PROPOSED CHANGES IN NATIONAL OMBUDSMAN REPORTING SYSTEM (NORS)—Continued

Current	Proposed change
	The instructions clarify the distinctions between complaint categories B.14, D.29, and M.96, all of which involve communication/language barriers and yet are different types of problems (as explained. in the ''Complaint Codes'' attachment to the instructions). The instructions emphasize that supplies not provided as part of the daily rate should be coded under E.36, ''Billing, etc.'' The instructions as well as the form emphasize that problems with a referral agency failing to substantiate a complaint should be coded under the Part III E.2.d.2) disposition category. The instructions emphasize in that complaints about ''nutrients out-of-date'' should be categorized under J.71 dealing with food quality. The instructions clarify that ''percentage of staff time spent on technical assistance for volunteers'' under ''other ombudsman activities'' includes staff resources devoted to the management and administration of the volunteer program as a whole. Add the following to the narrative issues section, Part II: B. Facility Closures: If your program has worked on facility closures, please include a description of these activities, including reasons for the closure(s) and outcomes of ombudsman activities.'' C. Alternative Care Systems: If your program has been involved in planning for alternatives to institutional care and/or has assisted individual residents to move to less restrictive settings of their choice, please describe these activities and provide an approximate number of the individuals who have been assisted.
OMB-approved form for certifying compliance with minimum funding requirement expired in FY 1997.	Add a form for state certification of compliance with the ombudsman minimum funding and non-supplantation provisions in the Act and to confirm expenditures reported in the NORS.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[Program Announcement 02045]

Cardiovascular Health Programs; Notice of Availability of Funds

A. Purpose

The Centers for Disease Control and Prevention (CDC) announces the availability of fiscal year (FY) 2002 funds for a cooperative agreement for Cardiovascular Health (CVH) Programs. The cardiovascular diseases (CVD) to be addressed are primarily heart disease and stroke. This program addresses the ''Healthy People 2010'' focus area of Heart Disease and Stroke and associated risk factors (*e.g.*, tobacco use, high cholesterol, high blood pressure, physical inactivity, and poor nutrition).

The Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP) is issuing this Program Announcement in an effort to simplify and streamline the grant pre- and post-award administrative process, provide increased flexibility in the use of funds, measure performance related to each grantee's stated objectives and identify and establish the long-term goals of a CVH program through stated performance measures. Some examples of the benefits of the streamline process are: elimination of separate documents (continuation application and semi-annual progress report) to issue a continuation award; consistency in reporting expectations; elevation to a Comprehensive Program based on performance when funds are available; and increased flexibility within approved budget categories.

Existing grantees under Program Announcement numbers 98084 or 00091 will have their grant project periods extended to FY 2007 upon receipt of a technically acceptable application. Other eligible applicants will have an opportunity to compete for funding.

The purpose of the program is to assist States in developing, implementing, and evaluating cardiovascular health promotion, disease prevention, and control programs and eliminating health disparities; and to assist States in developing their Core Capacity Programs into Comprehensive Programs. Core Capacity Programs are the foundation upon which comprehensive cardiovascular health programs are built. (See Logic Model for the State Cardiovascular Health program in Attachment I Background and Attachment III Performance Measures for a Comprehensive Program) in the application kit.

To improve the cardiovascular health of all Americans, every State health department should have the capacity, commitment, and resources to carry out a comprehensive cardiovascular health promotion, disease prevention and control program (*See* Attachment II Core Capacity and Comprehensive Program Descriptions) in the application kit.

B. Eligible Applicants

Assistance will be provided only to the health departments of States or their bona fide agents, including the Commonwealth of Puerto Rico, the Virgin Islands, the Commonwealth of the Northern Mariana Islands, American Samoa, Guam, the Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau, under a competitive review process.

States currently receiving CDC funds for Core Capacity Programs under Program Announcements 98084 or 00091, entitled State Cardiovascular Health Programs, are eligible to apply for Core Capacity or Comprehensive Program funding.

The following 22 Core Capacity States/Health Departments are eligible to apply for Core Capacity or Comprehensive Program funding:

Alabama, Alaska, Arkansas, Colorado, Connecticut, District of Columbia, Georgia, Illinois, Kentucky, Louisiana,

Massachusetts, Minnesota, Mississippi, Montana, Nebraska, Ohio, Oklahoma, Oregon, Tennessee, Utah, West Virginia, and Wisconsin.

States currently receiving CDC funds for Comprehensive Programs under Program Announcements 98084 or 00091, entitled State Cardiovascular Health Programs, are eligible to apply for Comprehensive Program funding only.

The following 6 Comprehensive Program States/Health Departments are eligible to apply for Comprehensive Program funds only:

Commonwealth of Virginia, Maine, Missouri, New York, North Carolina, and South Carolina Health Departments.

All applications received from current grant recipients under Program Announcements 98084 or 00091 will be funded for either Core Capacity or Comprehensive Programs, pending approval of a technically acceptable application.

Applications for Comprehensive funding received from current grant recipients that are not funded will continue with Core Capacity funding.

As a contingency, currently funded Core Capacity recipients should provide a separate Core Work plan, budget, and budget justification that address Core Capacity recipient activities to expedite the award process.

State health departments are uniquely qualified to define the cardiovascular disease problem throughout the State, to plan and develop statewide strategies to reduce the burden of CVD, to provide overall State coordination of cardiovascular health promotion, disease prevention, and control activities among partners, lead and direct communities, to direct and oversee interventions within overarching State policies, and to monitor critical aspects of CVD.

Note: Title 2 of the United States Code section 1611 states that an organization described in section 501(c)(4) of the Internal Revenue Code that engages in lobbying activities is not eligible to receive Federal funds constituting an award, grant or loan.

C. Availability of Funds

Approximately $16,000,000 is available in FY 2002 to fund approximately 31 awards. Approximately $6,700,000 is available to fund 22 existing Core Capacity Programs grantees under Program Announcement numbers 98084 and 00091. It is expected that the average award will be $300,000, ranging from $250,000 to $400,000. Approximately $7,300,000 is available to fund 6 existing Comprehensive Programs grantees under Program Announcement 98084 and 00091. It is expected that the average award will be $1,000,000, ranging from $850,000 to $1,400,000.

Approximately $1,000,000 is available in FY 2002 for one or two existing Core Capacity Programs grantees under Program Announcement numbers 98084 and 00091 to receive Comprehensive level funding.

In addition, approximately $1,000,000 is available in FY 2002 to fund one to three new Core Capacity Programs or approximately one new Comprehensive Program. Requests for these funds will be competitive and will be reviewed by an independent objective review panel. It is expected that the average award will be $300,000, ranging from $250,000 to $400,000 for new Core Capacity Programs. It is expected that the average award will be $1,000,000, ranging from $850,000 to $1,400,000 for new Comprehensive Programs. It is expected that Core Capacity and Comprehensive Program awards under this Program Announcement will begin on or about June 30, 2002 and will be made for a 12-month budget period within a project period of up to five years. Funding estimates may change.

Applicants should submit two (2) separate budgets in response to this Program Announcement: (1) A detailed budget and narrative justification that supports the activities for year one funding in response to this Program Announcement for FY 2002 support, and (2) a categorical budget consistent with budget Form 424A for each year 2 through 5 that describes the financial resources that would be needed for these funding years to fully fund a Cardiovascular Health program over a five-year project period.

Continuation awards within an approved project period will be made on the basis of satisfactory progress as evidenced by required progress reports and the availability of funds.

1. Use of Funds

Cooperative agreement funds may be used to support personnel and to purchase equipment, supplies, and services directly related to program activities and consistent with the scope of the cooperative agreement. Funds provided under this Program Announcement are not intended to be used to conduct research projects. Cooperative agreement funds may not be used to supplant State or Local funds. Cooperative agreement funds may not be used to provide patient care, personal health services, medications, patient rehabilitation, or other cost associated with the treatment of CVD. Although public health may have an assurance role in health screening, it is not recommended that these funds be used to provide health screening.

As part of the increased flexibility efforts, applicants are encouraged to maximize the public health benefit from the use of CDC funding within the approved budget line items and to enhance the grantee's ability to achieve stated goals and objectives and to respond to changes in the field as they occur within the scope of the award. Recipients also have the ability to redirect up to 25 percent of the total approved budget or $250,000, whichever is less, to achieve stated goals and objectives within the scope of the award except from categories that require prior approval such as contracts, change in scope, and change in key personnel. A list of required prior approval actions will be included in the Notice of Grant Award.

Applicants are encouraged to identify and leverage opportunities, which will also enhance the recipient's work with other State health department programs that address related chronic diseases or risk factors. This may include cost sharing to support a shared position such as Chronic Disease epidemiologist, health communication specialist, program evaluator, or policy analyst to work on risk factors or other activities across units/departments within the State health department. This may include, but is not limited to, joint planning activities, joint funding of complementary activities based on program recipient activities, coalition alliances and joint public health education, combined development and implementation of environmental, policy, systems, or community interventions and other cost sharing activities that cut across Chronic Disease Programs and related to recipient program activities.

2. Recipient Financial Participation

Under the Comprehensive Program of this Program Announcement, matching funds are required from State sources in an amount not less than $1 for each $5 of Federal funds awarded. Applicants for the Comprehensive Program must provide evidence of State-appropriated resources targeting cardiovascular health promotion, disease prevention, and control of at least 16 percent of the total approved budget. A cost sharing or match requirement may not be met by costs borne by another federal grant. For example, the Preventive Health and Health Services (PHHS) Block Grant may not be included as State resource evidence.

D. Program Requirements

In conducting activities to achieve the purpose of this program, the recipient will be responsible for conducting the activities under 1.a. (Recipient Activities for Core Capacity Programs), 1.b. (Recipient Activities for Comprehensive Programs), and CDC will be responsible for the activities listed under 2. (CDC Activities). For all Core Capacity and Comprehensive Program Recipient Activities, efforts to address tobacco use, poor nutrition, physical inactivity, diabetes and school health should be coordinated with State tobacco, nutrition, physical activity, diabetes and coordinated school health programs; activities of these programs should not be duplicated.

1.a. Recipient Activities for Core Capacity Programs

(1) Develop and Coordinate Partnerships

Identify, consult with, and appropriately involve State cardiovascular health partners to identify areas critical to the development of a State level cardiovascular health promotion, disease prevention, and control program, coordinate activities, avoid duplication of effort, and enhance the overall leadership of the State with its partners. Within the State health department, coordinate and collaborate with partners such as tobacco, nutrition, physical activity, secondary prevention, diabetes, school health, health education, PHHS Block Grant, state minority health liaison, office on aging, public information officer, laboratory, as well as with data partners such as vital statistics and the State's Behavioral Risk Factor Surveillance System (BRFSS). Within State government, collaborate and partner with other departments such as education, transportation, agriculture, agency on aging, parks and recreation and with State agency data partners, such as the Youth Risk Behavioral Surveillance System (YRBSS).

Within the State, collaborate with organizations that address heart disease and stroke or related risk factors (*e.g.*, tobacco use, high cholesterol, high blood pressure, physical inactivity, and poor nutrition) such as the American Heart Association, Biking and Walking Federation, smoke-free coalitions, Federally Qualified Health Centers, State Quality Improvement Organization, State medical society, and association of managed care organizations. Partners should also include organizations that improve health and quality of life (*e.g.*, smart growth coalition) or provide access to a setting (*e.g.*, business coalition on health) or a Priority Populations (*e.g.*, State black nurses' association, association of Hispanic congregations, State Indian health boards). Partnerships and collaborative efforts may develop into memorandums of agreement (MOA) or similar formalized arrangements. The State health department should organize a statewide work group with representation from many of the groups mentioned above as well as other agencies, professional and voluntary groups, academia, community organizations, the media, and the public to develop a comprehensive CVH State plan.

(2) Develop Scientific Capacity To Define the Cardiovascular Disease Burden

Enhance chronic disease epidemiology, statistics, monitoring, and data analysis from existing data systems such as vital statistics, hospital discharges, BRFSS and YRBSS. This should include the collection of cardiovascular-related data using the BRFSS protocols and time line. It is recommended that, as an essential element of defining the burden, funded States collect data on the BRFSS sections or modules on Hypertension Awareness, Cholesterol Awareness, and Cardiovascular Disease in odd years (i.e., 2003, 2005).

It is recommended that funded States collect data using the Module on Heart Attack and Stroke Signs and Symptoms in 2005 and every four years after 2005 as a minimum. It is recommended that State CVD burden data be analyzed for program planning at least every two years or as needed and that a CVD Burden document be published every five years. The enhanced scientific capacity should include efforts to determine:

(a) Trends in cardiovascular diseases, including age of onset of disease and age at death.

(b) Geographic distribution of cardiovascular diseases.

(c) Disparities in cardiovascular diseases and related risk factors by race, ethnicity, gender, geography, and socio-economic status.

(d) Ways to integrate systems to provide comprehensive data needed for assessing and monitoring the cardiovascular health of populations and for program planning and assessment of program outcomes.

Monitoring and program evaluation are considered essential components of building scientific capacity.

The evaluation plan should address measures considered critical to determine the success of the program in meeting the required program activities, and program results should be used for program improvement. Evaluation should also address implementation of required program activities.

(3) Develop an Inventory of Policy and Environmental Strategies

Develop an assessment of existing polices and environmental supports related to CVD risk factors (*e.g.*, tobacco use, high cholesterol, high blood pressure, physical inactivity, and poor nutrition) and related conditions (*e.g.*, diabetes and obesity). Information from the assessment or environmental scan should be used for program planning and priority setting related to key polices and environmental supports to be addressed by the CVH State program. For example, if the inventory shows that the State has policies restricting tobacco use in public buildings, then the CVH State program might not focus on this policy issue.

The inventory would assess public policies (*e.g.*, State policies, regulations, and legislation), as well as organizational policies (*e.g.*, policies in schools, worksites, health care, and communities). The inventory should address the needs of Priority Populations, and should focus on primary and secondary prevention of cardiovascular diseases and related risk factors (*e.g.*, tobacco use, high cholesterol, high blood pressure, physical inactivity, and poor nutrition) and related conditions (*e.g.*, diabetes and obesity). The initial focus of the inventory should be on assessing policies at the State level that have an impact on settings: schools, worksites, health care, and communities (*e.g.*, State legislation or Department of Education polices that may affect CVH-related policies in schools (*see www.cdc.gov/nccdphp/dash/shpps* for school policy data), State-level agency policies which affect whether a percentage of highway funds are dedicated to transportation alternatives which encourage people to be physically active, and association policies that provide guidance for use of accepted guidelines for the prevention and control of CVD in health care settings. During the project period, the inventory should assess supports at the State-level and then at other levels (*e.g.*, district, local) for each of the four settings (*e.g.*, schools, worksites, health care, and communities).

Items inventoried could include issues related to food service policies; availability of environmental strategies for being active such as recreation centers, parks, walking trails; and restrictions on tobacco use. Health care-related policy and environmental issues

should relate to the guidelines on standards of care for primary and secondary prevention and should be assessed in collaboration with the State Quality Improvement Organization, purchasers of medical care, managed care organizations, and consumers.

(4) Develop or Update a CVH State Plan

Develop or update a comprehensive State Plan for cardiovascular health promotion, disease prevention, and control to include specific objectives for future reductions in heart disease and stroke and related risk factors and the promotion of heart health. Develop a thorough description of the cardiovascular disease burden geographically and demographically, set objectives, and include population-specific strategies for achieving the objectives. The strategies should emphasize population-based policy and environmental approaches and education as well as the increased awareness of signs and symptoms of primarily heart attack and stroke. It should address the needs of Priority Populations. The strategies may also include planning for program development within settings, particularly culturally appropriate strategies to reach Priority Populations. Partners should be involved in the development and implementation of the cardiovascular health State Plan. The CVH State Plan may be a stand alone plan or an identifiable section within another State plan.

(5) Provide Training and Technical Assistance

Increase the skill-level of State and local health department staff and partners in areas such as population-based interventions, policy and environmental strategies, CVD and related risk factors (*e.g.*, tobacco use, high cholesterol, high blood pressure, physical inactivity, and poor nutrition), secondary prevention, communication, epidemiology, cultural competence, use of data in program planning, and program planning and evaluation. Training may include provision of technical assistance to communities, worksites, health care sites, schools, and faith-based organizations.

(6) Develop Population-Based Strategies

Develop plans for population-based intervention strategies to promote cardiovascular health, primary and secondary prevention of cardiovascular diseases and related risk factors (*e.g.*, tobacco use, high cholesterol, high blood pressure, physical inactivity, and poor nutrition); increase awareness of signs and symptoms of primarily heart attack and stroke, educate about the need for policy and environmental approaches, and reduce the burden of cardiovascular diseases in the State. The strategies may include working with State-level organizations, health systems, worksites, schools, media, community organizations, non-traditional partners and government agencies as effective means to reach people.

System changes are encouraged in four settings: schools, worksites, health care, and communities. Interventions within systems are encouraged at the highest level possible, for example, activities with business coalitions and unions rather than individual worksites and with managed care organizations (MCOs) and State medical associations rather than individual healthcare settings or physicians. Information regarding the CVD burden in the State and information from the inventories should be used to identify priority areas for interventions.

(7) Develop Culturally-Competent Strategies for Priority Populations

Develop plans for enhanced program efforts to address Priority Populations. Specify how interventions would be designed appropriately for the Priority Populations to be addressed. Strategies should focus on policy and environmental approaches specific for the population to be addressed but may, on a limited basis, include interventions such as community events and campaigns designed to increase awareness of the cardiovascular disease burden and risk factors (e.g., tobacco use, high cholesterol, high blood pressure, physical inactivity, and poor nutrition) in the Priority Populations and to promote policy and environmental strategies to improve cardiovascular health and reduce risk factors. Initiatives may be used to demonstrate the effectiveness of selected strategies or as a means to generate community support for policy and environmental strategies.

1.b. Recipient Activities for Comprehensive Programs

In addition to continuing and enhancing the Recipient Activities for Core Capacity Programs, Activities 1–5, Comprehensive Program will:

(1) Implement Population-Based Intervention Strategies Consistent With the State Plan

Strategies should include policy and environmental approaches, education and awareness supportive of the need for policy and environmental approaches, and other population-based approaches. Priority intervention strategies include changes in policies and physical and social environments or settings to make the settings supportive of heart health and the prevention of CVD. Priority education and awareness strategies would include communication efforts to address CVD and risk factors, need for policy and environmental approaches and awareness of signs and symptoms, primarily of heart attack and stroke. The CDC Cynergy, CVH edition, is a communication planning tool in CD-ROM format that may be used by States to plan health communication activities within a public health context.

These strategies/interventions may be disseminated through various settings and groups including State-level organizations, health care systems, worksites, schools, community organizations, governments, and the media. Interventions should be population-based, with objectives established that specify the population-wide changes sought. Approaches should emphasize State-level activities that bring about policy and environmental systems changes. Any approach should extend to a relatively large proportion of the population to be addressed, rather than a few selected communities. Interventions should be coordinated such that health messages, policies, and environmental measures are consistent, the most cost-effective methods are used for reaching the populations, and duplication of effort is avoided. Interventions should address tobacco use, elevated blood pressure, elevated cholesterol, physical inactivity, poor nutrition, diabetes, and secondary prevention. Implementation may extend to grants and contracts with local health agencies, communities, and nonprofit organizations.

(2) Implement Strategies Addressing Priority Populations

These strategies may include interventions directed to specific communities and segments of the population, and may include all appropriate modes of interventions needed to reach the populations to be addressed. These strategies may include more intensive, directed interventions by organizations concerned with improving the health and quality of life of Priority Populations, including State-level organizations, work sites, health care sites, communities, and schools. Priority intervention strategies include changes in policies and physical and social environments or settings to make the settings supportive of heart health and the prevention of CVD. Priority education and awareness strategies

should include health communication efforts to address CVD and risk factors, need for policy and environmental approaches and awareness of signs and symptoms, primarily of heart attack and stroke.

(3) Specify and Evaluate Intervention Components

Design and implement a program evaluation system. The evaluation plan should address measures considered critical to determine the success of the program, and evaluation results should be used for program improvement. Evaluation should be limited in scope to address strategy implementation, changes in policies and the physical and social environments affecting cardiovascular health. Evaluation should not include comparison communities or quasi-experimental designs. Evaluation should cover both population-based strategies as well as targeted strategies focused on Priority Populations. Evaluation should rely primarily upon existing data systems.

(4) Implement Professional Education Activities

Provide or collaborate with partners to provide professional education to health providers and others to assure appropriate standards of care for primary and secondary prevention of CVD are offered routinely to all.

(5) Collaborate on Secondary Prevention Strategies

Secondary prevention activities should be integrated into such things as partnerships, policy and environmental changes, and training and education in areas such as hypertension, high cholesterol, stroke, heart attack, diabetes, and congestive heart failure to ensure that recognized guidelines for secondary guidelines are followed. Activities in secondary prevention should include monitoring the delivery of secondary prevention practices (*e.g.,* drug therapy, physical activity regimens, dietary changes, and hypertension and lipid management) and collaborating with partners on professional education and policy and practice change related to the implementation of the guidelines on standards of care for CVD. Development of monitoring systems and implementation of approaches for secondary prevention practices should be coordinated with partners such as the State Quality Improvement Organization, Federally Qualified Health Centers, managed care providers, Medicaid, major employers, insurers, other organized health care providers, and purchasers of health care. Secondary prevention strategies may be integrated with professional education initiatives.

2. CDC Activities

a. Provide technical assistance in the coordination of monitoring and other data systems to measure and characterize the burden of cardiovascular diseases. Provide technical assistance in the design of monitoring instruments and sampling strategies, and provide assistance in the processing of data for States. Provide data on populations at highest risk. Provide data for national-level comparisons.

b. Collaborate with the States and other appropriate partners to develop and disseminate programmatic guidance and other resources for specific interventions, media campaigns, and coordination of activities.

c. Collaborate with the States and other appropriate partners to develop and disseminate recommendations for policy and environmental interventions including the measurement of progress in the implementation of such interventions.

d. Collaborate with appropriate public, private, and nonprofit organizations to coordinate a cohesive national program.

e. Provide technical assistance to the State public health laboratory or contract laboratory to standardize cholesterol, high density lipoproteins, and triglyceride measurements.

f. Provide training and technical assistance regarding the coordination of interventions, policy and environmental strategies, and population-based strategies.

E. Content

Applications

Use the information in the Program Requirements, Other Requirements, and Evaluation Criteria sections to develop the application content. Your application will be evaluated using the criteria listed, so it is important to follow them in laying out your program plan. Applications for the Core Capacity Program should not exceed 52 double-spaced pages, printed on one side, with one inch margins, in 12-point font, excluding budget, justification, and appendixes. Applications for the Comprehensive Program should not exceed 90 double-spaced pages, printed on one side, with one inch margins, in 12-point font, excluding budget, justification, and appendixes. All applicants should also submit appendices including resumes, job descriptions, organizational chart, facilities, and any other supporting documentation as appropriate. All materials must be suitable for photocopying (*i.e.,* no audiovisual materials, posters, tapes, etc.).

Applicants may apply for funding of either Core Capacity Program or Comprehensive Program, but not both, and must designate in the Executive Summary of their application the component (Core Capacity Program or Comprehensive Program) for which they are applying. Provide the following information:

1. Executive Summary

All applicants must provide a summary of the program described in the proposal (two pages maximum

2. Core Capacity Program

(Application portion of the Core Capacity Program application may not exceed 50 double-spaced pages using 12-point font):

a. Staffing (not included in 50-page limitation). Describe program staffing and qualifications including access to expertise in tobacco, physical activity, nutrition, secondary prevention, epidemiology, and evaluation. Provide organizational chart, resumes, job descriptions, and experience for all budgeted positions. Describe lines of communication between various related chronic disease programs and risk factors. It is recommended that staff include a full-time program manager and a one-half time chronic disease epidemiologist. Assurance should be given that staff have the skills to carry out Recipient Activities, such as program development, health education, and partnership development.

b. Facilities (not included in 50-page limitation). Describe facilities and resources available to the program, including equipment available, communications systems, computer capabilities and access, and laboratory facilities if appropriate.

c. Background and Need. Describe the need for funding and the current resources available for Core Capacity activities, to include:

(1) The overall State cardiovascular disease problem.

(2) The geographic patterns, trends, age, gender, racial and ethnic patterns, and other measures or assessments.

(3) The barriers the State currently faces in developing and implementing a Statewide program for the prevention of cardiovascular diseases.

(4) The advisory groups, partnerships, or coalitions currently involved with the State health department for cardiovascular disease prevention and control, including the current chronic

disease programs within the State health department and present linkages with those programs.

(5) The gaps in resources, staffing, capabilities, and programs that, if addressed, might further the progress of cardiovascular disease prevention.

d. Core Capacity Work Plan. Provide a work plan that addresses each of the required Core Capacity elements cited in the Recipient Activities section above, to include the following information:

(1) Program objectives for each of the Recipient Activities. Objectives should describe what is to happen, by when, and to what degree.

(2) The proposed methods for achieving each of the objectives.

(3) The proposed partnerships and collaborations for achieving each of the objectives.

(4) The proposed plan for evaluating progress toward attainment of the objectives.

(5) A milestone, time line, and completion chart for all objectives for the project period.

e. Core Capacity Program Budget. Provide a detailed line-item budget with justifications consistent with the purpose and proposed objectives, using the format on PHS Form 5161–1. Applicants are encouraged to include budget items for travel for two trips to Atlanta, Georgia for two individuals to attend a three-day training and technical assistance workshops.

Supporting materials such as organizational charts, tables, position descriptions, relevant publications, letters of support that specify the type of support, MOA, etc., should be included in the appendixes and be reproducible. Materials included in the appendixes should be responsive to the Program Announcement. Including extensive materials is not recommended.

3. Comprehensive Program (Application portion of the Comprehensive Program application may not exceed 90 double-spaced pages using 12 point font)

a. Background and Need.

(1) Provide evidence that the State health department has significant core capacity as specified in the Core Capacity Program Recipient Activities 1 through 5.

(2) Provide a description of the overall burden of Cardiovascular disease and related risk factors in the State and the need for support in the State; the geographic and demographic distribution, age, sex, racial and ethnic groups, educational, and economic patterns of the diseases as well as the trends over time. Describe the key barriers to successful implementation of a statewide program for prevention of cardiovascular diseases within the State; partnerships and collaboration with related agencies, and the status of policies and environmental approaches in place that influence risk factors and public awareness. Provide a description of the populations to be addressed, including Priority Populations, and their constituencies and leadership potential to develop and conduct program activities.

b. Staffing (not included in 90-page limitation). Describe project staffing and qualifications including access to expertise in tobacco, physical activity, nutrition, secondary prevention, evaluation, and epidemiology. Provide organizational chart, curriculum vitae, job descriptions, and experience needed for all budgeted positions. Describe lines of communication between various related chronic disease programs. It is recommended that staff include a full-time program manager and at least a one-half time chronic disease epidemiologist. Assurance should be given that staff have the skills to carry out Recipient Activities, such as program development, health education, partnership development, policy development, evaluation, and training.

c. State Plan. Provide the current State plan (dated January 1997 or later) that includes population-based policy and environmental strategies as well as strategies for implementing programs which utilize health care settings, worksites, the media, schools, and communities; and which includes strategies addressing specific Priority Populations and communities.

d. Comprehensive Program Work Plan. Address briefly how each of the Core Capacity recipient activities, cited in the Recipient Activities section above will be continued and enhanced. Address each of the required Comprehensive Program recipient activities cited in the Recipient Activities section above in sufficient detail to describe the results expected and how the State will achieve the results. Objectives and strategies should be consistent with the State Plan and specify Priority Populations to be addressed, communities, or geographic areas of concern; complete listings of the policy and environmental changes sought to create heart-healthy environments for the population; other intervention strategies; coordination among State partners; and strategies for closing the gaps in cardiovascular disease disparities. Interventions should be expressed in terms of changes sought for the general population as well as changes in Priority Populations to be addressed. Population-based approaches should extend to a relatively large proportion of the State population rather than a few selected communities. Targeted strategies should clearly define the Priority Populations to be addressed. Objectives should describe what is to happen, by when, and to what degree. A milestone and activities completion chart or time line should be provided for all objectives for the project period.

e. Evaluation. Provide a description of monitoring activities that include mortality, changes in environmental and policy indicators, and behavioral risk factors including statistically valid estimates for populations to be addressed. Describe the capability for special one-time surveys to be conducted by the State. Describe how each of the program elements will be evaluated and which measures are considered critical to monitor for evaluating the success of the program. Describe the various existing data systems to be employed, how the systems might be adapted, and the specific program elements to be evaluated by those systems. Describe the schedules for data collection and when analyses of the data will become available.

f. Collaboration. Provide letters of support describing the nature and extent of involvement by outside partners and coordination among State health department programs, other State agencies, and non-governmental health and non-health organizations. Describe how the overall delivery of interventions for Priority Populations will be enhanced by these collaborative activities.

g. Training Capability. Provide a description of training sessions for health professionals provided within the past three years. Include agendas, dates, professional status or occupation, and number of attendees. Provide other evidence of training capabilities deemed appropriate to the program.

h. Comprehensive Program Budget Justification. Provide a line-item budget consistent with CDC Form 0.1246 along with appropriate justifications. Applicants are encouraged to include budget items for travel for two trips to Atlanta, Georgia for two individuals to attend a three-day training and technical assistance workshops. State matching funds should be listed on question 15 (estimated funding) of the application face page and Section C of the Budget Information worksheet.

F. Submission and Deadline

Application

Submit the original and two copies of CDC form 0.1246. Forms are available in the application kit and at the following Internet address: *www.cdc.gov/od/pgo/forminfo.htm.*

On or before April 17, 2002, submit the application to the Grants Management Specialist identified in the ''Where to Obtain Additional Information'' section of this announcement.

Deadline: Applications shall be considered as meeting the deadline if they are either:

1. Received on or before the deadline date; or

2. Sent on or before the deadline date and received in time for submission to the independent review group. (Applicants must request a legibly dated U.S. Postal Service postmark or obtain a legibly dated receipt from a commercial carrier or U.S. Postal Service. Private metered postmarks shall not be acceptable as proof of timely mailing.)

Late: Applications which do not meet the criteria in 1. or 2. will be returned to the applicant.

G. Evaluation Criteria

Each competitive application will be evaluated individually against the following criteria by an independent review group appointed by CDC. Applications received from grantees funded under Program Announcement number 98094 or 00091 will be reviewed by independent reviewers utilizing the Technical Acceptability Review (TAR) process.

Applications Received From

1. Core Capacity Program (Total 100 points)

a. Staffing (10 Points).

The degree to which the proposed staff have the relevant background, qualifications, and experience; and the degree to which the organizational structure supports staffs' ability to conduct proposed activities. The degree to which recommended staffing allow for needed skills. Confirmation of staffing that allows for one FTE program manager and .5 FTE of a chronic disease epidemiologist.

b. Facilities (5 Points).

The extent to which the applicant's description of available facilities and resources are adequate.

c. Background and Need (15 Points).

The extent to which the applicant identifies specific needs and resources available for Core Capacity activities. The extent to which the funds will successfully fill the gaps in State capabilities.

d. Core Capacity Work Plan (60 Points).

(1) (20 Points) The extent to which the plan for achieving the proposed activities appears realistic and feasible and relates to the stated program requirements and purposes of this cooperative agreement.

(2) (20 Points) The extent to which the proposed methods for achieving the activities appear realistic and feasible and relate to the stated program requirements and purposes of the cooperative agreement.

(3) (10 Points) The extent to which the proposed plan for evaluating progress toward meeting objectives and assessing impact appears reasonable and feasible.

(4) (10 Points) The degree to which partnerships, within and external to the State health department, are demonstrated through documented and collaborative activities and letters of support that describe the nature and extent of involvement and commitment.

e. Objectives (10 Points).

The degree to which objectives are specific, time-phased, measurable, realistic, and related to identified needs, program requirements, and purpose of the program.

f. Budget (Not Scored).

The extent to which the budget appears reasonable and consistent with the proposed activities and intent of the program.

2. Comprehensive Program (Total 100 points)

a. Background and Need (35 Points).

(1) (25 points) The extent to which the applicant provides evidence that it has significant core capacity as specified in the Core Capacity Program Recipient Activities 1–5 (see Program Recipient Activities section).

(2) (10 Points) The extent to which the applicant identifies specific needs in relation to geographic and demographic distribution of cardiovascular diseases with particular emphasis on Priority Populations; identifies trends in mortality and risk factors (e.g., tobacco use, high cholesterol, high blood pressure, physical inactivity, and poor nutrition) and related conditions (e.g., diabetes and obesity); identifies barriers to successful program implementation; describes current partnerships and collaborations; and describes existing policy and environmental influences in terms of their affect on public awareness and the risk factors (e.g., tobacco use, high cholesterol, high blood pressure, physical inactivity, and poor nutrition) for cardiovascular diseases.

b. Staffing (10 points).

The degree to which the proposed staff have the relevant background, qualifications, and experience; the degree to which the organizational structure supports staffs' ability to conduct proposed activities; the degree to which the recommended staffing and skills are addressed. Confirmation of staffing that allows for one FTE program manager and .5 FTE of a chronic disease epidemiologist.

c. Comprehensive Work Plan (40 Points).

(1) (20 Points) The extent to which the work plan addresses briefly how the Core Capacity recipient activities will be continued and enhanced and, in detail, how they will address the Comprehensive Program recipient activities. The extent to which the work plan addresses primary and secondary prevention of CVD and promotion of CVH, policy and environmental strategies, education and awareness, and other appropriate population-based approaches and the extent of program activities that appropriately use settings (e.g., schools, worksites, health care, and communities). The extent to which the plan identifies and addresses the needs of Priority Populations.

(2) (15 Points) The degree to which the objectives are specific, time-phased, measurable, realistic, and relate to identified needs and purposes of the program, for both the general population as well as the Priority Populations. The extent to which the work plan for achieving the proposed activities appears realistic and feasible, is consistent with the State Plan, and relates to the stated program requirements and purposes of this cooperative agreement. The extent to which the plan addresses the needs of the State and the appropriateness of the planned interventions to the cardiovascular disease problem.

(3) (5 Points) The extent to which collaboration with State tobacco, nutrition, physical activity, health promotion, data systems (BRFSS), diabetes, coordinated school health and other chronic disease programs and with external partners is used to deliver the program; the extent to which coordination with other State chronic disease programs and other State agencies enhances the cardiovascular disease program; and the extent of involvement of other organizations within the State in the implementation of the program.

d. Training Capability (5 Points).

The extent to which the applicant demonstrates the provision of training sessions for health professionals and provides evidence of other training

capabilities deemed appropriate to the program.

e. Evaluation (10 Points).

The extent to which the evaluation plan appears capable of monitoring progress toward meeting specific project objectives, assessing the impact of the program on the general population, assessing changes in the Priority Populations, monitoring utilization of secondary prevention strategies, and assessing the implementation of policy and environmental strategies.

f. Budget (Not Scored).

The extent to which the budget appears reasonable and consistent with the proposed activities and intent of the program. For the Comprehensive application, matching funds should be provided.

H. Other Requirements

Technical Reporting Requirements

Provide CDC with original plus two copies of:

1. Semi-Annual Progress Reports

The first report is due March 15, 2003, outlining the requirements under items a through e, and subsequent semi-annual reports will be due on the 15th of March each year through March 15, 2006. The second report is due 90 days after the end of the budget period, outlining the requirements under items a through c. Semi-annual progress reports should include the following information. (The March 15th semi-annual progress report and accompanying budget and budget justification will be used to process your continuation award):

a. A succinct description of the program accomplishments/narrative and progress made in meeting each program objective during the first six months of the budget period (June 30 through December 31) and should consist of no more than 50 pages,

b. The reason for not meeting established program goals and strategies to be implemented to achieve unmet objectives (see performance measures below),

c. A description of any new objectives including the expected impact on the overall burden of cardiovascular diseases and related risk factors and method of evaluating effectiveness and,

d. A one-year line item budget and budget justification, and

e. For all proposed contracts, provide the name of contractor, period of performance, method of selection, method of accountability, scope of work, and itemized budget and budget justification. If the information is not available when the application is submitted, please indicate To Be Determined until the information is available. When the information becomes available, it should be submitted to the CDC Procurement and Grants Management Office contact identified in this Program Announcement.

The semiannual progress report will be used as evidence of Core Capacity Program's attainment of Core Capacity goals and objectives and the program's readiness to compete for a Comprehensive Program award should funds be available. Core Capacity Program grantees wishing to compete for a Comprehensive Program, should submit an application that is responsive to the Core Capacity Performance Measures, Application Content and Recipient Activities section of this program announcement including a line item budget and budget justification. Competitive Comprehensive applications will be reviewed by CDC staff utilizing the Technical Acceptability Review (TAR) process. Applications can be submitted in fiscal year 2003, 2004, 2005, or 2006. Applications must be submitted (post mark) by March 15 of the fiscal in which the applicant wishes to be considered for Comprehensive funding.

Funding decisions will be made on the basis of satisfactory progress on the Core Capacity Performance Measures as evidenced by required reports (semi-annual report), application score, and the availability of funds.

Core Capacity Performance Measures include evidence that the applicant has significant core capacity as specified in the Core Capacity Program Recipient Activities 1–5.

(1) Evidence of at least 8 diverse and active partnerships: documentation such as minutes of meetings that delineates partners leadership for completing tasks, lists of work group members, memoranda of understanding, outcomes or products of the partnership, training agendas, and other documents that demonstrate collaboration on CVH program activities with partners that include State health department programs, other States agencies, organizations that promote CVH or address CVD or related risk factors; organizations that improve health and quality of life, and organizations that address the needs of Priority Populations.

(2) Evidence that the cardiovascular disease burden has been defined: provision of a CVD Burden Document (published in the past three years) or description of the burden of CVD and related risk factors, geographic and demographic distribution of CVD, including racial and ethnic disparities, and trends in CVD.

(3) Evidence that an assessment of existing policy and environmental strategies has been completed for state-level organizations and groups that impact on the four settings (*i.e.,* worksites, health care, schools, and communities) and performed at other levels (*e.g.,* district, local) for at least 1 of the 4 settings; provision of summaries of the data collected and methods used.

(4) Evidence that a comprehensive CVH State Plan has been developed: provision of the CVH State Plan that uses CVD burden data and other assessment data to identify priorities, addresses primary and secondary prevention of CVD and related risk factors; promotes CVH, population-based approaches, and policy and environmental strategies; addresses Priority Populations; and confirms that it was developed with the input of partners within and external to the State health department.

(5) Evidence that training and technical assistance has been provided or coordinated by the State CVH Program within the state for State health department staff, local health department staff, and partners: provision of agendas, documents confirming training and assistance provided in at least 4 of the following priority areas (i.e., population-based interventions, policy and environmental strategies, CVD and related risk factors, secondary prevention, health communication, epidemiology, cultural competence, use of data in program planning, and program planning and evaluation).

2. Financial status reports are due, no more than 90 days after the end of the budget period; and

3. Final financial and performance reports are due, no more than 90 days after the end of the project period.

Send all reports to the Grants Management Specialist identified in the ''Where to Obtain Additional Information'' section of this announcement.

The following additional requirements are applicable to this program. For a complete description of each, see Attachment IV in the application kit.

AR–7 Executive Order 12372 Review
AR–8 Public Health System Reporting Requirements
AR–9 Paperwork Reduction Act Requirements
AR–10 Smoke-Free Workplace Requirements
AR–11 Healthy People 2010
AR–12 Lobbying Restrictions

I. Authority and Catalog of Federal Domestic Assistance Number

This program is authorized under section 301(a) and 317(k)(2) of the Public Health Service Act, (42 U.S.C. section 241(a) and 247b(k)(2)), as amended. The Catalog of Federal Domestic Assistance number is 93.945.

J. Where To Obtain Additional Information

This and other CDC announcements can be found on the CDC home page Internet address—*http://www.cdc.gov.* Click on ''Funding,'' then ''Grants and Cooperative Agreements.''

If you have questions after reviewing the contents of all the documents, business management technical assistance may be obtained from: Michelle Copeland, Grants Management Specialist, Grants Management Branch, Procurement and Grants Office, Centers for Disease Control and Prevention, 2920 Brandywine Road, Room 3000, Atlanta, GA 30341–4146. Telephone number: 770–488–2686. E-mail address: *stc8@cdc.gov.*

For program technical assistance, contact: Nancy B. Watkins, M.P.H., Team Leader for Program Services, Intervention and Evaluation Cardiovascular Health Branch, Centers for Disease Control and Prevention, Division of Adult and Community Health, 4770 Buford Highway, NE, MS K–47, Atlanta, GA 30341. Telephone number: 770–488–8004. Fax: 770–488–8151. E-mail address: *NWatkins@cdc.gov.*

Dated: February 22, 2002.

Robert L. Williams,

Chief, Acquisition and Assistance Branch B, Procurement and Grants Office, Center for Disease Control and Prevention (CDC).

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[Program Announcement 02041]

Traumatic Injury Biomechanics Research;Notice of Availability of Funds

A. Purpose

The Centers for Disease Control and Prevention (CDC) announces the availability of fiscal year (FY) 2002 funds for a grant program for Extramural Grants for Traumatic Injury Biomechanics Research. This program addresses the ''Healthy People 2010'' focus areas of Injury and Violence Prevention.

The purposes of the program are to:

1. Solicit research applications that address the priorities reflected under the heading, ''Programmatic Interests.''

2. Build the scientific base for the prevention of injuries, disabilities, and deaths.

3. Encourage professionals from a wide spectrum of disciplines such as engineering, bioengineering, medicine, health care, public health, health care research, behavioral and social sciences, and others, to undertake research to prevent and control injuries.

4. Encourage investigators to propose research that involves intervention development and testing as well as research on methods, to encourage individuals, organizations, or communities to adopt and maintain effective intervention strategies.

B. Eligible Applicants

Applications may be submitted by public and private nonprofit and for-profit organizations and by governments and their agencies; that is, universities, colleges, research institutions, hospitals, other public and private nonprofit and for-profit organizations, State and local governments or their bona fide agents, including the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, the Commonwealth of the Northern Mariana Islands, American Samoa, Guam, the Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau, federally recognized Indian tribal governments, Indian tribes, or Indian tribal organizations, and small, minority, and women-owned businesses.

Current grantees are also eligible to apply for supplemental funding to enhance or expand existing projects, or to conduct one year pilot studies.

Note: Title 2 of the United States code section 1611 states that an organization described in section 501 (c)(4) of the Internal Revenue Code that engages in lobbying activities is not eligible to receive Federal funds constituting an award, grant or loan.

Applications that are incomplete or non-responsive to the below requirements will be returned to the applicant without further consideration. The following are applicant requirements:

1. A principal investigator, who has conducted research, published the findings in peer-reviewed journals, and has specific authority and responsibility to carry out the proposed project.

2. Demonstrated experience on the applicant's project team in conducting, evaluating, and publishing injury control research in peer-reviewed journals.

3. Effective and well-defined working relationships within the performing organization and with outside entities which will ensure implementation of the proposed activities.

4. The ability to carry out injury control research projects as defined under Attachment 2 (1.a–c) in the application kit.

5. The overall match between the applicant's proposed theme and research objectives, and the program interests as described under the heading, ''Programmatic Interests.''

C. Availability of Funds

Approximately $1,000,000 is available in FY 2002 to fund approximately four to five awards. The specific program priorities for these funding opportunities are outlined with examples in this announcement under the section, ''Programmatic Interests.''

It is expected that the awards will begin on or about September 30, 2002, and will be made for a 12-month budget period within a three year project period. The maximum funding level will not exceed $300,000 (including both direct and indirect costs) per year or $900,000 for the three-year project period. Those grantees applying for supplemental funding may request up to $150,000 (including both direct and indirect costs) for one year. Supplemental awards will be made for the budget period to coincide with the actual budget period of the grant, and are based on the availability of end-of-fiscal year funds. Applications that exceed the funding cap of $300,000 per year will be excluded from the competition and returned to the applicant. The availability of Federal funding may vary and is subject to change.

Continuation awards within the project period will be made based on satisfactory progress demonstrated by investigators at work-in-progress monitoring workshops (travel expenses for this annual one-day meeting should be included in the applicant's proposed budget), and the achievement of work plan milestones reflected in the continuation application.

Note: Grant funds will not be made available to support the provision of direct care. Eligible applicants may enter into contracts, including consortia agreements (as set forth in the PHS Grants Policy Statement, dated April 1, 1994), as necessary to meet the requirements of the program and strengthen the overall application.

Funding Preferences

While extending and adapting results and conclusions of the above efforts to