rates, formerly published in appendix A to 41 CFR chapter 301, solely on the Internet at *http://www.gsa.gov/perdiem.* This new process will ensure more timely increases or decreases in per diem rates established by GSA for Federal employees on official travel within CONUS. This notice advises agencies of revisions in per diem rates prescribed by OGP for CONUS. Notices published periodically in the **Federal Register**, such as this one, now constitute the only notification of revisions in CONUS per diem rates to agencies.

Dated: May 2, 2003.

G. Martin Wagner,

Associate Administrator.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[Program Announcement 03135]

Steps to a HealthierUS: A Community-Focused Initiative To Reduce the Burden of Asthma, Diabetes, and Obesity; Notice of Availability of Funds

Application Deadline: July 15, 2003.

A. 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., sections 241(a) and 247b(k)(2), as amended. The Catalog of Federal Domestic Assistance Number is 93.283.

B. Purpose

The Department of Health and Human Services (HHS), acting through the Centers for Disease Control and Prevention (CDC), and combining the strengths and resources of all relevant HHS agencies and programs, announces the availability of fiscal year (FY) 2003 funds for a cooperative agreement program to implement the Secretary of HHS Initiative for Americans entitled Steps to a HealthierUS (hereafter referred to as STEPS). The relevant HHS agencies and offices include, but are not limited to, the Administration on Aging, Administration for Children and Families, Agency for Healthcare Research and Quality, CDC, Centers for Medicare and Medicaid Services, Food and Drug Administration, Health Resources and Services Administration, Indian Health Service, National Institutes of Health, Office of Disease Prevention and Health Promotion, and the Substance Abuse and Mental Health Services Administration hereafter referred to as ''HHS agencies'').

STEPS is a bold new initiative. The centerpiece of this initiative is a five-year cooperative agreement program to create healthier communities by improving the lives of Americans through innovative and effective community-based health promotion and chronic disease prevention and control programs.

STEPS is based on the President's HealthierUS Initiative, which highlights the influence that healthy lifestyles and behaviors—such as making healthful nutritional choices, being physically active, and avoiding tobacco use and exposure—have in achieving and maintaining good health for persons of all ages. STEPS will work through public-private partnerships at the community level to support community-driven programs that enable persons to adopt healthy lifestyles that contribute directly to the prevention, delay, and/or mitigation of the consequences of diabetes, asthma, and obesity.

The initiative's goals are to:

- Prevent 75,000 to 100,000 Americans from developing diabetes
- Prevent 100,000 to 150,000 Americans from developing obesity
- Prevent 50,000 Americans from being hospitalized for asthma

The purpose of STEPS is to enable communities to reduce the burden of chronic disease, including: Preventing diabetes among populations with prediabetes; increasing the likelihood that persons with undiagnosed diabetes are diagnosed; reducing complications of diabetes; preventing overweight and obesity; reducing overweight and obesity; and reducing the complications of asthma. STEPS will achieve these outcomes by improving nutrition; increasing physical activity; preventing tobacco use and exposure, targeting adults who are diabetic or who live with persons with asthma; increasing tobacco cessation, targeting adults who are diabetic or who live with persons with asthma; increasing use of appropriate health care services; improving the quality of care; and increasing effective self-management of chronic diseases and associated risk factors.

The key to the success of STEPS will be community-focused programs that include the full engagement of schools, businesses, faith-communities, health care purchasers, health plans, health care providers, academic institutions, senior centers, and many other community sectors working together to promote health and prevent chronic disease. STEPS programs need to build on, but not duplicate, current and prior HHS programs and coordinate fully with existing programs and resources in the community.

Background

In the United States today, seven of ten deaths and the vast majority of serious illness, disability, and health care costs are caused by chronic diseases, such as diabetes, asthma, and obesity. Underlying these serious diseases are several important risk factors that can be modified years before they contribute to illness and death. Three risk factors—poor nutrition, lack of physical activity, and tobacco use and exposure—are major contributors to the nation's leading causes of death and must be addressed as part of this initiative. The first two of these risk factors contribute primarily to obesity and diabetes. Tobacco use contributes primarily to asthma, but it also contributes to the risk of poor circulation and heart disease among those who have diabetes. Research has demonstrated a clear link between exposure to tobacco smoke and exacerbation of asthma, and has provided evidence of a causal link between exposure to tobacco smoke and the development of asthma. Research has also shown that smoking heightens the risk for diabetes-related complications of neuropathy and nephropathy; cigarette use has been shown to be a significant risk factor for death by coronary heart disease in type 2 diabetes. By requiring recipients to address nutrition, physical activity, and tobacco use as core components of their community interventions, STEPS programs will reduce the burden of diabetes, asthma, and obesity.

Efforts to address risk factors and disease management through improved health care access, health care utilization, health care quality, and self-management skills, including adherence to medication and other health regimens, also may be addressed as part of this initiative. While payment for health care services is not an allowable expense under this program announcement, increasing access to and use of diagnostic screening and improved treatment can be accomplished in four primary ways: (1) Identifying existing services and resources in the community and linking/referring persons to treatment; (2) educating health care providers on current standards of care and methods for implementing those standards; (3) developing consumer awareness and demand for quality health care (*e.g.*, using media to promote increased

demand for vaccinations, appropriate screenings, and treatment); (4) helping health care providers implement effective office-based strategies, such as patient reminder systems, that help ensure timely and appropriate care.

This cooperative agreement is designed to establish community-based, coordinated, comprehensive health promotion, prevention, and control programs of sufficient intensity and durability to create sustainable change and thereby achieve the ''Healthy People 2010'' objectives shown in Attachment A. All referenced attachments are posted with this announcement on the CDC Web site (*http://www.cdc.gov*). Click on ''Funding'' then ''Grants and Cooperative Agreements''.

Resources useful to the preparation of applications and in support of program implementation are available in Attachment B.

Cooperative agreement recipients are expected to participate fully in coordinated monitoring and evaluation activities that include collecting and reporting common performance measures as well as participating in an independent, external evaluation to measure the impact of STEPS.

C. Eligible Applicants

Cities, urban communities, states, and Tribes or Tribal consortia are eligible under this announcement. The District of Columbia, other large cities, and urban communities (defined as a contiguous geographic area (including counties) with a population exceeding 400,000 persons) with substantial expertise and infrastructure for the design, delivery and evaluation of chronic disease prevention and control interventions can apply directly under this announcement (hereafter referred to as ''Large City and Urban Community'' applicants). Federally recognized Tribal Governments, Regional Area Indian Health Boards, Urban Indian organizations, and Inter-Tribal Councils which serve 10,000 or more American Indians/Alaskan Natives in their catchment area(s) can apply directly under this announcement (hereafter referred to as ''Tribal'' applicants). All other communities, not otherwise included in the applications above, may be eligible for awards under state applications (hereafter referred to as ''State-Coordinated Small City and Rural Community'' applicants).

In determining eligibility, Large Community and Urban Community applicants must meet the criteria under number 1 below, Tribal applicants must meet the criteria under number 2 below, and State-Coordinated Small Cities and Rural Community applicants must meet the criteria under number 3 below.

Note: Public Law 104–65 states that an organization described in section 501(c)(4) of the Internal Revenue Code of 1986 which engages in lobbying activities shall not be eligible for the receipt of Federal funds constituting an award, grant, contract, or any other form.

1. Large City and Urban Community Applicants

The official local health department (or its bona fide agent), or its equivalent, as designated by the mayor, county executive, or other equivalent governmental official, will serve as the lead/fiduciary agent for a Large City and Urban Community application. For this announcement, the term ''large cities and urban communities'' is defined as any contiguous geographic area (including counties) with a population exceeding 400,000 persons. The District of Columbia is eligible to apply for funding under this section of the program announcement. Large City and Urban Community Applicants can specify an intervention area that is smaller than the entire city or community, but the intervention area must be geographically contiguous and must include a population of at least 150,000 residents, but not more than 500,000 residents. Only one application will be accepted from each eligible large city and urban community.

2. Tribal Applicants

Federally recognized Tribal Governments, Regional Area Indian Health Boards, Urban Indian organizations, and Inter-Tribal Councils as designated by the Principal Tribal elected official or chief executive officer will serve as the lead/fiduciary agency for tribal applications. Each tribal application must include a minimum population of 10,000 American Indians/Alaskan Natives within a defined geographic area or set of areas that may or may not be geographically contiguous.

3. State-Coordinated Small City and Rural Community Applicants

The official state health department (or its bona fide agent), or its equivalent, as designated by the Governor, is to serve as the lead/fiduciary agency for Small City and Rural Community applications. For this announcement, the term ''State'' includes the 50 states, 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. States must identify two to four communities of total resident size not to exceed 800,000 persons combined. Each selected community must be geographically contiguous and include a minimum population of 10,000 persons. Neighboring small or rural counties may be grouped together to form a single, contiguous ''community.'' States are strongly encouraged to include diverse communities that vary in size and location. HHS anticipates funding some programs that encompass rural communities as well as small cities. Only one application will be accepted from each state.

D. Funding

Availability of Funds

Approximately $13,650,000 is available in FY 2003 to fund STEPS. Of this amount, approximately $9,000,000 is available to fund 9 to 12 Large City and Urban Community applications. It is expected that the average award will be $1,000,000 and will range from $750,000 to $1,250,000. Approximately $250,000 is available to fund one Tribal application. Of the total amount available, approximately $4,400,000 is available to fund up to four State-Coordinated Small City and Rural Community application. It is expected that the average award will be $1,500,000 and will range from $1,000,000 to $2,000,000. State Health Departments must ensure that 75 percent of the total STEPS award is distributed on an annual basis to the identified communities in the state-coordinated application within four months of the award date, and that the remaining funds are used to support the funded communities through technical assistance and other means.

It is expected that awards will begin on or about September 22, 2003, and will be made for a 12-month budget period within a project period of up to five years. It is expected that projects will emphasize program assessment and evaluation during the first two years of funding. Continuation awards and level of funding within an approved project period (FY 2004 through FY 2007) will be based on the availability of funds and satisfactory progress in achieving performance measures as evidenced by required progress reports.

Funding for FY 2004 and beyond is expected to range from $2,000,000 to $3,000,000 for each Large City and Urban Community recipient; $300,000 to $1,000,000 for each Tribal recipient; and from $4,000,000 to $10,000,000 for each State-Coordinated Small City and Rural Community recipient. It is also anticipated that additional FY 2004

resources may enable the Secretary to fund additional prevention initiatives based on this announcement or a separate announcement.

Applicants funded for the first time in FY 2004 will be required to submit a revised work plan and budget in order to receive funds at FY 2004 funding levels during their first year of funding.

Pending availability of funds, beginning in FY 2004 and each of the remaining years of this program announcement (September 22, 2004 through September 21, 2007), there may be an open season for new competitive applications. Specific guidance will be provided with exact application due dates and funding levels each year.

Recipient Financial Participation

Matching funds, that is, a specific percentage of program costs that must be contributed by a recipient in order to be eligible for this announcement, are not required. Applicants are encouraged, however, to identify financial and in-kind contributions from their own organization and their partners to support and sustain the activities of this program announcement. Program applications that include private partners who contribute in-kind or funding support and incentives to these efforts are strongly encouraged.

Funding Preferences

Preference in funding, based on well-documented data, may be given to ensure:

- Inclusion of populations disproportionately affected by chronic disease and associated risk factors.
- Inclusion of geographic areas with high, age-adjusted rates of chronic disease and associated risk factors.
- Geographic distribution of STEPS programs nationwide.
- Inclusion of communities of varying sizes, including rural, suburban, and urban communities.

Use of Funds

Cooperative agreement funds may be used to expand, enhance, or complement existing activities to accomplish the objectives of this program announcement. Funds may be used to pay for, but are not limited to: staffing, consultants, contractors, materials, resources, travel, and associated expenses to implement and evaluate intervention activities such as: promoting healthy food choices in away-from-home settings; encouraging restaurants to label heart-healthy menu items; establishing community walking programs; helping schools, worksites, shopping malls, senior centers, and other community locations establish health-promoting programs and environments; establishing community-based education, exercise, healthy nutrition, and smoking cessation programs in accessible locations; educating health plans and providers regarding standards for preventive health care practices and how to fully implement them; enhancing office-based systems to ensure that persons with chronic disease are called for routine exams and other follow-up; using information technology (such as the web and email) to communicate with people with chronic disease or associated risk factors; developing community support groups for persons with chronic disease or associated risk factors; conducting awareness and media campaigns to educate persons about their risk of chronic disease and what actions to take; using health risk appraisals such as the American Diabetes Association's self-assessment risk tool, ''Take the Test/Know Your Score''; conducting community-based outreach to high-risk individuals, encouraging them to seek appropriate care; establishing telephone hotlines for tobacco cessation and other health information needs; training lay health workers (''promotoras'') to conduct health promotion programs.

Funds received under this announcement may not be used to supplant/replace existing local, state, or federal funds or activities. Cooperative agreement funds may not be used for direct patient care, diagnostic medical testing, patient rehabilitation, pharmaceutical purchases, facilities construction, lobbying, basic research or controlled trials.

Lead/fiduciary agencies will be eligible to receive up to five percent of their total award for indirect costs.

Direct Assistance

Direct assistance, that is, assistance provided by the Federal government in the form of Federal employee staffing when detailed to the recipient (pay, allowances, and travel), supplies, or equipment in lieu of cooperative agreement/financial assistance funds, is not available as part of FY 2003 STEPS awards. Direct assistance in lieu of cash may be available in subsequent years.

E. Program Requirements

All recipient activities funded under this program announcement need to coordinate with and reinforce, but not duplicate, related, existing federal, state, and local activities. In conducting activities to achieve the purpose of this program announcement, Large Cities and Urban Community applicants will be responsible for the activities listed under number 1 below, Tribal applicants for the activities listed under number 2 below, State-Coordinated Small City and Rural Community applicants for the activities listed under number 3 below, and HHS Agencies for the activities listed under number 4 below. All recipients must address both community and school-based components.

1. Large City and Urban Community Recipient Activities

(a) Fiduciary Responsibilities

i. *Lead Agency.* Establish the lead/fiduciary agency to be the local health department (or its bona fide agent) or its equivalent as designated by the mayor, county executive, or other equivalent governmental official.

ii. *Allocate Funds.* Allocate and disperse funds to the local education agency or agencies responsible for schools within the intervention area, and additional key partners and collaborators to implement recipient activities. Include adequate funds to participate fully in the substantial data collection and evaluation activities associated with this award.

iii. *Contract Services.* Contract for services, as needed, to accomplish the objectives of this program announcement.

vi. *Link Budget to Performance.* Provide integrated progress and financial reports that link the performance and expenditures of the local health department and all key partners.

v. *Sustainability.* If funded for years three through five, engage in efforts that will sustain successful interventions on a long-term basis.

(b) Community Consortium

Identify key partners and coalitions that focus on the prevention and control of chronic disease and associated risk factors. Build an alliance of partnerships and coalitions committed to participating actively in the planning, implementation, and evaluation of STEPS. Effective partnerships are central to the success and sustainability of STEPS. Key partners should demonstrate a high-level commitment to the initiative by their willingness to invest expertise, leadership, personnel, and other resources in the success of the project.

Partners must include, but are not limited to, the mayor's office (or equivalent); local and state health departments; local and state education agencies; key community, health care, voluntary, and professional

organizations; business, community, and faith-based leaders; and at least one lay person representative of the population to be served. Other partners may include, but are not limited to, existing community coalitions (especially those already focusing on chronic diseases), Federally Qualified Health Centers including community health centers [1], worksite wellness programs, health care purchasers, health plans, unions, health care providers for farm and migrant workers and their families, school-based and school-linked clinics, health care providers for the homeless, primary care associations, social service providers, health maintenance organizations, private providers, hospitals, universities, schools of public health, academic health centers, organizations that serve young children and youth, parks and recreation departments, departments of transportation, public housing authorities, state Medicaid officials, service organizations, food manufacturers and distributors, aging services organizations, senior centers, community action groups, consumer groups, and the media.

Note: [1] Consolidated Health Centers under Section 330, of the Public Health Service Act are commonly referred to as community health centers. They include centers that tailor resources for populations such as low-income persons, the uninsured, homeless people, migrant and seasonal farm workers, and public housing residents.

(c) Leadership, Coordination, and Management

i. *Leadership Team.* Establish and coordinate a leadership team responsible for overseeing project activities, establishing and maintaining an organizational structure and governance for the community consortium (including decision-making procedures), determining the project budget and subcontracts, and participating in project-related local and national meetings. The leadership team must include, but is not limited to, the local health department, the local education agency or agencies, and other key leaders from the community.

ii. *Project Staff.* Establish and maintain paid project staff to include a full-time project coordinator with management experience in risk factor interventions and community-based chronic disease prevention and control. Other part-time or full-time staff, contactors, and consultants must be sufficient in number and expertise to ensure project success and have demonstrated skills and experience in coalition and partnership development, community mobilization, health care systems, public health, program evaluation, epidemiology, data management, health promotion, policy and environmental interventions, health care quality improvement, communications, resource development, school health, and the risk factor and disease areas targeted by the program.

iii. *Project Management.* The project coordinator with the other project staff and leadership team, should:

a. Encourage active participation of consortium members in project activities and decisions, through regular meetings and other proactive methods of communication

b. Actively oversee all project activities during their planning, development, implementation, and evaluation phases

c. Track performance in relationship to the achievement of short-term and intermediate outcomes and budgetary expenditures

d. Seek technical assistance from the State, HHS agencies, other Federal agencies, other recipients, national voluntary organizations, universities, or other sources

e. Keep the Project Officer informed and seek Project Officer input and assistance

f. Take corrective action promptly when necessary to ensure project success

g. Participate in STEPS-wide program evaluations.

iv. *Coordinate with State Plans and Activities.* Ensure that community objectives, activities, and interventions are consistent with and supportive of state plans and activities for the prevention and control of diabetes, asthma, obesity, and associated risk factors. Ensure that community objectives, activities, and interventions do not duplicate existing efforts.

(d) Community Action Plan, Community and School-Based Interventions

Identify and implement high priority, eligible intervention strategies proven to prevent and control diabetes, asthma, and obesity. To establish such priorities, communities must examine their chronic disease burden, at-risk populations, current services and resources, and partnership capabilities to develop a comprehensive community action plan.

Communities can select particular areas of programmatic focus within STEPS. However, all communities must address nutrition, physical activity, and tobacco use and exposure since these areas will positively impact primary and/or secondary prevention in diabetes, asthma, and obesity. Additionally, communities are expected to implement other specific interventions to reduce the burden of the diseases/conditions addressed by STEPS (asthma, diabetes, and obesity). Such interventions might include: (1) Conducting community-wide campaigns to implement a diabetes assessment questionnaire (*e.g.*, American Diabetes Association's ''Are You at Risk?''); (2) promoting quality care by providing health care settings with effective systems for handling referrals, follow-ups, and patient reminder systems; and (3) providing training for health care providers on how to establish effective asthma care plans with patients and their families.

i. *Community Interventions.* Programs are expected to employ multiple, evidence-based public health strategies based on the existing and emerging research base and careful scientific reviews such as the Guide to Community Preventive Services (*http://www.thecommunityguide.org/*), the Guide to Clinical Preventive Services (*http://www.odphp.osophs.dhhs.gov/pubs/guidecps/)* and *http://www.ahrq.gov/clinic/prevnew.htm),* and the National Registry for Effective Programs (*http://modelprograms.samhsa.gov/template.cfm?page=nrepbutton*). Effective public health strategies may include changes to the social and physical environments; health promotion, public education, and information; media and other communication strategies; technological advances; economic incentives and disincentives; system improvements; provider education and medical office-based improvement strategies. (*See* Attachment C for additional, example intervention strategies).

While project activities should reach all persons in an identified intervention area, special efforts should be taken to ensure focus on populations with disproportionate burden of chronic diseases/conditions who also tend to experience disparities in access to and use of preventive and health care services. Populations of special focus might include racial and ethnic minorities, low-income persons, the medically underserved, persons with disabilities, and others with special needs. Programs must be culturally competent, and meet the health literacy and linguistic needs of target populations in the intervention area.

Programs should optimize resources by coordinating and partnering with existing programs and resources in the community, surrounding areas, and the state (*e.g.*, state incentive grant programs). Programs should expand the resources available through public-

private ventures, foundation grants, public funding, and in-kind contributions in order to achieve and sustain STEPS outcomes.

Collaborative partnerships with, for example, professional organizations; health care providers, employers/purchasers, and plans; faith-based organizations; schools; child care, early childhood programs, and other organizations that serve children and youth; senior centers or service organizations; primary care associations; area health education centers; community health centers; local, regional, and state chapters of national chronic disease organizations (*e.g.*, the American Diabetes Association, the American Heart Association, the American Lung Association, the Asthma and Allergy Foundation of America, the American Cancer Society); and many others will be key to reaching affected populations and delivering and sustaining effective programs. Strong, cooperative linkages between clinical preventive care and community public health should be established and maintained.

With direction and coordination from the leadership team, the community consortium should develop and implement priority community health interventions to prevent and control diabetes, asthma, obesity, and associated risk factors in the identified intervention area. Such interventions may include:

a. Actively engaging members of the intended audience in community assessments, program planning (including establishing program goals and specifying intervention content and design), delivery, evaluation, and program improvement.

b. Supporting community-based initiatives to increase physical activity, improve nutrition, and eliminate tobacco use and exposure.

c. Increasing healthy food choices in restaurants, grocery stores, vending machines, worksites, shopping malls, senior centers, and other community settings. *http://www.cdc.gov/nccdphp/dnpa/obesity/index.htm*

d. Increasing access to and use of attractive and safe locations for engaging in physical activity.

e. Increasing access to and use of effective cessation programs for persons who use tobacco, targeting adults who are diabetic or who live with persons with asthma. (*http://www.surgeongeneral.gov/tobacco/default.htm*)

f. Improving strategic communication through the use of media and information technologies to improve public awareness and motivation to establish healthy nutrition, physical activity, and avoidance of tobacco use.

g. Developing supportive environments to complement and sustain individual change efforts.

h. Providing social support, reinforcement, and inducements to make healthy choices.

i. Enlisting the support of organizations and settings (*e.g.*, after school programs, worksites, youth-serving organizations, families, faith-based organizations, senior centers, and health care partners) to encourage and support healthy behavior.

j. Working with health care providers, health plans, and employer/purchasers to increase the use of evidence-based preventive care practices.

k. Improving access to and utilization of quality health care services for primary and secondary prevention of the Steps diseases/conditions (asthma, diabetes, and obesity).

l. Increasing self-management skills, including adherence to medication and other health regimens, among persons with established risk factors or chronic disease.

m. Ensuring adequate provider education, including strategies to implement national guidelines on quality care, and improving provider communication and counseling skills.

n. Educating persons with chronic disease on the proper management of their disease and the importance of seeking early, appropriate care to prevent and minimize complications.

o. Raising levels of health literacy to enable persons to make informed health decisions.

ii. *School interventions.* With guidance from the local education agency or agencies, implement school health interventions to prevent and control diabetes, asthma, and obesity in the same intervention area being served by the community interventions. Such interventions may include:

a. Identifying or establishing a full-time school health program coordinator and School Health Council to direct project activities and assist in their implementation. See the American Cancer Society's Guide on the Role of the School Health Coordinator and Guide to School Health Councils. (*http://www.schoolhealth.info*)

b. Reviewing and strengthening the schools' health-related policies and instructional programs using the CDC's School Health Index (*http://www.cdc.gov/nccdphp/dash/SHI/*), and the National Association of State Boards of Education's Fit, Healthy and Ready to Learn: A School Health Policy Guide. (*http://www.nasbe.org/HealthySchools/fithealthy.mgi*)

c. Providing adequate physical education for all students throughout the school year and increasing opportunities for physical activity through recess, intramural activities, and other offerings. (*http://www.cdc.gov/nccdphp/dash/healthtopics/physical_activity/guidelines/index.htm*)

d. Providing professional development for staff to enable them to deliver effective, skills-based health instruction for students (*http://www.nasn.org/*).

e. Implementing staff wellness programs that include health assessment, health promotion, and health management components.

f. Ensuring that school food service personnel are qualified and trained in the use of United States Department of Agriculture (USDA) guidelines for healthy eating.

g. Wherever food is served in school, make appealing foods available that are low in fat, sodium, and added sugars. Limit the sale and distribution of foods of minimal nutritional value. (*http://www.cdc.gov/nccdphp/dash/healthtopics/nutrition/guidelines/index.htm*)

h. Establishing a tobacco-free school environment that prohibits tobacco use on school property, in school vehicles, at school-sponsored events (on and off school property) for students, staff, and visitors, at all times in order to reduce potential exposure to those with asthma. Offer or refer students and staff to school- or community-based tobacco use cessation programs, targeting those who have diabetes or who live with persons with asthma. (*http://www.cdc.gov/nccdphp/dash/healthtopics/tobacco/guidelines/index.htm*)

i. Alleviating indoor air quality problems caused by allergens and irritants such as smoke, dust, mites, molds, warm-blooded animals, and cockroaches.

j. Establishing management and support systems for students with targeted health problems. Ensure communication and coordination among students, families, relevant school staff, and community health and mental health providers.

k. Coordinating school, family, and community efforts. Assist families to support a healthy lifestyle for their children and families. Link school efforts to community programs and activities.

l. Working with school-based and school-linked clinics, assist students and families in meeting their chronic disease-related health needs.

(e) Updated Community Action Plans

Within the first eight months, finalize a five-year community action plan, based on the guidelines of this announcement, the preliminary plan submitted with this application, input from the application review process, newly available community information, HHS agencies and other sources of technical support, and continuing discussions with the community consortium. Base your revised action plan on a logic model that serves as the foundation for prioritizing, planning, and budgeting interventions, program management, and program sustainability (See Attachment B for references regarding logic model development and use). Review and update the community action plan annually to reflect community needs, opportunities, resources, and program evaluation findings.

(f) Project Monitoring and Evaluation

i. *Risk Factor Surveillance.* Work with the state health department and CDC to expand existing surveillance mechanisms to collect representative Behavioral Risk Factor Surveillance System (BRFSS) baseline data for 1,500 to 2,000 adults within the intervention area, and repeat such assessments on an annual basis. (*http://www.cdc.gov/brfss/*)

Work with the state education agency and CDC to collect representative baseline data from the Youth Risk Behavior Surveillance System (YRBSS) (including, at a minimum, information on nutrition, physical activity, asthma, and tobacco) for 1,500 to 2,000 middle and/or high school students within the intervention area, and repeat such assessments on at least a biennial basis. (*http://www.cdc.gov/nccdphp/dash/yrbs/about_yrbss.htm*)

ii. *Existing Data Sources.* Identify existing data sources that can be used to design and monitor STEPS interventions, including hospital discharge data; medical care practice data; vital statistics data; Women, Infants, and Children (WIC) data; community health centers data; Medicaid and Medicare data; school data such absentee rates, academic, health, and risk information; and other sources of information about individual, group, or community health status, needs, and resources.

iii. *Common Performance Measures.* STEPS recipients will participate in establishing a common set of core performance measures to track the number and types of persons served by various intervention strategies and the achievement of related short-term, intermediate, and long-term outcomes. Recipients must agree to collect and report on core performance measures using standardized methodology to document how intervention strategies are being implemented and are successfully addressing STEP priorities. Performance goals should show the link between program activities and the achievement of the initiative's overarching goals. See Attachment A for selected ''Healthy People 2010'' objectives that are anticipated to form part of the core performance measures.

iv. *Comprehensive Evaluation Plan.* Agree to participate fully in a STEPS-wide independent, external evaluation to examine and document the effectiveness of this cooperative agreement program. An important mechanism for changing behavior and implementing effective practices in a variety of settings is the ability to examine and act on successes, barriers to success, and failures. The recipients are expected to be full partners in the evaluation of this initiative by actively gathering and submitting data on selected outcome and performance measures. Grantees will also participate in other evaluation activities that may include regular debriefings, descriptive case studies, special analyses, and mid-course adjustments.

v. *Data-Based Decision Making.* Projects are expected to use all the information above, in consultation with their Project Officer, to design and modify intervention strategies and the community action plan; revise budgets and subcontracts; request technical assistance from HHS agencies and/or contracted experts; recruit new members to the consortium; and/or change the structure of the consortium to improve project participation and outcomes.

(g) Information Sharing

Actively promote the sharing of experiences, strategies, and results with both funded and unfunded cities, communities, and interested partners. Ensure effective, timely communication and exchange of information, experiences, and results through the use of the internet; management information systems; other electronic approaches and formats; workshops; site visits to and between communities and cities; and other activities.

2. Tribal Recipient Activities

Recipient activities are the same as the activities outlined under sections E.1. (a) through (g) for Large Cities and Urban Communities.

3. State-Coordinated Small City and Rural Community Recipient Activities

(a) State Fiduciary Responsibilities

i. *Lead Agency.* Establish the lead/fiduciary agency to be the state health department (its bona fide agent) or its equivalent as designated by the Governor.

ii. *Allocate Funds.* Allocate and disperse funds to communities, the state education agency, other key partners to implement recipient activities at the community level. Include adequate funds to participate fully in the substantial data collection and evaluation activities associated with this award.

iii. *Contract Services.* Contract for services, as needed, to accomplish the objectives of this program announcement.

iv. *Link Budget to Performance.* Provide integrated progress and financial reports that link the performance and expenditures of the communities and all key partners.

v. *Sustainability.* If funded for years three through five, engage in efforts that will sustain successful community programs on a long-term basis.

(b) Small City and Rural Community Responsibilities

Each of the two to four identified communities is expected, with state assistance, to assume the responsibilities identified under Large City and Urban Community Recipient Activities section E.1. (a) through (g).

(c) Leadership/Coordination/Management

In support of the communities, the state health department should establish and coordinate a State-Community Management Team, including participation from the funded communities, the state health department, education agency, Office of Rural Health, any city or large community that is funded within the state borders under this program announcement, and other key public and private sector partners.

i. *Coordinate community objectives with state health plans.* Ensure that, community, and city objectives, activities, and interventions are consistent with, and are supportive of state plans and activities for the prevention and control of diabetes, asthma, and obesity.

ii. *Collaboration.* Ensure collaboration between the community and city programs funded under this program announcement and other state and local chronic disease prevention and control programs.

iii. *Project Staff.* Establish and maintain project staff sufficient to provide oversight and technical assistance to the funded communities.

(d) Technical Assistance

The state health department and state education agency should provide or facilitate the provision of technical assistance, consultation, and support to the funded communities in:

i. *Monitoring Disease Burden.* Defining and monitoring the burden of chronic diseases and disparities through surveillance, epidemiology, and existing data sources (*e.g.,* vital statistics, hospital discharge data, WIC data, community health centers data, Health Centers Uniform Data System, Medicaid and Medicare data).

ii. *Risk Factor Surveillance.* Working with participating communities and other interested parties, ensure that surveillance mechanisms are in place to monitor changes in risk factors (*e.g.,* BRFSS & YRBSS).

iii. *Program Evaluation.* Work with funded communities on on-going evaluation, including assessing the effectiveness of, targeting of, number of persons reached by, and use of intervention strategies; tracking the accomplishment of activities and the achievement of short-term and intermediate outcomes; monitoring changes in health outcomes; tracking performance in relationship to budget execution; and using program evaluation findings to adjust plans and strengthen the program.

iv. *Evidence-Based Practices.* Accessing and sharing with funded communities current prevention effectiveness, intervention effectiveness, and other research and program evaluation findings. Identifying and sharing promising practices.

v. *Community Support.* Helping to build community engagement, mobilization, ownership, and organization.

vi. *Intervention Selection and Development.* Identifying, recommending, and adapting, evidence-based intervention strategies consistent with the needs, cultures, and resources of the communities.

vii. *Resource Development.* Promoting public and private resource development in support of community-based intervention strategies and long-term sustainability.

(e) Project Monitoring and Evaluation

The state health department should work with each of the selected communities to ensure that surveillance mechanisms collect representative data for program planning and monitoring. Obtain existing and new data sources to better understand the burden and trends of chronic diseases, and associated risk factors, and the effects of the STEPS program.

(f) Information Sharing

The state health department should actively promote the sharing of experiences, strategies, and results among communities and cities within the state, between states funded under this program announcement, and with other interested communities. Support community efforts by ensuring effective, timely communication and exchange of information, experiences, and results through the use of the internet; management information systems; other electronic approaches and formats; workshops; site visits to and between communities and cities; and other activities.

4. HHS Activities

(a) Leadership and Coordination

i. *HHS Prevention Steering Committee.* An HHS Prevention Steering Committee has been established to coordinate and organize the ''Steps to a HealthierUS'' initiative and is comprised of high-level representatives of relevant HHS agencies and offices. The Committee will provide ongoing policy oversight and direction to STEPS and will coordinate technical assistance from each agency in support of the successful achievement of the purposes and performance objectives of this program announcement.

ii. *STEPS workgroup.* A STEPS workgroup comprised of representatives from funded communities, cities, tribes and states will be established and coordinated by the HHS Prevention Steering Committee in collaboration with the National Association of City and Community Health Officers, the Association of State and Territorial Health Officials, the National Association of Community Health Centers, the Association of Maternal and Child Health Programs, and other public health leadership organizations to:

a. Ensure collaboration between the recipients and their key partners funded under this program announcement and other local and state chronic disease prevention and control programs.

b. Anticipate the priority needs of recipients and prepare to meet these needs on a timely basis so that STEPS is implemented efficiently and successfully.

c. Assist in organizing and facilitating approaches to sharing experiences, lessons learned, results, and resources among recipients and existing community and state local chronic disease programs.

d. Make available the expertise, staff, and evidence-based resources of HHS agencies to assist and enhance the work of funded communities, states, and tribes.

iii. In concert with all of the HHS activities planned in support of STEPS, the Indian Health Service will provide additional coordination and assistance to the tribe funded under this announcement.

(b) Technical Assistance

Provide technical assistance, training, and support to funded projects in the areas of surveillance and epidemiology, community assessment and planning, evidence-based interventions, community mobilization and partnership development, monitoring of program performance outcomes, data management, program sustainability, and other areas as needed. Provide on-site assistance, workshops, webforums, training and intervention materials.

(c) Evaluation Oversight and Coordination

HHS will separately fund and direct an independent, external evaluation of STEPS. However, recipients are expected to budget for their full participation in the data collection associated with this external review. Additionally, HHS will coordinate cross-site evaluation activities, including the establishment of core performance measures. HHS will provide, or ensure the provision of, expert resources to assist communities, states and tribes in the design, collection, analysis, and use of comparable evaluation data for evaluating and strengthening their programs.

F. Content

Letter of Intent (LOI)

An LOI is requested from all potential applicants for the purpose of planning the competitive review process. The narrative should be no more than two pages, double-spaced, printed on one side, with one-inch margins, and unreduced 12-point font. LOIs should include the following information: (1) The program announcement title and number; (2) whether the application will be from a Large City and Urban Community applicant, a Tribal applicant, or a State-Coordinated Small City and Rural Community applicant; and (3) the name of the applicant agency or organization, the official contact person and that person's telephone

number, fax number, mailing and e-mail addresses. If the LOI is being sent from a Large City and Urban Community applicant, also provide the exact boundaries and total population size of the contiguous geographic area with population exceeding 400,000 persons that qualifies the applicant as eligible for this program announcement.

Application

The program announcement title and number must appear in the application. Use the information in the Program Requirements, Other Requirements, Evaluation Criteria, and this section to develop the application content. Your application will be evaluated on the criteria listed, so it is important to follow this guidance carefully. Content requirements for Large City and Urban Community applicants are listed under number 1 below; for Tribal applicants under number 2 below; and for State-Coordinated Small City and Rural Community applicants under number 3 below:

1. Large City and Urban Community Applicants

The narrative (excluding appendices) must be no more than 50 pages, double-spaced, printed on one side, with one-inch margins, and unreduced 12-point font. In addition to the application forms, the application must contain the following in this order:

(a) Official Transmittal Letter. Letter of transmittal from the Chief Executive Officer (Mayor, county executive, or other equivalent governmental official) committing local government support, identifying the lead agency (local health department, bona fide agent, or equivalent) and citing the amount requested.

(b) Table of Contents. Table of Contents with page numbers for each of the following sections.

(c) Executive Summary. Executive summary briefly describing the overall project, intervention area and population size, partnerships, intervention strategies, and major short-term and intermediate outcomes.

(d) Lead Agency. Description of the lead agency, including fiduciary and programmatic capabilities, as well as an inventory of current agency activities related to this announcement.

(e) Intervention Area. Description of the intervention area, including its demographic, geographic and political boundaries, target populations to receive special focus under this award, as well as evidence of the burden of disease, disparities in diabetes, asthma, obesity, associated risk factors, and access to and use of proven prevention and control interventions. Description of current activities and projects underway to address chronic diseases in the intervention area. Overview of the assets and deficiencies of the intervention area, including state, local, and private sector efforts, and a description of findings from any community assessments or asset mapping done in the past three years.

(f) Staff. Description of the proposed STEPS staff, including resumes or job descriptions for the full-time project coordinator and other key staff, the qualifications and responsibilities of each staff member and the percent of time each are committing to STEPS.

(g) Community. Description of the community consortium, including a list of key partners, and documentation of their capabilities; their commitment to specific functions, responsibilities, and resources; and evidence of prior successful collaborations. The structure, decision-making processes, and methods for accountability of the members should be described as well as how coordination and linkage with existing programs and interventions with similar focus will be maintained.

(h) Community Action Plan. A preliminary five-year community action plan that includes the community and school interventions to be employed in the intervention area. The community action plan should include time-phased, specific, measurable, and realistic short-term and intermediate outcomes based on the needs of the community and gaps in current prevention and control activities. The community action plan should identify likely approaches, strategies, and interventions to be used over the entire five-year project period to address nutrition, physical activity, and tobacco use and exposure as well as additional interventions to address the targeted STEPS chronic diseases/conditions. The organizations responsible for the interventions should be clearly identified as well as the target populations to be addressed. The community action plan should address first year activities in depth and their relationship to attaining specific short-term and intermediate outcomes. The community action plan should include a plan to ensure long-term sustainability of project efforts and outcomes.

(i) Financial Contributions. Description of financial and in-kind resources, if any, that will be contributed toward activities initiated as part of STEPS.

(j) Evaluation and Monitoring. A plan for data identification, collection, and use for program planning and monitoring. Describe efforts to obtain existing and new data sources to better understand chronic disease burden and trends, related risk factors and the effects of STEPS. Provide specific assurances to track common performance measures and participate fully in an independent, external evaluation of STEPS processes and outcomes. Performance goals should directly link program activities to the achievement of the initiative's overarching goals. Describe how the project is anticipated to improve specific performance measures and outcomes compared to baseline performance.

(k) Communications Plan. A plan to communicate and share information with the members of the consortium, the community, and other key partners. The plan should describe the proposed exchange of information, the means and proposed timing of communication, with an emphasis on communications innovations such as electronic formats, management information systems, webforums, etc.

(l) Budget and Budget Justification/Narrative. i. *Allocate Budget.* Clearly indicate estimated budget amounts to be allocated and dispersed to the local education agency or agencies and other key consortium members. Provide a description of the funding mechanisms and timelines that will be used to disperse these funds.

ii. *One-Year and Five-Year Budgets.* In support of the five-year community action plan, provide both a detailed budget and budget justification/narrative for the first budget year, and a budget estimate for budget years two through five.

a. Provide a detailed budget for the first budget year in support of each activity that must be completed in the first year of program operations to accomplish the short-term and intermediate outcomes specified in the five-year community action plan. Develop a budget justification and narrative that describes all requested funds by object class category: personnel, fringe benefits, travel, equipment, supplies, contractual, and other direct costs. As part of the request for travel funds in FY 2003, applicants should budget for two trips to workshops and/or conferences for key staff members of the lead/fiduciary organization and its key partners. For planning purposes, use Atlanta and Washington, DC as the travel destinations. Summarize all of the first-year requested funds in the form included in Attachment D, Activity-Based Plan and Budget. This information must be consistent with the first year budget information entered in Section B of Standard Form 424A

(Budget Information—Non-Construction Programs).

b. Provide estimated budgets for FY 2004 through FY 2007 that are linked to the accomplishment of intermediate outcomes. For each budget year, include budget estimates for two trips to workshops and/or conferences for key staff members of the lead/ fiduciary organization and its key partners. For planning purposes, use Atlanta and Washington, DC as the travel destinations. Provide budget estimates for each year for each object class category in Section B of a separate Standard Form 424A (Budget Information—Non-Construction Programs).

(m) Letters of Support. Provide letters of support and Memoranda of Understanding (as appropriate) from the local health agencies, local Education Agency or agencies, Health Center Networks or Primary Care Associations and other key members of the consortium that specify their roles, responsibilities, and resources.

2. Tribal Applicants

The narrative (excluding appendices) should be no more than 50 pages double-spaced, printed on one side, with one-inch margins, and unreduced 12-point font. In addition to the application forms, the application must contain the following in this order:

(a) Official Transmittal Letter. Letter of transmittal from the Principal Tribal elected official or the chief executive officer of the Tribe, Inter-Tribal Council, Urban Indian Organization, or Regional Area Indian Health Board identifying the lead agency and citing the amount requested.

(b) Narrative Content. The remainder of the narrative should address the content described under F.1. b) through m) above for Large Cities and Urban Communities.

3. State-Coordinated Small City and Rural Community Applicants

The narrative (excluding appendices) should be no more than 100 pages, double-spaced, printed on one side, with one-inch margins, and unreduced 12-point font. In addition to the application forms, the application must contain the following in this order:

(a) Official Transmittal Letter. Letter of transmittal from the Governor committing state support, identifying the lead agency (state health department, bona fide agent, or equivalent) and citing the amount requested.

(b) Table of Contents. Table of Contents with page numbers for each of the following sections.

(c) Executive Summary. Executive Summary briefly describing the overall project; intervention area(s) and population sizes; partnerships, intervention strategies, and major short-term and intermediate outcomes.

(d) State Lead Agency. Description of the lead agency including fiduciary and programmatic capabilities, as well as an inventory of current agency activities related to this announcement. Description of the state health department's ability to provide, and history of providing, expert assistance to local communities in the design and delivery of evidence-based approaches to chronic disease prevention and control.

(e) Community Lead Agencies. Description of the lead agency (local health department or equivalent) for each of two to four separate community intervention areas, including fiduciary and programmatic capabilities, as well as an inventory of current agency activities related to this announcement.

(f) Intervention Areas. Description of each of the community intervention areas, including their demographic, geographic and political boundaries, target populations to receive special focus under this award, as well as evidence of the burden of disease, and disparities in diabetes, asthma, obesity, associated risk factors, and access to and use of proven prevention and control interventions. Description of current state, local, and private-sector activities underway to address chronic diseases in the intervention areas. Overview of the assets and deficiencies of the intervention areas including a description of findings from any community assessments or asset mapping done in the past three years.

(g) Staffing. Description of the proposed STEPS staff including resumes or job descriptions for full-time project coordinators in each community and other key staff at the state and community levels, the qualifications and responsibilities of each staff member and percent of time each is committing to STEPS.

(h) Community Consortia. Description of the community consortia for each community including a list of key partners and documentation of their capabilities; their commitment to specific functions, responsibilities, and resources; and evidence of prior successful collaborations. The structure, decision-making processes, and methods for accountability of the members should be described as well as how coordination and linkage with existing programs and interventions with similar focus will be maintained.

(i) Community Action Plans. A preliminary five-year community action plan for each community that includes the community and school interventions to be employed in the intervention areas. The community action plans should include time-phased, specific, measurable, and realistic short-term and intermediate outcomes that are based on the needs of the communities and gaps in current prevention and control activities. The community action plans should identify likely approaches, strategies, and interventions to be used over the entire five-year project period to address nutrition, physical activity, and tobacco use and exposure as well as additional interventions to address the STEPS chronic diseases/conditions (asthma, diabetes, and obesity). The organizations responsible for the interventions should be clearly identified as well as the target populations to be addressed. The community action plan should address first year activities in depth and their relationship to attaining specific short-term and intermediate outcomes. The community action plan should include a plan to ensure long-term sustainability of project efforts and outcomes.

(j) Financial Contributions. Description of financial and in-kind resources that will be contributed toward new activities initiated as part of STEPS.

(k) Evaluation and Monitoring. A plan for data identification, collection, and use for program planning and monitoring for each community. Describe efforts to obtain existing and new data sources to better understand the burden and trends of chronic diseases and their risk factors and the effects of the STEPS program. Provide specific assurance from each community, and from the state, to track common performance measures and to participate fully in an independent, external evaluation of STEPS outcomes. Describe for each community how the project is anticipated to improve specific performance measures and outcomes compared to baseline performance.

(l) Communication Plans. A plan for each community to communicate and share information with the members of their consortia, other key partners, and their own communities broadly, as well as with other funded communities and the state. The plans should describe the proposed exchange of information, the proposed means and timing of communication, with an emphasis on communications innovations such as electronic formats, management information systems, webforums, etc.

(m) Budget and Budget Justification/Narrative i. *Community Funding.* Provide a description of how the state will distribute a minimum of 75 percent of total STEPS funds to the identified communities within four months of the receipt of their award.

ii. *Allocate Budget.* Clearly indicate estimated budget amounts to be allocated and dispersed to the funded communities, the State Education Agency, and other state partners. Provide a description of the funding mechanisms and timelines that will be used to disperse these funds.

iii. *One-Year and Five-Year Budgets.* In support of the five-year community action plans, provide a detailed budget and budget justification/narrative for the first budget year and a budget estimate for years two through five.

a. Provide a detailed budget for the first budget year in support of each activity that must be completed in the first year of program operations to accomplish the short-term and intermediate outcomes specified in the five-year community action plans. This detailed budget must include:

• *State expenditures.* A budget justification and narrative that describes all requested funds for the State Health and Education Agencies, and other key state partners by object class category: personnel, fringe benefits, travel, equipment, supplies, contractual, and other direct costs. State expenditures should clearly reflect activities that support the efforts of the funded communities. As part of the request for travel funds in FY 2003, applicants should budget for two trips to workshops and/or conferences for key staff members of the lead/fiduciary organization and its key partners. For planning purposes, use Atlanta and Washington, DC as the travel destinations. Summarize all of the first-year state-level expenditures in the form included in Attachment D, Activity-Based Plan and Budget.

• *Community expenditures.* For each community, a budget justification and narrative that describe all requested funds for the local health department, the local education agency or agencies, and other key community partners by object class category in support of first-year activities in the five-year community action plan. As part of the request for travel funds in FY 2003, applicants should budget for two trips to workshops and/or conferences for key community members. For planning purposes, use Atlanta and Washington, DC as the travel destinations. Summarize all of the first-year requested funds, by community, in the form included in Attachment D, Activity-Based Plan and Budget Form.

• The information above should be consistent with the first year budget information entered in Section B of Standard Form 424A (Budget Information—-Non-Construction Programs).

b. Provide estimated budgets for FY 2004 through FY 2007 that are linked to the accomplishment of intermediate outcomes for each funded community. For each budget year, include budget estimates for two trips to workshops and/or conferences for key staff members of the lead/fiduciary organization and its key partners. For planning purposes, use Atlanta and Washington, DC as the travel destinations. Provide the estimated total budget for each year (*i.e.,* state plus all funded communities) for each object class category in Section B of Standard Form 424A (Budget Information—-Non-Construction Programs).

(n) Letters of Support. Provide letters of support and Memoranda of Understanding (as appropriate) from the local health departments and education agencies, state education agency, and other key members of the consortia that specify their roles, responsibilities, and resources.

G. Submission and Deadline

Letter of Intent (LOI) Submission

On or before June 1, 2003 submit the LOI to: Dr. Stephanie Zaza, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention, 4770 Buford Highway E.E., Mailstop K–40, Atlanta, GA 30341.

Application Forms

Submit the signed original and two copies of the CDC 0.1246 form. Forms are available at: *http://www.cdc.gov/od/pgo/forminfo.htm.*

If you do not have access to the Internet, or if you have difficulty accessing the forms on-line, please contact the CDC Procurement and Grants Office Technical Information Management Section (PGO–TIM) at: 770–488–2700. Application forms can be mailed to you.

Submission Date, Time, and Address

The application must be received by 4 p.m. Eastern Time, July 15, 2003. Submit the application to: Technical Information Management—PA 03135, CDC Procurement and Grants Office, Centers for Disease Control and Prevention, 2920 Brandywine Rd., Atlanta, GA 30341–4146.

Applications may not be submitted electronically.

Acknowledgement of Application Receipt

A postcard will be mailed by PGO–TIM, notifying you that CDC has received your application.

Deadline

LOIs and applications shall be considered as meeting the deadline if they are received before 4:00 p.m. Eastern Time on the deadline date. Any applicant who sends their application by the United States Postal Service or commercial delivery services must ensure that the carrier will be able to guarantee delivery of the application by the closing date and time. If an application is received after closing due to 1) carrier error, when the carrier accepted the package with a guarantee for delivery by the closing date and time, or 2) significant weather delays or natural disasters, CDC will upon receipt of proper documentation, consider the application as having been received by the deadline.

Any application that does not meet the above criteria will not be eligible for competition, and will be returned to the applicant. The applicant will be notified of their failure to meet the submission requirements.

H. Evaluation Criteria

An Independent Objective Review Group appointed by HHS will evaluate each application against the following criteria. Evaluation criteria for Large City and Urban Communities are listed under number 1 below, for Tribes under number 2 below, and for State-Coordinated Small City and Rural Communities under number 3 below.

1. Large City and Urban Community Applicants

(a) Intervention Strategies (40 Points)

i. Community Interventions (30 of 40 points). a. The degree to which the applicant describes a five-year community action plan with objectives and activities that are specific, time-phased, measurable, realistic, and related to identified needs and gaps in existing programs, program requirements, and purposes and goals of this cooperative agreement program.

b. The degree to which the science-base for effective community interventions is being used to create the community action plan and its evaluation.

c. The likely effectiveness of each intervention strategy as well as the plan as a whole. This includes the estimated efficacy of each intervention based on existing science, the likely reach of each intervention (percentage of the

community likely to be engaged/impacted by the intervention), the extent to which interventions build on and complement, but do not duplicate, existing programs, and the potential synergy created through multiple interventions.

d. The degree to which the proposed plan addresses nutrition, physical activity, tobacco, and intervention strategies/activities to address the chronic diseases/conditions covered by STEPS (asthma, diabetes, and obesity).

e. The degree to which the plan reflects and builds on a substantiated and comprehensive understanding of the assets, attributes, and deficiencies of the communities including non-STEPS-related activities completed or on-going in these communities.

f. The extent to which the applicant includes a plan to sustain the project long term.

ii. School Interventions (10 of 40 points). a. The extent to which the applicant describes plans to implement school-based interventions that promote healthy lifestyles among students and their families, and address the prevention and control of chronic diseases within the same intervention area as the community interventions.

b. The clarity and feasibility of a plan to establish a full-time school health program coordinator and a school health council that will direct school-based activities and assist in their implementation.

c. The degree to which the science-base for effective school-based interventions is being used to create the community action plan and its evaluation.

d. The extent to which the proposed objectives and activities are specific, time-phased, measurable, realistic, feasible, and related to identified needs and gaps in existing programs, program requirements, and purposes and goals of this cooperative agreement program.

(b) Project Leadership and Management (20 Points)

i. The identification of a lead/fiduciary agency that will ensure accountability for expenditures in relationship to performance of all key partners.

ii. The extent to which the applicant describes the proposed structure of the project including decision-making processes.

iii. The extent to which the applicant provides letters of support and Memoranda of Understanding (as appropriate) with partner agencies and organizations, and the extent to which these documents describe specific collaborative actions to be undertaken and the role of the partners.

iv. The extent to which the applicant and its key partner organizations provide financial or in-kind contributions toward the success of the STEPS initiative.

v. The extent to which the applicant describes realistic plans to coordinate proposed activities with state- and community-level programs to prevent and control chronic disease.

vi. The degree to which proposed staff have the relevant background, expertise, qualifications, and experience.

vii. The degree to which the proposed staffing plan appears appropriate to the level of work proposed and demonstrates the intent to minimize staff levels in order to maximize funding for interventions.

viii. The extent to which the applicant describes clearly defined roles of project staff and an appropriate percent of time each is committing to STEPS.

(c) Plan for Project Monitoring and Evaluation (15 Points)

i. The extent to which the applicant describes plans to collaborate with other STEPS recipients in developing and implementing a set of common performance measures to monitor the success of funded projects.

ii. The extent to which appropriate data sources are currently available or will be made available, and are used to monitor and track changes in community capacity; the extent to which interventions reach populations at high risk; changes in risk factors, chronic disease burden, and disparities; the relationship between interventions and outcomes; and changes in program efficiency.

iii. The extent to which the applicant describes plans to collaborate fully in external, independently coordinated evaluation activities to evaluate the overall impact of STEPS.

iv. The extent to which evidence is provided to demonstrate the applicant's capability to conduct surveillance and program evaluation, access and analyze official data sources, and use evaluation to strengthen the program.

v. The extent to which the applicant describes how the project is anticipated to improve specific performance measures and outcomes compared to baseline performance.

(d) Background and Need (10 Points)

i. The extent to which the proposed intervention area is described, including the populations to be served.

ii. The extent to which data are provided substantiating existing burden and/or disparities of chronic diseases and conditions, specifically diabetes, asthma, and obesity in the proposed intervention area and populations to be served.

iii. The extent to which data are provided substantiating existing health risk behaviors and risk factors related to chronic diseases in the proposed intervention area and populations to be served.

iv. The extent to which assets and barriers to successful program implementation are identified.

v. The extent to which existing resources will be utilized to complement or contribute to the effort planned in the proposal.

(e) Community Consortium (10 Points)

i. The extent to which the applicant demonstrates the ability to establish a consortium that is inclusive of key partners, and related coalitions.

ii. The extent to which the applicant describes the capacity of the proposed consortium in terms of leadership, expertise, community representation, collaborative experience/abilities, and agency representation.

iii. The extent to which key partners demonstrate a high-level commitment to planning, implementing, and evaluating the proposed project, including a commitment of staff and other resources.

iv. The extent to which members of the proposed consortia have successfully worked together or with others in the past to achieve improved health outcomes.

(f) Communication and Information Sharing (5 Points)

i. The extent to which the applicant describes plans to share experiences, strategies, and results with other interested states, communities, and partners.

ii. The extent to which the applicant describes plans to ensure effective and timely communication and exchange of information, experiences and results through mechanisms such as the internet, management information systems, other electronic formats, workshops, publications, and other innovations.

(g) Budget (not scored)

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

2. Tribal Applicants

Will be evaluated according to the Large City and Urban Community evaluation criteria listed under H.1. (a) through (g) above.

3. State-Coordinated Small City and Rural Community Applicants

(a) Intervention Strategies (40 Points)

The points for this section will be divided equally between the two to four pre-selected communities where project activities and interventions will occur (*i.e.*, 20 points per community if the project proposes to work in two communities, 13 points per community if three communities, ten points per community if four communities). This section will be evaluated according to the same criteria for Large City and Urban Community proposals under H.1.a) (i-ii) above.

(b) Project Leadership, Collaboration, and Proposed Structure (15 Points)

i. The identification of a lead/fiduciary agency that will ensure accountability for expenditures in relationship to performance of all key partners.

ii. The extent to which the applicant describes the proposed structure of the project including decision-making processes, monitoring, problem solving, and providing support to community-based programs.

iii. The extent to which the applicant provides letters of support and Memoranda of Understanding (as appropriate) with partner agencies and organizations, and the extent to which these documents describe specific collaborative actions to be undertaken and the role, responsibilities, and commitment of resources of the partners.

iv. The extent to which the applicant and its key partner organizations provide financial or in-kind contributions toward the success of the STEPS initiative.

v. The extent to which the applicant describes realistic plans to coordinate proposed activities with state- and community-level programs to prevent and control chronic disease.

vi. The degree to which proposed staff have the relevant background, qualifications, and experience to facilitate support to community-level efforts.

vii. The degree to which the proposed staffing plan appears appropriate to the level of work proposed and demonstrates the intent to minimize staff levels in order to maximize funding for interventions.

viii. The extent to which the applicant describes clearly defined roles of project staff and an appropriate percent time each is committing to STEPS.

ix. The capacity of the proposed local consortia in terms of leadership, expertise, community representation, collaborative experience/abilities, and agency representation.

x. Past history and evidence of effectiveness of community-state partnerships in relation to health issues and interventions (especially those related to chronic disease prevention and control, and those involving the specific communities selected for this program).

xi. Past history and evidence of effectiveness of community partnerships in the two to four proposed communities in relation to health issues and interventions (especially those involving chronic disease prevention and control).

(c) Plan for Project Monitoring and Evaluation (15 Points)

i. The extent to which the applicant describes plans for the state and proposed communities to collaborate with other STEPS recipients in developing and implementing a set of common performance measures to monitor the success of funded projects.

ii. The extent to which appropriate data sources are currently available or will be made available to monitor and track changes in community capacity; the extent to which community-driven interventions reach populations at high risk; changes in risk factors, chronic disease burden, and disparities; the relationship between interventions and outcomes; and changes in program efficiency.

iii. The extent to which the applicant describes plans for the state, proposed communities, and other key partners to collaborate fully in external, independently coordinated evaluation activities to evaluate the overall impact of STEPS.

iv. The extent to which evidence is provided to demonstrate the applicant's capability to conduct surveillance and program evaluation, access and analyze official data sources, and use evaluation to strengthen the program and support community-based efforts.

v. The extent to which the applicant describes how the project is anticipated to improve specific performance measures and outcomes compared to baseline performance.

(d) Capacity to Guide and Support Intervention Communities (15 Points)

i. The extent to which the applicant proposes a State-Community Management Team fully capable of guiding and directing the overall project.

ii. The extent of state experience, expertise, and capacity to assist local communities in the activities of this project are described. Evidence of having provided guidance and support to local communities that resulted in successful implementation and outcomes.

iii. The extent to which specific methods are described to assist local communities in the activities of this project.

(e) Background and Need (10 Points)

i. The extent to which the proposed intervention communities are described, including the populations to be served.

ii. The extent to which data are provided substantiating the burden and disparities of chronic diseases and conditions, specifically diabetes, asthma, and obesity in the proposed intervention communities and populations to be served.

iii. The extent to which data are provided substantiating health risk behaviors and risk factors related to chronic diseases in the proposed intervention communities and populations to be served.

iv. The extent to which assets and barriers to successful program implementation are identified in each intervention community.

v. The extent to which existing resources will be utilized to complement or contribute to the effort planned in the proposal.

(f) Communication and Information Sharing (5 Points)

i. The extent to which the applicant describes plans to share experiences, strategies, and results between the proposed communities, with the state, and with other interested communities and partners.

ii. The extent to which the applicant describes plans to ensure effective and timely communication and exchange of information, experiences, and results between the proposed communities, the state, and others through mechanisms such as the internet, managements information systems, other electronic formats, workshops, and other innovations.

(g) Budget (Not Scored)

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

I. Other Requirements

Technical Reporting Requirements

Provide CDC with original and two copies of:

1. Interim progress report will be due May 30, 2004, and subsequent interim progress reports will be due on the 30th of May each year through May 30, 2008. The progress report will serve as the

non-competing continuation application for the subsequent year, and must contain the following elements:

(a) A succinct description of the program accomplishments/narrative and progress made in achieving short-term and intermediate outcomes and other performance measures within the planned budget during the first six months of the budget period.

(b) The reason(s) for not achieving established short-term and intermediate outcomes and other performance measures within the planned budget and what will be done to achieve unmet objectives.

(c) Current budget period financial progress.

(d) New budget period proposed program activities and objectives.

(e)Detailed changes in the activity-based budget, the line-item budget, existing contracts, summary budget, and budget justification.

(f)For newly proposed contracts, provide the name of the contractor(s), method of selection, period of performance, scope of work, and itemized budget and budget justification/narrative.

2. An annual progress report summarizing the budget period (12 month) accomplishments for each budget period objective. The annual progress report will be due on November 20, 2004 and subsequent annual progress reports will be due on the 20th of November each year through November 20, 2007.

3. Financial status report, no more than 90 days after the end of the budget period.

4. Final financial, performance, and evaluation reports, no more than 90 days after the end of the five-year project period.

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

Additional Requirements

The following additional requirements are applicable to this program. For a complete description of each, see Attachment I of the program announcement as posted on the CDC web site.

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

J. Where To Obtain Additional Information

A live, interactive satellite broadcast and webcast about this announcement and the STEPS Program will be held on May 22, 2003, from 1 to 3 pm Eastern Standard Time. After May 1, 2003, updates about this broadcast and participation information may be found at *http://www.phppo.cdc.gov/phtn.*

This and other CDC announcements, the necessary applications, and associated forms can be found on the CDC Web site, Internet address: *http://www.cdc.gov*

Click on ''Funding'' then ''Grants and Cooperative Agreements''.

For general questions about this announcement, contact: Technical Information Management, CDC Procurement and Grants Office, 2920 Brandywine Rd., Room 3000, Atlanta, GA 30341–2700, Telephone: 770–488–2700.

For business management and budget assistance, contact: Ms. Sylvia Dawson, Procurement and Grants Office, Centers for Disease Control and Prevention, 2920 Brandywine Rd., Room 3000, Atlanta, GA 30341–4146, Telephone: 770–488–2771, E-mail address: *snd8@cdc.gov.*

For business management and budget assistance, in the territories contact: Charlotte Flitcraft, Procurement and Grants Office, Centers for Disease Control and Prevention, 2920 Brandywine Rd., Room 3000, Atlanta, GA 30341–4146, Telephone: 770–488–2632, Email address: *caf5@cdc.gov.*

For program technical assistance, contact: Dr. Stephanie Zaza, Centers for Disease Control and Prevention, 4770 Buford Highway NE., Mailstop K–40, Atlanta, GA 30341, Telephone: 770–488–6452, E-mail address: *sxz2@cdc.gov.*

Edward Schultz,

Acting Director, Procurement and Grants Office, Centers for Disease Control and Prevention.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

Healthcare Infection Control Practices Advisory Committee (HICPAC): Meeting

In accordance with section 10(a)(2) of the Federal Advisory Committee Act (Pub. L. 92–463), the Centers for Disease Control and Prevention (CDC) announces the following meeting.

Name: Healthcare Infection Control Practices Advisory Committee.

Times and Dates: 8:30 a.m.–5 p.m., June 2, 2003. 8:30 a.m.–4 p.m., June 3, 2003.

Place: Centers for Disease Control and Prevention, Building 17, Rooms 1039/1041, 1600 Clifton Road, NE, Atlanta, Georgia 30333.

Status: Open to the public, limited only by the space available.

Purpose: The committee is charged with providing advice and guidance to the Secretary; the Assistant Secretary for Health; the Director, CDC; and the Director, National Center for Infectious Diseases (NCID), regarding (1) the practice of hospital infection control; (2) strategies for surveillance, prevention, and control of infections (*e.g.*, nosocomial infections), antimicrobial resistance, and related events in settings where healthcare is provided; and (3) periodic updating of guidelines and other policy statements regarding prevention of healthcare-associated infections and healthcare-related conditions.

Matters to be Discussed: Agenda items will include a review of the Draft Guideline for Preventing Transmission of Infectious Agents in Healthcare Settings (formerly Guideline Isolation Precautions in Hospitals); infection control issues related to Severe Acute Respiratory Syndrome (SARS); strategies for prevention of surgical site infections; and updates on CDC activities of interest to the committee.

Agenda items are subject to change as priorities dictate.

Contact Person for More Information: Michele L. Pearson, M.D., Executive Secretary, HICPAC, Division of Healthcare Quality Promotion, NCID, CDC, 1600 Clifton Road, NE, M/S A–07, Atlanta, Georgia 30333, telephone 404/498–1182.

The Director, Management Analysis and Services Office, has been delegated the authority to sign **Federal Register** notices pertaining to announcements of meetings and other committee management activities, for both CDC and the Agency for Toxic Substances and Disease Registry.

Dated: May 2, 2003.

Diane C. Allen,

Acting Director, Management Analysis and Services Office, Centers for Disease Control and Prevention.

[FR Doc. 03–11533 Filed 5–8–03; 8:45 am]

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Food and Drug Administration

[Docket No. 03N–0169]

Dental Amalgam; Request for Information

AGENCY: Food and Drug Administration, HHS.

ACTION: Notice.