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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

Program Announcement CDC-RFA-DP07-704

State Heart Disease and Stroke Prevention Programs

Notice of Availability of Funds

Announcement Type: New.

Funding Opportunity Number (FOA): CDC-RFA-DP07-704

Catalog of Federal Domestic Assistance Number: 93.283

Key Dates:

Letter of Intent Deadline: February 12, 2007

Application Deadline: March 12, 2007

Executive Summary:

The Centers for Disease Control and Prevention (CDC), National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP), Division for Heart Disease and Stroke Prevention (DHDSP), announces the opportunity to apply for funds to increase the leadership of State health departments in cardiovascular disease prevention. Based on the Socio-ecological Model, the essential strategies of the programs are use of educational, policy and systems change to increase heart disease and stroke prevention with emphasis on the six program priority areas: addressing control of high blood pressure and high

blood cholesterol primarily in adults and older adults, increasing knowledge of signs and symptoms for heart disease and stroke and the importance of calling 9-1-1, improving emergency response, improving quality of heart disease and stroke care, and eliminating disparities, focusing on the health care and worksite settings.

Approximately $25,000,000 is available to fund State health departments through cooperative agreements. A Capacity Building Program develops the foundation for a comprehensive cardiovascular disease prevention program through such activities as partnership development, definition of the burden, development of a State plan, and pilot testing interventions. Approximately $8,000,000 is available to fund 19 to 22 State health departments to support Capacity Building programs (ranging from $200,000 to $400,000 each for a 5-year budget period). In future years of the project period, if resources are available, States with Capacity Building programs that meet performance measures (see Reporting Requirements section) can request Optional Funding for Capacity Building Programs or Basic Implementation level funding.

A Basic Implementation Program enhances Capacity Building activities and implements, disseminates, and evaluates intervention activities that address the State plan objectives and the CDC program priority areas 1-6. Approximately $16,000,000 is available to fund 12 to 14 State health departments to support Basic Implementation programs (ranging from $900,000 to $1,300,000 each for a 5-year budget period). State health departments funded for Basic Implementation programs under Program Announcement 02045 may compete for Basic Implementation funding. No new Basic Implementation programs will

be funded in the initial year of this FOA.

Optional Funding for Capacity Building Programs supports pilots of intervention activities that address the CDC program priority areas 1-6. Approximately $1,000,000 is available to fund 5 to 10 State health departments as Optional funding available only to Capacity Building programs (ranging from $100,000 to $200,000 each for a 3-year budget period).

Stroke Network funding supports a State health department to increase in stroke prevention activities across a group of 3 to 6 contiguous, member States with emphasis on increasing awareness and implementing priority policy or systems changes across the States. Approximately $600,000 is available to fund about 3 to 4 State health departments to support Stroke Network activities (ranging from $165,000 to $195,000 each for a 3-year budget period depending on the number of member States). States that do not border other States, such as Alaska and Hawaii, are considered for this FOA to be contiguous with their respective DHHS region. States with a stroke age-adjusted death rate greater than 10% of the US total (53.5 per 100,000) may be given preference to ensure geographic distribution of programs and direction of funds to areas with high stroke burden and mortality.

Funding decision related to Capacity Building and Basic Implementation awards may include a preference for States that are 10 % above the national average for ischemic

heart disease or stroke.

This competition for State Heart Disease and Stroke Prevention (HDSP) program funding is open to all State health departments since they have the ability to convene and work with the private and public sectors to address heart disease and stroke in a coordinated manner. They can also apply public health methods to bring about policy and systems change using the Socio-ecological Model. Awards will begin on or about June 30, 2007 for a 12-month budget period within a project period of up to 5 years. Continuation awards within an approved project period will be made based on satisfactory progress as evidenced by required reports, performance measures, and the availability of funds.

This announcement contains the following information:

I. Funding Opportunity Description

- Authority
- Background
- Purpose
- Activities
  1. Capacity Building Programs
  2. Basic Implementation Programs
  3. Optional Funding for Capacity Building Programs
  4. Stroke Networks
  5. CDC Activities

II. Award Information

1. Capacity Building Programs

2. Basic Implementation Programs

3. Optional Funding for Capacity Building Programs

4. Stroke Networks

III. Eligibility Information

1. Eligible Applicants

2. Cost Sharing

3. Other Eligibility Requirements

IV. Application and Submission Information

1. Address to Request Application Package

2. Content and Form of Submission

Letter of Intent

Application

3. Submission Dates and Times

Explanation of Deadlines

4. Intergovernmental Review of Applications

5. Funding Restrictions

6. Other Submission Requirements

V. Application Review Information

1. Criteria

2. Review and Selection Process

3. Anticipated Announcement and Review Dates

VI. Award Administration Information

1. Award Notices

2. Administration and National Policy Requirements

3. Reporting Requirements

VII. Agency Contacts

VIII. Other Information

Attachment I Background and HDSP Program Logic Model
Attachment II Performance Measures for Capacity Building and Basic Implementation Programs and Stroke Networks
Attachment III Roles of State HDSP Programs
Table 1 Ischemic Heart Disease and Stroke Mortality by State

I. Funding Opportunity Description

Authority: Section 317(k)(2) of the Public Health Service Act (PHS Act), 42 U.S.C. 247b(k)(2); Section 301(a) of the PHS Act, 42 U.S.C. 241(a); Section 307(a) and (b) of the PHS Act, 42 U.S.C. 2421(a) and (b).

Background: Heart disease and stroke are the first and third leading causes of death for both men and women in the United States. In 2003, a total of 685,089 people died of heart disease and 157,689 people died of stroke. In 2003, age-adjusted death rates for heart disease were 32 percent higher for African Americans than for whites, and stroke death rates were 45 percent higher. Coronary heart disease is a leading cause of premature, permanent disability in the U.S. workforce. Stroke alone accounts for

disability among about 1 million Americans. In 1998, the U.S. Congress provided funding for CDC to initiate a national, State-based heart disease and stroke prevention program. These resources have built State capacity to address heart disease and stroke prevention. For more information on the CDC State Heart Disease and Stroke Prevention Program, visit http://www.cdc.gov/dhdsp/State_program/index.htm.

Purpose: The Centers for Disease Control and Prevention (CDC) announces the availability of fiscal year (FY) 2007 funds for a cooperative agreement for State Heart Disease and Stroke Prevention (HDSP) Programs. This program addresses the “Healthy People 2010" focus area(s) Chapter 12: Heart Disease and Stroke.

The primary purpose of the program is to implement heart disease and stroke prevention (HDSP) interventions to reduce morbidity, mortality, and related health disparities. The purpose is to be achieved by enhancing capacity of State health departments to implement evidence-based public health practice and to collaborate with the private and public sectors for State-level coordinated and sustainable approaches. To improve the cardiovascular health of all Americans, every State health department should have the capacity, commitment, and resources to carry out comprehensive cardiovascular disease prevention program.

Heart disease and stroke are complex diseases that require the involvement and collaboration of multiple partners such as State and local governments, voluntary health

organizations, employer groups, and health care providers. A purpose of the State Heart Disease and Stroke Prevention Program funding is to encourage a dual role in working with partners. The first is to convene or facilitate collaboration to develop and implement a comprehensive State plan and intervention implementation strategies that addresses heart disease and stroke and related risk factors. The second is to develop strategies to leverage resources and coordinate interventions with partners that address the program priority areas 1-6 (referred to in this announcement as the "program priority areas 1-6"):

1. Increase control of high blood pressure primarily in adults and older adults.
2. Increase control of high blood cholesterol primarily in adults and older adults.
3. Increase knowledge of signs and symptoms for heart attack and stroke and the importance of calling 9-1-1.
4. Improve emergency response.
5. Improve quality of heart disease and stroke care.
6. Eliminate health disparities in terms of race, ethnicity, gender, geography, or socio-economic status.

State Heart Disease and Stroke Prevention Programs have the ability to convene and work with the private and public sectors to address heart disease and stroke in a coordinated manner. They can also apply public health methods to bring about policy and systems change using the Socio-ecological Model. This model focuses on policy and systems changes in settings (e.g., worksite, health, community) that make it easier for individuals to make heart healthy choices and for health care systems, for example, to

implement changes to ensure compliance with national guidelines of care (see Attachment I; 2001 Institute of Medicine report, The Future of Public's Health, at http://www.iom.edu/CMS/3793/4720/4304.aspx). (For definition and examples of program expectations using the Socio-ecological Model, see Attachment I).

This program announcement is an outcome of the 2005 Congressional encouragement for CDC to create the new Division for Heart Disease and Stroke Prevention (see Attachment I for Congressional language). It also builds on the body of knowledge developed by programs funded under the State Cardiovascular Health Program, initiated by Congress in 1998 with 8 States and expanded in 2006 to 32 States and District of Columbia. Nineteen States received Capacity Building funding to enhance their capacity to comprehensively address heart disease and stroke in partnership with multiple sectors and 14 received Basic Implementation funding to implement interventions.

In order to develop a national program that supports a systematic and sustainable approach to prevent heart disease and stroke and eliminate related health disparities, a two step approach is proposed. Capitalizing not only on what has been learned from 8 years of working with State programs but also on the momentum of the existing State programs, other research, and expertise in the field, this program announcement provides funding to States for Capacity Building programs. States with Capacity Building funding that have sufficient capacity can also enhance their programs by requesting Optional funding to implement an evidence-based or promising practice demonstration project. In

any future year of the project period, if resources are available, States with Capacity Building programs that meet performance measures (see Reporting Requirements section) can request Optional funding or Basic Implementation level funding. This process will ensure that the needed capacities and collaborations are in place prior to larger fiscal investment in State programs that will enhance protection and strengthen improvements in the public's health. In order to increase stroke awareness and prevention, this program announcement includes a regional stroke network supplement.

State programs funded under the State Cardiovascular Health Program (including Program Announcement 02045) have provided evidence that building capacity and developing multi-sector partnerships better enables States to leverage sustainable resources to address heart disease and stroke prevention. An additional purpose of this FOA is to build on the momentum of the existing Capacity Building and Basic Implementation programs by not only providing a mechanisms for these programs to compete for funding levels but also supporting States that apply for Capacity Building and Optional funding to demonstrate their capacity to apply for Basic Implementation funding in years 2 through 4 of this announcement based on accomplishment of performance measures. Basic Implementation programs enhance Capacity Building activities (e.g., sustaining partnerships, defining the burden) and also implement, disseminate, and evaluate intervention activities that address the State plan objectives and the CDC six program priority areas. Measurable outcomes of the program will be in alignment with performance goal(s) for the National Center for Chronic Disease

Prevention and Health Promotion (NCCDPHP). This includes the goal: To reduce death and disability due to heart disease and stroke and eliminate disparities.

This announcement is only for non-research activities supported by CDC. If research is proposed, the application will not be reviewed. For the definition of research, please see the CDC Web site at the following Internet address:
http://www.cdc.gov/od/ads/opspoll1.htm

Activities:

All Capacity Building and Basic Implementation Programs have a direct role in addressing Goals 2, 3, and 4 and a collaborative role in addressing Goal 1 in the Public Health Action Plan to Prevent Heart Disease and Stroke (www.cdc.gov/dhdsp/library) which are based on the Healthy People 2010 goal for heart disease and stroke prevention (see Attachment III):

- Implement efforts within the State for addressing Goals 2, 3, and 4.
- Collaborate to address Goal 1 (e.g., tobacco use, diabetes, poor nutrition, physical inactivity, health disparities, and schools as a worksite) through partnerships with other State health department programs, including the State WISEWOMAN, tobacco, diabetes, nutrition, physical activity, minority health, or coordinated school health programs.

I. 1. Activities for Capacity Building Programs

Awardee activities for the Capacity Building program for both new and existing States are as follows, with new States establishing and maintaining activities and existing States enhancing and maintaining activities:

1. Demonstrate program infrastructure that will enhance the State health department's capacity to address heart disease and stroke prevention by:
    - employing one full-time staff position (one person devoting 100% of time to this cooperative agreement) with the responsibility and authority to carry out the activities identified in the work plan provided to CDC for funding under this program announcement and to serve as the project manager and the primary point of contact for CDC;
    - employing a one-half time epidemiologist with education in chronic disease epidemiology;
    - establishing and maintaining sources of skilled people for carrying out activities under this cooperative agreement including expertise in program evaluation, program planning, and partnership development and maintenance;
    - establishing and maintaining methods of collaboration between State health department programs that relate to heart disease and stroke prevention, and
    - committing to send two representatives to two 3-day CDC-sponsored

meetings or trainings related to content update and promising practices designed for State Heart Disease and Stroke Prevention Program awardees.

2. Develop and maintain partnerships that can collaborate on developing:
   - a comprehensive State plan that addresses heart disease and stroke prevention and related risk factors (e.g., high blood pressure, high blood cholesterol, tobacco use, diabetes, obesity) as well as the program priority areas 1-6. Describe how an official body or work group will be established to develop the State plan and implement its objectives and strategies.
   - strategies to leverage resources and coordinate interventions that address program priority areas 1-6.

     a. Develop and maintain strategic multi-sector partnerships within the following sectors:

        - State health department, those who address related risk factors (e.g., high blood pressure, high blood cholesterol, tobacco use, diabetes, obesity), populations, or settings, and data partners such as vital statistics and the State's Behavioral Risk Factor Surveillance System (BRFSS).
        - State government, those who address heart disease and stroke or related risk factors or conditions, populations or

settings, and data partners such as Medicaid.

- State organizations, those who: address heart disease and stroke or related risk factors (with emphasis on prevention and control of high blood pressure and high blood cholesterol), such as the voluntary health organizations, federally qualified health centers, quality improvement organizations; provide knowledge of and access to Priority Populations (e.g., State black nurses' association); provide knowledge of and access to settings (e.g., business coalition on health); improve health (e.g., emergency medical services association); and others such, as academia and the media.

b. Develop a plan for convening and maintaining State partnerships:

- Define partner roles and responsibilities in letters of understanding and memoranda of agreement or similar formalized arrangements.
- Assess the training needs of staff and partners and provide or collaborate with partners, within or external to the State health department, to meet training needs. Assure training is conducted which focuses on identified needs and is part

of a larger strategy to meet required program activities (e.g., the background and skills to develop a State plan). Training should focus on increasing the skill levels of staff and partners in areas such as population-based interventions, policy and systems change strategies, communication, use of data for program planning, program evaluation, cultural competence, and program planning.

- Assess partnerships and coordinate efforts to enhance effectiveness to address the mission and purpose of the partnerships. Describe means of collaboration with partners within the State health department and partners outside the State health department to accomplish work plan goals, objectives, and activities.

3. Define and Monitor the Burden of Heart Disease and Stroke:

The burden should be monitored and interpreted for program planning by:

a. Appling chronic disease epidemiology, statistics, monitoring, and data analysis to existing data systems (e.g., vital statistics, hospital discharges, Behavioral Risk Factor Surveillance System (BRFSS), State Medicaid) and data from partners (e.g., quality improvement organizations, health plans, employer groups).

b. Collecting cardiovascular-related information using the BRFSS modules, protocols, and time line. It is required that the BRFSS sections or modules on Actions to Control High Blood Pressure be collected in odd years (i.e., 2009, 2011) and the module on Heart Attack and Stroke Signs and Symptoms be collected in 2009 and every four years after 2009 as a minimum.

c. Developing a profile (e.g., a summary of data in a format suitable for use in program planning) of the burden of heart disease, stroke, and related risk factors within the State during year 1 of funding and at least every two years or more frequently as needed for program planning and evaluation; publish a heart disease and stroke burden document in print or electronic format no later than year 2 of funding and at least every five years or more frequently as needed. The burden document may be a stand-alone document or an identifiable section within another State burden document. The burden information should include:

- Description of heart disease and stroke health outcomes (e.g., mortality, hospitalizations) and risk factor data by race and age groups.
- Trends in heart disease and stroke health outcomes for race and age groups, with emphasis on disparities and trends for Priority Populations.
- Trends from the core BRFSS and the required BRFSS HDSP

modules and sections (e.g., disparities in awareness of signs and symptoms, awareness of high blood pressure).

- Geographic distribution of health outcomes (e.g., mortality).
- Disparities in outcomes and related risk factors by race, ethnicity, gender, geography, and socio-economic status.
- A summary or interpretation of the burden information.

d. Identifying Priority Population(s) for interventions and provide a rationale for the selection of one or more population groups. Rationale for identifying a population as a priority should be supported by data (e.g., mortality, access to care, behavioral risk factors) showing disparities (e.g., race/ethnicity, gender, geographic, geography, socioeconomic status).

e. Develop a plan for dissemination of the burden document.

4. Develop, update, and facilitate the implementation of a comprehensive State heart disease and stroke prevention plan. The State heart disease and stroke prevention plan may be a stand-alone plan or an identifiable section within another State health promotion-related plan. It might reference or build upon other State health promotion-related plans, as appropriate.

a. Develop the process and structure used to develop or update a State plan or facilitate work among partners to implement an existing State plan. The comprehensive State plan should include specific objectives that can impact prevention of heart disease and stroke and related risk factors (e.g.,

high blood pressure, high blood cholesterol, tobacco use, diabetes, obesity), as well as address the program priority areas 1-6.

- When developing a plan or enhancing a plan that does not have all the components described, gather and analyze information needed (e.g., a thorough description of the burden of cardiovascular disease as described in the Activity 3 above; gain commitments from partners from multiple sectors, and jointly define roles and timeline for completing the plan.
- When implementing an existing plan, gain commitments from partners from multiple sectors and jointly define roles and timeline for implementing the plan.
- Ensure the plan includes goals and measurable objectives for general and Priority Populations; population-specific intervention strategies for achieving the objectives; use of policy and systems change strategies and education.

b. Describe how the State plan was or will be disseminated and implemented with partners.

5. Develop Plans to Implement Population-Based Intervention Strategies;

a. Develop plans for public health population-based interventions to address the program priority areas 1-6 for the prevention of heart disease and stroke. Plans must address high blood pressure and high

blood cholesterol within the health care and worksite settings. Show how information regarding the heart disease and stroke burden in the State and existing policy and system data were used to identify priority areas for interventions for general populations and Priority Populations.

Plan interventions that:

- Focus on at least one of the program priority areas 1-6 using population–based education, policy, and systems change strategies;
- Are implemented at the highest level appropriate within the system, for example, develop activities with business coalitions rather than individual worksites;
- Identify priority population(s) and address these populations;
- Assure collaboration with partners within and external to the State health department.

6. Enhance program evaluation:

a. Develop a plan to evaluate program activities to assess progress toward meeting stated work plan objectives. Develop a more detailed evaluation plan for Partnerships, the Capacity Building activity #2. Possible evaluation issues might include partner satisfaction, commitment, and involvement, infrastructure and functioning of the partnership, effectiveness and outcomes of partnership, and sustainability. (See the DHDSP Evaluation Guide Developing an

Evaluation Plan at www.cdc.gov/dhdsp).

b. Develop an overall program logic model that graphically describes the relationship between program activities and expected outcomes and reflects program priorities. (See the DHDSP Evaluation Guide Logic Models at www.cdc.gov/dhdsp).

c. Utilize the HDSP Management Information System (MIS) for post award administration and development of Interim and Annual Progress Reports. Programs should enter progress information into the MIS at least quarterly or more frequently to address technical assistance needs. (Office of Management and Budget (OMB) approval No. 0920-0679; expiration date 5/31/08).

I. 2. Activities for Basic Implementation Programs

1. Continue to enhance Capacity Building Activities by:

- Enhancing Capacity Building Activity 1, Demonstrate Program Infrastructure, to include the equivalent of a one-half time program evaluator for the program.
- Documenting capacity developed to date and developing a work plan for enhancing all Capacity Building Activities.

2. Implement Population-Based Interventions:

- Develop a program work plan with measurable, long-term objectives (5 year) and supporting objectives (1 year) and activities, an evaluation plan, and timeline for implementing public health interventions to address program priority areas 1-6.

- Describe how program efforts will support, complement, or align with other programs within the State health department and with other partners outside the State health department to accomplish work plan goals, objectives, and activities.

- Interventions may address any of the program priority areas 1-6 in the health care, work site and community settings. The interventions must address high blood pressure and high blood cholesterol in the health care and worksite settings. Interventions must utilize policy and systems change strategies, and education as needed to support those strategies (see Purpose Section and Attachment I). Intervention plans should reflect the following:

    - A rationale for selecting proposed interventions (e.g., burden data, identified needs, and strategic opportunities).

- Approaches should emphasize working at the highest level appropriate to bring about changes within systems in order to impact a large proportion of the population (e.g., State-level for State agency policy or procedural/regulatory change; regional level if EMS is organized regionally). Approaches should be culturally appropriate for the specific population(s) of focus.

- Provide intervention activities related to program priority areas 1-6 that address the general population and Priority Populations, using education, policy and systems change strategies.

Intervention activities should also address prevention of recurrent heart disease or stroke. Implementation of approaches for secondary prevention practices should be done in partnership with such groups as the State Quality Improvement Organization, Federally Qualified Health Centers, managed care providers, Medicaid, major employers, insurers, other organized health care providers, and purchasers of health care.

Education should be a component of a larger strategy to bring about policy and systems change. Education should focus on the need to prevent heart disease and stroke; the need for policy and systems change as population-based approaches supportive of the prevention of CVD; and awareness of

signs and symptoms primarily of heart attack and stroke and the need to call 9-1-1.

Training activities (e.g., training of staff, partners, professional education for health providers; training provided in collaboration with partners) should be part of a larger strategy to bring about policy and systems change.

- Implementation of activities related to program priority areas 1-6 may extend to sub-grants and sub-contracts with local health agencies, communities, and nonprofit organizations. Sub-contractors and sub-grantees should be required to focus on program priority areas 1-6, use policy, systems change, and education strategies, and evaluate progress and outcomes, and share outcome information.

3. Enhance capacity for program evaluation:

- Develop and implement a plan to assess progress toward meeting stated work plan objectives;

- The evaluation plan should include process and outcome evaluation for at least one major policy or systems change intervention to demonstrate

effectiveness or impact. In year 2 of the project period, the evaluation plan should describe how progress toward achieving HDSP performance measures will be monitored (see Attachment II, Performance Measures). (See the DHDSP Evaluation Guide Developing an Evaluation Plan at www.cdc.gov/dhdsp/library; the CDC Evaluation Framework at www.cdc.gov/eval/framework.htm).

- Develop an overall program logic model that graphically describes the relationship between program activities and expected outcomes and a detailed logic model for at least one policy/systems change intervention. Development of a logic model for major interventions is recommended during the project period. (See the DHDSP Evaluation Guide Logic Models at www.cdc.gov/dhdsp).

- Utilize the HDSP Management Information System (MIS) for post award administration and development of Interim and Annual Progress Reports. Programs are expected to ensure that information is entered into the MIS at least quarterly. (Office of Management and Budget (OMB) approved No. 0920-0679; expiration date 5/31/08).

I.3. Activities for Optional funding for Capacity Building Programs

1. Implement a demonstration public health project that addresses at least one of the program priority areas 1-6 using policy and systems change strategies (not to include mass communication projects). The demonstration project should have potential for being expanded within larger regions of the State or Statewide. The applicant must:

- Provide goals, measurable objectives, work plan, and timeline for implementing a demonstration public health project to address at least one of the six program priority areas in at least one of the settings (i.e., health care, worksite, community) with the health care and worksite setting being priority settings.

- Provide in the work plan the rationale for selecting the intervention (e.g., identified need or opportunity, burden or other data) and demonstrate how it has potential for expansion on a larger scale. Describe how components of the intervention will be focused and coordinated (e.g., policies, systems change, collaboration with other health programs and partners, and training) to meet goals and objectives of the project. Any education or training components must be focused and part of a larger strategy to bring about policy and systems change.

2. Describe means of collaboration with partners within and external to the State health department to accomplish work plan goals, objectives, activities, and program evaluation.

3. Assess demonstration project progress and success:

- Develop a plan to assess progress toward meeting stated work plan objectives.
- The evaluation plan should include process and outcome evaluation to assess effectiveness and potential impact of the project.
- Develop a logic model that graphically describes the relationship between the project and expected outcomes.
- Utilize the HDSP Management Information System (MIS) to report on the optional project in the States' Interim and Annual Progress Reports.

I.4 Activities for Stroke Networks

1. Demonstrate commitment by the lead State Heart Disease and Stroke Prevention Program by employing a full-time project coordinator for the

network and working with all network States to establish a structure (e.g., work group, committees) that will assist in building collaboration and cooperation in implementing regional or network activities.

2. Develop and enhance strategic partnerships with key stakeholders across member States and priority settings (e.g. healthcare and worksite).

3. Collaborate across States to develop a regional strategic plan (driven by burden and opportunities identified in item #5 below) that address policy and systems level initiatives across the region. Develop goals and objectives across the region to educate policy and decision makers and improve emergency response and systems of care.

4. Leverage efforts and resources across States to maximize program impact in the region.

5. Collect, consolidate, and analyze regional stroke data (e.g., mortality, pre-transport death, trend data, quality of care policies) to identify gaps and opportunities for intervention.

6. Enhance the awareness of and urgency to address stroke and stroke-related issues across the region.

7. Educate public policy and organizational decision makers about stroke issues and the need to develop, implement and adopt policies related to stroke prevention, systems of care, emergency medical services, enhanced 9-1-1, and quality of care. Identify key policies, systems changes, and educational messages that can be the foci for member States.

8. Develop and conduct process and outcome evaluation toward meeting objectives and assessing impact.

I. 5. CDC Activities

In a cooperative agreement, CDC staff is substantially involved in the program activities, above and beyond routine grant monitoring. CDC activities under this FOA are as follows:

1. Provide ongoing consultation, training and technical assistance through such things as guidance documents, website postings, conference calls, listserv, site visits, meetings, and trainings for recipients regarding:

   a. program planning and management.

   b. policy and environmental strategies, population-based strategies, and promising interventions.

c. evaluation guidance of State program progress, impact, and the identification of promising practices.

d. the Heart Disease and Stroke Prevention Management Information System (MIS).

e. describing the burden of heart disease and stroke; provision of data for national-level comparisons.

f. coordination, cooperation, and collaboration with other State health department programs or activities that address risk factors, populations, or settings related to heart disease and stroke prevention and program priority areas of work.

g. flexibility regarding use of funds.

h. effective intervention activities

i. guidance for moving to Basic Implementation and other levels or components of program funding.

2. Collaborate with the States that are funded and States that are not presently funded and other appropriate partners to develop and disseminate programmatic guidance and other resources for specific interventions, media materials, and coordination of activities.

3. Collaborate with the States and other appropriate partners to develop and

disseminate recommendations for policy and environmental interventions including the measurement of progress in the implementation of such interventions.

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

5. Provide technical assistance to the State public health laboratory or contract laboratory to standardize total cholesterol, high density lipoproteins, cholesterol, triglyceride measurements, and other as appropriate.

II. Award Information

II.1. Capacity Building Programs

Type of Award: Cooperative Agreement. CDC's involvement in this program is listed in the Activities Section above.

Award Mechanism: U50

Fiscal Year Funds: FY07

Category A (New States):

Approximate Current Fiscal Year Funding: $ 1,000,000

Approximate Total Project Period Funding: $ 5,000,000 This amount is an

estimate, and is subject to availability of funds and includes Direct and Indirect costs.

Approximate Number of Awards: approximately 2 to 5

Approximate Average Award: $ 350,000 This amount is for the first 12-month budget period, and includes both direct and indirect costs.

Floor of Individual Award Range: $200,000

Ceiling of Individual Award Range: $400,000 This ceiling is for the first 12-month budget period and includes Direct and Indirect costs.

Anticipated Award Date: June 30, 2007

Budget Period Length: 12 months

Project Period Length: 5 years

Category A (Existing States):

Approximate Current Fiscal Year Funding: $ 6,200,000

Approximate Total Project Period Funding: $ 31,000,000 This amount is an estimate, and is subject to availability of funds and includes Direct and Indirect costs.

Approximate Number of Awards: approximately 17 to 19

Approximate Average Award: $ 350,000 This amount is for the first 12-month budget period, and includes both direct and indirect costs.

Floor of Individual Award Range: $200,000

Ceiling of Individual Award Range: $400,000 This ceiling is for the first 12-month budget period and includes Direct and Indirect costs.

Anticipated Award Date: June 30, 2007

Budget Period Length: 12 months

Project Period Length: 5 years

II.2. Basic Implementation Programs (Existing States):

Type of Award: Cooperative Agreement. CDC's involvement in this program is listed in the Activities Section above.

Award Mechanism: U50

Fiscal Year Funds: FY 07

Approximate Current Fiscal Year Funding: $ 16,800,000

Approximate Total Project Period Funding: $ 84,000,000 This amount is an estimate, and is subject to availability of funds and includes Direct and Indirect costs.

Approximate Number of Awards: approximately 12 to 14

Approximate Average Award: $ 1,200,000. This amount is for the first 12-month budget period, and includes both direct and indirect costs.

Floor of Individual Award Range: $900,000

Ceiling of Individual Award Range: $1,300,000 This ceiling is for the first 12-month budget period and includes Direct and Indirect costs.

Anticipated Award Date: June 30, 2007

Budget Period Length: 12 months

Project Period Length: 5 years

II.3. Optional Funding for Capacity Building Programs

Type of Award: Cooperative Agreement. CDC's involvement in this program is listed in the Activities Section above.

Award Mechanism: U50

Fiscal Year Funds: FY 07

Approximate Current Fiscal Year Funding: $ 1,000,000

Approximate Total Project Period Funding: $ 3,000,000 This amount is an estimate, and is subject to availability of funds and includes Direct and Indirect costs.

Approximate Number of Awards: approximately 5 to 10

Approximate Average Award: $ 150,000 This amount is for the first 12-month budget period, and includes both direct and indirect costs.

Floor of Individual Award Range: $100,000

Ceiling of Individual Award Range: $200,000 This ceiling is for the first 12-month budget period and includes Direct and Indirect costs.

Anticipated Award Date: June 30, 2007

Budget Period Length: 12 months

Project Period Length: 3 years

Implementation of specific activities may extend to sub-grants and sub-contracts. However, leadership for the project is to be located within the State HDSP program. Sub-

contractors and sub-grantees must focus on program priority areas 1-6; use policy, systems change strategies; evaluate progress and outcomes; and provide outcome information to the State HDSP program.

II.4. Supplemental Funds for Stroke Networks of three to six States each

Approximate Current Fiscal Year Funding: $ 600,000

Approximate Total Project Period Funding: $1,800,000 This amount is an estimate, and is subject to availability of funds and includes Direct and Indirect costs.

Approximate Number of Awards: approximately 2 to 4

Approximate Average Award: Award is proportional to size of Network; approximately $ 165,000 for Network of three States and $ 195,000 for Network of six States. This amount is for the first 12-month budget period, and includes both direct and indirect costs.

Floor of Individual Award Range: $165,000

Ceiling of Individual Award Range: $195,000 This ceiling is for the first 12-month budget period and includes Direct and Indirect costs.

Anticipated Award Date: June 30, 2007

Budget Period Length: 12 months

Project Period Length: 3 years

Throughout the project period, CDC's commitment to continuation of awards will be conditioned on the availability of funds, evidence of satisfactory progress by the recipient (as documented in required reports), and the determination that continued funding is in the best interest of the Federal government. Performance will be measured by the extent to which the program completes proposed activities. If all activities are not completed as planned, detail should be given on barriers encountered.

III. Eligible Information

III.1. Eligible applicants

Heart Disease and Stroke Prevention Program (HDSP) activities include the establishment or maintenance of State-specific population-based programs. Eligible applicants that can apply for this funding opportunity are listed below:

- State departments of health including the District of Columbia

Existing HDSP States are the States funded under Program Announcement 02045. States funded for Capacity Building are Alabama, Alaska, Colorado, Connecticut, District of Columbia, Illinois, Kansas, Kentucky, Louisiana, Minnesota, Mississippi, Nebraska, North Dakota, Ohio, Oklahoma, Oregon, Tennessee, Texas, and Wisconsin. States funded for Basic Implementation are Arkansas, Florida, Georgia, Maine, Massachusetts, Missouri, Montana, New York, North Carolina, South Carolina, Utah, Virginia, Washington, and West Virginia.

Applicants listed above as existing Capacity Building States should apply for capacity building funding under Category A – Existing States. New applicants should apply for capacity building funding under Category A – New States. Category A applicants may apply for capacity building funding and optional funding but not basic implementation funding. Applicants listed above as existing Basic Implementation States should apply under Category B but may not apply for Optional funding. States may not apply for both Category A and B funding. All States may apply for Stroke Network funding. Stroke Network funds will only be awarded to health departments of States that successfully compete for a Heart Disease and Stroke Prevention Program under Program Announcement DP-07-704. States that do not border other States, such as Alaska and Hawaii, are considered in this program announcement as contiguous with their respective DHHS regions (see http://www.hhs.gov/about/regionmap.html).

Eligibility is limited to State health departments because they are uniquely qualified to define the cardiovascular disease problem throughout the State, to plan and develop Statewide strategies to reduce the burden of CVD, to provide overall State coordination of cardiovascular health promotion, disease prevention, and control activities among partners, lead and direct communities, to direct and oversee interventions within overarching State policies, and to monitor critical aspects of CVD. (For supportive Congressional language, see Attachment I).

III.2. Cost Sharing

Under the Basic Implementation Program of this Program Announcement, cost sharing is required from State sources in an amount not less than $1 for each $5 of Federal funds awarded. Applicants for the Basic Implementation Program must provide evidence of cost sharing targeting cardiovascular health promotion and disease prevention of at least 16 percent of the total approved budget. A cost sharing requirement may not be met by costs borne by another federal grant. For example, the Preventive Health and Health Services (PHHS) Block Grant may not be included as State resource evidence. Cost sharing may be cash, in-kind, or a combination from State and/or public and private sources. Cash and in-kind cost sharing must be from non-federal sources.

III.3. Other

CDC will accept and review applications with budgets greater than the ceiling of the award range.

Special Requirements:

If the application is incomplete or non-responsive to the special requirements listed in this section, it will not be entered into the review process. The applicant will be notified that the application did not meet submission requirements.

- Late applications will be considered non-responsive. See section "IV.3. Submission Dates and Times" for more information on deadlines.

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

Special Guidelines for Technical Assistance Conference Call

Technical assistance will be available for potential applicants on a conference call to be held January 23, 2007 from 3:00 p.m. EST to 4:30 p.m. EST. This conference call can be accessed by calling 1-888-323-2712 [Federal call (404) 639-3277] and entering access code 31738.

Potential applicants are requested to call in using only one telephone line. The purpose of the conference call is to help potential applicants to:

1. Understand the scope and intent of the Program Announcement for State Heart Disease and Stroke Prevention Programs;
2. Be familiar with the Public Health Services funding policies and application and review procedures.

Participation in this conference call is not mandatory. At the time of the call, if you have problems accessing the call, contact 404-639-7550.

IV. Application and Submission Information

IV.1. Address to Request Application Package

To apply for this funding opportunity use application form PHS 5161-1.

Electronic Submission

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

Registering your organization with grants.gov is the first step in submitting applications online. Registration information is located in the "Get Started" screen of www.Grants.gov. While application submission through grants.gov is optional, we strongly encourage you to use this online tool.

Please visit www.Grants.gov at least 30 days prior to filing your application to familiarize yourself with the registration and submission process. Under "Get Started," the one-time registration process will take three to five days to complete. We suggest submitting electronic applications prior to the closing date so if difficulties are encountered, you can submit a hard copy of the application prior to the deadline.

Paper Submission

Application forms and instructions are available on the CDC Web site, at the following Internet address: www.cdc.gov/od/pgo/forminfo.htm

If access to the Internet is not available, or if there is difficulty accessing the forms on-line, contact the CDC Procurement and Grants Office Technical Information Management Section (PGO-TIM) staff at 770-488-2700 and the application forms can be mailed.

IV.2. Content and Form of Submission

Letter of Intent (LOI): Your LOI must be written in the following format:

- Maximum number of pages: 1
- Font size: 12-point unreduced, Times New Roman
- Single spaced
- Paper size: 8.5 by 11 inches
- Page margin size: One inch
- Printed only on one side of page
- Written in plain language, avoid jargon

The LOI must contain the following information: name of the applicant, the contact information for the applicant, and the intent to apply for Capacity Building or Basic Implementation Program funding, and the intent to apply for the supplemental funding

for Stroke Network available to all applicants or the Optional funding available to Capacity Building programs.

Application

If the applicant is requesting more than one category of funding, the application must include complete, stand-alone sections (including such things as the project abstract, narrative, budget, and budget justification) for each funding category requested (i.e., Capacity Building, Basic Implementation, Optional Funding for Capacity Building Programs, Stroke Network) so each request for a funding category can be easily identified and provided to different Objective Review Panels. Each section and appendix of the application submitted to Grants.gov should clearly state the category of funding for which it is submitted. Applicants may add abbreviations in the file names to identify the State and the category (i.e., AL for Alabama, CB for Capacity Building, BI for Basic Implementation, OP for Optional Funding for Capacity Building, SN for Stroke Network). Each detailed budget and narrative justification should support the activities for year 1 funding in response to this Program Announcement and a summary narrative for the 5 year project period.

A Project Abstract must be submitted with the application forms. The abstract must be submitted in the following format:

- Maximum of one page.

- Font size: 12 point unreduced, Times New Roman
- Single spaced
- Paper size: 8.5 by 11 inches
- Page margin size: One inch

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

A project narrative must be submitted with the application forms. The narrative must be submitted in the following format:

- Maximum number of pages: 50 pages for Capacity Building, 90 pages for Basic Implementation, 10 pages for the Optional Funding for Capacity Building, and 20 pages for a Stroke Network. If your narrative exceeds the page limit, only the first pages which are within the page limit will be reviewed.
- Font size: 12 point unreduced, except fonts as low as 10 point may be used in tables or charts.
- Double spaced text; may include single spaced items such as tables,

charts, timelines, logic models, letters of support, resumes, and attached existing documents (e.g., State HDSP plan).

- Paper size: 8.5 by 11 inches.
- Page margin size: One inch.
- Number all pages of the application sequentially from page 1 (Application Face Page) to the end of the application, including charts, figures, tables, and appendices.
- Printed only on one side of page.
- Held together only by rubber bands or metal clips; not bound in any other way.

Additional information may be included in the application appendices. The appendices will not be counted toward the narrative page limit; however, including extensive materials is not recommended. This additional information should include: materials such as organizational charts, positions descriptions, curriculum vitae, relevant publications, letters of support that specify the nature and extent of involvement by partners, and Memoranda of Agreement.

Additional information submitted via Grants.gov should be labeled as Appendices when uploaded into Grants.gov and give file names that identify the State and the category of funding represented.

The narrative should address activities to be conducted over the entire project period and provide more specific information for activities during year 1 of funding. It must include the following items in the order listed:

Capacity Building Applications (Narrative portion may not exceed 50 pages)

1. Background and Need:

   Describe the need for funding and the current resources available for Capacity Building activities, to include:

   a. Provide a description of the overall burden of heart disease and stroke and related risk factors in the State and the need for support in the State; the geographic and demographic distribution, age, sex, racial and ethnic groups, education, and economic patterns of cardiovascular diseases as well as the trends over time; populations with disparities, including Priority Populations to be addressed by program activities.
   b. The progress made toward achieving any of the capacity building activities 1-6.
   c. The experience the State health department has had addressing HDSP program priority areas 1-6 and developing and implementing policy and systems change strategies.
   d. The needs and barriers the State currently faces in developing and implementing a State program for heart disease and stroke prevention and how the State will address them.

e. The advisory groups, partnerships, or coalitions currently involved with the State health department for heart disease and stroke prevention, including those with related programs within the State health department, and how they have partnered in the past.

f. The gaps in resources, staffing, capabilities, and programs that, if addressed, could further the progress of heart disease and stroke prevention.

2. Management Plan:

Submit a management plan that describes program staffing and qualifications in terms of ability to carry out all Awardee Capacity Building Activities, including evaluation. Staff should include a full-time program manager and one-half time chronic disease epidemiologist. Provide (in the appendices) organizational charts, curricula vitae, and job descriptions for all budgeted positions. Describe a system for sound fiscal management. Describe lines of communication between State health department programs that relate to heart disease and stroke prevention including program priority areas 1-6. Address how coordination, cooperation, and collaboration among existing categorical program efforts will be facilitated, while allowing each program to maintain individual integrity and identity.

3. Work Plan:

Provide a work plan that addresses each of the six required elements cited in the Awardee Capacity Building Activities section to include the following:

a. Program objectives addressing all Activities. Objectives should be specific, measurable, achievable, relevant, and time-bound (SMART), describing what is to happen, by when, and to what degree. Proposed methods for achieving each of the objectives should include activities to be taken and position responsible.

b. An overall logic model that graphically displays program activities and intended outcomes.

c. The partnerships and collaborations for achieving each of the objectives. Provide letters of support, memoranda of agreement, and other supporting material in the appendices, including the commitment of the State health department related to required BRFSS modules for heart disease and stroke. Provide a milestone, timeline, and completion chart for all objectives for the project period (see Capacity Building Performance Measures section)

d. The plan for evaluating progress toward attainment of the objectives and overall measures of effectiveness.

4. Itemized Budget and Justification (not counted in the 50-page limitation): Provide a detailed line-item budget with justifications consistent with the Purpose section and the applicant's proposed objectives, using the format on PHS Form 5161-1. Participation in CDC-sponsored training workshops and meetings is essential to the effective implementation of State programs. Applicants should

include annual travel budget funds for two individuals to participate in two, three-day training and technical assistance workshops in Atlanta, Georgia.

Basic Implementation Applications (Narrative portion may not exceed 90 pages)

1. Background and Need:
    a. Provide evidence that the State health department has met the Capacity Building Performance Measures for requesting Basic Implementation level funding (see Reporting Requirements section VI.3.).
    b. Provide a description of the overall burden of heart disease and stroke and related risk factors in the State and the need for support in the State; the geographic and demographic distribution, age, sex, racial and ethnic groups, education, and economic patterns of cardiovascular diseases as well as the trends over time; populations with disparities, including Priority Populations to be addressed by program activities.
    c. Describe the key barriers to successful implementation of a Statewide program for heart disease and stroke prevention within the State and how barriers will be addressed.
    d. Describe partnerships and collaboration with related programs and agencies.
    e. Describe the status of policy and systems approaches in place that influence the six program priority areas and outcomes (see Purpose section).

2. Management Plan:

Submit a management plan that describes program staffing and qualifications in terms of ability to carry out all Basic Implementation Activities, including evaluation. Staff should include a full-time program manager, a one-half time chronic disease epidemiologist, and the equivalent of a one-half time program evaluator. Provide (in the appendices) organizational charts, curricula vitae, and job descriptions for all budgeted positions. Describe a system for sound fiscal management. Describe lines of communication between related State health department programs. Address how coordination, cooperation, and collaboration among existing categorical program efforts will be facilitated, while allowing each program to maintain individual integrity and identity.

3. Work Plan:

   a. Address each of the 3 required Awardee Basic Implementation Activities in sufficient detail to describe the results expected and how the State program will achieve the results. The work plan should be consistent with the State Plan, address program priority areas 1-6, utilize policy and systems change strategies a the highest level appropriate, and specify Priority Populations to be addressed.

   b. An overall logic model that graphically displays program activities and intended outcomes.

   c. Propose long-term(about 4 to 5 years) and supporting (about 1 to 2 years) objectives which are specific, measurable, achievable, relevant, and

time-bound (SMART), describing what is to happen, by when, and to what degree and provide the methods and position responsible.

d. Describe partnerships and collaborations for achieving each of the objectives. Provide evidence of specific collaboration through letters of support, memoranda of agreement, and other supporting material in the appendices, including the commitment of the State Health Department related to required BRFSS modules for heart disease and stroke.

e. Provide a milestone and activities completion chart or timeline for all objectives for the project period (see Basic Implementation Performance Measures section).

f. Propose a plan for evaluating progress toward attainment of the objectives, including overall measures of effectiveness and a more detailed plan for evaluating at least one intervention.

4. Itemized Budget and Justification (not counted in the 90-page limitation): Provide a detailed line-item budget with justifications consistent with the Program Announcement's purpose and the applicant's proposed objectives, using the format on PHS Form 5161-1. Participation in CDC-sponsored training workshops and meetings is essential to the effective implementation of State programs. Applicants should include annual travel budget funds for two individuals to participate in two, three-day training and technical assistance workshops in Atlanta, Georgia.

State cost sharing funds should be listed on question 15 (estimated funding) of the application face page and Section C of the Budget Information worksheet.

Content for Optional Funding for Capacity Building Programs (Narrative portion may not exceed 10 pages)

Optional Application: A project narrative must be submitted with the application forms. The narrative must address how the State will implement activities over the proposed Optional project period with more specific information for activities for year 1 of funding. It must include the following items in the order listed:

1. Background and Need:
    a. Provide evidence that the State health department has significant experience and capacity to carryout the demonstration project, including experience with policy and systems change approaches and the six program priority areas.
    b. Demonstrate that the project relates to part of the draft or published State plan.
    c. Provide the rationale for proposing the project and its potential for being expanded for increased reach.
2. Management Plan: Submit a management plan that describes
    a. Staffing and qualifications in terms of ability to carry out and evaluate the project.
    b. Organizational structure assuring leadership within the HDSP

program and support for staff including support for coordinating and collaborating with others within the State health department.

3. Work Plan: Provide a work plan that:

   a. Addresses each of the required Activities; provides objectives and describes what is to happen, by when, and to what degree and position responsible; describe the population(s) to be affected.

   b. Proposes methods, including partnerships, collaborations, and policy and systems change, for achieving the objectives.

   c. Describes partnerships and collaborators and their role in the project.

4. Evaluation plan:

   a. Provide a plan for evaluating progress and outcomes of the project and for identifying lessons learned.

5. Itemized Budget and Justification (not counted in the 10-page limitation): Provide a detailed line-item budget with justifications using the format on PHS Form 5161-1.

Stroke Network Applications (Narrative portion may not exceed 20 pages)

1. Background and Experience:

   a. The epidemiology (e.g., mortality, disability, hospitalization, pre-transport death, cost) of stroke within the region and rationale for consideration with preference status.

b. Experience working with partners to address stroke, including descriptions of past, current, and proposed systems and policy-level strategies.

c. Experience applying and evaluating policy and systems change strategies to address stroke.

2. Collaboration:

a. Demonstrate a willingness (i.e., provides letters of support or other memorandum of agreements) by State health departments and other key partners in the member States to participate in the stroke network. Shows strong support as evidenced by letters of support from member States, health departments and relevant stroke-related organizations (e.g., hospital systems, universities, and emergency medical services) demonstrating commitment to collaborate on a stroke network group and jointly agreed upon activities (e.g., education, policy, surveillance) to implement across the region, and the value the network will bring to State Heart Disease and Stroke Prevention Programs.

b. Demonstrate the appropriateness of committed members and plans to engage additional partners if funded. Representatives should include stroke-related experts, organizations and individuals from each State heart disease and stroke prevention program. Representatives might include public health staff, legislators, medical university staff, hospital emergency department personnel, neurologists, nurses, clinicians,

emergency medical services personnel, State hospital associations, State medical associations, State primary care organization, media, quality improvement organizations, and voluntary organizations.

c. Describe how member States will collaborate across the region.

d. Describe a current or proposed stroke advisory committee or structure to support the planning, development and evaluation of activities across the region.

e. Describe current collaborations within the State and with other States or national organizations interested in stroke prevention and stroke management.

3. Implementation Plan and Timeline:

Provide a regional work plan and timeline for addressing the required program activities 1-8 that includes:

a. Development of staff capacity and establishment of network structure.

b. Assurance that the State heart disease and stroke prevention programs receiving funds have a substantial role in implementation of project objectives.

c. Proposal for developing and enhancing partnerships across State lines.

d. Infrastructure for data acquisition, sharing, and utilization across member States.

e. Description of methodology to be used in planning, implementing, leveraging resources, and evaluating activities across the region.

f. Utilization of logic models to illustrate program design.

g. Project timetable for realistic achievement of proposed implementation and operational activities with appropriate dates for the accomplishment of specific project activities.

h. Development of clearly defined objectives with emphasis on policy and systems change strategies

4. Management Plan:

a. Provide proposed staffing, organizational structures, staff experience and background, job descriptions and curricula vitae for both proposed and current staff to support and carry out the purposes and activities of the program.

b. Describe how the organizational structure(s) supports the member States' and network's ability to conduct proposed activities, including coordination and collaboration.

c. Provide a fiscal management plan that is supportive of responsible project functioning.

5. Evaluation Plan:

a. Provide an evaluation plan with a mechanism for monitoring progress toward meeting specific project objectives.

b. Provide an evaluation plan that identifies evaluation questions for work plan objectives, describes when and how data will be collected and analyzed, indicates who is responsible, and describes how results will be used and disseminated.

c. Describe the evaluation plan either in a narrative summary or a table. Accompany the plan with a logic model which addresses short, intermediate and long-term program objectives.

6. Budget:

Provide a detailed budget and justification consistent with the stated objectives and program activities. The applicant should also provide a detailed line-item budget with justifications consistent with the purpose and proposed objectives (required each project year), using the format on PHS Form 5161-1.

Additional information may be included in the application appendices. This additional information includes: position descriptions, curricula vitae, relevant publications, and letters of support that specify the nature and extent of involvement by partners. The appendices will not be counted toward the narrative page limit; however, including extensive materials is not recommended.

The agency or organization is required to have a Dun and Bradstreet Data Universal

Numbering System (DUNS) number to apply for a grant or cooperative agreement from the Federal government. The DUNS number is a nine-digit identification number, which uniquely identifies business entities. Obtaining a DUNS number is easy and there is no charge. To obtain a DUNS number, access www.dunandbradstreet.com or call 1-866-705-5711.

Additional requirements that may require submittal of additional documentation with the application are listed in section "VI.2. Administrative and National Policy Requirements."

IV.3. Submission Dates and Times

Letter of Intent (LOI) Deadline Date: February 12, 2007

CDC requests that an applicant submit an LOI if the applicant intends to submit a full application for this funding opportunity. Although the LOI is not required, not binding, and does not enter into the review of the subsequent application, it will be used to gauge the level of interest in this program and to allow CDC to plan the application review.

Application Deadline Date: March 12, 2007

Explanation of Deadlines: Applications must be received in the CDC Procurement and Grants Office by 4:00 p.m. Eastern Time on the deadline date.

Applications may be submitted electronically at www.grants.gov. Applications

completed on-line through Grants.gov are considered formally submitted when the applicant organization's Authorizing Official electronically submits the application to www.grants.gov. Electronic applications will be considered as having met the deadline if the application has been submitted electronically by the applicant organization's Authorizing Official to Grants.gov on or before the deadline date and time.
If submittal of the application is done electronically through Grants.gov (http://www.grants.gov), the application will be electronically time/date stamped, which will serve as receipt of submission. Applicants will receive an e-mail notice of receipt when CDC receives the application.

If submittal of the application is by the United States Postal Service or commercial delivery service, the applicant must ensure that the carrier will be able to guarantee delivery by the closing date and time. If CDC receives the submission after the closing date due to: (1) carrier error, when the carrier accepted the package with a guarantee for delivery by the closing date and time, or (2) significant weather delays or natural disasters, the applicant will be given the opportunity to submit documentation of the carrier's guarantee. If the documentation verifies a carrier problem, CDC will consider the submission as having been received by the deadline.

If a hard copy application is submitted, CDC will not notify the applicant upon receipt of the submission. If questions arise on the receipt of the application, the applicant should first contact the carrier. If the applicant still has questions, contact the PGO-TIM staff at

(770)488-2700. The applicant should wait two to three days after the submission deadline before calling. This will allow time for submissions to be processed and logged.

This announcement is the definitive guide on LOI and application content, submission address, and deadline. It supersedes information provided in the application instructions. If the application submission does not meet the deadline above, it will not be eligible for review and will be discarded. The applicant will be notified if the application did not meet the submission requirements.

IV.4. Intergovernmental Review of Applications

Executive Order 12372 does not apply to this program.

IV.5. Funding restrictions

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

- Funds may not be used for research.
- Reimbursement of pre-award costs is not allowed.
- Funds may not be used to supplant State or local funds.
- Funds may not be used for construction.
- Funds may not be used to provide health screening, patient care, personal health services, medications, patient rehabilitation, or other cost associated with the treatment of heart disease or stroke.

- Awardees may not generally use HHS/CDC/ATSDR funding for the purchase of furniture, or equipment. Any such proposed spending must be identified in the budget.
- The direct and primary recipient in a cooperative agreement program must perform a substantial role in carrying out project objectives and not merely serve as a conduit for an award to another party or provider who is ineligible.

If requesting indirect costs in the budget, a copy of the indirect cost rate agreement is required. If the indirect cost rate is a provisional rate, the agreement should be less than 12 months old.

Guidance for completing the budget can be found on the CDC Web site, at the following Internet address: http://www.cdc.gov/od/pgo/funding/budgetguide.htm

Cooperative agreement funds may be used to support personnel and to purchase supplies and services directly related to program activities and consistent with the scope and purpose of this program announcement. Funds provided under this Program Announcement may be used for program evaluation.

This Program Announcement is also simplifying the grant pre- and post-award

administrative process and providing increased flexibility in the use of funds. Some examples of the benefits of the streamlined process are: elimination of separate documents (continuation application and semi-annual progress report) to issue a continuation award; consistency in reporting expectations; ability to award Optional Funding to Capacity Building States and elevation to a Basic Implementation Program based on performance measures when funds are available.

Applicants are encouraged to identify and leverage opportunities, which will also enhance the recipient's work with other State health department programs that address related chronic diseases or risk factors. This may include cost sharing to support a shared position such as Chronic Disease epidemiologist, health communication specialist, program evaluator, or policy analyst to work on risk factors or other activities across units/departments within the State health department. This may include, but is not limited to, joint planning activities, joint funding of complementary activities based on program recipient activities, coalition alliances and joint public health education, combined development and implementation of environmental, policy, systems, or community interventions and other cost sharing activities that cut across State health department programs and relate to recipient program activities. State HDSP programs should engage in joint planning of strategies to address program priority areas 1-6 and Goal 1 (for information and examples on collaboration and flexibility in use of funds see Attachment III).

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

IV.6. Other Submission Requirements

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

Chanel A. Recasner

CDC, NCCDPHP

Division for Heart Disease and Stroke Prevention

Atlanta, Georgia 30341

E-mail: crecasner@cdc.gov

Mailing address:

4770 Buford Highway, NE, MS K-47

Atlanta, GA 30341-37171

Overnight/courier delivery address:

2877 Brandywine Road

Koger Center, Williams Building

Suite 4000

Phone: 770-488-2424

Fax: 770-488-8151

Application Submission Address

Electronic Submission

CDC strongly encourages applicants to submit applications electronically at www.Grants.gov. The application package can be downloaded from www.Grants.gov. Applicants are able to complete it off-line, and then upload and submit the application via the Grants.gov Web site. E-mail submissions will not be accepted. If the applicant has technical difficulties in Grants.gov, costumer service can be reached by E-mail at http://www.grants.gov/CustomerSupport or by phone at 1-800-518-4726 (1-800-518-GRANTS). The Customer Support Center is open from 7:00a.m. to 9:00p.m. Eastern Time, Monday through Friday.

CDC recommends that submittal of the application to Grants.gov should be early to resolve any unanticipated difficulties prior to the deadline. Applicants may also submit a back-up paper submission of the application. Any such paper submission must be

received in accordance with the requirements for timely submission detailed in Section IV.3. of the grant announcement. The paper submission must be clearly marked: "BACK-UP FOR ELECTRONIC SUBMISSION." The paper submission must conform to all requirements for non-electronic submissions. If both electronic and back-up paper submissions are received by the deadline, the electronic version will be considered the official submission.

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

Paper Submission

Applicants should submit the original and two hard copies of the application by mail or express delivery service to:

Technical Information Management CDC-RFA-DP07-704
Department of Health and Human Services
CDC Procurement and Grants Office
2920 Brandywine Road
Atlanta, GA 30341

V. Application Review Information

V.1. Criteria

The application will be evaluated against the following criteria:

1. Capacity Building Program Applications (Total 100 points)
    a. Work Plan (50 points)
        i. (10 points) The degree to which existing and proposed partnerships within and external to the State health department appear likely to support work on the State plan and program priority areas 1-6; and are demonstrated through documented and collaborative activities and letters of support that describe the nature and extent of involvement and commitment (Capacity Building activity 2).
        ii. (20 points) The extent to which the plan addresses how the applicant will define and monitor the CVD burden; develop, update, or facilitate the implementation of a State plan; and develop plans to implement population-based strategies in the general population or Priority Populations. (Capacity Building activities 3-5)
        iii. (20 points) The extent to which the proposed objectives and methods are specific, measurable, achievable, and time-bound, appear supportive of the grantee Capacity Building Activities, and are likely to be achieved within the

proposed timeframe.

b. Background and Need (25 points)

   i. (10 points) The extent to which the applicant identifies need based on disease burden, including disproportionately affected populations, and gaps in State capacity; and existing collaboration and resources available for Capacity Building activities.

   ii. (15 points) The extent of the applicant's experience in program priority areas 1-6; and experience using policy and systems change strategies.

c. Evaluation (15 points)

   The extent to which the proposed plan for evaluating progress toward meeting objectives and assessing impact appears reasonable, feasible, and relates to Capacity Building Performance Measures; extent to which the logic model reflects program activities and intended outcomes appears appropriate. (Capacity Building activity 6)

d. Management Plan (10 points)

   The degree to which the proposed staff have the relevant background, qualifications, and experience (see Capacity Building activity 1). The degree to which the organizational structures support staff ability to conduct proposed activities,

including coordination and collaboration. The degree to which fiscal management appears adequate and supportive of responsible program functioning. (Capacity Building activity 1)

e. Budget (Not Scored)

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

2. Basic Implementation Program Applications (Total 100 points)

a. Work Plan (50 points)

i. (20 points) The extent to which the plan comprehensively addresses the implementation of population-based interventions focused on conducting policy and systems change interventions for program priority areas 1-6 in the general population and Priority Populations. (Basic Implementation activity 2)

ii. (10 points) The extent to which the plan addresses how Capacity Building activities will be continued and enhanced (Basic Implementation activity 1).

iii. (10 points) The extent to which the plan addresses existing and proposed partnerships, within and external to the State health department, and how they will support

achievement of interventions as demonstrated through documented and collaborative activities and letters of support that describe the nature and extent of involvement and commitment. (Basic Implementation activity 4)

iv. (10 points) The extent to which the proposed objectives and methods appear specific, measurable, supportive of the Basic Implementation Activities, and are likely to be achieved within the proposed timeframe.

b. Background and Need (30 points)

The extent to which the applicant:

i. (20 points) provides evidence of completion of Capacity Building Performance Measures for Requesting Basic Implementation Program funding as stated in V.1. Reporting Requirements: has diverse, active partnerships, a HDSP State burden document no more than 3 years old, a HDSP State plan, evidence of evaluation experience.

ii (10 points) addresses Background and Need in Basic Implementation Application Content 1.b-e.

c. Evaluation (10 points)

The extent to which the proposed plan for evaluating progress toward meeting objectives and assessing impact appears reasonable, feasible, and relates to Basic Implementation

Performance Measures; extent to which the logic model reflects program activities and intended outcomes appear appropriate (see Basic Implementation activity 3).

d. Management Plan (10 points)

i. (5 points) The degree to which the proposed staff have the relevant background, qualifications, and experience.

ii. (5 points) The degree to which the organizational structures support staff ability to conduct proposed activities, including coordination and collaboration within and external to the State health department.

e. Budget (Not Scored)

The extent to which the budget appears reasonable and consistent with the proposed activities and purpose of the program announcement. The documentation of State cost sharing/matching funds in an amount not less than $1 for each $5 of Federal funds awarded.

3. Optional Funding for Capacity Building Programs Applications (Total 100 points)

a. Work Plan (60 points)

i. (25 points) The extent to which the plan addresses program priority areas 1-6 and uses policy and systems

change strategies.

ii. (25 points) The extent to which the proposed objectives and methods appear specific, measurable, feasible, supportive of the project and are likely to be achieved within the proposed timeframe.

iii. (10 points) The degree to which existing and proposed partnerships, within and external to the State health department, appear likely to support achievement of the project as demonstrated through documented and collaborative activities and letters of support that describe the nature and extent of involvement and commitment.

b. Background and Need (15 points)

The extent to which the applicant provides evidence of its experience and capacity to carryout the demonstration project, including experience with policy and system approaches and the six program priority areas. The extent to which the applicant provides a rationale for proposing the project and describes its potential for being expanded for increased reach.

c. Evaluation (15 points)

The extent to which the plan for evaluating progress toward meeting objectives and assessing impact appears reasonable and feasible. The extent to which the logic model reflects

program activities and intended outcomes appears appropriate.

d. Management Plan (10 points)

The degree to which the plan assures leadership within the HDSP program, proposed staff have the relevant background, qualifications, and experience and an organizational structures support staffs' ability to conduct the project, including coordination and collaboration.

e. Budget (Not Scored)

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

4. Stroke Networks (Total 100 points)

a. Implementation Plan and Timeline (40 points)

i. (20 points) The extent to which the plan and timeline address the development of strategies and activities to increase awareness about the urgency of stroke, educate policy and decision makers, and develop and implement coordinated policy and systems change activities across the region.

ii. (10 points) The extent to which the plan addresses capacity, existing and proposed partnerships, within and external to

the State health department, and how the network will support development and implementation of activities across the region through documented and collaborative activities and letters of support that describe the nature and extent of involvement and commitment.

iii. (10 points) The extent to which the proposed objectives, methods, and timeline appear specific, measurable, supportive of the stroke network activities, and are likely to be achieved within the proposed timeframe.

b. Background and Experience (20 points)

i. (10 points) The extent to which the applicant addresses the burden of stroke and stroke-related issues across the region and within the member States.

ii. (10 points) The applicant provides a thorough description of experience in developing and implementing stroke and stroke-related policy and systems change activities.

c. Collaboration (20 points)

i. (10 points) The applicant provides letters of commitment from each of the State health department members of the proposed network that pledge participation in the network and support for helping to achieve proposed activities.

ii. (5 points) The extent of support which the applicant provides as evidenced by letters of support or memorandum of agreement that describe partner (e.g., health systems organizations, voluntary organizations) roles and responsibilities in helping to achieve proposed activities.

iii. (5 points) The extent to which the applicant provides evidence of past and future collaboration with partners on stroke policy and systems change activities.

d. Management Plan (10 points)

i. (5 points) The extent to which the applicant has documented staff experience and describes an existing or proposed organizational structure.

ii. (5 points) The extent to which the organizational structure and fiscal management plan appear to be both feasible and capable of supporting the proposed activities.

e. Evaluation Plan (10 points)

i. (5 points) The extent to which the applicant provides an evaluation plan that describes the methodology to be used to assess the achievement of objectives, project performance measures, and impact of policy and systems change activities.

ii. (5 points) The degree to which the evaluation plan addresses data use and dissemination issues, and describes program objectives that are specific, measurable, achievable, realistic, and time bound.

f. Budget: (Not Scored)

The extent to which the applicant provides a detailed budget and justification consistent with the stated objectives and program activities. The applicant also provides a detailed line-item budget with justifications consistent with the purpose and proposed objectives (required each project year), using the format on PHS Form 5161-1. Applicants are required to include budget items for travel for one annual trip to Atlanta, GA for two individuals to attend two-day training and technical assistance workshops.

V.2. Review and Selection Process

Applications will be reviewed for completeness by the Procurement and Grants Office (PGO) staff, and for responsiveness jointly by NCCDPHP and PGO. Incomplete applications and applications that are non-responsive to the eligibility criteria will not advance through the review process. Applicants will be notified if the application did not meet submission requirements.

An objective review panel will evaluate complete and responsive applications according to the criteria listed in the "V.1. Criteria" section above. The panel will consist of CDC employees with 100% being from outside the funding Division and at least 51% being from outside the funding Center. The objective review process will follow the policy requirements as stated in the GPD 2.04 at http://198.102.218.46/doc/gpd204.doc. Applications will be funded in order by score and rank determined by the review panel. In addition, funding decisions related to Capacity Building and Basic Implementation awards may include a preference for States that are 10 % above the national average for ischemic heart disease or stroke (see Table 1). Funding decisions related to Stroke Networks may include a preference for States with a stroke age-adjusted death rate greater than 10% of the U.S. total.

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

V.3. Anticipated Announcement Award Dates

June 30, 2007

VI. Award Administration Information

VI.1. Award Notices

Successful applicants will receive a Notice of Award (NoA) from the CDC Procurement and Grants Office. The NoA shall be the only binding, authorizing document between

the recipient and CDC. The NoA will be signed by an authorized Grants Management Officer and emailed to the program director and a hard copy mailed to the recipient fiscal officer identified in the application.

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

VI.2. Administrative and National Policy Requirements

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

- AR-8 Public Health System Reporting Requirements
- AR-9 Paperwork Reduction Act Requirements
- AR-10 Smoke-Free Workplace Requirements
- AR-11 Healthy People 2010
- AR-12 Lobbying Restrictions
- AR-14 Accounting System Requirements
- AR-23 States and Faith-Based Organizations
- AR-24 Health Insurance Portability and Accountability Act Requirements
- AR-25 Release and Sharing of Data

- AR-27 Conference Disclaimer and Use of Logos

Additional information on the requirements can be found on the CDC Web site at the following Internet address: http://www.cdc.gov/od/pgo/funding/Addtl_Reqmnts.htm.

For more information on the Code of Federal Regulations, see the National Archives and Records Administration at the following Internet address: http://www.access.gpo.gov/nara/cfr/cfr-table-search.html

VI.3. Reporting Requirements

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

1. Interim progress report, due March 15. The progress report will serve as the non-competing continuation application, and must contain the following elements:

    a) Current Budget Period Activities/Objectives Progress.

    b) Current Budget Period Financial Progress.

    c) New Budget Period Program Proposed Activities and Objectives.

    d) Budget.

    e) Measures of Effectiveness.

    f) Additional Requested Information.

The Interim Progress Report should be submitted using the HDSP MIS.

2. Financial status report and annual progress report due no more than 90 days after the end of the budget period. Annual progress report should be submitted using the CDC Heart Disease and Stroke Prevention MIS. It should report on activities for the year of funding.

3. Final performance and Financial Status reports due no more than 90 days after the end of the project period.

   The reports must be mailed to the Grants Management Specialist listed in the "Agency Contacts" section of this announcement.

The interim progress report will be used as evidence of Capacity Building Program's progress on Capacity Building activities and the program's readiness to compete for Optional Funding for Capacity Building should funds be available. Capacity Building Program grantees wishing to compete for Optional funding, should submit an application that is responsive to the Capacity Building Performance Measures for Optional funding, Application Content and Activities section of this program announcement including a line item budget and budget justification. Competitive applications for Optional funding will be reviewed by CDC staff utilizing the Technical Review process. Applications can be submitted in fiscal year 2008, 2009, 2010, or 2011. Applications must be submitted by Interim Report due date of the fiscal year in which the applicant wishes to be considered for Optional funding.

Funding decisions will be made on the basis of satisfactory progress on the Capacity Building Performance Measures for Optional funding as evidenced by required reports (interim progress report), application score, and the availability of funds.

Capacity Building Performance Measures for Optional funding include evidence that the applicant has built significant capacity as specified in the Capacity Building Program Activities 1-4.

1. Evidence of a management plan that describes a) program staffing and qualifications in terms of requirements in the program announcement; and b) methods of communication between State health department programs that relate to heart disease and stroke prevention including program priority areas 1-6.

2. Evidence of at least 10 diverse and active partners that include partners from State health department programs, other State agencies, organizations that promote cardiovascular health or address heart disease and stroke or related risk factors, organizations that improve health, and organizations that provide access to populations (including Priority Populations) or settings (including health care and worksites) by provision of documentation such as memoranda of understanding or other letters of agreements, summaries of meetings which delineate partners' leadership for completing tasks, outcomes or products of the partnership, and other

documents that demonstrate collaboration on HDSP program activities with partners.

3. Evidence that a heart disease and stroke burden document has been published by provision of a burden document (published in the past three years) that describes the burden of heart disease and stroke and related risk factors, geographic and demographic distribution of heart disease and stroke including racial and ethnic disparities, and trends in heart disease and stroke.

4. Evidence of a draft heart disease and stroke prevention State plan developed with the input of partners from within and external to the State health department; evidence of a process for finalizing, publishing and implementing the plan.

The interim progress report will be used as evidence of a Capacity Building Program's completion of Capacity Building activities and the program's readiness to compete for a Basic Implementation Program award should funds be available. Capacity Building Program grantees wishing to request Basic Implementation Program funding should submit an application that is responsive to the Capacity Building Performance Measures for Requesting Basic Implementation Program funding, Application Content and

Activities section of this program announcement including a line item budget and budget justification. Basic Implementation applications will be reviewed by CDC staff utilizing the Technical Review process that considers performance as a major determining factor for funding. Applications can be submitted in fiscal year 2008, 2009, 2010, or 2011. Applications must be submitted by Interim Report due date of the fiscal year in which the applicant wishes to be considered for Basic Implementation funding.

Funding decisions will be made on the basis of satisfactory progress on the Capacity Building Performance Measures for Requesting Basic Implementation Program funding as evidenced by required reports (semi-annual report) and products, application score, and the availability of funds.

Capacity Building Performance Measures for Requesting Basic Implementation Program funding include evidence that the applicant has achieved significant capacity as specified in the Capacity Building Program Activities 1-5.

1. Evidence of a management plan that describes: a.) program staffing and qualifications in terms of requirements in the program announcement; and b.) methods of communication between State health department programs that relate to heart disease and stroke prevention including program priority areas 1-6.

2. Evidence of at least 10 diverse and active partners that include partners

from State health department programs, other States agencies, organizations that promote cardiovascular health or address heart disease and stroke or related risk factors; organizations that improve health, and organizations that provide access to populations (including Priority Populations) or settings (including health care and worksites): documentation such as memoranda of understanding or other letters of agreements, summaries of meetings which delineate partners' leadership for completing tasks, outcomes or products of the partnership, and other documents that demonstrate collaboration on HDSP program activities with partners.

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

4. Evidence that a comprehensive heart disease and stroke prevention State plan has been developed with the input of partners from within and external to the State health department: provision of the State plan that

uses heart disease and stroke burden data and other assessment data to identify priorities, addresses primary and secondary prevention of CVD and related risk factors; memoranda of understanding or other letters of agreements from partners stating their commitment to developing and implementing the plan, confirmation that the plan promotes population-based approaches using policy and systems change strategies and addresses Priority Populations.

5. Evidence that program activities have been evaluated: provision of evaluation results for work plan objectives, a summary of the detailed evaluation of one capacity building activity.

VII. Agency Contacts

CDC encourages inquiries concerning this announcement.

For general questions, contact:

Technical Information Management Section

Department of Health and Human Services

CDC Procurement and Grants Office

2920 Brandywine Road

Atlanta, GA 30341

Telephone: 770-488-2700

For program technical assistance, contact:

Nancy B. Watkins, MPH

Chief, Program Development and Services Branch

Department of Health and Human Services

CDC Division for Heart Disease and Stroke Prevention

2877 Brandywine Rd, Mailstop K-47

Atlanta, Georgia 30341

Telephone: 770-488-2424

E-mail: nwatkins @cdc.gov

For financial, grants management, or budget assistance, contact:

Sheila Edwards, Grants Management Specialist

Department of Health and Human Services

CDC Procurement and Grants Office

2920 Brandywine Road, Mail stop: E-14

Atlanta, GA 30341

Telephone: 770-488-1644

E-mail: SJEdwards@cdc.gov

CDC Telecommunications for the hearing impaired or disabled is available at: TTY 770-488-2783.

VIII. Other Information

I. Authority and Catalog of Federal Domestic Assistance Number

Authority: Section 317(k)(2) of the Public Health Service Act (PHS Act), 42 U.S.C. 247b(k)(2); Section 301(a) of the PHS Act, 42 U.S.C. 241(a); Section 307(a) and (b) of the PHS Act, 42 U.S.C. 2421(a) and (b).

The Catalog of Federal Domestic Assistance number is 93.945.

ATTACHMENT I

Background and HDSP Logic Model

Heart disease and stroke are the first and third leading causes of death for both men and women in the United States. Coronary heart disease is the leading cause of permanent disability in the U.S. workforce, and stroke alone accounts for disability among more than 1 million Americans. In 1998, the U.S. Congress provided funding for CDC to initiate a national, State-based cardiovascular health program. The Senate Appropriations Committee in 2005 encouraged CDC to create the Division for Heart Disease and Stroke Prevention and increased resources enabling CDC to reach 32 of the 50 States and the District of Columbia with funding for heart disease and stroke prevention. As the Division for Heart Disease and Stroke Prevention developed, so did the focus of the State HDSP Program. Focusing on the 6 program priority areas (noted below) should impact morbidity and mortality of these diseases. For example, 70% of people with high blood pressure do not have it under control. A reduction of 12-13 points in systolic blood pressure in the population would result in a 37% reduction in stroke and a 21% reduction in coronary heart disease. Therefore, blood pressure control is one the 6 priorities. State programs should increase heart disease and stroke prevention policies and systems change with the potential to impact the general population and Priority Populations (see Prevention Works: CDC Strategies for a Heart-healthy and Stroke-free America, www.CDC.gov/dhdsp/library). For more information on the CDC State Heart Disease and Stroke Prevention Program, visit

http://www.cdc.gov/dhdsp/State_program/index.htm.

A Public Health Action Plan to Prevent Heart Disease and Stroke (see www.CDC.gov/dhdsp/library) documents the multiple intervention opportunities for preventing heart disease and stroke. It is important to work with partners collaboratively in leveraging resources to address the multiple risk factors that are associated with these diseases.

This program announcement supports program components considered essential to enhancing the leadership of State health departments in heart disease and stroke prevention. It provides for the funding of Capacity Building and Basic Implementation Programs and for Capacity Building programs who meet performance measures to request Basic Implementation funding.

A Capacity Building Program develops the foundation for a comprehensive cardiovascular disease prevention program through such activities as partnership development, definition of the burden, and development of a State plan. A Basic Implementation Program enhances Capacity Building activities and implements, disseminates, and evaluates intervention activities that address the State plan objectives and the CDC program priority areas 1-6:

1. Increase control of high blood pressure primarily in adults and older adults.
2. Increase control high blood cholesterol primarily in adults and older adults.

3. Increase knowledge of signs and symptoms for heart attack and stroke and the importance of calling 9-1-1.

4. Improve emergency response.

5. Improve quality of heart disease and stroke care.

6. Eliminate disparities in terms of race, ethnicity, gender, geography, or socio-economic status.

The State Heart Disease and Stroke Prevention Program (HDSP) is anchored on the framework of the Socio-ecological Model which conceptualized the influences of individual behaviors, family and social relationships, community and environmental effects, and societal influences such as policies on health status. In order to promote significant impact for improving the health of the population, interventions should focus on implementing policy and systems change strategies that support heart disease and stroke prevention.

Policy change can be addressed through 1.) public policy (e.g., establishing certification for hospital-based stroke centers) or 2.) organizational policy (e.g., businesses providing health benefits plans that cover preventive services that include blood pressure control).

System changes are encouraged in 3 settings: worksites, health care, and communities. An example of a systems change is when a health care setting implements electronic records and patient care management systems that improve the quality of health care.

Interventions within systems are encouraged at the highest level possible, for example, activities with business coalitions rather than individual worksites and with managed care organizations (MCOs) and State medical associations rather than individual health care sites or physicians. By working at higher levels to affect systems change, States can impact larger segments of the population.

Education and awareness efforts to enhance public understanding and promote actions related to cardiovascular diseases and the risk factors of high blood pressure and high cholesterol, signs and symptoms of heart attack and stroke, and the need to call 9-1-1 are also components of capacity enhancement.

An overarching goal of the State HDSP Program is to address disparities in heart disease and stroke and the related risk factors using policy and systems change strategies. Based on disparities (e.g., race/ethnicity, gender, geographic, geography, socioeconomic status) in mortality, access to care, or burden of risk factors, the State HDSP program should identify Priority Populations and implement interventions to reach those Priority Populations.

No one organization will be able to address the prevention of heart disease and stroke. It will require many organizations working in collaboration if progress is to be made in accomplishing the Healthy People 2010 Objectives. Collaboration is defined by the Wilder Foundation as “a mutually beneficial and well-defined relationship entered into

by two or more organizations to achieve common goals. The relationship includes a commitment to mutual relationships and goals; a jointly developed structure and shared responsibility; mutual authority and accountability for success; and sharing of resources and rewards." Developing and maintaining strategic partnerships are key to the leveraging of skills and resources to prevent heart disease and stroke in a comprehensive way. The State HDSP Program has two major roles related to partners. The first is to convene or facilitate collaboration to develop and implement a comprehensive State plan and intervention implementation strategies that addresses heart disease and stroke and related risk factors. The second is to develop strategies to leverage resources and coordinate interventions with partners that address the 6 program priority areas.

A logic model has been developed to describe the State HDSP Program as intended by the CDC funding to State health departments (Figure 1). The model depicts relationships and actions (e.g., links between environment and policy change and individual-level behavioral change) which are expected to culminate in reduction in heart disease and stroke. The CDC may be only one funding source and a State's HDSP efforts as a whole may be more elaborate than this model. It is important to note that logic models are often cyclical and that an outcome from one activity can provide information that then feeds back into a previous activity.

The CDC and State activities are outlined in terms of capacity building, surveillance/monitoring, and interventions. Both the CDC and State activities influence

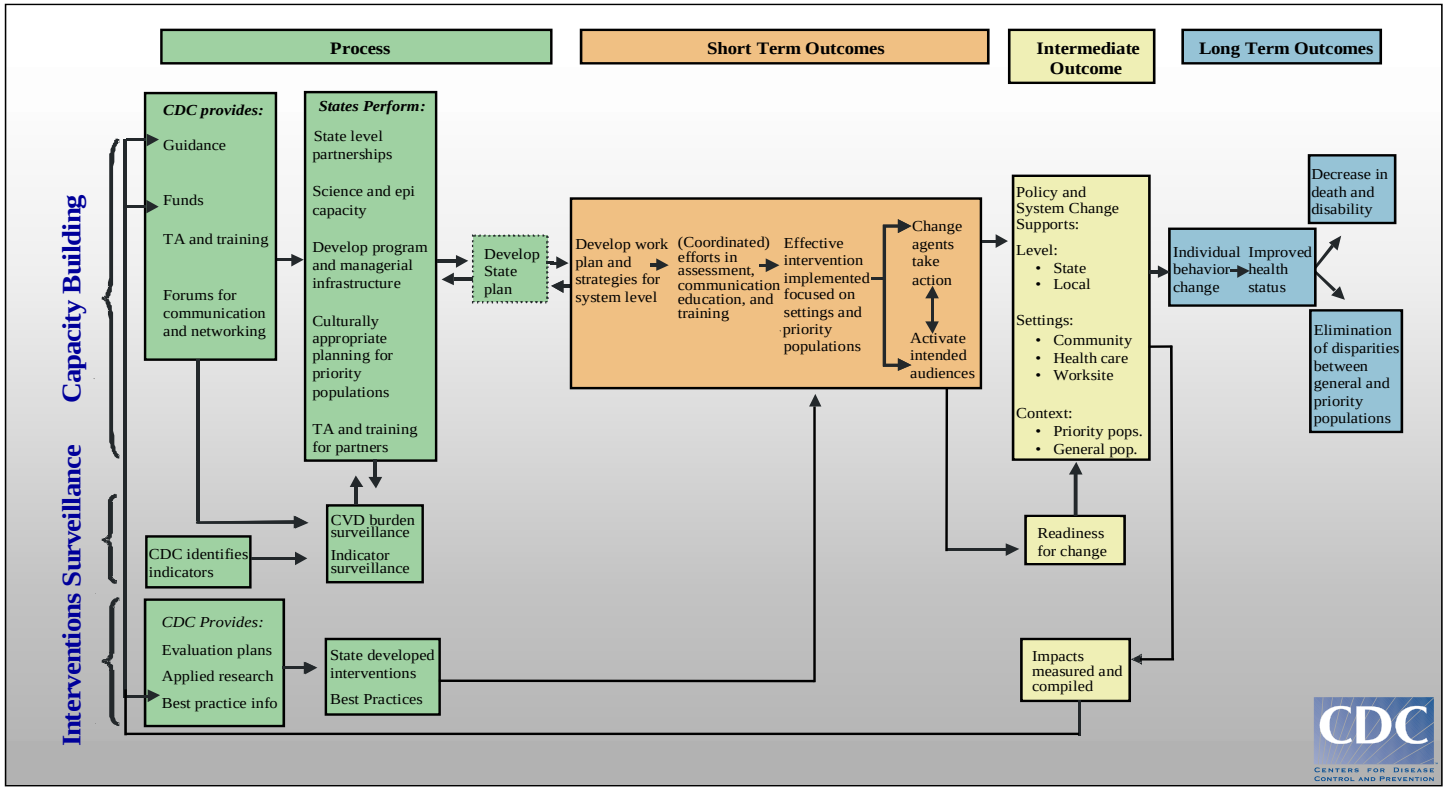
changes that lead to short-term outcomes such as development of a work plan and strategies for system-level changes, effective implementation of interventions, and action by target audiences and change agents (those who are in the position to influence policies and systems such as hospital administrators and MCO decision makers). These activities and outcomes result in changes in policy and environmental supports, which in turn influence behavior changes and improve health status. Ultimately these changes decrease premature death and disability and eliminate cardiovascular disparities between general and Priority Populations.

The State HDSP logic model also is a tool to guide program evaluation. By identifying the steps necessary to reach intended outcomes, the logic model provides guidance in evaluating the short and intermediate outcomes of the program.

State evaluation efforts should relate to the Logic Model in Figure 1 or to a logic model that the State develops that complements Figure 1 and the required program recipient activities. The logic model can also be seen in the CDC Evaluation Framework for Heart Disease and Stroke Prevention State Programs at www.cdc.gov.cvh.

FIGURE 1

Heart Disease and Stroke Prevention State Program Logic Model



Attachment II

Performance Measures for Capacity Building and Basic Implementation Programs and Stroke Networks

Capacity Building Performance Measures

At the time of application, States applying for funding may have already achieved various performance measures for Capacity Building. States should review the following measures, identify those already achieved, and plan to address the remaining performance measures within the first one to two years of funding.

Annually:

- Collaborate with State health department partners on the planning and implementation of at least one capacity building activity or State heart disease and stroke prevention plan activity.
- Leverage resources from external partners to facilitate the development or implementation of the State heart disease and stroke prevention plan. Provide two narrative examples.

By the end of year 1:

- Employ one full-time project manager.
- Employ one half-time chronic disease epidemiologist.
- Develop a heart disease and stroke burden profile for program planning and training.

- Establish a State partnership comprising diverse partners.
- Develop a plan for convening and maintaining a State partnership.
- Convene one partnership meeting toward the development of a State plan.

By the end of year 2:

- Complete a training needs assessment. Develop and implement a training plan to increase the capacity of staff and partners.
- Publish in hard copy a State heart disease and stroke burden report.

By the end of year 3:

- Publish in hard copy a comprehensive State plan that uses burden and assessment findings; addresses prevention of heart disease and stroke; addresses heart disease and stroke risk factors; proposes policy and systems changes as approaches to the 6 priority areas; identifies how progress toward successful achievement of the plan will be evaluated; and documents partner involvement in planning and implementing the State plan.
- Complete an evaluation of the State partnership, including, for example, partner satisfaction, commitment and involvement, infrastructure and functioning, effectiveness and outcomes, and sustainability.
- Develop an approach to implementing the State plan as part of the program work plan.

By the end of year 4:

- Implement the State plan in collaboration with partners using policy and systems change to address the 6 State HDSP Program priority areas.
- Develop an implementation plan for at least 2 population-based, policy or systems change interventions in 1 or more of the State HDSP Program priority areas, in collaboration with partners.

By the end of 5 years:

- Implement and initiate evaluation of a small scale version of at least 1 of the population-based interventions proposed in year 4.
- Update the burden profile.
- Meet all criteria for requesting Basic Implementation funds and apply for Basic Implementation funding.

Basic Implementation Program Performance Measures

Annually:

- Demonstrate progress toward achieving goals of the comprehensive State plan in collaboration with partners.

- Assure the State burden document has been published within the previous 5 years.
- Collaborate with State health department partners on the implementation of at least one State heart disease and stroke prevention plan activity.
- Collaborate with State health department partners on the implementation of at least one activity related to priority areas 1-6.
- Leverage resources from external partners to implement at least one State heart disease and stroke prevention plan activity. Provide a narrative example.
- Leverage resources from external partners to implement at least one intervention activity related to priority areas 1-6. Provide a narrative example.

By the end of year 1:

- Maintain one full-time project manager.
- Maintain one half-time chronic disease epidemiologist.
- Provide for one half-time evaluator or equivalent.
- Complete a training needs assessment of staff and partners. Develop and implement a training plan based on needs assessment.
- Update as needed a State heart disease and stroke burden profile for program planning.

By the end of year 2:

- Implement and initiate evaluation of at least 2 population-based policy/system change interventions to control high blood pressure and/or high blood cholesterol in the healthcare or worksite setting. This should include consideration of Priority Populations.
- Evaluate the State partnership. Include an evaluation of the effectiveness of the partnership in leveraging resources and implementing interventions.

By the end of year 3:

- Implement and initiate evaluation of at least one additional population-based policy/systems change intervention strategy in one of the remaining program priority areas (quality of care (other than high blood pressure or high cholesterol), emergency response, signs and symptoms in the healthcare or worksite setting). This should include consideration of Priority Populations.
- Update State heart disease and stroke burden profile.
- Document contributions of partners (leveraged resources) to implementing priority area policy and system change interventions.

By the end of year 4:

- Document continued progress on implementing and evaluating population-based interventions using the MIS.
- As applicable, evaluate interventions among Priority Populations.

- Use evaluation findings for program improvement. Submit a brief summary of intervention evaluation findings that includes an improvement plan.

By the end of the year 5:

- Expand existing or implement new population-based policy/systems change interventions in the program priority areas. As applicable, evaluate interventions among Priority Populations.
- Update State heart disease and stroke burden profile.
- Complete an executive summary of program accomplishments that covers the funding cycle including policy and systems changes, impact of policy and systems changes, and contributions of the partners (leveraged resources) to implementing priority area policy and systems change interventions.

Stroke Network Performance Measures

By the end of Project Year 1:

1. Hire a project coordinator.
2. Convene a stroke network structure that may be composed of an advisory group with supporting work groups and committees.
3. Demonstrate evidence of diverse partnerships with key stakeholders across member States and the region.

4. Develop a document/publication describing regional stroke burden, risk factors, and geographic and demographic distribution of stroke.
5. Develop a strategic plan with timelines that describes policy and systems change strategies that will be implemented in years 2 and 3.

By the end of Project Year 2:

1. Utilize the strategic plan, timeline, burden data, and other assessment data (e.g., of policies, systems of care) to develop a stroke regional plan that defines goals, objectives, priorities and policy and systems approaches, and describes participation and commitment by partners across the region and within member States.
2. Prioritize and select policy and systems level activities that will be implemented in a coordinated and uniform fashion across the region.
3. Develop an evaluation strategy that will be used to assess the selected activities.

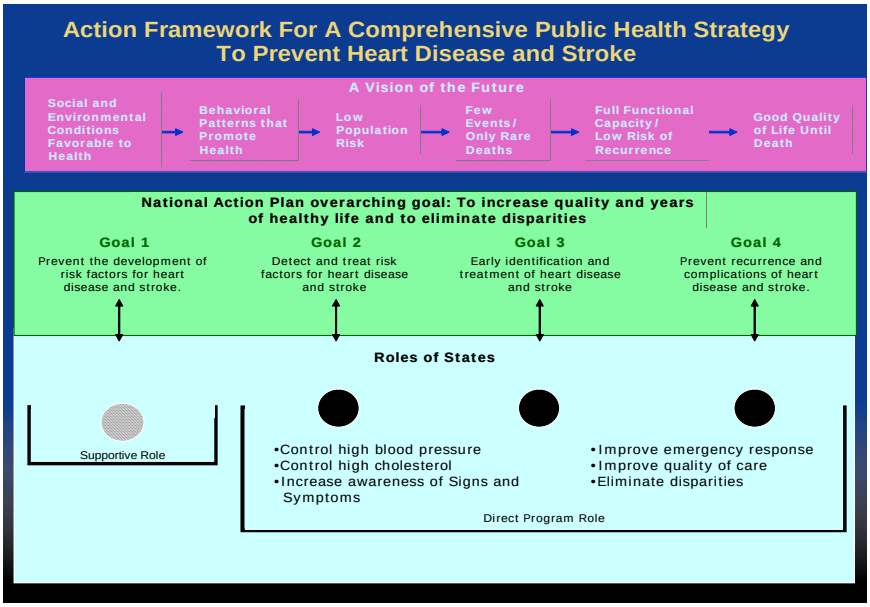
By the end of Project Year 3:

1. Provide evidence of the implementation of uniform policy and systems change activities across the region.
2. Demonstrate the effectiveness of stroke network structure and partnerships.
3. Utilize network data to engage stakeholders in promoting policy and systems change activities. Promote stroke network accomplishments through such means as reports, journal articles, presentations, best practices, website, etc.

4. Evaluate stroke network impact on the regional stroke burden, Statewide or organizational policies, or policy and decision makers.
5. Enhance stroke network partnership and leverage resources to ensure sustainability of activities.

Attachment III

Roles for the State Heart Disease and Stroke Prevention Programs



In A Public Health Action Plan to Prevent Heart Disease and Stroke, there are 4 major goals which are based on Healthy People 2010:

Goal 1: Prevention of risk factors.

Goal 2: Detection and treatment of risk factors.

Goal 3: Early identification and treatment of heart attacks and strokes.

Goal 4: Prevention of recurrent cardiovascular events.

CDC-funded State HDSP Programs have a direct impact on Goals 2, 3, and 4, by addressing HDSP program priority areas 1-6 (see Purpose section). HDSP programs have

a supportive role with other State health department programs and partners in addressing Goal 1. Efforts to address Goal 1 related to tobacco use, diabetes, obesity, poor nutrition, physical inactivity, and schools as a worksite should be done through a supportive or collaborative role with the State WISEWOMAN, diabetes, tobacco, nutrition, physical activity, or coordinated school health programs.

- State HDSP Programs are encouraged to coordinate with other programs in ways that:
  1. address Goal 1 (e.g., State HDSP and Nutrition Programs identify primary prevention messages related to cholesterol and salt to be included in Nutrition Programs where appropriate; State HDSP and Tobacco Programs collaborate to promote use of State tobacco quit lines; State HDSP program refers managed care organizations to materials developed by the Parks and Recreation Department and Physical Activity Program on safe places to exercise; State HDSP and WISEWOMAN Programs collaborate to create systems for educating health care providers on guidelines focused on risk factor prevention).

  2. enhance inclusion of key messages in the work of related programs (e.g., State HDSP Program works to implement JNC7 guidelines which include referral to nutrition counseling; the WISEWOMAN Program incorporates education on signs and symptoms of heart disease and stroke into ongoing activities; the State HDSP Program encourages implementation of patient record systems that include family history).

3. coordinate work with partners (e.g., multiple health department programs that work with American Heart Association coordinate efforts with this partner where possible).

4. coordinate work within settings (e.g., programs with related interests in healthy work places coordinate efforts to engage worksites or business coalitions; State HDSP and other chronic disease programs work collaboratively with community health centers to implement systems change to increase blood pressure control).

5. maximize the public health benefit from the use of CDC funding within approved budget line items to enhance the State's ability to achieve stated goals and objectives and respond to changes in the field (See Funding Section IV.5. for flexibility language related to use of funds) Flexibility language includes using staff time and funds for:

    a) sharing positions (e.g., the State HDSP and Nutrition Program sharing the costs of a policy analyst)

    b) conducting training activities (e.g., program funding staff and partners on common skills such as program evaluation, ways to reduce disparities, use of data for program planning or use of policy and systems change strategies).

    c) planning (e.g., joint planning on how to address disparities; programs

jointly plan a State public health conference that addresses common skills and specific program-related sessions).

d) developing procedures and formats that increase understanding across programs (e.g., consistent formats for documents such as State plans and descriptions of burden).

- State health departments should determine how best to facilitate coordination and cooperation among existing categorical program efforts while allowing each program to maintain individual integrity and identity.

- States should utilize tools, including the Partners for Prevention document Comprehensive and Integrated Chronic Disease Prevention: Action Planning Handbook for States and Communities (at www.prevent.org), which contains activities to assist State programs identify areas of collaboration for mutual benefit, increase efficiency, and better serve the people of the State.

TABLE 1
HEART DISEASE AND STROKE MORTALITY BY STATE, 2003

Diseases of heart (I00-I09, I11, I13, I20-I51)			Stroke (I60-I69)		
	Age-adjusted Death Rate (per 100,000)	% Diff relative to US Total		Age-adjusted Death Rate (per 100,000)	% Diff relative to US Total
US Total	232.3	0.0	US Total	53.5	0.0
Alabama	281.7	21.3	Alabama	65.1	21.7
Alaska	181.8	-21.7	Alaska	60.7	13.5
Arizona	198.3	-14.6	Arizona	44.4	-17.0
Arkansas	258.4	11.2	Arkansas	69.6	30.1
California	219.8	-5.4	California	56.8	6.2
Colorado	178.0	-23.4	Colorado	50.7	-5.2
Connecticut	201.8	-13.1	Connecticut	43.5	-18.7
Delaware	243.1	4.6	Delaware	49.0	-8.4
DC	287.3	23.7	DC	45.0	-15.9
Florida	212.7	-8.4	Florida	43.4	-18.9
Georgia	251.8	8.4	Georgia	64.5	20.6
Hawaii	176.9	-23.8	Hawaii	53.9	0.7
Idaho	197.0	-15.2	Idaho	58.8	9.9
Illinois	235.1	1.2	Illinois	54.2	1.3
Indiana	246.3	6.0	Indiana	57.7	7.9
Iowa	208.1	-10.4	Iowa	53.7	0.4
Kansas	212.5	-8.5	Kansas	56.8	6.2
Kentucky	275.9	18.8	Kentucky	60.4	12.9
Louisiana	274.2	18.0	Louisiana	60.4	12.9
Maine	200.6	-13.6	Maine	51.5	-3.7
Maryland	235.6	1.4	Maryland	53.6	0.2
Massachusetts	198.4	-14.6	Massachusetts	45.6	-14.8
Michigan	254.0	9.3	Michigan	53.5	0.0
Minnesota	152.0	-34.6	Minnesota	47.1	-12.0
Mississippi	310.3	33.6	Mississippi	62.1	16.1
Missouri	262.9	13.2	Missouri	57.2	6.9
Montana	190.7	-17.9	Montana	55.1	3.0
Nebraska	196.9	-15.2	Nebraska	53.9	0.7
Nevada	242.6	4.4	Nevada	57.0	6.5
New Hampshire	210.8	-9.3	New Hampshire	41.8	-21.9
New Jersey	234.8	1.1	New Jersey	42.2	-21.1
New Mexico	191.5	-17.6	New Mexico	43.7	-18.3
New York	266.0	14.5	New York	35.1	-34.4
North Carolina	231.9	-0.2	North Carolina	65.6	22.6

North Dakota	198.5	-14.6	North Dakota	55.4	3.6
Ohio	247.9	6.7	Ohio	55.7	4.1
Oklahoma	300.1	29.2	Oklahoma	67.6	26.4
Oregon	181.6	-21.8	Oregon	65.4	22.2
Pennsylvania	241.8	4.1	Pennsylvania	51.7	-3.4
Rhode Island	227.7	-2.0	Rhode Island	42.1	-21.3
South Carolina	234.5	0.9	South Carolina	69.0	29.0
South Dakota	208.0	-10.5	South Dakota	49.8	-6.9
Tennessee	273.4	17.7	Tennessee	67.8	26.7
Texas	237.8	2.4	Texas	59.7	11.6
Utah	183.5	-21.0	Utah	53.9	0.7
Vermont	199.3	-14.2	Vermont	44.9	-16.1
Virginia	218.1	-6.1	Virginia	59.2	10.7
Washington	188.6	-18.8	Washington	60.8	13.6
West Virginia	284.6	22.5	West Virginia	60.2	12.5
Wisconsin	205.1	-11.7	Wisconsin	52.3	-2.2
Wyoming	199.5	-14.1	Wyoming	53.0	-0.9

**unstable estimate

Source: Table 29. Hoyert DL, Heron MP, Murphy SL, Kung HC. *Deaths: Final Data for 2003*. National Vital Stat Rep Vol. 54, No. 13 Hyattsville MD: National Center for Health Statistics; 2006