funding and Working with Private/Public Insurers and Employers to Provide or Reimburse the Cost of Barrier-Free Quit Support Services:** To ensure sustainability, the recipient is required to complete the following.

- Develop and/or implement public-private partnerships or other strategies to sustain long-term quitline capacity and cessation support systems.
- Identify strategies to remove barriers to accessing evidence-based cessation treatments, including quitlines, for underserved populations, including the uninsured, the underinsured, Medicaid enrollees, persons with behavioral health conditions, and other populations with particularly high rates of tobacco use and dependence and with other tobacco-related disparities.
- Increase use of evidence-based quit support services, including the quitline, digital-based technologies, and use of cessation counseling and FDA-approved tobacco use and dependence treatment medications among Medicaid enrollees.

**Expand Implementation and Reach of Evidence-Based Tobacco Use Dependence Treatment Services, Including Quitline:** State quitlines on average reach only about 1% of adult who smoke annually. Digital-based technologies may be more appealing than quitlines to some populations, including young adults. To extend quitlines' reach and increase their impact, recipients are required to complete the following.

- Make available digital-based cessation services using platforms such as text messaging, web, chat, and apps.

**Conduct Assessments of Tobacco Use and Dependence Disparities and Develop an Action Plan to Address Identified Disparities; Transfer Calls to Culturally Appropriate Quitlines (Asian Smokers' Quitline, 1-855-DEJELO-YA, 1-855-QUIT-VET):** Recipients are required to:

- Identify populations experiencing tobacco-related disparities and underserved populations specific to quitline use and barriers to effective tobacco use and dependence treatment.
- Provide seamless access to and promote greater use of existing culturally and linguistically appropriate federal resources, such as the Spanish Quitline Portal 1-855-DÉJELO-YA (1-855-335-3569), the National Asian Language Quitline, and SmokefreeVET (1-855-QUIT-VET).

**Conduct Strategic Efforts to Increase Awareness of Quit Support Services to**

**Providers, People Who Use Tobacco Products, and Populations Experiencing Tobacco-Related Disparities (e.g., Medicaid) Using Culturally-Appropriate Protocols,Channels, and Messages to Increase Quitlines Use and Referrals:** Recipients are required to complete the following.

- Identify populations disproportionately impacted by tobacco use and dependence and tobacco-related disparities, including populations that are less likely to use the state quitline, to use other proven cessation treatments, and to succeed in quitting.
- Implement culturally appropriate, evidence-based policy, systems, and environmental strategies to reduce tobacco-related disparities and improve equity in access to tobacco cessation services, including supplementing national tobacco education campaigns like *Tips*® with additional placements in markets or among populations with high smoking prevalence.
- Include strategies to specifically address individuals that are disparately affected by tobacco use and dependence and SHS exposure, including the following populations:
    - African Americans.
    - American Indians/Alaska Natives.
    - Asian Americans, Native Hawaiians, or Pacific Islanders.
    - Geographic regions.
    - Hispanic/Latinos.
    - Lesbian, Gay, Bisexual, Transgender, and Queer.
    - Individuals with low socioeconomic status.
    - Individuals with behavioral health conditions.
    - Individuals living with a disability.
    - Individuals with military/veteran status.

**Evaluate Quit Support Services and Monitor Each of the Services Delivered, Including Digital-based Technologies, and Submit Data to the National Quitline Data Warehouse:** Recipients must have access to statewide quitline data. The data can be used to inform program and policy direction, demonstrate program effectiveness, ensure accountability to those with fiscal oversight, and engage stakeholders. Recipients are required to complete the following.

- Evaluate the reach and effectiveness of the digital-based technologies within and across populations groups experiencing tobacco-related disparities.
- Evaluate the impact of efforts to increase use of quit support services.
- Evaluate culturally appropriate, evidence-based strategies and activities to reduce tobacco-related disparities and improve health equity through quitlines and other quit support services.
- Monitor use of evidence-based quit support services, including the quitline, digital-based technologies, and use of cessation counseling and FDA-approved tobacco use and dependence treatment medications among Medicaid enrollees.
- Collect and provide data to the National Quitline Data Warehouse quarterly.
- Collect and analyze seven (7) month follow up state quitline data at least once during the cooperative agreement.

- Incorporate evaluation activities for quitline services into the statewide comprehensive tobacco control evaluation plan.
- Analyze state quitline data, including data for population groups, and share findings with relevant stakeholders.
- Submit a minimum of one impact statement during each project year.

**1. Collaborations**

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

**All Components**

**Requirement:** Recipients are required to collaborate with CDC-funded programs in the state department of health that work with populations affected by tobacco-related disparities. Applicants are required to submit two letters of support that address how they will collaborate with the CDC-funded programs. Applicants must name the file "Letters of Support", and upload them at www.grants.gov.

**Required Collaborations:** Collaborative activities under this funding opportunity should align with state tobacco control priorities as described in the comprehensive state tobacco control and sustainability plan, state chronic disease and health promotion plan, and state behavioral health plan, be consistent with CDC's *Best Practice - 2014* and the Guide to Community Preventive Services (The Community Guide), and support the four NTCP goal areas. To accomplish the work, recipients are required to collaborate with the following:

- CDC and CDC-funded programs in state health department chronic disease prevention and health promotion programs, including the following:
  - Arthritis.
  - Cancer Prevention and Control.
  - CDC's National Networks:Networking2Save.
  - Diabetes.
  - Good Health and Wellness in Indian Country.
  - Heart Disease and Stroke Prevention.
  - Nutrition, Physical Activity, and Obesity.
  - Oral Health.
  - REACH.
  - Reproductive Health.
  - School Health.
  - Tobacco Control Network.
- CDC-funded programs conducting tobacco control activities at the community level, including, yet not limited to Racial and Ethnic Approaches to Community Health (REACH) and Good Health and Wellness in Indian Country.
- CDC-funded surveillance programs [including Behavioral Risk Factor Surveillance System (BRFSS), Youth Risk Behavioral System (YRBS), and Youth Tobacco Survey (YTS)] responsible for collecting, analyzing, and disseminating risk factor and tobacco-related disease, death, and disability data.
- CDC-funded Tobacco Control Network (TCN) engagements and regional discussions.

**Encouraged Collaborations:** Recipients are strongly encouraged to collaborate with other CDC-funded programs/technical assistance providers in their state or communities, including the following:

- CDC's OSH Technical Assistance Providers.
- CDC's Disability and Health Programs.
- CDC's National Asthma Control Program.
- CDC's HIV Program.
- State Tuberculosis Control Offices.
- Maternal and Child Health.
- Environmental Health.
- Opioid Overdose Prevention.

Recipients with an Asian population of 100,000 or greater are strongly encouraged to partner with the Asian Smokers' Quitline (ASQ) and leverage resources to meet the needs of the state population calling ASQ.

**b. With organizations not funded by CDC:**

**All Components**

**Required Collaborations:** Recipients are required to have a sociodemographic and multi-disciplinary diverse statewide coalition comprised of members such as the following: state and community organizations, voluntary health organizations (e.g., American Cancer Society, American Lung Association, American Heart Association, Americans for Nonsmokers' Rights, Campaign for Tobacco Free Kids, Truth Initiative), Medicaid, behavioral health partners, tribes and organizations that represent tribes, educational institutions, multi-sector partners such as housing, business, and education, community-based organizations, community government entities, other state agencies, community coalitions, and boards, commissions, Funders Alliance for State-Based Tobacco Prevention and Control Programs within their state, and advisory groups who have a stake in tobacco control.

**Requirements**: Applicants are required to complete the following:

- Describe the statewide coalition.
- List the organizations that are involved in the statewide coalition. A sample table is located below. Applicants are not required to use the table, but are required to include all of the elements listed within the table.
- Submit one letter of support from an active coalition member on the represented organization's letterhead. Applicant must name the file "Coalition Member LOS" and upload it to www.grants.gov.

**Statewide Tobacco Control Coalition**

| Organization Category | Example(s) | List Organizations that are Members of the |
|---|---|---|

| | | Statewide Coalition |
|---|---|---|
| **State Health Department** | Cancer, HIV, Asthma, Heart Disease and Stroke, Oral Health | |
| **Voluntary Health Organizations** | American Cancer Society, American Heart Association, American Lung Association, American Dental Association | |
| **Higher Professional Education** | Schools of medicine, Public health, Nursing, Dentistry, Prevention Research Centers, Other colleges and universities | |
| **Health Care Providers** | Doctors, Dentists, Hospitals, and Their respective associations (e.g., state medical society, state dental society) | |
| **Behavioral Health Providers** | Doctors, Behavioral health facilities, Community workers, Social workers | |
| **Government Programs or Agencies** | State career services; Behavioral health agency; Woman, Infant, and Child (WIC) program | |
| **Education** | School Administrator, PTA, School Nurse Association, | |

| | | |
|---|---|---|
| | Department of Education, Department of Higher Education; School Wellness Councils | |
| **Worksite and Business** | Representatives of businesses, Business organizations (e.g., Chamber of Commerce) | |
| **Community** | Community organizations, Community coalitions; Local health departments, Community government; Head Start organizations | |
| **Legal System** | Law enforcement agencies, Prosecutors or district attorneys, Judges, or Magistrates | |
| **Faith-Based Organizations** | Churches, Faith-based associations, Synagogues, Temples, Mosques | |
| **Youth-Focused Organizations** | YMCA/YWCA, 4-H, Boys/Girls Clubs, Youth sport organizations; Youth tobacco prevention clubs/coalitions | |
| **Third-Party Payers** | Managed care, Insurance companies, Medicaid | |
| **Organizations working with populations affected by** | Networking2Save, Community centers, Community | |

| | | |
|---|---|---|
| **tobacco-related disparities** | organizations | |

**Component 2: Commercial Tobacco Use and Dependence Treatment Support System**

Recipients are required to collaborate with organizations that work with populations that are disparately affected by tobacco use and dependence and SHS exposure. Recipients are encouraged to expand partnerships with organizations external to CDC including Medicaid, state and community organizations, voluntary health organizations, education institutions, local health departments, organizations that represent diverse communities, Networking2Save National Network Consortium representing population groups experiencing tobacco-related disparities, tribes and tribal organizations, multi-disciplinary and diverse partners (e.g., housing, business, and education), community-based organizations, other state agencies, statewide and community coalitions, boards, commissions, and advisory groups who have stake in tobacco control.

**2. Target Populations**

Tobacco-related disparities are created and affected by a complex mix of factors. Social determinants of health, tobacco industry influence, a lack of comprehensive tobacco control policies, and a changing United States population can contribute to and maintain tobacco-related disparities. These disparities can affect populations on the basis of certain factors, including but not limited to the following:

- Age.
- Disabilities.
- Educational attainment.
- Housing status.
- Geographic location (e.g., rural/urban).
- Income.
- Behavioral health conditions.
- Employment status.
- Race / ethnicity.
- Sex.
- Sexual orientation and gender identity.
- Veteran and active military status.

Strategies and activities that directly involve the populations that are disproportionally impacted by tobacco use and dependence are critical in accelerating helping to alleviate the health and economic burden experienced by some populations.

**Component 1: National Tobacco Control Program (State Based)**

**Applicants are required to provide the following:**

- Summarize three (3) outcomes accomplished since 2015 with populations disproportionally impacted by tobacco use and dependence in the state.
- Identify specific populations to work with 1) throughout the state and 2) within a community to address tobacco-related disparities and improve health equity. The

applicant should provide background on the selected populations and the approach for working with the populations over the next five years. Applicants must provide objectives and activities in the work plan for the selected populations.

**a. Health Disparities**

Addressing social determinants of health and health equity in tobacco control and prevention is the opportunity for all people to live a healthy, tobacco-free life, regardless of their race or ethnicity, level of education, gender identity, sexual orientation, the job they have, the neighborhood they live in, or whether or not they live with a disability. With the goal of reducing overall tobacco use and dependence and secondhand smoke exposure, recipients will implement strategies that reduce tobacco-related disparities among people who use tobacco. Recipients are required to collaborate with local health department, communities, and organizations that have the potential to reach populations affected by tobacco-related disparities, including those that service populations experiencing low socioeconomic status (SES) and behavioral health conditions (including mental health conditions and substance use disorders). Additionally, the recipient should develop strategies - and collaborate with groups - that are inclusive of and reach individuals experiencing tobacco-related disparities( i.e., individuals with disabilities; lesbian, gay, bisexual, transgender, and queer (LGBTQ) persons; African Americans; American Indians/Alaska Natives; Asian Americans, Native Hawaiians, or Pacific Islanders; Hispanic/Latinos; and individuals with military/veteran status).

**iv. Funding Strategy**

**Component 1: National Tobacco Control Program (State Based)**

State governments or their bona fide agents (includes the District of Columbia) can apply for Component 1.

Using methodology derived from CDC's *Best Practices - 2014,* the funding formula is based on the following: [Base ($500,000 + Weighted State-By-State Calculations]. The weighted state-by-state calculations is made up of the following factors:

- Percent representing populations disproportionality impacted by tobacco use.
- Level of poverty.
- Number of adults (ages 18-64) who use cigarettes (2017 BRFSS smoking prevalence and 2010 Census population).
- State youth tobacco prevalence (2017 YRBS and 2017 Census population).
- Number of local health departments.
- Land Area
- Wage Rate

The funding strategy will also include the applicant’s proposed activities and goals, estimated population reach, and program capacity as described in the application.

The maximum estimated budget for Component 1 is $2,300,000. Year 1 budget period is 10 months; therefore, the ceiling is lower than the anticipated amount for subsequent 12-month budget periods.

**Component 2: Commercial Tobacco Use and Dependence Treatment Support System**

State governments or their bona fide agents (includes the District of Columbia) and 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 can apply for Component 2.

Funding is based on the number of adults (ages 18-64) who use cigarettes (2017 BRFSS smoking prevalence and 2010 Census population).

The maximum estimated budget for Component 2 is $1,500,000. Year 1 budget period is 10 months; therefore, the ceiling is lower than the anticipated amount for subsequent 12-month budget periods.

**b. Evaluation and Performance Measurement**

**i. CDC Evaluation and Performance Measurement Strategy**

CDC will use an evaluation approach that consists of the following:

- CDC-led national evaluation,
- Recipient-led evaluation, and
- Ongoing program monitoring and evaluation through the collection and reporting of performance measures.

For the national-level evaluation, CDC will lead the design, data collection, analysis, and reporting. Recipients will be asked to participate in national evaluation activities such as surveys, interviews, case studies, and other data collection efforts. CDC will provide guidance and support to recipients on participation to achieve national evaluation requirements. The recipient-led evaluation will answer questions that support the national-level evaluation and questions important to each individual state tobacco control program. For Component 1 and Component 2 of the evaluation, CDC and recipients will only collect data that will be analyzed and used. Both the CDC-led and the recipient-led evaluations will consist of process and outcomes questions that seek to answer the following overarching questions in the following areas below:

**Component 1: State-based and community-based disparities evaluation requirement:** The recipient will be required to evaluate their efforts to address the following evaluation questions for two of the following population groups: 1. State: Persons with behavioral health conditions or experiencing low SES (can include Medicaid) 2. Community-Based: selected population affected by tobacco-related disparities.

- Outcomes: To what extent did recipient efforts improve tobacco-related outcomes, such as increased protection and reduced exposure from secondhand smoke, increased use of evidence-based cessation treatment, increased quit attempts and sustained quits, and reduced tobacco use and dependence among the selected populations affected by tobacco-related disparities?
- Effectiveness: What evidence-based strategies, promising practices, and/or culturally tailored interventions were effective (and not effective) at reaching and improving positive tobacco-related outcomes among the selected populations affected by tobacco-

related disparities? What were lessons learned, promising practices, and unintended consequences?

**Component 1: Policy or Health Systems Change Impact Evaluation Requirement:** The recipient will be required to evaluate the impact of one policy or health systems change to address the following questions:

- Outcomes: What impact did the policy or systems change have on achieving tobacco-related outcomes for one of the following: 1) Decreasing access and tobacco use among youth, including e-cigarette use, 2) Increasing protection and reducing exposure to secondhand smoke, or 3) Promoting cessation, such as increasing use of evidence-based cessation treatment and increasing quit attempts and sustained quits?
- Intended and unintended consequences: What effect did the policy or health systems change have overall, and as appropriate among population experiencing tobacco-related disparities? To what extent were there unintended consequences (e.g., exacerbating disparities or disproportionately benefiting population groups, illicit sales of tobacco products?

**Component 2: Commercial Tobacco Use and Dependence Treatment Support System:** In order to assess sustained quits, recipients are required to collect 7-month follow-up data among tobacco users who used quitline services at least one time during the NOFO performance period. Recipients that routinely collect 7-month follow-up data will be asked to report the data as part of their annual evaluation reporting as available.

- Outcomes: To what extent did recipient efforts contribute to a measurable change in quit attempts and sustained quits at 7-month follow-up, overall, and among populations experiencing tobacco-related disparities?
- Effectiveness: What services and modalities and/or combination of services resulted in increased quit attempts and sustained quits at 7-month follow-up? For whom?

To answer the required evaluation questions, the recipient-led evaluations should employ use of methods and data sources that fit the evaluation questions; this may include, but is not limited to, quantitative, qualitative, mixed methods, and quasi-experimental design. The rigor, methods, and data sources used may vary depending on the selected outcomes and population group(s). CDC will provide technical assistance and guidance in planning the recipient-led evaluation and will support coordination between states evaluating the same outcomes.

While the recipient is encouraged to implement strategies and activities to achieve all outcomes listed in the logic model, as appropriate for their program, the recipient will only be asked to report on performance measures related to outcomes that are bolded in the logic model. 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.The performance measures listed in the table below relate to specific outcomes in the logic model.

The recipient will be required to report on all Tier 1 performance measures. For Tier 2 performance measures, the recipient will report only on the performance measures for strategies and activities implemented by the recipient that are intended to achieve the related outcome. For

example, if the recipient is implementing mass-reach health communication interventions to increase earned media reaching populations experiencing disparities, then they will be asked to report on the related Tier 2 performance measures' number and reach of earned media in media outlets reaching populations experiencing disparities. CDC will track surveillance-related performance measures to assess long-term logic model outcomes.

CDC will work with the recipient on operationalizing and further defining each performance measure, and guidance will be provided prior to the first year of reporting. Additionally, the recipients must participate in the CDC, OSH, NQDW (e.g, quarterly reporting of intake data on quitline callers and information on services provided through the NQDW Online Services Survey). Participation may include the collection of data on new and emerging products such as electronic nicotine delivery systems such as e-cigarettes (e.g. current use, type of product used, frequency of use, and reasons for use) collaboratively developed with CDC.

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-level evaluation and performance measures, including requirements for the evaluation plan and reporting. All evaluation findings produced by CDC and recipients, where appropriate, will contribute to: 1) demonstrating the value of the program; 2) continuous improvement and effectiveness of program strategies; 3) the evidence base; 4) documentation and sharing of lessons learned; and/or 5) future funding opportunities supported by CDC.

| | **Outcome** | **Performance Measures**<br>**Data Source: Annual Progress Report** |
|---|---|---|
| **Component 1: National Tobacco Control Program (State Based)** | | |
| Short Term | Increased health communication interventions and messages to reach general population and populations experiencing tobacco-related disparities** | Number and reach (e.g., GRPs) of paid, earned, and digital media efforts targeting the general population and populations experiencing disparities to prevent and reduce tobacco use and dependence promote quitting, including use of quitline services |
| Short Term | Increased health care system changes to promote and support tobacco use and dependence treatment** | Number and reach of health systems that promote and support evidence-based quit support services |
| Short Term | Increased access to and awareness of barrier-free coverage of evidence-based | Number and reach of health insurers that promote and support evidence-based quit |

| | | |
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| | tobacco use and dependence treatments** | support services |
| Intermediate | Decreased exposure to tobacco marketing and access to tobacco products** | Number and reach of state and local jurisdictions with policies that reduce tobacco marketing and access to tobacco products (e.g., decrease the sale of flavored tobacco products) |
| Intermediate | Increased implementation of tobacco control policies, including comprehensive smokefree policies* | Number and reach of comprehensive state and community smokefree/tobacco-free policies implemented, including workplaces, restaurants, and bars; multi-unit housing, and mental health and substance use facilities |
| Intermediate | Increased implementation and reach of evidence-based, culturally appropriate strategies and activities to reduce tobacco-related disparities* | Type, reach, and impact of two (2) or more targeted evidence-based interventions for a populations group experiencing tobacco-related disparities |
| **Component 2: Commercial Tobacco Use and Dependence Treatment Support System** | | |
| Short Term | **Optimized quitline intake**** | Maintain or decrease average intake time compared to benchmark |
| Short Term | Increased awareness of quit support services among people who use tobacco ** | Number and reach (e.g., GRPs, impressions) of paid, earned, and digital media efforts targeting the general population and populations experiencing disparities to prevent and reduce tobacco use and dependence and promote quitting, including use of quitline services and the use of digital-based technologies, such as texting, apps, web, and chat |
| Intermediate | Increased number of insurers and employers that provide or reimburse for tobacco use and dependence treatment services, including the quitline** | Number and reach of insurers and/or employers that provide or reimburse for quit support services, including quitline |
| Intermediate | Increase use and reach of evidence-based quit support | Number and reach of evidence-based quit support services, |

| | | |
|---|---|---|
| | services, including the quitline, and use of digital technologies, such as texting, apps, and chat.* | including quitline and the use of digital-based technologies, such as texting, apps, web, and chat |
| Intermediate | Decreased disparities in use of quit support services/treatments* | Number and proportion of who register for quit support services among populations experiencing tobacco-related disparities (e.g., uninsured, Medicaid, LGBTQ, behavioral health conditions) |

*The recipient is required to report on all Tier 1 performance outcomes.

** For Tier 2 performance outcomes, the recipient will report only on the performance outcomes for strategies and activities implemented by the recipient that are intended to achieve the related outcome.

**Long-Term Outcome Evaluation Measures**

All long-term outcome evaluation measures will be provided by CDC.

**Data Management Plan**

**Applicants will need to supply a preliminary draft or outline of a Data Management Plan (DMP).** The DMP must describe the data to be collected or generated in the proposed project; standards to be used for collected or generated data; mechanisms for providing access to and sharing of the data (including provisions for the protection of privacy, confidentiality, security, intellectual property, or other rights); plans to share data with CDC that meet CDC reporting and surveillance requirements; use of data standards that ensure all released data have appropriate documentation that describes the method of collection, what the data represent, and potential limitations for use; and plans for archival and long-term preservation of the data, or explaining why long-term preservation and access are not justified. Recipients will be required to submit a more detailed DMP, within the first six (6) months of award, as described in the Reporting Section of this NOFO (See CDC DMP policy https://www.cdc.gov/grants/additionalrequirements/ar-25.html).

**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 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), if applicable, for accuracy throughout the lifecycle of the project. The DMP should provide a description of the data that will be produced using these NOFO funds; access to data; data standards ensuring released data have documentation describing methods of collection, what the data represent, and data limitations; and archival and long-term data preservation plans. For more information about CDC's policy on the DMP, see https://www.cdc.gov/grants/additionalrequirements/ar-25.html.

Where the applicant chooses to, or is expected to, take on specific evaluation studies, 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 a DMP, if applicable, within the first 6 months of award, as described in the Reporting Section of this NOFO.

Applicants are required to provide an evaluation and performance measurement plan that will fulfill the requirements in the CDC Evaluation and Performance Measure section. Applicants must:

- Develop an initial evaluation and performance plan to indicate how they will identify progress in implementing program strategies, activities, and achieving program outcomes.
- Ensure that the evaluation plan follows the CDC Evaluation Framework and describes how they will collect data to report on the performance measures.

This plan should cover the 5-year cooperative agreement, and can be updated as work plans change throughout the cooperative agreement. It should include process and outcome evaluation questions, and a data collection plan that informs performance measures.

Recipients will refine their evaluation and performance measurement plan within six (6) months of award and more detailed plan should be developed by the recipient with support from CDC as part of first year project activities and should build on the elements stated in the initial evaluation plan described in this proposal. Recipients will be required to update CDC on progress in implementing the plan by reporting evaluation findings; evaluation findings must be reported annually in the Annual Progress Report, and per CDC guidance throughout the cooperative agreement. More information on developing evaluation plans can be found at https://www.cdc.gov/tobacco/data_statistics/data-resources/index.htm.

**c. Organizational Capacity of Recipients to Implement the Approach**

**All Components**

Applicants need to demonstrate the capacity to complete all activities proposed. Organizational capacity demonstrates the applicant's ability to successfully execute the funding opportunity

strategies and meet project outcomes. Applicants should have adequate infrastructure (physical space and equipment), workforce capacity and competence, relevant skill sets, information and data systems, and electronic information and communication systems to implement the award. Applicants should include an organizational chart(s). Applicants must name the file "Organizational Chart" and upload it to www.grants.gov.

Applicants must describe their organizational capacity to carry out the strategies and activities proposed. Please describe:

- Adequate program management and diverse staffing with sufficient workforce capacity and competence to ensure program success, including full-time program manager, full-time tobacco use and dependence treatment coordinator, full-time staff person to manage youth and young adult activities, and access to evaluation staff to conduct required evaluation activities. Applicants should include CVs/resumes for the tobacco control manager, an evaluator, and the tobacco use and dependence treatment coordinator, name the file "Resumes", and upload to www.grants.gov.
- Ability to implement evidence-based strategies and activities related to tobacco prevention and control including capacity to address populations most affected by tobacco use and dependence and SHS exposure.
- Capacity to conduct surveillance, epidemiology, and evaluation activities including conducting the BRFSS annually.
- Experience developing multi-disciplinary diverse partnerships, engage and mobilize communities, and build coalitions.
- Experience using data to identify populations most affected by tobacco use and dependence, SHS exposure, and associated disease, disability, and death, and implement evidence-based interventions and strategies in conjunction with key partners to reduce health disparities and improve health equity at the state and community level.
- Experience engaging multi-disciplinary diverse groups of partners and stakeholders in promoting the use and implementation of evidence-based policy, systems, and environmental approaches to address tobacco use and dependence, SHS exposure, and tobacco-related disparities.
- Ability to delivery statewide quitline and other quit support services.
- Ability to inform the public and decision makers about the dangers of tobacco use and dependence, SHS exposure, tobacco-related disparities and associated disease, disability, and death, and the most effective evidence-based interventions and strategies to address the tobacco problem.
- Ability to coordinate and collaborate with state health department chronic disease prevention and health promotion programs and external partners to leverage limited resources and maximize reach and impact.
- Adequate travel and financial management systems and full capacity to manage contracting and procurements efforts.
- Ability to attend CDC-sponsored trainings, meetings and events and other training opportunities recommended by CDC.

**d. Work Plan**

### Component 1: National Tobacco Control Program (State Based)

Applicants should provide a detailed work plan for the first year of the project and a high-level work plan for subsequent years. Objectives should be written in SMART (specific, measurable, achievable, realistic, timely) format. The work plan should include evidence-based strategies and activities to achieve all outcomes listed in the logic model. A sample work plan template is available for use at https://www.cdc.gov/tobacco/about/foa/index.htm. Applicants are not required to use the work plan template, but are required to include all of the elements listed within the template.

CDC will provide feedback and technical assistance to recipients to finalize the work plan post-award.

Applicants must name this file "Component 1 Work Plan" and upload to www.grants.gov.

Applicants should organize the work plan according to the five components of a comprehensive tobacco control as outlined in Best Practices - 2014.

1. State and community interventions
2. Mass-reach health communication interventions
3. Tobacco use and dependence treatment interventions
4. Surveillance and evaluation
5. Infrastructure, administration, and management

The work plan at a minimum should include:

- Evidence-based strategies and activities to support achievement of NOFO outcomes (strategies and activities must be in alignment with the NOFO logic model and should have appropriate performance measures).
- A timeline that identifies key activities and assigns approximate dates for inception and completion.
- Staff roles and responsibilities to support implementation of strategies and activities.
- Project monitoring and evaluation processes to ensure successful implementation.

### Components 2: Commercial Tobacco Use and Dependence Treatment Support System

Applicants should provide a detailed work plan for the first year of the project and a high-level work plan for subsequent years. Objectives should be written in SMART (specific, measurable, achievable, realistic, timely) format. The work plan should include evidence-based strategies and activities to achieve all outcomes listed in the logic model. A sample work plan template is available for use at https://www.cdc.gov/tobacco/about/foa/index.htm. Applicants are not required to use the work plan template, but are required to include all of the elements listed within the template.

CDC will provide feedback and technical assistance to recipients to finalize the work plan post-award.

Applicants must name this file "Component 2 Work Plan" and upload to www.grants.gov.

Applicants should organize the work plan according to the four components of a comprehensive tobacco control as outlined in Best Practices - 2014.

1. Mass-reach health communication interventions
2. Tobacco use and dependence treatment interventions
3. Surveillance and evaluation
4. Infrastructure, administration, and management

The work plan at a minimum should include:

- Evidence-based tobacco use and dependence treatment strategies and activities to support achievement of NOFO outcomes (strategies and activities must be in alignment with the NOFO logic model and should have appropriate performance measures).
- A timeline that identifies key activities and assigns approximate dates for inception and completion.
- Staff roles and responsibilities to support implementation of strategies and activities.
- Project monitoring and evaluation processes to ensure successful implementation.

Quantitative baselines should be provided for each outcome that leads to an increase, decrease, or maintenance over time.

**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.

Attending required trainings and conferences is critical for building and maintaining the skills of the staff with responsibility for carrying out the requirements of this NOFO. This NOFO requires attendance at specific trainings and conferences as a term and condition of this award. Specific

meeting dates and guidance related to travel will be provided at a later date.

**Component 1: National Tobacco Control Program (State Based)**

In Year 1, applicants should budget to attend the following trainings:

- Three day training in Atlanta, Georgia for three staff members and two individuals that understand the unique cultural differences of the selected population affected by tobacco-related disparities.

Starting in Year 2 and each subsequent year, recipients must budget for three staff members to travel to Atlanta, Georgia for a three day National Tobacco Control Program training.

For the period of performance in Years 2 and 3, the budget should include annual reverse site visits for a minimum of two program staff to visit Atlanta and meet with CDC staff.

**Component 2: Commercial Tobacco Use and Dependence Treatment Support System**

In Year 1, applicants should budget to attend the following trainings:

- One staff member to travel to Atlanta, Georgia for a three day training in Atlanta, Georgia.

Starting in Year 2 and each subsequent year, recipients must budget for three staff members to travel to Atlanta, Georgia for a three day National Tobacco Control Program training.

For the period of performance in Years 2 and 3, the budget should include annual reverse site visits for a minimum of one program staff to visit Atlanta, Georgia and meet with CDC staff.

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

CDC will provide substantial involvement beyond regular performance and financial monitoring during the period of performance. Substantial involvement means that recipients can expect federal programmatic partnership in carrying out the effort under the award. CDC will work in partnership with recipients to ensure the success of the cooperative agreement by:

- Providing technical assistance to revise annual work plans.
- Assisting in advancing program activities to achieve project outcomes.
- Providing scientific subject matter expertise and resources.
- Collaborating with recipients to develop evaluation plans that align with CDC evaluation activities.
- Providing technical assistance on recipient's evaluation and performance measurement plan.
- Providing ongoing training, technical assistance, and consultation on policy, systems, and environmental strategies and activities for tobacco control, including tobacco use and dependence treatment strategies and activities.
- Providing up-to-date information that includes dissemination of best practices for tobacco prevention and control.
- Informing and educating recipients and other partners about evidence-based policy,

systems, and environmental strategies and activities for tobacco control through workshops, conferences, training, electronic and verbal communication, including the National Conference on Tobacco or Health.

- Identifying, developing, and disseminating education media campaign materials for use by programs; facilitating coordination of education media ads between programs; providing technical assistance on design, implementation, and evaluation of media.
- Providing monthly National Tobacco Control Program, Media Network, and periodic Evaluation Technical Assistance webinars to provide updates from subject matter experts about relevant tobacco-related topics and issues.
- Maintaining electronic mechanisms for information sharing, program planning, and progress reporting.
- Developing and maintaining partnerships with federal and non-federal organizations to assist in tobacco control and maintain a national infrastructure that complements the state infrastructure.
- Serving as a resource to recipients in identifying and eliminating tobacco-related disparities among population groups.
- Maintaining a website with access to a data warehouse containing comparable measures of tobacco use and dependence prevention and control from different data sources.
- Helping identify gaps in the evidence-base of tobacco control and prioritizing efforts to fill those gaps; providing training and technical assistance on publications and opportunities for dissemination of program evaluation findings.
- Serving as a convener and resource for the continued expansion of the evidence-base of tobacco control.
- Providing technical assistance, as requested, for developing impact statements and publishing selected statements on the CDC/OSH website as appropriate.
- Providing technical assistance, as requested, on the submission of data to the National Quitline Data Warehouse (NQDW).
- Facilitating development of the evidence base especially in areas of innovative strategies in reaching populations disproportionately impacted by tobacco use and dependence and associated disease, disability, and death through tobacco use and dependence treatment initiatives.
- Collecting and analyzing data that can be used to monitor and evaluate tobacco use and dependence treatment initiatives.
- Disseminating the Weekly Dose newsletter containing pertinent information regarding tobacco-related topics and NOFO-related information.
- Providing access to CDC's Office on Smoking and Health Media Campaign Resource Center.
- Collaborating with the Food and Drug Administration to provide information related to regulatory action.
- Providing data visualization training and technical assistance.
- Providing a Tobacco Control Network, Communities of Practice, and tailored webinars that include lessons learned from peers, and opportunities for tailored technical assistance and sustainability planning.
- Providing 12-month on-boarding support for new tobacco control program managers.
- Providing leadership development through the OSH Leadership and Sustainability School

for program managers.

## B. Award Information

**1. Funding Instrument Type:** Cooperative Agreement

CDC's substantial involvement in this program appears in the CDC Program Support to Recipients Section.

**2. Award Mechanism:** U58

| | |
|---|---|
| Chronic Disease Control Cooperative Agreement | In cooperation with State and local public health agencies and other public or private organizations to assist in controlling and preventing chronic diseases. Efforts are directed at the integrated application of surveillance; applied epidemiology; laboratory sciences; evaluation; health education; dynamic and productive relationships; training; and extensive applied management of effective disease control programs. |

**3. Fiscal Year:** 2020

**4. Approximate Total Fiscal Year Funding:** $71,000,000

**5. Approximate Period of Performance Funding:** $403,000,000

This amount is subject to the availability of funds.

Component 1: National Tobacco Control Program (State Based): $326,000,000

Component 2: Commercial Tobacco Use and Dependence Treatment Support System: $77,000,000

Year 1 budget period is 10 months.

Estimated Total Funding: $403,000,000

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

**7. Expected Number of Awards:** 53

**8. Approximate Average Award:** $1,600,000 Per Budget Period

Component 1: National Tobacco Control Program (State Based): $1,300,000

Component 2: Commercial Tobacco Use and Dependence Treatment Support System: $300,000

Year 1 budget period is 10 months; therefore, the average award is lower than the anticipated amount for subsequent 12-month budget periods.

**9. Award Ceiling:** $3,600,000 Per Budget Period

This amount is subject to the availability of funds.

Component 1: National Tobacco Control Program (State Based): $2,300,000

Component 2: Commercial Tobacco Use and Dependence Treatment Support System: $1,300,000

Year 1 budget period is 10 months; therefore, the ceiling is lower than the anticipated amount for subsequent 12-month budget periods.

**10. Award Floor:** $500,000 Per Budget Period

Component 1: National Tobacco Control Program (State Based): $500,000

Component 2: Commercial Tobacco Use and Dependence Treatment Support System: $50,000

Year 1 budget period is 10 months; therefore, the floor for Component 2 is lower than the anticipated amount for subsequent 12-month budget periods.

**11. Estimated Award Date:** 05/28/2020

**12. Budget Period Length:** 12 month(s)

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).

**13. Direct Assistance**

Direct Assistance (DA) is available through this NOFO.

Direct Assistance is available for Statistical Analysis Software (SAS) licenses only through Component 1.

## C. Eligibility Information

### 1. Eligible Applicants

Eligibility Category: State governments

Additional Eligibility Category:

Government Organizations:

State governments or their bona fide agents (includes the District of Columbia)
Territorial governments or their bona fide agents in the Commonwealth of Puerto Rico, the Virgin Islands, the Commonwealth of the Northern Marianna Islands, American Samoa, Guam, the Federated States of Micronesia, the Republic of the Marshall

Islands, and the Republic of Palau.

## 2. Additional Information on Eligibility

Eligible applicants may apply for one or more components and may only submit a single application for this funding announcement.

**Component 1: National Tobacco Control Program (State Based)**

State governments or their bona fide agents (includes the District of Columbia) can apply for Component 1. The award ceiling for Component 1 is $2,300,000. CDC will consider any application requesting an award higher than this amount as non-responsive and it will receive no further review.

**Component 2: Commercial Tobacco Use and Dependence Treatment Support System**

State governments or their bona fide agents (includes the District of Columbia) and 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 can apply for Component 2. The award ceiling for Component 2 is $1,300,000. CDC will consider any application requesting an award higher than this amount as non-responsive and it will receive no further review.

## 3. Justification for Less than Maximum Competition

State and territorial health departments are uniquely positioned to carry out the activities under the NOFO. Specifically, state and territorial health departments have the data, skills, experience, and are charged with the responsibility to protect the health status of residents, which includes efforts to implement tobacco control and prevention policy, systems, and environmental strategies.

**Component 1:** Only state governments and the District of Columbia or their bona fide agents are eligible to apply for Component 1. U.S. Affiliated Pacific Islands (USAPIs), U.S. Virgin Islands (USVI), and Puerto Rico are currently funded under NOFO *CDC-RFA-DP19-1901* and Native American tribal governments (Federally recognized) and Native American tribal organizations (other than Federally recognized tribal governments) are currently funded under NOFO *CDC-RFA-DP19-1903*.

**Component 2:** Only state governments and the District of Columbia or their bona fide agents and 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 are eligible to apply for Component 2. Native American tribal governments (Federally recognized) and Native American tribal organizations (other than Federally recognized tribal governments) are currently funded under NOFO *CDC-RFA-DP19-1903.*

## 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. Application and Submission Information

### 1. Required Registrations

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

**a. Data Universal Numbering System:**

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

The applicant organization may request a DUNS number by telephone at 1-866-705-5711 (toll free) or internet at http:// fedgov.dnb. com/ webform/ displayHomePage.do. The DUNS number will be provided at no charge.

If funds are awarded to an applicant organization that includes sub-recipients, those sub-recipients must provide their DUNS numbers before accepting any funds.

**b. System for Award Management (SAM):**

The SAM is the primary registrant database for the federal government and the repository into which an entity must submit information required to conduct business as a recipient. All applicant organizations must register with SAM, and will be assigned a SAM number. All information relevant to the SAM number must be current at all times during which the applicant has an application under consideration for funding by CDC. If an award is made, the SAM information must be maintained until a final financial report is submitted or the final payment is received, whichever is later. The SAM registration process can require 10 or more business days, and registration must be renewed annually. Additional information about registration procedures may be found at https://www.sam.gov/SAM/.

**c. Grants.gov:**

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

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

| Step | System | Requirements | Duration | Follow Up |
|---|---|---|---|---|
| 1 | Data | 1. Click on http:// | 1-2 | To confirm that |

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

## 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 notice of funding opportunity at www.grants.gov.

## 4. Submission Dates and Times

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

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

Due Date for Letter of Intent: **N/A**

### b. Application Deadline

Due Date for Applications: **04/13/2020** , 11:59 p.m. U.S. Eastern Standard Time, at www.grants.gov. If Grants.gov is inoperable and cannot receive applications, and circumstances preclude advance notification of an extension, then applications must be submitted by the first business day on which grants.gov operations resume.
Modification to the NOFO due date. Applications are due on 4/13/2020.

Date for Information Conference Call

Information Conference Call #1: Wednesday, February 12, 2020, 3:00 – 4:00 U.S. Eastern Standard Time

Information Call Number: 1-866-803-2146

Passcode: 19609609#

Link: https://adobeconnect.cdc.gov/rr1ym55lt24e/

Information Conference Call #2 Thursday, February 13, 2020, 11:00 – 12:00 U.S. Eastern Standard Time

Information Call Number: 1-866-803-2146

Passcode: 19609609#

Link: https://adobeconnect.cdc.gov/rr1ym55lt24e/

A list of Frequently Asked Questions is available at

https://www.cdc.gov/tobacco/about/foa/national-state-tobacco-control-program/index.html

## 5. CDC Assurances and Certifications

All applicants are required to sign and submit "Assurances and Certifications" documents indicated at http://wwwn.cdc.gov/ grantassurances/ (S(mj444mxct51lnrv1hljjjmaa)) /Homepage.aspx.
Applicants may follow either of the following processes:

- Complete the applicable assurances and certifications with each application submission, name the file "Assurances and Certifications" and upload it as a PDF file with at www.grants.gov
- Complete the applicable assurances and certifications and submit them directly to CDC on an annual basis at http://wwwn.cdc.gov/ grantassurances/ (S(mj444mxct51lnrv1hljjjmaa))/ Homepage.aspx

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

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

CDC requires all applicants to complete the Risk Questionnaire, OMB Control Number 0920-1132 annually. This questionnaire, which is located at https://www.cdc.gov/grants/documents/PPMR-G-CDC-Risk-Questionnaire.pdf, along with supporting documentation must be submitted with your application by the closing date of the Notice of Funding Opportunity Announcement. If your organization has completed CDC's Risk Questionnaire within the past 12 months of the closing date of this NOFO, then you must submit a copy of that questionnaire, or submit a letter signed by the authorized organization representative to include the original submission date, organization's EIN and DUNS.
When uploading supporting documentation for the Risk Questionnaire into this application package, clearly label the documents for easy identification of the type of documentation. For example, a copy of Procurement policy submitted in response to the questionnaire may be labeled using the following format: Risk Questionnaire Supporting Documents _ Procurement Policy.

**Duplication of Efforts**

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

## 6. Content and Form of Application Submission

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

## 7. Letter of Intent

LOI is not requested or required as part of the application for this NOFO.

## 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

(Maximum 1 page)
A project abstract is included on the mandatory documents list and must be submitted at www.grants.gov. The project abstract must be a self-contained, brief summary of the proposed project including the purpose and outcomes. This summary must not include any proprietary or confidential information. Applicants must enter the summary in the "Project Abstract Summary" text box at www.grants.gov.

## 10. Project Narrative

(Unless specified in the "H. Other Information" section, maximum of 20 pages, single spaced, 12 point font, 1-inch margins, number all pages. This includes the work plan. Content beyond the specified page number will not be reviewed.)
Applicants must submit a Project Narrative with the application forms. Applicants must name this file "Project Narrative" and upload it at www.grants.gov. The Project Narrative must include **all** of the following headings (including subheadings): Background, Approach, Applicant Evaluation and Performance Measurement Plan, Organizational Capacity of Applicants to Implement the Approach, and Work Plan. The Project Narrative must be succinct, self-explanatory, and in the order outlined in this section. It must address outcomes and activities to be conducted over the entire period of performance as identified in the CDC Project Description section. Applicants should use the federal plain language guidelines and Clear Communication Index to respond to this Notice of Funding Opportunity. 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 public health problem as described in the CDC Background section.

### ii. Outcomes

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

### 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 project period. See the Strategies and Activities section of the CDC Project Description.

### 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.

For Component 1 and Component 2, Year 1 budget period is 10 months; therefore, the ceiling is lower than the anticipated amount for subsequent 12-month budget periods.

When applying for more than one component, the applicant should include a budget for each component. The budgets should be labeled as follows: "Component 1 Budget," and "Component 2 Budget" and uploaded to www.grants.gov.

**Component 1: National Tobacco Control Program (State Based)**

Applicants should budget the following:

- In Year 1, three staff members and two individuals that understand the unique cultural differences of the selected population to travel to Atlanta, Georgia for a three day training.
- *Best Practices - 2014* recommends that funds be awarded directly to local lead agencies (e.g., community-based organizations, local health departments, federally-recognized American Indian Tribe/Alaska Native Villages) that serve specific populations, in order to implement evidence-based programs and activities targeted to that population. **All recipients must direct funds from their Component 1 award or state dollars to fund one local lead agency to implement tobacco control strategies and activities in a community.**
- *Best Practices - 2014* recommends that 10% of total annual tobacco control program funds be allocated for surveillance and evaluation. **A minimum of 10% of funding to implement evaluation activities.**

Recipients may not use funds to provide direct tobacco use and dependence treatment services or other direct services other than those through evidence-based quitline and quit support

services. Recipients may **ONLY** use funds to purchase FDA-approved tobacco use and dependence treatment medications or other products used for tobacco use and dependence treatment in **Component 2**.

**Component 2: Commercial Tobacco Use and Dependence Treatment Support System**

Applicants should budget to attend the following training in Year 1:

- One staff member to travel to Atlanta, Georgia for a three day training in Atlanta, Georgia.

In order to meet all the terms of the award, CDC is allowing recipients to use a percentage of the CDC funds to purchase and provide a minimum of a two-week supply of FDA-approved tobacco use and dependence treatment medications to eligible participants through the quitline. According to *Best Practice – 2014*, all individuals who use the quitline should receive some form of quit support services, including at least one coaching session. To increase the use of the quitline and tobacco cessation success rate, the recipient can use a percentage of the budget to purchase and provide a minimum of a two-week supply of FDA-approved tobacco use and dependence treatment medications to *ensure* the medications are available through the quitline during the *Tips From Former Smokers® Nicotine Replacement Therapy Promotion.*

## 13. 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 2 CFR 200 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.

## 14. Intergovernmental Review

The application is subject to Intergovernmental Review of Federal Programs, as governed by

Executive Order 12372, which established a system for state and local intergovernmental review of proposed federal assistance applications. Applicants should inform their state single point of contact (SPOC) as early as possible that they are applying prospectively for federal assistance and request instructions on the state's process. The current SPOC list is available at: https://www.whitehouse.gov/wp-content/uploads/2020/01/spoc_1_16_2020.pdf.

## 15. Pilot Program for Enhancement of Employee Whistleblower Protections

Pilot Program for Enhancement of Employee Whistleblower Protections: All applicants will be subject to a term and condition that applies the terms of 48 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.

## 16. 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.

## 17. 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 and additional 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.
- In accordance with the United States Protecting Life in Global Health Assistance policy, all non-governmental organization (NGO) applicants acknowledge that foreign NGOs that receive funds provided through this award, either as a prime recipient or subrecipient, are strictly prohibited, regardless of the source of funds, from performing abortions as a method of family planning or engaging in any activity that promotes abortion as a method of family planning, or to provide financial support to any other foreign non-governmental organization that conducts such activities. See Additional Requirement (AR) 35 for applicability (https://www.cdc.gov/grants/additionalrequirements/ar-35.html).

**Component 1: National Tobacco Control Program (State Based)**

- Recipients may not use funds to purchase tobacco prevention curriculum for K-12 schools.
- Recipients may not use funds for tobacco compliance check inspections.
- Recipients may not use funds to pay for Synar or FDA compliance monitoring.
- Recipients must direct a minimum of **10%** of the funds for evaluation activities.

## 18. Data Management Plan

As identified in the Evaluation and Performance Measurement section, applications involving

data collection must include a Data Management Plan (DMP) as part of their evaluation and performance measurement plan. The DMP is the applicant's assurance of the quality of the public health data through the data's lifecycle and plans to deposit data in a repository to preserve and to make the data accessible in a timely manner. See web link for additional information:
https://www.cdc.gov/grants/additionalrequirements/ar-25.html

## 19. Other Submission Requirements

**a. Electronic Submission:**
Applications must be submitted electronically by using the forms and instructions posted for this notice of funding opportunity at www.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 when www.grants.gov receives the application. The tracking number documents that the application has been submitted and initiates the required electronic validation process before the application is made available to CDC.

**c. Validation Process:** Application submission is not concluded until the validation process is completed successfully. After the application package is submitted, the applicant will receive a "submission receipt" e-mail generated by www.grants.gov. A second e-mail message to applicants will then be generated by www.grants.gov that will either validate or reject the submitted application package. This validation process may take as long as two business days. Applicants are strongly encouraged to check the status of their application to ensure that submission of their package has been completed and no submission errors have occurred. Applicants also are strongly encouraged to allocate ample time for filing to guarantee that their application can be submitted and validated by the deadline published in the 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=
Get_Started%2FGet_Started. htm

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

that www.grants.gov is managed by HHS.

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

1. Include the www.grants.gov case number assigned to the inquiry
2. Describe the difficulties that prevent electronic submission and the efforts taken with the www.grants.gov Contact Center to submit electronically; and
3. Be received via e-mail to the GMS/GMO listed below at least three calendar days before the application deadline. Paper applications submitted without prior approval will not be considered.

   If a paper application is authorized, OGS will advise the applicant of specific instructions for submitting the application (e.g., original and two hard copies of the application by U.S. mail or express delivery service).

## E. Review and Selection Process

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

**a. Phase 1 Review**
All applications will be initially reviewed for eligibility and completeness by CDC Office of Grants Services. Complete applications will be reviewed for responsiveness by the 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:45 |
|---|---|

**Component 1: National Tobacco Control Program (State Based) - 45 Points**

Applicants will be scored on the extent to which the problem of tobacco use and dependence, SHS exposure, and tobacco-related diseases within the state by population group is described, the evidence-based strategies and activities that will be incorporated to address the problem, how equity will be achieved to reduce tobacco-related disparities, and active partner collaboration, coordination and involvement in tobacco control. Applicants will be scored on the following elements of their project narrative and work plan:

**State and Community Interventions (30 Points)**

Statewide Programs (15 Points)

1. Describe an overall strategy and activities consistent with the CDC Project Description and logic model.
2. Describe what efforts will be undertaken to develop and maintain active statewide and community partnerships across programs, agencies, and stakeholder groups for the purpose of achieving the four NTCP goals.
3. Discuss a plan to develop or collaborate with an active statewide coalition, advisory board, or other tobacco control entity that brings external partners together to address tobacco control issues.
4. Describe the process to administer, monitor, and evaluate organizations and activities funded through contracts or grants and how to ensure that CDC recommended evidence-base strategies and activities are implemented.
5. Describe how the applicant will be inclusive of populations affected by tobacco use and dependence and secondhand smoke exposure.
6. Describe the evidence-based strategies and activities that will be implemented to prevent tobacco use and dependence among individuals with behavioral health conditions or low socioeconomic status.
7. Describe a plan to engage and educate leaders, decision makers, and the public to prevent tobacco use and dependence and secondhand smoke exposure.
8. Describe the evidence-based strategies that will be implemented to reduce emerging tobacco products use, including e-cigarettes, among youth and young adults.
9. Describe a plan to engage parents, teachers, education professionals, and other stakeholders who influence youth and young adults about the rapidly evolving tobacco product landscape, the harms of use, and the benefits of prevention.
10. Discuss collaborative work with health care professionals to strengthen systems through the integration of child and family centered tobacco control initiatives to address the initiation of emerging tobacco products, including e-cigarettes.

Community Programs (15 Points)

1. Summarize three (3) outcomes accomplished by the applicant since 2015 with populations disproportionally impacted by tobacco use and dependence in the state.
2. Describe the process to recruit and select individuals that understand the unique cultural differences of the selected population to assist with selecting the community during the first three (3) months of the award.
3. Describe how the applicant will ensure that the local lead agency addresses the disparities requirements and demonstrates an understanding of evidence-based strategies (including policy, systems, and environmental change approaches) to reduce

tobacco prevalence.
4. Outline the specific steps the local lead agency will take to collaboratively with partners, including the CDC-funded Networking2Save, to address tobacco use and dependence and secondhand smoke exposure among the selected population.
5. Submit a draft request for proposal (RFP) or cooperative agreement to fund at least one local lead agency.

**Mass-Reach Health Communication Interventions (10 points)**

1. Describe how the applicant will implement and evaluate health communication strategies and activities (i.e. earned, social, paid, and program communications).
2. Provide a description for determining if health communication strategies and activities increase referrals and volume to the quitline and quit support services.
3. Describe how the applicant will assess if the strategies and activities effectively reached populations affected by tobacco use and dependence and secondhand smoke exposure.
4. Describe how the applicant will leverage the CDC National Educational Campaigns, Surgeon General and other scientific reports, and other countermarketing strategies.
5. Describe how the applicant will evaluate and expand media efforts on emerging tobacco products, including e-cigarettes, to effectively reach youth and young adults (i.e. earned, social, paid, and program communications).

**Tobacco Use and Dependence Treatment Support System (5 points)**

1. Describe how the applicant will maintain the infrastructure of a tobacco quitline for the duration of *Tips*®.
2. Describe how the applicant will increase health care system changes to promote and support tobacco use and dependence treatment.
3. Describe strategies that will be implemented to ensure barrier-free coverage of evidence-based tobacco use and dependence treatments.
4. Describe collaborations with health care systems and their readiness to integrate tobacco use and dependence treatment interventions into clinical care.

**Component 2: Commercial Tobacco Use and Dependence Treatment Support System - 45 Points**

Applicants will be scored on the extent to which the problem (quit support services, including quitline capacity) is described, the evidence-based strategies and activities that will be implemented to address the populations above the state's adult smoking prevalence and use the state quitline less frequently, and active partner collaboration, coordination and involvement in tobacco control. Applicants will be scored on the following elements of their project narrative and work plan:

**Background and Need (10 points):**

1. Describe how the quitline/quit support services, and tobacco use and dependence treatment activities are part of a comprehensive tobacco control program.
2. Describe the capacity for the quitline to handle calls during national education media

campaigns and any gaps in current quitline capacity.
3. Discuss current quitline services provided, current eligibility requirements for quitline services, and quitline utilization among populations above the state's adult smoking prevalence and use the state quitline less frequently.

**Improve Quitline Infrastructure to Ensure Efficiency and Capacity (9 points):**

1. Describe processes that will be implemented to ensure the quitline infrastructure can absorb increases in demand during a national media education campaign.
2. Describe the capacity of the quitline to accept e-referrals though patient electronic health records from health care systems/providers.
3. Describe processes that will be implemented to triage callers when eligible to receive services from other quitlines.

**Enhance Quitline Sustainability (6 points):**

1. Describe strategies to increase long-term sustainability of the state quitline and quit support services through partnerships and collaborations.
2. Describe collaborations with private and public insurers and employers to provide or reimburse for barrier-free evidence-based quitline services.

**Leverage and Expand Reach and Range of Available Quit Support Services Through the Quitline (10 points):**

1. Describe a plan to expand the range of tobacco use and dependence treatment services beyond the quitline, including the use of digital-based technologies, such as texting, apps, web, and chat.
2. Describe processes to ensure callers are referred to culturally appropriate national quitlines (National Asian Language Quitline & 1-855-DEJELO-YA, 1-855-QUIT-VET, others).
3. Discuss promotional efforts that will be implemented to increase use of culturally-appropriate quit support services, including the quitline, by populations affected by tobacco use and dependence and secondhand smoke exposure.

**Conduct Strategic Promotional Efforts to Increase Use of Available Quit Support Services, Including the Quitline (10 points):**

1. Identify populations disproportionately impacted by tobacco use and dependence and tobacco-related disparities, including populations that are less likely to use the state quitline, to use other proven cessation treatments, and to succeed in quitting.
2. Describe a plan to promote tobacco use and dependence quit support services using culturally-appropriate protocols, channels, and messages to individuals and populations affected by tobacco use and dependence and secondhand smoke exposure.
3. Describe a plan to promote the quitline and quit support services to providers and individuals on Medicaid who smoke.

| ii. Evaluation and Performance Measurement | Maximum Points:25 |
|---|---|

## Component 1: National Tobacco Control Program (State Based) - 25 Points

Applicants will be scored on the extent to which the evaluation and performance measurement plan demonstrates the following:

**Surveillance and Evaluation (15 points)**

1. Describe the data to be collected and the survey instruments that will be used.
2. Describe how the data will be analyzed and how the applicant will use the data to evaluate program implementation and impact policy, systems, and environmental changes, including monitoring changes in the retail environment and use of emerging tobacco products, including e-cigarettes.
3. Describe what types of reports will be developed, how the reports will link existing data with data collected, and how these data will be disseminated and to what audiences including partners.
4. Describe how the data collected will be used to identify populations affected by tobacco-related disparities, including disparities that exist within these populations, demographic characteristics, health status, and tobacco control policies.
5. Describe ability to access Behavioral Risk Factor Surveillance System (BRFSS) data and YTS/YRBS or data sources that provide equivalent data.
6. Discuss the data to be collected and the survey instrument that will be used when conducting the state youth tobacco survey or state youth risk behavior survey.

**Evaluation and Performance Measurement Plan (10 Points)**

1. Describe how key program partners will be engaged in the evaluation and performance measurement planning processes and how the program will engage partners and stakeholder with the evaluation information.
2. Describe key evaluation questions, the types of evaluations conducted (i.e. process and/or outcome), and how performance measures are addressed, evaluated, and reported.
3. Describe available data sources and feasibility of collecting appropriate evaluation and performance data.
4. Describe how evaluation findings are used for continuous program and quality improvement.
5. Describe how the program plans to provide evidence for progress on the performance measures outlined in the evaluation and performance measurement strategy section.

## Component 2: Commercial Tobacco Use and Dependence Treatment Support System - 25 Points

Applicants will be scored on the extent to which the evaluation and performance measurement plan demonstrates the following:

**Evaluation Strategies (10 points)**

1. Explain how examining the impact of federal and state strategies and activities on tobacco use and dependence quit support services will be used to develop appropriate strategies.

2. Describe a plan to evaluate the impact of evidence-based tobacco use and dependence quit support services, including the use of digital-based technologies, such as texting, apps, web, and chat.
3. Provide information on any state media education campaign activity during CDC's national tobacco education campaign.
4. Describe plans to ensure that an evaluator and key program partners are engaged with evaluation efforts.

**Evaluation and Performance Measurement Plan (15 points)**

1. Describe how strategies and activities will be implemented as planned, progress is being made, and program evaluations are conducted.
2. Describe how the performance measures will be collected, the process for responding to the evaluation questions, and the use of evaluation findings for continuous program quality improvement.
3. Describe how data will be collected for the intermediate and long-term outcomes identified in the logic model.
4. Describe how quit support services' data, including intake data and services provided, will be collected and tracked. Data includes demographic data on quitline callers, and total call volume.
5. Describe ability to submit data to CDC's National Quitline Data Warehouse.

| iii. Applicant's Organizational Capacity to Implement the Approach | Maximum Points:30 |
|---|---|

**Component 1: National Tobacco Control Program (State Based) - 30 Points**

Applicants will be scored on the extent to which the applicant demonstrates adequate infrastructure and capacity to implement a comprehensive statewide tobacco control program to achieve the outcomes of the NOFO.

**Infrastructure, Administration, and Management (20 points)**

The extent to which the applicants develop and maintain infrastructure aligned with the five core components of the Component Model of Infrastructure including:

1. Networked Partnerships – Describe how the applicant will collaborate with CDC, relevant CDC-funded programs, and external organizations necessary to execute the proposed work plan. Applicants are required to submit two letters of support from CDC-funded programs in the state department of health, addressing how the applicant and the program will collaborate with each other.
2. Multi-level Leadership – Describe how the applicant will identify and nurture leaders and champions at all levels, i.e., individuals, local and statewide government agencies, and non-governmental organizations.
3. Engaged Data – Describe how the applicant will use data to engage staff, partners, decision makers, and community programs to act and to promote and implement activities to reach public health goals.
4. Managed Resources – Describe current staff and staff that will be hired to carry out the project activities, including a description of tasks or roles, required experience, and time

commitment for each of the project staff and the organizational capacity and history to manage funds effectively; applicant must also provide an organization chart.

5. Responsive Plan/Planning – Describe how a comprehensive statewide tobacco control and sustainability plan, including health communication plan, and evaluation plan will be developed or revised in partnership with a multi-disciplinary and diverse group of stakeholders, i.e., partners, local community members, and non-governmental organizations.
6. Fiscal Management – Describe the recent history and the plan to manage the program fiscally including timely spending, contract management of awards with state and community partners.
7. Describe how the applicant will execute the proposed work plan and collaborate with partners (i.e., state education system, health care organizations, military base personnel, and other organizations, including youth sports organization to prevent initiation of tobacco products among youth and young adults.
8. Describe staff capacity, experience, and expertise to manage and implement strategies and activities that prevent initiation of emerging tobacco products for youth and young adults.
9. Discuss how the applicant plans to direct a minimum of 10% of funding to evaluation activities, including the availability of an evaluator.

**Implementation Readiness (10 Points)**

Applicants will be scored on the extent to which the following items are addressed:

1. Describe how the applicant will dedicate experienced, qualified staff for a full-time equivalent Program Manager who is responsible for the day-to day operations, a full-time tobacco use and dependence treatment coordinator to manage and support tobacco use and dependence treatment-related strategies and activities, a full-time staff to manage prevention of initiation of emerging tobacco products, including e-cigarettes among youth and young adults, and a program evaluator to conduct program evaluations. CVs/Resumes are required.
2. Discuss how the applicant plans to fund a local lead agency to implement tobacco control strategies and activities in a community; clarify how to ensure the local lead agency demonstrates expertise in evidence-based strategies (including policy, systems, and environmental change approaches) to reduce tobacco use and dependence and secondhand smoke exposure.
3. Describe how the applicant plans to develop and/or engage a community coalition to implement evidence-based strategies and activities that reduce tobacco use and dependence and secondhand smoke exposure among the selected population within a selected community.
4. Describe mechanisms to ensure the funded local lead agency has capacity to administer, monitor, and evaluate activities and ensure that CDC recommended evidence-base strategies and activities are implemented.
5. Submit one letter of support from an active statewide coalition member on the represented organization's letterhead.

**Component 2: Commercial Tobacco Use and Dependence Treatment Support System - 30**

**Points**

Applicants will be scored on the extent to which the following items are addressed:

1. Provide evidence at least five (5) years of experience providing proactive tobacco quitline services or other similar quitline services across a state or territory to ensure continuous services.
2. Provide evidence of a full-time tobacco use and dependence treatment coordinator.
3. Discuss staffing and tobacco use and dependence quit support services capacity, including quitline.
4. Describe current delivery of tobacco use and dependence quit support services, including quitline and digital-based technologies, such as texting, apps, web, and chat, and involvement of public-private partnerships in supporting these services.
5. Describe how the applicant works seamlessly with current partner organizations to ensure quitline services are delivered quickly and effectively.
6. Demonstrates the ability to administer program funds in accordance with standard accounting practices and HHS accounting rules.

Budget

The extent to which the proposed budget is reasonable and consistent with the state objectives and planned activities. The applicant can obtain guidance for completing a detailed justified budget on CDC's website, at https://www.cdc.gov/grants/documents/Budget-Preparation-Guidance.pdf.

**c. Phase III Review**

All applications will be evaluated by an objective review panel on the basis of each item referenced in Section E. *Review and Selection Process*.

**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

Applicants can anticipate notice of funding May 20, 2020 - June 3, 2020.

## F. Award Administration Information

### 1. Award Notices

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

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

Unsuccessful applicants will receive notification of these results by e-mail with delivery receipt

or by U.S. mail.

## 2. Administrative and National Policy Requirements

Recipients must comply with the administrative and public policy requirements outlined in 45 CFR Part 75 and the HHS Grants Policy Statement, as appropriate.
Brief descriptions of relevant provisions are available at http://www.cdc.gov/grants/additionalrequirements/index.html#ui-id-17.
The HHS Grants Policy Statement is available at http://www.hhs.gov/sites/default/files/grants/grants/policies-regulations/hhsgps107.pdf.

The 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

## 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 | Annual progress report. | 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 project period. | Yes |
| Payment Management System (PMS) Reporting | Quarterly reports due January 30; April 30; July 30; and October 30. | Yes |
| Impact Statement for Each Component | 30 days after the end of the budget period. | Yes |
| Communication Plan | 6 months into award. | Yes |
| Evaluation Plan Template | 90 days after the end of the budget period. | Yes |
| Comprehensive State Tobacco Control and Sustainability Plan | 6 months into the award. | Yes |

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

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

Performance Measurement

• Performance measures and targets
• The frequency that performance data are to be collected.
• How performance data will be reported.
• How quality of performance data will be assured.
• How performance measurement will yield findings to demonstrate progress towards achieving NOFO goals (e.g., reaching target populations or achieving expected outcomes).
• Dissemination channels and audiences.
• Other information requested as determined by the CDC program.

Evaluation

• The types of evaluations to be conducted (e.g. process or outcome evaluations).
• The frequency that evaluations will be conducted.
• How evaluation reports will be published on a publically available website.

• How evaluation findings will be used to ensure continuous quality and program improvement.
• How evaluation will yield findings to demonstrate the value of the NOFO (e.g., effect on improving public health outcomes, effectiveness of NOFO, cost-effectiveness or cost-benefit).
• Dissemination channels and audiences.

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

**b. Annual Performance Report (APR) (required)**

The recipient must submit the APR via www.Grantsolutions.gov no later than120 days prior to the end of the budget period. This report must not exceed 45 pages excluding administrative reporting. Attachments are not allowed, but web links are allowed.
This report must include the following:

- **Performance Measures:** Recipients must report on performance measures for each budget period and update measures, if needed.
- **Evaluation Results:** Recipients must report evaluation results for the work completed to date (including findings from process or outcome evaluations).
- **Work Plan:** Recipients must update work plan each budget period to reflect any changes in period of performance outcomes, activities, timeline, etc.
- **Successes**
    - Recipients must report progress on completing activities and progress towards achieving the period of performance outcomes described in the logic model and work plan.
    - Recipients must describe any additional successes (e.g. identified through evaluation results or lessons learned) achieved in the past year.
    - Recipients must describe success stories.
- **Challenges**
    - Recipients must describe any challenges that hindered or might hinder their ability to complete the work plan activities and achieve the period of performance outcomes.
    - Recipients must describe any additional challenges (e.g., identified through evaluation results or lessons learned) encountered in the past year.
- **CDC Program Support to Recipients**
    - Recipients must describe how CDC could help them overcome challenges to complete activities in the work plan and achieving period of performance outcomes.
- **Administrative Reporting** (No page limit)
    - SF-424A Budget Information-Non-Construction Programs.
    - Budget Narrative – Must use the format outlined in "Content and Form of Application Submission, Budget Narrative" section.

- Indirect Cost Rate Agreement.

The recipients must submit the Annual Performance Report via www.Grantsolutions.gov no later than 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. 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)**
This report is due 90 days after the end of the period of performance. 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 project period, 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).

## 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.

## G. Agency Contacts

CDC encourages inquiries concerning this notice of funding opportunity.

### Program Office Contact

**For programmatic technical assistance,** contact:

Randi Frank, Project Officer
Department of Health and Human Services
Centers for Disease Control and Prevention
4770 Buford Hwy, S107-7

Atlanta GA 30341

Telephone: (770) 488-5114
Email: dp202001@cdc.gov

### Grants Staff Contact

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

Monique Tatum, Grants Management Specialist
Department of Health and Human Services
Office of Grants Services
Telephone: (770) 488-2617

Email: itn8@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
- CDC Assurances and Certifications
- 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
- Letters of Support
- Organization Charts
- Indirect Cost Rate, if applicable
- Bona Fide Agent status documentation, if applicable

In responding to this NOFO, applicants' Project Narrative section is expanded to include 20 pages for each component with a limit of 40 total pages.

Required attachments include:

- Draft Local Lead Agency RFP or Cooperative Agreement

## I. Glossary

**Activities:** The actual events or actions that take place as a part of the program.
**Administrative and National Policy Requirements, Additional Requirements (ARs):** Administrative requirements found in 45 CFR Part 75 and other requirements mandated by statute or CDC policy. All ARs are listed in the Template for CDC programs. CDC programs must indicate which ARs are relevant to the NOFO; recipients must comply with the ARs listed in the NOFO. To view brief descriptions of relevant provisions, see http:// www.cdc.gov/ grants/ additional requirements/ index.html. Note that 2 CFR 200 supersedes the administrative requirements (A-110 & A-102), cost principles (A-21, A-87 & A-122) and audit requirements (A-50, A-89 & A-133).
**Approved but Unfunded:** Approved but unfunded refers to applications recommended for approval during the objective review process; however, they were not recommended for funding by the program office and/or the grants management office.
**Assistance Listings (CFDA):** A government-wide compendium published by the General Services Administration (available on-line in searchable format as well as in printable format as a .pdf file) that describes domestic assistance programs administered by the Federal Government.
**Assistance Listings (CFDA) 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 project period. Traditionally, budget periods are 12 months or 1 year.
**Carryover:** Unobligated federal funds remaining at the end of any budget period that, with the approval of the GMO or under an automatic authority, may be carried over to another budget period to cover allowable costs of that budget period either as an offset or additional authorization. Obligated but liquidated funds are not considered carryover.
**CDC Assurances and Certifications:** Standard government-wide grant application forms.
**Competing Continuation Award:** A financial assistance mechanism that adds funds to a grant and adds one or more budget periods to the previously established period of performance (i.e., extends the "life" of the award).
**Continuous Quality Improvement:** A system that seeks to improve the provision of services with an emphasis on future results.
**Contracts:** An award instrument used to acquire (by purchase, lease, or barter) property or services for the direct benefit or use of the Federal Government.
**Cooperative Agreement:** A financial assistance award with the same kind of interagency relationship as a grant except that it provides for substantial involvement by the federal agency funding the award. Substantial involvement means that the recipient can expect federal programmatic collaboration or participation in carrying out the effort under the award.
**Cost Sharing or Matching:** Refers to program costs not borne by the Federal Government but by the recipients. It may include the value of allowable third-party, in-kind contributions, as well as expenditures by the recipient.
**Direct Assistance:** A financial assistance mechanism, which must be specifically authorized by statute, whereby goods or services are provided to recipients in lieu of cash. DA generally

involves the assignment of federal personnel or the provision of equipment or supplies, such as vaccines. DA is primarily used to support payroll and travel expenses of CDC employees assigned to state, tribal, local, and territorial (STLT) health agencies that are recipients of grants and cooperative agreements. Most legislative authorities that provide financial assistance to STLT health agencies allow for the use of DA. http:// www.cdc.gov /grants /additionalrequirements /index.html.

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

**Evaluation (program evaluation):** The systematic collection of information about the activities, characteristics, and outcomes of programs (which may include interventions, policies, and specific projects) to make judgments about that program, improve program effectiveness, and/or inform decisions about future program development.

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

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

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

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

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

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

grant.
**Grants Management Specialist (GMS):** A federal staff member who oversees the business and other non-programmatic aspects of one or more grants and/or cooperative agreements. These activities include, but are not limited to, evaluating grant applications for administrative content and compliance with regulations and guidelines, negotiating grants, providing consultation and technical assistance to recipients, post-award administration and closing out grants.
**Health Disparities:** Differences in health outcomes and their determinants among segments of the population as defined by social, demographic, environmental, or geographic category.
**Health Equity:** Striving for the highest possible standard of health for all people and giving special attention to the needs of those at greatest risk of poor health, based on social conditions.
**Health Inequities:** Systematic, unfair, and avoidable differences in health outcomes and their determinants between segments of the population, such as by socioeconomic status (SES), demographics, or geography.
**Healthy People 2030:** National health objectives aimed at improving the health of all Americans by encouraging collaboration across sectors, guiding people toward making informed health decisions, and measuring the effects of prevention activities.
**Inclusion:** Both the meaningful involvement of a community's members in all stages of the program process and the maximum involvement of the target population that the intervention will benefit. Inclusion ensures that the views, perspectives, and needs of affected communities, care providers, and key partners are considered.
**Indirect Costs:** Costs that are incurred for common or joint objectives and not readily and specifically identifiable with a particular sponsored project, program, or activity; nevertheless, these costs are necessary to the operations of the organization. For example, the costs of operating and maintaining facilities, depreciation, and administrative salaries generally are considered indirect costs.
**Intergovernmental Review:** Executive Order 12372 governs applications subject to Intergovernmental Review of Federal Programs. This order sets up a system for state and local governmental review of proposed federal assistance applications. Contact the state single point of contact (SPOC) to alert the SPOC to prospective applications and to receive instructions on the State's process. Visit the following web address to get the current SPOC list: https://www.whitehouse.gov/wp-content/uploads/2017/11/Intergovernmental_-Review-_SPOC_01_2018_OFFM.pdf.
**Letter of Intent (LOI):** A preliminary, non-binding indication of an organization's intent to submit an application.
**Lobbying:** Direct lobbying includes any attempt to influence legislation, appropriations, regulations, administrative actions, executive orders (legislation or other orders), or other similar deliberations at any level of government through communication that directly expresses a view on proposed or pending legislation or other orders, and which is directed to staff members or other employees of a legislative body, government officials, or employees who participate in formulating legislation or other orders. Grass roots lobbying includes efforts directed at inducing or encouraging members of the public to contact their elected representatives at the federal, state, or local levels to urge support of, or opposition to, proposed or pending legislative proposals.
**Logic Model:** A visual representation showing the sequence of related events connecting the activities of a program with the programs' desired outcomes and results.

**Maintenance of Effort:** A requirement contained in authorizing legislation, or applicable regulations that a recipient must agree to contribute and maintain a specified level of financial effort from its own resources or other non-government sources to be eligible to receive federal grant funds. This requirement is typically given in terms of meeting a previous base-year dollar amount.

**Memorandum of Understanding (MOU) or Memorandum of Agreement (MOA):** Document that describes a bilateral or multilateral agreement between parties expressing a convergence of will between the parties, indicating an intended common line of action. It is often used in cases where the parties either do not imply a legal commitment or cannot create a legally enforceable agreement.

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

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

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

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

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

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

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

**Plain Writing Act of 2010:** The Plain Writing Act of 2010 requires that federal agencies use clear communication that the public can understand and use. NOFOs must be written in clear, consistent language so that any reader can understand expectations and intended outcomes of the funded program. CDC programs should use NOFO plain writing tips when writing NOFOs.

**Program Strategies:** Strategies are groupings of related activities, usually expressed as general headers (e.g., Partnerships, Assessment, Policy) or as brief statements (e.g., Form partnerships, Conduct assessments, Formulate policies).

**Program Official:** Person responsible for developing the NOFO; can be either a project officer, program manager, branch chief, division leader, policy official, center leader, or similar staff member.
**Public Health Accreditation Board (PHAB)**: A nonprofit organization that works to promote and protect the health of the public by advancing the quality and performance of public health departments in the U.S. through national public health department accreditation http://www.phaboard.org.
**Social Determinants of Health:** Conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.
**Statute:** An act of the legislature; a particular law enacted and established by the will of the legislative department of government, expressed with the requisite formalities. In foreign or civil law any particular municipal law or usage, though resting for its authority on judicial decisions, or the practice of nations.
**Statutory Authority:** Authority provided by legal statute that establishes a federal financial assistance program or award.
**System for Award Management (SAM):** The primary vendor database for the U.S. federal government. SAM validates applicant information and electronically shares secure and encrypted data with federal agencies' finance offices to facilitate paperless payments through Electronic Funds Transfer (EFT). SAM stores organizational information, allowing www.grants.gov to verify identity and pre-fill organizational information on grant applications.
**Technical Assistance:** Advice, assistance, or training pertaining to program development, implementation, maintenance, or evaluation that is provided by the funding agency.
**Work Plan:** The summary of period of performance outcomes, strategies and activities, personnel and/or partners who will complete the activities, and the timeline for completion. The work plan will outline the details of all necessary activities that will be supported through the approved budget.

## NOFO-specific Glossary and Acronyms

**Adult Tobacco Survey (ATS):** Assess the prevalence of tobacco use, as well as the factors promoting and impeding tobacco use among adults.

**Award Ceiling**: The maximum amount of funding an applicant may request in the application budget.

**Award Floor**: The minimum amount of funding an applicant may request in the application budget.

**Behavioral Health Conditions:** Includes mental health conditions and substance use disorders

**Behavioral Risk Factor Surveillance System (BRFSS)**: The nation's premier system of health-related telephone surveys that collect state data about U.S. residents regarding their health-related risk behaviors, chronic health conditions, and use of preventive services.

**Commercial Tobacco Use and Dependence**: Commercial tobacco is manufactured by companies for recreational and habitual use in cigarettes, e-cigarettes, smokeless tobacco, pipe tobacco, cigars, hookahs, and other products.

**Community-Based:** Local-level policy, systems, and environmental changes.

**Data Visualization:** Using visuals to convey data in a meaningful way to the intended audience.

**Health Care Systems:** Interventions to improve the clinical environment to more effectively deliver quality preventive services and help Americans more effectively use and benefit from those services. The result: some chronic diseases and conditions will be avoided completely, and others will be detected early, or managed better to avert complications and progression and improve health outcomes. Health care system and quality improvement changes such as electronic health records, systems to prompt clinicians and deliver feedback on performance, and requirements for reporting on outcomes such as control of high blood pressure and the proportion of the population up-to-date on chronic disease screenings can encourage providers and health plans to focus on preventive services. Effective outreach to consumers and reducing barriers to accessing these services is also key, as coverage alone will not ensure use of preventive services.

**National Center for Chronic Disease Prevention and Health Promotion Domains:** Four key domains for transforming the nation's health and providing individuals with equitable opportunities to take charge of their health. These domains are (1) epidemiology and surveillance to gather, analyze, and disseminate data and information and conduct evaluation to inform, prioritize, deliver, and monitor programs and population health; (2) environmental approaches that promote health and support and reinforce healthful behaviors statewide and in communities; (3) health system interventions to improve the effective delivery and use of clinical and other preventive services in order to prevent disease, detect diseases early, and reduce or eliminate risk factors and mitigate or manage complications; (4) strategies to improve community-clinical linkages ensuring that communities support and clinics refer patients to programs that improve management of chronic conditions.

**National Quitline Data Warehouse:** The National Quitline Data Warehouse (NQDW) was established to assist in the evaluation of Centers for Disease Control and Prevention (CDC)-funded State and territorial quitlines and to provide a resource to states for ongoing tobacco control program evaluation and improvement.

**Pregnancy Risk Assessment Monitoring System (PRAMS):** PRAMS collects state-specific, population-based data on maternal attitudes and experiences before, during, and shortly after pregnancy.

**Proactive Quitlines:** Telephone line providing evidence-based behavioral counseling and support to help individuals who use tobacco and want to quit by initiating calls as well as receiving calls. For example, proactive quitlines schedule follow-up calls with individuals who use tobacco who are trying to quit in order to support them throughout their quit attempt.

**Statewide:** Policy, systems, and environmental changes that occur throughout the entire state.

**United States Preventive Services Task Force (USPSTF)**: An independent group of national experts in prevention and evidence-based medicine that works to improve the health of all Americans by making evidence-based recommendations about clinical preventive services such as screenings, counseling services, or preventive medications.

**Young Adult:** 18-24 years of age.

**Youth:** Less than 18 years of age.

**Youth Risk Behavioral Surveillance System (YRBSS):** YRBSS includes the Youth Risk Behavior Survey (YRBS) and administered to high school students to monitor health behaviors that contribute markedly to the leading causes of death, disability, and social problems among youth and adults in the United States.

**Youth Tobacco Survey (YTS):** YTS collects data from students in grades 6 through 12 and is intended to enhance the capacity of state agencies and organizations to design, implement, and evaluate tobacco prevention and control programs for the purposes of preventing young people from using tobacco and helping current users quit.