

THE BOARD OF SUPERVISORS OF THE COUNTY OF STANISLAUS  
ACTION AGENDA SUMMARY

DEPT: Health Services Agency *ms*

BOARD AGENDA # \*B-1

Urgent  Routine

AGENDA DATE November 10, 2009

CEO Concurs with Recommendation YES  NO   
(Information Attached)

4/5 Vote Required YES  NO

SUBJECT:

Approval for the Health Services Agency to Submit an Application for The American Recovery and Reinvestment Act of 2009 Centers for Disease Control's (CDC) Communities Putting Prevention to Work (CPPW) Grant to Decrease Overweight/Obesity Prevalence, Increase Levels of Physical Activity and Improve Nutrition, and to Designate Stanislaus County Office of Education to Serve as a Bona Fide Agent to Apply for the CDC's CPPW Grant to Decrease Tobacco Use and Exposure to Secondhand Smoke and if Awarded to Enter the Grant Agreements and fulfill the Grantee's Responsibilities

STAFF RECOMMENDATIONS:

1. Approve the Health Services Agency Managing Director or her designee to submit an application for the American Recovery and Reinvestment Act of 2009 Centers for Disease Control's Communities Putting Prevention to Work (CPPW) grant to decrease overweight/obesity prevalence, increase levels of physical activity and to improve nutrition, and if awarded, to enter the grant agreement.
2. Authorize the designation of the Stanislaus County Office of Education as the Local Health Department's Bona Fide Agent specifically to submit an application for the American Recovery and Reinvestment Act of 2009 Centers for Disease Control's Communities Putting Prevention to Work grant to decrease tobacco use and

(Continued on Page 2)

FISCAL IMPACT:

The term of the grants is a 24-month period, with an anticipated award date of February 26, 2010. The amount of funding provided to urban applicants, which includes Stanislaus County, is estimated to range between \$4 million-\$10 million for each grant. The specific amount of funding per community will be determined by the variety of interventions, population size, ability to reduce health disparities, and likelihood of success. If the grant(s) are awarded, the Health Services Agency will return to the Board of Supervisors to request the appropriate budget adjustments.

BOARD ACTION AS FOLLOWS:

No. 2009-761

On motion of Supervisor Grover, Seconded by Supervisor Chiesa

and approved by the following vote,

Ayes: Supervisors: O'Brien, Chiesa, Grover, Monteith, and Chairman DeMartini

Noes: Supervisors: None

Excused or Absent: Supervisors: None

Abstaining: Supervisor: None

1)  Approved as recommended

2)  Denied

3)  Approved as amended

4)  Other:

MOTION:

*Christine Ferraro*

ATTEST: CHRISTINE FERRARO TALLMAN, Clerk

File No.

Approval for the Health Services Agency to Submit an Application for The American Recovery and Reinvestment Act of 2009 Centers for Disease Control's (CDC) Communities Putting Prevention to Work (CPPW) Grant to Decrease Overweight/Obesity Prevalence, Increase Levels of Physical Activity and Improve Nutrition, and to Designate Stanislaus County Office of Education to Serve as a Bona Fide Agent to Apply for the CDC's CPPW Grant to Decrease Tobacco Use and Exposure to Secondhand Smoke and if Awarded to Enter the Grant Agreements and fulfill the Grantee's Responsibilities  
Page 2

**STAFF RECOMMENDATIONS (Continued):**

exposure to secondhand smoke, and if awarded, to accept the funding and responsibility to perform the scope of work and to ensure that all grant requirements are appropriately achieved.

3. Authorize the Chairman of the Board of Supervisors to sign the designation letter and to enter the Letter of Agreement with the Stanislaus County Office of Education.
4. Authorize the Health Services Agency Managing Director or her designee to ensure the Local Health Department participation on the grant required leadership teams, and to provide oversight of the agency relationship with the Stanislaus County Office of Education.

**DISCUSSION:**

The American Recovery and Reinvestment Act of 2009 (Recovery Act), signed into law February 17, 2009, was designed to stimulate economic recovery in various ways, including preserving and creating jobs, promoting economic recovery, assisting those most impacted by the recession, stabilizing State and local government budgets in order to minimize and avoid reductions in essential services and counterproductive state and local tax increases, and strengthening the nation's healthcare infrastructure and reduce healthcare costs through prevention activities. The Recovery Act includes \$650 million for evidence-based clinical and community-based prevention and wellness strategies that support specific, measurable health outcomes to reduce chronic disease rates. The legislation provides an important opportunity to advance public health initiatives and reduce health disparities across subpopulations.

In September of 2009, the Centers for Disease Control and Prevention (CDC), National Center for Chronic Disease Prevention and Health Promotion, Division of Adult and Community Health, announced the opportunity to apply for Recovery Act funds to reduce risk factors, prevent and/or delay chronic disease, and promote wellness through an initiative entitled Communities Putting Prevention to Work (CPPW). The CPPW Recovery Act prevention initiative focuses on two categories of activities: Category A: Obesity prevention, physical activity and nutrition, and Category B: Tobacco prevention and control. Applicants can apply and propose activities in Category A or Category B or both. However, if applying for both categories, separate applications must be submitted for each category, as these are separate grant opportunities.

Approval for the Health Services Agency to Submit an Application for The American Recovery and Reinvestment Act of 2009 Centers for Disease Control's (CDC) Communities Putting Prevention to Work (CPPW) Grant to Decrease Overweight/Obesity Prevalence, Increase Levels of Physical Activity and Improve Nutrition, and to Designate Stanislaus County Office of Education to Serve as a Bona Fide Agent to Apply for the CDC's CPPW Grant to Decrease Tobacco Use and Exposure to Secondhand Smoke and if Awarded to Enter the Grant Agreements and fulfill the Grantee's Responsibilities  
Page 3

Through the CPPW grant initiatives, the CDC will support intensive community approaches to chronic disease prevention and control in selected communities (urban and rural), to achieve the following:

- Category A:
  - Increased levels of physical activity;
  - Improved nutrition (e.g. increased fruit/vegetable consumption, reduced salt and transfat;
  - Decreased overweight/obesity prevalence
- Category B:
  - Decreased smoking prevalence and decreased teen smoking initiation; and
  - Decreased exposure to secondhand smoke.

The CDC anticipates CPPW awardees will achieve long term goals such as:

### **Category A: Obesity/Physical Activity/Nutrition**

#### Adults

- Stabilize or begin to decrease (up to 2%) adult overweight/obesity prevalence, thus reversing long term trends.
- 20% increase in the percentage of adults getting adequate physical activity, meaning 20% more adults meeting Physical Activity Guidelines.
- 5% decrease in consumption of sugar-sweetened beverages, for adults, a decrease of about 5 gallons per person per year.

#### Youth

- Stabilize or begin to decrease (up to 2%) youth overweight/obesity prevalence (up to age 2-18), thus reversing long term trends.
- 35% increase in the percentage of high school students getting adequate physical activity (duration, frequency, intensity) meaning 35% more high school students meeting Physical Activity Guidelines.
- 5% decrease in consumption of sugar-sweetened beverages in high school students, a decrease of approximately 4 gallons per person per year.
- A 30% increase in average daily fruit and vegetable consumption among high school students, an increase of approximately 1 serving.

### **Category B: Tobacco**

#### Adults

- 10% decrease in adult smoking prevalence, preventing tobacco-related death in 1/3

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Page 4

of these populations.

- 40% decrease in the percentage of non-smokers exposed regularly to secondhand smoke.

#### Youth

- 25% decrease in youth smoking prevalence (up to age 18), preventing tobacco-related death in 1/3 of these youth.
- 30% decrease in the percentage of youth (ages 2-18) exposed regularly to secondhand smoke.

The Health Services Agency Public Health division has entered into collaborations with community partners to address Obesity and Nutrition related issues. The Category A CPPW grant would allow the Agency's Public Health division to enhance the capacity of staff and broaden existing collaborative efforts to address broad determinants of health that contribute to the current problematic health status, including the built environment, safety and education.

The focus of the grants is prevention and enhancement of the capacity within Public Health.

The grants involve outcome oriented scopes of work and rigorous federal reporting requirements. After consideration of local health trends, current interventions and both benefits and limitations of infrastructure, the Health Services Agency wishes to apply for Category A only. The grant specifications allow however for a Bona Fide Agent to apply for either grant opportunity. The Stanislaus County Office of Education (SCOE) expressed a strong desire to apply for the Category B – tobacco prevention opportunity. SCOE has been an on-going partner of the Health Services Agency to address tobacco related issues in schools, and has conveyed a willingness to serve as the Bona Fide Agent for this purpose. SCOE currently holds other federal grants and is aware of and reportedly capable to meet the rigorous requirements.

A bona fide agent is the official fiscal agent and would function on behalf of Stanislaus County's local health department. According to the grant information, a bona fide agent, in most instances is a foundation, or nonprofit organization, that serves as the legal agent for applying for federal grants for the state or local health agency. Other entities (i.e., Departments of Education, a nonprofit organization, a university) may be proposed as a bona fide agent, and the highest elected official must designate those agents and the agents must have an established capability to serve as fiduciary agents. Stanislaus County Health Services Agency's Public Health division would be required to serve as part of the

Approval for the Health Services Agency to Submit an Application for The American Recovery and Reinvestment Act of 2009 Centers for Disease Control's (CDC) Communities Putting Prevention to Work (CPPW) Grant to Decrease Overweight/Obesity Prevalence, Increase Levels of Physical Activity and Improve Nutrition, and to Designate Stanislaus County Office of Education to Serve as a Bona Fide Agent to Apply for the CDC's CPPW Grant to Decrease Tobacco Use and Exposure to Secondhand Smoke and if Awarded to Enter the Grant Agreements and fulfill the Grantee's Responsibilities  
Page 5

required leadership team if the intended SCOE Category B CPPW grant application is successful and SCOE serves as the "bona fide agent".

**POLICY ISSUES:**

The Board of Supervisors' approval of an application for and acceptance of one or two CPPW grant awards from the Centers for Disease Control will enable the Health Services Agency to continue to work with local partners to implement health-promoting policies and develop interventions aimed at reducing the harmful effects of obesity and chronic disease. This meets with the Board's priorities of *A healthy community* and *Effective partnerships*.

**STAFFING IMPACT:**

If awarded, additional staffing will be required in order to fulfill the grant agreement scope of work. The Health Services Agency would make the appropriate requests for related staffing.

November 2, 2009

Mary Ann Lee, Managing Director  
Stanislaus County Health Services Agency  
830 Scenic Drive  
Modesto, CA 95350

Dear Ms. Lee:

Thank you for the opportunity to collaborate with Stanislaus County and serve as a bona fide agent in applying for the Tobacco Control grant initiative under the American Recovery and Reinvestment Act of 2009, *Communities Putting Prevention to Work* (CPPW). The Stanislaus County Office of Education (SCOE) is excited to represent the county in applying for the grant and subsequently implementing a comprehensive community-based prevention and wellness program focusing on tobacco control.

We regularly collaborate with the region's leading health, social services, law enforcement and community organizations to identify and address not just pressing social needs but their root causes. This can be seen time and again through such initiatives as the Healthy Start Family Resource Centers and ongoing dropout-, gang- and drug-prevention programs. Our project management experience includes more than a decade of ongoing Prop 99 grant funding through the California Department of Education Tobacco Use Prevention and Education (TUPE) program as well as the leadership of a six-county region for both After School and School Safety initiatives. Our office is fully capable of writing and submitting the grant, and will be able to fill effectively and manage any additional staffing positions required for the project.

We would be pleased to serve as the grantee and fiscal agent of the CPPW initiative and will write and submit the grant application as part of that role. Following a successful application, we look forward to continuing to partner with Stanislaus County in the implementation of the grant-funded program. We are committed to working closely with your agency and other partners to ensure the project is meeting the needs of our county.

Please let us know if you have any questions or if there is any additional information that we can provide. Thank you again for the opportunity to represent Stanislaus County in this initiative. We look forward to hearing from you soon to begin the grant application process.

Sincerely,



Tom Changnon  
County Superintendent of Schools



Vicki Bauman  
Prevention Programs Director II



**BOARD OF SUPERVISORS**

**William O'Brien, 1<sup>st</sup> District**  
**Vito Chiesa, 2<sup>nd</sup> District**  
**Jeff Grover, 3<sup>rd</sup> District**  
**Dick Monteith, 4<sup>th</sup> District**  
**Jim DeMartini, 5<sup>th</sup> District**

1010 10th Street, Suite 6500, Modesto, CA 95354  
Phone: 209.525.4494 Fax: 209.525.4410

November 10, 2009

Tracey Sims, Grant Management Specialist  
Centers for Disease Control and Prevention  
2920 Brandywine Road  
MSE-09  
Atlanta, GA 30341

Re: Designation of Bona Fide Agent  
CPPW – Category B – Tobacco Prevention grant opportunity

In accordance with the Centers for Disease Control grant instructions, Stanislaus County hereby designates the Stanislaus County Office of Education (SCOE) as the Bona Fide Agent specifically to submit an application for the American Recovery and Reinvestment Act of 2009 Communities Putting Prevention to Work Category B grant to decrease tobacco use and exposure to secondhand smoke, and if awarded, to accept the funding and responsibility to perform the scope of work and to ensure that all grant requirements are appropriately achieved.

Stanislaus County's Health Services Agency and the Stanislaus County Office of Education have a proven record of collaboration on various public health initiatives. Supported by experience, SCOE has the infrastructure and capability to serve as the fiduciary agent.

If SCOE's grant application is successful, the Stanislaus County Health Services Agency which is the Local Health Department will provide participation on the Stanislaus County of Education's leadership team relative to the grant.

Respectfully submitted,

Jim DeMartini  
Chairman  
Stanislaus County Board of Supervisors

**LETTER OF AGREEMENT  
BETWEEN STANISLAUS COUNTY AND  
STANISLAUS COUNTY OFFICE OF EDUCATION**

This Letter of Agreement sets forth the understanding and agreement between the parties as relates the American Recovery and Reinvestment Act of 2009 Centers for Disease Control's Communities Putting Prevention to Work grant opportunity.

I. Background

- A. Pursuant to the grant instructions, funding is available on a competitive basis for two project areas. Category A is focused on Obesity prevention, nutrition and physical activity, while Category B is focused on Tobacco prevention and exposure reduction to secondhand smoke. Eligibility for these grant opportunities in our County is limited to the Local Health Department with one noted exception. The grant instructions allow for the designation of a Bona Fide Agent to apply for one or both of the grant opportunities.
- B. Stanislaus County Health Services Agency's Public Health division (HSA - the Local Health Department) is committed to making application for the Category A – Obesity Prevention, Improving Nutrition and Physical Activity grant opportunity.
- C. Stanislaus County Office of Education (SCOE) has conveyed interest in applying for the Category B – Tobacco Prevention and Exposure Reduction to Secondhand Smoke grant opportunity as the Bona Fide Agent of the Local Health Department. Additionally SCOE has reported the existence of infrastructure, experience, expertise and flexibility to properly fulfill the expectations as a fiduciary agent. See Attachment A.

II. Terms of Agreement

- A. Stanislaus County designates SCOE as the Bona Fide Agent specific to the American Recovery and Reinvestment Act of 2009 Centers for Disease Control's Communities Putting Prevention to Work – Category B Tobacco Prevention and Exposure Reduction to Secondhand Smoke grant opportunity.
- B. SCOE accepts the designation as the Bona Fide Agent as set forth above, and further accepts the responsibilities of the grant application, and if awarded, accepts the responsibilities as the fiduciary agent including the scope of work activities and federal reporting requirements, and any liabilities resulting from audit or disallowances by the grantor.

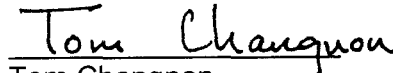


- C. Stanislaus County agrees to provide the required participation by the Local Health Department on SCOE's grant leadership team as required in the CDC grant.
- D. SCOE will provide periodic reporting to the HSA in support of a reasonable oversight process.

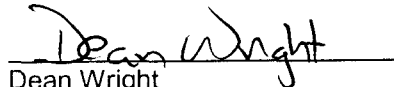
ACKNOWLEDGED AND AGREED  
For Stanislaus County

For Stanislaus County Office of Education

  
Jim DeMartini  
Chairman  
Stanislaus County Board of Supervisors

  
Tom Changnon  
County Superintendent  
of Schools

Approved as to Form  
County Counsel

  
Dean Wright  
Deputy County Counsel



**HEALTH SERVICES AGENCY**

**Public Health Services**  
820 Scenic Drive, Modesto, CA 95350-6194

**John A. Walker, M.D.**  
Public Health Officer

Phone: 209.558.8804 Fax: 209.558.7286  
[www.hsahealth.org](http://www.hsahealth.org)

October 30, 2009

To: Centers for Disease Control and Prevention Procurement and Grants Office

Subject: **Letter of Intent (LOI)**

Stanislaus County Health Services Agency, which is the Local Health Jurisdiction for Stanislaus County, intends to submit a request for funding for the American Recovery and Reinvestment Act of 2009, Communities Putting Prevention to Work. Funding Opportunity Number: CDC-RFA-DP09-912ARRA09, and Catalog of Federal Domestic Assistance Number: 93.724.

Stanislaus County is located in the central valley of California, with a population of about 525,000, hence considered as an Urban Area. Stanislaus County Health Services Agency will be the lead/fiduciary agency for this grant funding. The Agency intends to apply for risk factor area Category A – Obesity prevention, physical activity and nutrition.

In addition, the Health Services Agency intends to apply for Category B – Tobacco prevention and control, either directly, or via its designated bona fide agent.

The official contact person for both category A and B is as follows:

Cleopathia Moore-Bell, Director of Public Health Services

Stanislaus County Health Services Agency

P.O. Box 3271

Modesto, CA 95353

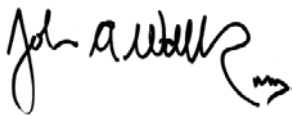
Telephone: (209) 558-6010

Fax: (209) 558-8320

E mail: [cmoore@schsa.org](mailto:cmoore@schsa.org)

We look forward to submitting our grant applications. Thank you for your attention.

Sincerely,

A handwritten signature in black ink, appearing to read "John A. Walker" with a stylized flourish at the end.

John A. Walker, MD

Stanislaus County Public Health Officer

1 The following amendments have been incorporated into FOA CDC-RFA-DP09-912ARRA09 – American  
2 Recovery and Reinvestment Act of 2009 – Communities Putting Prevention to Work:

- 3  
4 1. Under pre-application support, the time zone for each of the pre-application calls – **Eastern Daylight**  
5 **Time** – is now included.
- 6  
7 2. The MAPPS Strategy Tables under Section I. and Attachment C., have an added phrase, “consistent  
8 with federal law,” to the media and advertising restrictions in both nutrition and tobacco categories.
- 9  
10 3. Under Section III.1. Eligible Applicants, the language has been slightly edited to clarify the eligible  
11 applicants.
- 12  
13 4. Under Section III. Eligibility Information, the following has been added to section III.3 Other to  
14 clarify the allowable number of applications per state health department: **“Only one application can**  
15 **be submitted per state for Category A and only one application per state for Category B, for a**  
16 **maximum of two applications per state if applying for Category A and Category B. Within**  
17 **each state application, states may only submit up to 2 communities to fund: i.e. a combination**  
18 **of one small city and one rural community; two small cities; or two rural communities. State**  
19 **health departments that have not identified a maximum of 2 communities per application will**  
20 **be considered non-responsive and not entered into the review process.”**
- 21  
22 5. Under Section III.3 Other, the following has been changed to more accurately describe the Letter of  
23 Intent: **“Applicants**~~You~~ **are required to submit a Letter of Intent (LOI) to be eligible to apply for this**  
24 **program. Failure to submit a LOI will result in non-responsiveness and the applicant will be**  
25 **prohibited from applying.”** See Sections IV.2, IV.3, and IV.6 of this announcement for more  
26 information on LOI submission. The LOI must identify the type of applicant, ~~the size of the~~  
27 **jurisdiction**, and the risk factor area to be addressed. If an applicant wishes to apply for both tobacco  
28 and obesity/ physical activity/ nutrition funding, one LOI can be submitted to indicate that intention.”
- 29  
30 6. Under Section III. Eligibility Information, Special Requirements, the following sentence has been  
31 deleted: “CDC reserves the flexibility to redirect funding from poor performing grants to those  
32 performing in the green benchmark level” and has been replaced with the following sentence: **“In**  
33 **accordance with applicable laws and regulations including 45 CFR 92.43, CDC may take**  
34 **certain enforcement actions, including termination of funding, against poor performing**  
35 **grants.”**
- 36  
37 7. Under Section III. Eligibility Information, Special Requirements, the paragraph describing quarterly  
38 benchmarks has been moved to section VI.3. Reporting Requirements, Recovery Act-Specific  
39 Reporting Requirements, item 2: Quarterly Benchmarks.
- 40  
41 8. Under Section III. Eligibility Information, Special Requirements, the following change has been  
42 made: “If the application is non-responsive ~~incomplete or non-responsive to the special~~  
43 **requirements listed in this section**, it will not be entered into the review process.”
- 44  
45 9. Under Section IV.6. Other Submission Requirements, the following sentence has been moved under  
46 IV. 3. Submission Dates and Times: “HHS/CDC strongly recommends that submittal of the  
47 application to Grants.gov should be prior to the closing date to resolve any unanticipated difficulties  
48 prior to the deadline.”
- 49  
50 10. Under Section V.1. Criteria, A. Program Infrastructure and Fiscal Management, separate scoring for  
51 State applications has been included and highlighted.

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11. Under Section V.1. Criteria, B. Leadership team and community coalitions, vii. sub-points have been increased from 2 to 3.
12. Under Section VI.3. Reporting Requirements, Recovery Act-Specific reporting Requirements, the following dates have been added: “Not later than 10 days after the end of each calendar quarter, starting with the quarter ending **March 30, 2010** and reporting by **April 10, 2010**, the recipient must submit quarterly reports to HHS that will posted to Recovery.gov, containing the following information:”
13. In Attachment B, the first sentence has been revised as follows: “*Applicants showing collaboration across these and similar programs will receive ~~extra~~ points in the application review.*”
14. In Attachment C, Reference #77 has been changed from “COCOMO” to the following: **Centers for Disease Control and Prevention. Recommended Community Strategies and Measurements to Prevent Obesity in the United States. MMWR 2009; 58(No. RR-07): 1-26.**

103 U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES  
104 Centers for Disease Control and Prevention (CDC)  
105 American Recovery and Reinvestment Act of 2009  
106 *Communities Putting Prevention to Work*  
107  
108 Announcement Type: Cooperative Agreement  
109 Funding Opportunity Number: CDC-RFA-DP09-912ARRA09  
110 Catalog of Federal Domestic Assistance Number: 93.724  
111 Key Dates:  
112 Letter of Intent Deadline: October 30, 2009  
113 Application Deadline: December 1, 2009  
114  
115 **Pre-Application Support:**  
116 Pre-Application Conference Calls:  
117 Funding Opportunity Announcement (FOA) information will be available for potential  
118 applicants on three separate conference calls, conducted by the Centers for Disease Control and  
119 Prevention (CDC), as follows:  
120 • The first call will be for potential applicants (see section III) that are in Mountain or  
121 Pacific Time zones, and will be held on Wednesday, September 30 from 3:00 – 4:30  
122 Eastern Daylight Time (EDT). The conference call can be accessed by calling 1-888-  
123 390-0788. The leader for this call is Amy Bell and the pass code is 3746637. The pass  
124 code and leader’s name is required to join the call.

- 125       • The second call will be for potential applicants (see section III) that are in Atlantic,  
126       Eastern, or Central time zones, and will be held on Thursday, October 1 from 11:00 –  
127       12:30 EDT. The conference call can be accessed by calling 1-888-390-0788. The leader  
128       for this call is Amy Bell and the pass code is 3746637. The pass code and leader’s name  
129       is required to join the call.
- 130       • A third call will be held particularly for tribal and territorial organizations on Thursday,  
131       October 1 from 3:00 – 4:30 EDT. The conference call can be accessed by calling 1-888-  
132       390-0788. The leader for this call is Amy Bell and the pass code is 3746637. The pass  
133       code and leader’s name is required to join the call.

134

135   The purpose of the conference calls is to 1) help potential applicants understand the scope and  
136   intent of the FOA for the *Communities Putting Prevention to Work* Initiative and 2) become  
137   familiar with the Public Health Services funding policies and application and review procedures.

138

139   Participation in a conference call is voluntary. Potential applicants are requested to call in using  
140   only one telephone line. If during the call you need technical assistance, press \*0 to speak to an  
141   operator. Please note restrictions may exist when accessing free phone/toll free numbers using a  
142   mobile telephone. Since this is a competitive selection process, applicants should follow the  
143   requirements as they are laid out in the FOA and any related amendments. Should applicants  
144   find they have questions or need clarification prior to this call, please see section VII Agency  
145   Contacts.

146

147 Other Pre-application support:

- 148 • A dedicated mailbox for inquiries: CPPW@cdc.gov
- 149 • A series of expert-led webinars, each offered live and then available by web archive  
150 covering the following topics: Obesity/ Physical activity/ Nutrition Policy, Tobacco  
151 Policy, and Evidence-based Policy Intervention. The scheduled dates and times for these  
152 webinars is located on CDC’s Community Health Web Portal at  
153 [www.cdc.gov/CommunityHealthResources](http://www.cdc.gov/CommunityHealthResources)
- 154 • A single source for community tools for application development via CDC’s Community  
155 Health Web Portal [www.cdc.gov/CommunityHealthResources](http://www.cdc.gov/CommunityHealthResources)
- 156 • Engagement of foundations with expertise in community-based tobacco and obesity/  
157 physical activity/ nutrition programming in advising on pre-application work and  
158 encouraging them to support high quality community applications.

159

160 **I. Funding Opportunity Description**

161 Authority: This program is authorized under section 311 and 317(k)(2) of the Public Health  
162 Service Act, 42 U.S. Code 243 and 247b(k)2.

163

164 **Executive Summary:** The American Recovery and Reinvestment Act of 2009 (Recovery Act),  
165 signed into law February 17, 2009, is designed to stimulate economic recovery in various ways,  
166 including preserving and creating jobs and promoting economic recovery, assisting those most  
167 impacted by the recession, stabilizing State and local government budgets in order to minimize  
168 and avoid reductions in essential services and counterproductive state and local tax increases,  
169 and strengthening the Nation’s healthcare infrastructure and reducing healthcare costs through



170 prevention activities. The Recovery Act includes \$650 million for evidence-based clinical and  
171 community-based prevention and wellness strategies that support specific, measurable health  
172 outcomes to reduce chronic disease rates. The legislation provides an important opportunity for  
173 states, cities, rural areas, and tribes to advance public health across the lifespan and to reduce  
174 health disparities. The CDC will support intensive community approaches to chronic disease  
175 prevention and control in selected communities (urban and rural), to achieve the following  
176 prevention outcomes:

- 177 • Increased levels of physical activity;
- 178 • Improved nutrition (e.g. increased fruit/vegetable consumption, reduced salt and  
179 trans fats);
- 180 • Decreased overweight/obesity prevalence
- 181 • Decreased smoking prevalence and decreased teen smoking initiation; and
- 182 • Decreased exposure to secondhand smoke.

183

184 The Centers for Disease Control and Prevention (CDC), National Center for Chronic Disease  
185 Prevention and Health Promotion (NCCDPHP), Division of Adult and Community Health  
186 (DACH), announces the opportunity to apply for Recovery Act funds to reduce risk factors,  
187 prevent and/or delay chronic disease, and promote wellness. This initiative, entitled  
188 *Communities Putting Prevention to Work (CPPW)*, will address obesity, physical inactivity, poor  
189 nutrition and tobacco use/exposure with the anticipated long term goals of:

190

191 **OBESITY, PHYSICAL ACTIVITY, AND NUTRITION**

192 Measures for communities addressing physical activity and nutrition:

193 **Adults**

- 194 • Stabilize or begin to decrease (up to 2%) adult overweight/obesity prevalence, thus reversing  
195 long term trends.
- 196 • 20% increase in the percentage of adults getting adequate physical activity, meaning 20%  
197 more adults meeting Physical Activity Guidelines.
- 198 • 5% decrease in consumption of sugar-sweetened beverages, for adults, a decrease of about 5  
199 gallons per person per year.
- 200 • A 20% increase in average daily fruit and vegetable consumption, an increase of  
201 approximately 1 serving.
- 202 • 15% increase in the percentage of adults with a heart-healthy diet based USDA’s Healthy  
203 Eating Index (HEI), meaning 15% more adults with diet including adequate fruits and  
204 vegetables and reduced intake of fats
- 205 • 6% decrease in the percentage of adults getting excess calories based on USDA’s Healthy  
206 Eating Index (HEI).

207

208 **Youth**

- 209 • Stabilize or begin to decrease (up to 2%) youth overweight/obesity prevalence (up to age 2-  
210 18), thus reversing long term trends.
- 211 • 35% increase in the percentage of high school students getting adequate physical activity  
212 (duration, frequency, intensity) meaning 35% more high school students meeting Physical  
213 Activity Guidelines.
- 214 • 5% decrease in consumption of sugar-sweetened beverages in high school students, a  
215 decrease of approximately 4 gallons per person per year.

- 216 • A 30% increase in average daily fruit and vegetable consumption among high school  
217 students, an increase of approximately 1 serving.
- 218 • 15% increase in the percentage of youth (ages 2-18) with a heart-healthy diet based on the  
219 USDA’s Healthy Eating Index (HEI), meaning 15% more youth with diets including  
220 adequate fruits and vegetables and reduced intake of fats.
- 221 • 6% decrease in the percentage of youth (ages 2-18) getting excess calories based on USDA’s  
222 Healthy Eating Index (HEI).

223

224 **TOBACCO**

225 Measures for communities addressing tobacco:

226 ***Adults***

- 227 • 10% decrease in adult smoking prevalence, preventing tobacco-related death in 1/3 of these  
228 adults.
- 229 • 40% decrease in the percentage of non-smokers exposed regularly to secondhand smoke.

230

231 ***Youth***

- 232 • 25% decrease in youth smoking prevalence (up to age 18), preventing tobacco-related death  
233 in 1/3 of these youth.
- 234 • 30% decrease in the percentage of youth (ages 2-18) exposed regularly to secondhand smoke.

235

236 This effort aims to address the needs of the diverse demographics of the United States by  
237 identifying four well-established population areas: large cities, urban areas, tribal communities,  
238 and state-coordinated small cities and rural areas. The focal points for the implementation of

239 plans for this effort are state health departments, local health departments, and tribes (see section  
240 III. 1. “Eligible Applicants” for specific requirements), which possess the infrastructure to  
241 rapidly deploy programs and interventions to their citizens. Funding will provide support to  
242 address the risk factors within the defined demographic areas set out below.

- 243 • **Large cities:** For this announcement, the term “large city” is defined as a local health  
244 department that serves a jurisdiction with a population of more than 1 million people.
- 245 • **Urban areas:** For this announcement, the term “urban area” is defined as a local health  
246 department that serves a jurisdiction with a population more than 500,000 and up to 1  
247 million people.
- 248 • **Tribal communities:** For this announcement, “tribal communities” is defined as  
249 Federally recognized Tribal Governments, Regional Area Indian Health Boards, Urban  
250 Indian organizations, and Inter-Tribal Councils.
- 251 • **State-coordinated small cities and rural areas:** State health departments will  
252 coordinate the small city and rural area applications. For this announcement, the term  
253 “small city” is defined as a local health department that serves a jurisdiction with a  
254 population between 50,000 – 500,000 people and the term “rural area” is defined as a  
255 local health department that serves a jurisdiction with a population of 50,000 people and  
256 below.

257

258 This FOA focuses on two categories of activities: Category A: Obesity prevention, physical  
259 activity and nutrition and Category B: Tobacco prevention and control. Applicants will be asked  
260 to propose activities in Category A or Category B or both. If applying for both categories, a  
261 separate application must be submitted for each category.

262 In order to address the selected risk factors, awardees will implement population-based  
263 approaches such as policy, systems, and environmental changes across 5 evidence-based MAPPS  
264 strategies –**Media, Access, Point of decision information, Price and, Social support services** – in  
265 both communities and schools such that the entire jurisdiction of the health department or tribal  
266 area is impacted. Reach across both components (community and school) is necessary to  
267 achieve behavior change in youth and to sustain healthy behavior into adulthood. Awardees will  
268 work from a prescribed menu of MAPPS strategies and interventions (referenced in recipient  
269 activities) and will be required to implement specific high priority interventions, including  
270 implementing comprehensive smoke free air policies, using evidence-based pricing strategies  
271 that discourage tobacco use, and/or limiting availability of unhealthy food and beverages.  
272 Awardees may also propose evidence-based interventions not listed within the prescribed  
273 MAPPS menu, but must provide a strong justification of how the proposed intervention will have  
274 sufficient reach and potential impact consistent with the short and long-term goals of the  
275 initiative. The Centers for Disease Control and Prevention (CDC) will provide community  
276 programmatic support and tools to strengthen and develop effective strategies tailored to  
277 community needs.

278

279 States that propose coordinating community awards will be responsible for the following  
280 activities:

- 281 • Identifying in their application up to two pre-selected communities (a combination of one  
282 small city and one rural community; two small cities; or two rural communities) that will  
283 be expected, with state assistance, to conduct the same activities and for achieving the  
284 same performance measure identified below in either Category A or Category B. Each

285 community must have an established coalition and will be monitored for progress toward  
286 benchmarks, performance measures, and outcomes.

- 287 • Establishing and coordinating a State-Community Management Team, including  
288 participation from the funded communities and key state-level public health officials.
- 289 • Providing or facilitating the provision of programmatic support and consultation to their  
290 funded communities in risk factor surveillance; program evaluation; sustainability;  
291 evidence-based and practice-based policies, systems, and environmental changes  
292 (including the built environment where applicable); community engagement, and  
293 intervention selection and development.
- 294 • Ensuring that at least 75% of the total award is distributed to the identified communities  
295 in the state-coordinated application.

296

297 Monitoring and evaluation of the Recovery Act-funded efforts in communities will focus on the  
298 implementation of community-wide policy, systems, and environmental changes. These are the  
299 expected changes during the funding period, and are also demonstrated to be major drivers of the  
300 more downstream changes in risk behaviors and risk factors. Awardees are also expected to  
301 participate in national evaluation activities, including tracking relevant behavioral outcomes  
302 using BRFSS and YRBSS, participating in modeling studies, and examining cost and context  
303 within which community change occurs. Applicants will be asked to participate in monitoring  
304 and evaluation efforts within funded communities, including pre and post measurement.

305 This may include the collection of biometric measurements especially among applicants  
306 who already have such measurement systems in place. Applicants may also wish to include  
307 plans to improve the quality of these efforts.

308 The intent of this announcement is to fund highly qualified applications from applicants with the  
309 following experience and support in place: active coalitions and demonstrated experience  
310 working with community leaders to implement policy, systems, and environmental change  
311 strategies; demonstrated support from the mayor, county executive, tribal leader, or other  
312 equivalent governmental official for this initiative; demonstrated support from all public school  
313 districts within the intervention area for the collection of Youth Risk Behavior Surveillance  
314 System (YRBSS) data among a representative sample of 9<sup>th</sup>-12<sup>th</sup> grade students for baseline  
315 during fall 2010 and follow-up at the end of the project period using standard YRBSS protocol;  
316 and demonstrated ability to meet reporting requirements such as programmatic, financial, and  
317 management benchmarks as required by the Recovery Act in section VI.3. Reporting  
318 Requirements under “Recovery Act-Specific Reporting Requirements.”

319  
320 Awardees will be responsible for coordinating with CDC on national-level activities outlined  
321 under “CDC Activities.” Awards will vary with size of jurisdiction, the proposed activities, and  
322 the needs of each community. Approximately 30-40 awards will be made for the CPPW  
323 Initiative, but the number of awards will depend on the preceding factors and may be outside of  
324 this approximate range of number of awards and amount of funding per award. Awardees will  
325 be funded with awards beginning on or about February 26, 2010 for a 24-month budget period.

326  
327 Following the award of funds, up to \$10 million will be made available for a limited set of  
328 awardees to provide peer-to-peer mentorship to other funded communities (more information can  
329 be found in Category A, item 9 and Category B, item 9 under Recipient activities). These funds  
330 will be awarded as a competitive supplement.

331 **Background:** In the United States today, seven of ten deaths and the vast majority of serious  
332 illness, disability, and health care costs are caused by chronic diseases, such as obesity, diabetes  
333 and cardiovascular disease. Key risk factors—lack of physical activity, poor nutrition and tobacco  
334 use—are major contributors to the nation’s leading causes of death. More than 75% of health care  
335 expenditures in the United States are spent to meet the health needs of persons with chronic  
336 conditions ([www.cdc.gov/nccdphp/overview.htm](http://www.cdc.gov/nccdphp/overview.htm)). Many Americans die prematurely and suffer  
337 from diseases that could be prevented or more effectively managed.

338

339 Understanding patterns of health or disease requires a focus not only on personal behaviors and  
340 biologic traits, but also on characteristics of the social and physical environments that offer or  
341 limit opportunities for positive health outcomes. These characteristics of communities – social,  
342 physical, and economic – are a major influence on the public’s health and have both short- and  
343 long-term consequences for health and quality of life. Research has shown that implementing  
344 policy, systems, and environmental changes, such as improving physical education in schools,  
345 improving safe options for active transportation, providing access to nutritious foods, and other  
346 broad-based policy change strategies, can result in positive behavior changes related to physical  
347 activity, nutrition, and tobacco use, which positively impact multiple chronic disease outcomes.

348

349 The key to the success of this initiative, *Communities Putting Prevention to Work*, will be to  
350 implement community-wide policies, systems, and environmental changes that reach across all  
351 levels of the socio-ecological model and include the full engagement of the leadership in city  
352 government, boards of health, schools, businesses, community and faith-based organizations,  
353 community developers, transportation and land use planners, parks and recreation officials,



354 health care purchasers, health plans, health care providers, academic institutions, foundations,  
355 other Recovery Act-funded community activities, and many other community sectors working  
356 together to promote health and prevent chronic diseases. Funded programs need to build on, but  
357 not duplicate current Federal programs as well as state, local, or community programs and  
358 coordinate fully with existing programs and resources in the community.

359

360 **Purpose:** The purpose of this FOA is to create healthier communities through sustainable,  
361 proven, population-based approaches such as broad-based policy, systems, organizational and  
362 environmental changes in communities and schools. Awardees funded under this FOA will work  
363 collaboratively to promote and sustain policy change efforts in communities and schools. It is  
364 recommended that awardees include a strong focus on the needs of populations who suffer  
365 disproportionately from the burden of disease.

366

367 Proposals should focus on implementing broad-based policy changes that are chosen from the  
368 prescribed set of evidence-based interventions. Each community will address all 5 evidence-  
369 based MAPPS strategies (**M**edia, **A**ccess, **P**oint of decision information, **P**rice and, **S**ocial  
370 support services) for each application: tobacco and/or obesity/physical activity/nutrition.

371

372 This FOA addresses the “Healthy People 2010” focus areas of nutrition and overweight, physical  
373 activity, environmental health: healthy homes and communities, and tobacco use.

374

375 This announcement is only for non-research activities supported by CDC. If research is  
376 proposed, the application will not be reviewed. For the definition of research, please see the

377 CDC Web site at the following Internet address:

378 <http://www.cdc.gov/od/science/regs/hrpp/researchDefinition.htm>

379

380 **Recipient Activities**

381

382 Applicant activities for this program are as follows:

383

384 Activities will be awarded for two categories:

385

386 **Category A:** Applicants addressing obesity, physical activity, and nutrition.

387 **Category B:** Applicants addressing tobacco prevention and control.

388

389 Applicants can propose activities in Category A or Category B or both. If applying for both

390 categories, a separate application must be submitted for each category. Should an applicant

391 compete successfully in both categories to receive two awards, CDC will conduct budget

392 negotiations with the applicant to merge the staffing plans and reduce the requested budgets

393 accordingly in order to reflect a combined operating structure.

394

395 For state-coordinated small city and rural areas, the State Health Department is responsible for

396 ensuring that the state application contains the community applications and that they fulfill the

397 requirements highlighted in this FOA. State Health Departments will identify in their application

398 up to two pre-selected communities (a combination of one small city and one rural community;

399 two small cities; or two rural communities) that will be expected, with state assistance, to

400 conduct the same activities and for achieving the same performance measure identified below in

401 either Category A or Category B. If applying for both categories, a separate application must be  
402 submitted for each category.

403

404 **Category A. Applicants addressing obesity, physical activity, and nutrition**

405 1) Program infrastructure, staffing, program management and support.

- 406 • Establish and maintain required paid project or contract staff sufficient in number and  
407 expertise to ensure project success on the following timeline:
  - 408 ○ 30 days post-award, establish and/or retain the minimum staffing requirements to  
409 include a representative of the leadership of the health department, such as a  
410 Program Director; a full-time staff person or equivalent responsible for managing  
411 the planning, implementation, and evaluation of the program, with management  
412 experience in physical activity and/or nutrition; and the identification of  
413 individuals with demonstrated capacity in media planning, administrative, and  
414 fiscal management support necessary to meet the needs of the program.
  - 415 ○ 90 days post-award, establish and/or retain the required additional staff,  
416 contractors, or collaborations to include leadership and expertise within the  
417 education agency for school health, and leadership and expertise for  
418 fiscal/accountability, community outreach and coordination, injury and crime  
419 reduction, built environment, evaluation, and YRBSS coordination (responsible  
420 for conducting a YRBSS in the intervention area). The awardee should ensure that  
421 this complement of staff and contract support is sufficient to meet the  
422 requirements of this FOA.

- 423 • Over the course of the project period, establish and maintain other part-time or full-  
424 time staff, contactors, and consultants sufficient in number and expertise to ensure  
425 project success and have demonstrated skills and experience in coalition and  
426 partnership development, community mobilization, health care systems, public health,  
427 program evaluation, epidemiology, data management, health promotion, policy and  
428 environmental interventions, built environment (e.g. urban and regional planning,  
429 transportation, parks, community development), health care quality improvement,  
430 communications, resource development, school health, and the policies related to  
431 physical activity/nutrition targeted by the FOA.
- 432 • For state-coordinated small city and rural areas, State Health Departments must  
433 establish and coordinate a State-Community Management Team, including  
434 participation from the funded communities; the state health department's  
435 collaborative FOA designated healthy communities coordinator; the state education  
436 agency, the state planning agency, the state obesity or physical activity/nutrition  
437 coordinator, and the Office of Rural Health (where appropriate).
- 438 • Recovery Act funding should be considered one-time funding. Ensure that a  
439 sustainability plan is in place that leverages all resources available, including federal,  
440 state, and local sources, taking into account staffing levels and contractor  
441 commitments that support the CPPW Initiative.

442 Performance will be measured by evidence that the program is appropriately staffed to  
443 administer, manage, and evaluate the program as evidenced by the submission of  
444 staff/contractor name, date of hire and/or projected date of hire or staff to be retained due  
445 to Recovery Act funds and by the submission of resumés and/or curriculum vitae for key

446 personnel and position descriptions for other positions supported by funds under this  
447 cooperative agreement. In addition, performance will be measured by the state health  
448 department's ability, with assistance from the funded communities, to develop a State-  
449 Community Management Team. Performance related to sustainability will be measured  
450 by outreach to resources, including leveraging other Federal Government recovery funds  
451 to meet the above mentioned skill set (See Attachment B), and the number of  
452 commitments achieved by the end of the program.

453

454 2) Fiscal management.

- 455 • Provide funding to local entities and organizations that will: support the goals of the  
456 initiative and the selected interventions, focus on population-based strategies, are  
457 evidence-based and policy-focused, and will reach diverse groups.
- 458 • Utilize fiscal management procedures for this funding to track and monitor  
459 expenditures separate from other federal funding streams.
- 460 • Implement reporting systems to meet the online reporting criteria and timelines as  
461 stated for the Recovery Act required reporting located in section VI.3. Reporting  
462 Requirements under "Recovery Act-Specific Reporting Requirements" of this FOA.
- 463 • Recovery Act funding to existing or new awardees should be considered one-time  
464 funding. Ensure that a sustainability plan is in place that leverages all resources  
465 available, including federal, state, and local sources, taking into account funding  
466 commitments that support the CPPW Initiative.

467 Performance will be measured by evidence that the awardee will provide funding to local  
468 agencies and partner organizations committed to the goals of the initiative and the

469 selected interventions; has established procedures to track and report expenditures  
470 separate from other federal funding; and is able to prepare required reports submitted on  
471 the designated schedule.

472

473 3) Leadership team and community coalition.

474 • 60 days post award, develop a Leadership Team consisting of 8-10 high-level  
475 community leaders (e.g. the mayor, tribal leaders, city and county officials, school  
476 superintendents, local business association or corporation leaders, hospital and health  
477 systems directors, boards of health) or other leaders of influence in the community.

478 The Leadership Team should also include the Program Director and the overall  
479 manager of the program. The Leadership Team will: oversee the strategic direction of  
480 the project activities, be responsible for enacting policies related to the evidence-  
481 based MAPPS strategies recommended in item 4 of this section, establish and  
482 maintain an organizational structure and governance for the community coalition or  
483 coalitions, and participate in project-related local and national meetings.

484 • 90 days post-award, revise or add to the existing community coalition (or coalitions)  
485 committed to participating actively in the planning, implementation, and evaluation of  
486 the *Communities Putting Prevention to Work Initiative*. Partners should include a  
487 wide representation of community leaders and community members familiar with  
488 promoting physical activity and nutrition. Examples could include representatives  
489 from education agencies (local education agencies, school districts, school board  
490 members, or parent teacher organizations); school health advocates, community  
491 development/planning agencies (land use and/or transportation); key community-

492 based governmental and non-governmental organizations, health care, voluntary, and  
493 professional organizations; business, community, faith-based leaders; local Aging  
494 centers and senior centers; universities; and at least one lay person representative of  
495 the population to be served. Linkages with mental health/substance abuse  
496 organizations, health plans, foundations, and other community partners working  
497 together to promote health and prevent chronic diseases are encouraged. The  
498 community coalition will advise the Leadership Team on the planning,  
499 implementation, and evaluation of the CPPW Initiative.

500 • Encourage linkages with other community-based efforts and the Office of the  
501 Regional Health Administrator, with special attention to leveraging other Federally  
502 funded (including Recovery Act funded) and foundation activities. Applicants will  
503 also be asked to demonstrate through letters of support that they have political  
504 support and connections with other community development and livability efforts,  
505 and that they build on and leverage existing place-based revitalization and reform  
506 projects funded by the US Government. These could include efforts funded by the  
507 US Department of Health and Human Services (HHS), and programs supported by  
508 other agencies such as the US Department of Housing and Urban Development, the  
509 Environmental Protection Agency, the US Park Service, US Department of  
510 Transportation, US Department of Agriculture, the Corporation for National and  
511 Community Service, and the US Department of Education. Applicants are also  
512 encouraged to coordinate with other US Government-funded Recovery Act efforts in  
513 multiple sectors, such as transportation, education, health care delivery, agriculture

514 and others, as well as coordinating with HHS Regional Offices. See Attachment B for  
515 examples.

516 Performance will be measured by the level of partner engagement throughout the project  
517 period including the involvement of key community-based and public health partners  
518 comprising an alliance of partnerships and coalitions committed to participating actively  
519 in planning, implementation, and evaluation of CPPW. This will include evidence of  
520 regularly scheduled meetings, membership lists, attendance rates, participation, and  
521 meeting minutes.

522

523 4) Intervention area and selection of interventions.

- 524 • Ensure that the intervention area encompasses the entire jurisdiction of the health  
525 department so that the focus of policies, systems, and environmental changes will  
526 have the broadest impact possible. The mix of interventions, taken together, must  
527 address physical activity and nutrition with sufficient reach and potential impact.
- 528 • Choose a mix of interventions that addresses obesity/nutrition/physical activity for all  
529 five evidence-based MAPPS strategies in communities and schools. Awardees are not  
530 required to select strategies in each MAPPS area for *both* physical activity and  
531 nutrition (i.e.10 strategies). Rather, the mix of MAPPS interventions, taken together,  
532 must address obesity and related risk factors consistent with the long term goals of the  
533 initiative, and therefore must include robust interventions in both nutrition and  
534 physical activity.
- 535 • The evidence-based interventions below are drawn from the peer-reviewed literature  
536 as well as expert syntheses from the community guide and other peer-reviewed



537 sources (for a complete list of citations, please see Attachment C). Communities and  
 538 states have found these interventions to be successful in practice. Awardees are  
 539 expected to use this list of evidence-based strategies to design a comprehensive and  
 540 robust set of strategies to produce the desired outcomes for the initiative. Other  
 541 evidence-based strategies may be proposed but must be documented as to their  
 542 evidence base, their likely addition to the overall outcomes, and the rationale for the  
 543 choice of intervention (e.g., identified need or opportunity).

544 **MAPPS Table**

|   | <b>Nutrition</b>   | <b>Physical Activity</b>  |
|---|--|---|
| <b>Media</b>                            | <ul style="list-style-type: none"> <li>• Media and advertising restrictions consistent with federal law</li> <li>• Promote healthy food/drink choices</li> <li>• Counter-advertising for unhealthy choices</li> </ul>  | <ul style="list-style-type: none"> <li>• Promote increased activity</li> <li>• Promote use of public transit</li> <li>• Promote active transportation (bicycling and walking)</li> <li>• Counter-advertising for screen time</li> </ul>   |
| <b>Access</b>                           | <ul style="list-style-type: none"> <li>• Healthy food/drink availability (e.g., incentives to food retailers to locate/offer healthier choices in underserved areas, healthier choices in child care, schools, worksites)</li> <li>• Limit unhealthy food/drink availability (whole milk, sugar sweetened beverages, high-fat snacks)</li> <li>• Reduce density of fast food establishments</li> <li>• Eliminate transfat through purchasing actions, labeling initiatives, restaurant standards</li> <li>• Reduce sodium through purchasing actions, labeling initiatives, restaurant standards</li> <li>• Procurement policies and practices</li> <li>• Farm to institution, including schools, worksites, hospitals and other community institutions</li> </ul> | <ul style="list-style-type: none"> <li>• Safe, attractive accessible places for activity (e.g. access to outdoor recreation facilities, enhance bicycling and walking infrastructure, place schools within residential areas, increase access to and coverage area of public transportation, mixed use development, reduce community designs that leads to injuries).</li> <li>• City planning, zoning and transportation (e.g., planning to include the provision of sidewalks, mixed use, parks with adequate crime prevention measures, and Health Impact Assessments)</li> <li>• Require daily quality PE in schools</li> <li>• Require daily physical activity in afterschool/childcare settings</li> <li>• Restrict screen time (afterschool, daycare)</li> </ul> |
| <b>Point of Purchase/<br/>Promotion</b> | <ul style="list-style-type: none"> <li>• Signage for healthy vs. less healthy items</li> <li>• Product placement &amp; attractiveness</li> <li>• Menu labeling</li> </ul>  | <ul style="list-style-type: none"> <li>• Signage for neighborhood destinations in walkable/mixed-use areas</li> <li>• Signage for public transportation, bike lanes/boulevards.</li> </ul>  |
| <b>Price</b>                            | <ul style="list-style-type: none"> <li>• Changing relative prices of healthy vs. unhealthy items (e.g. through bulk purchase/procurement/competitive pricing).</li> </ul>  | <ul style="list-style-type: none"> <li>• Reduced price for park/facility use</li> <li>• Incentives for active transit</li> <li>• Subsidized memberships to recreational facilities</li> </ul>   |
| <b>Social</b>                           | <ul style="list-style-type: none"> <li>• Support breastfeeding through policy change</li> </ul>  | <ul style="list-style-type: none"> <li>• Safe routes to school</li> </ul>   |

|                    |                              |   |
|--------------------|------------------------------|---|
| Support & Services | and maternity care practices | <ul style="list-style-type: none"> <li>Workplace, faith, park, neighborhood activity groups (e.g., walking hiking, biking)</li> </ul> |
|--------------------|------------------------------|---|

545

546

- Selection of evidence-based interventions to pursue should be based on a thorough analysis of gaps and opportunities that exist in the community and should reflect the potential for broad reach, impact, and successful implementation.

547

548

549

- Propose strategies that are most likely to affect community-wide burden and therefore where appropriate emphasize plans to reduce health disparities.

550

551

- Select interventions that limit the availability of unhealthy food and beverages.

552

Applicants should provide current information about such restrictions, and should

553

include this strategy in the intervention selection unless there is justification based on

554

existing strong policies.

555

- Engage existing coalition or coalitions and potential members of the leadership team in the selection process.

556

557

Performance will be measured by evidence that the intervention area encompasses the

558

jurisdiction of the health department; the communities have selected interventions that

559

address all five evidence-based MAPPS strategies and; the interventions have broad

560

reach and impact in the community.

561

562

5) Community Action Plan (CAP).

563

- Submit a two-year CAP as part of the application that describes an overall integrated strategy that identifies the selected interventions; describes key activities; describes milestones and timelines on achieving intervention implementation; identifies

564

565

566 anticipated policy outcomes; and includes SMART Objectives (Specific, Measurable,  
567 Achievable, Relevant, Time-Framed) for each intervention.

568 • 90 days post-award, finalize the two-year CAP utilizing recommendations from the  
569 application objective review process and input from community information, HHS  
570 agencies, other sources of programmatic support, and on-going discussions with  
571 internal staff and community partners.

572 • Clearly articulate how activities and interventions highlighted in the CAP will be  
573 sustained after Recovery Act funding has ceased.

574 Performance will be measured by evidence that the CAP contains program objectives that  
575 are SMART, that there are plans for sustainability, and that the plan is approved by CDC.

576 Additionally, performance will be measured on a quarterly basis that the awardee is  
577 successfully meeting milestones and benchmarks as indicated in the CAP.

578

579 6) Community-wide and school-based policy, systems, and environmental change  
580 strategies.

581 • Address all five evidence-based MAPPs strategies for obesity/physical  
582 activity/nutrition in communities and in schools, such that the reach and potential  
583 impact is consistent with achieving the long-term goal of the initiative (e.g. PE in  
584 schools that impact an entire school district in the jurisdiction, menu labeling that  
585 impacts the entire jurisdiction).

586 • Where applicable, implement a targeted strategy in areas with a disproportionate  
587 burden of chronic diseases/conditions that tend to experience disparities in access to  
588 and use of preventive and health care services. This focused strategy should include

589 significant areas of the community in order to have the broadest impact possible (e.g.  
590 not one school, but an entire school district; not one corner store stocked with fresh  
591 produce, but the availability of fresh produce in an entire neighborhood, not one  
592 health clinic, but a major health care system).

- 593 • Work with media-buying contractors to develop and refine a media-buy strategy.
- 594 • Collaborate with CDC to implement emotional, hard-hitting counter-marketing and  
595 messaging and normative marketing to promote active behaviors and healthy eating.  
596 Co-brand and locally tag all campaign advertisements and materials with locally  
597 relevant information and resources.

598 Performance will be measured by evidence of progress in building community capacity to  
599 institute policy, systems, and environmental changes.

600

601 7) Evaluation to monitor/measure progress.

- 602 • 60 days post award, establish a monitoring plan that includes the following:
  - 603 ○ The systematic collection of data on a bi-annual basis (twice a year) of progress  
604 on and implementation of existing policy, systems, and environmental change  
605 strategies using the Community Health Assessment aNd Group Evaluation  
606 (CHANGE) tool related to chronic disease prevention and health promotion, to  
607 evaluate the process and outcomes of program activities. For awardees who  
608 have failed to meet benchmarks in Year 1, reporting of some elements of the  
609 CHANGE tool will be required quarterly.
  - 610 ○ The collection of implementation cost information for each initiative, to evaluate  
611 the process and outcomes of program activities.

- 612 • 120 days post award, finalize a comprehensive evaluation plan that is directly tied to  
613 the Community Action Plan.
- 614 • Track progress on implementing activities to create policy, system, and  
615 environmental changes utilizing the CHANGE Tool.
- 616 • Collaborate with and provide necessary information to your state health department,  
617 which will be responsible for collecting BRFSS data at the community level at  
618 baseline and follow-up.
- 619 • Work with state and local education and health agencies and CDC to conduct a  
620 YRBSS using standard YRBSS protocol among a representative sample of as many  
621 as 1,500 to 2,000 9<sup>th</sup> - 12<sup>th</sup> grade students in the intervention area during the fall  
622 semester of the 2010-2011 school year that measures at least dietary behaviors and  
623 physical activity. Repeat the YRBSS among another representative sample of 9<sup>th</sup>-12<sup>th</sup>  
624 grade students at the end of the project period. Cooperative agreement funds may be  
625 spent on school incentives.
- 626 • If selected as a case study site, collaborate with CDC and contractors in implementing  
627 a site-specific case study that examines contextual and environmental factors that act  
628 as facilitators or barriers to program implementation and achievement of intended  
629 outcomes and lead to variations in implementation costs across sites.
- 630 • Monitor and evaluate efforts, including pre and post measurement. This includes the  
631 use of biometric measurements for those applicants already engaged in biometric  
632 measurements and who wish to improve the quality of those efforts as they relate to  
633 collection of height and weight in school-age children and youth. All applicants  
634 should describe any current activities to collect these data in school-age populations.

- 635           • In collaboration with CDC, provide information that will assist with modeling  
636           studies, which will allow, even in the short term, some estimation of long-term impact  
637           of policy and environmental changes on risk behavior and health outcomes.
- 638           • In collaboration with CDC, provide implementation cost information in a uniform  
639           format that will permit examination of efficiency and cost effectiveness of program  
640           activities.

641           Performance will be measured by evidence that the evaluation plan addresses the lifespan  
642           of the program; that the awardee is appropriately participating in any national evaluation  
643           activities; and that adequate progress is made on targets for specific outcome and output  
644           measures.

645

646           8) Participation in Programmatic Support Activities

- 647           • 30 days post-award, ensure that three members of the Leadership Team (the Program  
648           Director, the program coordinator or equivalent, and one additional leader outside the  
649           health department) attend a kick-off meeting in Atlanta.
- 650           • 90 days post-award, ensure that all 8-10 members of the Leadership Team participate  
651           in an Action Institute that will promote the importance of policy, systems, and  
652           environmental change strategies.
- 653           • Ensure that two members of the Leadership Team attend two peer-peer meetings  
654           during the project period.
- 655           • Ensure that the YRBSS lead attends a CDC-led 3-day YRBSS training in August  
656           2010.

- 657 • In collaboration with CDC, work with currently-funded community-based programs  
658 (e.g. Healthy Communities, REACH, Active Living by Design, and others) to learn  
659 about cutting-edge policy and environmental change strategies and interventions to  
660 eliminate health disparities.
- 661 • If applicable, invite national experts and health-related foundations to provide  
662 programmatic support with the selected interventions.
- 663 • In collaboration with CDC, provide information on successful initiatives at the  
664 community level that can be published on the web and shared with other  
665 communities.
- 666 • For state-coordinated small city and rural areas, the State-Community Management  
667 Team should provide or facilitate the provision of programmatic support and  
668 consultation to their funded communities in risk factor surveillance, program  
669 evaluation, evidence-based and practice-based policies, systems, and environmental  
670 changes; community engagement, and intervention selection and development.
- 671 • For state-coordinated small city and rural areas, the State Health Department is  
672 responsible for ensuring that at least 75% of the total award is distributed to the  
673 identified communities in the state-coordinated application.

674 Performance will be measured by attendance and participation in training programs, peer-  
675 peer meetings, and dissemination activities. State health department performance will be  
676 measured by the level of programmatic support provided and the percentage of funds  
677 distributed to identified communities.

678

679 Peer-to-Peer Mentorship

680 Note: There will be an opportunity for successful applicants to apply for up to \$10  
681 million supplement (April 2010) to support peer-to-peer mentoring in the following  
682 areas:

- 683 • Serving as an expert center in selected areas of expertise by coordinating  
684 programmatic support to communities that request information sharing and on-  
685 the-ground lessons learned in specific intervention areas.
- 686 • Providing on-site workshops to profile outstanding success and give peer  
687 communities on-the-ground access to seeing interventions in place, information  
688 sharing sessions with leadership and staff, and sharing lessons learned.
- 689 • Serving as an information warehouse of broad-based policy change interventions,  
690 implementation tools, promising approaches, and strategies for addressing broad-  
691 based policy changes.

692 **Category B. Applicants addressing tobacco prevention and control**  
693

694 1) Program infrastructure, staffing, program management and support.

- 695 • Establish and maintain required paid project or contract staff sufficient in number and  
696 expertise to ensure project success on the following timeline:
  - 697 ○ 30 days post-award, establish and/or retain the minimum staffing requirements to  
698 include a representative of the leadership of the health department, such as a  
699 Program Director; a full-time staff person or equivalent responsible for managing  
700 the planning, implementation, and evaluation of the program, with management  
701 experience in tobacco prevention and control; and the identification of individuals



702 with demonstrated capacity in media planning, administrative, and fiscal  
703 management support necessary to meet the needs of the program.

704 ○ 90 days post-award, establish and/or retain the required additional staff,  
705 contractors, or collaborations to include leadership and expertise within the  
706 education agency for school health, and leadership and expertise for  
707 fiscal/accountability, community outreach and coordination, evaluation, and  
708 YRBSS coordination (responsible for conducting a YRBSS in the intervention  
709 area). The awardee should ensure that this complement of staff and contract  
710 support is sufficient to meet the requirements of this FOA.

711 • Over the course of the project period, establish and maintain other part-time or full-  
712 time staff, contactors, and consultants sufficient in number and expertise to ensure  
713 project success and have demonstrated skills and experience in coalition and  
714 partnership development, community mobilization, health care systems, public health,  
715 program evaluation, epidemiology, data management, health promotion, policy and  
716 environmental interventions, health care quality improvement, communications,  
717 resource development, school health, and the policies related to tobacco control  
718 targeted by the FOA.

719 • For state-coordinated small city and rural areas, State Health Departments must  
720 establish and coordinate a State-Community Management Team, including  
721 participation from the funded communities; the state health department's  
722 collaborative FOA designated healthy communities coordinator; the state education  
723 agency, the state tobacco control coordinator, and the Office of Rural Health (where  
724 appropriate).

725 Performance will be measured by evidence that the program is appropriately staffed to  
726 administer, manage, and evaluate the program as evidenced by the submission of  
727 staff/contractor name, date of hire and/or projected date of hire or staff to be retained due  
728 to Recovery Act funds and by the submission of resumés and/or curriculum vitae for key  
729 personnel and position descriptions for other positions supported by funds under this  
730 cooperative agreement. In addition, performance will be measured by the state health  
731 department’s ability, with assistance from the funded communities, to develop a State-  
732 Community Management Team. Performance related to sustainability will be measured  
733 by outreach to resources, including leveraging other Federal Government recovery funds  
734 to meet the above mentioned skill set (See Attachment B), and the number of  
735 commitments achieved by the end of the program.

736

737 2) Fiscal management.

- 738 • Provide funding to local entities and organizations that will: support the goals of the  
739 initiative and the selected interventions, focus on population-based strategies, are  
740 evidence-based and policy-focused, and will reach diverse groups.
- 741 • Utilize fiscal management procedures for this funding to track and monitor  
742 expenditures separate from other federal funding streams.
- 743 • Implement reporting systems to meet the online reporting criteria and timelines as  
744 stated for the Recovery Act required reporting located in section VI.3. Reporting  
745 Requirements under “Recovery Act-Specific Reporting Requirements” of this FOA.  
746 Recovery Act funding to existing or new awardees should be considered one-time  
747 funding.

- 748
- Recovery Act funding to existing or new awardees should be considered one-time
- 749 funding. Ensure that a sustainability plan is in place that leverages all resources
- 750 available, including federal, state, and local sources, taking into account funding
- 751 commitments that support the CPPW Initiative.

752 Performance will be measured by evidence that the awardee will provide funding to local

753 agencies and partner organizations committed to the goals of the initiative and the

754 selected interventions; has established procedures to track and report expenditures

755 separate from other federal funding; and is able to prepare required reports submitted on

756 the designated schedule.

757

758 3) Leadership team and community coalition.

- 60 days post award, develop a Leadership Team consisting of 8-10 high-level
- 760 community leaders (e.g. the mayor, tribal leaders, city and county officials, school
- 761 superintendents, local business association or corporation leaders, hospital and health
- 762 systems directors, boards of health) or other leaders of influence in the community.
- 763 The Leadership Team should also include the Program Director and the overall
- 764 manager of the program. The Leadership Team will: oversee the strategic direction of
- 765 the project activities, be responsible for enacting policies related to the evidence-
- 766 based MAPPS strategies recommended in item 4 of this section, establish and
- 767 maintain an organizational structure and governance for the community coalition or
- 768 coalitions, and participate in project-related local and national meetings.
- 90 days post-award, revise or add to the existing community coalition (or coalitions)
- 770 committed to participating actively in the planning, implementation, and evaluation of

771 the *Communities Putting Prevention to Work Initiative*. Partners should include a  
772 wide representation of community leaders and community members familiar with  
773 tobacco prevention and control. Examples could include representatives from  
774 education agencies (local education agencies, school districts, school board members,  
775 or parent teacher organizations); school health advocates, key community based  
776 governmental and non-governmental organizations, health care, voluntary, and  
777 professional organizations; business, community, faith-based leaders; local Aging  
778 centers and senior center; universities; and at least one lay person representative of  
779 the population to be served. Linkages with mental health/substance abuse  
780 organizations, health plans, foundations and other community partners working  
781 together to promote health and prevent chronic diseases are encouraged. The  
782 community coalition will advise the Leadership Team on the planning,  
783 implementation, and evaluation of the CPPW Initiative.

- 784 • Encourage linkages with other community-based efforts and the Office of the  
785 Regional Health Administrator, with special attention to leveraging other Federally  
786 funded (including Recovery Act funded)- and foundation activities. See Attachment  
787 B for examples.

788 Performance will be measured by the level of partner engagement throughout the project  
789 period including the involvement of key community-based and public health partners  
790 comprising an alliance of partnerships and coalitions committed to participating actively  
791 in planning, implementation, and evaluation of CPPW. This will include evidence of  
792 regularly scheduled meetings, membership lists, attendance rates, participation, and  
793 meeting minutes.

794 4) Intervention area and selection of interventions.

- 795 • Ensure that the intervention area encompasses the entire jurisdiction of the health  
 796 department so that the focus of policies, systems, and environmental changes will  
 797 have the broadest impact possible. The mix of interventions, taken together, must  
 798 address tobacco prevention and control with sufficient reach and potential impact.
- 799 • Choose interventions that address all five evidence-based MAPPS strategies in  
 800 communities and schools (as relevant) from the table of evidence-based interventions.
- 801 • The evidence-based interventions below are drawn from the peer-reviewed literature  
 802 as well as expert syntheses from the community guide and other peer-reviewed  
 803 sources (for a complete list of citations, please see Attachment C). Communities and  
 804 states have found these interventions to be successful in practice. Awardees are  
 805 expected to use this list of evidence-based strategies to design a comprehensive and  
 806 robust set of strategies to produce the desired outcomes for the initiative. Other  
 807 evidence-based strategies may be proposed but must be documented as to their  
 808 evidence base, their likely addition to the overall outcomes, and the rationale for the  
 809 choice of intervention (e.g., identified need or opportunity).

810 **MAPPS Table**

|                           | <b>Tobacco</b>   |
|---------------------------|--|
| <b>Media</b>              | <ul style="list-style-type: none"> <li>• Media and advertising restrictions consistent with federal law</li> <li>• Hard hitting counter-advertising</li> <li>• Ban brand-name sponsorships</li> <li>• Ban branded promotional items and prizes</li> </ul>  |
| <b>Access</b>             | <ul style="list-style-type: none"> <li>• Usage bans (i.e. 100% smoke-free policies or 100% tobacco-free policies)</li> <li>• Usage bans (tobacco-free worksites and or school campuses)</li> <li>• Zoning restrictions</li> <li>• Restrict sales (e.g. internet; sales to minors; stores/events w/o tobacco)</li> <li>• Ban self-service displays &amp; vending</li> </ul> |
| <b>Point of Purchase/</b> | <ul style="list-style-type: none"> <li>• Restrict point of purchase advertising</li> <li>• Labeling/ signage/ placement to discourage consumption of</li> </ul>  |

|                           |  |
|---------------------------|--|
| Promotion                 | tobacco  |
| Price                     | <ul style="list-style-type: none"> <li>• Use evidence-based pricing strategies that discourage tobacco use</li> <li>• Ban free samples and price discounts</li> </ul>  |
| Social Support & Services | <ul style="list-style-type: none"> <li>• Quitline and other cessation services (please note that only up to 5% of the total award for tobacco prevention and control can be spent on nicotine replacement therapy (NRT)).</li> </ul> |

- 811
- 812       • Selection of evidence-based interventions to pursue should be based on a thorough
- 813           analysis of the gaps and opportunities that exist in the community and should reflect
- 814           the potential for broad reach, impact, and successful implementation.
- 815       • Propose strategies that are most likely to affect community-wide burden and therefore
- 816           where appropriate emphasize plans to eliminate health disparities.
- 817       • Select interventions to implement smoke free air policies within the jurisdiction. If
- 818           there is not a comprehensive tobacco ban, the applicant must include a detailed plan
- 819           for implementation.
- 820       • Select evidence-based pricing interventions demonstrated to discourage tobacco use.
- 821           Applicants must provide current information and plans to address the price of tobacco
- 822           consistent with the evidence base cited in Attachment C.
- 823       • Applicants should engage the existing coalition or coalitions and potential members
- 824           of the leadership team in the selection process.

825       Performance will be measured by evidence that the intervention area encompasses the

826       jurisdiction of the health department and that the communities have selected interventions

827       that address all five evidence-based MAPPs strategies and that the interventions have

828       broad reach and impact in the community.

829

830 5) Community Action Plan (CAP).

- 831 • Submit a two-year CAP as part of the application that describes an overall integrated  
832 strategy that identifies the selected interventions; describes key activities; describes  
833 milestones and timelines on achieving intervention implementation; identifies  
834 anticipated policy outcomes; and includes SMART Objectives (Specific, Measurable,  
835 Achievable, Relevant, Time-Framed) for each intervention.
- 836 • 90 days post-award, finalize the two-year CAP utilizing recommendations from the  
837 application objective review process and input from community information, HHS  
838 agencies, other sources of programmatic support, and on-going discussions with  
839 internal staff and community partners.
- 840 • Clearly articulate how activities and interventions highlighted in the CAP will be  
841 sustained after Recovery Act funding has ceased.

842 Performance will be measured by evidence that the CAP contains program objectives that  
843 are SMART, that there are plans for sustainability, and that the plan is approved by CDC.  
844 Additionally, performance will be measured on a quarterly basis that the awardee is  
845 successfully meeting milestones and benchmarks as indicated in the CAP.

846

847 6) Community-wide and school-based policy, systems, and environmental change  
848 strategies.

- 849 • Address all five evidence-based MAPPs strategies for tobacco prevention and control  
850 in communities and, as relevant, in schools, such that the reach and potential impact  
851 is consistent with achieving the long-term goal of the initiative (e.g. a smoke-free

852 indoor air policy that impacts the entire jurisdiction, evidence-based pricing strategies  
853 that discourage tobacco use that impacts the entire jurisdiction).

- 854 • Where applicable, implement a targeted strategy in areas with a disproportionate  
855 burden of chronic diseases/conditions that tend to experience disparities in access to  
856 and use of preventive and health care services. This focused strategy should include  
857 significant areas of the community in order to have the broadest impact possible (e.g.  
858 low literacy media messages that influence quitting or lead smokers to the quitline;  
859 county wide smoke-free air policies not just one worksite, school or health care)
- 860 • Work with media-buying contractors to develop and refine a media-buy strategy.
- 861 • Collaborate with CDC to implement emotional, hard-hitting counter-marketing and  
862 messaging and normative marketing to reduce tobacco use and prevent youth  
863 initiation. Co-brand and locally tag all campaign advertisements and materials with  
864 locally relevant information and resources.
- 865 • Severely curtail tobacco promotion and advertising consistent with federal law, which  
866 can include but is not limited to, restricting or eliminating “power walls” of cigarettes  
867 offered for sale at retail outlets, limiting the number or size of tobacco product ads at  
868 retail outlets, and requiring that all tobacco products be kept away from cash  
869 registers.

870 Performance will be measured by evidence of progress in building community capacity to  
871 institute policy, systems, and environmental changes.

872

873 7) Evaluation to monitor/measure progress.

- 874 • 60 days post award, establish a monitoring plan that includes the following:



- 875           ○ The systematic collection of data on a bi-annual basis (twice a year) of progress  
876           on and implementation of existing policy, systems, and environmental change  
877           strategies using the Community Health Assessment aNd Group Evaluation  
878           (CHANGE) tool related to chronic disease prevention and health promotion, to  
879           evaluate the process and outcomes of program activities. For awardees who  
880           have failed to meet benchmarks in Year 1, reporting of some elements of the  
881           CHANGE tool will be required quarterly.
- 882           ○ The collection of implementation cost information for each initiative, to evaluate  
883           the process and outcomes of program activities.
- 884           ● 120 days post award, finalize a comprehensive evaluation plan that is directly tied to  
885           the Community Action Plan.
- 886           ● Track progress on implementing activities to create policy, system, and  
887           environmental changes utilizing the CHANGE Tool.
- 888           ● Collaborate with and provide necessary information to your state health department,  
889           which will be responsible for collecting BRFSS data at the community level at  
890           baseline and follow-up.
- 891           ● Work with state and local education and health agencies and CDC to conduct a  
892           YRBSS using standard YRBSS protocol among a representative sample of as many  
893           as 1,500 to 2,000 9<sup>th</sup> - 12<sup>th</sup> grade students in the intervention area during the fall  
894           semester of the 2010-2011 school year that measures at least tobacco use. Repeat the  
895           YRBSS among another representative sample of 9<sup>th</sup>-12<sup>th</sup> grade students at the end of  
896           the project period. Cooperative agreement funds may be spent on school incentives.

- 897           • If selected as a case study site, collaborate with CDC and contractors in implementing  
898           a site-specific case study that examines contextual and environmental factors that act  
899           as facilitators or barriers to program implementation and achievement of intended  
900           outcomes and lead to variations in implementation costs across sites.
- 901           • In collaboration with CDC, provide information that will assist with modeling  
902           studies, which will allow, even in the short term, some estimation of long-term impact  
903           of policy and environmental changes on risk behavior and health outcomes.

904           Performance will be measured by evidence that the evaluation plan addresses the lifespan  
905           of the program; that the awardee is appropriately participating in any national evaluation  
906           activities; and that adequate progress is made on targets for specific outcome and output  
907           measures.

908

909           8) Participation in Programmatic Support Activities

- 910           • 30 days post-award, ensure that three members of the Leadership Team (the Program  
911           Director, the program coordinator or equivalent, and one additional leader outside the  
912           health department) attend a kick-off meeting in Atlanta.
- 913           • 90 days post-award, ensure that all 8-10 members of the Leadership Team participate  
914           in an Action Institute that will promote the importance of policy, systems, and  
915           environmental change strategies.
- 916           • Ensure that two members of the Leadership Team attend two peer-peer meetings  
917           during the project period.
- 918           • Ensure that the YRBSS lead attends a CDC-led 3-day YRBSS training in August  
919           2010.

920 • In collaboration with CDC, work with currently-funded community-based programs  
921 (e.g. Healthy Communities, REACH, Active Living by Design, and others) to learn  
922 about cutting-edge policy and environmental change strategies and interventions to  
923 eliminate health disparities.

924 • If applicable, invite national experts and health-related foundations to provide  
925 programmatic support with the selected interventions.

926 • In collaboration with CDC, provide information on successful initiatives at the  
927 community level that can be published on the web and shared with other  
928 communities.

929 • For state-coordinated small city and rural areas, the State-Community Management  
930 Team should provide or facilitate the provision of programmatic support and  
931 consultation to their funded communities in risk factor surveillance, program  
932 evaluation, evidence-based and practice-based policies, systems, and environmental  
933 changes, community engagement, and intervention selection and development.

934 • For state-coordinated small city and rural areas, the State Health Department is  
935 responsible for ensuring that at least 75% of the total award is distributed to the  
936 identified communities in the state-coordinated application.

937 Performance will be measured by attendance and participation in training programs, peer-  
938 peer meetings, and dissemination activities. State health department performance will be  
939 measured by the level of programmatic support provided and the percentage of funds  
940 distributed to identified communities.

941

942 Peer-to-Peer Mentorship

943 Note: There will be an opportunity for successful applicants to apply for up to \$10  
944 million supplement (April 2010) to support peer-to-peer mentoring in the following  
945 areas:

- 946 • Serving as an expert center in selected areas of expertise by coordinating  
947 programmatic support to communities that request information sharing and on-  
948 the-ground lessons learned in specific intervention areas.
- 949 • Providing on-site workshops to profile outstanding success and give peer  
950 communities on-the-ground access to seeing interventions in place, information  
951 sharing sessions with leadership and staff, and sharing lessons learned.
- 952 • Serving as an information warehouse of broad-based policy change interventions,  
953 implementation tools, promising approaches, and strategies for addressing broad-  
954 based policy changes.

955 CDC Activities  
956

957  
958 In a cooperative agreement, CDC staff is substantially involved in the program activities, above  
959 and beyond routine grant monitoring.

960  
961 CDC activities for this program, applicable to all applicants, are as follows:

- 962
- 963 • Provide ongoing community programmatic support to ensure success for Recovery  
964 Act-funded communities in the following areas:
    - 965 1. Community assessment and planning,

- 966 2. Evidence-based and practice-based approaches,  
967 3. Community mobilization and partnership development,  
968 4. Implementation of broad-based policy, systems, and environmental changes,  
969 5. Program sustainability,  
970 6. Evaluation of policy, system, and environmental level change,  
971 7. Monitoring of risk behavior change and longer-term health outcomes,  
972 8. Developing and revising Community Action Plans.
- 973
- 974 • Foster the transfer of successful evidence and practice-based interventions, program  
975 models and other forms of community programmatic support by convening meetings,  
976 workshops, web forums, conferences, and conference calls with awardees.
- 977
- 978 • Conduct on-site visits to awardees to ensure achievement of quarterly benchmarks  
979 and project success as determined by the Recovery Act and outlined within this FOA.
- 980
- 981 • Plan, implement, and organize Recovery Act Action Institutes and Peer-to-Peer  
982 meetings for awardees and teams.
- 983
- 984 • Participate in a national media campaign strategy and coordinate with local  
985 implementation of media interventions that will foster effective and hard-hitting  
986 prevention and wellness messages and advertisements that will complement and  
987 reinforce state and community activities.
- 988

- 989
- Maintain an electronic community health web portal and other mechanisms for  
990 information sharing among awardees that includes a web-site and web-board.  
991
- 992
- Record best practices and community experiences for dissemination to existing  
993 awardees and other communities for replication of successful interventions.  
994
- 995
- Fund national experts to provide programmatic support in implementing the  
996 prescribed set of evidence-based MAPPS strategies and the selected interventions.  
997
- 998
- Provide project monitoring that includes the analysis of performance measures and  
999 the consistency of measurement and comparability of Recovery Act reporting  
1000 measures and CHANGE tool data.  
1001
- 1002
- Coordinate with other Federal agencies and existing place-based revitalization and  
1003 reform projects funded by the US Government, including community development  
1004 and livability efforts and activities funded by the Recovery Act.  
1005
- 1006
- In addition to community evaluation efforts, HHS has allocated \$39.5 million to  
1007 support evaluation of community efforts through community and state level risk  
1008 factor surveillance, case studies in funded communities and states, cost tracking, and  
1009 modeling. Behavioral outcomes will be tracked using existing BRFSS and YRBSS  
1010 tools, and the CDC CHANGE Tool data collected in funded communities. CDC will  
1011 utilize data from BRFSS, YRBSS, and modeling techniques to monitor behavior

1012 changes and changes to chronic disease risk factors on a national scale, supplemented  
1013 by cost studies as well as case studies in selected sites.

1014

- 1015 • Provide a 3-day YRBSS training in August 2010 and prior to administration of the  
1016 second YRBSS at the end of the project period and ongoing technical assistance to  
1017 support implementation of the YRBSS using standard YRBSS protocols.

1018

## 1019 **II. Award Information**

1020 Type of Award: Cooperative Agreement.

1021 CDC's involvement in this program is listed in the Activities Section above.

1022 Award Mechanism: U58

1023 Fiscal Year Funds: 2009-2010 Recovery Act

1024 Approximate Current Fiscal Year Funding: \$373 million

1025 Approximate Total Project Period Funding: \$373 million. This amount is an estimate, and is  
1026 subject to availability of funds. This includes direct and indirect costs.

1027

1028 Awards for both categories will vary with size of jurisdiction, the proposed activities, and the  
1029 needs of each community. Approximately 30-40 awardees will be made for the CPPW Initiative,  
1030 but the number of awards will depend on the preceding factors and may fall outside of this  
1031 approximate range of number of awards and amount of funding per award.

1032

1033 Illustrative ranges are:

1034

1035 **Category A: Obesity/Physical Activity/Nutrition**

- 1036 • Large city applicants: \$10 million – \$20 million
- 1037 • Urban area applicants: \$4 million – \$10 million
- 1038 • Tribal applicants: \$500,000 – \$1.2 million
- 1039 • State coordinated small city and rural area applicants: \$3 million - \$8 million

1040

1041 **Category B: Tobacco Prevention and Control**

- 1042 • Large city applicants: \$10 million – \$20 million
- 1043 • Urban area applicants: \$4 million – \$10 million
- 1044 • Tribal applicants: \$500,000 – \$1.2 million
- 1045 • State coordinated small city and rural area applicants: \$3 million - \$8 million

1046

1047 This amount is for the 24-month budget period, and includes both direct and indirect costs.

1048 Anticipated Award Date: February 26, 2010

1049 Budget Period Length: 24 months

1050 Project Period Length: 24 months

1051

1052 The specific amount of funding per community will be determined by a mix of interventions,  
1053 population size, ability to reduce health disparities, and likelihood of success.

1054

1055 Throughout the project period, CDC's commitment to continuation of awards will be  
1056 conditioned on the availability of funds, evidence of satisfactory progress by the recipient (as



1057 documented in required reports), and the determination that continued funding is in the best  
1058 interest of the Federal government.

1059  
1060 Please note: Applicants who apply for both Categories A and B of this announcement will  
1061 submit two separate applications. Should an applicant compete successfully in both categories to  
1062 receive two awards, CDC will conduct budget negotiations with the applicant to merge the  
1063 staffing plans and reduce the requested budgets accordingly in order to reflect a combined  
1064 operating structure.

1065

### 1066 **III. Eligibility Information**

#### 1067 III.1. Eligible Applicants

1068 Eligible applicants that can apply for this funding opportunity are listed below:

- 1069 • An official local health department (or its bona fide agent), or its equivalent, as  
1070 designated by the mayor, county executive, or other equivalent governmental official,  
1071 will serve as the lead/fiduciary agent for a **Large City** application. For this  
1072 announcement, the term “large city” is defined as a local health department that serves a  
1073 jurisdiction with a population of more than 1 million people.
- 1074 • An official local health department (or its bona fide agent), or its equivalent, as  
1075 designated by the mayor, county executive, or other equivalent governmental official,  
1076 will serve as the lead/fiduciary agent for an **Urban Area** application. For this  
1077 announcement, the term “urban area” is defined as a local health department that serves a  
1078 jurisdiction with a population more than 500,000 and up to 1 million people.

- 1079 • Federally recognized Tribal Governments, Regional Area Indian Health Boards, Urban  
1080 Indian organizations, and Inter-Tribal Councils as designated by the Principal Tribal  
1081 elected official or chief executive officer will serve as the lead/fiduciary agency for  
1082 **Tribal Community** applications.
- 1083 • An official state health department (or its bona fide agent), or its equivalent, as  
1084 designated by the Governor, is to serve as the lead/fiduciary agency for **Small City and**  
1085 **Rural Community** applications. For this announcement, the term “State” includes the  
1086 50 states, the Commonwealth of Puerto Rico, the Virgin Islands, the Commonwealth of  
1087 the Northern Marianna Islands, American Samoa, Guam, the Federated States of  
1088 Micronesia, the Republic of the Marshall Islands, and the Republic of Palau. The term  
1089 “small city” is defined as a local health department that serves a jurisdiction with a  
1090 population between 50,000 – 500,000 people. The term “rural area” is defined as a local  
1091 health department that serves a jurisdiction with a population of 50,000 people and  
1092 below.

1093

### 1094 III.2. Cost Sharing To Promote Sustainability

1095

1096 There is no match requirement for this program. However, leveraging other resources and  
1097 related on-going efforts to promote sustainability is encouraged. Examples include foundation  
1098 funding, other US government funding sources including the Recovery Act, and state  
1099 appropriations. (See Attachment B)

1100

### 1101 III.3. Other

1102

1103 Applications that do not address all activities will be considered non-responsive, and will not be  
1104 entered into the review process.

1105

1106 For state-coordinated small city and rural areas, state health department applicants that have not  
1107 pre-selected the communities to be funded under this initiative will be considered non-responsive  
1108 and not entered into the review process. Only one application can be submitted per state for  
1109 Category A and only one application per state for Category B, for a maximum of two  
1110 applications per state if applying for Category A and Category B. Within each state application,  
1111 states may only submit up to 2 communities to fund: i.e. a combination of one small city and one  
1112 rural community; two small cities; or two rural communities. State health departments that have  
1113 not identified a maximum of 2 communities per application will be considered non-responsive  
1114 and not entered into the review process.

1115

1116 The applicant will be notified the application did not meet the submission requirements.

1117

1118 Applicants are required to submit a Letter of Intent (LOI) to be eligible to apply for this program.  
1119 Failure to submit a LOI will result in non-responsiveness and the applicant will be prohibited  
1120 from applying. See Sections IV.2, IV.3, and IV.6 of this announcement for more information on  
1121 LOI submission. The LOI must identify the type of applicant and the risk factor area to be  
1122 addressed. If an applicant wishes to apply for both tobacco and obesity/ physical activity/  
1123 nutrition funding, one LOI can be submitted to indicate that intention.

1124

1125 Note: Title 2 of the United States Code section 1611 states that an organization described in  
1126 section 501(c)(4) of the Internal Revenue Code that engages in lobbying activities is not eligible  
1127 to receive Federal funds constituting an award, grant, or loan.

1128

1129 Special Requirements:

1130

1131 If the application is non-responsive it will not be entered into the review process. The applicant  
1132 will be notified the application did not meet submission requirements.

- 1133 • Late applications will be considered non-responsive. See section “IV.3. Submission  
1134 Dates and Times” for more information on deadlines.

1135 In accordance with applicable laws and regulations including 45 CFR 92.43, CDC may take  
1136 certain enforcement actions, including termination of funding, against poor performing grants.

1137

#### 1138 **IV. Application and Submission Information**

1139 IV.1. Address to Request Application Package

1140 To apply for this funding opportunity use the application forms package posted in Grants.gov.

1141

1142 Electronic Submission:

1143 CDC strongly encourages the applicant to submit the application electronically by utilizing the  
1144 forms and instructions posted for this announcement on [www.Grants.gov](http://www.Grants.gov), the official Federal  
1145 agency wide E-grant Web site. Only applicants who apply on-line are permitted to forego paper  
1146 copy submission of all application forms.

1147

1148 Registering your organization through [www.Grants.gov](http://www.Grants.gov) is the first step in submitting  
1149 applications online. Registration information is located in the “Get Registered” screen of  
1150 [www.Grants.gov](http://www.Grants.gov). While application submission through [www.Grants.gov](http://www.Grants.gov) is optional, we  
1151 strongly encourage you to use this online tool.

1152

1153 Please visit [www.Grants.gov](http://www.Grants.gov) at least 30 days prior to filing your application to familiarize  
1154 yourself with the registration and submission processes. Under “Get Registered,” the one-time  
1155 registration process will take three to five days to complete; however, as part of the Grants.gov  
1156 registration process, registering your organization with the Central Contractor Registry (CCR)  
1157 annually, could take an additional one to two days to complete. We suggest submitting electronic  
1158 applications prior to the closing date so if difficulties are encountered, you can submit a hard  
1159 copy of the application prior to the deadline.

1160

1161 Application forms and instructions are available on the CDC Web site, at the following Internet  
1162 address: [http://www.cdc.gov/od/pgo/funding/grants/app\\_and\\_forms.shtm](http://www.cdc.gov/od/pgo/funding/grants/app_and_forms.shtm)

1163

1164 IV.2. Content and Form of Submission

1165

1166 **Letter of Intent (LOI):**

1167 Prospective applicants are required to submit a letter of intent that includes the following  
1168 information (failure to submit a LOI will result in non-responsiveness and the applicant will be  
1169 prohibited from applying):

- 1170
- Program announcement title and number;

- 1171 • Whether the application will be from a Large City, Urban Area, Tribal Community or a  
1172 State-Coordinated Small City/ Rural Area, as defined in section III.1. Eligible Applicants;
- 1173 • The name of the lead/fiduciary agency or organization, the official contact person and  
1174 that person’s telephone number, fax number, mailing and email addresses; and
- 1175 • Each risk factor area (tobacco and/or obesity/ physical activity/ nutrition) for which the  
1176 applicant intends to apply.

1177

1178 *Format:*

1179 The LOI should be no more than two pages (8.5 x 11), double-spaced, printed on one side, with  
1180 one-inch margins, written in English (avoiding jargon), and unreduced 12-point font.

1181

1182 **Letter of Intent (LOI):** A letter of intent (LOI) from the Chief Health Officer (Local Health  
1183 Officer, Tribal Health Officer, State Health Officer, or other equivalent governmental official) is  
1184 required from all potential applicant communities for the purposes of planning the competitive  
1185 review process. Failure to submit a LOI will result in non-responsiveness and the applicant will  
1186 be prohibited from applying.

1187

1188 Although the LOI will not be scored as part of the application process, submission of the LOI is  
1189 considered the submission of a formal application and the applicant will be subject to lobbying  
1190 restrictions highlighted in section VIII. “Recovery Act Lobbying Restrictions.” Applicants will  
1191 be notified by email upon receipt of the LOI by CDC.

1192

1193 **Application:**

1194 A Project Abstract must be submitted with the application forms. All electronic project abstracts  
1195 must be uploaded in a PDF file format when submitting via Grants.gov. The abstract must be  
1196 submitted in the following format, if submitting a paper application:

- 1197 • Maximum of 2-3 paragraphs.
- 1198 • Font size: 12 point unreduced, Times New Roman
- 1199 • Single spaced
- 1200 • Paper size: 8.5 by 11 inches
- 1201 • Page margin size: One inch

1202

1203 The Project Abstract must contain a summary of the proposed activity suitable for dissemination  
1204 to the public. It should be a self-contained description of the project and should contain a  
1205 statement of objectives and methods to be employed. It should be informative to other persons  
1206 working in the same or related fields and insofar as possible understandable to a technically  
1207 literate lay reader. This Abstract must not include any proprietary/confidential information.

1208 A project narrative must be submitted with the application forms. All electronic narratives must  
1209 be uploaded in a PDF file format when submitting via Grants.gov. The narrative must be  
1210 submitted in the following format:

1211

- 1212 • Maximum number of pages: 30. If your narrative exceeds the page limit, only the first  
1213 pages which are within the page limit will be reviewed.
- 1214 • Font size: 12 point unreduced, Times New Roman
- 1215 • Double spaced
- 1216 • Paper size: 8.5 by 11 inches

- 1217 • Page margin size: One inch
- 1218 • Number all narrative pages; not to exceed the maximum number of pages.

1219

1220 The narrative should address activities to be conducted over the entire project period for either  
1221 Category A or Category B and must include the following items in the order listed:

1222

1223 I. Program Infrastructure and Fiscal Management

1224 A. Identify required staff, qualifications, and responsibilities.

1225 B. For state-coordinated small city and rural areas, state health departments need to  
1226 identify staff, qualifications, and responsibilities for the state-community  
1227 management team. Describe plans for programmatic support to the funded  
1228 communities.

1229 C. Describe financial management systems that are in place to fulfill the Recovery  
1230 Act reporting requirements outlined in section VI.3. Reporting Requirements  
1231 under “Recovery Act-Specific Reporting Requirements.”

1232 D. Describe how proposed efforts will be sustained after Recovery Act funding has  
1233 ceased.

1234

1235 II. Leadership Team and Coalitions

1236 A. Identify potential members of the Leadership Team, including letters of support  
1237 that detail their commitment to advancing the broad-based policy changes  
1238 selected from the menu of evidence-based MAPPS strategies or other proposed  
1239 interventions (letters of support can be included as part of the Appendices).



- 1240 B. Provide a description of the existing community coalition or coalitions, including  
1241 the types of groups represented (membership lists can be included as part of the  
1242 Appendices). Describe the past successes of the existing coalition(s) working with  
1243 community leaders in advancing broad-based policy, systems, and environmental  
1244 change strategies.
- 1245 C. Include a letter of support from the mayor, county executive, tribal leader, or  
1246 other equivalent government official that demonstrates their commitment to  
1247 supporting the CPPW Initiative and the reporting requirements as highlighted in  
1248 this FOA (letter of support can be included as part of the Appendices).
- 1249 D. Include list of other Federal ARRA collaborations.

1250

1251 III. Intervention Area and Populations of Need

- 1252 A. Describe the jurisdiction of the health department (intervention area) including a  
1253 thorough description of the exact population size and location of the populations  
1254 to be served.
- 1255 B. Include local data (where available), that provides the population size;  
1256 substantiates the existing burden and/or disparities of chronic diseases and  
1257 conditions; substantiates existing health risk behaviors and risk factors related to  
1258 chronic diseases; and describes assets and barriers to successful program  
1259 implementation, including an understanding of the policy, systems, and  
1260 environmental policies in the community. Ensure that these data highlight  
1261 geographic areas and populations of high need, which may include racial and  
1262 ethnic minorities, low-income persons, the medically underserved, persons with

1263 disabilities, persons affected by mental illness, or persons affected by substance  
1264 abuse.

1265

1266 IV. Selection of Risk Factors and Interventions

1267 A. Clearly indicate which risk factors will be addressed: tobacco or obesity/ physical  
1268 activity/ nutrition. If selecting both, please provide separate descriptions of how  
1269 each risk factor will be addressed.

1270 B. Identify intervention strategies across the five evidence-based MAPPs strategies,  
1271 provide a justification of why these interventions were selected including an  
1272 assessment of the current needs and assets in the community related to tobacco or  
1273 obesity/physical activity/nutrition, and indicate plans for sustainability and  
1274 leveraging resources. Identify how the applicant has addressed priority  
1275 interventions (tobacco smoke free policies and evidence-based pricing strategies  
1276 OR removing/limiting availability of unhealthy food and beverages).

1277 C. If proposing an intervention not included in the prescribed menu of interventions,  
1278 provide a justification for the choice of the intervention (e.g. identified need or  
1279 opportunity) and demonstrate that it has the potential for broad reach and impact  
1280 not achievable with a listed intervention.

1281 D. Explain how the intervention strategies will impact the entire jurisdiction of the  
1282 health department and how they have the potential for broad reach and impact.  
1283 Ensure that the selection of interventions takes into account the gaps and  
1284 opportunities that exist in the community.

1285 E. Include a Community Action Plan that describes an overall integrated strategy  
1286 that identifies the selected interventions; describes key activities; describes  
1287 milestones and timelines on achieving intervention implementation; identifies  
1288 anticipated policy outcomes; and includes SMART Objectives (Specific,  
1289 Measurable, Achievable, Relevant, Time-Framed) for each intervention.  
1290 (Community Action Plans can be included as part of the Appendices).

1291 F. Provide examples of how the awardee will interact with the state health  
1292 department, national experts, foundations and CDC on the implementation of  
1293 selected interventions.

1294

1295 V. Evaluation to Monitor/Measure Progress

1296 A. Include a description of the overall plan to evaluate the initiative at the  
1297 community level, including participation in the national evaluation strategy.

1298 B. Provide letters of support from all public school districts within the intervention  
1299 area indicating support for implementing the YRBSS survey using standard  
1300 YRBSS protocol for baseline during the fall semester of the 2010-2011 school  
1301 year and follow-up at the end of the project period (letters of support can be  
1302 included as part of the Appendices).

1303 C. Provide examples of how the awardees will interact with the state health  
1304 department, national contractors, and CDC on evaluation activities.

1305 D. For those communities engaged in biometric data collection and who wish to  
1306 improve their efforts, describe current approach (e.g. target audience including  
1307 which school-age populations (which ages/grades), method of data collection,

1308 frequency of data collection, and evidence of validity and reliability of data  
1309 collected) as well as plans for upgrading the current approach with these funds.  
1310 All applicants should describe any current activities to collect these data in  
1311 school-age populations.

1312 VI. Community Programmatic Support Needs

1313 A. Include a detailed description of support needed that could be addressed by CDC,  
1314 national experts, and/or expert communities.

1315  
1316 The budget and budget justification will be included as separate attachments, not to be counted in  
1317 the narrative page limit.

1318  
1319 Additional information may be included in the application appendices. The appendices will not  
1320 be counted toward the narrative page limit. This additional information includes:

- 1321 • Curricula Vitae, Resumés, Organizational Charts, Letters of Support, Membership Lists,  
1322 and Indirect Cost Agreement.
- 1323 • Community Action Plan that includes the selected evidence-based MAPPS strategies;  
1324 describes key activities; identifies anticipated policy outcomes; and includes SMART  
1325 Objectives (Specific, Measurable, Achievable, Relevant, Time-Framed) for each  
1326 intervention.

1327  
1328 Additional information submitted via Grants.gov should be uploaded in a PDF file format, and  
1329 should be named:

- 1330 • “807\_(state two letter abbreviation)\_(document name)”

1331 (e.g., 807\_GA\_ResuméSmith.pdf; 807\_GA\_OrgChartDivision.pdf)

1332

1333 No more than 10 appendices should be uploaded per application. Letters of support can be  
1334 included as one appendix.

1335 The agency or organization is required to have a Dun and Bradstreet Data Universal Numbering  
1336 System (DUNS) number to apply for a grant or cooperative agreement from the Federal  
1337 government. The DUNS number is a nine-digit identification number, which uniquely identifies  
1338 business entities. Obtaining a DUNS number is easy and there is no charge. To obtain a DUNS  
1339 number, access the [Dun and Bradstreet website](#) or call 1-866-705-5711.

1340

1341 Additional requirements that may request submission of additional documentation with the  
1342 application are listed in section “VI.2. Administrative and National Policy Requirements.”

1343

1344 IV.3. Submission Dates and Times

1345

1346 Letter of Intent (LOI) Deadline Date: October 30, 2009 (EDT)

1347 Application Deadline Date: December 1, 2009 (EST)

1348

1349 Explanation of Deadlines: Applications must be received in the CDC Procurement and Grants  
1350 Office by 5:00 p.m. Eastern Daylight/Standard Time on the deadline date.

1351

1352 Applications must be submitted electronically at [www.Grants.gov](http://www.Grants.gov). Applications completed on-  
1353 line through Grants.gov are considered formally submitted when the applicant organization’s

1354 Authorizing Organization Representative (AOR) electronically submits the application to  
1355 [www.Grants.gov](http://www.Grants.gov). Electronic applications will be considered as having met the deadline if the  
1356 application has been successfully submitted electronically by the applicant organization's AOR  
1357 to Grants.gov on or before the deadline date and time.

1358 When submission of the application is done electronically through Grants.gov  
1359 (<http://www.grants.gov>), the application will be electronically time/date stamped and a tracking  
1360 number will be assigned, which will serve as receipt of submission. The AOR will receive an e-  
1361 mail notice of receipt when HHS/CDC receives the application.

1362

1363 **IMPORTANT NOTICE:** It is the applicant's responsibility to determine that the application has  
1364 been received. If you do not receive a receipt confirmation and either a validation confirmation  
1365 or a rejection email message within 48 hours, please contact Grants.gov. The Grants.gov Contact  
1366 Center can be reached by email at [support@grants.gov](mailto:support@grants.gov), or by telephone at 1-800-518-4726.

1367 Always include your Grants.gov tracking number in all correspondence. The tracking numbers  
1368 issued by Grants.gov look like GRANTXXXXXXXX. HHS/CDC strongly recommends that  
1369 submittal of the application to Grants.gov should be prior to the closing date to resolve any  
1370 unanticipated difficulties prior to the deadline.

1371

1372 If your application is successfully validated and subsequently retrieved by the CDC Procurement  
1373 and Grants Office from the Grants.gov system, you will receive an additional e-mail. This e-  
1374 mail may be delivered several days or weeks from the date of submission, depending on when  
1375 the application is retrieved.

1376

1377 You may also monitor the processing status of your submission within the Grants.gov system by  
1378 using the following steps:

1379

- 1380 1. Go to <http://www.grants.gov>
- 1381 2. Click on the “Track Your Application” link on the left side  
1382 navigation bar on the Grants.gov homepage.
- 1383 3. Login to the system using your AOR user ID and password
- 1384 4. Click on the “Check Application Status” link on the left side  
1385 navigation bar.

1386

1387 Note: Once the CDC Procurement and Grants Office have retrieved your application from  
1388 Grants.gov, you will need to contact the CDC Procurement and Grants Office directly for any  
1389 subsequent status updates. Grants.gov does not participate in making any award decisions.

1390

1391 This announcement is the definitive guide on letter of intent (LOI) and application content,  
1392 submission address, and deadline. It supersedes information provided in the application  
1393 instructions. If the application submission does not meet the deadline above, it will not be  
1394 eligible for review. The application face page will be returned by HHS/CDC with a written  
1395 explanation of the reason for non-acceptance. The applicant will be notified the application did  
1396 not meet the submission requirements.

1397

1398 IV.4. Intergovernmental Review of Applications

1399 Executive Order 12372 does not apply to this program.

1400

1401 IV.5. Funding Restrictions

1402 Restrictions, which must be taken into account while writing the budget, are as follows:

- 1403 • Recipients may not use funds for research.
- 1404 • Recipients may not use funds for clinical care, but can include funds for clinical services  
1405 where appropriate.
- 1406 • Recipients may only expend funds for reasonable program purposes, including personnel,  
1407 travel, supplies, and services, such as contractual.
- 1408 • Recipients may not generally use HHS/CDC/ATSDR funding for the purchase of  
1409 furniture or equipment. However, if equipment purchase is integral to a selected MAPPS  
1410 strategy, it will be considered. Any such proposed spending must be identified in the  
1411 budget.
- 1412 • Recipients may not use funding for construction.
- 1413 • The direct and primary recipient in a cooperative agreement program must perform a  
1414 substantial role in carrying out project objectives and not merely serve as a conduit for an  
1415 award to another party or provider who is ineligible.
- 1416 • Reimbursement of pre-award costs is not allowed.
- 1417 • Recipients may not spend more than 5% of the total award for tobacco prevention and  
1418 control on nicotine replacement therapy (NRT).

1419

1420 If requesting indirect costs in the budget, a copy of the indirect cost rate agreement is required.

1421 If the indirect cost rate is a provisional rate, the agreement should be less than 12 months of age.



1422 The indirect cost rate agreement should be uploaded as a PDF file with “Other Attachment  
1423 Forms” when submitting via Grants.gov.

1424

1425 The recommended guidance for completing a detailed justified budget can be found on the CDC  
1426 Web site, at the following Internet address:

1427 <http://www.cdc.gov/od/pgo/funding/budgetguide.htm>.

1428

1429 IV.6. Other Submission Requirements

1430

1431 LOI Submission Address: Submit the LOI by express mail, delivery service, fax, or E-mail to:

1432 Tracey Sims, Grants Management Specialist

1433 Procurement and Grants Office

1434 Centers for Disease Control and Prevention

1435 2920 Brandywine Road, MS E-09

1436 Atlanta, GA 30341

1437 Phone Number: 770-488-2739

1438 Fax Number: 770-488-2677

1439 E- mail: atu9@cdc.gov

1440

1441 Please send a courtesy copy of the LOI by express mail, delivery service, fax, or E-mail to:

1442

1443 Adrienne S. Brown, Public Health Analyst

1444 Division of Adult and Community Health

1445 National Center for Chronic Disease Prevention and Health Promotion  
1446 Centers for Disease Control and Prevention  
1447 3005 Chamblee-Tucker Road, Mailstop K-45  
1448 Atlanta, GA 30341  
1449 Fax: (770) 488-5964

1450  
1451 The information contained within the LOI is required and allows CDC Program staff to estimate  
1452 the potential review workload and plan the review of applications. Failure to submit a LOI will  
1453 result in non-responsiveness and the applicant will be prohibited from applying.

1454  
1455 Application Submission Address:  
1456 Electronic Submission:  
1457 HHS/CDC strongly encourages applicants to submit applications electronically at  
1458 [www.Grants.gov](http://www.Grants.gov). The application package can be downloaded from [www.Grants.gov](http://www.Grants.gov).  
1459 Applicants are able to complete it off-line, and then upload and submit the application via the  
1460 Grants.gov Web site. E-mail submissions will not be accepted. If the applicant has technical  
1461 difficulties in Grants.gov, customer service can be reached by E-mail at [support@grants.gov](mailto:support@grants.gov) or  
1462 by phone at 1-800-518-4726 (1-800-518-GRANTS). The Customer Support Center is open from  
1463 7:00a.m. to 9:00p.m. Eastern Time, Monday through Friday.

1464  
1465 The applicant must submit all application attachments using a PDF file format when submitting  
1466 via Grants.gov. Directions for creating PDF files can be found on the Grants.gov Web site. Use  
1467 of file formats other than PDF may result in the file being unreadable by staff.

1468

1469 **V. Application Review Information**

1470 V.1. Criteria

1471

1472 The application will be evaluated against the following criteria:

1473

1474 Application will be scored on the extent to which the proposed plan provides a robust  
1475 combination of interventions with broad reach, and provides evidence that this plan is likely to  
1476 produce the long term outcomes of this initiative. The applicant should provide evidence that  
1477 performance measures will be achieved during the annual project years or cooperative agreement  
1478 project period, as appropriate, in each of the following areas (points indicate the weight of each  
1479 criterion):

1480

1481 Evaluation criteria for all applicants are listed under number 1 below.

1482

1483 **1. Applicants**

1484

1485 **A. Program Infrastructure and Fiscal Management (20 points) NOTE: Scoring**  
1486 **criteria applicable only to State applications are represented in bold type.**

- 1487 i. Is the lead/fiduciary agency clearly identified? (2 pts) / **(2 pts)**
- 1488 ii. Does the lead/fiduciary agency exhibit the capacity to ensure  
1489 accountability for expenditures in relationship to performance of all key  
1490 partners and Recovery Act requirements? (4 pts)/ **(3 pts)**

- 1491           iii.   How well does the applicant provide evidence of the ability to implement  
1492                          funding for this program in the time required? (2 pts) / **(2 pts)**
- 1493           iv.   Does the applicant identify the required staff for the program, including  
1494                          the provision of resumés or CVs? How well does the applicant identify  
1495                          ways in which to engage the required skill sets to fulfill the CPPW  
1496                          benchmarks? (3 pts) / **(2 pts)**
- 1497           v.   Does the applicant provide letters of support from government leaders  
1498                          (e.g. the mayor, the Governor, or Tribal Council Leader) indicating  
1499                          support for the CPPW Initiative? (3 pts) / **(2 pts)**
- 1500           vi.   Does the applicant describe clearly defined roles and abilities of project  
1501                          staff, especially related to policy-related efforts, and an appropriate  
1502                          percent of time each is committing to the project? (4 pts) / **(3 pts)**
- 1503           vii. Does the applicant demonstrate staff experience with policy making and  
1504                          briefing political leaders and policy makers? (2 pts) / (2 pts)
- 1505           viii. For state-coordinated small city and rural community applicants, how well  
1506                          does the state health department describe their State-Community  
1507                          Management Team, including participation from the funded communities,  
1508                          the state health department’s collaborative FOA designated Healthy  
1509                          Communities coordinator, the state education agency, the state planning  
1510                          agency (where applicable), and the state tobacco or obesity/physical  
1511                          activity/nutrition coordinator (where applicable), and the Office of Rural  
1512                          Health (where applicable). **(2 pts)**

1513 ix. For state-coordinated small city and rural community applicants, how well  
1514 does the state health department describe their plans to provide  
1515 programmatic support to the funded communities in their state? (2 pts)

1516

1517

1518 **B. Leadership team and community coalitions (25 points)**

1519 i. Is the leadership team identified and defined to the extent that they will  
1520 actively participate in overseeing the strategic direction of project  
1521 activities, be responsible for enacting the selected policy changes selected  
1522 from the prescribed set of interventions, establish and maintain an  
1523 organizational structure and governance for the community coalition or  
1524 coalitions, and participate in project-related local and national meetings?  
1525 What roles will they play in meeting the purpose of the Initiative? (4 pts)

1526 ii. Do members of the leadership team represent the leadership of the  
1527 organizations or institutions that they represent? (2 pts)

1528 iii. Do the members of the leadership team demonstrate a high-level  
1529 commitment to the CPPW Initiative, including a commitment of time and  
1530 other resources? (3 pts)

1531 iv. Does the applicant have an established community coalition that is  
1532 inclusive of key partners, and related coalitions? Does the applicant  
1533 include a list of current members, meeting minutes, or a memorandum of  
1534 understanding? (5 pts)

- 1535 v. How well does the applicant describe the capacity of the existing coalition  
1536 in terms of leadership, expertise, community representation, collaborative  
1537 experience/abilities, and agency representation? (3 pts)
- 1538 vi. Have members of the existing coalition successfully worked together and  
1539 in collaboration with community leaders to implement broad-based policy,  
1540 systems, and environmental change initiatives? Does the applicant provide  
1541 examples of past successes? (5 pts)
- 1542 vii. Does the applicant provide evidence that they will encourage linkages  
1543 with other community-based efforts and the Office of the Regional Health  
1544 Administrator, with special attention to leveraging other Federally funded  
1545 (including Recovery Act funded)- and foundation activities? See  
1546 Attachment B for examples. (3 pts)

1547

1548 **C. Intervention Area, Community Action Plan, and Intervention Strategies (30**  
1549 **points)**

- 1550 i. Is the plan sufficiently robust to impact the entire jurisdiction and to  
1551 achieve the short and long-term goals of the initiative? (2 pts)
- 1552 ii. Does the proposed intervention area encompass the entire jurisdiction of  
1553 the health department, including a thorough description of the exact size  
1554 and location of the populations to be served? (2 pts)
- 1555 iii. Are data provided that substantiate the existing burden and/or disparities  
1556 of chronic diseases, conditions, existing health behaviors, and risk factors  
1557 in the jurisdiction and populations to be served? (2 pts)

- 1558                   iv. Are assets and barriers to successful program implementation identified,  
1559                                   including an understanding of the policy, systems, and environmental  
1560                                   policies in the community? (3 pts)
- 1561                   v. Does the applicant clearly articulate which risk factors they will address:  
1562                                   tobacco or obesity/physical activity/nutrition? Has the applicant selected  
1563                                   from the prescribed set of MAPPS evidence-based strategies and the  
1564                                   appropriate mix of interventions? (2 pts)
- 1565                   vi. How well does the applicant justify the selected of interventions? Does the  
1566                                   justification reflect the assets and needs of the community, the decision to  
1567                                   include or to not include the required interventions, and the potential for  
1568                                   broad reach and impact consistent with the short and long-term goals of  
1569                                   the initiative? (4 pts)
- 1570                   vii. Does the two -year community action plan describe an overall integrated  
1571                                   strategy that identifies the selected interventions; describes key activities;  
1572                                   describes milestones and timelines on achieving intervention  
1573                                   implementation; identifies anticipated policy outcomes; and includes  
1574                                   SMART Objectives (Specific, Measurable, Achievable, Relevant, Time-  
1575                                   Framed) for each intervention? (5 pts)
- 1576                   viii. Does the applicant describe realistic plans to coordinate proposed  
1577                                   activities with state- and community-level programs to prevent and control  
1578                                   chronic disease? (2 pts)

- 1579 ix. Do the intervention strategies build on and complement, but not duplicate,  
1580 existing programs and the potential synergy created through multiple  
1581 interventions? (2 pts)
- 1582 x. Does the applicant clearly articulate how the activities and interventions  
1583 highlighted in the CAP will be sustained after Recovery Act spending is  
1584 complete? Does the applicant provide evidence of leveraging other  
1585 resources in the community (e.g. foundations, state funding, private sector  
1586 funds, etc.)? (4 pts)
- 1587 xi. How well does the applicant incorporate cultural and linguistic diversity  
1588 and the needs of specific populations disproportionately impacted by  
1589 chronic diseases (i.e. low-income groups, racial and ethnic groups, persons  
1590 with disabilities, and people with clinical and sub-clinical substance use  
1591 and/or mental disorders) in their intervention strategies? (2 pts)

1592

1593 **D. Plan for Project Monitoring and Evaluation (20 points)**

- 1594 i. Does the applicant indicate that they will collect Recovery Act  
1595 performance measures in the required format and according to the required  
1596 schedule? (Highlighted in section VI.3. Reporting Requirements under  
1597 “Recovery Act-Specific Reporting Requirements”). (5 pts)
- 1598 ii. Does the applicant describe plans to collaborate fully in external,  
1599 independently coordinated evaluation activities to evaluate the overall  
1600 impact of the initiative, especially the national evaluation activities? (3  
1601 pts)



- 1602                   iii. How well does the applicant describe the overall plan to evaluate the  
1603                                   initiative at the community level? (3 pts)
- 1604                   iv. Does the applicant describe a detailed plan to collect YRBSS data  
1605                                   according to standard YRBSS protocol, including the identification of a  
1606                                   YRBSS lead who will attend a 3-day YRBSS training in August 2010 and  
1607                                   methods for collecting the data? (4 pts)
- 1608                   v. Does the application contain letters of support from school districts and  
1609                                   schools in the intervention area indicating that school districts and schools  
1610                                   are aware and supportive of the upcoming YRBSS data collection during  
1611                                   the fall semester of the 2010-2011 school year and at the end of the project  
1612                                   period? (4 pts)
- 1613                   vi. How well does the applicant describe their plans to upgrade or expand  
1614                                   their biometric data collection (if applicable)? (1 pt)

1615

1616                   **E. Programmatic Support Needs (5 points)**

- 1617                   i. Does the applicant identify opportunities, supports and barriers to  
1618                                   achieving intended outcomes? (1 pts)
- 1619                   ii. How realistically does the applicant describe barriers to achieving broad  
1620                                   reach and impact? (2 pts)
- 1621                   iii. Does the applicant identify specific topic areas where programmatic  
1622                                   support will be needed? (2 pts)

1623

1624                   **F. Budget (not scored)**

1625 i. Is the budget reasonable and consistent with the proposed activities and  
1626 intent of the initiative?

1627

## 1628 V.2. Review and Selection Process

1629 Applications will be reviewed for responsiveness by the Procurement and Grants Office (PGO)  
1630 and the National Center for Chronic Disease Prevention and Health Promotion. Applications that  
1631 are non-responsive to the eligibility criteria will not advance through the review process.

1632 Applicants will be notified the application did not meet submission requirements.

1633 An objective review panel will evaluate complete and responsive applications according to the  
1634 criteria listed in the “V.1. Criteria” section above. The panel will be comprised of HHS  
1635 employees. A primary, secondary, and tertiary reviewer will score the applications and  
1636 document their strengths and weaknesses. The applications will be scored against the criteria not  
1637 against one another. These comments will be presented to the panel and a vote will take place by  
1638 the panel to determine if the application is approved, disapproved, or deferred.

1639

1640 Applications will be provided to the funding office in order by score and rank determined by the  
1641 review panel.

1642

1643 In addition, funding decisions may be made to ensure:

- 1644 • Representation of tobacco and obesity/physical activity/nutrition across communities,  
1645 including a varied type of interventions and evidence-based strategies.
- 1646 • Geographic distribution of The Communities Putting Prevention to Work Initiative  
1647 nationwide.

- 1648 • Inclusion of communities of varying sizes, including rural, suburban, and urban  
1649 communities.
- 1650 • Inclusion of populations disproportionately affected by chronic disease and associated  
1651 risk factors.

1652

1653 CDC will provide justification for any decision to fund out of rank order.

1654

## 1655 VI. Award Administration Information

### 1656 VI.1. Award Notices

1657 Successful applicants will receive a Notice of Award (NoA) from the CDC Procurement and  
1658 Grants Office. The NoA shall be the only binding, authorizing document between the recipient  
1659 and CDC. The NoA will be signed by an authorized Grants Management Officer and emailed to  
1660 the program director and a hard copy mailed to the recipient fiscal officer identified in the  
1661 application.

1662

1663 Unsuccessful applicants will receive notification of the results of the application review by mail.

1664

### 1665 VI.2. Administrative and National Policy Requirements

- 1666 • Successful applicants must comply with the administrative requirements outlined in 45  
1667 CFR Part 74 and Part 92, as appropriate. The following additional requirements apply to  
1668 this project:

- 1669 • AR-9 Paperwork Reduction Act Requirements

- 1670 • AR-10 Smoke-Free Workplace Requirements

- 1671 • AR-11 Healthy People 2010
- 1672 • AR-12 Lobbying Restrictions
- 1673 • AR-14 Accounting System Requirements
- 1674 • AR-15 Proof of Non-Profit Status
- 1675 • AR-20 Conference Support
- 1676 • AR-21 Small, Minority, And Women-owned Business
- 1677 • AR 23 Compliance with 45 C.F.R. Part 87
- 1678 • AR 26 National Historic Preservation Act of 1966
- 1679 • AR-27 Conference Disclaimer and Use of Logos

1680 Additional information on the requirements can be found on the CDC Web site at the following

1681 Internet address: [http://www.cdc.gov/od/pgo/funding/Addtl\\_Reqmnts.htm](http://www.cdc.gov/od/pgo/funding/Addtl_Reqmnts.htm).

1682

1683 CDC Assurances and Certifications can be found on the CDC Web site at the following Internet

1684 address: <http://www.cdc.gov/od/pgo/funding/grants/foamain.shtm>

1685

1686 For more information on the Code of Federal Regulations, see the National Archives and

1687 Records Administration at the following Internet address:

1688 <http://www.access.gpo.gov/nara/cfr/cfr-table-search.html>

1689

1690 VI.3. Reporting Requirements

1691

1692 The applicant must provide quarterly reports that provide the necessary information related to the  
1693 output and outcome measures appropriate to the activities which they have undertaken. As  
1694 noted, awardees will be monitored on the following output and outcome measures.

1695

1696 **Outcome Measures**

- 1697 • Measure: Number of policies or strategies fully implemented from the family of  
1698 recommended evidence-based policies and strategies in [specific focus area: physical  
1699 activity and nutrition or tobacco]
- 1700 • Reporting: CHANGE Tool outcome module
- 1701 • Frequency: Semi-annually. Awardee will report to CDC; CDC will compile into  
1702 average scores for aggregate reporting. For awardees who have failed to meet  
1703 benchmarks in Year 1, reporting of some elements of the CHANGE tool will be  
1704 required quarterly.

1705

1706 **Output Measures**

- 1707 • Measure: Rating (on 1-5 scale) of progress implementing each of the chosen  
1708 strategies in [specific focus area: physical activity and nutrition or tobacco]
- 1709 • Reporting: CHANGE Tool progress module
- 1710 • Frequency: Semi-annually. Awardee will report to CDC; CDC will compile into  
1711 average scores for aggregate reporting. For awardees who have failed to meet  
1712 benchmarks in Year 1, reporting of some elements of the CHANGE tool will be  
1713 required quarterly.

1714

- 1715           • Measure: Score (green, yellow, red) on quarterly implementation scorecard during the  
1716           first year of implementation.
- 1717           • Reporting: Awardee progress reporting “benchmark” scorecard
- 1718           • Frequency: Quarterly report by awardee to Project Officer
- 1719
- 1720           • Measure: Score (green, yellow, red) on quarterly implementation of Community  
1721           Action Plan during the second year of implementation.
- 1722           • Reporting: Awardee progress reporting on CAP benchmarks
- 1723           • Frequency: Quarterly report by awardee to Project Officer
- 1724

1725 **Recovery Act-Specific Reporting Requirements**

1726

1727 **1. Other Standard Terms and Conditions**

1728 All other grant policy terms and conditions contained in applicable Department of Health  
1729 and Human Services (HHS) Grant Policy Statements apply unless they conflict or are  
1730 superseded by the following terms and conditions implementing the American Recovery  
1731 and Reinvestment Act of 2009 (Recovery Act) requirements below. Recipients are  
1732 responsible for contacting their HHS grant/program managers for any needed  
1733 clarifications.

1734

1735 **2. Quarterly Benchmarks**

1736 Awardees are required to meet quarterly benchmarks in the first year of implementation,  
1737 located in Attachment A. During year 1, at the end of each quarter, the awardee will  
1738 receive a score card that indicates the percentage of benchmarks being met (100%-70%  
1739 of benchmarks = green; 70%-50% of benchmarks = yellow; less than 50% of benchmarks  
1740 = red). Leadership within CDC will be made aware of those awardees that are scoring in  
1741 the yellow and red. Quarterly scores resulting in a red designation will result in an  
1742 immediate on-site meeting with CDC staff, community leadership and selected national  
1743 experts to establish an emergency plan for overcoming barriers to success. Depending on  
1744 the type of community, state and/or local government leaders (e.g. the Governor, Mayor,  
1745 or Tribal Council leader) will also be informed. Awardees within the red scorecard  
1746 category will be asked to submit a performance improvement plan, and teams of experts  
1747 will be available to provide intensive programmatic support and to verify progress. In

1748 accordance with applicable laws and regulations including 45 CFR 92.43, CDC may take  
1749 certain enforcement actions, including termination of funding, against poor performing  
1750 grants.

1751

1752 3. Recovery Act-Specific Requirements

1753 Recipients of Federal awards from funds authorized under Division A of the Recovery  
1754 Act must comply with all requirements specified in Division A of the Recovery Act  
1755 (Public Law 111-5), including reporting requirements outlined in Section 1512 of the Act  
1756 and designated Recovery Act outcome and output measures as detailed at the end of this  
1757 section. For purposes of reporting, Recovery Act recipients must report on Recovery Act  
1758 sub-recipient (sub-grantee and sub-contractor) activities as specified below.

1759 Not later than 10 days after the end of each calendar quarter, starting with the quarter  
1760 ending March 30, 2010 and reporting by April 10, 2010, the recipient must submit  
1761 quarterly reports to HHS that will posted to Recovery.gov, containing the following  
1762 information:

1763

- 1764 a. The total amount of Recovery Act funds under this award;
- 1765 b. The amount of Recovery Act funds received under this award that were obligated and  
1766 expended to projects or activities;
- 1767 c. The amount of unobligated award balances;
- 1768 d. A detailed list of all projects or activities for which Recovery Act funds under this  
1769 award were obligated and expended, including
- 1770
  - The name of the project or activity;



- 1771                   • A description of the project or activity;
- 1772                   • An evaluation of the completion status of the project or activity;
- 1773                   • An estimate of the number of jobs created and the number of jobs retained by
- 1774                   the project or activity (see OMB Guidance M-09-21, June 22, 2009) and;
- 1775                   • For infrastructure investments made by State and local governments, the
- 1776                   purpose, total cost, and rationale of the agency for funding the infrastructure
- 1777                   investment with funds made available under this Act, and the name of the
- 1778                   person to contact at the agency if there are concerns with the infrastructure
- 1779                   investment.
- 1780           e. Detailed information on any sub-awards (sub-contracts or sub-grants) made by the
- 1781           grant recipient to include the data elements required to comply with the Federal
- 1782           Funding Accountability and Transparency Act of 2006 (Public Law 109-282).
- 1783
- 1784           For any sub-award equal to or larger than \$25,000, the following information:
- 1785                   • The name of the entity receiving the sub-award;
- 1786                   • The amount of the sub-award;
- 1787                   • The transaction type;
- 1788                   • The North American Industry Classification System code or Catalog of
- 1789                   Federal Domestic Assistance (CFDA) number;
- 1790                   • Program source;
- 1791                   • An award title descriptive of the purpose of each funding action;
- 1792                   • The location of the entity receiving the award;

- 1793                   • The primary location of performance under the award, including the city,  
1794                   State, congressional district, and county.
- 1795                   • A unique identifier of the entity receiving the award and of the parent entity of  
1796                   the recipient, should the entity be owned by another entity;
- 1797                   • The date the sub-award was issued;
- 1798                   • The term of the sub-award (start/end dates);
- 1799                   • The scope/activities of the sub-award;
- 1800                   • The amount of the total sub-award that has been obligated or disbursed by the  
1801                   sub-recipient; and
- 1802                   • The amount of the total sub-award that remains unobligated by the sub-  
1803                   recipient.
- 1804           f. All sub-awards less than \$25,000 or to individuals may be reported in the aggregate,  
1805           as prescribed by HHS.
- 1806           g. Recipients must account for each Recovery Act award and sub-award (sub-grant and  
1807           sub-contract) separately. Recipients will draw down Recovery Act funds on an  
1808           award-specific basis. Pooling of Recovery Act award funds with other funds for  
1809           drawdown or other purposes is not permitted.
- 1810           h. Recipients must account for each Recovery Act award separately by referencing the  
1811           assigned CFDA number for each award.

1812

1813           The definition of terms and data elements, as well as any specific instructions for  
1814           reporting, including required formats, will be provided in subsequent guidance issued by  
1815           HHS.



1817 4. Buy American - Use of American Iron, Steel, and Manufactured Goods  
1818 Recipients may not use any funds obligated under this award for the construction,  
1819 alteration, maintenance, or repair of a public building or public work unless all of the  
1820 iron, steel, and manufactured goods used in the project are produced in the United States  
1821 unless HHS waives the application of this provision. (Recovery Act Sec. 1605)

1822

1823 5. Wage Rate Requirements

1824 *[This term and condition shall not apply to tribal contracts funded with this*  
1825 *appropriation. (Recovery Act Title VII—Interior, Environment, and Related Agencies,*  
1826 *Department of Health and Human Services, Indian Health Facilities)]*

1827 Subject to further clarification issued by the Office of Management and Budget, and  
1828 notwithstanding any other provision of law and in a manner consistent with other  
1829 provisions of Recovery Act, all laborers and mechanics employed by contractors and  
1830 subcontractors on projects funded directly by or assisted in whole or in part by and  
1831 through the Federal Government pursuant to this award shall be paid wages at rates not  
1832 less than those prevailing on projects of a character similar in the locality as determined  
1833 by the Secretary of Labor in accordance with subchapter IV of chapter 31 of title 40,  
1834 United States Code. With respect to the labor standards specified in this section, the  
1835 Secretary of Labor shall have the authority and functions set forth in Reorganization Plan  
1836 Numbered 14 of 1950 (64 Stat. 1267; 5 U.S.C. App.) and section 3145 of title 40, United  
1837 States Code. (Recovery Act Sec. 1606)

1838

1839 6. Preference for Quick Start Activities (Recovery Act)

1840 In using funds for this award for infrastructure investment, recipients shall give  
1841 preference to activities that can be started and completed expeditiously, including a goal  
1842 of using at least 50 percent of the funds for activities that can be initiated not later than  
1843 120 days after the date of the enactment of Recovery Act. Recipients shall also use grant  
1844 funds in a manner that maximizes job creation and economic benefit. (Recovery Act Sec.  
1845 1602)

1846

1847 7. Limit on Funds (Recovery Act)

1848 None of the funds appropriated or otherwise made available in Recovery Act may be  
1849 used by any State or local government, or any private entity, for any casino or other  
1850 gambling establishment, aquarium, zoo, golf course, or swimming pool. (Recovery Act  
1851 Sec. 1604)

1852

1853 8. Disclosure of Fraud or Misconduct

1854 Each recipient or sub-recipient awarded funds made available under the Recovery Act  
1855 shall promptly refer to the HHS Office of Inspector General any credible evidence that a  
1856 principal, employee, agent, contractor, sub-recipient, subcontractor, or other person has  
1857 submitted a false claim under the False Claims Act or has committed a criminal or civil  
1858 violation of laws pertaining to fraud, conflict of interest, bribery, gratuity, or similar  
1859 misconduct involving those funds. The HHS Office of Inspector General can be reached  
1860 at <http://www.oig.hhs.gov/fraud/hotline/>

1861

1862 9. Recovery Act: One-Time Funding

1863 Unless otherwise specified, Recovery Act funding to existent or new awardees should be  
1864 considered one-time funding.

1865

1866 10. Schedule of Expenditures of Federal Awards

1867 Recipients agree to separately identify the expenditures for each grant award funded  
1868 under Recovery Act on the Schedule of Expenditures of Federal Awards (SEFA) and the  
1869 Data Collection Form (SF-SAC) required by Office of Management and Budget Circular  
1870 A-133, “Audits of States, Local Governments, and Non-Profit Organizations.” This  
1871 identification on the SEFA and SF-SAC shall include the Federal award number, the  
1872 Catalog of Federal Domestic Assistance (CFDA) number, and amount such that separate  
1873 accountability and disclosure is provided for Recovery Act funds by Federal award  
1874 number consistent with the recipient reports required by Recovery Act Section 1512(c).  
1875 (2 CFR 215.26, 45 CFR 74.26, and 45 CFR 92.26)

1876

1877 11. Responsibilities for Informing Sub-recipients

1878 Recipients agree to separately identify to each sub-recipient, and document at the time of  
1879 sub-award and at the time of disbursement of funds, the Federal award number, any  
1880 special CFDA number assigned for Recovery Act purposes, and amount of Recovery Act  
1881 funds. (2 CFR 215.26, 45 CFR 74.26, and 45 CFR 92.26)

1882

1883           12. Reporting Jobs Creation  
1884           HHS’ recipients of Recovery Act funding who are subject to Section 1512 reporting  
1885           should report job-created data as prescribed in Section 5 of the Office of Management  
1886           and Budget (OMB) guidance M-09-21. HHS will not accept statistical sampling methods  
1887           to estimate the number of jobs created and retained. All recipients must report a direct  
1888           and comprehensive count of jobs, as specified by OMB guidance M-09-21. See Section  
1889           5.3 of the OMB guidance for more information on calculating jobs, including job  
1890           estimation examples. For the full OMB guidance, please visit:  
1891           [http://www.whitehouse.gov/omb/assets/memoranda\\_fy2009/m09-21.pdf](http://www.whitehouse.gov/omb/assets/memoranda_fy2009/m09-21.pdf)

1892  
1893  
1894           To fulfill Paperwork Reduction Act requirements, CDC will utilize a modified version of form  
1895           OMB 0970-0334 - Performance Progress Report (SF-PPR) as a standard quarterly reporting  
1896           format to facilitate uniform collection of performance measures as set forth in the Recovery  
1897           Program Plan, Funding Opportunity Announcement (FOA), and Notice of Grant Award Standard  
1898           Terms and Conditions (as appropriate) for all CDC Recovery Act funded financial assistance  
1899           award recipients. This requirement is in addition to the financial reporting requirements outlined  
1900           in Section 1512 of the Recovery Act.

1901           Additionally, the applicant must provide CDC with an original, plus two hard copies of the  
1902           following reports:

- 1903           1. Final performance and Financial Status reports, no more than 90 days after the end of the  
1904           project period.

1905

1906 These reports must be submitted to the attention of the Grants Management Specialist listed in  
1907 the “VII. Agency Contacts” section of this announcement.

1908

1909 VII. Agency Contacts

1910 CDC encourages inquiries concerning this announcement.

1911 For general questions, contact:

1912 Technical Information Management Section

1913 Department of Health and Human Services

1914 CDC Procurement and Grants Office

1915 2920 Brandywine Road, MS E-14

1916 Atlanta, GA 30341

1917 Telephone: 770-488-2700

1918

1919 For programmatic assistance:

1920

1921 Please send questions to the CPPW mailbox at [CPPW@cdc.gov](mailto:CPPW@cdc.gov). Responses will be posted on

1922 the Community Health Resources website at [www.cdc.gov/communityhealthresources](http://www.cdc.gov/communityhealthresources)

1923

1924 If you need further assistance, contact:

1925 Adrienne S. Brown, Public Health Analyst

1926 Division of Adult and Community Health

1927 National Center for Chronic Disease Prevention and Health Promotion

1928 Centers for Disease Control and Prevention



1929 3005 Chamblee-Tucker Road, Mailstop K-45  
1930 Atlanta, GA 30341  
1931 E-mail: CPPW@cdc.gov  
1932  
1933 For financial, grants management, or budget assistance, contact:  
1934 Tracey Sims  
1935 Procurement and Grants Office  
1936 Centers for Disease Control and Prevention  
1937 2920 Brandywine Road, MS E-09  
1938 Atlanta, GA 30341  
1939 E- mail: atu9@cdc.gov  
1940 Phone Number: 770-488-2739  
1941  
1942 CDC Telecommunications for the hearing impaired or disabled is available at: TTY 770-488-  
1943 2783.  
1944  
1945 VIII. Recovery Act Lobbying Restrictions  
1946 This funding announcement is subject to restrictions on oral conversations during the period of  
1947 time commencing with the submission of a formal application\* by an individual or entity and  
1948 ending with the award of the competitive funds. Federal officials may not participate in oral  
1949 communications initiated by any person or entity concerning a pending application for a  
1950 Recovery Act competitive grant or other competitive form of Federal financial assistance,

---

\* Formal Application includes the preliminary application and letter of intent phases of the program.

1951 whether or not the initiating party is a federally registered lobbyist. This restriction applies  
1952 unless:  
1953  
1954 (i) the communication is purely logistical;  
1955 (ii) the communication is made at a widely attended gathering;  
1956 (iii) the communication is to or from a Federal agency official and another Federal Government  
1957 employee;  
1958 (iv) the communication is to or from a Federal agency official and an elected chief executive of a  
1959 state, local or tribal government, or to or from a Federal agency official and the Presiding Officer  
1960 or Majority Leader in each chamber of a state legislature; or  
1961 (v) the communication is initiated by the Federal agency official.  
1962 For additional information see [http://www.whitehouse.gov/omb/assets/memoranda\\_fy2009/m09-](http://www.whitehouse.gov/omb/assets/memoranda_fy2009/m09-24.pdf)  
1963 [24.pdf](http://www.whitehouse.gov/omb/assets/memoranda_fy2009/m09-24.pdf) .

1964

1965 VIII. Other Information

1966 Other CDC funding opportunity announcements can be found on the CDC Web site, [Internet](http://www.cdc.gov/od/pgo/funding/FOAs.htm)  
1967 [address: http://www.cdc.gov/od/pgo/funding/FOAs.htm](http://www.cdc.gov/od/pgo/funding/FOAs.htm).

1968

1969 Applicants may access the application process and other awarding documents using the  
1970 Electronic Research Administration System (eRA Commons). A one-time registration is  
1971 required for interested institutions/organizations at  
1972 <http://era.nih.gov/ElectronicReceipt/preparing.htm>

1973 Program Directors/Principal Investigators (PD/PIs) should work with their  
1974 institutions/organizations to make sure they are registered in the eRA Commons.

1975 1. [Organizational/Institutional Registration in the eRA Commons](#)

1976 • To find out if an organization is already eRA Commons-registered, see the "[List of](#)  
1977 [Grantee Organizations Registered in eRA Commons.](#)"

1978 • Direct questions regarding the eRA Commons registration to:  
1979 eRA Commons Help Desk

1980 Phone: 301-402-7469 or 866-504-9552 (Toll Free)

1981 TTY: 301-451-5939

1982 Business hours M-F 7:00 a.m. – 8:00 p.m. Eastern Time

1983 Email [commons@od.nih.gov](mailto:commons@od.nih.gov)

1984 2. Project Director/Principal Investigator (PD/PI) Registration in the eRA Commons: Refer  
1985 to the [NIH eRA Commons System \(COM\) Users Guide](#).

1986 • The individual designated as the PD/PI on the application must also be registered in the  
1987 eRA Commons. It is not necessary for PDs/Pis to register with Grants.gov.

1988 • The PD/PI must hold a PD/PI account in the eRA Commons and must be affiliated with  
1989 the applicant organization. This account cannot have any other role attached to it other  
1990 than the PD/PI.

1991 • This registration/affiliation must be done by the Authorized Organization  
1992 Representative/Signing Official (AOR/SO) or their designee who is already registered in  
1993 the eRA Commons.

1994 • Both the PD/PI and AOR/SO need separate accounts in the eRA Commons since both  
1995 hold different roles for authorization and to view the application process.

1996 Note that if a PD/PI is also an HHS peer-reviewer with an Individual DUNS and CCR  
1997 registration, that particular DUNS number and CCR registration are for the individual reviewer  
1998 only. These are different than any DUNS number and CCR registration used by an applicant  
1999 organization. Individual DUNS and CCR registration should be used only for the purposes of  
2000 personal reimbursement and should not be used on any grant applications submitted to the  
2001 Federal Government.

2002 Several of the steps of the registration process could take four weeks or more. Therefore,  
2003 applicants should check with their business official to determine whether their  
2004 organization/institution is already registered in the eRA [Commons](#). HHS/CDC strongly  
2005 encourages applicants to register to utilize these helpful on-line tools when applying for funding  
2006 opportunities.

2007  
2008  
2009

**Attachment A: Communities Putting Prevention to Work - Year 1 & Year 2 Benchmarks  
Federal Quarters**

|  |  |   |  |
|--|--|---|--|
| <b>2<sup>nd</sup> – 3<sup>rd</sup><br/>Quarters</b>  | <b><u>1-30 days</u></b><br>-Establish minimum staffing requirements.<br>-3 members of the Leadership Team attend the kick-off meeting (1 should be the leader of the fiduciary agent).   | <b><u>30-60 days</u></b><br>-Leadership Team is finalized based on feedback from the project officers.<br>-Formalize monitoring plan.                   | <b><u>60-90 days</u></b><br>-Collect data using the CHANGE Tool.<br>-Ensure that the majority of staff/contractors are hired.<br>-Leadership Team attends Action Institute.<br>-Finalize the Community Action Plan (CAP).<br>-Submission of quarterly measures that will be included in community performance plans. |
| <b>3<sup>rd</sup> – 4<sup>th</sup><br/>Quarters</b>  | <b><u>90 – 120 days</u></b><br>-Report on ARRA requirements to recovery.gov and report on CHANGE Tool.<br>-Refine media-buy strategy in concert with national media contractors.<br>-Identify and begin to implement intervention/policy strategies.<br>-Initiate evaluation plan. | <b><u>120 – 150 days</u></b><br>-Implement media campaign and counter advertising strategies.<br>-Continue to implement intervention/policy strategies. | <b><u>150 – 180 days</u></b><br>-Ensure that at least 25% of the interventions are being established as outlined in the CAP.<br>-Submission of quarterly measures that will be included in community performance plans.  |
| <b>4<sup>th</sup> – 5<sup>th</sup><br/>Quarters</b>  | <b><u>180 – 210 days</u></b><br>-Report on ARRA requirements to recovery.gov.  | <b><u>210 – 240 days</u></b>  | <b><u>240 – 270 days</u></b><br>-Collect data using the CHANGE Tool.<br>-Ensure that at least 50% of the interventions are being established as outlined in the CAP.<br>- Submission of quarterly measures that will be included in community performance plans.   |
| <b>5<sup>th</sup> - 6<sup>th</sup><br/>Quarters</b>  | <b><u>270 – 300 days</u></b><br>-Report on ARRA requirements to recovery.gov and report on CHANGE Tool.  | <b><u>300 – 330 days</u></b><br>-Attend peer-peer meeting.  | <b><u>330 – 360 days</u></b><br>- Ensure that at least 75% of the interventions are being established as outlined in the CAP.<br>- Submission of quarterly measures that will be included in community performance plans.  |
| <b>6<sup>th</sup> - 11<sup>th</sup><br/>Quarters</b> | Awardees will submit quarterly reports on the implementation and evaluation of interventions contained within the CAP and anticipated policy outcomes.   |   |  |
| <b>Federal<br/>Quarters</b>                          | Quarter 1: Oct - Dec 2009<br>Quarter 2: Jan - Mar 2010<br>Quarter 3: Apr - Jun 2010<br>Quarter 4: Jul - Sep 2010   | Quarter 5: Oct - Dec 2010<br>Quarter 6: Jan - Mar 2011<br>Quarter 7: Apr - Jun 2011<br>Quarter 8: Jul - Sep 2011  | Quarter 9: Oct - Dec 2011<br>Quarter 10: Jan - Mar 2012<br>Quarter 11: Apr - Jun 2012  |

2010 **Attachment B: US Government-funded Recovery Act Programs Potentially Leveraged by**  
2011 **the Prevention and Wellness Communities Program**

2012  
2013 *Applicants showing collaboration across these and similar programs will receive points in the*  
2014 *application review.*

2015  
2016 **US Department of Transportation**

- 2017 • Federal Highway Administration funding for park roads, parkways, forest highways, ferry
- 2018 boats, etc.
- 2019 • Special discretionary grant program to fund large transportation projects of all modes with
- 2020 costs between \$20 and \$300 million.
- 2021 • Supplemental Grants for a National Surface Transportation System.
- 2022 • Federal Transit Administration capital assistance grants to public transit agencies for capital
- 2023 improvements to assist in reducing energy consumption.
- 2024

2025 **US Department of Agriculture**

- 2026 • Special Supplemental Nutrition Program for Women, Infants, and Children The Emergency
- 2027 Food Assistance Program
- 2028 • Food Distribution Programs on Indian Reservations
- 2029 • National School Lunch Program funding for schools to make necessary improvements to
- 2030 school kitchens in order to handle and process healthy foods.
- 2031 • US Forest Service projects involving capital improvement, bridges, trails, reconstruction,
- 2032 forest improvement and enhancement.
- 2033 • Recognize excellence in nutrition and physical activity by increasing the number of schools
- 2034 certified as a Healthier US School Challenge School
- 2035 • Rural Development Water and Waste Disposal program to provide loans and grants for rural
- 2036 water and wastewater infrastructure
- 2037 • Rural Community Facilities Program loans and grants to develop essential community
- 2038 facilities in rural areas and towns of up to 20,000 in population. Funds to be used for facility
- 2039 acquisition, construction, renovation, or the purchase of equipment and furnishings
- 2040 • Team Nutrition is an initiative of the USDA Food and Nutrition Service to support the Child
- 2041 Nutrition Programs through training and technical assistance for foodservice, nutrition
- 2042 education for children and their caregivers, and school and community support for healthy
- 2043 eating and physical activity.
- 2044 • Expanded Food and Nutrition Education Program (EFNEP) is designed to assist limited-
- 2045 resource audiences in acquiring the knowledge, skills, attitudes, and changed behavior
- 2046 necessary for nutritionally sound diets, and to contribute to their personal development and the
- 2047 improvement of the total family diet and nutritional well-being.
- 2048 • Community Food Projects are designed to increase food security in communities by bringing
- 2049 the whole food system together to assess strengths, establish linkages, and create systems that
- 2050 improve the self-reliance of community members over their food needs.
- 2051 • Kids in the Woods is an agency-wide effort to focus attention and resources in connecting
- 2052 children with nature and their public lands. Efforts encompass a range of activities and
- 2053 programs including summer camping and hiking programs, service opportunities, classroom
- 2054 presentations and engagement, and special events such as National Get Outdoors Day and
- 2055 National Public Lands Day.

- 2056 • Get Fit with US - Forests are working with communities as a part of Get Fit with US to
- 2057 increase participation in outdoor recreation, thereby leading to healthier lifestyles.
- 2058 • Winter Trails Day - Numerous forests are partnering with communities to host Winter Trails
- 2059 Day (and Winter Feels Good) activities to promote winter recreation activities like
- 2060 snowshoeing and cross country skiing to increase physical activity during the winter months.
- 2061 • Summer Food Service Program is the single largest Federal resource available
- 2062 for local organizations that want to combine a feeding program with a summer activity
- 2063 program for children.
- 2064 • School Breakfast Program provides cash assistance to States to operate nonprofit breakfast
- 2065 programs in schools and residential childcare institutions.
- 2066 • National School Lunch Program funding for schools to make necessary improvements to
- 2067 school kitchens in order to handle and process healthy foods.
- 2068 • Participates in the National School Lunch Program and receives and utilizes Team Nutrition
- 2069 materials.
- 2070 • Conservation Youth Corps - Provides “at risk” youth with additional education and skills so
- 2071 they can make better health choices and avoid risky behavior.

2072

2073 **US Department of Interior**

- 2074 • Construction projects at US Fish and Wildlife Service facilities
- 2075 • US Fish and Wildlife programs for habitat restoration, deferred maintenance, trail
- 2076 maintenance, and renewable energy projects.
- 2077 • Bureau of Indian Affairs construction projects, including improvements and repairs to
- 2078 buildings, roads, schools, and jails on Tribal lands.
- 2079 • National Park Service construction and rehabilitation of major buildings, roads, and historic
- 2080 sites

2081

2082 **US Department of Education**

- 2083 • Carol M. White Physical Education Program (page G-56:
- 2084 <http://www.ed.gov/about/overview/budget/budget10/justifications/g-ssce.pdf>)
- 2085 • Safe and drug-free schools and communities: National programs (Page G-24:
- 2086 <http://www.ed.gov/about/overview/budget/budget10/justifications/g-ssce.pdf>)

2087

2088 **Environmental Protection Agency**

- 2089 • Clean Water State Revolving Fund.
- 2090 • Brownfields projects to address environmental site assessment and cleanup. Funds will
- 2091 capitalize revolving funds and provide low interest loans, job training grants and technical
- 2092 assistance to local governments and non-profit organizations.

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2094 **US Department of Housing and Urban Development**

- 2095 • Community Development Block Grants (& Indian CDBG) with eligible activities include
- 2096 housing rehab that will include site improvements and development of community
- 2097 infrastructure which can improve walkable community design and investments that promote
- 2098 physical activity.

- 2099 • Public Housing Capital Fund for capital repairs and improvements to federally-subsidized  
2100 public housing, including renovations and retrofits that improve walkability and community  
2101 investments that promote physical activity.
- 2102 • Native American Housing Block Grants for capital investments in energy efficiency and  
2103 development of sustainable communities, including walkability and investments that promote  
2104 physical activity.
- 2105 • Lead Hazard Reduction Grants invested in lead paint hazard reduction abatement activities  
2106 (not directly related to initiative’s goals, but health-related)
- 2107 • The OHHLHC Healthy Homes Demonstration (HHD) grants are well-suited for leveraging  
2108 with HHS’s initiative. There were 20 ARRA HHD grants awarded in the past few months in  
2109 communities across the country.
- 2110 • Specifically, the purpose of the HHD grant program is to “develop, demonstrate, and promote  
2111 cost-effective, preventive measures to correct
- 2112 • The Healthy Homes Demonstration Program is committed to supporting the Departmental  
2113 Strategic Goal of strengthening communities by addressing housing conditions that threaten  
2114 health.
- 2115

2116 **US Federal Emergency Management Administration**

- 2117 • Emergency Food and Shelter Program
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2119 **US Department of Health and Human Services**

- 2120 • The Community Health Center Program which provides community-based primary and  
2121 preventive health services including outreach and health education.
- 2122 • Head Start which supports a comprehensive array of health, nutritional and social services to  
2123 eligible four and five year old preschoolers and their families.
- 2124 • Early Head Start which promotes healthy prenatal outcomes for pregnant women, enhances  
2125 the development of very young children, and promotes healthy family functioning.
- 2126 • Senior Nutrition Programs to support congregate nutrition services provided at senior centers  
2127 and other community sites, home delivered nutrition services delivered to frail elders at  
2128 home, and Native American nutrition programs.
- 2129 • Child Care and Development Fund enables low-income parents and parents receiving  
2130 Temporary Assistance for Needy Families (TANF) to work or to participate in the  
2131 educational or training programs they need in order to work. Funds may also be used to serve  
2132 children in protective services. In addition, a portion of CCDF funds must be used to enhance  
2133 child care quality and availability.
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**Attachment C: MAPPS Interventions for Communities Putting Prevention to Work**

Five evidence-based MAPPS strategies, when combined, can have a profound influence on improving health behaviors by changing community environments: Media, Access, Point of decision information, Price, and Social support/services. Communities will take evidence-based action in each of these areas, choosing from the actions listed in the table. Each community will address all 5 strategies for each risk factor area. These actions will change policy and environment in schools and communities, including in worksites and businesses, health care settings, faith-based communities, and other places where people live, work and play.

|               | <b>Tobacco</b>   | <b>Nutrition</b>   | <b>Physical Activity</b>  |
|---------------|--|--|---|
| <b>Media</b>  | <ul style="list-style-type: none"> <li>• Media and advertising restrictions consistent with federal law (k)</li> <li>• Hard hitting counter-advertising (l-n)</li> <li>• Ban brand-name sponsorships (o)</li> <li>• Ban branded promotional items and prizes (p)</li> </ul>  | <ul style="list-style-type: none"> <li>• Media and advertising restrictions consistent with federal law (38-44)</li> <li>• Promote healthy food/drink choices (42, 43, 45)</li> <li>• Counter-advertising for unhealthy choices (46)</li> </ul>  | <ul style="list-style-type: none"> <li>• Promote increased physical activity (i, ii, vi, ix, xxix-xxx)</li> <li>• Promote use of public transit (i, ii, vi, ix, xxix-xxx)</li> <li>• Promote active transportation (bicycling and walking for commuting and leisure activities) (i, ii, vi, ix, xxix-xxx)</li> <li>• Counter-advertising for screen time (i, ii, vi, ix, xxix-xxx)</li> </ul>   |
| <b>Access</b> | <ul style="list-style-type: none"> <li>• Usage bans (i.e. 100% smoke-free policies or 100% tobacco-free policies) (f, g, v)</li> <li>• Usage bans (tobacco-free school campuses) (e-g, h-j)</li> <li>• Zoning restrictions (e-g)</li> <li>• Restrict sales (e.g. internet; sales to minors; stores/events w/o tobacco) (e-g)</li> <li>• Ban self-service displays &amp; vending (e-g)</li> </ul> | <ul style="list-style-type: none"> <li>• Healthy food/drink availability (e.g., incentives to food retailers to locate/offer healthier choices in underserved areas, healthier choices in child care, schools, worksites) (7-9, 10-21, 63-68, 76-82)</li> <li>• Limit unhealthy food/drink availability (whole milk, sugar sweetened beverages, high-fat snacks) (17, 22-25, 69-73)</li> <li>• Reduce density of fast food establishments (15, 26)</li> <li>• Eliminate transfat through purchasing actions, labeling initiatives, restaurant standards (29-31)</li> <li>• Reduce sodium through purchasing actions, labeling initiatives, restaurant standards (32-34)</li> <li>• Procurement policies and</li> </ul> | <ul style="list-style-type: none"> <li>• Safe, attractive accessible places for activity (i.e., access to outdoor recreation facilities, enhance bicycling and walking infrastructure, place schools within residential areas, increase access to and coverage area of public transportation, mixed use development, reduce community design that lends to increased injuries) (xxxix – xli)</li> <li>• City planning, zoning and transportation (e.g., planning to include the provision of sidewalks, parks, mixed use, parks with adequate crime prevention measures, and Health Impact Assessments) (ii,iii,iv,v,viii,ix)</li> <li>• Require daily quality PE in schools (xvi – xxiii)</li> <li>• Require daily physical</li> </ul> |

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|  |   | practices<br>(8, 9, 13, 14, 35, 36) <ul style="list-style-type: none"> <li>• Farm to institution, including schools, worksites, hospitals, and other community institutions (35, 36, 37)</li> </ul>                               | activity in afterschool/childcare settings (i, ii, iii, v, viii, ix, xxiv-xxvii) <ul style="list-style-type: none"> <li>• Restrict screen time (afterschool, daycare) (x, xi, xii, xiii, xiv)</li> </ul>  |
| <b>Point of Purchase/<br/>Promotion</b>  | <ul style="list-style-type: none"> <li>• Restrict point of purchase advertising (q)</li> <li>• Product placement (q)</li> </ul>   | <ul style="list-style-type: none"> <li>• Signage for healthy vs. less healthy items (8, 9, 47, 48, 74-75)</li> <li>• Product placement &amp; attractiveness (8, 9, 47, 48, 49, 74-75)</li> <li>• Menu labeling (50-53)</li> </ul> | <ul style="list-style-type: none"> <li>• Signage for neighborhood destinations in walkable/mixed-use areas (library, park, shops, etc) (ii, iii, iv, ix, xlxiii)</li> <li>• Signage for public transportation, bike lanes/boulevards (ii, iii, iv, ix, xlxi, xlxiii)</li> </ul> |
| <b>Price</b>                             | <ul style="list-style-type: none"> <li>• Use evidence-based pricing strategies to discourage tobacco use (a-c)</li> <li>• Ban free samples and price discounts (d)</li> </ul> | <ul style="list-style-type: none"> <li>• Changing relative prices of healthy vs. unhealthy items (e.g. through bulk purchase/procurement/competitive pricing) (5-9, 60-62)</li> </ul>   | <ul style="list-style-type: none"> <li>• Reduced price for park/facility use (xxxvi – xxxviii)</li> <li>• Incentives for active transit (xxxvii, xxxviii)</li> <li>• Subsidized memberships to recreational facilities (ii, iii, viii, ix)</li> </ul>                           |
| <b>Social Support &amp;<br/>Services</b> | <ul style="list-style-type: none"> <li>• Quitline and other cessation services (r-t)</li> </ul>   | <ul style="list-style-type: none"> <li>• Support breastfeeding through policy change and maternity care practices (54-59)</li> </ul>  | <ul style="list-style-type: none"> <li>• Safe routes to school (vii, xv, xxxi-xxxv)</li> <li>• Workplace, faith, park, neighborhood activity groups (e.g., walking hiking, biking) (ii, iii, viii, ix)</li> </ul>   |

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2158  
2159  
2160  
2161  
2162  
2163

**Tobacco references**

Use evidence-based strategies to discourage tobacco use

- a. Centers for Disease Control and Prevention. Reducing tobacco use: a report of the Surgeon General. Atlanta, GA: US Department of Health and Human Services, CDC; 2000
- b. Institute of Medicine. Ending the tobacco problem: a blueprint for the nation. Washington, DC: The National Academies Press; 2007.
- c. Task Force on Community Preventive Services. Guide to community preventive services: tobacco use prevention and control. Am J Prev Med 2001;20(2 Suppl 1):1--87.

Ban free samples and price discounts

- d. Loomis BR, Farrelly MC, Mann NH. The Association of retail promotions for cigarettes with the Master Settlement Agreement, tobacco control programmes and cigarette excise taxes. Tob. Control 2006; 15:458-63.

- 2164 Access (youth specific)  
2165  
2166 e. Centers for Disease Control and Prevention. Reducing tobacco use: a report of the Surgeon General.  
2167 Atlanta, GA: US Department of Health and Human Services; 2000  
2168 f. Institute of Medicine. Ending the tobacco problem: a blueprint for the nation. Washington, DC: The  
2169 National Academies Press; 2007.  
2170 g. Task Force on Community Preventive Services. Guide to community preventive services: tobacco use  
2171 prevention and control. *Am J Prev Med* 2001;20(2 Suppl 1):1--87.  
2172
- 2173 Usage bans (smoke free campuses)  
2174  
2175 h. Pentz MA. The power of policy: the relationship of smoking policy to adolescent smoking. *American*  
2176 *journal of public health* 1989;79(7):857-62.
- 2177 i. Wakefield MA. Effect of restrictions on smoking at home, at school, and in public places on teenage  
2178 smoking: cross sectional study. *BMJ* 2000;321(7257):333-7.
- 2179 j. Kumar R. School tobacco control policies related to students' smoking and attitudes toward smoking:  
2180 national survey results, 1999-2000. *Health education & behavior* 2005;32(6):780-94.  
2181
- 2182 Media and advertising restrictions  
2183  
2184 k. National Cancer Institute. The role of the media in promoting and reducing tobacco use. Tobacco Control  
2185 Monograph, No. 19; 2008.  
2186
- 2187 Hard-hitting counter-advertising  
2188  
2189 l. Task Force on Community Preventive Services. Guide to community preventive services: tobacco use  
2190 prevention and control. *Am J Prev Med* 2001;20(2 Suppl 1):1--87.  
2191 m. National Cancer Institute. The role of the media in promoting and reducing tobacco use. Tobacco Control  
2192 Monograph, No. 19; 2008.  
2193 n. Institute of Medicine. Ending the tobacco problem: a blueprint for the nation. Washington, DC: The  
2194 National Academies Press; 2007.  
2195
- 2196 Ban Brand-name sponsorship  
2197  
2198 o. National Cancer Institute. The role of the media in promoting and reducing tobacco use. Tobacco Control  
2199 Monograph, No. 19; 2008.  
2200
- 2201 Ban Branded promotional items and prizes  
2202  
2203 p. National Cancer Institute. The role of the media in promoting and reducing tobacco use. Tobacco Control  
2204 Monograph, No. 19; 2008.  
2205
- 2206 Restrict point of purchase advertising/product placement  
2207  
2208 q. National Cancer Institute. The role of the media in promoting and reducing tobacco use. Tobacco Control  
2209 Monograph, No. 19; 2008.  
2210
- 2211 Quitline and other cessation services  
2212  
2213 r. Fiore MC, Jaen CR, Baker, TB, et al. Treating tobacco use and dependence: 2008 Update. Quick Reference  
2214 Guide for Clinicians. Public Health Service; 2008.  
2215 s. Task Force on Community Preventive Services. Guide to community preventive services: tobacco use  
2216 prevention and control. *Am J Prev Med* 2001;20(2 Suppl 1):1--87.

- 2217 t. Institute of Medicine. Ending the tobacco problem: a blueprint for the nation. Washington, DC: The  
2218 National Academies Press; 2007.  
2219  
2220

### 2221 Nutrition References

2222  
2223 1. Dietary Guidelines for Americans, 2005. U.S. Department of Health and Human Services and U.S. Department of  
2224 Agriculture. Dietary Guidelines for Americans, 2005. 6th Edition, Washington, DC: U.S. Government Printing  
2225 Office, January 2005. Foods Encouraged, Available at:  
2226 <http://www.health.gov/DietaryGuidelines/dga2005/document/html/chapter5.htm>  
2227

2228 5. French, S.A., M. Story, and R.W. Jeffery, *Environmental influences on eating and physical activity*. Annu Rev  
2229 Public Health, 2001. 22: p. 309-35.  
2230

2231 6. French SA, Wechsler H. School-based research and initiatives: fruit and vegetable environment, policy, and  
2232 pricing workshop. Prev Med. 2004 Sep;39 Suppl 2:S101-7.  
2233

2234 7. Ayala G. et al., 2009 – Evaluation of the Healthy Tienda project. The Public Health Effects of Food Deserts.  
2235 Workshop Summary. Institute of Medicine and National Research Council, p 49-51.  
2236 <http://www.iom.edu/Object.File/Master/62/082/Session%204%20920%20am%20Ayala.pdf>.  
2237

2238 8. Glanz K, Yaroch AL. Strategies for increasing fruit and vegetable intake in grocery stores and communities:  
2239 policy, pricing, and environmental change. Prev Med. 2004 Sep;39 Suppl 2:S75-80. Review.  
2240

2241 9. Nonas C, 2009. Health Bucks in New York City. The Public Health Effects of Food Deserts. Workshop  
2242 Summary. Institute of Medicine and National Research Council, p 59-60. Available at  
2243 <http://www.iom.edu/CMS/3788/59640/62040/62078.aspx>  
2244

2245 Increase healthy food/drink availability (e.g., grocery, child care, schools, worksites)  
2246

#### 2247 Grocery

2248 10. Bodor, J. N., Rose, D., Farley, T. A., Swalm, C., & Scott, S. K. (2007). Neighbourhood fruit and vegetable  
2249 availability and consumption: the role of small food stores in an urban environment. *Public Health Nutrition*.  
2250

2251 11. Gittelsohn J, Ethelbah M. Evaluation of the White Mountain and San Carlos Apache Healthy Stores Program, a  
2252 multi-component intervention that included stocking healthier food items. Available at  
2253 <http://www.farmfoundation.org/news/articlefiles/450-Gittelsohn.pdf>.  
2254

2255 12. Morland K, Diez Roux AV, Wing S. Am J Prev Med. 2006 Apr;30(4):333-9 Supermarkets, other food stores,  
2256 and obesity: the atherosclerosis risk in communities study.  
2257

2258 13. Larson, N., Story, M., & Nelson, M. (2009). Neighborhood Environments Disparities in Access to Healthy  
2259 Foods in the U. S. *American Journal of Preventive Medicine*. 36(1):74-81.  
2260

2261 14. Story M, Kaphingst KM, Robinson-O'Brien R, Glanz K. Creating healthy food and eating environments: policy  
2262 and environmental approaches. Annu Rev Public Health. 2008;29:253-72.  
2263

2264 15. Moore, L.V., et al., *Associations of the local food environment with diet quality--a comparison of assessments*  
2265 *based on surveys and geographic information systems: the multi-ethnic study of atherosclerosis*. Am J Epidemiol,  
2266 2008. 167(8): p. 917-24.  
2267

#### 2268 Childcare

2269 16. Ward, D. S., Benjamin, S. E., Ammerman, A. S., Ball, S. C., Neelon, B. H., & Bangdiwala, S. I. (2008).  
2270 Nutrition and physical activity in child care: results from an environmental intervention. *Am J Prev Med.*, 35(4),  
2271 352-356. Epub 2008.  
2272

2273 *School*  
2274 17. IOM (2007). Nutrition Standards for Foods in Schools: Leading the Way Toward Healthier Youth Committee on  
2275 Nutrition Standards for Foods in Schools. Washington, D.C., The National Academies Press.  
2276  
2277 18. Ritenbaugh C, Tufel-Shone N, et al. A lifestyle intervention improves plasma insulin levels among Native  
2278 American high school youth. *Prev Med.*2003;36:309-319.  
2279  
2280 19. Jaime, P.C. and K. Lock, Do school based food and nutrition policies improve diet and reduce obesity? *Prev*  
2281 *Med*, 2009. 48(1): p. 45-53.  
2282  
2283 *Worksite*  
2284 20. Sorensen, G., Linnan, L., & Hunt, M. K. (2004). Worksite-based research and initiatives to increase fruit and  
2285 vegetable consumption. *Prev.Med.*, 39 *Suppl* 2, S94-100.  
2286  
2287 21. The Community Guide to Preventive Services. Obesity prevention through worksite programs. Available at  
2288 <http://www.thecommunityguide.org/obesity/workprograms.html>  
2289  
2290  
2291 Limit unhealthy food/drink availability (whole milk, sugar sweetened beverages, snacks)  
2292  
2293 See Ref 17  
2294  
2295 22. Schwartz, M. B., Novak, S. A., & Fiore, S. S. (2009). The Impact of Removing Snacks of Low Nutritional Value  
2296 From Middle Schools. *Health Educ Behav*, 5, 5.  
2297  
2298 23. Kubik, M.Y., et al., *The association of the school food environment with dietary behaviors of young adolescents*.  
2299 *Am J Public Health*, 2003. 93(7): p. 1168-73.  
2300  
2301 24. Cullen, K.W. and I. Zakeri, *Fruits, vegetables, milk, and sweetened beverages consumption and access to a la*  
2302 *carte/snack bar meals at school*. *Am J Public Health*, 2004. 94(3): p. 463-7.  
2303  
2304 25. Templeton, S.B., M.A. Marlette, and M. Panemangalore, *Competitive foods increase the intake of energy and*  
2305 *decrease the intake of certain nutrients by adolescents consuming school lunch*. *J Am Diet Assoc*, 2005. 105(2): p.  
2306 215-20.  
2307  
2308 Reduce density fast food establishments  
2309  
2310 See Refs 12, 15  
2311  
2312 26. Ashe M, Jernigan D, Kline R, Galaz R. Land use planning and the control of alcohol, tobacco, firearms, and fast  
2313 food restaurants. *Am J Pub Health*. 2003;93(9):1404-1408.  
2314  
2315 Eliminate trans fat  
2316  
2317 29. Mozaffarian D. Katan MB. Ascherio A. Stampfer MJ. Willett WC. Trans Fatty Acids and Cardiovascular  
2318 Disease. *New England Journal of Medicine*. April 13, 2006. 354;15:1601-13.  
2319  
2320 30. Panel on Macronutrients, Institute of Medicine. Letter report on dietary reference intakes for trans fatty acids  
2321 drawn from the Report on dietary reference intakes for energy, carbohydrate, fiber, fat, fatty acids, cholesterol,  
2322 protein, and amino acids. Washington, DC 2003.  
2323  
2324 31. Trans Fat Regulation: NYC Department of Health and Mental Hygiene – Board of Health Approves Regulation  
2325 to Phase Out Artificial Trans Fat. Available at:  
2326 <http://www.nyc.gov/html/doh/html/cardio/cardio-transfat-healthcode.shtml>; How to Comply: What Restaurants,  
2327 Caterers, Food-Vending Units, and Others Need to Know” Accessed June 24, 2009  
2328 <http://www.nyc.gov/html/doh/downloads/pdf/cardio/cardio-transfat-bro.pdf>

- 2329  
2330 Reduce sodium  
2331  
2332 32. Sacks, FM et al.(2001) Effects on blood pressure of reduced dietary sodium and the Dietary Approaches to Stop  
2333 Hypertension (DASH) diet. DASH-Sodium Collaborative Research Group. New England Journal of Medicine  
2334 344(1):3-10.  
2335  
2336 33. City Purchasing Standards: New York City executive order for formal nutrition standards for all food purchased  
2337 or served by New York City agencies including sodium. Available at :  
2338 <http://www.nyc.gov/html/doh/downloads/pdf/cardio/cardio-food-standards.pdf>  
2339  
2340 34. New York City, Advocacy for External Efforts: Initiative to develop a voluntary partnership with industry  
2341 leaders to reduce the level of sodium in processed and prepared foods nationwide. Available at:  
2342 <http://www.nyc.gov/html/doh/html/cardio/cardio-salt-initiative.shtml>  
2343  
2344 Procurement policies and practices  
2345  
2346 See Refs 8, 9, 13, 14  
2347  
2348 35. Joshi, A., & Azuma, A. (2008). Do Farm-to-School Programs Make a Difference? Findings and Future Research  
2349 Needs. *Journal of Hunger & Environmental Nutrition*, 3, 2-3.  
2350  
2351 36. Zudrow D (2005) Food Security Begins at Home: Creating Community Food Coalitions in the South. Southern  
2352 Sustainable Agriculture Working Group, pp 45-67, Available at: <http://www.ssawg.org/cfs-handbook.html>  
2353  
2354 Farm to institution  
2355  
2356 See Ref 35  
2357  
2358 37. Texas, Farm to Work program. Farm to Work Initiative of the Texas State Health Service provides a Farm to  
2359 Work Toolkit. Available at <http://www.texasbringinghealthyback.org/> and  
2360 <http://www.dshs.state.tx.us/obesity/pdf/F2WToolkit1008.pdf>  
2361
- 2362  
2363 Media and advertising restrictions  
2364  
2365 38. The Guide to Community Preventive Services - Obesity Prevention: Interventions to Reduce Screen  
2366 Time <http://www.thecommunityguide.org/obesity/screentime/index.html>  
2367  
2368 39. Story M, French S. Food Advertising and Marketing Directed at Children and Adolescents in the US. *Int J*  
2369 *Behav Nutr Phys Act.* 2004 Feb 10;1(1):3.  
2370  
2371 40. Chou SY, Rashad I, Grossman M. Fast-Food Restaurant Advertising on Television and Its Influence on  
2372 Childhood Obesity. *The Journal of Law and Economics*, 2008;51; p 599-618  
2373  
2374 41. Coon KA, Tucker KL: Television and children's consumption patterns. A review of the literature. *Minerva*  
2375 *Pediatr* 2002, 54:423-436.  
2376  
2377 42. WHO. 2004. Global Strategy on Diet, Physical Activity and Health. WHA 57.17. Geneva: WHO. Available at  
2378 [http://apps.who.int/gb/ebwha/pdf\\_files/WHA57/A57\\_R17-en.pdf](http://apps.who.int/gb/ebwha/pdf_files/WHA57/A57_R17-en.pdf)  
2379  
2380 43. Norwegian ministry of Children and Family Affairs, 2005. Norway enacted a ban on TV advertisements to  
2381 children ages 12 years and younger in 1992. Available at  
2382 <http://www.regjeringen.no/en/dep/bld/Documents/Reports-and-plans/Plans/2003-2/The-Norwegian-action-plan-to-reduce-comm.html?id=462256>  
2383

- 2384  
2385 44. Kwate, NOA. Take one down, pass it around, 98 alcohol ads on the wall: outdoor advertising in New York  
2386 City's Black neighbourhoods. *International Journal of Epidemiology*. 2007; 36 (5): 988-990.  
2387
- 2388 Promote healthy food/drink choices  
2389  
2390 See Refs 42, 43  
2391
- 2392 45. Evidence of impact of advertising on food and beverage purchase requests of 2-11 year olds and usual dietary  
2393 intake of 2-5 year olds: IOM (2006), Committee on Food Marketing and the Diets of Children and Youth. Food  
2394 Marketing to Children and Youth: Threat or Opportunity? Washington, D.C., National Academies Press.  
2395
- 2396 Counteradvertising for unhealthy choices  
2397
- 2398 46. Dixon HG, Scully ML, Wakefield MA, White VM, Crawford DA. The effects of television advertisements for  
2399 junk food versus nutritious food on children's food attitudes and preferences. *Soc Sci Med*. 2007 Oct;65(7):1311-23.  
2400
- 2401 Signage for healthy vs. less healthy items  
2402  
2403 See Refs 8, 9  
2404
- 2405 47. Seymour JD, Yaroch AL, Serdula M, Blanck HM, Khan LK. Impact of nutrition environmental interventions on  
2406 point-of-purchase behavior in adults: a review. *Prev Med*. 2004 Sep;39 Suppl 2:S108-36. Review.  
2407
- 2408 48. Glanz K, Hoelscher D. Increasing fruit and vegetable intake by changing environments, policy and pricing:  
2409 restaurant-based research, strategies, and recommendations. *Prev Med*. 2004 Sep;39 Suppl 2:S88-93.  
2410
- 2411 Product placement & attractiveness  
2412 Ref 8, 9, 47, 48  
2413
- 2414 49. Curhan, R.C., The effects of merchandising and temporary promotional activities on the sales of fresh fruit and  
2415 vegetables in supermarket. *Journal of Marketing Research* 1974. 11: p. 286-94.  
2416
- 2417 Menu labeling  
2418
- 2419 50. Bassett, M.T., et al., Purchasing behavior and calorie information at fast-food chains in New York City, 2007.  
2420 *Am J Public Health*, 2008. 98(8): p. 1457-9.  
2421
- 2422 51. Simon, Jarosz, Kuo & Fielding. Menu Labeling as a Potential Strategy for Combating the Obesity Epidemic: A  
2423 Health Impact Assessment. Los Angeles, CA: Los Angeles County Dept of Public Health; 2008  
2424
- 2425 52. Burton S and Creyer EH. "What Consumers Don't Know Can Hurt Them: Consumer Evaluations and Disease  
2426 Risk Perceptions of Restaurant Menu Items." *Journal of Consumer Affairs*, 38(1): 121-45, 2004.  
2427
- 2428 53. Kozup KC, Creyer EH and Burton S. "Making Healthful Food Choices: The Influence of Health Claims and  
2429 Nutrition Information on Consumers' Evaluations of Packaged Food Products and Restaurant Menu Items." *Journal*  
2430 *of Marketing*, 67(2): 19-34, 2003.  
2431
- 2432 Support Breastfeeding  
2433
- 2434 54. Philipp BL et al. 2001. Baby-Friendly Hospital Initiative Improves Breastfeeding Initiation Rates in a US  
2435 Hospital Setting. *Pediatrics* 108(3):677-681.  
2436
- 2437 55. DiGirolamo AM, Grummer-Strawn LM, Fein SB. Effect of Maternity-Care Practices on Breastfeeding.  
2438 *Pediatrics* 2008 October 1;122(Supplement\_2):S43-S49.  
2439

- 2440 56. Baby-Friendly USA. Implementing the UNICEF/WHO Baby Friendly Hospital Initiative in the U.S; Available  
 2441 at: <http://www.babyfriendlyusa.org/eng/index.html> Accessed June 24, 2009.  
 2442
- 2443 57. Cohen R, Mrtek MB. The impact of two corporate lactation programs on the incidence and duration of  
 2444 breastfeeding by employed mothers. *American Journal of Health Promotion* 1994;8(6):436–41.  
 2445
- 2446 58. Fein SB, Mandal B, Roe BE. Success of Strategies for Combining Employment and Breastfeeding. *Pediatrics*  
 2447 2008 October 1;122(Supplement\_2):S56-S62.  
 2448
- 2449 59. Health Resources and Services Administration. The Business Case for Breastfeeding Toolkit. HRSA 2008;  
 2450 Available at: <http://ask.hrsa.gov/detail.cfm?PubID=MCH00254&recommended=1> Accessed June 2, 2009.  
 2451
- 2452 Selective Pricing (schools)  
 2453
- 2454 60. French, S.A., Story, M., Jefferey, R.W., Snyder, P., Marla, E., Sidebottom, A., & Murray, D. (1997). Pricing  
 2455 strategy to promote fruit and vegetable purchase in high school cafeterias. *J Am Diet Assoc*, 97(9): 1008-1010.  
 2456
- 2457 61. French, S.A., Jefferey, R.W., Story, M., Breitlow, K.K., Baxter, J.S., Hannan, P., & Snyder, M.P. (2001). Pricing  
 2458 and promotion effects on low-fat vending snack purchases: The CHIPS study. *Am J Public Health*, 91(1): 112-117.  
 2459
- 2460 62. Hannan, P., French, S.A., Story, M., & Fulkerson, J.A. (2002). A pricing strategy to promote sales of lower fat  
 2461 foods in high school cafeterias: Acceptability and sensitivity analysis. *Am J Hlth Prom*, 17(1): 1-6.  
 2462
- 2463 Healthy food/drink availability (schools)  
 2464
- 2465 63. Cullen, K.W., Hartstein, J., Reynolds, K.D., Vu, M., Resnicow, K., Greene, N., et al., 2007. Improving the  
 2466 school food environment: results from a pilot study in middle schools. *J. Am. Diet Assoc.* 107 (3), 484–489.  
 2467
- 2468 64. Lytle, L.A., Kubik, M.Y., Perry, C., Story, M., Birnbaum, A.S., Murray, D.M., 2006. Influencing healthful food  
 2469 choices in school and home environments: results from the TEENS study. *Prev. Med.* 43 (1), 8–13.  
 2470
- 2471 65. Perry, C.L., Bishop, D.B., Taylor, G.L., Davis, M., Story, M., Gray, C., et al., 2004. A randomized school trial of  
 2472 environmental strategies to encourage fruit and vegetable consumption among children. *Health Educ. Behav.* 31 (1),  
 2473 65–76.  
 2474
- 2475 66. Sahota, P., Rudolf, M.C., Dixey, R., Hill, A.J., Barth, J.H., Cade, J., 2001. Evaluation of implementation and  
 2476 effect of primary school based intervention to reduce risk factors for obesity. *BMJ* 323 (7320), 1027–1029.  
 2477
- 2478 67. Sahota, P., Rudolf, M.C., Dixey, R., Hill, A.J., Barth, J.H., Cade, J., 2001. Randomised controlled trial of  
 2479 primary school based intervention to reduce risk factors for obesity. *BMJ* 323 (7320), 1029–1032.  
 2480
- 2481 68. Muckelbauer R, Libuda L, Clausen K, Toschke AM, Reinehr T, Kersting M. Promotion and provision of  
 2482 drinking water in schools for overweight prevention: Randomized, controlled cluster trial. *Pediatrics*  
 2483 2009;123:e661-e667  
 2484
- 2485 Limit unhealthy food/drink
- 2486 69. Cullen, K.W., Hartstein, J., Reynolds, K.D., Vu, M., Resnicow, K., Greene, N., et al., 2007. Improving the  
 2487 school food environment: results from a pilot study in middle schools. *J. Am. Diet Assoc.* 107 (3), 484–489.  
 2488
- 2489 70. Cullen, K.W., Watson, K., Zakeri, I., Ralston, K., 2006. Exploring changes in middle-school student lunch  
 2490 consumption after local school food service policy modifications. *Public Health Nutr.* 9 (6), 814–820.  
 2491
- 2492 71. Cullen, K.W., Watson, K. 2009. The Impact of the Texas Public School Nutrition Policy on Student Food  
 2493 Selection and Sales in Texas. *Am J Public Health.* 2009 Apr;99(4):706-12  
 2494



2495 72. Kubik M, Lytle L, Hannan P, Perry C, Story M. The association of the school food environment with dietary  
2496 behaviors of young adolescents. *Am J Public Health* 2003;93:1168-73.  
2497  
2498 73. Stone, E.J., Osganian, S.K., McKinlay, S.M., Wu, M.C., Webber, L.S., Luepker, R.V., et al., 1996. Operational  
2499 design and quality control in the CATCH multicenter trial. *Prev.*  
2500 *Med.* 25 (4), 384–399.  
2501  
2502 Farm to institution  
2503  
2504 See Ref 35  
2505  
2506 Point of purchase promotion (in schools)  
2507  
2508 74. French, S. A., Jeffery, R. W., Story, M., Breitlow, K. K., Baxter, J. S., Hannan, P. & Snyder, M. P. (2001)  
2509 Pricing and promotion effects on low-fat vending snack purchases: The CHIPS study. *Am. J. Public Health* 91:112-  
2510 117.  
2511  
2512 75. French SA, Story M, Fulkerson JA, Hannan P. An Environmental Intervention to Promote Lower-Fat Food  
2513 Choices in Secondary Schools: Outcomes of the TACOS Study. *Am J Public Health* 2004;94:1507-12  
2514  
2515 76. Institute of Medicine. *Local Government Actions to Prevent Childhood Obesity*. Washington, DC: The National  
2516 Academies Press; 2009.  
2517  
2518 77. Centers for Disease Control and Prevention. Recommended Community Strategies and Measurements to Prevent  
2519 Obesity in the United States. *MMWR* 2009;58(No. RR-07): 1-26.  
2520  
2521 78. Ed Bolen et al., *Neighborhood Groceries: New Access to Healthy Food in Low-Income Communities*, (San  
2522 Francisco, CA: California Food Policy Advocates, 2003).  
2523  
2524 79 PolicyLink: Equitable Development Toolkit: Healthy Food Retailing provides an online tool that focuses on  
2525 increasing access to retail outlets that sell nutritious, affordable food in low-income communities of color.  
2526 <http://www.policylink.org/EDTK/HealthyFoodRetailing>  
2527  
2528 80. Gittelsohn, J., et al., Process Evaluation of Baltimore Healthy Stores: A Pilot Health Intervention Program With  
2529 Supermarkets and Corner Stores in Baltimore City. *Health Promot Pract*, 2009.  
2530  
2531 81. Flournoy R and Treuhaft S (2005). *Healthy food, healthy communities: improving access and opportunities*  
2532 *through food retailing*. Oakland, CA: PolicyLink.  
2533  
2534 82. Bitler, M., and S. J. Haider. *An Economic View of Food Deserts in the United States. Research Conference on*  
2535 *Understanding the Economic Concepts and Characteristics of Food Access*. Washington, DC: USDA, Economic  
2536 Research Service and University of Michigan National Poverty Center, 2009.  
2537  
2538  
2539

### Physical Activity References

2540  
2541  
2542 i. US Department of Health and Human Services. Physical Activity Guidelines for Americans. Available at:  
2543 <http://www.health.gov/PAGuidelines/>  
2544  
2545 ii. The Guide to Community Preventive Services: What works to Promote Health?. Oxford University Press, 2005,  
2546 pp 80-113.  
2547 The Guide to Community Preventive Services is also Available at:  
2548 <http://www.thecommunityguide.org/pa/index.html>  
2549

- 2550 iii. Kahn, E.B., Ramsey, L.T., Brownson, R.C., Heath, G.W., Howze, E.H., Powell, K.E. et al. 2002. The  
 2551 effectiveness of interventions to increase physical activity. A systematic review by the U.S. Task Force on  
 2552 Community Preventive Services. *American Journal of Preventive Medicine* 22, S73–102.  
 2553
- 2554 iv. Heath GW, Brownson RC, Kruger J, et al. The effectiveness of urban design and land use and transport policies  
 2555 and practices to increase physical activity: a systematic review. *J Phys Act Health*. 2006;3(suppl 1):S55-S76.
- 2556 v. Hoehner CM, Soares J, Parra DP, Ribeiro IC, Joshi C, Pratt M et al. 2008. Systematic review of physical activity  
 2557 interventions in Latin America. *Am J Prev Med* 34(3), 224-233  
 2558
- 2559 vi. Roux L, Pratt M, Tengs TO, Yanagawa T, Yore M, et al., 2008. Cost Effectiveness of Community-based  
 2560 Physical Activity Interventions. *Am J Prev Med* 35(6), 578-588  
 2561
- 2562 vii. Active Living Research Brief. Walking and biking to school, physical activity and health outcomes. May 2009  
 2563
- 2564 viii. Ramsey LT, Brownson RC. Increasing physical activity. *Am J Prev Med* 2002 (4S); 73-107  
 2565
- 2566 ix. Centers for Disease Control and Prevention. Planning, implementing and evaluating interventions. Available at:  
 2567 [http://www.cdc.gov/nccdphp/dnpa/physical/health\\_professionals/interventions/index.htm](http://www.cdc.gov/nccdphp/dnpa/physical/health_professionals/interventions/index.htm)  
 2568
- 2569 x. The Guide to Community Preventive Services - Obesity Prevention: Interventions to Reduce Screen  
 2570 Time. <http://www.thecommunityguide.org/obesity/screentime/index.html>  
 2571
- 2572 xi. New York City Amendments to the NYC Health Code (established limits on passive, sedentary TV viewing in  
 2573 group childcare services to 60 minutes or less per day.  
 2574 [http://www.frac.org/pdf/nyc\\_cacfp\\_childcare\\_nutrphysact\\_law.pdf](http://www.frac.org/pdf/nyc_cacfp_childcare_nutrphysact_law.pdf)  
 2575
- 2576 xii. Delaware Child Care Policy to Improve Children's Health: regulatory changes through the Office of Child Care  
 2577 Licensing for all childcare in DE (center-based, family and after-school) that limit sedentary and media exposure to  
 2578 a maximum of 1 hour per day for children >2 years. [http://www.nemours.org/departments/nhps/policy-leader/child-](http://www.nemours.org/departments/nhps/policy-leader/child-care.html)  
 2579 [care.html](http://www.nemours.org/departments/nhps/policy-leader/child-care.html)  
 2580
- 2581 xiii. Benjamin SE, Cradock A Walker EM, Slining M, Gillman MW. Obesity prevention in child care: a review of  
 2582 U.S. state regulations. *BMC Public Health*. 2008;8:188.  
 2583
- 2584 xiv. Kaphingst LM, Story M. Child care as an untapped setting for obesity prevention: State child care licensing  
 2585 regulations related to nutrition, physical activity, and media use for preschool-aged children in the United States.  
 2586 *Preventing Chronic Disease*. 2009;6:1.  
 2587
- 2588 xv. Centers for Disease Control and Prevention. Kids Walk to School. Available at:  
 2589 <http://www.cdc.gov/nccdphp/dnpa/kidswalk/>  
 2590
- 2591 Require daily quality PE  
 2592
- 2593 xvi. Kahn EB, Ramsey LT, Brownson RC, Heath GW, Howze EH, Powell KE. The effectiveness of interventions to  
 2594 increase physical activity: a systematic review. *Am J Prev Med* 2002; 22(4S): 73-107.  
 2595
- 2596 xvii. McKenzie TL, Nader PL, Strikmiller PK, Yang M, Stone EJ, Perry CL, et al. School physical education: effect  
 2597 of the Child and Adolescent Trial for Cardiovascular Health. *Prev Med* 1996 25:423-431.  
 2598
- 2599 xviii. Pangrazi RP, Beighle A, Vehige T, Vack C. Impact of Promoting Lifestyle Activity for Youth (PLAY) on  
 2600 children's physical activity. *J Sch Health* 73(8): 317-321.  
 2601
- 2602 xix. Pate RR, Ward DS, Saunders RP, Felton G, Dishman RK, Dowda M. Promotion of physical activity among  
 2603 high school girls: a randomized controlled trial. *Am J Public Health* 2005; 95(9): 1582-1587.  
 2604

- 2605  
2606 xx. Harrell JS, McMurray RG, Bangdiwala SI, Frauman AC, Gansky SA, Bradley CB. Effects of a school-based  
2607 intervention to reduce cardiovascular disease risk factors in elementary-school children: The Cardiovascular Health  
2608 in Children (CHIC Study). *J Pediatr* 1996; 128:797-805.  
2609
- 2610 xxi. Reed KE, Warburton DER, Macdonald HM, Naylor PJ, McKay HA. Action schools! BC: a school-based  
2611 physical activity intervention designed to decrease cardiovascular risk factors in children. *Prev Med* 2008; 46:525-  
2612 531.  
2613
- 2614 xxii. Webber LS, Catellier DJ, Lytle LA, Murray DM, Pratt CA, Young DR, et al. Promoting physical activity in  
2615 middle school girls: Trial of Activity for Adolescent Girls. *Am J Prev Med* 2008; 34(3): 173-184.  
2616
- 2617 xxiii. Manios Y, Moschandreas J, Hatzis C, Kafatos A. Evaluation of a health and nutrition education program in  
2618 primary school children of Crete over a three-year period. *Prev Med* 1999; 28:149-159.  
2619
- 2620 Daily physical activity in after school  
2621
- 2622 xxiv. Sallis JF, McKenzie TL, Conway TL, Elder JP, Prochaska JJ, Brown M et al. Environmental interventions for  
2623 eating and physical activity: a randomized controlled trial in middle schools. *Am J Prev Med* 2003;24:209-17.  
2624
- 2625 xxv. Kelder S, Hoelscher DM, Barroso CS, Walker JL, Cribb P, Shaohua H. The CATCH Kids Club: a pilot after-  
2626 school study for improving elementary students' nutrition and physical activity. *Public Health Nutrition* 2005; 8(2):  
2627 133-140.  
2628
- 2629 xxvi. Story M, Sherwood NE, Himes JH, Davis M, Jacobs DR, et al. An after-school obesity prevention program for  
2630 African American girls: the Minnesota GEMS pilot study. *Ethn Dis* 2003; 13(1 suppl 1): S54-64.  
2631
- 2632 xxvii. Yin, et al. Medical College of Georgia Fitkid Project. *Evaluation & the Health Professions* 2005; 67-89.  
2633
- 2634 xxviii. Kien LC & Chiodo AR. Physical activity in middle school-aged children participating in a school-based  
2635 recreation program. *Arch Pediatr Adolesc Med* 2003; 157:811-815.  
2636
- 2637 Media to promote increased physical activity  
2638
- 2639 xxix. Huhman M, Potter LD, Wong FL, Banspach SW, Duke JC, Heitzler CD. Effects of a mass media campaign to  
2640 increase physical activity among children: year 1 results of the VERB campaign. *Pediatrics* 2005;116:e277-3284.  
2641
- 2642 xxx. Huhman M, Bauman A, Bowles HR. Initial outcomes of the VERB campaign: tweens' awareness and  
2643 understanding of campaign messages. *Am J Prev Med* 2008; 34(6S):S241-S248.  
2644
- 2645 Safe routes to school  
2646
- 2647 xxxi. Cooper AR, Page AS, Foster LJ, Qahwaji D. Commuting to school: are children who walk more physically  
2648 active? *Am J Prev Med* 2003;25:273-6.
- 2649 xxxii. Cooper AR. Physical activity levels of children who walk, cycle, or are driven to school. *Am J Prev Med*  
2650 2005;29:179-84.
- 2651 xxxiii. Tudor-Locke C, Neff LJ, Ainsworth BE, Addy CL, Popkin BM. Omission of active commuting to school and  
2652 the prevalence of children's health-related physical activity levels: the Russian Longitudinal Monitoring Study.  
2653 *Child Care Health Dev* 2002;28:507-12.
- 2654 xxxiv. Alexander LM, Inchley J, Todd J, Currie D, Cooper AR, Currie C. The broader impact of walking to school  
2655 among adolescents: seven day accelerometry based study. *BMJ* 2005;331:1061-2.

2656 xxxv. Sirard J, Riner WJ, McIver K, Pate R. Physical activity and active commuting to elementary school. *Med Sci*  
2657 *Sports Exerc* 2005;37:2062-9.

2658 Reduced cost and use

2659  
2660 xxxvi. Managed-Medicare health club benefit and reduced health care costs among older adults. Nguyen HQ,  
2661 Ackerman RT, Maciejewski M, Berke E, Patrick M. Williams B, LoGerfo JP, *Prev. Chronic Disease*, 2008 Jan 5(1)  
2662 A14. Epub 2007 Dec 15.

2663  
2664 xxxvii. Economic interventions to promote physical activity. Application of the SLOTH model.  
2665 Pratt, M, Macera CA, Sallis JF, O'Donnell M, Frank LD. *Am J Prev. Med* 2004, 27(S1)  
2666

2667 xxxviii. The economics of physical activity: Societal trends and rationales for interventions. Strum R, *Am J Prev.*  
2668 *Med*, 2004, 27 (S1).  
2669

2670 Safety and Park Use

2671  
2672 xxxix. The built environment, neighborhood crime and constrained physical activity: An exploration of inconsistent  
2673 findings. Foster, S, Giles-Corti B. *Prev Med* 2008, 47 (3) pp 241-251.  
2674

2675 xl. Unsafe to play? Neighborhood disorder and lack of safety predict reduced physical activity among urban children  
2676 and adolescents. Molnar, S, Gortmaker, S, Bull F, Buka SL. *Am J Health Prom* 2004, 18(5) pp 378-386.  
2677

2678 xli. Parents' perceptions of neighborhood safety and children's physical activity. Weir, L, Etelson D, Brand D. *Prev.*  
2679 *Med* 2006, 43(3) pp 212-217.  
2680

2681 xlxi. Besser LM, Dannenberg AL. Walking to public transit: steps to help meet physical activity recommendations.  
2682 *Am J Prev Med*. 2005; 29(4):273-80.  
2683

2684 xlxiii. MMWR: Morbidity and Mortality Weekly Report. Recommended community strategies and measurements  
2685 to prevent obesity in the United States. Centers for Disease Control and Prevention. July 24, 2009 58(RR07);1-26.  
2686 <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5807a1.htm>  
2687

2688  
2689 **Additional references**

2690  
2691 Comprehensive State and Community Programs

2692  
2693 Arkansas Center for Health Improvement. Assessment of childhood and adolescent obesity in Arkansas; Year Four  
2694

2695 Economos CD, et al. A community intervention reduces BMI z-score in children: Shape Up Somerville first year  
2696 results. *Obesity* 2007;15:1325  
2697

2698 Hoelscher DM et al. Regional and state initiatives lead to significant decreases in the prevalence of child overweight  
2699 in Texas. Manuscript submitted.  
2700

2701 Other references for "Signage prompts" for deterring sedentary behavior:

2702  
2703 R.E Andersen, S.C Franckowiak, J Snyder, S.J Bartlett and K.R Fontaine, Can inexpensive signs encourage the use  
2704 of stairs? Results from a community intervention, *Ann Intern Med* **129** (1998), pp. 363-369.

2705 J Kerr, F Eves and D Carroll, Posters can prompt less active people to use the stairs, *J Epidemiol Community Health*  
2706 **54** (2000), pp. 942-943.  
2707

2708 W Russell, D Dziewaltowski and G Ryan, The effectiveness of a point-of-decision prompt in deterring sedentary  
2709 behavior, *Am J Health Promot* **13** (1999), pp. 257-259.