

Centers for Disease Control

National Center for Chronic Disease Prevention and Health Promotion

Good Health and Wellness in Indian Country
CDC-RFA-DP19-1903
Application Due Date: 06/12/2019

Good Health and Wellness in Indian Country
CDC-RFA-DP19-1903
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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 "Send Me Change Notifications Emails" link to ensure they receive notifications of any changes to CDC-RFA-DP19-1903. 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:

Good Health and Wellness in Indian Country

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-DP19-1903

E. Assistance Listings (CFDA) Number:

93.479

F. Dates:

1. Due Date for Letter of Intent (LOI):	**N/A**
2. Due Date for Applications:	**06/12/2019**, 11:59 p.m. U.S. Eastern Standard Time, at www.grants.gov.

3. Date for Informational Conference Call:

Tuesday, March 19, 2019 from 3:00 p.m. - 4:30 p.m., EDT. Call 1-800-857-9824. Participant Passcode: 4720690

To submit a question related to this NOFO, please email your question to GHWIC_requests@cdc.gov. Responses will be posted at https://www.cdc.gov/chronicdisease/about/foa/ghwic/index.htm in Frequently Asked Questions (FAQs).

G. Executive Summary:

1. Summary Paragraph:

The Centers for Disease Control and Prevention (CDC) announces the availability of Fiscal Year (FY) 2019 funds to implement *CDC-RFA-DP19-1903*, *Good Health and Wellness in Indian Country (GHWIC)*.

The purpose of this NOFO is to reduce rates of death and disability from commercial tobacco use, diabetes, heart disease and stroke, and reduce the prevalence of obesity and other chronic

disease risk factors and conditions (e.g., oral health, dementia, COPD). This NOFO has three (3) separate, competitive components with eligibility and scope of work requirements for each. Applicants must submit a separate application for each component for which they are applying.

The NOFO is based on the best available evidence for policy, systems, and environmental changes, and clinical-community linkage strategies, which may be culturally adapted to meet the needs of American Indian and Alaska Native communities.

The long-term outcomes of this NOFO are:

- Increased purchasing of healthy foods.
- Increased physical activity with an emphasis on walking.
- Increased breastfeeding.
- Reduced prevalence of commercial tobacco use.
- Reduced incidence of type 2 diabetes.
- Reduced prevalence of high blood pressure.
- Reduced prevalence of high blood cholesterol.

This is a five-year funding opportunity (five-year period of performance, one-year budget period).

For frequently asked questions (FAQs), go to https://www.cdc.gov/chronicdisease/about/foa/ghwic/index.htm. To submit an FAQ, send an email to GHWIC_requests@cdc.gov.

a. Eligible Applicants: Open Competition
b. NOFO Type: Cooperative Agreement
c. Approximate Number of Awards: 30
Component 1: Federally-recognized Tribes and Alaska Native Villages (12) and Urban Indian Organizations (4)
Component 2: Tribally-designated Organizations (13), up to 1 in each Area (the 12 IHS Administrative Areas) and the Urban Area defined as the Urban Indian Organizations.
Component 3: Tribally-designated Organization (1)

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

e. Average One Year Award Amount: $725,000
Component 1: $325,000 (range $100,000 - $375,000)
Component 2: $1,050,000 (range $750,000- $1,450,000)
Component 3: $800,000

f. Total Period of Performance Length: 5
g. Estimated Award Date: 09/30/2019
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

1. Background

a. Overview

American Indians and Alaska Natives (AI/AN) have higher rates of disease, injury, and premature death than other racial and ethnic groups [1, 2]. AI/AN adults have a higher prevalence of obesity and commercial tobacco use, and double the prevalence of diagnosed diabetes [3]. Deaths from stroke and heart disease are also higher [4]. Since 2014, NCCDPHP has funded three (3) cooperative agreements to reduce health disparities and increase health equity among AI/AN.

- Good Health and Wellness in Indian Country (DP14-1421, or GHWIC), launched in September 2014 and concluding September 2019, has the long-term goals of reducing rates of death and disability from tobacco use, diabetes, heart disease and stroke, and reducing obesity. GHWIC supported a holistic approach to healthy living and chronic disease prevention. GHWIC's Component 1 recipient activities addressed NCCDPHP's four domains: epidemiology and surveillance, environmental approaches, health system interventions, and community clinical linkages [6]. Component 2 recipients provided technical assistance and subawards to Area Tribes, increasing the reach of GHWIC funding to nearly 120 tribes.
- Tribal Epi Center Public Health Infrastructure (DP17-1704, or TECPHI), launched in October 2017, to reduce chronic disease and risk factors, reduce disparities in health outcomes, and improve overall health by building public health capacity and infrastructure in Indian Country for disease surveillance, epidemiology, prevention and control of disease, injury or disability, and program monitoring and evaluation [7].
- In May 2018, CDC launched Tribal Practices for Wellness in Indian Country (DP18-1812, or Tribal Practices). This 3-year funding opportunity supports traditional tribal practices that build resiliency and connections to community, family, and culture, which over time, can reduce risk factors for chronic disease among AI and AN [8].

This NOFO will build on the successes and lessons of GHWIC, TECPHI and Tribal Practices.

1. Arias, E., J. Xu, and M.A. Jim, *Period life tables for the non-Hispanic American Indian and Alaska Native population, 2007-2009.* Am J Public Health, 2014. **104 Suppl 3**: p. S312-9.
2. Espey, D.K., et al., *Leading Causes of Death and All-Cause Mortality in American Indians and Alaska Natives.* Am J Public Health, 2014.
3. Cobb, N., D. Espey, and J. King, *Health Behaviors and Risk Factors Among American Indians and Alaska Natives, 2000-2010.* Am J Public Health, 2014.
4. Veazie, M., et al., *Trends and disparities in heart disease mortality among American Indians/Alaska Natives, 1990-2009.* Am J Public Health, 2014. **104 Suppl 3**: p. S359-67.
5. Braun, P.A., et al., *A Cluster-Randomized, Community-Based, Tribally Delivered Oral Health Promotion Trial in Navajo Head Start Children.* J Dent Res, 2016. **95**(11): p.

1237-44.
6. *Good Health and Wellness in Indian Country*. 2015; Available from: https://www.cdc.gov/chronicdisease/tribal/factsheet.htm.
7. *Tribal Epidemiology Center Public Health Infrastructure*. 2017; Available from: https://www.cdc.gov/chronicdisease/tribal/tecphi.htm.
8. *Tribal Practices for Wellness in Indian Country*. 2017; Available from: https://www.cdc.gov/chronicdisease/tribal/tribalpractices.htm.

b. Statutory Authorities

This program is authorized under Sections 301(a) and 317 of the Public Health Service Act, 42 U.S.C. Section 241(a) and 247b.

c. Healthy People 2020

Heart Disease and Stroke, Nutrition and Weight Status, Oral Health, Tobacco Use, Physical Activity, Diabetes, Adolescent Health, Early and Middle Childhood, Maternal Infant and Child Health, Social Determinants of Health, and Public Health Infrastructure.

d. Other National Public Health Priorities and Strategies

- IHS Special Diabetes Program for Indians: https://www.ihs.gov/sdp/
- IHS Health Promotion Disease Prevention: https://www.ihs.gov/hpdp
- Public Health Accreditation Board (PHAB) Standards and Measures: https://www.phaboard.org/standards-and-measures-for-initial-accreditation/
- The Surgeon General's Call to Action to Support Breastfeeding: https://www.surgeongeneral.gov/library/calls/breastfeeding/index.html
- Step it Up! The Surgeon General's Call to Action to Promote Walking and Walkable Communities: https://www.surgeongeneral.gov/library/calls/walking-and-walkable-communities/index.html
- Physical Activity Guidelines for Americans, 2nd Edition: https://health.gov/paguidelines/second-edition/
- Dietary Guidelines for Americans 2015-2020: https://health.gov/dietaryguidelines/2015/
- Feeding Ourselves: Food Access, health disparities, and the pathways to healthy Native American communities: http://www.heart.org/HEARTORG/Advocate/VoicesforHealthyKids/Feeding-Ourselves_UCM_475570_Article.jsp#
- School Health Guidelines to Promote Healthy Eating and Physical Activity: http://www.cdc.gov/mmwr/pdf/rr/rr6005.pdf
- The National Tribal Behavioral Health Agenda: https://store.samhsa.gov/product/The-National-Tribal-Behavioral-Health-Agenda/PEP16-NTBH-AGENDA

- National Partnership for Action to End Health Disparities: https://minorityhealth.hhs.gov/npa/
- CDC-led National Diabetes Prevention Program: https://www.cdc.gov/diabetes/prevention/index.htm
- 2014 Surgeon General's Report: The Health Consequences of Smoking - 50 Years of Progress: https://www.surgeongeneral.gov/library/reports/50-years-of-progress/50-years-of-progress-by-section.htm
- Oral Health in America: A Report of the Surgeon General: https://profiles.nlm.nih.gov/ps/retrieve/ResourceMetadata/NNBBJT/
- A Million Hearts Initiative: https://millionhearts.hhs.gov/index.html
- NCCOR - National Collaborative on Childhood Obesity Research: https://www.nccor.org/

e. Relevant Work

These CDC programs have laid important groundwork in chronic disease prevention efforts in Indian Country:

- (2002-2004) Honoring Our Health
- (2005-2008) Identifying Indicators of Environmental Adaptations to Address Diabetes in AI/AN Communities
- (2002-2010) Diabetes Education K-12 curriculum, *Health is Life in Balance*
- (2008-2014) Using Traditional Foods and Sustainable Ecological Approaches to Promote Health and Prevent Diabetes in American Indian and Alaska Native Communities
- (2011-2013) Case studies from 8 tribal communities using *Eagle Books*
- (2013-2018) Tribal Public Health Capacity Building and Quality Improvement
- (2014-2019) A Comprehensive Approach to Good Health and Wellness in Indian Country
- (2017-2022) Cancer Prevention and Control Programs for State, Territorial, and Tribal Organizations
- (2017-2022) Building Public Health Infrastructure in Tribal Communities to Accelerate Disease Prevention and Health Promotion in Indian Country
- (2018-2021) Tribal Practices for Wellness in Indian Country
- (2018-2023) Networking2Save: CDC's National Network Approach to Preventing and Controlling Tobacco-related Cancers in Special Populations
- (2018-2023) Tribal Public Health Capacity Building and Quality Improvement Umbrella Cooperative Agreement and Supplement
- (2018-2023) Racial and Ethnic Approaches to Community Health (REACH)
- (2018-2023) Diabetes and Heart Disease & Stroke Prevent Programs-Improving the Health of Americans through Prevention and Management of Diabetes and Heart Disease and Stroke
- (2018-2023) Diabetes and Heart Disease & Stroke Prevent Programs-Innovative State and Local Public Health Strategies to Prevent and Manage Diabetes and Heart Disease and Stroke

- (2018-2023) High Obesity Program
- (2018-2023) State Physical Activity and Nutrition Program
- (2018-2023) Improving Student Health and Academic Achievement through Nutrition, Physical Activity and the Management of Chronic Conditions in Schools

2. CDC Project Description

a. Approach

Bold indicates period of performance outcome.

This NOFO is the collaborative effort of six (6) divisions/office within CDC's National Center for Chronic Disease Prevention and Health Promotion.

- Division of Diabetes Translation
- Division for Heart Disease and Stroke Prevention
- Division of Nutrition, Physical Activity, and Obesity
- Division of Oral Health
- Division of Population Health
- Office on Smoking and Health

The strategies, activities, and outcomes of this NOFO will build upon the national efforts of these divisions/office to increase the health impact throughout Indian Country. The NOFO combines evidence-informed (1) policy, systems, and environmental change (obesity, tobacco), and (2) clinical-community linkage (diabetes, heart disease and stroke prevention) strategies and activities. The strategies and activities of this NOFO may be culturally-adapted as appropriate to meet the cultural and health needs of American Indian and Alaska Native communities.

This NOFO has three (3) separate, competitive components with eligibility and scope of work requirements for each. Applicants must submit a separate application for each component for which they are applying.

Component 1 (C1) applicants must propose at least *one* activity from the policy, system, and environmental change (PSE) strategies (obesity or tobacco), *one* activity from the diabetes prevention community-clinical linkage (CCL) strategies, and *one* activity from the heart disease and stroke prevention community-clinical linkage strategies in their work plans (for a total of *at least three* activities). Applicants should describe their plans to implement evidence-informed and culturally-adapted strategies to improve the health of their community members and to prevent chronic diseases and their risk factors. PSE strategies are to prevent obesity and prevent and control commercial tobacco use and exposure. CCL strategies are to prevent type 2 diabetes and prevent heart disease and stroke. Applicants are limited to federally-recognized Tribes, Alaska Native Villages, and Urban Indian Organizations (UIOs) (see Section C, Eligibility Information).

Component 2 (C2) applicants must propose allocating at least 50% of their annual award in subawards to at least four (4) American Indian Tribes/Alaska Native Villages, Urban Indian Organizations (UIOs), and other tribal entities providing support for DP19-1903 activities to American Indian Tribes/Alaska Native Villages including rural populations, and providing training, technical assistance, and evaluation support to all Tribes/Villages/UIOs/other tribal

entities in their Area with remaining award funds. C2 applicants must describe how they will make subawards, including the rationale for their approach, so that all four Component 1 strategies (1. Obesity, 2. Commercial tobacco use, 3. Type 2 diabetes, and 4. Heart disease and stroke prevention) are addressed over the 5-year period of performance. This is to ensure these resources and programs reach additional local Tribes/Villages/UIOs/other tribal entities beyond those directly funded C1 recipients. Each subawardee must address at least one C1 strategy, yet does not need to address all four strategies; however, all four strategies must be addressed across the group of subawardees over the 5-year period. Applicants do not need to identify the subawardees in the application, but should describe how subawardees will be selected. Applicants must provide subawards and support to at least four (4) Area Tribes/Villages/UIOs/other tribal entities *and* provide technical assistance and support to all Tribes/Villages/UIOs in their Area. Applicants are limited to American Indian or Alaska Native Tribally-designated Organizations that support at least 4 Area Tribes/Villages/UIOs (see Section C, Eligibility Information).

Component 3 (C3) applicants must propose the establishment of a Tribal Coordinating Center (TCC). Applicants should describe how the TCC will be developed and plans to 1) Develop a national communication plan, 2) Coordinate the development and implementation of a national evaluation plan in collaboration with CDC evaluators, and 3) Establish and support a Community of Practice (CoP) consisting of representatives from each C1 and C2 recipient, and facilitate regular CoP meetings to support shared learning and peer support to advance the goals of GHWIC and support prevention of other chronic disease risk factors and conditions (e.g., oral health, dementia, COPD). Applicants are limited to American Indian or Alaska Native Tribally-designated Organizations that support at least 4 Area Tribes/Villages/UIOs (see Section C, Eligibility Information). C3 applicants may also be applicants for C2 funding.

Logic Models: Good Health and Wellness in Indian Country

Component 1 Logic Model

Bold Intermediate-term Outcomes indicates period of performance outcomes.

Strategy 1: Implement evidenced-informed and culturally-adapted policy, system, and environmental changes (PSE) to prevent obesity.			
Activities	**Short-term Outcomes (1-3 years)**	**Intermediate-term Outcomes (3-5 years)**	**Long-term Outcomes (5+ years)**
Improve tribal food and beverage programs/systems (e.g., community gardens, farmers markets, public transportation routes to food stores, access to healthy foods at community venues or	Increased number of places offering healthy foods (e.g., fresh produce, low sodium options) and beverages as a result of improvements to the food system.	**Increased number of places offering healthy foods (e.g., fresh produce, low sodium options) and beverages.** **Increased percent improvement in number of places**	Increased purchasing of healthier foods.

schools, using food service guidelines and nutrition standards).		**offering healthy foods (e.g., fresh produce, low sodium options) and beverages.**	
Collaborate with partners to improve land use design to connect activity-friendly routes (e.g., sidewalks, bicycle routes, public transit) with everyday destinations (e.g., homes, schools, work sites, parks).	Increased number of places where community design has been improved to connect places for physical activity in a safe and accessible manner.	**Increased number of people using safe and accessible places for physical activity.** **Increased percent improvement in number of people using safe and accessible places for physical activity.**	Increased physical activity with an emphasis on walking.
Increase continuity of care/community support for breastfeeding by incorporating services into existing community support services (e.g., early care and education centers, community health centers, home visiting programs); establishin g culturally-appropriate and accessible lactation support services (e.g., support groups, walk-in clinics, Baby Cafés); and providing breast feeding support training to health care providers, community health workers, peer support providers, etc. that work with mothers and babies.	Increased number of places that implement culturally-adapted continuity of care/community support strategies to promote and support breastfeeding.	**Increased number of breastfeeding mothers who use community services that support breastfeeding.** **Increased percent improvement in number of breastfeeding mothers who use community services that support breastfeeding.**	Increased breastfeeding.

Strategy 2: Implement evidenced-informed and culturally-adapted policy, system, and environmental changes (PSE) to prevent and control commercial tobacco use.			
Activities	**Short-term Outcomes (1-3 years)**	**Intermediate-term Outcomes (3-5 years)**	**Long-term Outcomes (5+ years)**
Implement commercial tobacco-free policies within workplaces, restaurants, bars, casinos, schools, multi-unit housing, indoor and outdoor events, celebrations and gatherings.	Increased number of practices and policies addressing protection from secondhand commercial tobacco smoke.	**Increased number of workplaces, restaurants, bars, casinos, schools, multi-unit housing, indoor and outdoor events, celebrations and gatherings that implement commercial tobacco-free policies.** **Increased percent improvement in number of workplaces, restaurants, bars, casinos, schools, multi-unit housing, indoor and outdoor events, celebrations and gatherings that implement commercial tobacco-free policies.**	Reduced prevalence of commercial tobacco use.
Provide referrals to evidence-based commercial tobacco cessation treatment, including counseling and FDA-approved medications.	Increased number of referrals to evidence-based commercial tobacco cessation.	**Increased number of commercial tobacco-using patients who receive commercial tobacco cessation interventions.** **Increased percent improvement in number of commercial tobacco-using patients who**	Reduced prevalence of commercial tobacco use.

		receive commercial tobacco cessation interventions.	
Strategy 3: Implement evidence-informed and culturally-adapted community-clinical linkages (CCL) to support type 2 diabetes prevention.			
Activities	**Short-term Outcomes (1-3 years)**	**Intermediate-term Outcomes (3-5 years)**	**Long-term Outcomes (5+ years)**
Expand access to the National Diabetes Prevention Program (National DPP) lifestyle change program in tribal communities by:			
Increasing awareness of prediabetes among tribal members and health care providers/ health professionals (e.g., community wide events, educational campaigns, health-care provider/health professionals training);	Increased number of community members/health professionals educated about prediabetes and associated risk for type 2 diabetes, heart attack, and stroke.	**Increased number of community members at high risk for diabetes enrolled in CDC-recognized type 2 diabetes prevention programs offered in AI/AN communities.**	Reduced incidence of type 2 diabetes.
Supporting prediabetes screening, testing, and referrals to CDC-recognized type 2 diabetes prevention programs by health care teams, community partners, health para-professionals;	Increased number of adult community members screened and tested for prediabetes and referred to a CDC-recognized type 2 diabetes prevention program if applicable.	**Increased number of community members at high risk for diabetes enrolled in CDC-recognized type 2 diabetes prevention programs offered in AI/AN communities.**	Reduced incidence of type 2 diabetes.
Establishing or expanding the reach of CDC-recognized type 2 diabetes prevention programs in AI/AN communities and promoting	Increased number of CDC-recognized type 2 diabetes prevention programs/classes offered in AI/AN communities to prevent or delay	**Increased number of community members at high risk for diabetes enrolled in CDC-recognized type 2 diabetes prevention**	Reduced incidence of type 2 diabetes.

sustainability (e.g., assess exiting resources, CDC-recognized programs offered by other organizations in the AI/AN community, and modes of program delivery options);	onset of type 2 diabetes.	**programs offered in AI/AN communities.**	
Developing culturally-relevant approaches to increase program participation and retention among AI/AN members (e.g., culturally-relevant materials, innovative retention strategies, community members trained as lifestyle coaches).	Increased number of CDC-recognized diabetes prevention programs/classes offering culturally-relevant materials and approaches to increase program participation and retention.	**Increased number of community members at high risk for diabetes enrolled in CDC-recognized type 2 diabetes prevention programs offered in AI/AN communities.**	Reduced incidence of type 2 diabetes.
Strategy 4: Implement evidence-informed and culturally-adapted community-clinical linkages (CCL) to support heart disease and stroke prevention.			
Activities	**Short-term Outcomes (1-3 years)**	**Intermediate-term Outcomes (3-5 years)**	**Long-term Outcomes (5+ years)**
Expand engagement of community health representatives and other health paraprofessionals to become effective members of chronic disease prevention/ management teams within their local health care systems to manage and refer community members with or at high risk of high blood pressure or high blood cholesterol to appropriate and	Increased number of trained community health representatives who are equipped to deliver evidence-informed, locally available community health programs to support prevention, detection, and control of high blood pressure and/or high blood cholesterol.	Increased percentage of patients 18-85 years of age with diagnosed hypertension who have a BP less than 140/90. Increased percentage of patients with total cholesterol at goal (LDL and HDL). **Increased number of patients with high blood pressure or high blood cholesterol engaged**	Reduced prevalence of high blood pressure. Reduced prevalence of high blood cholesterol.

locally available health and preventive care programs.		**in self-management and treatment programs.** **Increased percent improvement in number of patients with high blood pressure or high blood cholesterol engaged in self-management and treatment programs.**	
Implement team-based care, including non-physician team members (e.g., nurses, pharmacists, patient navigators), in managing patients with or at risk for high blood pressure and/or high blood cholesterol.	Increased number of patients with or at risk for high blood pressure and/or high blood cholesterol receiving team-based care.	Increased percentage of patients 18-85 years of age with diagnosed hypertension who have a BP less than 140/90. Increased percentage of patients with total cholesterol at goal (LDL and HDL). **Increased number of patients with high blood pressure or high blood cholesterol engaged in self-management and treatment programs.** **Increased percent improvement in number of patients with high blood pressure or high blood cholesterol engaged in self-management and treatment**	Reduced prevalence of high blood pressure. Reduced prevalence of high blood cholesterol.

		programs.	
Develop culturally-relevant materials and approaches to link tribal/village resources and clinical services to support prevention, detection, and control of high blood pressure and/or high blood cholesterol.	Increased number of culturally-relevant materials and approaches to link tribal/village resources and clinical services to support prevention, detection, and control of high blood pressure and/or high blood cholesterol.	Increased percentage of patients 18-85 years of age with diagnosed hypertension who have a BP less than 140/90. Increased percentage of patients with total cholesterol at goal (LDL and HDL). **Increased number of patients with high blood pressure or high blood cholesterol engaged in self-management and treatment programs.** **Increased percent improvement in number of patients with high blood pressure or high blood cholesterol engaged in self-management and treatment programs.**	Reduced prevalence of high blood pressure. Reduced prevalence of high blood cholesterol.

Component 2 Logic Model

Bold Intermediate-term Outcomes indicates period of performance outcomes.

Note: Component 2 Recipients will be required to provide the name, funding amount, C1 activities conducted, and progress on C1 outcomes by each Tribe/Village/UIO subawardee funded through this NOFO.

Strategy: Provide funding, training, technical assistance, and evaluation support to Area Tribes/Villages/UIOs/other tribal entities conducting activities across all four C1 strategies.			
Activities	**Short-term Outcomes (1-3 years)**	**Intermediate-term Outcomes (3-5 years)**	**Long-term Outcomes (5+ years)**
Expand the implementation of Component 1 strategies and activities to reach at least 4 additional Area Tribes/Villages or UIOs.	Increased number of Area Tribes/Villages/UIOs implementing activities across all four C1 strategies (PSEs and CCLs).	**Increased number of Area Tribes/Villages/UIOs implementing activities across all four C1 strategies (PSEs and CCLs).**	Increased purchasing of healthy foods. Increased physical activity with an emphasis on walking. Reduced prevalence of commercial tobacco use. Reduced incidence of type 2 diabetes. Reduced prevalence of high blood pressure. Reduced prevalence of high blood cholesterol.
Provide technical assistance, training, and resources to all Area Tribes/Villages/UIOs/ other tribal entities to support the planning, development, implementation, and evaluation of activities across all four C1 strategies.	Increased number of Area Tribes/Villages/UIOs implementing activities across all four C1 strategies (PSEs and CCLs).	**Increased number of Area Tribes/Villages/UIOs implementing activities across all four C1 strategies (PSEs and CCLs).**	Increased purchasing of healthy foods. Increased physical activity with an emphasis on walking. Reduced prevalence of commercial tobacco use. Reduced incidence of type 2 diabetes. Reduced prevalence of high blood pressure. Reduced prevalence of high blood cholesterol.
Assist Area Tribes/Villages/UIOs/ other tribal entities in developing multi-sector	Increased number of Area Tribes/Villages/UIOs/ other tribal	**Increased number of Area Tribes/Villages/UIOs implementing**	Increased purchasing of healthier foods. Increased physical

partnerships with organizations to support C1 strategies and activities in Tribes/Villages/UIOs.	entities engaged in active collaborations with health sector partners and non-health sector partners to support activities across all four C1 strategies.	**activities across all four C1 strategies (PSEs and CCLs)**.	activity with an emphasis on walking. Reduced prevalence of commercial tobacco use. Reduced incidence of type 2 diabetes. Reduced prevalence of high blood pressure. Reduced prevalence of high blood cholesterol.
Work with Area Tribes/Villages/UIOs/ other tribal entities to develop and implement tailored health communication/ messaging strategies to reach AI/AN populations at greatest risk for obesity, commercial tobacco use, type 2 diabetes, and/or heart disease and stroke in order to increase awareness and encourage healthier behaviors.	Increased number of communication messages disseminated by Area Tribes/Villages/UIOs/ other tribal entities to reach AI/AN populations at greatest risk for obesity, commercial tobacco use, type 2 diabetes, and/or heart disease and stroke in order to increase awareness and encourage appropriate health behaviors.	**Increased number of Area Tribes/Villages/UIOs implementing activities across all four C1 strategies (PSEs and CCLs).**	Increased purchasing of healthier foods. Increased physical activity with an emphasis on walking. Reduced prevalence of commercial tobacco use. Reduced incidence of type 2 diabetes. Reduced prevalence of high blood pressure. Reduced prevalence of high blood cholesterol.

Component 3 Logic Model

Bold Intermediate-term Outcomes indicates period of performance outcome.

Strategy: Establish a Tribal Coordinating Center (TCC) to collaborate with C1 and C2 recipients to foster peer-to-peer learning, share best- or promising-practices, coordinate national and local communication and evaluation efforts, and document success stories with measurable impact.			
Activities	**Short-term Outcomes (1-3 years)**	**Intermediate-term Outcomes (3-5 years)**	**Long-term Outcomes (5+ years)**
Coordinate the development and implementation of a communication strategy	Increased number of promising practices and success stories identified that	**Increased number of GHWIC promising practices and success stories disseminated**	Increased adoption of promising practices within AI/AN communities.

for promoting the value, impact, and achievements of the GHWIC program.	demonstrate a measurable impact of the program.	**among AI/AN communities.**	
Collaborate with CDC evaluators to develop and implement an evaluation plan for the national program, including the development of an evaluation measurement framework that includes performance measures for C1 and C2 recipients.	Increased number of C1 and C2 recipients using their data and evaluation findings to monitor progress in achieving the NOFO outcomes and to inform program improvements.	**Increased number of recipients submitting data to CDC to evaluate the national program in aggregate.**	Increased number of quality improvement activities implemented.
Develop and implement a coordinated, collaborative Community of Practice (CoP) focusing on chronic disease prevention, including oral health, to facilitate peer-to-peer learning, knowledge-sharing, problem-solving, and communication across the network using regular videoconferencing sessions.	Increased participation among C1 and C2 recipients in a collaborative virtual Community of Practice.	**Increased number of promising practices, lessons learned, and success stories identified, shared, and implemented over time.**	Increased implementation of promising practices within AI/AN communities.

i. Purpose

The purpose of this NOFO is to reduce rates of death and disability from commercial tobacco use, diabetes, heart disease and stroke, reduce the prevalence of obesity, and prevention of other chronic disease risk factors and conditions (e.g., oral health, dementia, COPD) among American Indians and Alaska Natives.

ii. Outcomes

Component 1:

Strategy1: Implement evidence-informed and culturally-adapted policy, system, and environmental changes (PSE) to prevent obesity.

- Increased number of people with access to healthy foods (e.g., fresh produce, low sodium options) and beverages.
- Increased percent improvement in number of people with access to healthy foods (e.g., fresh produce, low sodium options) and beverages.
- Increased number of people with access to safe and accessible places for physical activity.
- Increased percent improvement in number of people with access to safe and accessible places for physical activity.
- Increased number of breastfeeding mothers who use community services that support breastfeeding.
- Increased percent improvement in number of breastfeeding mothers who use community services that support breastfeeding.

Strategy 2: Implement evidence-informed and culturally-adapted policy, system, and environmental changes (PSE) to prevent and control commercial tobacco use.

- Increased number of workplaces, restaurants, bars, casinos, schools, multi-unit housing, indoor and outdoor events, celebrations and gatherings that implement commercial tobacco-free policies.
- Increased percent improvement in number of workplaces, restaurants, bars, casinos, schools, multi-unit housing, indoor and outdoor events, celebrations and gatherings that implement commercial tobacco-free policies.
- Increased number of commercial tobacco-using patients who receive commercial tobacco cessation interventions.
- Increased percent improvement in number of commercial tobacco-using patients who receive commercial tobacco cessation interventions.

Strategy 3: Implement evidence-informed and culturally-adapted community-clinical linkages (CCL) to support type 2 diabetes prevention.

- Increased number of community members at high risk for diabetes enrolled in CDC-recognized type 2 diabetes prevention programs offered in AI/AN communities.

Strategy 4: Implement evidence-informed and culturally-adapted community clinical linkages (CCL) to support heart disease and stroke prevention.

- Increased number of patients with high blood pressure or high blood cholesterol engaged in self-management and treatment programs.
- Increased percent improvement in number of patients with high blood pressure or high blood cholesterol engaged in self-management and treatment programs.

Component 2:

Strategy: Provide funding, training, technical assistance, and evaluation support to Area Tribes/Villages/UIOs/other tribal entities conducting activities across all four C1 strategies.

- Increased number of Area Tribes/Villages/UIOs/other entities implementing activities across all four C1 strategies (PSEs and CCLs). **Note:** Component 2 Recipients will be required to provide the name, funding amount, C1 activities conducted, and progress on C1 outcomes by each Tribe/Village/UIO/other tribal entity subawardee funded through this NOFO.

Component 3:

Strategy: Establish a Tribal Coordinating Center (TCC) to collaborate with C1 and C2 recipients to foster peer-to-peer learning, share best- or promising-practices, coordinate national and local communication and evaluation efforts, and document success stories with measurable impact.

- Increased number of GHWIC promising practices and success stories disseminated among AI/AN communities.
- Increased number of recipients submitting data to CDC to evaluate the national program in aggregate.
- Increased number of promising practices, lessons learned, and success stories identified, shared, and implemented over time.

iii. Strategies and Activities

Component 1: Applicants must propose at least *one* activity from the policy, system, and environmental change (PSE) strategies (obesity or tobacco), *one* activity from the diabetes prevention community-clinical linkage (CCL) strategies, and *one* activity from the heart disease and stroke prevention community-clinical linkage strategies in their work plans (for a total of at least three activities).

Strategy 1: Implement evidenced-informed and culturally-adapted policy, system, and environmental changes (PSE) to prevent obesity.

- Improve tribal food and beverage programs/systems (e.g., community gardens, farmers markets, public transportation routes to food stores, access to healthy foods at community venues or schools, using food service guidelines and nutrition standards).
- Collaborate with partners to improve land use design to connect activity-friendly routes (e.g., sidewalks, bicycle routes, public transit) with everyday destinations (e.g., homes, schools, work sites, parks).
- Increase continuity of care/community support for breastfeeding by incorporating services into existing community support services (e.g., early care and education centers, community health centers, home visiting programs); establishing culturally-appropriate and accessible lactation support services (e.g., support groups, walk-in clinics, Baby

Cafés); and providing breast feeding support training to health care providers, community health workers, peer support providers, etc. that work with mothers and babies.

Strategy 2: Implement evidence-informed and culturally-adapted policy, system, and environmental changes (PSE) to prevent and control commercial tobacco use.

- Implement commercial tobacco-free policies within workplaces, restaurants, bars, casinos, schools, multi-unit housing, indoor and outdoor events, celebrations and gatherings.
- Provide referrals to evidence-based commercial cessation treatment, including counseling and FDA-approved medications.

Strategy 3: Implement evidence-informed and culturally-adapted community-clinical linkages (CCL) to support type 2 diabetes prevention.

Expand access to the National Diabetes Prevention Program (National DPP) lifestyle change program in tribal communities by:

- Increasing awareness of prediabetes among tribal members and health care providers/health professionals (e.g., community wide events, educational campaigns, health-care provider/health professionals training);
- Supporting prediabetes screening, testing, and referral to CDC-recognized type 2 diabetes prevention programs by health care teams, community partners, health paraprofessionals;
- Establishing or expanding the reach of CDC-recognized type 2 diabetes prevention programs in AI/AN communities and promoting sustainability (e.g., assess existing resources, CDC-recognized programs offered by other organizations in the AI/AN community, and modes of program delivery options);
- Developing culturally-relevant approaches to increase program participation and retention among AI/AN members (e.g., culturally-relevant materials, innovative retention strategies, community members trained as lifestyle coaches).

Strategy 4: Implement evidence-informed and culturally-adapted community clinical linkages (CCL) to support heart disease and stroke prevention.

- Expand engagement of community health representatives and other health paraprofessionals to become effective members of chronic disease prevention/management teams within their local health care systems to manage and refer community members with or at high risk of high blood pressure or high blood cholesterol to appropriate and locally available health and preventive care programs.
- Implement team-based care, including non-physician team members (e.g., nurses, pharmacists, patient navigators), in managing patients with or at risk for high blood pressure and/or high blood cholesterol.
- Develop culturally-relevant materials and approaches to link tribal/village resources and clinical services to support prevention, detection, and control of high blood pressure and/or high blood cholesterol.

Component 2

Strategy: Provide funding, training, technical assistance, and evaluation support to all Area Tribes/Villages/UIOs/other tribal entities conducting activities across all four C1 strategies.

- Expand the implementation of Component 1 strategies and activities through subawards to at least four (4) additional Area Tribes/Villages or UIOs.
- Provide technical assistance, training, and resources to all Area Tribes/Villages/UIOs/other tribal entities to support the planning, development, implementation, and evaluation of activities across all four C1 strategies.
- Assist Area Tribes/Villages/UIOs/other tribal entities in developing multi-sector partnerships with organizations to support C1 strategies and activities in Tribes/Villages/UIOs.
- Work with Area Tribes/Villages/UIOs/other tribal entities to develop and implement tailored health communication/messaging strategies to reach AI/AN populations at greatest risk for obesity, commercial tobacco use, type 2 diabetes, and/or heart disease and stroke in order to increase awareness and encourage healthier behaviors.

Component 3

Strategy: Establish a Tribal Coordinating Center (TCC) to collaborate with C1 and C2 recipients to foster peer-to-peer learning, share best- or promising-practices, coordinate national and local communication and evaluation efforts, and document success stories with measurable impact.

- Coordinate the development and implementation of a communication strategy for promoting the value, impact, and achievements of the GHWIC program.
- Collaborate with CDC evaluators to develop and implement an evaluation plan for the national program, including the development of an evaluation measurement framework that includes performance measures for C1 and C2 recipients.
- Develop and implement a coordinated, collaborative Community of Practice (CoP) focusing on chronic disease prevention, including oral health, to facilitate peer-to-peer learning, knowledge-sharing, problem-solving, and communication across the network using regular videoconferencing sessions.

1. Collaborations

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

Collaboration with programs funded by CDC is encouraged, particularly those that are working to mitigate risk factors associated with diabetes, heart disease, stroke, and obesity. National initiatives, guidelines, and policies have been identified from The Community Guide and CDC's Division of Nutrition, Physical Activity, and Obesity; Division of Diabetes Translation; Division for Heart Disease and Stroke Prevention; Division of Cancer Prevention and Control; Office on Smoking and Health; and Division of Oral Health that may complement and build on culturally-based, grounded approaches. Access http://www.cdc.gov/chronicdisease/index.htm for additional information on CDC's chronic disease programs.

Collaboration with tribal public health capacity building programs funded by the Center for State, Territorial, Local, and Tribal Support and others at CDC is also encouraged, particularly those that are working to strengthen public health infrastructure and advance quality improvement of tribal public health services. Access https://www.cdc.gov/publichealthgateway/partnerships/ for additional information on CDC's programs with national partners, tribal organizations, and to promote infrastructure building.

Examples of CDC tribal programs that may provide collaboration opportunities to support achievement of Good Health and Wellness in Indian Country (GHWIC) outcomes include Building Public Health Infrastructure in Tribal Communities to Accelerate Disease Prevention and Health Promotion in Indian Country (also referred to as the Tribal Epidemiological Centers Public Health Infrastructure), and Tribal Practices for Wellness in Indian Country.

American Indian and Alaska Native populations have high rates of disability. Access https://www.cdc.gov/ncbddd/disabilityand health/index.html for additional information about disability inclusion and adaptive resources to help make GHWIC activities accessible for people with disabilities.

b. With organizations not funded by CDC:

Recipients are expected to collaborate with organizations external to CDC, such as those listed below, that are necessary to achieve project outcomes or that can enhance and accelerate achievement of project outcomes. Relationships with other potential partners, such as local and state health departments and relevant non-profit and provider groups, are encouraged. Building and/or continuing strategic partnerships and collaborations with organizations that have a role in achieving the long-term outcomes of this NOFO are encouraged. Examples include, but are not limited to, the following:

- Indian Health Service (Health Promotion Disease Prevention) - https://www.ihs.gov/hpdp/
- Indian Health Service Special Diabetes Program for Indians - https://www.ihs.gov/sdpi/
- Federally Recognized Tribes Extension Program (FRTEP) - https://nifa.usda.gov/funding-opportunity/federally-recognized-tribes-extension-program-frtep-formerly-extension-indian
- USDA (Rural Development grants: support housing, community facilities, and community and economic development projects in rural areas - https://www.rd.usda.gov/programs-services/rural-community-development-initiative-grants
- Land Grant University (LGU) system, including tribal colleges - https://nifa.usda.gov/land-grant-colleges-and-universities-partner-website-directory
- Food Distribution Program on Indian Reservations (FDPIR) nutrition education - http://www.fns.usda.gov/fdpir/fdpir-nutrition-education-grant-awards
- National Park Service - https://www.nps.gov/thpo/
- NIH (Multilevel Program and Policies to Reduce Chronic Disease for American Indians, Johns Hopkins Center for American Indian Health and NIH. Launched in 2015 and set to expire in 2020) - http://grantome.com/grant/NIH/R01-HL122150-04
- HHS (Child Care and Development Block Grant - reauthorization permitted healthy eating/exercise funding provisions. Funds also available to Tribes) - https://www2.ed.gov/fund/grants-apply.html?src=pn
- Department of Treasury - Community Development Financial Institutions Fund (CDFI

Fund) - https://www.cdfifund.gov/programs-training/Programs/cdfi-program/Pages/default.aspx
- Community Development Financial Institutions (CDFI) Office Locator - http://ofn.org/cdfi-locator
- National Council for Urban Indian Health - https://www.ncuih.org/index
- Healthy Native Communities Partnership - http://www.hncpartners.org/
- Bureau of Indian Affairs - https://www.bia.gov/
- National Indian Health Board - https://www.nihb.org/
- National Association of Chronic Disease Directors - https://www.chronicdisease.org
- NB3, Notah Begay III Foundation - http://www.nb3foundation.org/

2. Target Populations

American Indians, including urban Indians, and Alaska Natives

a. Health Disparities

Good Health and Wellness in Indian Country offers support to American Indians and Alaska Natives and the tribes, tribally-designated organizations and urban Indian health organizations that serve them, in order to reduce disparities in chronic disease and related risk factors and improve overall health outcomes.

iv. Funding Strategy

Up to 30 awards will be made to address the strategies identified in 3 separate components of this NOFO.

Component 1: Up to 12 Federally-recognized Tribes/Alaska Native Villages (up to 2 in each of the 12 IHS Administrative Areas) and up to 4 Urban Indian Organizations will be funded under Component 1 of this NOFO. Component 1 applicants may apply for up to $375,000.

Component 2: Up to 13 tribally-designated organizations, up to 1 in each Area (12 IHS Administrative Areas) and the Urban Area defined as the Urban Indian Organizations will be funded under Component 2 of this NOFO. Recipient tribally-designed organizations must provide subawards to at least 4 American Indian Tribes, Alaska Native Villages, Urban Indian Organizations, and other tribal entities providing support for DP19-1903 activities to American Indian Tribes/Alaska Native Villages including rural populations in their Area to ensure an increase in reach of funds to local tribal partners.

Component 2 applicants may apply as follows:

- IHS Areas with fewer than 25 federally recognized American Indian Tribes/Alaska Native Villages: recipients may receive up to $950,000.
- IHS Areas with 25-49 federally recognized American Indian Tribes/Alaska Native Villages: recipients may receive up to $1,250,000.
- The Urban Area: recipient may receive up to $1,250,000.
- IHS Areas with 50+ federally recognized American Indian Tribes/Alaska Native Villages: recipients may receive up to $1,450,000.

Component 2 recipients must provide at least 50% of their award to Area Tribes/Alaska Native Villages/UIOs/and other tribal entities providing support for DP19-1903 activities to American Indian Tribes/Alaska Native Villages including rural populations beyond those directly funded C1 recipients. These should not be Tribes/Alaska Native Villages/UIOs receiving a Component 1 award from this program.

Component 3: Up to 1 tribally-designated organization will be funded under Component 3 of this NOFO. Component 3 recipient may receive up to $800,000.

b. Evaluation and Performance Measurement

i. CDC Evaluation and Performance Measurement Strategy

Evaluation and performance measurement helps 1) demonstrate achievement of program outcomes; 2) build a stronger evidence base for specific program interventions; 3) clarify applicability of the evidence base to different populations, settings, and contexts; and 4) drive continuous program improvement. Evaluation and performance measurement can also determine if program strategies are scalable and effective at reaching the target or intended populations. CDC recommends all C1, C2, and C3 applicants allocate 10% of their annual budget to evaluation efforts.

Throughout the five year period of performance, CDC will work individually and collectively with C1, C2, and C3 recipients to answer the following evaluation questions based on the program Logic Model and activities:

Component 1- Tribes/Villages/UIOs

1. How have the number and percentage of places offering healthy foods and beverages among American Indian/Alaska Native populations been improved?
2. How have the number and percentage of American Indians/Alaska Natives using safe places for physical activities across the life span been improved?
3. How have the number and percentage of breastfeeding mothers who use community services that support breastfeeding been improved?
4. To what extent has the number and percentage of American Indians/Alaska Natives protected by implementation of commercial tobacco-free policies increased?
5. How have the number and percentage of commercial tobacco using patients who receive commercial tobacco cessation interventions been improved?
6. To what extent has the number of adults at high risk for diabetes participating in the National Diabetes Prevention Program been improved?
7. To what extent has the number and percentage of patients with high blood pressure or high blood cholesterol engaged in self-management and treatment programs improved?

Component 2- Tribally-Designed Organizations

1. How has the capacity for chronic disease prevention and management to support the prevention of obesity and diabetes, reduce commercial tobacco use, and control of hypertension or high blood cholesterol increased across the Area?
2. To what extent has the number of Tribes/Villages/UIOs health programs' progress on achieving C1 outcomes increased?

3. To what extent have team-based systems of care to support prevention, self-management and control of diabetes, hypertension, high blood cholesterol, and obesity been implemented across the Area? How has this increased over the period of performance?

Component 3- Tribal Coordinating Center (TCC)

1. To what extent has a coordinated and collaborative Community of Practice focusing on chronic disease prevention, including oral health, to facilitate knowledge-sharing, problem-solving, and communication across the Network been developed and implemented?
2. To what extent have GHWIC promising practices and success stories been disseminated and adapted over time among AI/AN communities?
3. To what extent has a plan for tracking and disseminating Network-related publications, presentations, products, and other materials been developed and implemented?
4. To what extent has an evaluation plan, including evaluation products and a dissemination plan, to coordinate monitoring of Components 1, 2, and 3 accomplishments in achieving the outcomes of the NOFO been developed and implemented?

To answer these questions, CDC will use a three-pronged evaluation approach. Recipients for Components 1, 2, and 3 will be required to: 1) report on performance measures, 2) develop recipient-specific evaluation plans and conduct the evaluation, and 3) participate as requested in national evaluation studies.

CDC will work with recipients to select performance measures that align with their chosen activities, operationalize the performance measures, and assist with identification of available and feasible data sources for these measures. Recipients are responsible for gathering and analyzing the data for the performance measures and any recipient-specific evaluations they choose to do. With these measures, the recipients and CDC will track the implementation of the recipients' efforts and the achievement of the intended outcomes. In collaboration with CDC evaluators, the C3 recipient will assist C1 and C2 recipients to develop evaluation plans. CDC will collaborate with recipients in developing annual performance measure reports, which will be used for program monitoring and for targeting areas for program quality improvement. CDC and the C3 recipient will develop annual, aggregate performance measure reports to be disseminated by multiple methods to recipients and other key stakeholders, including federal partners, non-funded partners, and policy makers as appropriate. These aggregate findings may also be presented during site visits and recipient meetings.

In addition, CDC will work with recipients to capture the performance measures listed below that align with their chosen strategies. As resources permit, CDC will also identify and conduct additional national evaluation projects to evaluate program activities and outcomes. CDC will lead the design, data collection, analysis, and reporting for these national evaluation efforts in collaboration with recipients. Recipients will be required to submit baseline and target performance measures for their proposed activities within the first 6 months of the award. Recipients may choose to submit baseline and targets with the application, if known. Evaluators will work with recipients in the first 6 months of the award to finalize these measures, if needed.

Component 1 Performance Measures:

1. Number of places offering healthy foods (e.g., fresh produce, low sodium options) and

beverages.
2. Percent improvement in number of places offering healthy foods (e.g., fresh produce, low sodium options) and beverages.
3. Number of people using to safe and accessible places for physical activity.
4. Percent improvement in number of people using to safe and accessible places for physical activity.
5. Number of breastfeeding mothers who use community services that support breastfeeding.
6. Percent improvement in number of breastfeeding mothers who use community services that support breastfeeding.
7. Number of workplaces, restaurants, bars, casinos, schools, multi-unit housing, indoor and outdoor events, celebrations and gatherings that implement commercial tobacco-free policies.
8. Percent improvement in number of workplaces, restaurants, bars, casinos, schools, multi-unit housing, indoor and outdoor events, celebrations and gatherings that implement commercial tobacco-free policies.
9. Number of commercial tobacco-using patients who receive commercial tobacco cessation interventions.
10. Percent improvement in number of commercial tobacco-using patients who receive commercial tobacco cessation interventions.
11. Number of community members at high risk for diabetes enrolled in CDC-recognized type 2 diabetes prevention programs offered in AI/AN communities.
12. Number of patients with high blood pressure or high blood cholesterol engaged in self-management and treatment programs.
13. Percent improvement in number of patients with high blood pressure or high blood cholesterol engaged in self-management and treatment programs.

Component 2 Performance Measures:

1. Number of Area Tribes/Villages/UIOs implementing activities across all four C1 strategies (PSEs and CCLs). (Recipients will be required to provide the name, funding amount, C1 activities conducted, and progress on C1 outcomes by each Tribe/Village/UIO subawardee funded through this NOFO.)

Component 3 Performance Measures:

1. Number of GHWIC promising practices and success stories disseminated among AI/AN communities.
2. Number of recipients submitting data to CDC to evaluate the national program in aggregate.
3. Number of promising practices, lessons learned, and success stories identified, shared, and implemented over time.

At the end of the five-year period of performance, CDC will report relevant outcome data from

the analyses of performance measures. CDC will also report findings from any potential tribe-, village-, and Area-specific evaluation studies as they are completed. Reports will be disseminated to the stakeholders noted above through multiple methods. CDC will use the overall evaluation findings from the five-year period of performance to establish key recommendations on program impact, sustainability, and continued program improvement upon completion of the award. CDC intends information from this project to further inform the evolving evidence base of strategies and approaches that are most likely to be successful in Indian Country.

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 encouraged to budget up to 10% of the total funding award for evaluation activities.

c. Organizational Capacity of Recipients to Implement the Approach

Applicants must describe their organizational capacity to carry out the activities, strategies,

performance measures, and evaluation requirements as outlined in the NOFO. CDC anticipates that all applicants will demonstrate capacity to carry out the activities and evaluation over the 5-year period of performance.

General Capacity: All applicants must describe their organizational capacity to carry out CDC program requirements and meet the period of performance outcomes. Day-to-day responsibilities for key tasks such as leadership of project, monitoring of the project's ongoing progress, preparation of reports, program evaluation, and communication with partners and CDC should be outlined.

Applicants must provide a description, including relevant examples of past successful experience, of:

- An adequate staffing plan to carry out the project (e.g., program coordinator, experienced evaluator, community health representatives). An organizational chart and CV/resume for all project staff or position description (if position is vacant) should be provided. For positions that need to be filled, a plan for hiring, including a timeline, should be provided.
- Experience with program planning, performance management and monitoring.
- Evaluation experience.
- Ability to travel (using Cooperative Agreement funds) and manage travel funds.
- Full capacity to manage the required procurement efforts, including the ability to write and award subcontracts in accordance with 45.C.F.R. Part 75.
- Financial reporting, budget management, and administration systems and methods.
- Personnel management experience (including developing staffing plans, developing and training workforce, managing Direct Assistance, and developing a sustainability plan).
- Roles and responsibilities of existing and/or proposed partnerships.
- Experience sharing lessons learned with other recipients.
- If applicable, applicants should also describe their experience using and meeting national health department accreditation standards. Information on accreditation may be found at https://www.phaboard.org.

Component 1 - American Indian Tribes, Alaska Native Villages, and Urban Indian Organization applicants should also provide a description of (including relevant examples of past successful experience) the following:

- Experience engaging community members to implement evidence-informed, culturally-adapted policy, system, and environmental approaches to 1) improve nutrition and physical activity opportunities, 2) reduce commercial tobacco use and exposure, and 3) support community-clinical linkages to prevent type 2 diabetes and heart disease and stroke, and decrease their risk factors.
- Ability to link community-based prevention resources to clinic-based resources.
- Experience convening and engaging coalitions and/or multi-sector partnerships, including non-health partners.
- Experience engaging successful clinical-community partnerships.

Component 2 - Tribally-designated Organization applicants should also provide a description of (including relevant examples of past successful experience) the following:

- Full capacity to manage the required procurement efforts, including the ability to write and award subcontracts in accordance with 45.C.F.R. 75, as applicable.
- Ability to provide subawards to at least four Area Tribes/Villages/UIOs/and other tribal entities providing support for DP19-1903 activities to American Indian/Alaska Native Villages including rural populations.
- Experience convening and engaging coalitions and/or multi-sector partnerships, including non-health partners.
- Providing technical assistance to all Area Tribes/Villages/UIOs in chronic disease prevention.

Component 3 - Tribally-designated Organization applicants should also provide a description of (including relevant examples of past successful experience) the following:

- Developing and implementing a multi-site evaluation plan.
- Providing evaluation technical assistance.
- Experience developing and facilitating a Community of Practice.
- Experience developing and implementing a communication plan.
- Providing communications technical assistance.

d. Work Plan

Applicants are required to provide a work plan consisting of a narrative for the five-year program and a detailed description of the first year of the award. All applicants should describe how the funding will be used to strengthen and build on existing efforts relevant to the component for which they are applying. Work plans for all recipients must include, at a minimum:

- Identification of the Component for which the applicant is applying. If applying for both Component 2 and Component 3, two separate applications must be submitted.
- Narrative (description) of proposed strategies and activities that will be implemented.
- Intended outcomes for the first year of the period of performance, as presented in the Logic Model.
- Proposed performance measure for each activity (see Performance Measures section).
- Timeline/due date for activities in the first year of the period of performance.
- Identify staff, contractors, consultants or partners responsible for overseeing implementation of the activities.

Component 1 work plans must include at least *one* activity from the policy, system, environmental (PSE) change strategies (tobacco, obesity), *one* activity from the community clinical linkage strategy for diabetes, and *one* activity from the community clinical linkage strategy for heart disease and stroke prevention. Component1 applicants should describe the rationale for selecting the strategies and activities to conduct, based on data, community assessments, and/or experience.

Component 1 and Component 2 applicants must provide a description of how they will effectively participate in and support the Community of Practice established by the Tribal Coordinating Center (C3 recipient), including attending routine monthly project-wide

videoconferences, sharing successes and lessons learned, and collaborating on communication, evaluation, and other NOFO efforts.

Component 2 work plans must contain all four activities under the single strategy, and should include plans in year 1 to provide subawards, in the amount equal to at least 50% of the total award, to at least 4 Area Tribes/Villages/UIOs/and tribal other entities providing support for DP19-1903 activities to American Indian/Alaska Native Villages including rural populations, (subawards should not be made to recipients of Component 1 awards).

Component 3 work plans must contain all three activities under the single required strategy.

A sample work plan template is provided below. Recipients may use a different format for their work plan, however, all required elements above must be included.

Period of Performance (5-year) Outcome: [from Logic Model]					
Strategy and Activity Description	Short-term (1-year) Outcome [from Evaluation and Performance Measurement section]	Responsible Position/Party	Timeline/ Due Date	Performance Measure	Rationale for Selecting Strategy/Activity

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

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

Monitoring may also include the following activities deemed necessary to monitor the award:

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

Monitoring and reporting activities that assist grants management staff (e.g., grants management officers and specialists, and project officers) in the identification, notification, and management of high-risk recipients.

CDC will monitor cooperative agreements in partnership with the recipients. Monitoring milestones and performance measures ensures the mutual success of CDC and the recipients in achieving the NOFO outcomes. The recipient and CDC staff will work together to assess key capacity areas aligned with strategies to establish a baseline for monitoring program improvement over time. The proposed work plan will be reviewed by the CDC project officer and/or evaluation staff and may need to be altered to better reflect the recipient program activities as outlined in the NOFO. Post-award cooperative agreement monitoring and provision of technical assistance and training will include:

- Ensuring that recipients' work plans are fiscally responsible and have acceptable milestones and timelines;
- Communicating as needed, or at minimum monthly, with the project coordinator and the project officer on conference calls/webinars;
- Participating in webinars and recipient meetings;
- Providing tools/resources aligned with program activities and NOFO outcomes; and
- Providing assessment and implementation support.

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

In a Cooperative Agreement, CDC and recipients share responsibility for successfully implementing the award and meeting identified outcomes. In addition to routine Cooperative Agreement monitoring, regular calls with recipients, site visits, and performance and financial monitoring, the following areas of substantial involvement will be provided by CDC:

- CDC will serve as a technical advisor and consultant for the project activities related to this cooperative agreement overall and monitor its progress, including conducting site visits to recipients.
- Provide guidance to recipients to improve the quality and effectiveness of work plans and evaluation strategies.
- Provide technical assistance to update annual work plans.
- Provide technical assistance to develop and implement evaluation plans.

- Serve as a member, technical consultant and advisor to the Tribal Coordinating Center (TCC).
- Assist the TCC in establishing a community of practice to facilitate the sharing of information among recipients;
- Provide scientific and programmatic technical assistance and advice as needed to assist recipients in achieving the project objectives.
- Facilitate distribution and dissemination of information and outcomes.
- Contribute to analyses, publications, technical reports and other products as co-authors within the CDC authorship guidelines, as helpful.
- Work with recipients to identify the best solutions and innovations to support effective, culturally-relevant and respectful program implementation.
- Use webinars and other social media for recipients and CDC to communicate and share tools and resources;
- Provide professional development and training opportunities - either in person or through virtual web-based training formats - for the purpose of sharing promising and best practices, success stories, and program models;
- Coordinate communication and program linkages with other CDC programs and Federal agencies, such as US Department of Education (USDOE); Health Resources and Services Administration (HRSA), Centers for Medicare and Medicaid Services (CMS), United States Department of Agriculture (USDA), Food and Drug Administration (FDA), Indian Health Service (IHS), and the National Institutes of Health (NIH);
- Translate and disseminate lessons learned through publications, meetings, and other means on promising and best practices to expand the evidence base.

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
3. Fiscal Year:	2019
4. Approximate Total Fiscal Year Funding:	$20,000,000
5. Approximate Period of Performance Funding:	$100,000,000

This amount is subject to the availability of funds.

Estimated Total Funding:	$20,000,000
6. Approximate Period of Performance Length:	5 year(s)
7. Expected Number of Awards:	30

Component 1: Federally-recognized Tribes and Alaska Native Villages (12) and Urban Indian Organizations (4)
Component 2: Tribally-designated Organizations (13), up to 1 in each Area (the 12 IHS Admin

istrative Areas) and the Urban Area defined as the Urban Indian Organizations.
Component 3: Tribally-designated Organization (1)

8. Approximate Average Award: $725,000 Per Budget Period
Component 1: $325,000 (range $100,000 - $375,000)
Component 2: $1,050,000 (range $750,000- $1,450,000)
Component 3: $800,000

9. Award Ceiling: $1,450,000 Per Budget Period

This amount is subject to the availability of funds.

Component 1: $375,000
Component 2: $1,450,000
Component 3: $800,000

CDC may consider as nonresponsive any application requesting an award higher than the Component-specific ceiling, and it will receive no further review.

10. Award Floor: $100,000 Per Budget Period
Component 1: $100,000
Component 2: $750,000
Component 3: $800,000

11. Estimated Award Date: 09/30/2019
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.
An official state, tribal nation, tribally-designated organization, local or territorial government applicant may request that CDC provide Direct Assistance (DA) in the form of federal personnel as a part of the cooperative agreement awarded through this NOFO. If your request for DA is approved as a part of your award, CDC will reduce the funding amount provided directly to you as a part of your award. The amount by which your award is reduced will be used to provide DA; the funding shall be deemed part of the award and as having been paid to you, the recipient.

C. Eligibility Information

1. Eligible Applicants

Eligibility Category:	Native American tribal governments (Federally recognized) Native American tribal organizations (other than Federally recognized tribal governments)
Additional Eligibility Category:	

2. Additional Information on Eligibility

Component 1: Federally-recognized American Indian Tribes and Alaska Native Villages, and Urban Indian Organizations (UIOs).
Component 2: Tribally-designated organizations that support all American Indian Tribes/Alaska Native Villages in their Area (12 IHS Administrative Areas), or Urban Indian Organizations (Urban Area defined for this NOFO) and have at least 4 Tribes/Villages or UIOs in their Area.
Component 3: Tribally-designated organizations that support all American Indian Tribes, Alaska Native Villages, or UIOs in their Area (12 IHS Administrative Areas and the Urban Area defined for this NOFO).
Please Note: Unless otherwise defined, the term "Area" in this NOFO refers to the 12 IHS Administrative Areas and the Urban Area defined for this NOFO as the group of UIOs listed at: https://www.ihs.gov/urban/nationalprograms/.
Eligibility is limited to a) Federally Recognized American Indian Tribes, ;b) Alaska Native Villages, c) Urban Indian Organizations (UIOs) that have current Title V Indian Health Care Improvement Act contracts with the Indian Health Services, and d) American Indian or Alaska Native Tribally-Designated Organizations. The Conference Report accompanying CDC's FY 2019 Appropriations states that CDC should be guided by HR 115-862 in supporting the Good Health and Wellness in Indian Country Program. HR 115-862 provides that funding is included to "expand the Good Health and Wellness in Indian Country program" stating that the "Good Health initiative supports efforts by American Indian and Alaska Native communities to implement holistic and culturally-adapted approaches to reduce tobacco use, improve physical activity and nutrition, and increase health literacy." This language builds on support for the program expressed in reports accompanying previous appropriations (e.g., the Explanatory Statement to the FY 2017 Appropriations stated that CDC should be guided by HR 114-699). HR114-699 provided that "CDC is expected to build on these existing programs 'Good Health and Wellness in Indian Country' (GHWIC) to allow for a more comprehensive public health infrastructure in tribal communities and the ability to develop mechanisms to improve good health and wellness in Indian Country."
Tribally-designated Organizations must serve all Tribes/Alaska Native Villages/UIOs in their Area.
Eligibility for Component 2 is limited to Tribally-designated Organizations that have at least 4 Area Tribes/Villages or UIOs in their Area.

3. Justification for Less than Maximum Competition

N/A

4. Cost Sharing or Matching

Cost Sharing / Matching Requirement: No

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

5. Maintenance of Effort

Maintenance of effort is not required for this program.

D. 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 ***www.SAM.gov*.**

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 Universal Number System (DUNS)	1. Click on http:// fedgov.dnb.com/ webform 2. Select Begin DUNS search/request process 3. Select your country or territory and follow the instructions to obtain your DUNS 9-digit # 4. Request appropriate staff member(s) to obtain DUNS number, verify & update information under DUNS number	1-2 Business Days	To confirm that you have been issued a new DUNS number check online at (http:// fedgov.dnb.com/ webform) or call 1-866-705-5711
2	System for Award Management (SAM) formerly Central Contractor Registration (CCR)	1. Retrieve organizations DUNS number 2. Go to www.sam.gov and designate an E-Biz POC (note CCR username will not work in SAM and you will need to have an active SAM account before you can register on grants.gov)	3-5 Business Days but up to 2 weeks and must be renewed once a year	For SAM Customer Service Contact https://fsd.gov/ fsd-gov/ home.do Calls: 866-606-8220
3	Grants.gov	1. Set up an individual account in Grants.gov using organization new DUNS number to become an authorized organization representative (AOR) 2. Once the account is set up the E-BIZ POC will be notified via email 3. Log into grants.gov using the password the E-BIZ POC received and create new password 4. This authorizes the AOR to submit applications on behalf of the organization	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. If Internet access is not available, or if the online forms cannot be accessed, applicants may call the CDC OGS staff at 770-488-2700 or e-mail OGS ogstims@cdc.gov for assistance. Persons with hearing loss may access CDC telecommunications at TTY 1-888-232-6348.

4. Submission Dates and Times

If the application is not submitted by the deadline published in the 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: **06/12/2019** , 11:59 p.m. U.S. Eastern Standard Time, at www.grants.gov. If Grants.gov is inoperable and cannot receive applications, and circumstances preclude advance notification of an extension, then applications must be submitted by the first business day on which grants.gov operations resume.

Date for Information Conference Call

Tuesday, March 19, 2019 from 3:00 p.m. - 4:30 p.m., EDT. Call 1-800-857-9824. Participant Passcode: 4720690

To submit a question related to this NOFO, please email your question to GHWIC_requests @cdc.gov. Responses will be posted at https://www.cdc.gov/chronicdisease/about/foa/ghwic /index.htm in Frequently Asked Questions (FAQs).

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 http://www.hhs.gov/ ocio/policy/collection/.
- 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.

Applicants must submit a budget and budget narrative following the guidance provided in CDC's Budget Preparation Guidelines.

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/2017/11/Intergovernmental_-Review-_SPOC_01_2018_OFFM.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).

In addition, recipients may not use funds for construction.

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.

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

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

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

Approach	Maximum Points:35

- Identifies the component for which the applicant is applying. (All applicants.)
- The extent to which the applicant presents a detailed descriptive year-one work plan, including intended outcomes aligned with selected strategies and activities, staff roles, milestones and a timeline to support the NOFO outcomes. (All applicants.)
- The extent to which the applicant describes how the funding will be used to strengthen and build on existing efforts relevant to the component for which they are applying. (All applicants.)
- The extent to which the applicant proposes at least *one* activity from the policy, system, environmental (PSE) change strategies (tobacco, obesity), *one* activity from the community clinical linkage strategy for diabetes prevention, and *one* activity from the

community clinical linkage strategy for heart disease/stroke prevention. (Component 1 applicants only.)

- The extent to which the applicant described the rationale for selecting strategies and activities based on data, community assessments, and/or experience (Component 1 applicants only).
- The extent to which the applicant describes how they will effectively participate in and support the Community of Practice established by the Tribal Coordinating Center, including attending routine monthly project wide videoconferences and other collaborative efforts. (Component 1 and 2 applicants only.)
- The extent to which the applicant proposes activities to provide leadership, technical assistance, training, and resources to Area Tribes/Villages/UIOs/other tribal entities to implement activities across all four C1 strategies. (Component 2 applicants only.)
- The extent to which the applicant includes plans to provide at least 50% of funds as subawards to at least 4 American Indian Tribes/Alaska Native Villages/Urban Indian Organizations/other tribal entities in their Area. (Component 2 applicants only.)
- The extent to which the applicant describes how they will make subawards, including their rationale for their approach, so that all four (4) Component 1 strategies are addressed over the 5-year period of performance. (Component 2 applicants only.)
- The extent to which the applicant provides a plan for establishing an ongoing network of funded organizations and partners. (Component 3 applicants only.)
- The extent to which the applicant provides a plan for establishing, convening, and facilitating routine videoconferences for the Component 1 and Component 2 recipients funded organizations and CDC. (Component 3 applicants only.)
- The extent to which the applicant provides a plan for developing and implementing a communication plan to demonstrate the value, impact, achievements, and success stories of the GHWIC program (Component 3 applicants only.)
- The extent to which the applicant provides a plan for developing and implementing an evaluation plan to coordinate monitoring of accomplishments in achieving the outcomes of the NOFO (Component 3 applicants only.)

Evaluation and Performance Measurement	Maximum Points:30

- The extent to which the applicant describes how key program partners will be engaged in the evaluation and performance measurement planning process. (All applicants.)
- The extent to which the applicant describes the types of evaluation (e.g., process, outcome) that will be used to demonstrate the effectiveness of planned activities related to outcomes. (All applicants.)
- The extent to which the applicant describes examples of data collection instruments and potentially available data sources (from partners, programs, agencies). (All applicants.)
- The extent to which the applicant lists key evaluation questions to address planned activities to achieve outcomes. (All applicants.)
- The extent to which the applicant describes how evaluation findings will be reported and used to demonstrate the outcomes of the NOFO and for continuous local program and quality improvement. (All applicants.)

Organizational Capacity to Implement the Approach	Maximum Points:35

- The extent to which the applicant provides a staffing plan, including roles and responsibilities, including how each will contribute toward outcomes, and a project management structure that will be sufficient to achieve program outcomes. (All applicants.)
- The extent to which the applicant describes evaluation expertise, both currently on staff, and expertise to be contracted or hired. (All applicants.)
- The extent to which the applicant provides evidence of timely and accurate financial reporting, budget management, and administrative systems and methods. (All applicants.)
- The extent to which the applicant describes successful collaborations with the community served and the ability to successfully involve community members in the proposed activities. (All applicants.)
- The extent to which the applicant demonstrates ability or record of linking community-based prevention resources to clinic-based resources. (Component 1 applicants only.)
- The extent to which the applicant demonstrates relevant experience, expertise, and capacity to provide leadership, technical assistance, training, and resources on all Component 1 strategies to all Tribes/Villages/UIOs/other tribal entities in their IHS Area. (Component 2 applicants only.)
- The extent to which the applicant documents capacity for developing, awarding and overseeing sub-contracts to at least 4 Area Tribes/Villages/UIOs/other tribal entities. (Component 2 applicants only.)
- The extent to which the applicant describes the staffing plan necessary for establishing and maintaining a Community of Practice of all Component 1 and Component 2 funded recipients. (Component 3 applicants only.)
- The extent to which the applicant demonstrates capacity to support videoconferencing for TCC participants. (Component 3 applicants only.)

Budget

- The extent to which the proposed budget aligns with the proposed work plan, and is consistent with the NOFO. (All applicants.)
- The extent to which the applicant budgeted 10% of their award for evaluation activities. (All applicants.)
- If indirect costs are proposed, a current indirect cost rate agreement is included. (All applicants.)

c. Phase III Review

Three separate rank order lists will be developed, based on type of applicant (Component 1, Component 2, Component 3), and the top ranking applicant in each will be funded, with the following factors possibly affecting the funding decision.

CDC reserves the right to fund applications out of rank order depending on geographic distribution of the highest scoring applications. CDC may fund out of rank order to achieve geographic (i.e., funding across all IHS Areas) diversity.

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

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

September 30, 2019

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.

- AR-7: Executive Order 12372 Review
- AR-9: Paperwork Reduction Act Requirements
- AR-10: Smoke-Free Workplace Requirements
- AR-11: Healthy People 2020
- AR-12: Lobbying Restrictions (June 2012)
- AR-13: Prohibition on Use of CDC Funds for Certain Gun Control Activities
- AR-14: Accounting System Requirements
- AR-16: Security Clearance Requirement
- AR-17: Peer and Technical Reviews of Final Reports of Health Studies ? ATSDR
- AR-21: Small, Minority, And Women-owned Business
- AR-22: Research Integrity
- AR-24: Health Insurance Portability and Accountability Act Requirements
- AR-25: Data Management and Access
- AR-26: National Historic Preservation Act of 1966

- AR-30: Compliance with Section 508 of the Rehabilitation Act of 1973
- AR-31: Research Definition
- AR-32: Enacted General Provisions
- AR-34: Language Access for Persons with Limited English Proficiency
- AR-8: Public Health System Reporting Requirements

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
Federal Financial Reporting Forms	90 days after the end of the budget period	Yes
Final Performance and	90 days after end of period of	Yes

Financial Report	performance	
Payment Management System (PMS) Reporting	Quarterly reports due January 30; April 30; July 30; and October 30	Yes

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

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

Performance Measurement

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

Evaluation

• The types of evaluations to be conducted (e.g. process or outcome evaluations).
• The frequency that evaluations will be conducted.
• How evaluation reports will be published on a publically available website.
• How evaluation findings will be used to ensure continuous quality and program improvement.
• How evaluation will yield findings to demonstrate the value of the NOFO (e.g., effect on improving public health outcomes, effectiveness of NOFO, cost-effectiveness or cost-benefit).
• Dissemination channels and audiences.

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

b. Annual Performance Report (APR) (required)

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

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

The carryover request must:

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

The 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:

Mary Hall, Project Officer
Department of Health and Human Services
Centers for Disease Control and Prevention
Telephone: (770) 488-5309
Email: moh4@cdc.gov

Grants Staff Contact

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

Kathy Raible, Grants Management Specialist
Department of Health and Human Services
Office of Grants Services
Telephone: (770) 488-2045
Email: kcr8@cdc.gov

For assistance with **submission difficulties related to** www.grants.gov, contact the Contact Center by phone at 1-800-518-4726.
Hours of Operation: 24 hours a day, 7 days a week, except on federal holidays.

For all other **submission** questions, contact:

Technical Information Management Section
Department of Health and Human Services
CDC Office of Financial Resources
Office of Grants Services
2920 Brandywine Road, MS E-14
Atlanta, GA 30341
Telephone: 770-488-2700
Email: ogstims@cdc.gov

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

H. Other Information

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

- Project Abstract
- Project Narrative
- Budget Narrative
- CDC Assurances and Certifications
- Report on Programmatic, Budgetary and Commitment Overlap
- Table of Contents for Entire Submission

For international NOFOs:

- SF424
- SF424A
- Funding Preference Deliverables

Optional attachments, as determined by CDC programs:

- Resumes / CVs
- Position descriptions
- Letters of Support
- Organization Charts
- Indirect Cost Rate, if applicable

- Current Indirect Cost Rate Agreement
- Letter of support dated after the release of this NOFO from tribal chairman, president, or council member that the tribe is in support of the application and the activities.

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.
Assitance 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 2020: 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

Alaska Native Village: Indian reservation or Alaska Native village includes the reservation of any federally or State recognized Indian tribe, including any band, nation, pueblo, or rancheria, any former reservation in Oklahoma, any community under the jurisdiction of an Indian tribe, including a band, nation, pueblo, or rancheria, with allotted lands or lands subject to a restriction against alienation imposed by the United States or a State, and any lands of or under the jurisdiction of an Alaska Native village or group, including any lands selected by Alaska

Natives or Alaska Native organizations under the Alaska Native Claims Settlement Act.

Area: The term "Area" in this NOFO refers to the 12 IHS Administrative Areas and the Urban Area as defined for this NOFO (the group of UIOs listed at: https://www.ihs.gov/urban/nationalprograms/).

Federally Recognized Tribal Governments: Indian tribes with whom the federal government maintains an official government-to-government relationship; usually established by a federal treaty, statute, executive order , court order, or a Federal Administrative Action. The Bureau of Indian Affairs (BIA) maintains and regularly publishes the list of federally recognized Indian tribes (Ref. HHS Tribal Consultation Policy, section 17).

IHS Administrative Area: The Indian Health Service (IHS) is divided into twelve physical areas of the United States; Alaska, Albuquerque, Bemidji, Billings, California, Great Plains (formerly named Aberdeen), Nashville, Navajo, Oklahoma City, Phoenix, Portland, and Tucson. Each of these areas has a unique group of Tribes that they work with on a day-to-day basis.

Indian Tribe: Any Indian tribe, band, nation, or other organized group or community, including any Alaska Native village or regional or village corporation as defined in or established pursuant to the Alaska Native Claims Settlement Act (85 Stat. 688), which is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians. Eligible applicants are listed on the Bureau of Indian Affairs website (www.bia.gov/DocumentLibrary/index.htm).

Other Entities: tribally-designed organizations providing support for DP19-1903 activities to American Indian Tribes/Alaska Native Villages including rural populations.

Tribally-Designated Organization: the tribally recognized intertribal organization which the recognized governing bodies of two or more Indian tribes on a reservation authorizes to provide public health leadership and/or programming on their behalf.

Tribes: Any Indian tribe, band, nation, or other organized group or community, including any Alaska Native village or regional or village corporation as defined in or established pursuant to the Alaska Native Claims Settlement Act (85 Stat. 688), which is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians. Eligible applicants are listed on the Bureau of Indian Affairs website (www.bia.gov/DocumentLibrary/index.htm).

Urban Area: the Urban Area defined for this NOFO is the group of UIOs listed at: https://www.ihs.gov/urban/nationalprograms/.