

Centers for Disease Control

National Center for Chronic Disease Prevention and Health Promotion

Cancer Prevention and Control Programs for State, Territorial, and Tribal Organizations
CDC-RFA-DP17-1701
Application Due Date: 03/24/2017

Cancer Prevention and Control Programs for State, Territorial, and Tribal Organizations
CDC-RFA-DP17-1701
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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-DP17-1701. Applicants also must provide an e-mail address to www.grants.gov to receive notifications of changes.

A. Federal Agency Name:

Centers for Disease Control and Prevention (CDC)

B. Funding Opportunity Title:

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

C. Announcement Type: New - Type 1

This announcement is only for non-research activities supported by CDC. If research is proposed, the application will not be considered. For this purpose, research is defined at https://www.gpo.gov/fdsys/pkg/CFR-2007-title42-vol1/pdf/CFR-2007-title42-vol1-sec52-2.pdf. Guidance on how CDC interprets the definition of research in the context of public health can be found at http://www.cdc.gov/od/science/integrity/docs/cdc-policy-distinguishing-public-health-research-nonresearch.pdf.

D. Agency Funding Opportunity Number:

CDC-RFA-DP17-1701

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

93.898

F. Dates:

1. Due Date for Letter of Intent (LOI): **01/12/2017**

Is a LOI: Recommended but not Required

The purpose of a Letter of Intent (LOI) is to allow CDC program staff to estimate the number of and plan for the review of submitted applications. An LOI is not required, but strongly encouraged for the **National Breast and Cervical Cancer Early Detection Program**, the **National Comprehensive Cancer Control Program** and the **National Program of Cancer Registries.**

The LOI should include the following:

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

If an LOI is submitted, it must be emailed or postmarked by **January 12, 2017, 11:59 p.m. U.S. Eastern Standard Time**

LOIs may be sent via email, U.S. express mail or delivery service to:

Frances Babcock

Department of Health and Human Services

Centers for Disease Control and Prevention

4770 Buford Hwy, NE, MS F-76

Atlanta, GA 30341

Telephone: 770-488-3069

Email: DP171701mailbox@cdc.gov

2. Due Date for Applications: **03/24/2017**, 11:59 p.m. U.S. Eastern Standard Time, at www.grants.gov.

3. Date for Informational Conference Call: **01/05/2017**

- **January 5, 2017 at 10:00 a.m. to 12:00 p.m. Eastern Daylight Savings Time -** For eligible applicants in the Atlantic, Eastern, and Central time zones. This conference call can be accessed by calling **1-888-942-9712**. The leader for this call is Tanya Hicks and the passcode is **8345600**.

- **January 5, 2017 at 3:30 p.m. to 5:30 p.m. Eastern Daylight Savings Time –** For eligible applicants in the Mountain and Western time zones. This conference call can be accessed by calling **1-888-942-9712**. The leader for this call is Tanya Hicks and the passcode is **8345600**.

- **January 5, 2017 at 7:30 p.m. to 9:30 p.m. Eastern Daylight Savings Time -** For eligible applicants in the Pacific Island Jurisdictions. This conference call can be accessed by calling **1-888-942-9712**. The leader for this call is Tanya Hicks and the passcode is **8345600**. If operator assistance is needed, call **1-517-308-9217** and the operator will assist you in joining the call.

G. Executive Summary:

1. Summary Paragraph:

The CDC, Division of Cancer Prevention and Control (DCPC) announces the availability of Fiscal Year 2017 funds to implement DP17-1701, a National Cancer Prevention and Control Program. This FOA supports implementation of a comprehensive and coordinated approach to inform policy, systems, and environmental change strategies to prevent and control cancer. It supports high quality breast and cervical cancer screening services, statewide cancer coalitions to plan and implement cancer control priorities, and surveillance programs to monitor and report cancer burden.

These priorities will be accomplished by funding three national programs:
1) The National Breast and Cervical Cancer Early Detection Program- funds will be awarded up to 75 applicants to include state health departments and the District of Columbia or their Bona Fide Agents; Territories/Pacific Island Jurisdictions; and Federally Recognized American Indian Tribes, Tribal Organizations, Alaska Native Organizations, and Urban Indian Organizations for implementing a program to provide breast and cervical cancer screening services to uninsured and underinsured women and implement key evidence-based strategies to reduce structural barriers to screening within health systems. Approximately $155 million per year is available.

2) The National Comprehensive Cancer Control Program- funds will be awarded to up to 65 applicants including one award per state and the District of Columbia; U.S Territories; and Federally Recognized American Indian Tribes, Tribal Organizations, Alaska Native Organizations, and Urban Indian Organizations for implementing a program to support cancer coalition efforts that leverage resources to plan and implement evidence-based strategies to promote the primary prevention of cancer; support cancer early detection efforts; address the needs of cancer survivors; and promote health equity. Approximately $22 million per

year is available.

3) The National Program of Cancer Registries- funds will be awarded to up to 55 applicants including state health departments, the District of Columbia (or their Bona Fide agent) and U.S Territories for implementing a population-based core Cancer Registry program. Approximately $38 million per year is available.
In addition, optional funding will be awarded to eligible NPCR applicants to pilot public health prevention surveillance projects related to one of 3 focus areas (Collection of cervical cancer precursors, Collection of screening data for breast and cervical cancer cases, and Collection of new or emerging prognostic factors) is submitted. Approximately $1.6 million per year is available.

a. Eligible Applicants:	Limited
b. FOA Type:	Cooperative Agreement
c. Approximate Number of Awards:	85
d. Total Project Period Funding:	$1,075,000,000
e. Average One Year Award Amount:	$850,000
f. Number of Years of Award:	5
g. Estimated Award Date:	06/30/2017
h. Cost Sharing and / or Matching Requirements:	Y

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

Program 2: NCCCP
Cost sharing is encouraged if it helps to leverage federal and state resources, is responsive to stated CDC recipient activities, supports the National Comprehensive Cancer Control Program priorities, and does not compromise the integrity or the ability of the comprehensive cancer control program to accomplish proposed activities. Matching funds are not required under this cooperative agreement, but are encouraged.

Program 3: NPCR
Per PHS Act (42 USC 280e-280e-4), matching funds are required for Program 3, NPCR applicants in an amount not less than 25 percent of such costs **or** one dollar for every three dollars of Federal funds awarded under this program; [Title 42, Chapter 6A, Subchapter II, Part M, § 280e(b)(1)]. Matching funds may be cash, in-kind, or donated services or equipment. Contributions may be made directly or through donations from public or private entities. However, Title 48 of the U.S. Code 1469a (d) requires DHHS to waive

matching fund requirements for Guam, U.S. Virgin Islands, American Samoa and the Commonwealth of the Northern Mariana Islands up to $200,000. Public Law 93-638 authorizes tribal organizations contracting under the authority of Title 1 to use funds received under the Indian Self-Determination Act as matching funds. Non-federal financial contributions in excess of the Maintenance of Effort may be used for matching.

Matching funds may not include: (1) payment for treatment services or the donations of treatment services (2) services assisted or subsidized by the Federal government; or (3) the indirect or overhead costs of an organization. All costs used to satisfy the matching requirement must be documented by the applicant and will be subject to audit. Documentation of appropriate matching is to be provided in the detailed budget and narrative justification.

Part II. Full Text

Executive Summary

The CDC, Division of Cancer Prevention and Control (DCPC) announces the availability of Fiscal Year 2017 funds to implement DP17-1701, a National Cancer Prevention and Control Program. This FOA supports implementation of a comprehensive and coordinated approach to inform policy, systems, and environmental change strategies to prevent and control cancer. It supports high quality breast and cervical cancer screening services, statewide cancer coalitions to plan and implement cancer control priorities, and surveillance programs to monitor and report cancer burden.

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3) The National Program of Cancer Registries- funds will be awarded to up to 55 applicants including state health departments, the District of Columbia (or their Bona Fide agent) and U.S Territories for implementing a population-based core Cancer Registry program. Approximately $38 million per year is available.
In addition, optional funding will be awarded to eligible NPCR applicants to pilot public health prevention surveillance projects related to one of 3 focus areas (Collection of cervical cancer precursors, Collection of screening data for breast and cervical cancer cases, and Collection of new or emerging prognostic factors) is submitted. Approximately $1.6 million per year is available.

A. Funding Opportunity Description

1. Background

a. Overview

Cancer remains the second leading cause of death in the United States. In 2013, approximately 1.6 million people were diagnosed with cancer and more than 584,000 people died of cancer, according to the United States Cancer Statistics. There is also an estimated 14 million cancer survivors. According to the National Cancer Institute, medical cost for cancer in the United States could reach an estimated $207 billion by 2020. The cost of cancer extends beyond the people diagnosed with cancer. Caregivers, family members, friends, and employers may face emotional, social, spiritual, and financial challenges.

CDC's Division of Cancer Prevention and Control (DCPC) works with state health agencies, tribes and tribal organizations, territorial health agencies, and other stakeholders to inform a comprehensive and collaborative approach that addresses cancer prevention and control practices. The goal of the FOA is to decrease cancer incidence, morbidity, and mortality by focusing on underserved populations who have increased cancer risk due to health disparities. This FOA will assist awardees by providing resources and comprehensive evidenced-based programs to prevent, detect, and treat cancers and to improve the quality of life of cancer survivors across the United States. These outcomes will be achieved by increasing appropriate cancer screening services through provision of cancer screenings, eliminating barriers, and implementing key evidence-based strategies; supporting state-wide cancer coalitions and cancer plans to inform strategic policy, systems and environmental changes; and collection and dissemination of cancer surveillance data with enhanced use of cancer data for state planning.

Awardees are expected to use a collaborative and coordinated approach to implement cancer prevention and control activities to reduce the burden of cancer in their communities. This collaboration between public health, communities and health care systems provides a framework to improve the scope and quality of efforts by building upon the efforts of the prior FOA DP12-1205.

b. Statutory Authorities

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

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

Program 3: The National Program of Cancer Registries (NPCR) is authorized under the Public Health Service Act, (42 USC 280e-280e-4; Public Law 102-515), as amended

c. Healthy People 2020

In accordance with the Healthy People 2020 objectives for the nation, this FOA focuses on addressing the national cancer burden. Measurable outcomes for awardees will be in alignment with the following performance objectives:

- Reduce the female breast cancer death rate (Healthy People C-3)
- Reduce the death rate from cancer of the uterine cervix (Healthy People C-4)
- Reduce invasive uterine cervical cancer (Healthy People C-10)
- Reduce late-stage female breast cancer (Healthy People C-11)
- Increase the number of central, population-based registries from the 50 States and the District of Columbia that capture case information on at least 95 percent of the expected number of reportable cancers (C-12)
- Increase age-appropriate screening prevalence for cervical and breast cancer (Healthy People C-15 and

C-17)
- Increase the proportion of women who were counseled by their providers about mammograms and Pap tests (Healthy People C-18.1 and C-18.2)

More info is available here: https://www.healthypeople.gov/2020/topics-objectives/topic/cancer/objectives

d. Other National Public Health Priorities and Strategies

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

The Guide to Community Preventive Services:
http://www.thecommunityguide.org/
The National Partnership for Action to End Health Disparities:
http://minorityhealth.hhs.gov/npa/
The National Prevention Strategy: http://www.cdc.gov/Features/PreventionStrategy/

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

e. Relevant Work

This FOA builds upon the work previously established by funded awards of DP12-1205 http://www.cdc.gov/cancer/ awards supported the coordination and integration of long-standing cancer activities to reduce cancer morbidity and mortality.

This FOA primarily relates to the four National Center for Chronic Disease Prevention and Health domains http://www.cdc.gov/chronicdisease/pdf/four-domains-factsheet-2015.pdf of action to transform the nation's health and support Americans to take charge of their own health: 1) epidemiology and surveillance, 2) environmental approaches, 3) health care system interventions, and 4) community programs linked to clinical services.

2. CDC Project Description

a. Approach

Bold indicates project period outcome.

CDC-RFA-*DP17-1701* Logic Model: *Cancer Prevention and Control Programs for State, Territorial and Tribal Organizations*

Bold indicates project period outcome

Strategies and Activities	Short-term Outcomes	Intermediate Outcomes	Long-Term Outcomes
Strategy 1 - Program Collaboration Support collaboration across NBCCEDP, NCCCP, NPCR, and other chronic disease prevention and health promotion programs **Strategy 2 - External Partnerships** Convene, support, and sustain partnerships and/or partnership networks necessary to support implementation of cancer program priorities and activities. *(e.g. Comprehensive Cancer Control partnerships, NPCR Advisory Boards, NBCCEDP Medical Advisory Board)* **Strategy 3 – Cancer Data and Surveillance** Apply established and innovative methods to maintain and enhance population-based central cancer registry and NBCCEDP minimum data elements **Strategy 4 - Environmental Approaches for Sustainable Cancer Control** Use cancer surveillance data and other available sources to identify targeted communities. Implement interventions to inform policy changes, environmental approaches, access to	Increased awareness, knowledge, and abilities among the target population about cancer prevention and screening Increased policies and systems that promote health lifestyle behaviors and support high quality cancer screening Increased use of evidence-based practices and systems to support screening by NBCCEDP and CRCCP grantees Increased use of proven data systems for program monitoring and tracking by all DCPC grantees Increased access to and uptake of screening in all priority populations Increased evidence of implementation and expansion of community programs and supports for community programs linked to clinical services Increased availability of health care extender services in communities Increased use of electronic reporting by cancer reporting facilities Increased use of cancer surveillance data for program planning, implementation and evaluation by all DCPC grantees	Increased appropriate cancer screening, rescreening, and surveillance among priority populations Improved access to health care and preventive services in target populations Increased use of evidence-based lifestyle programs, raising the demand for and utilization of these programs and addressing the community improvements that need to be in place to support people making lifestyle changes Increased use of evidenced-based lifestyle programs, clinical preventive services, and cancer care in priority populations Improved delivery of clinical preventive services and cancer care in priority populations Increased access and use of cancer surveillance data by Stakeholders, Partners and Researchers	Reduced cancer risk e.g. tobacco, alcohol, UV exposure Increase in health seeking and healthy lifestyle behaviors e.g. HPV vaccination, HBV vaccination, improved physical activity, improved diet, decreased tobacco use and appropriate use of genetic services for hereditary cancers Increased quality of life among cancer survivors Reduced cancer morbidity and mortality Reduce cancer disparities

quality clinical services, targeted outreach and education that facilitate healthy lifestyles and reduce cancer risk.*(e.g., working with CCC partnerships to increase HPV and HBV vaccination to reduce cervical cancer and liver cancer incidence)* **Strategy 5: Community-Clinical Linkages to Aid Patient Support:** Implement interventions that coordinate services among health systems, communities, and public health organizations to facilitate access to clinical care and promote health behaviors. **Strategy 6 - Health Systems Changes** Implement evidence-based interventions and provider-focused activities for improving cancer screening rates and facilitating transitional care among survivors in health systems (*e.g. Use of Patient Reminders to increase cancer screening rates in underserved populations)* **Strategy 7: Program Monitoring and Evaluation** Conduct program evaluation and use program performance measures for continuous program and data quality improvement			

i. Purpose

The purpose of this non-research FOA is to provide a comprehensive and coordinated approach to inform policy, systems, and environmental changes that decrease cancer burden. This will be achieved through support of high quality breast and cervical cancer screening services, statewide cancer coalitions and implementing cancer plan priorities at state and local levels, and monitoring cancer burden through surveillance. This will be accomplished by funding three national programs: **1) The National Breast and Cervical Cancer Early Detection Program**, **2) The National Comprehensive Cancer Control Program, and 3) The National Program of Cancer Registries.**

ii. Outcomes

Program 1: National Breast and Cervical Cancer Early Detection Program (NBCCEDP)

Short-term Outcomes

• Retention of high quality staff and providers
• Established community partnerships that support increased breast and cervical cancer screening
• Established health system partnerships with broad reach to increase breast and cervical cancer screening
• Measurement and use of high quality data
• Improved knowledge about the need for breast and cervical cancer screening among priority populations
• Reduced barriers and increased access to breast and cervical cancer and diagnostic screening for priority populations
• Increased use of and implementation of multiple EBIs & support strategies within health systems
• Improved provider knowledge of breast and cervical cancer screening and diagnostic guidelines
• Increased appropriate provider recommendations for patients to receive breast and cervical cancer screening
• Increased high quality screening
• Increased adherence to timely diagnostic follow-up
• Increased timely cancer treatment referral
Increased knowledge of healthy lifestyle behaviors

Intermediate Outcomes

• Decreased disparities in breast and cervical cancer screening
• Breast and cervical cancer is detected at early stage
• Increased rescreening rates
• Increased adherence to timely diagnostic follow-up and cancer treatment referral
• Increased timely cancer treatment referral
Increased health seeking and healthy lifestyle behaviors

Long-term Outcomes

• Reduced breast and cervical cancer morbidity and mortality
• Reduced disparities in breast and cervical cancer incidence and mortality

Program 2 : National Comprehensive Cancer Control Program (NCCCP)

Short-Term Outcomes:

• Increased awareness, knowledge, and abilities about cancer prevention and screening among target populations.
• Improved healthcare provider practices and systems to support screening.
• Increased health extender services.
• Improved community-clinical linkages.
• Increased chronic disease self-management support among cancer survivors.
• Improved systems to support quality screening.
• Increased environmental supports for prevention through:
New/enhanced school, worksite, adult & child care programs/strategies to support cancer prevention and screening activities

Increased evidence-based lifestyle & wellness survivorship programs.
• Increased policies and systems that promote health lifestyle behaviors and support high quality cancer screening.

Intermediate Outcomes:
• Increased appropriate cancer screening, rescreening, and surveillance of priority populations.
• Improved access to health care and preventive services.
• Increased evidenced-based lifestyle programs to increase healthy living.
• Increased use of evidenced-based lifestyle programs, clinical preventive services, and cancer care among cancer survivors.
• Improved delivery of clinical preventive services and cancer care.

Long-Term Outcomes:
• Reduced cancer risk e.g. tobacco, alcohol, UV exposure, HPV.
• Increase in health seeking and healthy lifestyle behaviors; e.g., HPV vaccination, HBV vaccination, improved physical activity, and improved diet.
• Increased early detection.
• Improved survivorship practices.
• Prevent cancer/ recurrence.
• Decreased cancer incidence.
• Increased quality of life among cancer survivors.
• Reduced cancer morbidity and mortality.
• Reduce cancer disparities.

Program 3 : National Program for Cancer Registries (NPCR)– Component 1

The goals of Component 1 are:
• Collection and dissemination of high-quality data on all reportable incident cancer cases in a timely manner for the purpose of public health cancer prevention and control.
• Improved and enhanced electronic reporting to central cancer registries.

Short Term Outcomes
• Increased access to quality and timely cancer data for stakeholders, partners and researchers
• Increased use of electronic reporting of cancer cases to the central cancer registry.
• Meet established NPCR's National Data Quality and Advanced National Data Quality standards
• Increased use of NPCR cancer data
• Improved access to enhanced cancer surveillance data

Intermediate Outcomes
• Targeted cancer screening for populations at risk
• Utilization of data for evidence-based decisions
• Utilization of data for cancer prevention and tobacco control strategies at state and local levels
• Increase in flexibility and utility of the cancer registry infrastructure to meet new data needs for cancer prevention and control

Long Term Outcomes
• Increased survival for all cancers
• Decreased incidence, morbidity, and mortality for all cancers
• Reduced cancer risk e.g. tobacco, alcohol, UV exposure
• Increased collaboration with Chronic Disease Programs at state and local levels

Program 3 : National Program for Cancer Registries (NPCR)– Component 2

The goal for Component 2 are to identify the feasibility of and/or barriers to collection of new information on cancer cases through cancer registries in one of three focus areas:
• Cervical cancer precursor data and outcomes directly related to cervical cancer prevention programs
• Cancer screening and diagnostic follow-up data on breast and cervical cancer cases

• New or emerging cancer prognostic factors or risk assessment models
The Short Term, Intermediate, and Long Term Outcomes for Program 3 - Component 2 (CINIII, Screening, Prognostic Factors) are the same as those listed in Component 1.

iii. Strategies and Activities

Program 1: National Breast and Cervical Cancer Early Detection Program (NBCCEDP)

Program Management
• Establish and enhance program infrastructure and capacity to increase breast and cervical cancer screening rates and navigation services to priority population(s) over the length of the project period.
• Hire or retain adequate and qualified staff to manage the program. Essential staff, at the minimum, includes a program director, a data manager, and an evaluator.
• Develop and maintain a fiscal system that tracks and monitors program expenditures, ensures the timely reimbursement of services, and provides detailed fiscal reporting on time.
• Develop an evaluation plan with CDC guidance based on program identified strategies; plan should be updated, as needed, throughout the project period. Plan must include stakeholders, program description, evaluation questions, analytic methods, reporting methods, and process/outcome measures.
• Acquire medical professionals to provide clinical consultation throughout the project period.
• Participate in required CDC meetings and trainings to facilitate the accomplishment of proposed objectives.

Strategy 1 - Program Collaboration (see Collaboration section)
• Collaborate with chronic disease programs on prevention and risk reduction activities.
• Collaborate with central cancer registries for reporting and use of cancer data, to include working with cancer registries who collect enhanced screening and other clinical data on women diagnosed with breast and cervical cancer.
• Collaborate with state cancer coalitions for program planning and identification of priority populations.
• Disseminate information and education including referrals to appropriate immunization programs for their children.

Strategy 2 - External partnerships (see Collaboration section)
• Develop strategic partnerships with local health care facilities such as community health centers, hospitals, and Indian Health Service.
• Partner with non-traditional agencies and organizations such as Bureau of Prisons, Department of Transportation and the Housing and Urban Development.
• Establish or continue partnerships with professional organizations such as state and local governments, American Indian/Alaska Native tribal governments and/or tribally designated organizations, primary care associations, employers, not-for-profit organizations (e.g., the American Cancer Society), the National Association of Community Health Centers, Health Center Controlled Networks, community-based organizations, for-profit organizations, non-governmental organizations, and community advocates.

Strategy 3 - Cancer data and surveillance (Domain 1)
• Use current state and local level survey data with GIS Mapping, or other information systems and data sources, to pre-identify and describe priority populations and/or communities of need.
• Collect, analyze, and report to CDC required patient-level clinical data (Minimal Data Elements (MDE)).
• Collect, analyze, and report to CDC required clinic-level data.
• Link cancers diagnosed for women who received NBCCEDP services to central cancer registry to collect cancer stage data in the MDEs.

Strategy 4 - Environmental Approaches for Sustainable Cancer Control (Domain 2)
• Educate and assist employers with policies that help make screening services available to women as a way to increase screening rate among low-income women.

Strategy 5 - Community-Clinical Linkages to Aid Patient Support (Domain 4)
• Use community and/or clinic-based health workers/lay advisors, native language speakers, or health

educators to conduct community outreach, identify eligible women for screening, provide patient education about risk factors and preventive health behaviors, and address barriers to care.
• Navigate women to community resources, medical homes, or health care systems for cancer screening, diagnostic, genomics and/or treatment resources.
• Work with community and national partners to reach disparate populations and use culturally appropriate interventions that are tailored for the communities for which they are intended.
• Facilitate or refer to health insurance enrollment, if applicable

Strategy 6 - Health Systems Changes (Domain 3)
• Provide timely and appropriate breast and cervical cancer screening services to uninsured or underinsured women who meet NBCCEDP eligibility criteria.
• Provide patient navigation services to assist NBCCEDP-eligible women overcome barriers to complete screening, diagnosis and initiation of cancer treatment. A description to expected patient navigation activities can be found at http://www.cdc.gov/cancer/dcpc/about/foa-dp17-1701/

• Provide timely and appropriate patient navigation services to support low-income women screened with other sources (e.g. insurance, state funds, Medicaid) through assessing and addressing barriers to cancer screening, diagnosis, and initiation of cancer treatment.
• Conduct a comprehensive assessment of each partner health care delivery system. The assessment should include: breast and cervical screening rates, data/electronic health record (EHR) functionality, patient/health system process flow, standing orders/policies for cancer screening, provider/health system adherence to clinical cancer screening guidelines, patient navigation/community health worker/support services, and use of priority evidence-based interventions (EBIs) or other strategies that support cancer screening.
• Improve breast and cervical cancer screening clinic-level rates and/or strengthen the delivery of cancer screening services through partnerships, including: 1) Implementing evidence-based interventions as described in the Community Guide. See recommended Community Guide interventions at http://www.cdc.gov/cancer/dcpc/about/foa-dp17-1701/; and 2) Using data to increase cancer screening rates among the priority population and to identify appropriate interventions.
• Enhance provider and health system/clinic EHRs and Health Information Technology (HIT) systems' capability to monitor clinic level screening rates and, where applicable, clinical tracking of completeness and timeliness of screening services. Establish a system wide chart audit process to periodically validate screening rates.

Strategy 7 - Program Monitoring and Evaluation (Domain 1)
• Establish and maintain a data system to collect and report to CDC required patient-level clinical data (MDEs) to monitor and track clinical care to ensure high quality screening and diagnostic services are delivered and treatment is initiated for women diagnosed with cancer, as needed, according to CDC performance standards
• Use data management systems to monitor whether women navigated receive appropriate screening, follow-up on abnormal screening results, and referral to treatment, as needed, according to CDC performance standards.
• Collect and report to CDC baseline and annual data, including breast and cervical cancer screening rates, from partner health system clinics where the program is implementing evidence-based interventions.

Program 2 : National Comprehensive Cancer Control Program (NCCCP)

Program Management
To maintain the infrastructure required to successfully implement program activities, awardees will:
• Use the majority of funding for program implementation to ensure the capacity to achieve the goals of the program. Staffing should not comprise more than 40% of the award as the program's success is related to capacity to support the implementation of the cancer plan strategies.
• Coordinate implementation of a statewide cancer plan by the coalition.
• Coordinate and support the periodic revision of a statewide cancer plan by the coalition.

Strategy 1: Program Collaboration

• NCCCP Awardees will convene the Leadership Team comprised of the NCCCP, NBCCEDP, and NPCR Program Directors in their state, tribe or jurisdiction. The NCCCP Program Director will be responsible for facilitating Leadership Team activities to coordinate cancer prevention and control activities across the 3 program components. See "Collaborations" section for additional details.
• Collaborate with central cancer registry to ensure that program efforts are informed by cancer surveillance data.
• Collaborate across all DP17-1701 programs to identify populations with relatively higher cancer risks, incidence, and/or mortality to determine strategies to reduce the burden of cancer for these groups.
• Recruit leadership from all DP17-1701 programs to participate in the cancer coalition.
• Collaborate across all DP17-1701 programs to create synergies that facilitate community level interventions and patient support and health systems change.
• Collaborate with other chronic disease or risk factor prevention programs to include cancer prevention and control strategies in coordinated and categorical chronic disease prevention and control plans.
• Collaborate with other chronic disease or risk factor prevention programs to align implementation of evidence based interventions to optimize prevention strategies addressing shared chronic disease risk factors (e.g. tobacco control strategies.)
See Collaboration section for more detailed information

Strategy 2: External Partnerships

• Support an existing state-, tribe-, territorial-, or jurisdiction-wide cancer coalition to achieve cancer plan goals and objectives.
• Leverage community resources to implement evidenced based interventions that are aligned with promoting the primary prevention and early detection of cancer, addressing cancer survivor needs, and promoting cancer-related health equity.
• Foster and sustain relationships with key organizations whose missions align with the reduction of cancer related morbidity and mortality.
See Collaboration section for more detailed information

Strategy 3: Cancer Data and Surveillance (Domain 1)

• Use cancer risk factor and surveillance data to develop burden reports that inform the state cancer plan and other related program documents.
• Use cancer risk factor and surveillance data to set baselines and targets for selected interventions.
• Routinely present to coalition partners on cancer burden trends data.

Strategies 4 – 6 (Domains 2 – 4)

• Environmental Approaches for Sustainable Cancer Control: implement evidence-based interventions to reduce risk and
promote healthy behaviors by enhancing social and physical environments
• Community-Clinical Linkages to Aid Patient Support: implement evidence-based interventions to increase availability and use of cancer-related preventive health services or health extender services.
• Health Systems Changes: implement evidence-based interventions that promote efficiency and effectiveness of clinical care.
Evidence-based interventions will be selected from the CDC NCCCP Library of Indicator and Data Sources published at: http://www.cdc.gov/cancer/dcpc/about/foa-dp17-1701/. Awardees should select three (3) evidence-based intervention strategies for each of the following priority areas:

Priority 1: Primary prevention of cancer
Priority 2: Screening and early detection of cancer
Priority 3: Improving quality of life of cancer survivors

• In addition, applicant must ensure that least one (1) of the selected evidence-based strategies in each priority area address cancer related disparities as evidenced by risk, incidence, and mortality.

Strategy 7: Program Monitoring and Evaluation

- Develop and implement a 5 year evaluation plan that defines both process and outcome measures (short-term, intermediate, and long-term) that will be evaluated. See Applicant Evaluation and Performance Measurement Plan section for more detailed information
- Develop and submit annual evaluation reports summarizing key findings
- Update the 5 year evaluation plan annually to reflect evaluation findings, current program context and program improvement measures
- Monitor, track, analyze, and report program data in a CDC-provided management information system
- Over the five-year period of the cooperative agreement, develop at least 4 dissemination documents that describe the monitoring, assessment, or evaluation of program efforts. These documents may be briefing reports, Success Stories and presentations at local and national conferences(including CDC-sponsored conferences.) At least one peer-reviewed manuscript should be developed.

Program 3 : National Program for Cancer Registries (NPCR)– Component 1
Strategy 1: Program Collaboration
• Promote use of central cancer registry data for planning and evaluation of cancer control objectives and public health practice.
• Collaborate with NCCCP and NBCCEDP programs on activities across the four domains with defined and measureable cancer prevention or control outcomes. See Collaboration Section for additional information.
• Coordinate and collaborate with other chronic disease programs, and with key external organizations and programs, such as, but not limited to, Medicaid, to

a) Identify priority populations
b) Select, implement and evaluate evidence-based interventions
c) Increase screening among priority population
d) Create synergies that facilitate the alignment of implementation and optimize shared priorities.
See Collaboration section for more detailed information

Strategy 2: External Partnerships
• Establish and convene an Advisory Committee to assist in enhancing and utilizing the central cancer registry data for cancer prevention and control and other chronic diseases, and for coordinating and collaborating with other cancer programs.
• Utilize the Advisory Committee to develop and refine quality improvement initiatives.
• Establish and promote greater awareness and utilization of the cancer registry data.

Strategy 3: Cancer Data and Surveillance (Domain 1)

Legislative Authority
• Maintain existing state law/regulations that provide legal authority for a central cancer registry as defined in Public Health Services Act Title 42, Chapter 6A, Sub-Chapter II, Part M, 280e, authorizing the National Program of Cancer Registries. http://www.cdc.gov/cancer/dcpc/about/foa-dp17-1701/

• Update existing state law/regulations as needed to support electronic data exchange

Administration/Operations
• Establish or retain staff sufficient in number and expertise to manage, implement, and evaluate the central cancer registry, as well as utilize and disseminate the data. Core staff must fill the roles of Program Director/Project Director/Principal Investigator, Quality Assurance/ Quality Control Manager, and Education and Training Coordinator. The Quality Assurance/ Quality Control Manager and Education and Training Coordinator positions must be filled by qualified, experienced Certified Tumor Registrars (CTRs).
• Ensure that adequate hardware and software systems are in place to support the central cancer registry activities, including data collection, database management, interstate data exchange, data linkages, quality assurance, data analysis, and management reporting.
• Ensure the confidentiality and security of central cancer registry data through software and hardware security standards. This includes:
• implemented and documented security policies and procedures

• documented data release policies and procedures that include both access and disclosure of information
• documented disaster data recovery plans; annual risk assessments and security audits for registry data tracked ongoing security training for staff. (Details included on the NPCR data security pages http://www.cdc.gov/cancer/npcr/tools/index.htm

Data Collection, Content and Format

• Conduct surveillance for all reportable cancer diagnoses and related data items according to the CDC Program Standards and Data Submission Specifications http://www.cdc.gov/cancer/dcpc/about/foa-dp17-1701/ for program standards and data submission specifications).

Electronic Data Exchange

• Develop and implement a plan to enhance timely reporting via the expansion of electronic reporting by one or more means (e.g., Meaningful Use and ePath reporting), and through data exchanges (including interstate data exchange).

Data Completeness/Timeliness/Quality

• Implement procedures to ensure timeliness, quality and completeness of data in accordance with CDC data quality standards.
• To obtain data on residents who have been diagnosed or treated out of catchment area, establish interstate data exchange agreements with out-of-state central cancer registries and perform data exchanges with them at least twice per year. Quarterly data exchange with geographically bordering central cancer registries is strongly encouraged.
• Perform linkages with external data sets to improve data completeness and quality.

Linkages

• Create and employ data linkages as described in the NPCR Program Standards and additional linkages which are necessary for Program functioning. Perform linkages that assist in addressing other public health issues as they relate to cancer, including tobacco use and obesity (e.g., behavioral risk factor data, socio-economic status data). Linkages include, but are not limited to:

State Vital Statistics (at a minimum, death records) annually
Indian Health Services Administrative records (as appropriate)
Social Security Administration Death Master File recommended annually
National Death Index recommended annually
Social Security Administration Vital Status Service recommended annually

Data Quality Assurance and Education

• Develop, implement, and maintain an education and training plan for internal staff and reporting facilities with the goal of improving central cancer registry data quality.
• Conduct internal audits and/or quality checks of data collected and processed by central registry staff, participate in national quality assurance studies (e.g., TNM Reliability Study), participate in ad hoc audits in collaboration with CDC to assess data quality, and conduct external audits of reporting sources to assure central cancer registry data quality.
• Complete and submit the Program Evaluation Instrument (PEI) by the stated deadline.

Data Use and Data Monitoring

• Develop a coordination plan to propose innovative ways cancer surveillance data will be used to improve public health in the catchment area.
• Produce or participate in the production of biennial reports of incidence measures appropriate for the cancer and population (e.g., rates, counts, proportions) at geographic levels appropriate for the local populations (e.g., county, city, statistical health area) for screening-amenable cancers (e.g., breast, cervix, colorectal, lung) diagnosed at late stage and cancers associated with obesity, tobacco, and the human papillomavirus (HPV).
• Submit final biennial report to CDC and disseminate to partners as appropriate.

Data Submission

• Submit electronic data files to the NPCR Cancer Surveillance System (CSS);
according to the timeframe and content established by CDC that meets the reporting requirements outlined in the NPCR-CSS Submission Specifications document that meets the criteria for:
publication in the United States Cancer Statistics (USCS) Web-based report,
the National Data Quality Standard,
and the Advanced National Data Quality Standard. http://www.cdc.gov/cancer/dcpc/about/foa-dp17-1701/
• Participate in all CDC-created and hosted analytic datasets and web-based data query systems as outlined in the annual NPCR CSS Data Release Policy.
http://www.cdc.gov/cancer/dcpc/about/foa-dp17-1701/

Strategy 4: Community Level Interventions and Patient Support (Domain 4)
• Disseminate cancer surveillance data with NCCCP and NBCCEDP programs, and other organizations/agencies as identified by the registry's Advisory Committee, to implement community level and patient support interventions

Strategy 5: Health Systems Change (Domain 3)
• Share cancer surveillance data with NCCCP and NBCCEDP programs, and other organizations/agencies as identified by the central cancer registry's Advisory Committee, to enable implementation of evidence-based interventions for health systems change.

Strategy 6: Program Monitoring and Evaluation
• Conduct program evaluation inclusive of reviewing processes, outputs and outcomes of the central cancer registry and use findings to continuously improve operations, data quality and completeness. (See Evaluation Section for more details)

Program 3 : National Program for Cancer Registries (NPCR)– Component 2: CINIII, Screening, Prognostic Factors

For Component 2, CIN III award recipients:
Strategy 1: Program Collaboration
• Collaborate with appropriate programs/partners to facilitate successful implementation of project and use of the data for program planning, and evaluation.
Strategy 3: Cancer Data and Surveillance (Domain 3)
• Obtain/maintain the legal authority of CCR to collect data electronically on cervical cancer precursors from medical and pathology records.
• Establish/improve infrastructure and partnerships, and develop a plan for CIN III data collection
• Implement CIN III project and collect enhanced data on cervical cancer precursors, using established data collection procedures, automated edits, quality control procedures and data submission specifications
• Link registry data with additional data sources, such as vaccine registry, cervical screening data, comprehensive cancer control activities, or other relevant information. (Additional data may come from the entire population-based area, or from areas within a state, such as data collected for the HPV IMPACT project- http://www.cdc.gov/cancer/dcpc/about/foa-dp17-1701/
• Submit CIN III data to CDC annually, in November of each year.
• Evaluate data and utilize quality assurance findings to continuously improve data quality and completeness
• Disseminate data and findings to key partners/stakeholders to identify priority areas and populations in need of increased access to HPV vaccines and/or cervical cancer screening and treatment.

For Component 2, SCREENING award recipients:
Strategy 1: Program Collaboration
• Collaborate with NBCCEDP and other appropriate programs/partners to facilitate successful implementation of project and use of the breast and cervical cancer screening and diagnostic follow-up data

for program planning, and evaluation.

Strategy 3: Cancer Data and Surveillance (Domain 3)

• Obtain/maintain the legal authority of CCR to collect screening and diagnostic follow-up data on women diagnosed with breast or cervical cancer.
• Establish/improve infrastructure and partnerships and develop a plan to electronically collect breast and cervical cancer screening and diagnostic follow-up data on women diagnosed with breast or cervical cancer.
• Establish data submission specifications, data collection procedures, automated edits, and quality control procedures in collaboration with NPCR and NBCCEDP award recipients in the catchment area.
• Implement project and collect breast and cervical cancer screening and diagnostic follow-up data.
• Link registry data with other relevant data sources (e.g., cervical and breast screening data) to improve quality and completeness of screening and diagnostic follow-up on breast and cervical cancer cases.
• Submit breast and cervical cancer screening and diagnostic follow-up data.to CDC annually, in November of each year.
• Evaluate data and utilize quality assurance findings to continuously improve breast and cervical cancer screening and diagnostic follow-up data quality and completeness.
• Disseminate breast and cervical cancer screening and diagnostic follow-up data and findings to key partners/stakeholders to identify priority areas and populations in need of increased access to cervical and breast cancer screening and treatment.

For Component 2, PROGNOSTIC FACTORS award recipients:
Strategy 1: Program Collaboration
• Collaborate with CDC and other relevant partners (e.g., the American College of Surgeons-American Joint Committee on Cancer, College of American Pathologists, etc.) to establish data submission specifications, data collection procedures, automated edits, and quality control procedures.

Strategy 3: Cancer Data and Surveillance (Domain 3)
• Obtain/maintain the legal authority of CCR to collect the selected new/emerging prognostic factors on persons diagnosed with cancer in the state/territory/district.
• Establish/improve infrastructure and partnerships and develop a plan for prognostic factors data collection.
• Select new or emerging prognostic factors or risk assessment models recommended for clinical care in the American Joint Committee on Cancer (AJCC) Cancer Staging Manual, 8th Edition, and not collected prior to 2018 in any national cancer surveillance system http://www.cdc.gov/cancer/dcpc/about/foa-dp17-1701/.
• Link registry data with other relevant data sources to improve quality and completeness of the prognostic factors.
• Submit prognostic factor data to CDC annually, in November of each year.
• Evaluate data and utilize quality assurance findings to continuously improve prognostic factor data quality and completeness.
• Collaborate with appropriate programs and partners to facilitate successful implementation of project and use of the prognostic factor data for program planning, and evaluation.
• Disseminate prognostic factor data and findings to key partners and stakeholders to improve cancer care and reduce the cancer burden.

1. Collaborations

In order to ensure program success, grantees are expected to collaborate across all three CDC-funded cancer programs and across other CDC-funded programs, as appropriate. To facilitate the collaboration of the cancer programs, the NCCCP awardee in each state or territory will be required to convene a state- or territorial-wide Cancer Control Leadership Team comprised of the Program Directors from the each of the three CDC-funded cancer programs (NBCCEDP, NCCCP, and NPCR) awarded in that state- or territorial-wide catchment area. The leadership team is essential for the education, referral, and screening components of the NBCCEDP, essential for cancer registries complete data collection, and essential for the NCCCP to coordinate the efforts to achieve the objective to decease cancer incidence. NBCCEDP and/or NCCCP tribal grantees are encouraged but not required to participate in the state or territorial wide Cancer Control Leadership Team. While NCCCP is expected to facilitate convening of the team, Program Directors from all three programs will have equal partnership and are expected to work collaboratively. Applicants for each program are required to include a letter of commitment addressed to CDC pledging full support of and active participation on the Leadership Team in the application. The NCCCP Program Director will be responsible for convening the leadership team and facilitating the development of a leadership plan that ensures coordination across all CDC-funded cancer programs to be submitted to CDC within 60 days of award receipt. The final leadership plan must be signed by all members of the Leadership Team.
Both the leadership plan as well as the program-specific work plan should include strategies to achieve the required activities listed in Table 1 (Required Collaborative Activities Over the period of this cooperative agreement these activities should include the design, implementation, and evaluation of the project outcomes. The Leadership Team will work collaboratively to implement the key priority areas in Table 1. All programs are required to participate in each collaborative activity.

Table 1: Required Collaborative Activities

Strategies	Collaborative Activity
Strategy 1 Program Collaboration	Recruit and maintain representatives from NPCR, Behavioral Risk Factor Surveillance System, and other state-based surveillance systems to actively participate on cancer control coalitions.
	Collaborate with chronic disease risk factor prevention programs to include cancer prevention and control strategies in statewide, territory-wide and tribal-wide chronic disease plans
	Coordinate technical assistance and training to build capacity to implement cancer prevention and control activities
Strategy 3 Cancer Data and Surveillance	Facilitate use of cancer data for program planning and implementation efforts
	Identify high risk populations in collaboration with cancer and other chronic disease programs (smoking and health, for example)
	Participate in joint reporting of population risks and cancer burden with other chronic disease programs using public health surveillance data
Strategy 4 Environmental Approaches for Sustainable Cancer Control	Collaborate with other chronic disease programs and/or other public health programs to inform policies that support cancer prevention and control (e.g. restrictions on tanning bed use; tobacco control interventions; paid employee time-off for cancer screening services, HPV vaccine uptake)
Strategy 5 Community-Clinical Linkages to Aid Patient Support	Use registry and/or cancer mortality data to identify populations at higher risk for late-stage diagnosis or higher cancer mortality
	Collaborate with other cancer and chronic disease programs in the design and targeting of prevention such as HPV vaccination and tobacco cessation or screening interventions to those with increased cancer burden.
	Support use of survivorship care planning and chronic disease self-management for cancer survivors
Strategy 6 Health Systems Changes	Implement (or support the implementation of) evidence-based interventions such as client reminders, provider assessment and feedback to improved cancer screening within health systems. Collaborate with other cancer and chronic disease programs where appropriate.
	Partner with health systems to use data to identify screening rates and treatment data to identify populations at risk for late-stage disease or not receiving recommended care
	Participate in and encourage electronic reporting from cancer care providers and collaborate with other state programs to achieve increased electronic reporting

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

See Collaborations Section

b. With organizations not funded by CDC:

Program 1: National Breast and Cervical Cancer Early Detection Program (NBCCEDP)

Awardees are required to collaborate with partners and agencies that serve priority population of interest or work with the identified communities of interest. For example:

- Partner with community-based organizations to reach underserved priority populations to improve cancer screening, diagnostic, and treatment rates.
- Partner with health systems to improve clinic level cancer screening rates.

Applicants should submit letters of support from organizations that will have a role in helping to achieve the FOA activities and outcomes. Letters must be dated within 30 days of the application and should state organizations role and how they will help applicant achieve the goals of the FOA. If awarded, MOUs or MOAs with these partner organizations must be submitted within 90 days of receiving award.

Applicants should consider strategic partnerships with community health centers including Federally Qualified Health Centers, Health Center Controlled Networks, Regional Extension Centers, state Primary Care Associations, health plans, health systems, clinics and hospitals, managed care organizations, Medicaid/Medicare, Indian Health Service clinics, American Indian/Alaska Native tribal governments and/or tribally designated organizations.

Applicants are also strongly recommended to partner with non-traditional partner agencies and organizations: (e.g., Bureau of Prisons, Department of Transportation, and Housing and Urban Development (HUD) to reach more underserved women.

Applicants should establish or continue strategic partnerships that support NBCCEDP goals with professional organizations; businesses; not-for-profit organizations, such as the American Cancer Society; community-based organizations; for-profit organizations; non-governmental organizations; state and local governments; community advocates and members; and other stakeholders that may have a vested interest in increasing breast and cervical cancer screening.

Program 2 : National Comprehensive Cancer Control Program (NCCCP)

Applicants are expected to collaborate with organizations not funded by CDC that have a role in achieving FOA outcomes in order to help maximize resources and increase public health impact. The collaboration may include data sharing with appropriate privacy protections, program implementation, reaching priority populations, communication, etc. Examples of these groups include local health departments, employer groups, health systems, non-governmental organizations, transportation and community organizations, providers, academicians, etc.

- Convene and support an existing cancer coalition comprised of key stakeholder uniquely positioned to achieve cancer plan goals and objectives.
- Collaborate with other key stakeholders such as the American Cancer Society, Prevention Research Centers, Comprehensive Cancer Centers, Primary Care Associations, Federally Qualified Health Centers, and other organizations whose missions align with the goal to reduce cancer incidence and mortality.
- Implement activities to enhance collaboration with both federal and non-federal partners including the CCC National Partnership http://www.cccnationalpartners.org/ to implement cancer education and awareness activities.
- Collaborate with public and private partners to leverage resources and maximize program reach and impact. These include the businesses, hospitals, non-governmental organizations, non-profit agencies, governmental agencies, tribes or tribal organizations, professional organizations, quality improvement organizations, and other members of the public health community.
- Formalize key collaborations with key stakeholders through the establishment of MOAs/MOUs, Letters of Support (LOS), and other mechanisms. Memorandum of Understanding/Memorandum of Agreement (MOUs/MOAs) and Letters of Support (LOS) are strongly encouraged for key collaborations. Applicants should consider activities that maximize resources such as the sharing of staff, identifying alternative funding streams, and sharing of organizational resources.

At a minimum, applicants must provide Letters of Support (LOS) from:

- The state's Chronic Disease Director committing support to the collaborative efforts required in this FOA, as appropriate.
- The state's current CDC-funded Colorectal Cancer Control Program manager (as applicable), as well as the state applicants requesting consideration for NBCCEP, NCCCP, and NPCR program funding through this opportunity. Each letter must commit support and participation on the State Leadership Team. Tribal and Territorial applicants requesting funding for multiple components through this opportunity must also submit similar letters supporting collaboration across those components.
- NCCCP applicants must submit a letter of support from its Cancer Coalition Chair committing support for activities to revise and update the state's cancer plan as appropriate and implement state cancer plan priorities.
- NCCCP applicants must also submit a minimum of 3 letters from state or local partners committing support of activities to implement cancer plan priorities at the local level.

Program 3 : National Program for Cancer Registries (NPCR)– Component 1
NPCR funded registries are required to develop effective collaboration with key organizations not funded by CDC who share the purpose and outcomes of this FOA. Collaboration efforts may include:
• Participating in the Central Cancer Registry's Advisory Board
• Expanding the reach and use of the cancer surveillance data
• Selecting, implementing and evaluating evidence-based interventions;
• Increasing screening among priority population(s);
• Leveraging resources to create synergies that facilitate implementation of shared priorities.
NPCR funded registries are encouraged to be strategic in identifying partners who can assist with meeting the mission and goals of the registry. Such partnerships should be formalized through Letters of Support (LOS), Memorandum of Understanding/Agreement (MOU/MOA) or other mechanisms. Some key partners may include:
• American Cancer Society
• American College of Pathologists
• American College of Surgeons
• American Joint Committee on Cancer
• Centers for Medicare and Medicaid Services
• Central Brain Tumor Registry of the United States
• Community Cancer Centers
• Environmental Protection Agency
• Indian Health Service
• National Cancer Registrars Association
• North American Association of Central Cancer Registries
• Surveillance, Epidemiology and End Results
• Federally or state recognized tribal organizations
• Universities

2. Target Populations

Program 1: NBCEDDP The primary target audience is all residents who live in the applicant's geographic area. The NBCCEDP target population is women who are at or below 250% of the federal poverty level, aged 40 to 64 years for breast cancer services, and aged 21-64 years for cervical cancer services across each State/Territory/Pacific Island Jurisdiction/Tribe/Tribal Organization. Applicants are required to describe their priority population based on available data such as race, ethnicity, gender, geography, socioeconomic status, health literacy, screening rates, and cancer incidence and mortality. Awardees must focus on health disparities and achieving health equity on a state- territory- or tribal-wide level.
Program 2: NCCCP The primary target audience is all residents who live in the applicant's geographic

area. Applicants should strive to improve health status for the entire population and seek to reduce gaps in health status by targeting some efforts on specific population groups disproportionately affected by cancer. Applicants should ensure that data, including burden data, are used to identify strategies and/or communities within their populations to support program initiatives. These data should also be used to identify cancer disparities by race, ethnicity, gender identity, sexual orientation, geography, socioeconomic status, disability status, primary language, health literacy, and other relevant dimensions (e.g., tribal communities) and to plan at least one initiative to address these.

Program 3: NPCR The target audience is all residents who live in the applicant's geographic area, this includes members of tribes or tribal organizations. Components 1 and 2 supports collection of all cancer cases in the award recipient's entire geographic catchment area (e.g., statewide). The aim of this portion of the FOA is to ensure federal support for all statewide and established territorial cancer registries in the United States (including DC).

a. Health Disparities

While all segments of society are affected by cancer, there are certain populations that are disproportionately burdened by the increased risk of cancer or by the lack of adequate healthcare options for prevention and/or treatment. Awardees should seek to achieve health equity by targeting efforts on populations disproportionately affected by cancer. Relevant data should be utilized to identify these populations and to select culturally appropriate interventions for implementation.

Disproportionately burdened populations may be defined by sex, race, ethnicity, disability, sexual orientation, gender identity, geographic location, or socioeconomic status. Among the populations that will benefit from this funding are those living in rural and frontier geographic areas; uninsured or underinsured persons; culturally isolated persons; incarcerated or institutionalized women; medically underserved persons; persons from minorities defined by race, religion, ethnicity, or culture, including African Americans, Alaska Natives, American Indians, Asian Americans, Pacific Islanders and Hispanics: lesbian, gay, bisexual, or transgender (LGBT), and women with low literacy, non-English speaking language barriers, and disabilities.

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

Program 1:

NBCCEDP funding will be burden based. The burden-based formula will include screening-eligible population size for breast and cervical cancer, screening rates, breast and cervical cancer incidence rates, poverty level, and the percent of counties designated as health professional shortage areas. Funding strategy will also include the awardees' proposed activities and goals, estimated population reach, and program capacity as described in the application.

Funding strategy for territories/Pacific Island and tribes/tribal organizations will be based upon the awardees' proposed activities and goals, population reach, and program capacity as described in the application since there is no reliable population level burden data.

Program 2:

The NCCCP funding formula is based on a model that uses $150,000 as base-funding with adjustments based on the state's population of individuals over age 40 (since cancer risk increases with age), the state's burden of cancer (crude incidence and death rates for the top ten cancers), the percentage of rural areas within the state, and the percentage of people living in poverty within the applicant's geographic area. The formula for Pacific Island Jurisdictions and tribes or tribal organizations will include as much information listed above as possible, but will be more limited due to lack of population-based data for some of these measures. Minor adjustments to all model outcomes may be made based on qualifying information such as demonstrated innovative and effective use of resources by the applicant.

Program 3:

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

b. Evaluation and Performance Measurement

i. CDC Evaluation and Performance Measurement Strategy

The evaluation and performance measurement enables CDC and grantees to track progress and measure outputs and outcomes. The evaluation and performance measurement will facilitate: 1) assessing the extent to which the activities and strategies were successfully implemented; 2) demonstrating whether activities led to expected outputs and to the projected outcomes; 3) informing program planning, decision making, and continuous program quality improvement.

Program 1: NBCCEDP Program monitoring and evaluation allows the awardee and CDC to track progress and measure outcomes of awardees' efforts. Evaluation and performance measurement will be used by awardees and CDC to assess the extent to which implemented strategies increase high quality breast and cervical screening and diagnostic services and to ensure continuous program and health system improvement.

• Performance on screening services will be measured by clinical data (known as Minimal Data Elements) to meet quality indicators that diagnostic services and treatment services are provided in a timely fashion. These data will be used to measure quality of services and allow for quality improvement interventions as indicated. Description of Minimal Data Elements (MDE) and Clinical Quality Indicators can be found at http://www.cdc.gov/cancer/dcpc/about/foa-dp17-1701/. These data will be reported to CDC twice a year. Purposed updates to the MDE and Clinical Quality Indicators will be implemented within the first two years of the FOA.

• Proposed measures for work with communities and health systems include the number of women who receive only patient navigation services that complete the screening process, annual clinic screening rates following implementation of interventions, and the number of disparate populations targeted with improvement in screening rates among that population.
• Performance on health system change will be measured by baseline and annual clinic-level data that assess changes in clinic-level screening rates and EBI implementation.
• Long-term outcomes of breast and cervical cancer incidence and death rates among targeted populations will be used to measure the contribution of the awardees activities.
• An annual grantee survey will collect additional information on partnerships, provider networks, training/technical assistance needs, and program challenges. These data will be used to assess partnership development, program reach, and to inform CDC about training/technical assistance needs of grantees.

Program 2: NCCCP

CDC will use information collected through grantee surveys, the Chronic Disease Management Information System (CDMIS) or other CDC-provided management information system, document reviews, and key informant interviews to measure NCCCP grantee progress in the following areas:

- Assessing coalition effectiveness and contribution to the implementation of program priorities;
- Using appropriate data to inform program practice;

- Implementing statewide cancer plan activities;
- Planning program sustainability and resource allocation;
- Using evidence-based approaches to address cancer burden in the general population as well as the target populations.

Specific performance measures for appropriate strategies for primary prevention, early detection, and survivorship interventions are provided in the CDC LIDS tool http://www.cdc.gov /cancer/dcpc/about /foa -dp17 -1701/. Long-term outcomes related to reduced risks, increased use of early detection services, and improved quality of life among survivors will measure the overall impact of the awardees' activities.

Program 3: NPCR

CDC will monitor and assess progress, results, and overall impact through;
a) The NPCR performance measures, outputs and program outcomes from both the Integrated Cancer Logic Model as well as the NPCR Program specific logic model.
b) The annual cancer data submissions for progress in meeting NPCR Program Standards, as well as timelines and completeness requirements;
c) Results of the NPCR Program Evaluation Instrument, the Data Quality Evaluation in conjunction with annual progress reports for a comprehensive view of grantee performance.

Key Performance Measures for Component 1 and 2 will include the following outputs from the NPCR Logic Model:
• Activities to evaluate and improve timeliness, quality, and completeness of cancer data.
• Status of infrastructure for increased and electronic reporting of cases.
• Timeliness of capturing cancer cases from facilities.
• Successful submission of electronic data files, according to the timeframe and content established by CDC, to the NPCR Cancer Surveillance System (CSS).
• Meeting NPCR standards as outlined in NPCR Program Standards and evaluated by annual reports and Program Evaluation Instrument survey results.
• Creation and maintenance of registry and state policies supportive of research uses of central cancer registry data.
• Data dissemination and data use through the development of surveillance reports and other products that identify and report on the cancer burden and trends by age, gender, race/ethnicity and geographic area in support of health equity initiatives, cancer control programs, and public health practice.

ii. Applicant Evaluation and Performance Measurement Plan

Applicants must provide an evaluation and performance measurement plan that demonstrates how the awardee will fulfill the requirements described in the CDC Evaluation and Performance Measurement and Project Description sections of this FOA. 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 FOA 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).

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

Program 1: NBCCEDP Applicants must provide an Evaluation and Performance Measurement Plan that demonstrates how the awardee will fulfill the requirements described in the CDC Evaluation and Performance Measurement and Project Description sections of this FOA. An NBCCEDP evaluation planning guidance can be found at http://www.cdc.gov/cancer/dcpc/about/foa-dp17-1701/. Awardees should measure short-term, intermediate, and long-term outcomes. At a minimum, the plan must describe:
• Stakeholders for the evaluation and their priority areas for evaluation.
• Specific evaluation questions that will be addressed.
• A plan for collecting data to assess the performance measures and address evaluation questions.
• Available data sources, feasibility of collecting appropriate evaluation and performance data, and other relevant data information (e.g., collecting clinic screening rates, monitoring screening outcomes for women receiving patient navigation services, assessing extent of implementation of EBIs, etc.).
• How data will be analyzed.
• How monitoring data and evaluation results will be reported to stakeholders and used for continuous program quality improvement.
• How evaluation and performance measurements will contribute to our understanding of the advantages and challenges of working collaboratively with health systems and communities.

Program 2: NCCCP During the five-year project period, awardees will be responsible for developing and implementing a comprehensive formal written evaluation plan that defines both process and outcomes (short-term, intermediate, and long-term) measures that will be evaluated.

Applicants must provide an initial evaluation and performance plan to indicate how they will identify progress in implementing program strategies, activities, and achieving program outcomes. Evaluation focus areas guiding this evaluation include, partnership function/contributions, program plan development, and implementation of interventions. The evaluation plan should consider components identified in the CCC Program Evaluation Toolkit http://www.cdc.gov/cancer/ncccp /prog_eval_ toolkit .htm

The comprehensive evaluation plan should:

- Identify key evaluation stakeholders, how they will be engaged, and their role in planning and implementation of the evaluation.
- Describe how evaluation stakeholders will utilize evaluation findings.
- Include a logic model to illustrate program design.
- Describe specific, measurable, and realistic short-term (one-year), intermediate, and long-term program objectives consistent with the intent of this FOA.
- Address how the applicant intends to assess the extent to which recipient activities are implemented appropriately and yield the intended outcomes.
- Describe indicators for process and outcome measures, address data collection sources, and methods.
- Describe how findings will be disseminated in order to support the use of evidence-based and practice-based strategies/interventions.
- Describe how evaluation findings will be used to enhance implementation efforts.

At the completion of each budget period, awardees will be responsible for submitting an evaluation report summarizing key findings; the evaluation plan will be updated to reflect evaluation findings and program improvement measures.

Program 3: NPCR
Applicants must provide an Evaluation and Performance Measurement Plan that demonstrates how the awardee will fulfill the requirements described in the CDC Evaluation and Performance Measurement and Project Description sections of the FOA. The plan at a minimum should include:

• How the applicant will collect the performance measures, respond to evaluation questions, and use evaluation results for continuous program improvement.
• Use of all available data sources, feasibility of collecting appropriate evaluation and performance data and other relevant data information.

Moreover, the applicant is encouraged to provide an evaluation plan that describes clear monitoring and evaluation procedures which address the following:
a. Evaluation of timeliness, quality, and completeness of data
b. Current status and improvements of electronic capture of cases,
c. Submission of data in accordance with NPCR standards
d. Effective collaborations with NCCCP, NBCCEDP and other chronic disease programs

c. Organizational Capacity of Awardees to Implement the Approach

Program 1: NBCCEDP
Applicants must be able to carry out the strategies outlined in the Approach section of the FOA.
Staffing
• Have existing and future capacity to successfully manage the NBCCEDP.
• Identify and maintain staff to manage the program. Applicants should submit an Organizational Chart and CVs showing the core staff and their assigned duties. As appropriate, integrate program management functions with other existing cancer screening or chronic disease programs. Core staff must include:
Program Manager, at 0.5 FTE minimum
Data manager, at 0.5 FTE minimum
Program evaluator, at 0.5 FTE minimum, with relevant education and experience in planning and conducting program evaluation and/or evaluation studies and has skills in designing evaluations, developing data collection instruments, collecting data, conducting quantitative and qualitative analysis, and creating dissemination products.
At least one medical advisor with relevant expertise in breast and cervical cancer screening to serve as clinical consultant throughout the five-year funding period.

Readiness
• Ability to use a fiscal system that tracks and monitors program expenditures, ensures the accurate and timely reimbursement for services provided by the program, and accurate and on-time reporting of expenditures.
• Capacity to implement relevant strategies and activities.
• Subject matter expertise to plan and implement strategies.
• Access to health systems data such as hospital, clinic, Medicaid, or health plan to measure screening rates and screening outcomes

Scope of work
• Demonstrate experience with implementing a comprehensive breast and cervical cancer screening program
• Established or newly built partnerships with community-based organizations, providers, health systems and other relevant organizations
• Experience implementing or facilitating systems-level change within health systems or other organizations to increase breast and cervical cancer screening
• Experience with planning and implementing programs at an organizational or systems-level
• Experience using population level data for program planning and assessment
• Experience implementing coordinated interventions with at least 2 other chronic disease or public health

programs

Program 2: NCCCP

Applicants must meet the following criteria to fully demonstrate capacity to carry out the strategies outlined in approach section of the FOA.

Staffing

• Identify adequate program management and staffing with sufficient knowledge, skills and abilities to ensure program success. Appropriate positions may include but are not limited to:

Program Director
Policy Systems and Environmental Change Strategy expert
Program Evaluator

• Staff must be proficient in the following:

Expertise to conduct communications (public relations, media relations, social media), surveillance epidemiology and utilization of health data, health care system interventions, fiscal and resource management, professional development , strategic planning and coalition and partnership development.

Expertise in issue framing, policy analysis, policy formulation, message tailoring, and media advocacy

Expertise in planning and implementing a utilization-focused evaluation for the purpose of documenting outcomes and facilitating program improvement

Readiness

• Provide proof of an active state-, tribal- or jurisdiction-wide cancer control coalition bringing external partners together with the state, tribal, or territorial departments of health to plan, prioritize, and implement cancer prevention and control strategies.
• Provide proof of a current state, tribal or territorial cancer control plan, which aims to address the burden of cancer though prevention of risk factors and healthy lifestyle behaviors, promotion of early detection and treatment activities, and establishment of systems to improve the quality of life of cancer survivors.
• Demonstrate prior experience collaborating with central cancer registries, as well as state and tribal epidemiology centers to use surveillance data to plan and implement cancer control and prevention program activities, such as conducting burden assessments for creating cancer plans, prioritizing cancer program activities, assessing risk factors, and assessing screening behaviors, etc.
• Demonstrate prior experience collaborating with established population-based cancer screening programs to plan, inform and support policy, systems, and environmental change interventions to increase recommended cancer screenings and support referrals to diagnostic follow-up as appropriate.
• Demonstrate prior experience collaborating with other CDC-funded chronic disease programs such as the National Tobacco Control Program, the National Diabetes Prevention and Control Program, the National Heart Disease and Stroke Prevention Program and others to inform and support policy, systems, and environmental change interventions to reduce risks of developing cancer, such as promoting tobacco cessation, reducing exposure to second-hand smoke, increasing access to safe places for physical activity, increasing access to healthy food choices, etc.
• Demonstrate prior experience collaborating with key stakeholders in cancer prevention and control; e.g., Prevention Research Centers, Comprehensive Cancer Centers, Primary Care Associations, Federally Qualified Health Centers, and not-for-profit organizations whose mission aligns with the reduction of cancer-related morbidity and mortality.
• Demonstrate prior experience collaborating with state-based surveillance systems that include the central cancer registries and behavioral risks surveillance systems.
• Demonstrate capacity to collaborate with state-based Immunization programs to increase vaccination coverage.
• Provide proof of published dissemination documents describing successes implementing comprehensive cancer control program strategies identified in the state's cancer plan.
• Demonstrate prior experience conducting comprehensive cancer control program evaluation.

Scope of Work

• Demonstrate experience serving in a leadership capacity on the executive board and/or various workgroups of the state's, tribe's, or territory's cancer coalition.
• Demonstrate experience and success implementing cancer prevention and control strategies at the local level; e.g., multiple counties, county, or city-wide.
• Demonstrate prior experience facilitating program improvement processes based on continuous assessment and evaluation.
• Describe experience implementing evidence-based policy, systems, and environmental change strategies and activities related to cancer prevention and control. This includes the capacity to address populations disproportionately affected by cancer by encouraging healthy behaviors such as not smoking or by quitting smoking, eating a healthy diet and maintaining a healthy weight; helping people find cancer early by getting screened as recommended; supporting early cancer diagnosis and treatment; and putting policies and practices in place to link those most in need to community activities that reinforce clinical recommendations pertaining to cancer.
• Describe experience identifying populations disproportionately affected by cancer using data and implementing evidence-based interventions and strategies. This should be done in conjunction with key partners to reduce health disparities and improve health equity at the state and community level.
• Describe existing capacity to inform the general public, stakeholders, and key decision-makers about cancer risks and burden and the potential positive impact of effective policy, systems, and environmental change interventions on this burden.

Program 3: NPCR

Component 1: NPCR CORE REGISTRY

Applicants must meet the following criteria to compete for funding:
• Demonstration of adequate staffing capacity
• Readiness to meet project requirements and plan for long-term sustainability
• Experience and capabilities to perform the scope of work

- *Staffing*
  Provide position descriptions and CVs or brief bios for all relevant leadership positions for the grantee's NPCR program. Demonstrate the leadership team has the qualifications, management experience, programmatic skills and technical expertise to assure adequate oversight and leadership for the cancer registry specialized functions, including: quality assurance of cancer registry data, hiring and retaining appropriate project staff, and working with internal and external partners to promote the use and dissemination of cancer surveillance data.
- Demonstrate adequate program management and staffing with sufficient workforce capacity and competence to ensure program success, including the retention of Certified Tumor Registrars (CTRs) and staff capable of providing ongoing quality control, creating the annual incidence file, data submission, and reports.
- Describe capacity of staff to communicate requirements and updates to a central cancer registry management software vendor, coordinate software conversions with the software vendor and Information Technology staff and report software issues for problem resolution, and perform analysis of data to ensure data integrity following conversions.
  Provide position description for: CTRs; staff capable of conducting educational needs assessment and providing relevant educational support to cancer data reporters and staff at the central cancer registry; staff with subject matter expertise in cancer registry management, analysis and data dissemination; and, IT staff with skills related to functions in the cancer registry.

Readiness

- Demonstrate at least 5 years of prior experience and expertise in implementing a central cancer registry program that meets NPCR quality, completeness and timeliness requirements for data collection and submission, including reporting data that meet the National Data Quality and Advanced National Data Quality standards.

- Demonstrate prior experience coordinating tumor linkages (including the state vital statistics death files and National Death Index) and data item consolidation to verify accuracy and timeliness of cancer incidence data.
- Demonstrate prior experience implementing updated state-specific Edit metafiles and participating in identifying, developing and testing new or revised standard and state-specific edits.
- Demonstrate prior experience participating in activities to incorporate data from new reporting sources including Electronic Health Records and electronic reporting initiatives such as Meaningful Use.
- Describe ability to electronically collect data from medical and pathology records.
- Describe current hardware and software systems that are in place to support the central cancer registry activities, including data collection, database management, data linkages, quality assurance, data analysis and management reporting.
- Describe ability to ensure confidentiality and security of central cancer registry data through software and hardware security standards.
- Describe ability to conduct internal audits and/or quality checks of data collected and processed by internal staff, ability to participate in national quality assurance studies, and ability to conduct external audits of reporting sources.
- Demonstrate that there is an active Advisory Board in place.
- Demonstrate prior experience collaborating with other CDC funded Cancer Programs and Chronic Disease programs to promote accessibility to the cancer registry data and reduce cancer burden.

Scope of Work

- Describe specific plans, mechanisms, and requirements intended to increase use of cancer surveillance data to guide decisions, inform public health policy, assess needed changes in priority and infrastructure, improve quality and efficiency of cancer prevention and treatment efforts, and improve access to data sets across states.
- Describe plans to participate in various CDC-sponsored meetings, trainings, conferences, webinars and workshops, and other relevant meetings to facilitate exchange of information and skills development with peers, CDC staff, and other subject matter experts. Describe any potential barriers to staff attendance at CDC-sponsored meetings (e.g. trainings, informational sessions, annual conferences, etc.) and plans to overcome those barriers.
- Describe plans to oversee the exchange of data with other central cancer registries, including the frequency of such exchanges with border and non-border states.
- Describe plans to develop, implement and maintain an education and training plan that meets the specific needs of the central cancer registry staff and reporters with the goal of improving data quality.
- Describe plans to participate in all CDC-created analytic datasets as outlined in the annual NPCR Cancer Surveillance Systems (NPCR-CSS) Data Release Policy.

<u>Component 2: ENHANCED SURVEILLANCE PROJECT (CINIII, Screening, Prognostic Factors)</u>
In addition to meeting all criteria for Component 1 (NPCR Core Registry), applicants for Component 2 (Enhanced Surveillance Project: CINIII, Screening, Prognostic Factors) must additionally meet the following criteria to compete for funding for Component 2:

Staffing

• Provide position descriptions for subject-matter positions relevant to the focus area (e.g., CIN III, breast and cervical cancer screening, or prognostic factors) to carry out project activities in a timely manner.
• Demonstrate the ability of registry to hire additional staff necessary to carry out project activities in a timely manner as evidenced by a signed statement from the governor's office.

Readiness

• Provide documentation demonstrating existing state law or regulations that provide legal authority for the cancer registry to collect all relevant data for the topic selected from all relevant health care providers, including physician offices, pathology and anatomical laboratories, clinical laboratories, and other

non-hospital facilities.
• Document inclusion in the most current United States Cancer Statistics (USCS) web-based report.
• Demonstrate that the applicant has the potential and capability to enhance their infrastructure for additional data collection, training, methodological development, and expansion of electronic reporting with the goal of enhancing cancer registry data for public health practice.
• Demonstrate that the applicant's registry data systems have the capability to collect and store new data items, whether captured through electronic reporting directly from providers, linkages, or data abstraction activities.
• Describe the ability to obtain local approval for data collection and use specified in this activity.
• CIN III project only: Document previous collection of cervical cancer precursor data in at least one area of the state, or demonstrate the ability to quickly implement the project statewide without previous data collection experience.

Scope of Work

- Describe plans to participate in the development of data submission specifications, data collection procedures, automated edits, and quality control procedures for new data items.
- Document a willingness of other relevant CDC grantees and external partners to collaborate on the project as evidenced by letters of support.
- Describe plans to establish relationships and/or MOUs with relevant healthcare providers to collect new data items.
- Describe plans to develop, implement, and maintain an education and training plan that meets the specific needs of the project.

d. Work Plan

Program 1: NBCCEDP Applicants must provide a detailed work plan with SMART (specific, measurable, attainable, relevant, time-based) objectives for the first year of the project period and a high level plan in narrative form for subsequent years in support of FOA outcomes. Three strategies (4: Environmental Approaches for Sustainable Cancer Control, 5: Community-Clinical Linkages to Patient Support, and 6: Health Systems Changes) are the primary strategies that are essential and lead directly to reaching the overarching goals of reduced breast and cervical cancer morbidity, mortality, and disparities in incidence and mortality. Applicants are also expected to implement cross-cutting strategies (1: Program Collaboration, 2: External Partnerships, 3: Cancer Data and Surveillance, and 7: Program Monitoring and Evaluation), in addition to Program Management, that support and lead to the success of the primary strategies. Activities must be in alignment with the proposed outcomes and the program strategies list in the FOA and must include those activities the applicant selects as priority, based on the cited evidence, for the first year of the project. Applicants are encouraged to use the sample workplan template at https://www.cdc.gov/cancer/dcpc/about/foa-dp17-1701/. CDC will provide feedback and technical assistance to awardees to finalize the work plan post-award. The work plan must, at a minimum, include:
• A narrative overview detailing realistic, annual projections for the first year of the project period. Projections should be based on data, take into consideration the size of the estimated eligible population, and be based on previous experience in providing high-quality breast and cervical cancer screening and diagnostic services.
• A detailed description of strategies and activities to be used in the first year of the project period to include collaborations with other cancer and chronic disease programs.
• A detailed description of working with health systems and community partners to identify and target specific populations.
• Activities for the first year of the project period that identify how awardee will identify and reach disparate populations.

• Outcomes (including measures to assess progress and accomplishments).
• A description of how the applicant will monitor and report progress on the short-term performance including evaluation of all strategies.
• A description of how the applicant will monitor and report progress on as many of the intermediate and long-term measures as feasible for the strategies selected.
• A description of intended outcomes for the five-year project period.
• An estimate of women to be served and clinical versus non-clinical service costs by completing the Service Delivery Projections and Budget Breakdown Worksheet found at http://www.cdc.gov/cancer/dcpc/about/foa-dp17-1701/

Program 2: NCCCP
Applicants must submit a work plan that will provide direction and guidance for the implementation environmental approaches for sustainable cancer control; community-clinical linkages to aid patient support; and healthy systems changes (strategies 4 - 6).
• The work plan must include project period objectives (long term objectives to be achieved over the life of the cooperative agreement) and annual objectives (short-term objectives that work toward the achievement of the project period objective) that are specific, measureable, achievable, realistic, and time-phased.
• Project period objectives will include the appropriate LIDS measure and must be aligned with the following priority areas: primary prevention of cancer, screening and early detection of cancer, and improving the quality of life of cancer survivors.
• Annual objectives will be aligned with environmental approaches for sustainable cancer control; community-clinical linkages to aid patient support; and healthy systems changes (strategies 4 – 6), and must include both measures and evidence-based strategies that are selected from LIDS.
• The work plan must also include activities that are essential to the achievement of program objectives including actions that determine how the applicant with collaborate with internal and external stakeholders, use data to inform intervention design, implement the intervention with validity, and monitor progress.
Applicants are encouraged to use the sample workplan template at http://www.cdc.gov/cancer/dcpc/about/foa-dp17-1701/.

Program 3: NPCR
Applicants must provide a detailed work plan for the first year of the project period and a high level plan in narrative form for subsequent years in support of the FOA. Activities must be in alignment with the proposed outcomes and the program strategies list
Applicants are encouraged to utilize the sample template provided on the FOA Website http://www.cdc.gov/cancer/dcpc/about/foa-dp17-1701/ a similar template with the following components:
• Project Outcomes
• Strategies/Activities
• Process Measures
• Responsible Position/Party
• Timeline and Completion Date
• Collaborators and Partners

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

- Tracking awardee progress in achieving the desired outcomes.
- Ensuring the adequacy of awardee systems that underlie and generate data reports.

- Creating an environment that fosters integrity in program performance and results.

Monitoring may also include the following activities 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 awardees are performing at a sufficient level to achieve outcomes within stated timeframes.
- Working with awardees on adjusting the work plan based on achievement of outcomes, evaluation results and changing budgets.
- Monitoring performance measures (both programmatic and financial) to assure satisfactory performance levels.

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

Other activities include monitoring and reporting that assist grants management specialists and project officers in the identification, notification, and management of financial issues.

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

All Programs as applicable

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

CDC activities in this FOA are as follows:

- Collaboration between program consultants across the division to provide coordination of program monitoring and technical assistance activities such as joint program calls, site visits, and regional consultations.
- Team Leads, Project Officers, and Subject Matter Experts from across the division jointly plan and participate in trainings and other capacity building activities that address crosscutting strategic areas.
- Resources and guides that address key programmatic needs across the FOA will be jointly developed and/or disseminated to ensure consistent messages with meeting grantee technical assistance needs.
- Technical assistance in the areas of program implementation, fiscal and grants management, surveillance and epidemiology, health education and promotion, evaluation, community-clinical linkages, and environmental approaches will be coordinated across programs to ensure consistency and build awardee capacity.
- CDC Chronic Project Officers will continue to identify collaboration and coordination opportunities through the NCCDPHP Regional Team meeting
- Coordinated Program Directors meetings and Cancer Conferences will be prioritized to reduce burden on grantees
- Establish program policies and guidelines collaboratively with grantees.
- Facilitate the exchange of information and coordination, collaboration, and service integration between grantees and chronic disease counterparts.
- Provide ongoing guidance, consultation and technical assistance to support the planning, implementation, monitoring, and evaluation of the activities listed within the components funded in this FOA.
- Monitor grantee progress in implementing the program and work with grantees through email, conference calls, and site visits, and review of progress reports and other data reports to support program progress and program improvement.
- Convene trainings, capacity building exercises, meetings, web forums, conference calls, and site visits with grantees.
- Provide relevant scientific research findings, peer-reviewed publications, success stories, public health

recommendations, and up-to-date clinical guidelines related to the FOA.

- Provide eligible population estimates for available geographic units. Estimates are currently available at the national, state, and county level. Estimates can be found at: http://www.census.gov/hhes/www/sahie/data/index.html.
- Design, implement, and evaluate program implementation of screening and patient support services.
- Provide strategies to work effectively with health care systems and community-based organizations to use available data and target populations to decrease disparities.
- Provide guidance on practical application of appropriate Public Laws based on the program specific needs. These laws include; Public Law101-354, including amendments to the law, Public Health Service Act, (42 USC 280e-280e-4; Public Law 102-515), as amended and Public Health Service Act, [42 U.S.C. section247b (e) and (k)(2)], as amended.
- Provide tools and methodologies to conduct linkages between the screening program data and central cancer registries data, and reporting registry stage data in the MDE.
- Develop regular data monitoring feedback reports based on clinical data submissions to support data use for quality assurance, program improvement, and program monitoring and evaluation.
- Evaluate, monitor, and report on progress toward meeting performance standards using interim progress reports, end of year reports, MDE reports, annual surveys, and others described in FOA.
- Provide analytic datasets through CDC's Research Data Center, restricted data access files for NPCR-sponsored registries, and a public use dataset.
- Provide mechanisms to facilitate external data linkages through CDC's National Death Index and Social Security Administration's Administrative Databases.
- Provide assistance with dissemination of information, including evaluation results, about awardee's program efforts to the public and public health audiences. When appropriate, evaluation findings will be described for individual awardees by name.
- Provide technical assistance and support to central cancer registries for electronic pathology, biomarkers and physician reporting/Meaningful Use efforts.
- Develop and provide publicly available software programs for collecting, receiving, validating, processing, and analyzing cancer registry data.
- Provide NPCR Program Standards and Program Manual to ensure standardized operations and data collection.
- Collaborate with national partners and organizations to standardize the reporting of cancer, promote education for cancer registrars, and advocate for central cancer registries by actively participating as chairs/members of committees/workgroups.
- Assess the quality of central cancer registry data by conducting NPCR-sponsored Data Quality Evaluations of central cancer registries.
- Receive, evaluate, and disseminate cancer surveillance data received from central cancer registries through the NPCR Cancer Surveillance System.
- Maintain online dissemination tools http://www.cdc.gov/cancer/npcr/tools.htm

B. Award Information

1. Funding Instrument Type:	Cooperative Agreement CDC's substantial involvement in this program appears in the CDC Program Support to Awardees Section.
2. Award Mechanism:	U58 Chronic Dis
3. Fiscal Year:	2017
Estimated Total Funding:	$215,000,000

4. Approximate Total Fiscal Year Funding: $215,000,000

This amount is subject to the availability of funds.

5. Approximate Project Period Funding: $1,075,000,000

6. Total Project Period Length: 5

7. Expected Number of Awards: 85

8. Approximate Average Award: $850,000 Per Budget Period

This amount is subject to the availability of funds.

9. Award Ceiling: $15,000,000 Per Budget Period

3/1/2017 AMENDMENT IS TO CLARIFY THE 3 PROGRAM COMBINED AWARD CEILING AMOUNT.

NO APPLICATIONS ARE BEING SOLICIATED

Program specific ceilings per budget period;

Program 1 NBCCEDP: $9,000,000

Program 2 NCCCP: $750,000

Program 3 NPCR (Component 1): $3,300,000

Program 3 NPCR (Component 2):

CIN3 - $75,000

Screening - $250,000

Biomarkers - $200,000

10. Award Floor: $300,000 Per Budget Period

11. Estimated Award Date: 06/30/2017

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

12. Budget Period Length: 12 month(s)

13. Direct Assistance

Direct Assistance (DA) is available through this FOA.

All Programs: In years 2 – 5 of the FOA, Statistical Analysis Software (SAS) Licensures/SUDAAN will be awarded as direct assistance (DA) and will be deducted from the amount of financial assistance (FA) that would otherwise be available for award.

C. Eligibility Information

1. Eligible Applicants

Eligibility Category:

State governments
Native American tribal governments (Federally recognized)
Native American tribal organizations (other than Federally recognized tribal governments)
Others (see text field entitled "Additional Information on Eligibility" for clarification)

Additional Eligibility Category:

Government Organizations:

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

2. Additional Information on Eligibility

Program 1: The National Breast and Cervical Cancer Early Detection Program (NBCCEDP)

• State governments or their bona fide agents (includes the District of Columbia)

• Territorial governments or their bona fide agents in the Commonwealth of Puerto Rico, the Virgin Islands, the Commonwealth of the Northern Marianna Islands, American Samoa, Guam, the Federated States of Micronesia, the Republic ofthe Marshall Islands, and the Republic of Palau. • American Indian or Alaska Native tribal governments (federally recognized or state-recognized)

• Native American tribal governments (Federally recognized)

• Native American tribal organizations (other than Federally recognized tribal governments) • American Indian or Alaska native tribal designated organizations

Program 2: National Comprehensive Cancer Control Program (NCCCP)

• State governments or their bona fide agents (includes the District of Columbia)

• Territorial governments or their bona fide agents in the Commonwealth of Puerto Rico, the Virgin Islands, the Commonwealth of the Northern Marianna Islands, American Samoa, Guam, the Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau.

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

• Native American tribal governments (Federally recognized)

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

• American Indian or Alaska native tribally designated organizations

Program 3: National Program of Cancer Registries (NPCR)

• State health departments or their Bona Fide Agents (this includes the District of Columbia) including

Central Cancer

Registries that are currently funded by the National Cancer Institute for the Surveillance, Epidemiology, and End Results

program (Connecticut, Hawaii, Iowa, New Mexico, and Utah) are eligible to apply.

• Territorial governments or their bona fide agents in the Commonwealth of Puerto Rico, the Virgin Islands, the Commonwealth of the Northern Marianna Islands, American Samoa, Guam, the Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau.

The award ceiling for each component under Section B. Award Information is $15,000,000. CDC will not consider any application requesting an award higher than the specified amount. If a pre-application is required, then specify here and include it in the special eligibility requirements section. (https://www.hhs.gov/sites/default/files/grants/grants/policies-regulations/gpd2-04.pdf)

3. Justification for Less than Maximum Competition

Program 2: National Comprehensive Cancer Control Program (NCCCP)

Justification for Eligibility to be limited to state health agencies or their bona fide agents, U.S. territories, and Native American tribal governments.

Cancer is the second leading cause of death in the United States. Every year, it claims the lives of more than half a million Americans - about 1,596 people a day. Programs that provide resources and support to convene community stakeholders and collaboratively assess burden and plan and invest in strategic cancer prevention and control approaches are essential. This funding opportunity announcement (FOA) supports cancer prevention and control activities in three national programs-the National Breast and Cervical Cancer Early Detection Program (NBCCEDP), the National Comprehensive Cancer Control Program (NCCCP), and the National Program of Cancer Registries (NPCR). While each of these three components is uniquely different, the three are also critically integrated because they provide and support comprehensive approaches to cancer prevention and control for states and jurisdictions across the country. These approaches include component support for developing and sustaining critical partner networks or coalitions, through the NCCCP, to plan and implement strategic priorities for cancer prevention and control through systems and environmental change. Coordinated management of these networks facilitates the development and implementation of cancer control plans with prioritized cancer prevention and control strategies in which all stakeholders can invest; leverages other community resources to support activities across cancer programs, and ensures limited resources are allocated most efficiently. Comprehensive cancer control is a proven approach that supports primary and secondary prevention activities as well as activities to impact the quality of life of cancer survivors. This FOA also supports the NBCCEDP, a population-based approach to breast and cervical cancer prevention and control that includes health systems transformation and clinical service provision that can serve as a model for prevention and/or early detection of screen-able cancers. The NBCCEDP relies heavily upon partner-support for program implementation. The NCCCP provides an extension of partners for the NBCCEDP to support navigation, outreach, awareness, and provider education ; hence it is essential that the types of awardees for the NCCCP to be the same as the other programs in this FOA. The FOA also provides critical support for population-based, statewide cancer surveillance registries through the NPCR. These registries are not only essential for assessing cancer incidence and mortality but they are also critical for planning and prioritizing all cancer prevention and control efforts. The success of each individual component relies heavily upon seamless and specific collaborations with the each of the other components. It is essential to limit the eligibility of the National Comprehensive Cancer Control Program in order to provide coverage and care to populations with disparate health outcomes, to maximize utilization of limited resources and to create efficiencies across the three national programs. Therefore

eligibility for funding for this component is limited to states, tribes, and territories. While not required, in order to maximize the reach of this limited funding, tribal organizations are encouraged to consider applying on behalf of the tribes in their organizations.

The NBCCEDP and the NPCR both have congressional language that limits eligibility to state health department applicants or their bona fide agents. In addition, congressional language also allows the NBCCEDP to fund tribes, tribal organizations and U. S Territories. Because the three program components are critically integrated and the success of each are interdependent upon each other, Program respectfully requests that eligibility for the NCCCP also be limited to the same potential applicants. Public health departments have the unique role and responsibility to strategically plan and implement public health programs to improve health in schools, workplaces and neighborhoods (Trust for America's Health, Investing in America's Health, Issue Report April 2016). This involves identifying the top health problems and developing strategies for how to address them. State health departments have the capacity to effectively define the scope of health problems, set goals to improve health and garner community support from those who make change happen. State health departments have the capacity, through state-based surveillance systems, to provide relevant information (public health data) on the community's health and provide essential public health services; inform the public about public health threats; mobilize community partnerships, and enforce state health laws. The NCCCP is founded on these principles and requires grantees to coordinate cancer prevention and control efforts across states and jurisdictions to establish cancer control plans with objectives determined through burden assessment. These plans prioritize prevention objectives and include NBCCEDP and NPCR program objectives. They allow stakeholders to prioritize activities and leverage federal and non-federal resources for greater impact. Cancer control planning requires constant assessment of data collected through state-based surveillance systems that include the state cancer registries and behavioral risks surveys. State-based NCCCP grantees have unique capacities to work within these systems to appropriately assess burden through established data sharing agreements that protect patient privacy and information to prioritize primary and secondary prevention strategies, as well as to plan and inform program activities to improve the quality of life of cancer survivors by appropriately linking registry data to provider records for survivorship care planning and chronic disease self-management. Again, state-based NCCCP grantees have essential collaboration capacity that does not exist among other entities. Program evaluation has demonstrated that collaborations across cancer and other chronic disease programs within state health departments are tremendous facilitators of successful cancer prevention and control activities, such as activities to increase HPV-vaccination rates among adolescents to reduce risks of developing vaccine preventable cancers and activities to decrease smoking prevalence to reduce risks of developing a number of cancers. Likewise, our program evaluations have also suggested that the lack of state health department facilitation of cancer prevention and control activities has often presented barriers to convening the appropriate stakeholders, securing appropriate buy-in, and mobilizing appropriate partnerships to leverage implementation resources. These barriers have led to segmented and often-disjointed activities that are not sustainable or impactful. Lastly, state-based NCCCP grantees also have the capacity to support and enhance systematic approaches to implement evidence-based patient navigation, chronic disease self-management, outreach, and education activities that create efficiencies and synergies within state-based systems that cannot otherwise be created.

The continued success of the programs in this FOA is dependent on the integration of the component programs. These programs have demonstrated that state-based applicants (or their bona fide agents) are highly successful at creating effective synergies across cancer and other chronic disease programs because of their unique capacities to support and enhance systems approaches by leveraging chronic disease program resources within existing state health department infrastructures. State cancer registry data and the behavioral risk surveillance data are the foundation of a state's Comprehensive Cancer Control Plan and related population-based efforts to reduce cancer incidence and mortality. Because cancer is a notifiable chronic condition, cancer registry data include a census of all cancer cases and can be used to define and monitor burden at the local, state, and national levels; to investigate patterns of cancer occurrence and treatment; and to evaluate the effectiveness of public health prevention efforts. Therefore,

the success of the NCCCP is critically dependent upon the grantee's capacity to work within existing state-based surveillance systems; create and support primary prevention activities across state-based systems that prevent cancer and other chronic diseases with shared risk factors; support health systems transformation that creates access to secondary prevention, primarily in systems that support medically underserved populations such as local health departments, community health and Federally qualified health centers; and improve the quality life of cancer survivors by enhancing linkages to community resources to support chronic disease self-management.

Limiting eligibility to the same pool of applicants for the NBCCEDP and NPCR is critical to the success of all three program components, particularly the NCCCP. These applicants or their bona fide agents have the capacity to implement evidence-based state-wide cancer prevention programs through their unique relationships with and access to state-based surveillance and chronic disease program systems and the capacity to convene coalitions to plan and prioritize cancer prevention and control activities that leverage additional non-federal resources to support program activities in all components.

Applicants without the infrastructure and capacity described above will be unable to achieve the goals and objectives of this project.

4. Cost Sharing or Matching

Cost Sharing / Matching Requirement: Yes

Program 1: NBCCEDP

Recipient financial participation is required for this program in accordance with the authorizing legislation. Section 1502(a) and (b)(1), (2), and (3) of the Public Health Services (PHS) Act, as amended, requires matching funds from non-Federal sources in an amount not less than one dollar for every three dollars of Federal funds awarded under this program. However, Title 48 of the U.S. Code 1469a (d) requires DHHS to waive matching fund requirements up to $200,000 for Guam, U.S. Virgin Islands, American Samoa and the Commonwealth of the Northern Mariana Islands.

Matching funds may be cash, in-kind or donated services or equipment. Contributions may be made directly or through donations from public or private entities. Public Law 93-638 authorizes tribal organizations contracting under the authority of Title I to use funds received under the Indian Self-Determination Act as matching funds.

Applicants may also designate as State/Tribal/Territorial/Pacific Island Jurisdiction matching funds any non-Federal amounts spent pursuant to Title XIX of the Social Security Act for the screening and case management of women for breast and cervical cancers.

Matching funds may not include: (1) payment for treatment services or the donation of treatment services; (2) services assisted or subsidized by the Federal government; or (3) the indirect or overhead costs of an organization. All costs used to satisfy the matching requirements must be documented by the applicant and will be subject to audit.

Program 2: NCCCP

Cost sharing is encouraged if it helps to leverage federal and state resources, is responsive to stated CDC recipient activities, supports the National Comprehensive Cancer Control Program priorities, and does not compromise the integrity or the ability of the comprehensive cancer control program to accomplish proposed activities. Matching funds are not required under this cooperative agreement, but are encouraged.

Program 3: NPCR

Per PHS Act (42 USC 280e-280e-4), matching funds are required for Program 3, NPCR applicants in an amount not less than 25 percent of such costs **or** one dollar for every three dollars of Federal funds awarded under this program; [Title 42, Chapter 6A, Subchapter II, Part M, § 280e(b)(1)]. Matching funds may be cash, in-kind, or donated services or equipment. Contributions may be made directly or through donations from public or private entities. However, Title 48 of the U.S. Code 1469a (d) requires DHHS to waive

matching fund requirements for Guam, U.S. Virgin Islands, American Samoa and the Commonwealth of the Northern Mariana Islands up to $200,000. Public Law 93-638 authorizes tribal organizations contracting under the authority of Title 1 to use funds received under the Indian Self-Determination Act as matching funds. Non-federal financial contributions in excess of the Maintenance of Effort may be used for matching.

Matching funds may not include: (1) payment for treatment services or the donations of treatment services (2) services assisted or subsidized by the Federal government; or (3) the indirect or overhead costs of an organization. All costs used to satisfy the matching requirement must be documented by the applicant and will be subject to audit. Documentation of appropriate matching is to be provided in the detailed budget and narrative justification.

5. Maintenance of Effort

Program 1: NBCCEDP Maintenance of Effort is required for this program in accordance with the authorizing legislation PL 101-354. The average amount of non-Federal contributions toward breast and cervical cancer programs and activities for the two-year period preceding the first Federal fiscal year of funding for NBCCEDP is referred to as Maintenance of Effort (MOE). Only those non-Federal contributions in excess of the MOE amount may be considered matching funds. Supplanting, or replacing, existing program efforts currently paid with Federal or non-Federal sources is not allowable.

Program 2: NCCCP Maintenance of effort is not required for this program

Program 3: NPCR Maintenance of Effort is required for this program. Recipients must agree to make available (directly or through donations from public or private entities) non-Federal contributions equal to the amount expended during the fiscal year preceding the first year of the original NPCR cooperative agreement award for the collection of data on cancer, as noted in Public Health Service Act (42 USC 280e-280e-4).

In determining the amount of non-Federal contributions for cost-sharing or matching, the recipient may include only those contributions that are in excess of the amount of contributions made by the State for collection of data on cancer for the fiscal year preceding the first year of the original NPCR cooperative agreement award. CDC may decrease the amount of non-Federal contributions required if the State can show that the amount will cause them financial hardship [Title 42, Chapter 6A, Subchapter II, Part M, § 280e(b)(2)(B)].

D. Required Registrations

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

1. Required Registrations

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

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

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

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

b. System for Award Management (SAM): The SAM is the primary registrant database for the federal

government and the repository into which an entity must submit information required to conduct business as an awardee. All applicant organizations must register with SAM, and will be assigned a SAM number. All information relevant to the SAM number must be current at all times during which the applicant has an application under consideration for funding by CDC. If an award is made, the SAM information must be maintained until a final financial report is submitted or the final payment is received, whichever is later. The SAM registration process 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 "Get Registered" option atwww.grants.gov.

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

Step	System	Requirements	Duration	Follow Up
1	Data Universal Number System (DUNS)	1. Click on http:// fedgov.dnb.com/ webform 2. Select Begin DUNS search/request process 3. Select your country or territory and follow 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 issues 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 the 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	Register early! Log into Grants.gov and check AOR status until it shows you have been approved

			and SAM account before applying to grants.gov	

2. Request Application Package

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

3. Application Package

Applicants must download the SF-424, Application for Federal Assistance, package associated with this funding opportunity at www.grants.gov. If Internet access is not available, or if the online forms cannot be accessed, applicants may call the CDC 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 FOA, 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: **01/12/2017**

The purpose of a Letter of Intent (LOI) is to allow CDC program staff to estimate the number of and plan for the review of submitted applications. An LOI is not required, but strongly encouraged for the **National Breast and Cervical Cancer Early Detection Program**, the **National Comprehensive Cancer Control Program** and the **National Program of Cancer Registries.**

The LOI should include the following:

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

If an LOI is submitted, it must be emailed or postmarked by **January 12, 2017, 11:59 p.m. U.S. Eastern Standard Time**

LOIs may be sent via email, U.S. express mail or delivery service to:

Frances Babcock

Department of Health and Human Services

Centers for Disease Control and Prevention

4770 Buford Hwy, NE, MS F-76

Atlanta, GA 30341

Telephone: 770-488-3069

Email: DP171701mailbox@cdc.gov

b. Application Deadline

Due Date for Applications: **02/23/2017** , 11:59 p.m. U.S. Eastern Standard Time, at www.grants.gov. If Grants.gov is inoperable and cannot receive applications, and circumstances preclude advance notification of an extension, then applications must be submitted by the first business day on which grants.gov operations resume.

Date for Informational Conference Call: 01/05/2017

- **January 5, 2017 at 10:00 a.m. to 12:00 p.m. Eastern Daylight Savings Time -** For eligible applicants in the Atlantic, Eastern, and Central time zones. This conference call can be accessed by calling **1-888-942-9712**. The leader for this call is Tanya Hicks and the passcode is **8345600**.

- **January 5, 2017 at 3:30 p.m. to 5:30 p.m. Eastern Daylight Savings Time –** For eligible applicants in the Mountain and Western time zones. This conference call can be accessed by calling **1-888-942-9712**. The leader for this call is Tanya Hicks and the passcode is **8345600**.

- **January 5, 2017 at 7:30 p.m. to 9:30 p.m. Eastern Daylight Savings Time -** For eligible applicants in the Pacific Island Jurisdictions. This conference call can be accessed by calling **1-888-942-9712**. The leader for this call is Tanya Hicks and the passcode is **8345600**. If operator assistance is needed, call **1-517-308-9217** and the operator will assist you in joining the call.

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.

Duplication of Efforts

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

an individual's effort greater than 100 percent, is not permitted. Any overlap will be resolved by the CDC with the applicant and the PD/PI prior to award.
Report Submission: The applicant must upload the report in Grants.gov under "Other Attachment Forms." The document should be labeled: "Report on Programmatic, Budgetary, and Commitment Overlap."

6. Content and Form of Application Submission

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

7. Letter of Intent

Is a LOI: Recommended but not Required

The purpose of a Letter of Intent (LOI) is to allow CDC program staff to estimate the number of and plan for the review of submitted applications. An LOI is not required, but strongly encouraged for the National Breast and Cervical Cancer Early Detection Program, the National Comprehensive Cancer Control Program and the National Program of Cancer Registries.

The LOI should include the following:
• Descriptive title of proposed project
• Name, address, telephone number, and email address of the Principal Investigator or Project Director, or both
• Name, address, telephone number, and e-mail address of the primary contact for writing and submitting this application
• Number and title of this FOA

If an LOI is submitted, it must be emailed or postmarked by January 12, 2017, 11:59 p.m. U.S. Eastern Standard Time

LOIs may be sent via email, U.S. express mail or delivery service to:

Frances Babcock

Department of Health and Human Services
Centers for Disease Control and Prevention
4770 Buford Hwy, NE, MS F-76
Atlanta, GA 30341
Telephone: 770-488-3069
Email: DP171701mailbox@cdc.gov

8. Table of Contents

(There is no page limit. The table of contents is not included in the project narrative page limit.): The applicant must provide, as a separate attachment, the "Table of Contents" for the entire submission package. Provide a detailed table of contents for the entire submission package that includes all of the documents in the application and headings in the "Project Narrative" section. Name the file "Table of Contents" and upload it as a PDF file under "Other Attachment Forms" at www.grants.gov.

9. Project Abstract Summary

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

10. Project Narrative

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

Text should be single spaced, 12 point font, 1-inch margins, and number all pages.

Page limits include work plan; content beyond specified limits may not be reviewed.
Applicants should use the federal plain language guidelines and Clear Communication Index to respond to this Funding Opportunity Announcement. Note that awardees should also use these tools when creating public communication materials supported by this FOA. Failure to follow the guidance and format may negatively impact scoring of the application.

Disregard the language above concerning the maximum number of pages for the project narrative.

If applying for a single program: a maximum of **35 pages**, single spaced, 12 point font, 1-inch margins, and number all pages.

If applying for more than one program: maximum of **35 pages for each program** and up to **15 additional pages** are allowed for each subcomponent under NPCR Program 3 is allowed.

Text should be single spaced, 12 point font, 1-inch margins, and number all pages.

Page limits include work plan; content beyond specified limits will not be reviewed.

a. Background

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

b. Approach

i. Purpose

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

ii. Outcomes

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

iii. Strategies and Activities

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

1. Collaborations

Applicants must describe how they will collaborate with programs and organizations either internal or external to CDC. Applicants must address the Collaboration requirements as described in the CDC Project Description.

All Programs:

- Applicants must submit letters of support dated within 30 days of the application from programs and organizations including tribes as appropriate with whom they will collaborate.
- Applicants for each program are required to include a letter of commitment addressed to CDC pledging full support of and active participation on the Leadership Team as described in the collaboration section.
- Applicants must submit an MOU /MOA within 90 days of receiving the notice of award (NOA). The agreement must describe the programs' or organization's role and list specific strategies on which they will work with the organization to achieve identified outcomes listed in the FOA.
- Guidance on what must be included in letters of support and MOU/MOAs can be found at http://www.cdc.gov/cancer/dcpc/about/foa-dp17-1701/

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 awardee will fulfill the requirements described in the CDC Evaluation and Performance Measurement and Project Description sections of this FOA. 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).

Awardees 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 FOA.

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

d. Organizational Capacity of Applicants to Implement the Approach

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 awardee plans to carry out achieving the project period outcomes, strategies and activities, evaluation and performance measurement.
Additional guidance can be found at http://www.cdc.gov/cancer/dcpc/about/foa-dp17-1701/

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 will not be reimbursed under grants to foreign organizations, international organizations, and foreign components of grants to domestic organizations (does not affect indirect cost reimbursement to the domestic entity for domestic activities). For guidance on completing a detailed budget, see Budget Preparation Guidelines at: http:// www.cdc.gov /grants /interested in applying /application resources.html.
If applicable and consistent with the cited statutory authority for this announcement, applicant entities may use funds for activities as they relate to the intent of this FOA to meet national standards or seek health department accreditation through the Public Health Accreditation Board (see: http://www.phaboard.org).
Applicant entities to whom this provision applies include state, local, territorial governments (including the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, the Commonwealth of the Northern 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 FOA. Proposed activities must be included in the budget narrative and must indicate which standards will be addressed.
Applicants must name this file "Budget Narrative" and upload it as a PDF file at www.grants.gov. If requesting indirect costs in the budget, a copy of the indirect cost-rate agreement is required. If the indirect

costs are requested, include a copy of the current negotiated federal indirect cost rate agreement or a cost allocation plan approval letter for those Grantees under such a plan. Applicants must name this file "Indirect Cost Rate" and upload it at www.grants.gov.

ALL Programs: Provide a detailed budget and line item justification for all proposed operating expenses in Year 1. The budget and justification will not be counted as part of the page limit for the narrative. In addition to the 424A, one 424A should be submitted that shows funding request by Object Class Categories for each of the components. The budget narrative should be reasonable and consistent with the purpose, outcomes, and program strategy outlined in the narrative. The budget must include these additional elements as appropriate:

- Maintenance of Effort
- Matching/Cost sharing Funds (Procedures for documenting the value of non-cash matching/cost sharing funds)

Indirect Costs

If indirect costs are requested, a copy of the organization's current negotiated Federal Indirect Cost Rate Agreement or a Cost Allocation Plan must be included

TRAVEL

All Programs: Budget for CDC Sponsored Travel including:, one Reverse Site Visit, and the 2017 Cancer Conference / DP17-1701 Program Kickoff Meeting in August 2017

OTHER BUDGET CONSIDERATIONS

Program 1: National Breast and Cervical Cancer Early Detection Program

NBCCEDP applicants should budget for modifications to their data management system to support MDE updates.

Program 2: National Comprehensive Cancer Control Program - NCCCP

Applicants must ensure that not more than 40% of the requested budget is allocated for program staffing. In addition, applicant must ensure that at least 60% of the requested budget is allocated to program implementation at state and local levels.

Travel: Applicants must also budget for travel support for the Cancer coalition or Steering Committee Chairperson to participate in the 2017 Cancer Conference/Kickoff Meeting in August 2017

Program 3: National Program of Cancer Registries - NPCR

Applicants must provide an itemized budget narrative for Components 1 and if applicable, Component 2.

Applicants must disclose all state and federal (e.g., NCI SEER) funding provided to entities within the catchment area directed toward core cancer surveillance operations. Grantees are encouraged to list all registry staff regardless of funding source to facilitate future budget requests including travel and overtime purposes when appropriate.

Applicants should note the following budget guidelines:

Central Registry Staff

For **each** proposed staff, provide detailed justification of need based on conducting the NPCR Recipient Activities in Section I and include the following:

- type of personnel (FTE, contractor, consultant)
- specific tasks/activities to be performed
- percent of time to be spent on specific tasks/activities; e.g., percent of time spent on IT activities if 100% of time is not dedicated to IT

- percent of time funded by each source (NPCR, state, other federal)

Travel: In addition to the travel listed above include the following program specific travel; NAACCR Annual Meeting, NCRA Annual Meeting, and Education Training Coordinator's Meeting

13. 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: http://www.whitehouse.gov/omb/grants_spoc/.

14. 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 grantees inform their employees in writing (in the predominant native language of the workforce) of employee whistleblower rights and protections under 41 U.S.C. 4712.

14a. 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). Grantees will be required to draw down funds from award-specific accounts in the PMS. Ultimately, the subaccounts will provide grantees 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.

14b. 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.

14c. 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 grantee 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 grantee did not pay any taxes during the reporting period.]

2) Quarterly Report: The grantee 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. grantee 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 grantee must include this reporting requirement in all applicable subgrants and other subagreements.

14d. 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

15. Funding Restrictions

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

- Awardees may not use funds for research.
- Awardees may not use funds for clinical care except as allowed by law.
- Awardees may use funds only for reasonable program purposes, including personnel, travel, supplies, and services.
- Generally, awardees may not use funds to purchase furniture or equipment. Any such proposed spending must be clearly identified in the budget.
- Reimbursement of pre-award costs generally is not allowed, unless the CDC provides written approval to the awardee.
- 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 awardees.
- The direct and primary recipient in a cooperative agreement program must perform a substantial role in carrying out project outcomes and not merely serve as a conduit for an award to another party or provider who is ineligible.

Program 1: NBCCEDP

• As specified in PL 101-354, use of federal funds for treatment is prohibited.
• As specified by PL 101-354, not more than 10 percent of cooperative funds awarded may be spent annually for administrative expenses. These administrative expenses are in lieu of and replace indirect costs [Section 1504(f) of the PHS Act, as amended].

Program 3: NPCR

• As specified in the Public Health Service Act, (42 USC 280e-280e-4), as amended, cooperative agreement funds must not be used for purposes other than those outlined in this announcement.
• Purchase, licensing, or development of central cancer registry applications or database systems that perform the same functions as tools provided by CDC/NPCR (see CDC/NPCR Registry Plus module description).
• Design and development of new software and/or enhancement of an existing central cancer registry database management system where publicly available products exist.
• Funding for activities associated with the maintenance and support of a central registry database system that exceeds 20 percent of the total direct budget request per year. For additional information see http://www.cdc.gov/cancer/dcpc/about/foa-dp17-1701/
• Direct data collection in reporting facilities unless justified. For additional information see http://www.cdc.gov/cancer/dcpc/about/foa-dp17-1701/
• Abstracting from hard-copy medical records at the central cancer registry unless justified. For additional information see http://www.cdc.gov/cancer/dcpc/about/foa-dp17-1701/
• Promotional items.
• International travel (exception Canada for NAACCR conference).
• Travel to meetings not directly related to cancer registries.

• Travel for non-registry staff NOTE: In accordance with Health and Human Services (HHS) Grants Policy Statement, travel is only allowable for personnel directly charged and approved on the grant/cooperative agreement.
• Cell phones, blackberries, palm pilots, or any other personal electronic device.
• Automobiles.
• Construction.
• Funds must be used to supplement not to supplant existing State and/or other Federal resources.

16. Other Submission Requirements

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

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

If Internet access is not available or if the forms cannot be accessed online, applicants may contact the 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 FOA. Non-validated applications will not be accepted after the published application deadline date.

If you do not receive a "validation" e-mail within two business days of application submission, please contact www.grants.gov. For instructions on how to track your application, refer to the e-mail message generated at the time of application submission or the Grants.gov Online User Guide. http://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 I Review
All applications will be initially reviewed for eligibility and completeness by the Office of Grants Services. Complete applications will be reviewed for responsiveness by Grants Management Officials and Program Officials. Non-responsive applications will not advance to Phase II review. Applicants will be notified that their applications did not meet eligibility and/or published submission requirements.

b. Phase II Review
A review panel will evaluate complete, eligible applications in accordance with the criteria below.
i. Approach ii. Evaluation and Performance Measurement iii. Applicant's Organizational Capacity to Implement the Approach
Not more than thirty days after the Phase II review is completed, applicants will be notified electronically if their application does not meet eligibility or published submission requirements.

Program 1: Approach	Maximum Points: 35

Evaluate the extent to which the applicant:

- Presents outcomes that are consistent with the project period outcomes described in the CDC Project Description and logic model.
- Describes an overall strategy and activities consistent with the CDC Project Description and logic model.
- Describes strategies and activities that are achievable, appropriate to achieve the outcomes of the project, and evidence-based (to the degree practicable).
- Shows that the proposed use of funds is an efficient and effective way to implement the strategies and activities and attain the project period outcomes.
- Presents a work plan that is aligned with the strategies/activities, outcomes, and performance measures in the approach and is consistent with the content and format proposed by CDC.
- Provides letters of support stating organization's role in helping applicant to achieve the FOA activities and outcomes. Letter must be dated within 30 days of the application.

Program 1: Evaluation and Performance Measurement	Maximum Points: 25

Evaluate the extent to which the applicant:

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

Describes any evaluation studies they are to undertake. Describe in sufficient detail to identify the key evaluation questions, and data sources and analysis methods.

Program 1: Applicant?s Organizational Capacity to Implement the Approach	Maximum Points: 40

Evaluate the extent to which the applicant addresses the items below.

- Demonstrates relevant experience and capacity (management, administrative, and technical) to implement the activities and achieve the project outcomes.
- Demonstrates previous 5-year experience implementing a breast and cervical cancer screening program
- Demonstrates experience and capacity to implement the evaluation plan.

Provides a staffing plan and project management structure that will be sufficient to achieve the project outcomes and which clearly defines staff roles. Provides an organizational chart and CVs

Program 1: Budget	Maximum Points: 0

Evaluate whether the budget aligns with the proposed work plan.

Program 2: Approach	Maximum Points: 40

Applicants must provide a comprehensive project description and work plan which aligns with the core activities described in the CDC Project Description. Specifically, applicants must:

- Describe how their application addresses the cancer burden in their jurisdiction as described in the Background section.
- Clearly identify outcomes to be achieved at the end of the project period as specified in both the Integrated Logic Model and the NCCCP Logic Model posted on http://www.cdc.gov/cancer/dcpc/about/foa-dp17-1701/
- Describe how infrastructure will be maintained to implement program activities especially as it relates to the use of program funding for staffing and implementation of activities, convened of key stakeholders through the sustainability of a state cancer coalition, and support of a statewide cancer plan.
- Describe efforts to facilitate the collaboration of the cancer programs and collaborations with organizations not funded by CDC for the purposes of maximizing resources and increasing public health impact.
- Describe how cancer risk factor and surveillance data will be used to inform implementation efforts.
- Describe core interventions that will enhance social and physical environments; increase preventive health services or health care extender services; and promote clinical care. The applicant must also describe how these efforts will emphasize primary prevention of cancer, promote early detection and screening, and improve the quality of life among cancer survivors.

Describe how chosen strategies will strive to improve health status for the entire population and seek to reduce gaps in health status by targeting some efforts on specific population groups disproportionately affected by cancer.

Program 2: Evaluation and Performance Measurement	Maximum Points: 20

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

- Develop an initial evaluation and performance plan to indicate how they will identify progress in implementing program strategies, activities, and achieving program outcomes.
- Ensure that the evaluation plan follows the CDC Evaluation Framework and describes their efforts to evaluation partnerships, program interventions, and statewide cancer plan implementation.

Program 2: Applicant?s Organizational Capacity to Implement the Approach	Maximum Points: 40

- Demonstrates relevant experience and capacity (management, administrative, and technical) to implement the activities and achieve the project outcomes.
- Demonstrates previous 5-year experience implementing a comprehensive cancer control program
- Demonstrates experience and capacity to implement the evaluation plan.
- Provides a staffing plan (that includes a Program Director, Policy, Systems, and Environmental Change Expert, and A Program Evaluator) and project management structure that will be sufficient to achieve the project outcomes and which clearly defines staff roles. Provides an organizational chart and CVs.

Program 2: Budget	Maximum Points: 0

- Does the submitted budget align with staffing and proposed project and work plan?
- Is an itemized budget narrative provided?
- Does awardee allocate no more than 40% of the total budget for program staffing and at least 60% of total budget for program implementation at the state and local levels?

Program 3 - component 1: Approach	Maximum Points: 25

1. Applicants must presents a coherent project description and work plan that aligns with the Integrated Cancer logic model and NPCR logic model and describes an effective approach to collect and enhance cancer surveillance data (NPCR Core Registry).

Project descriptions should address the following:

a. Project Management and administration of overall central cancer registry program: describes current capacity and resources to be used in managing the project. Include, an organizational chart, position descriptions, CVs or brief bios for leadership staff and a plan that describes how the personnel and consultants operate within the organization and the person(s) responsible for implementation of each activity.
b. Documentation of the percentage of time each staff member will contribute to the project and activities for which they are responsible.
c. Documentation of the legal authority for the central cancer registry to collect and or receive cancer data.
d. Applicant describes plans for operating and managing a central cancer surveillance registry including what software the central cancer registry currently uses and what will be used over the next five years.

e. Describe current and future partnerships and collaborations that will assist with effective implementation of the project.
f. The project description should include how recipient strategies and activities will be expanded and/or strengthen to meet the outcomes of this program. Be sure to address these categories:

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

a. Develop a work plan that aligns with the project description and logic models and includes:

- Project outcomes
- Activities
- Process measures
- Responsible position or party
- Partners
- Timeline/completion date

Program 3 - component 1: Evaluation and Performance Measurement	Maximum Points: 25

1. Describes clear monitoring and evaluation plans for:
    a. Current status and improvements of electronic capture of cancer cases,
    b. Evaluation of timeliness, quality, and completeness of data
    c. Submission of data in accordance to NPCR standards
2. Details capacity and intent to analyze, apply and disseminate cancer registry data, including:
    a. Ability to perform descriptive analysis of cancer counts, rates, trends, and disparities;
    b. Data sources to capture data on sex, race, ethnicity, and geography
    c. Production of summary reports, at least biennially
    d. Policies related to access and sharing of data or analyses
    e. Integration with tobacco use and cancer screening program data (e.g. NBCCEDP)
3. Provides names of key internal and external partners that support, or will be invited to advise, central cancer? registry activities (e.g., Advisory Committee) as well as utilize cancer registry data to plan and evaluate activities to improve public health and eliminate disparities

Program 3- component 1: Applicant?s Organizational Capacity to Implement the Approach	Maximum Points: 50

1. Provide a staffing plan that aligns with the work plan and includes estimated hours for each proposed activity. Ensure staffing plan includes:
    a. Defined leadership with previous experience managing programs; knowledge and experience with cancer surveillance process and quality assurance; evidence of maintaining high staff retention and partnerships building.
    b. Certified Tumor Registrar(s) with experience in training, providing ongoing quality control, and conducting data quality audits.
    c. Defined staff with strong IT skills and demonstrated ability to manage and ensure security of large datasets, interface with software vendor and state IT departments, and support direct

electronic reporting from external facilities.
   d. Defined staff with demonstrated ability to analyze data and synthesize reports and presentation for dissemination to a wide variety of stakeholders.
2. Describe infrastructure and experience to meet or exceed collection of cancer data by central cancer registry:
   a. IT resources and support for electronic data capture and timely submission, security standards, management of software installation, updates, and conversions; ability to perform data linkage and exchanges, electronic capture from medical records and pathology labs.
   b. Legal authority and policies to support collection and submission of cancer data in accordance with NPCR program standards and data release policy.
3. Document prior success related to data collection, submission and application
   a. Years which program has achieved NPCR National Data Quality and Advanced National Data Quality standards for inclusion in US Cancer Statistics.
   b. Activities and outcomes from partnerships and coalitions
   c. Reports, publications, and presentation of data to public, policy makers, and partners (e.g., healthcare, academic, and non-profit organizations)

1. Provide letters of commitment and letters of support from other cancer programs and key partners demonstrating ongoing collaborations
2. Provide evidence of an established Advisory Board that supports the Central Cancer Registry

Program 3 - component 1: Budget	Maximum Points: 0

- Does the submitted budget align with staffing and proposed project and work plan?
- Is an itemized budget narrative provided?
- Does awardee allocate no more than 20% of the total budget for registry software support (i.e. IT support, server, etc.) if relevant?
- Are matching funds, maintenance of effort and additional and in-kind funds provided in budget?

Program 3 - component 2: Approach	Maximum Points: 25

1. Applicants must present a coherent project description and work plan that aligns with NPCR logic model and describes an approach to collect enhanced data from one of the three Component 2 focus areas (CIN III, screening, or prognostic factors).
2. Project description should address the following:
   a. Description of the approach and resources to be used in enhanced data collection goals, including

      i. A staffing plan showing personnel and consultants including

1. An organizational chart that describes how the personnel and consultants operate within the organization and the person(s) responsible for implementation of activities related to the pertinent focus area, and;
2. Documentation of the percentage of time each staff member will contribute to the project and activities for which they will be responsible.

      ii. Documentation of legal authority for the cancer registry to obtain necessary information to achieve enhanced data collection goals; i.e., access electronic medical records. (*Note: patient contact is not required*.)

   b. Work plan to establish or build upon infrastructure to collect enhanced data.

i. Plan should describe process to establish data submission specifications, collection procedures, automated edits, and quality control procedures.

ii. Plan should describe inclusion of technical expertise from partners and collaborators.

3. Timeline, including projected dates for milestones and completion by activity.

Program 3 - component 2 Evaluation and Performance Measurement	Maximum Points: 25

1. Applicants must provide the following:
    a. Demonstration of previous successful collection of relevant data or organizational ability to collect such data (e.g. CIN III, screening data, or data on prognostic factors)
    b. Demonstration of collection of similar data or linkage with additional relevant data sources (may come from the entire population, or from an area or special research project)
2. Applicants must describe clear monitoring and evaluation procedures for:
    a. Evaluation of timeliness, quality, and completeness of enhanced data

    a. Submission of enhanced data in accordance with requested timeline (November of each year)
    b. Plan should describe strategies and activities to continuously improve data quality and completeness, including formal external audits of reporting facilities and processes and informal quality checks, as needed.

3. Applicants must detail capacity and intent to analyze, apply and disseminate cancer registry data, including:
    a. Plan to evaluate and disseminate enhanced data in order to improve state cancer control programs and to share information on feasibility of enhanced data collection;
    b. Plan to link registry data with enhanced data and additional sources, such as vaccine registry data, screening data, or other relevant information such as population-level disparities and areas of need (especially in the case of screening)

Program 3 - component 2 Applicant?s Organizational Capacity to Implement the Approach	Maximum Points: 50

1. Describe infrastructure to meet or exceed collection of cancer data by central cancer registry:
    a. IT resources and support for electronic collection of enhanced registry data and linkages with relevant data
    b. Legal authority and policies to support collection and submission of enhanced cancer data in accordance with NPCR program standards and data release policy.
2. Document prior success related to data collection, submission and application
    a. Years which program has achieved NPCR National Data Quality and Advanced National Data Quality standards for inclusion in US Cancer Statistics.
    b. Activities and outcomes from partnerships and coalitions
    c. Reports, publications, and presentation of data to public, policy makers, and partners (e.g., healthcare, academic, and non-profit organizations)
    d. Previous collection of data included in enhanced data collection (e.g. pre-invasive cervical cancers, screening or medical history studies, collection of additional biomarkers or other prognostic factors)

Program 3 - component 2: budget	Maximum Points: 0

- Does the submitted budget align with staffing and proposed project and work plan?
- Is an itemized budget narrative provided?
- Does awardee allocate no more than 20% of the total budget for registry software support (i.e. IT Support, Server, etc.) if relevant?
- Are Matching funds, Maintenance of Effort and Additional and in-kind funds provided in budget?

c. Phase III Review

Applications will be funded in order by score and rank determined by the review panel. In addition, CDC may fund out of rank order to ensure maximum geographic representation and inclusion of each of the programmatic target populations identified in the "Target Population" section of this FOA. CDC will provide justification for any decision to fund out of rank order.

Review of risk posed by applicants.

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

In accordance 41 U.S.C. 2313, CDC is required to review the non-public segment of the OMB-designated integrity and performance system accessible through SAM (currently the Federal Awardee 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 funding opportunity announcement.

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

(1) Financial stability;

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

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

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

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

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

2. Announcement and Anticipated Award Dates

Anticipated announcement date: 12/15/2016

Anticipated award date: 06/29/2017

F. Award Administration Information

1. Award Notices

Awardees 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 awardee and CDC. The NOA will be signed by an authorized GMO and emailed to the Awardee Business Officer listed in application and the Program Director.

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

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

2. Administrative and National Policy Requirements

Awardees must comply with the administrative and public policy requirements outlined in 45 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
- AR-8 Public Health System Reporting Requirements
- AR-9 Paperwork Reduction Act Requirements
- AR-10 Smoke-Free Workplace Requirements
- AR-11 Healthy People 2020
- AR-12 Lobbying Restrictions
- AR-13 Prohibition on Use of CDC Funds for Certain Gun Control Activities
- AR-14 Accounting System Requirements
- AR-20 Conference Support
- AR-23 States and Faith-Based Organizations
- AR-24 Health Insurance Portability and Accountability Act Requirements
- AR-25 Release and Sharing of Data
- AR-27 Conference Disclaimer and Use of Logos
- AR-29 Compliance with E.O. 13513 Federal Leadership on Reducing Text Messaging While Driving, October 1, 2009.
- AR-30 Information Letter 10-006. – Compliance with Section 508 of the Rehabilitation Act of 1973
- AR-31 Research Definition

For more information on the CFR visit http://www. access.gpo.gov/ nara/cfr/cfr-table- search.html.

3. Reporting

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

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

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

Report	When?	Required?
Awardee Evaluation and Performance Measurement Plan	6 months into award	Yes
Annual Performance Report (APR)	The awardee must submit the APR via www.grants.gov no later than 120 days before the end of the budget period.	Yes
Data on Performance Measures	CDC program determines. Only if program wants more frequent performance measure reporting than annually in APR.	No
Federal Financial Reporting Forms	90 days after end of calendar quarter in which budget period ends	Yes
Final Performance and Financial Report	90 days after end of project period.	Yes
Payment Management System (PMS) Reporting	Quarterly reports due October 30, 2017; January 30, 2018. ; April 30, 2018; July 30, 2018;	Yes

a. Awardee Evaluation and Performance Measurement Plan (required)

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

Awardee 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 FOA 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 FOA (e.g., effect on improving public health outcomes, effectiveness of FOA, 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 awardee must submit the APR via www.grants.gov 120 days before the end of the budget period. This report must not exceed 45 pages excluding administrative reporting. Attachments are not allowed, but weblinks are allowed.
This report must include the following:

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

- **Administrative Reporting** (No page limit)
  - SF-424A Budget Information-Non-Construction Programs.
  - Budget Narrative – Must use the format outlined in "Content and Form of Application Submission, Budget Narrative" section.
  - Indirect Cost Rate Agreement.

The awardee must submit the Annual Performance Report via www.grants.gov 120 days before 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 awardees at the beginning of the award period.

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

Awardees should provide a breakdown for each program in the submitted FFR.

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

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

No additional information

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.

G. Agency Contacts

CDC encourages inquiries concerning this FOA.

Program Office Contact

For programmatic technical assistance, contact:
Frances Babcock, Project Officer
Department of Health and Human Services
Centers for Disease Control and Prevention
Telephone: (770) 488-4378
Email: fhm2@cdc.gov

Grants Management Office Information

For **financial, awards management, or budget assistance,** contact:
Pamela Render , Grants Management Specialist
Department of Health and Human Services
Office of Grants Services
, GA
Telephone: (770) 488-2712
Email: plr3@cdc.gov

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

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
E-mail: 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 FOAs:

- SF424
- SF424A
- Funding Preference Deliverables

Optional attachments, as determined by CDC programs:

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

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 FOA; awardees must comply with the ARs listed in the FOA. 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.
Award: Financial assistance that provides support or stimulation to accomplish a public purpose. Awards include grants and other agreements (e.g., cooperative agreements) in the form of money, or property in lieu of money, by the federal government to an eligible applicant.
Budget Period or Budget Year: The duration of each individual funding period within the project period. Traditionally, budget periods are 12 months or 1 year.
Carryover: Unobligated federal funds remaining at the end of any budget period that, with the approval of the GMO or under an automatic authority, may be carried over to another budget period to cover allowable costs of that budget period either as an offset or additional authorization. Obligated but liquidated funds are not considered carryover.
Catalog of Federal Domestic Assistance (CFDA): A government-wide compendium published by the General Services Administration (available on-line in searchable format as well as in printable format as a

.pdf file) that describes domestic assistance programs administered by the Federal Government.
CFDA Number: A unique number assigned to each program and FOA throughout its lifecycle that enables data and funding tracking and transparency.
CDC Assurances and Certifications: Standard government-wide grant application forms.
Competing Continuation Award: A financial assistance mechanism that adds funds to a grant and adds one or more budget periods to the previously established project period (i.e., extends the "life" of the award).
Continuous Quality Improvement: A system that seeks to improve the provision of services with an emphasis on future results.
Contracts: An award instrument used to acquire (by purchase, lease, or barter) property or services for the direct benefit or use of the Federal Government.
Cooperative Agreement: A financial assistance award with the same kind of interagency relationship as a grant except that it provides for substantial involvement by the federal agency funding the award. Substantial involvement means that the recipient can expect federal programmatic collaboration or participation in carrying out the effort under the award.
Cost Sharing or Matching: Refers to program costs not borne by the Federal Government but by the awardees. It may include the value of allowable third-party, in-kind contributions, as well as expenditures by the awardee.
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 FOA evaluation plan is used to describe how the awardee 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: http://www.whitehouse.gov/omb/ grants_spoc/.
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.

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. FOAs 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 FOA plain writing tips when writing FOAs.

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 FOA; can be either a project officer, program manager, branch chief, division leader, policy official, center leader, or similar staff member.

Project Period Outcome: An outcome that will occur by the end of the FOA's funding period.

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