Funding Opportunity Number:	CDC-RFA-CE16-1602
Funding Opportunity Title:	Core State Violence and Injury Prevention Program (Core SVIPP)
Program Office:	National Center for Injury Prevention and Control
Drafter:	Ted Castellanos
FOA Analyst:	Rene Benyard

Special Instructions:

Gray shaded text denotes standardized language that is required content in every announcement.

Gray shaded underlined text denotes optional standard language where users can opt to include certain text when appropriate.

Summary:

System Generated Number:	CDC-40838
Funding Opportunity Number:	CDC-RFA-CE16-1602
Funding Opportunity Title:	Core State Violence and Injury Prevention Program (Core SVIPP)
FOA FY Processing Year:	2016
Fiscal Year:	2016
Program Office:	NCIPC
Program Funding Type:	Discretionary
Announcement Type:	Discretionary - NCIPC Non-Research Multi Component
Announcement Template:	Non-Research Multi Component
Funding Activity Category:	Health
Recovery Act:	No
Affordable Care Act (ACA):	No
Funding Instrument Type:	Cooperative Agreement
Primary CFDA Number:	93.136

Award / Funding Information:

Cost Sharing / Matching Requirement:	N
Percentage of Cost Sharing / Matching Requirement:	0
Expected Number of Awards:	20
Estimated FY Funding:	$6,135,000
Estimated Total Funding:	$30,675,000
Estimated Award Ceiling:	$475,000 Per Budget Period
Estimated Award Floor:	$200,000 Per Budget Period
Project Period | Expected Duration in Months:	60
Project Type:	Non-Research

Eligibility:

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

Additional Information on Eligibility (4,000 character limit):

State Health Departments (States) or their bona fide agents (this includes the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, the Commonwealth of the Northern Marianna Islands, American Samoa, Guam, the Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau) and Federally recognized or state-recognized American Indian/Alaska Native tribal governments (Tribes). A bona fide agent is an agency/organization identified by the State Health Department as eligible to submit an application under the state eligibility in lieu of a state application.

Statutory Authority:

Section 301 (a) [42 U.S.C. 241a)] of the Public Health Service Act, and Section 391 (a) [42 U.S.C. 280 b (a)] of the Public Health Service Act

Description (Grants.gov/Forecast) (18,000 character limit):

The overall purpose of this funding is to: 1) decrease and prevent injury and violence related morbidity and mortality and 2) increase sustainability of injury prevention programs and practices. This will be achieved through support to State Health Departments (SHDs) in the implementation, evaluation and dissemination of programs, practices, and policies with the best available evidence (see Glossary for best available evidence definition). Strategies that address injury and violence prevention (IVP) through the lens of shared risk and protective factors are encouraged to promote maximum impact of limited resources. Required strategies will align with NCIPC priorities related to child abuse and neglect, traumatic brain injury (TBI), motor vehicle crash injury and death, and intimate partner/sexual violence.

Administrative Policies

Non-Competing:	No
Non-Competing Description:	
Single Source Justification:	
Limited Competition:	Yes
Additional Disqualification Factors:	N

FOA History

New Opportunity:	Yes
Previously Published Fiscal Year:	0
Previously Published Funding Opportunity Number:	

Information Collection

Expected Number of Applications:	40

Estimated Milestone Dates	
Submit Initial Draft:	06/19/2015 (Edit)
Estimated Post Date:	01/15/2016
Estimated Application Due Date:	04/08/2016
Application Due Date Explanation :	Electronically submitted applications must be submitted no later than 11:59 p.m., ET, on the listed application due date.
Estimated Award Date:	08/01/2016
Estimated Project Start Date:	08/01/2016
Estimated Project End Date:	07/31/2021

Part I. Overview Information

Applicants must go to the synopsis page of this announcement at www.grants.gov and click on the "Send Me Change Notifications Emails" link to ensure they receive notifications of any changes to CDC-RFA-CE16-1602. Applicants also must provide an e-mail address to www.grants.gov to receive notifications of changes.

A. Federal Agency Name:

Centers for Disease Control and Prevention (CDC)

B. Funding Opportunity Title:

Core State Violence and Injury Prevention Program (Core SVIPP)

C. Announcement Type: New - Type 1

This announcement is only for non-research domestic activities supported by CDC. If research is proposed, the application will not be considered Research for this purpose is defined at http://www.cdc.gov/od/science/integrity/docs/cdc-policy-distinguishing-public-health-research-nonresearch.pdf.

D. Agency Funding Opportunity Number:

CDC-RFA-CE16-1602

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

93.136

F. Dates:

1. Due Date for Letter of Intent (LOI):	**03/01/2016**
Is a LOI:	Recommended but not Required
2. Due Date for Applications:	**04/08/2016**, 11:59 p.m. U.S. Eastern Standard Time, at www.grants.gov.
3. Date for Informational Conference Call:	**02/01/2016**

The Informational Conference Call will be held for potential applicants to further understand the conceptual framework of this Funding Opportunity Announcement (FOA). The call will start promptly on Monday (02/01/2016) at 2:00 p.m. Eastern Standard Time. Conference call can be accessed at either: (770) 488-3600 OR (855) 644-0229 and the Conference ID is 1634049.

G. Executive Summary:

1. Summary Paragraph:

The overall purpose of this funding is to: 1) decrease and prevent injury and violence related morbidity and mortality, and 2) increase sustainability of injury prevention programs and practices. This will be achieved through support to states in the implementation, evaluation and dissemination of programs, practices, and policies with the best available evidence (see Glossary for best available evidence definition). Strategies that address injury and violence prevention (IVP) through the lens of shared risk and protective factors are encouraged to promote maximum impact of limited resources. Required strategies will align with NCIPC priorities related to child abuse and neglect, traumatic brain injury (TBI), motor vehicle crash injury and death, and intimate partner/sexual violence.

a. Eligible Applicants:	Limited
b. FOA Type:	Cooperative Agreement
c. Approximate Number of Awards:	20
d. Total Project Period Funding:	$30,675,000

e. Average One Year Award Amount: $250,000

f. Number of Years of Award: 5

g. Estimated Award Date: 08/01/2016

h. Cost Sharing and / or Matching Requirements: N

Cost sharing or matching funds are not required for this program. While there is no cost sharing requirement for the BASE component, applicant institutions, including any collaborating institutions, are encouraged to devote resources to the program and cost share at least ten percent (10%) of direct costs. Any non-Federal support (funds or other resources) indicates a greater potential of success and sustainability of the program. Non-federal support will be considered in the scoring of the Evaluation Criteria in the BASE section. Examples of support include donated equipment and space or funded staff time and effort. Applicants that plan to provide support should provide detailed documentation in an appendix outlining specific contributions to the program and the value of those contributions. Although no statutory matching requirement for this FOA exists, leveraging other resources and related ongoing efforts to promote sustainability is strongly encouraged.

Consistent with the cited authority for this announcement and applicable grants regulations, sources for cost sharing or matching may include complementary foundation funding, other U.S. government funding sources including programs supported by HHS or other agencies (e.g., Department of Agriculture, Department of Education, Department of Housing and Urban Development, Department of Transportation, Environmental Protection Agency, U.S. Park Service) and other funding sources. Applicants should coordinate with multiple sectors such as public health, transportation, education, health care delivery, and agriculture.

Part II. Full Text

A. Funding Opportunity Description

1. Background

a. Overview

CDC's National Center for Injury Prevention and Control (NCIPC) is committed to working with its partners to promote action that reduces injuries, violence, and disabilities, by providing leadership in identifying priorities, promoting prevention strategies, developing useful tools, and monitoring the effectiveness of Injury and Violence Prevention (IVP) program activities.

Unintentional and violence-related injuries and their consequences are the leading causes of death for the first four decades of life, regardless of gender, race, or socioeconomic status. More than 192,000 individuals in the United States die each year as a result of unintentional injuries and violence, and more than 27 million others suffer non-fatal injuries requiring emergency department (ED) visits each year. Most events that result in injury and/or death could be prevented if evidence-based public health strategies, practices, and policies were used throughout the nation. This multi-component FOA includes the BASE and two optional enhanced components: Surveillance Quality Improvement (SQI) and Regional Network Coordinating Organization (RNCO).

BASE: Support to states to strengthen their IVP programs and policies and demonstrate impact in the reduction of IVP related morbidity and mortality. Strategies that address IVP through the lens of shared risk and protective factors are encouraged to promote maximum impact of limited resources. By concentrating efforts in four priority focus areas of IVP (child abuse and neglect, TBI, motor vehicle crash injury and death, and intimate partner/sexual violence) and demonstrating and sustaining general capacity in the four priority focus areas, states will be better able to demonstrate impact on health outcomes. To allow for some flexibility, this announcement includes an option that 10% of the funding may be used for programmatic innovation beyond the four priority focus areas.

SQI: Both high-quality data resources and up to date analysis tools are required to ensure that state-based injury surveillance is conducted effectively and accurately. As such, the SQI component's purpose is to conduct injury data investigations supportive of promoting and advancing uniform injury case definitions, improving data quality, and advancing methodology and exploring emerging sources of injury data. The result of this work should be to advance a consensus process for developing and implementing injury surveillance activities and to develop and/or improve standardized analysis and publication procedures for specific causes of injury. A consensus process may be conducted in conjunction with either governmental partners or injury membership organizations such as the Safe States Alliance and the Council of State and Territorial Epidemiologists.

RNCO: To provide coordination across and between all states (regardless of funding status) and collaboration with IVP organizations for sharing of scientific evidence and programmatic best practices. Resources and capacity for IVP are limited and vary by state. The purpose of the regional network coordinating organizations are to provide structured coordination across their region via peer learning teams and to facilitate and coordinate one national/cross-regional collaborative peer learning group on a specific, CDC-identified topic. The selected topic for the national/cross-regional collaborative peer learning group must be in alignment with one of the four priority focus areas detailed in this FOA.

b. Statutory Authorities

Section 301 (a) [42 U.S.C. 241a)] of the Public Health Service Act, and Section 391 (a) [42 U.S.C. 280 b (a)] of the Public Health Service Act

c. Healthy People 2020

This FOA supports the Healthy People 2020 IVP objectives: 1) Reduce fatal and non-fatal injuries, and 2) Reduce fatal and non-fatal violence related incidents. http://www.healthypeople.gov/2020/topics-objectives/topic/injury-and-violence-prevention

d. Other National Public Health Priorities and Strategies

This FOA aligns with and supports the Surgeon General's National Prevention Strategy (NPS) in a few ways: 1) addresses one of the seven priorities designated in the NPS (i.e., Injury and Violence Free Living); 2) emphasizes engaging partners across disciplines, sectors, and institutions as an important factor in significantly improving well-being; and 3) supports state governments to facilitate collaboration among diverse sectors when making decisions to have a significant effect on health. http://www.surgeongeneral.gov/initiatives/prevention/strategy/

e. Relevant Work

This FOA builds upon the previous work of the Core VIPP program (CE11-1101) which focused on supporting infrastructure and capacity development for IVP in 20 funded states. All funded state partners were expected to maintain and strengthen their IVP programs with a focus on key components: building a solid infrastructure; collecting and analyzing data; designing, implementing and evaluating programs; providing technical support and training; and, affecting behavior and knowledge. Additional (optional) funding was also available for 1) building IVP leadership in all HHS Regions; 2)promoting and advancing uniform injury case definitions, improving data quality, and advancing surveillance methodology; 3) preventing older-adult falls by integrating evidence-based practices and strategies with the community and clinical care practice; 4) addressing the issue of motor vehicle-related injuries among children and teens by: using data to better understand who is at risk and what works to prevent motor vehicle injury; develop programs; and, inform decision-makers about strategies to help keep drivers, passengers, bicyclists and pedestrians safe on the road each day. For more information, see http://www.cdc.gov/injury/stateprograms/index.html

2. CDC Project Description

a. Approach

Bold indicates project period outcome.

<table>
<tr><td colspan="4">LOGIC MODEL (BOLD ARE ACCOUNTABLE OUTCOMES IN THE PROJECT PERIOD)
Core SVIPP 2016</td></tr>
<tr><td>Strategies and Activities</td><td>Short-term Outcomes</td><td>Mid-term Outcomes</td><td>Long-term Outcomes</td></tr>
<tr><td>1. Educate health department leaders and policy makers about PH approaches to IVP</td><td>Increased recognition of the role of public health in IVP</td><td rowspan="2">Increase in state and local sharing and leveraging of IVP funds and/or resources</td><td rowspan="7">Increase in sustainability of injury and violence prevention programs and practices

Decrease in risk factors and increase in protective factors associated with IVP proximal measures

Statewide reduction in focus area injury and violence related morbidity and mortality</td></tr>
<tr><td>2. Engage, coordinate, & leverage other internal (SHD) and external partners (NGO) and Injury Control Research Centers (ICRC) (or other injury research institutes)</td><td>Connect science and practice within the field of violence and injury prevention</td></tr>
<tr><td>3. Enhance statewide IVP plan and logic model for 4 priority focus areas</td><td>Increase the number or scope of IVP strategies based on the best evidence that states or their partners are implementing</td><td>Increase in reach and effectiveness of state IVP strategies</td></tr>
<tr><td>4. Implement 3 strategies that address 4 priority focus areas (one selected strategy must address shared risk and protective factors across two priority focus areas)</td><td rowspan="3">Identify barriers and facilitators to implementation of strategies based on best available evidence</td><td rowspan="3"></td></tr>
<tr><td>5. Develop evaluation plan reflecting process and outcome measures</td></tr>
<tr><td>6. Disseminate surveillance and evaluation information to stakeholders and use to inform continuous quality improvements</td><td rowspan="2">Increase in IVP surveillance data quality, consistency, and use (standard definition and types of analysis)</td><td rowspan="2">Increase the development and evaluation of surveillance guidance</td></tr>
<tr><td>7. Enhance surveillance systems to capture IVP data</td></tr>
</table>

i. Purpose

As depicted in the logic model, the overall purpose of this FOA is to decrease injury and violence related morbidity and mortality in four NCIPC priority focus areas: child abuse and neglect, TBI, motor vehicle crash injury and death, and intimate partner/sexual violence by decreasing shared risk factors and increasing shared protective factors. The FOA is intended to support SHDs in the dissemination, implementation, and evaluation of programs, practices, and policies in accordance with best available evidence strategies.

ii. Outcomes

As noted in the logic model, awardees will be held accountable for **all** the outcomes in the logic model, as they pertain to the four priority focus areas: child abuse and neglect, TBI, motor vehicle crash injury and death, and intimate partner/sexual violence. Awardees must identify, track, and monitor outcomes related to all four priority focus areas. It is expected that data for the selected outcomes will be accessible through existing data collections. Awardees will track required long-term outcomes and will also propose short-term and mid-term outcomes in their application. Implementation or process outcomes will be updated by awardee in consultation with CDC within three months post-award. CDC will provide more detailed guidance related to these variables post-award (CDC OMB package approval in process). These outcomes include:

Short-term

- Increased recognition of the role of public health in IVP
- Connect science and practice within the field of violence and injury prevention
- Increase the number or scope of evidenced-based IVP strategies states or their partners are implementing
- Identify barriers and facilitators to implementation of strategies based on best available evidence
- Increase in IVP surveillance data quality, consistency, and use (standard definition and types of analysis)

Mid-term

- Increase in state and local sharing and leveraging of IVP funds and/or resources
- Increase in reach and effectiveness of state IVP strategies

Long-term

- Increase in sustainability of injury and violence prevention programs and practices
- Decrease risk factors and increase protective factors associated with IVP proximal measures
- Statewide reduction in focus area injury and violence related morbidity and mortality

The performance and evaluation section later on shows the measures that awardees will monitor related to these general outcomes.

Awardees have significant autonomy in the work they do within the strategies, thus, they must identify relevant short-term and mid-term outcomes for the strategies they have chosen in the four priority focus areas. The performance and evaluation section later displays some sample measures. The Awardees' proposed short-term and mid-term outcomes will be presented in their application—and in a related logic model. Process and outcome measures for these will be developed post-award in consultation with CDC.

iii. Strategies and Activities

As depicted in the logic model, the FOA comprises seven (7) overarching strategies. Applicants should consult with implementation partners in selecting program/policy sub-strategies, with an emphasis on selecting approaches within each of the seven (7) overarching strategies that have a science-based approach to prevention to achieve collective impact on injury and violence. In addition, as described below, there are two enhanced components that awardees may choose to undertake.

BASE STRATEGIES:

To achieve the purpose of the BASE component, the awardee will be responsible for the activities elaborated below for each of the seven (7) overarching strategies listed in the logic model.

Strategy 1: Educate health department leaders & policymakers about PH approaches to IVP

SHD violence and injury prevention programs have a critical role to play in informing all types (organizational, regulatory, and legislative) of policy strategies that prevent injury, violence, and their

consequences (See http://ftp.cdc.gov/pub/TBI/2016_CORE_SVIPP_FOA __State Health Department Guide to Affecting Policy). Public health policy strategies are targeted to influence systems development, organizational change, social norms, and individual behavior and environments to promote improvement in the health of a population. Policy strategies are important as they are effective community and societal level strategies for improving the public's health. This type of population-based approach can also be less expensive and more cost-effective. While the policy process from planning to development to implementation and evaluation should include the full engagement of multiple stakeholders, the activities listed below should align with the priorities identified by the ICIG (Injury Community Implementation Group) as described below in Logic Model Strategy 2:

YEAR 1

- Develop a structure with all relevant stakeholders (e.g. internal health department legislative liaisons and communications team/public information office, regional/statewide representatives of key governmental and non-governmental agencies, media outlets, private sector partners, education agencies, non-governmental public health organizations and other academic and practice partners and stakeholders) to be able to strategically assess policy and focus on state injury and violence priorities

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- Conduct or support activities that inform policy in the four Core SVIPP priority focus areas as appropriate. Activities may include, but are not limited to: draft a cost benefit analysis of an existing/proposed law; draft a health impact analysis; evaluate existing/new policies including an assessment of effectiveness; meet with stakeholders to inform or educate on the burden of injuries and violence; etc. (see http://ftp.cdc.gov/pub/TBI/2016_CORE_SVIPP_FOA for more examples)
- Analyze data to identify trends and opportunities for evidenced based prevention
- Identify and connect with stakeholders to gather feedback, implement communication strategies, and deliver relevant messages and materials
- Provide science and evidence to educate decision makers about the components and potential effects of policies
- Educate the public about existing policies or laws
- Evaluate the impact of policies or laws

Strategy 2: Engage, coordinate, & leverage other internal (SHD) and external partners (NGO) and Injury Control Research Centers (ICRC) (or other injury research institutes)

YEAR 1

- Participate with CDC-appointed technical advisors to conduct program and policy evaluation activities, including the submission of annual progress reports using the CDC provided template
- Develop, or enhance, existing multi-disciplinary public/private collaborative group focused on implementation of IVP prevention strategies (e.g. an Injury Community Implementation Group [ICIG])
- The ICIG should include representation from all CDC funded IVP programs in your state (e.g.: DELTA FOCUS, Rape Prevention and Education [RPE], Essentials for Childhood, Striving to Reduce Youth Violence Everywhere [STRYVE], Prescription Drug Overdose Prevention for States [PDO Prevention for States], National Violent Death Reporting System [NVDRS], Injury Control Research Centers [ICRC], Youth Violence Prevention Injury Center [YVPC])
- Facilitate creation of a Charter document for ICIG, which identifies such things as the goals and objectives of the ICIG, the roles and responsibilities of ICIG members, membership, quorums or decision making processes, frequencies of meetings, etc.
    - Role of the ICIG may include, but should not be limited to:

1. Providing information on the effectiveness of existing state policies related to IVP and control
2. Reviewing surveillance data to help identify and prioritize injury and violence problems within the state
3. Reviewing, identifying, and selecting appropriate evidence-based strategies
4. Identifying implementation partners for identified policies and strategies
5. Ensuring participation of members on other injury prevention control boards and commissions

- Attend/participate in at least 75% of Regional Network (RNCO) meetings (as described in RNCO Enhanced Component section below)

ANNUALLY

- Attend/participate in at least 75% of Regional Network (RNCO) meetings (as described in RNCO Enhanced Component section below)
- Provide coordination and integration of resources within and between the ICIG stakeholder organizations
- Maintain ICIG and continue to mobilize support and build partnerships by:

1. Identifying, contacting and inviting potential key private, professional, voluntary and nonprofit injury prevention and control organizations, injury care providers, consumers, payers, media, State and Federal agencies, surveillance, research and academic institutions (such as Injury Control Research Centers - ICRC), and others to become members
2. Using media and communication strategies, including any appropriate existing CDC materials, to disseminate information related to injury and/or violence prevention

- Implement activities, roles, and responsibilities agreed upon with partners and ICIG (i.e. those identified by the ICIG's Charter document and letters of support).

Strategy 3: Enhance statewide IVP plan & logic model for four (4) focus areas

Strategy 4: Implement three (3) strategies for four (4) focus areas, one must address shared risk and protective factors across two focus areas

Strategy 5: Develop evaluation plan reflecting process and outcome measures

Activities for strategies 3, 4, & 5 include the following:

Implementation, evaluation, and dissemination of best available evidence program and/or policy strategies (the term strategy refers to both program and/or policy) in four priority areas of IVP: child abuse and neglect, TBI, motor vehicle crash injury and death, and intimate partner/sexual violence.

YEAR 1

- Refine selected implementation strategies that address IVP through the lens of shared risk and protective factors that promote maximum impact of limited resources. Applicants must select at least one IVP strategy that impacts at least two of the four priority focus areas. In addition, States must choose two other IVP strategies that may or may not impact more than one priority focus area. In other words, each applicant must address at least three IVP strategies that impact all four of the priority focus areas (at least one strategy must overlap). Below is an example of how you can choose IVP strategies

EXAMPLE:

Priority Focus Area	**IVP Strategy**

Child Abuse and Neglect	Strategy A (shared across both focus areas - Child Abuse and Neglect & TBI)*
TBI	Strategy A (shared across both focus areas - Child Abuse and Neglect & TBI)*
Intimate Partner/Sexual Violence	Strategy B
Motor Vehicle Crash Injury and Death	Strategy C

*Please note that this is only one example. There are many strategies that address a variety of shared risk and protective factors. More information is available in Table 1 below and on the FTP site - http://ftp.cdc.gov/pub/TBI/2016_CORE_SVIPP_FOA.

- Work with CDC to enhance a state-specific IVP logic model for the strategies selected. See the information below and the information detailed in the evaluation and performance measurement strategy section
- Refine detailed evaluation plan to measure program progress in implementing the selected evidence-based strategies and the effectiveness and impact of those strategies. See the detailed information on developing short, mid- and long-term outcomes associated with strategies in each focus area. Awardees will be required to submit a more detailed Evaluation and Performance Measurement Plan within the first six months of the project, as outlined in the Evaluation and Performance Management section of this FOA
- Identify implementing organizations for each identified program or policy strategy. The implementing organization may be the state health department or partner, such as a community based organization, another governmental partner, university, or some combination of these entities.
  Identified implementing organizations must be included in the Injury Community Implementation Group (ICIG)
- Work with partners to create a specific plan for the provision of technical assistance related to the implementation of selected best available evidence strategies

For the selected IVP strategy that has shared risk and/or protective factors, applications must include justification that includes evidence in the form of peer-reviewed publication or evaluation report from a rigorous evaluation of the shared impact. Examples of acceptable IVP strategies are included on the IVP Strategies Table 1 below. Additional IVP strategies, beyond those listed below, may be considered and are included as Technical Packages on the FTP site - http://ftp.cdc.gov/pub/TBI/2016_CORE_SVIPP_FOA.

To allow for some flexibility, this announcement includes an option that 10% of the funding may be used for programmatic innovation beyond the four priority focus areas. States may include a focus on strategies that address a state-specific injury and violence priority area. Examples include, but are not limited to, Older Adult Falls, Improving IVP through social determinants of health, enhanced evaluation, etc. Additionally, states not currently awarded under CE15-1501 and/or CE14-1404, Prescription Drug Overdose Prevention for States or Prescription Drug Overdose: Boost for State Prevention, may apply for PDO readiness activities under this 10% of funding innovation. If focused on PDO readiness activities, program funds cannot be used for purchasing naloxone, implementing or expanding drug “take back” programs, or directly funding or expanding substance abuse treatment programs. PDO readiness activities may consist of strategic planning for prescription drug abuse and overdose prevention and/or enhancing use of data to identify and assist high-risk communities. Just as in the four priority focus areas listed above, the innovation funding focus should support the implementation, evaluation and dissemination of programs, practices and policies in accordance with best available evidence strategies. More information about best available evidence strategies can be found at http://vetoviolence.cdc.gov/index.php/understanding-evidence.

TABLE 1: IVP Strategies

Child Abuse and Neglect Prevention Strategy	**Other Focus Areas (FOA focus areas in BOLD) that may be Impacted by Strategy (blank means no evidence suggests that strategy will impact other focus area outcomes or risk or protective factors)**
Home Visitation **EXAMPLE STRATEGIES:** - Nurse Family Partnerships - SafeCare - Early Head Start	**Intimate Partner Violence** Youth Violence Substance use
Positive Parenting **EXAMPLE STRATEGIES:** • Adults and Children Together Against Violence Parents Raising Safe Kids Program (ACT-PRSK) • Safe Environments for Every Kid (SEEK) • Incredible Years Parent • Essentials for Parenting Toddlers and Preschoolers	**Intimate Partner/Sexual Violence** Youth Violence
Child-Parent Centers **EXAMPLE STRATEGIES:** http://www.promisingpractices.net/program.asp?programid=98	**Sexual Violence** **Traumatic Brain Injury** Youth Violence
Safe Sleep Procedures for Child Care Centers	**Traumatic Brain Injury**
Therapeutic Strategies **EXAMPLE STRATEGIES:** • Early Head Start • Cognitive Behavioral Therapy ○ Children with Sexual Behavior Problems • Multisystemic Therapy (MST)	**Intimate Partner Violence/Sexual Violence** **Traumatic Brain Injury** Youth Violence Suicide

Sexual or Intimate Partner Violence Prevention Strategy	**Other Focus Areas (FOA focus areas in BOLD) that may be Impacted by Strategy (blank means no evidence suggests that strategy will impact other focus area outcomes or risk or protective factors)**
Positive Relationship Between Child and Parent(s) **EXAMPLE STRATEGIES:** - Evidenced-based Home Visitation - Child Parent Centers	**Child Abuse and Neglect** Falls - child Youth Violence
Environmental Approaches **EXAMPLE STRATEGIES:** - Crime Prevention Through Education - CPTED (includes Shifting Boundaries-Building Level Component) - Safe Routes to School - Safe Environment for Every Kid (SEEK)	**Child Abuse and Neglect** Youth Violence Pedestrian Injuries
PBIS (Positive Behavioral Interventions and Supports)	Youth Violence
Norms Changing Strategies **EXAMPLE STRATEGIES:** - Coaching Boys Into Men	**Intimate Partner Violence** Youth Violence Teen Dating Violence
Social/Emotional Learning **EXAMPLE STRATEGIES:** - Good Behavior Game - Fourth R - Second Step	Youth Violence Teen Dating Violence
Families for Safe Dates	**Traumatic Brain Injury** **Motor Vehicle Injury Prevention** Youth Violence Suicide
Bystander Approaches - Bringing in the Bystander - Safe Dates	Youth Violence Sexual Violence
A science-based approach to the development of a coalition of stakeholders to develop and implement prevention at the community-level. The goal of the coalition is to achieve a collective impact on child & youth development to reduce delinquency (strong risk factor for SV). **EXAMPLE STRATEGIES:** - Essentials for Childhood - Communities that Care - Green Dot	**Child Abuse and Neglect** Youth Violence
Strategies which may include individual, family, peer, school and community interventions, including parent training and other skill-building sessions, reduces recidivism and re-arrests for violent and sexual offenses among adjudicated youth **EXAMPLE STRATEGIES:** - Multisystemic Therapy (MST)	Youth Violence Suicide

Traumatic Brain Injury Prevention Strategies	Other Focus Areas (FOA focus areas in BOLD) that may be Impacted by Strategy (blank means no evidence suggests that strategy will impact other focus area outcomes or risk or protective factors)
Shift cultural norms related to youth sports that increase risk of concussion and a culture of denial about symptoms. **EXAMPLE STRATEGIES:** • Enhance implementation of return to learn/play policies by: analyzing gaps and opportunities for improvement in laws or policies; creating implementation guidance for schools, sports leagues, health care providers and parents based on best existing evidence; evaluating implementation/enforcement of existing laws to evaluate practices, reporting, treatment, and health outcomes. • CDC Heads Up materials for training of Coaches	
Disseminate Pediatric Mild TBI guidelines through large health systems or state health organizations. **EXAMPLE STRATEGIES:** • http://www.cdc.gov/traumaticbraininjury/MTBI_pediatric.html	**Motor vehicle** Falls Violence
Integrated Approach to Sports Concussion Prevention and Management (Return to Learn and Play Processes) • http://pediatrics.aappublications.org/content/early/2013/10/23/peds.2013-2867 • https://www.aan.com/concussion/ • http://thesportjournal.org/article/a-countywide-program-to-manage-concussions-in-high-school-sports/	

Motor Vehicle Injury Prevention Strategy	Other Focus Areas (FOA focus areas in BOLD) that may be Impacted by Strategy (blank means no evidence suggests that strategy will impact other focus area outcomes or risk or protective factors)
RESTRAINT USE • Implementing interventions that will increase seat belt use among drivers and all passengers. See state fact sheets: http://www.cdc.gov/motorvehiclesafety/seatbelts/states.html • Improving child passenger safety by implementing strategies to increase car seat and booster seat use.	**Traumatic Brain Injury**
ALCOHOL AND SUBSTANCE USE • Implementing strategies for reducing or preventing drunk driving. See state fact sheets: http://www.cdc.gov/motorvehiclesafety/impaired_driving/states.html	**Traumatic Brain Injury**
TEEN DRIVING • Improve teen driver safety through the use of comprehensive GDL systems that contain the following components: 1. Minimum age of 16 years for a learner's permit 2. Mandatory holding period of at least six months for a learner's permit 3. Restrictions against nighttime driving between 10:00 pm and 5:00 am (or longer) 4. Limit of zero or one for the number of young passengers without adult supervision 5. Minimum age of 18 years for full licensure 6. Teen-parent agreements such as those found within the Checkpoints program http://www.injurycenter.umich.edu/programs/checkpoints-program%E2%84%A2 http://www.cdc.gov/parentsarethekey/agreement/index.html 7. Evaluation of Parent Training Programs	**Traumatic Brain Injury**

Strategies 3, 4, & 5:

ANNUALLY

- Provide substantial support for the IVP strategies. Substantial support for the purpose of this FOA is defined as: direct state health department implementation of a strategy; provision of assistance to partner implementation of a strategy; and/or provision of surveillance data to inform targeting of strategies or to inform program improvements
- Continuously evaluate (as lead evaluator or in conjunction with partner evaluators) the implementation and monitoring of outcomes of the selected best available evidence strategies and related objectives and activities
- Provide reports of evaluation results to CDC and partners and use the information for programmatic decisions and continuous program improvement
- Partner with CDC-appointed technical advisor and CDC evaluation staff to conduct program or policy evaluation activities

Strategy 6: Disseminate surveillance & evaluation information to stakeholders & use to inform continuous quality improvements

Strategy 7: Enhance surveillance systems to capture IVP data

YEAR 1

- Collect baseline health impact measures (i.e. morbidity and mortality data) for the four priority focus areas

ANNUALLY

- Collect and analyze health impact measures, same as those gathered during year 1 for baseline
- Use data to inform, develop, and evaluate violence and injury prevention programs and policies
- Disseminate surveillance and evaluation information collected, to include:

a. Data Quality and Impact:

i. Injury Indicator Spreadsheets – awardees will be required to complete and submit CDC-provided spreadsheets of aggregated numbers and rates categorized by sex, age group, and external cause for inclusion in multistate Injury Indicator products. Data should include state-wide centralized electronic vital statistics data, state-wide centralized electronic hospital discharge data, and state-wide centralized emergency department discharge data. Data from additional data sets may be requested during the cooperative agreement project period (See http://www.cdc.gov/injury/stateprograms/indicators.html for State Injury Indicator Instructions)

ii. State Data Use and Impact – Awardees will be required to demonstrate the use and impact of state-level surveillance data. This may be accomplished by submitting state data reports, topic specific data reports, data use summary statements, and various other reports that show the use and impact of surveillance data at the state level

iii. Special Emphasis Reports - Produce and submit to CDC data-driven special emphasis reports that align with chosen topic areas. The format to be used for these reports will be provided by CDC.

iv. Surveillance Data for Evaluation Purposes - To the extent possible, surveillance data submitted for evaluation purposes will overlap with surveillance data submitted with the injury indicator spreadsheets. (See the evaluation section of this FOA for further instructions regarding evaluation requirements)

ENHANCED COMPONENTS: In addition to the BASE Component, applicants may apply for one or both of two enhanced components. NOTE: Applicants must be approved and funded for the BASE Component to be eligible for review and funding for one or both of the following Enhanced Components:

- ***Surveillance Quality Improvement (SQI)***
- ***Regional Network Coordinating Organization (RNCO)***

SQI- Awardee Activities

ANNUALLY

- SQI funded staff participates in at least one annual meeting with CDC (Joint Annual Meeting of the CDC Core SVIPP or other meetings agreed upon by CDC)
- Participate in RNCO Regional Peer Learning Team/s and National/Cross-Regional Collaborative Peer Learning Group/s
- Design, propose and conduct annual **state-specific** surveillance evaluations that address current and/or emerging data resource and etiologic issues within the state.
    1. Select topics and develop methodology in the context of the state group consensus process.
    2. Conduct investigation and analysis

3. Develop academic and translation products (i.e. publications, fact sheets, presentations) that lead to advancement of injury surveillance within the state.

- Design, propose and conduct annual **multi-state** cross-cutting injury surveillance evaluations that address evaluation of current and/or emerging data resources and etiologic issues.
    1. Select topics and develop methodology in the context of the multi-state group consensus process.
    2. Conduct investigations that are generalizable to all states.
    3. Develop academic and translation products that lead to advancement of injury surveillance across all states. Each state will be expected to take the chairperson role of the multi-state group at least one time during the funding period.

        a. Potential topics for consideration for either multi-state or state specific projects may include, but are not limited to the following:

            1. Validation of ICD-10-CM Cause-of-Injury Matrix
            2. Impact on cause-of-injury trends
            3. Validation of ICD-10-CM Injury Diagnosis Matrix
            4. Sensitivity and predictive values positive testing of diagnostic code groupings
            5. Impact on injury diagnosis trends
            6. Evaluation of Syndromic Surveillance
            7. Cross jurisdictional system capabilities and similarities
            8. Completeness, timeliness, usability

- Evaluate and develop surveillance publication guidance and templates that leverage other NCIPC funded injury surveillance such as the National Violent Death Reporting System (NVDRS) and Drug Overdose Deaths
- Evaluate economic data resources and development of methods for state level analysis

RNCO - Awardee Activities

Regional Network Coordinating Organization Activities:

YEAR 1

- Conduct needs assessment within the first 3 months to inform development of Charter
- Develop Charter in first 6 months through a consensus, shared decision making process with network states and organizations
- Develop annual action plan for regional network activities (webinars, trainings, TA, etc.) (Year 1 plan to be included in application)
- Initiate regional network Peer Learning Teams. Network members to decide topics through consensus process based on burden and other driving factors such as emerging issues
- Recruit relevant agencies and organizations to participate as members in the regional network including at least one Injury Control Research Center (ICRC) or similar research entity

ANNUALLY

- Develop annual action plan for regional network activities (webinars, trainings, TA, etc.)
- Provide coordination of technical assistance to member states (plan to be included in application)
- Collaborate with IVP related organizations in region (collaboration plan to be included in application)
- Coordinate one in-person meeting per year. Meeting can be held in region or in conjunction with biannual Core SVIPP Awardees Meeting and/or other region agreed upon meeting
- RNCO funded staff participates in at least one annual meeting with CDC (Joint Annual Meeting of the CDC Core SVIPP or other meetings agreed upon by CDC)
- Facilitate RNCO monthly calls, evaluation activities, meetings, etc. as described in the FOA -
    1. Track and strive for at least 75% of network member participation in activities (calls, webinars, meetings)

2. Report quarterly during routine calls with CDC Program Consultant
- Participate in Core SVIPP state interviews in collaboration with CDC
- Assist CDC Evaluation Team with dissemination of Regional Network Satisfaction Survey
- Collaborate with ICRC or similar research entity, including invitation as a participatory member
- Continue to expand Regional Network membership and invite relevant new members to participate
- Work with regional network members to capitalize on sharing resources to advance prevention of injury and violence

National/Cross-Regional Collaborative Peer Learning Group Activities:

YEAR 1

- In addition to coordinating regional network peer learning teams, RNCOs will each initially develop/coordinate/facilitate a national/cross regional collaborative peer learning group for one of the Core SVIPP (NCIPC) priority areas: child abuse and neglect; TBI; motor vehicle crash injury and death; and sexual/interpersonal violence and a 5th topic to be determined in conjunction with CDC
    1. RNCOs, in coordination with CDC input, will decide which RNCO will facilitate which topic
- Once group is established, RNCO should provide support and facilitation but not necessarily lead
- Collaborate for topic selection (must include other regions, national associations, academic/research and other national organizations working on the topic such a ICRCs, YVPCs, Prevention Research centers [PRC], Brain Injury Association of America [BIAA], etc.)
- Upon determination of focus area, conduct a SWOT (Strengths, Weaknesses, Opportunities, Threats) analysis to determine best approach

ANNUALLY

- Coordinate implementation of National Peer Learning Group plan (developed in year 1)
- Develop metrics for evaluation of the national RNCO peer learning groups in collaboration with CDC evaluation team
- National/Cross-Regional Peer Learning Group activities to include coordination/facilitation of:
    1. Learning Opportunities
    2. Peer-to-peer technical assistance
    3. Discussion of best practices, needs and opportunities.
    4. Other activities as deemed beneficial to improving implementation of the topic

ADDITIONAL ONE TIME ACTIVITIES

- Year 3: For the topic chosen for National discussion, development of report with recommended best practices, resources, etc. (RNCO with CDC input will develop this report format and content)
- Year 4: Dissemination of Year 3 report through presentations, webinars, publications, etc.
- Year 5: Development of lessons learned document evaluating national collaborative peer learning group and/or recommendations for next steps (RNCO with CDC input will develop this evaluation product)

1.Collaborations

Collaborations are a vital part of this work, no single player can address all the levers that impact injury and violence. Success in this work is not possible without effective collaboration with key stakeholders. Below are both required and optional collaborations. See Strategy 2: Engage, coordinate, & leverage other internal (SHD) and external partners (NGO) and Injury Control Research Centers (ICRC) (or other injury research institutes)

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

Awardees are required to collaborate with CDC to improve technical and program guidance and conduct evaluations. Awardees will also be expected to work with CDC staff to identify and develop impact statements arising from their program. Here are some collaborations to address in the application, as applicable:

Awardees currently receiving funding from NCIPC (e.g.: DELTA FOCUS, Rape Prevention and Education [RPE], Essentials for Childhood, Striving to Reduce Youth Violence Everywhere [STRYVE], Prescription Drug Overdose Prevention for States [PDO Prevention for States], National Violent Death Reporting System [NVDRS], Injury Control Research Centers [ICRC], Youth Violence Prevention Injury Center [YVPC])

b. With organizations not funded by CDC:

State and local organizations included in the ICIG. These organizations may be affiliated with federal programs of other federal agencies (e.g.: Maternal, Infant, and Early Childhood Home Visiting (MIECHV); CoIIN) and Non-federal partners

2. Target Populations

N/A

a. Inclusion

N/A

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

This announcement contains three separate components. Applicants must submit an application for the BASE and may apply for one or both of the Enhanced Components (Regional Network Coordinating Organization and/or Surveillance Quality Improvement); however, applicants must be approved and funded for the BASE to be eligible for review and funding for one or both of the Enhanced Components.

BASE: $200,000 - $250,000 (approximately 20 awards)

Enhanced Components (only eligible if awarded BASE):

SQI: $150,000 (4 awards)
RNCO: $75,000 (5 awards)

b. Evaluation and Performance Measurement

i. CDC Evaluation and Performance Measurement Strategy

This section presents how CDC and awardees will monitor the degree to which strategies were effectively implemented and the degree to which the project period outcomes in the logic model AND the proposed short-term and mid-term outcomes they identified for their specific strategies have been achieved (CDC OMB package approval in process). The core evaluation questions align with the outcomes depicted in the logic model and will be tracked and measured with the CDC-developed annual reporting template:

1. Increased recognition of the role of public health in IVP (Potential measures: Increase in governmental and non-governmental partners on ICIG)
2. Increased connection of science and practice within the field of violence and injury prevention (Potential measure: Collaboratively developed translation products via ICIG or RNCO activities)
3. Increased number or scope of evidenced-based IVP strategies states or their partners are implementing (Potential measure: same as outcome)
4. Identification of barriers and facilitators to implementation of strategies based on best available evidence (Potential measure: list of barriers and facilitators to implementation in Annual State of the States Survey)

5. Increased IVP surveillance data quality, consistency and use (standard definition and types of analysis) (Potential measures: degree to which awardee surveillance data meet quality and consistency standards; increase in use of awardee data by key users)
6. Increased state and local sharing and leveraging of IVP funds and/or resources (Potential measure: Interagency or multi-organizational examples of shared funding of IVP efforts)
7. Increased reach and effectiveness of state IVP strategies (Long-term performance measures as described below)
8. Increased sustainability of injury and violence prevention programs and practices (Potential measure: Increase in number of stakeholder led IVP implementation)
9. Decreased risk factors and increased protective factors associated with IVP proximal measures (Short-term and mid-term performance measures to be developed by awardee as described below)
10. Reduction in focus area injury and violence related morbidity and mortality (Short-term and mid-term performance measures to be developed by awardee as described below)

In addition, as outlined in the next section, because the awardees have some flexibility in which strategies they choose, they will need to identify process measures to track the implementation of the chosen strategies, and outcome measures for the outcomes relevant to those strategies in the four focus areas of interest.

ii. Applicant Evaluation and Performance Measurement Plan

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

- How applicant will collect the performance measures, respond to the evaluation questions, and use evaluation findings for continuous program quality improvement.
- How key program partners will participate in the evaluation and performance measurement planning processes.
- Available data sources, feasibility of collecting appropriate evaluation and performance data, and other relevant data information (e.g., performance measures proposed by the applicant).

Where the applicant chooses to, or is expected to, take on specific evaluation studies, they should be directed to:

- Describe the type of evaluations (i.e., process, outcome, or both).
- Describe key evaluation questions to be addressed by these evaluations.
- Describe other information (e.g., measures, data sources).

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

All awardees must develop a draft evaluation and performance measurement plan as part of this application. However, they will refine their evaluation and performance measurement plan within 6 months of award. This more detailed plan should be developed by the awardee with support from CDC as part of first year project activities and should build on the elements stated in the initial evaluation plan described in this proposal. The plan submitted in the application must be **no longer than 15 pages** and must:

- Identify implementation measures for each strategy they proposed. Some strategies may be cross-cutting strategies (those selected for more than one priority focus area). Additionally, reference documents in the form of Technical Packages can be found on the FTP site. These documents may include additional strategies that may be considered in the application
- Define short, mid-term, and long-term outcome measures for the outcomes presented in their logic model/approach presented earlier. As noted, short-term and mid-term outcomes will typically include changes in the risk and protective factors associated with the selected focus areas. Long-term outcomes must, at minimum, include those listed in the Table below. Applicants may also add long-term

outcomes that are relevant to state and local stakeholders. Measures for these long-term outcomes are presented in the table below. They are not all inclusive. Final process and outcome measures will be developed in consultation with CDC during the first six months of award

- Describe where (data source), how (rate, percent, count), by whom (which organization), and how often the measures for the short, mid-term and long-term outcomes will be collected and indicate if the state health department has access to this information or intended plans to gain access
- Describe dissemination channels and audiences (including stakeholder and public dissemination) for performance measurement and evaluation findings

BASE focus areas	Short-Term Outcomes– awardee generated based on IVP strategy	Intermediate Outcomes – awardee generated based on IVP strategy	Long-Term Outcomes– PRESCRIBED – all awardees must collect	Possible Data Source for LT Outcomes
	Awardee to develop short-term outcomes based on focus area and IVP strategy selection	**Awardee to develop mid-term outcomes based on focus area and IVP strategy selection**	**Awardee to adopt the outcomes presented below for the focus areas selected**	
Child abuse and neglect	EXAMPLE: Increase in birthing hospitals with parental family risk screening	EXAMPLE: Increase in parental skills or knowledge	Decrease the rate (per 1000 children) of children reported to child protective services (CPS)	Child Protective Services Reports http://www.acf.hhs.gov/programs/cb/research-data-technology/statistics-research/child-abuse and neglect
			Decrease in rate of emergency department visits specifically coded as child abuse and neglect	Emergency department data, ICD 10
			Decrease in the rate of inpatient hospitalizations due to child abuse and neglect	Hospital Data
			Decrease in fatality rate of children ages 5 and under due to any injury or violence	Child Fatality Review data
			Decrease in rates of first time victims of child abuse and neglect	CPS Reports
Sexual Violence			Decrease in percentage of youth experiencing forced sexual intercourse	Youth Risk Behavior Survey
			Decrease in rates of any sexual violence victimization within the past 12 months	National Intimate Partner and Sexual Violence Survey (NISVS) Survey (will only have data at baseline and project period end)
Sexual/ Intimate Partner			Decrease in teen dating violence victimization	Youth Risk Behavior Survey

Violence (Teen Dating Violence)				
			Decrease in domestic violence 911 calls	Police data
Intimate Partner Violence			Decrease in emergency department visits due to intimate partner violence	Emergency department data, ICD 10
			Decreases in suspected intimate partner violence cases in emergency departments	Emergency department data, ICD 10
Motor Vehicle Crashes			Decrease in rate of alcohol-related motor vehicle crashes	Fatality Analysis Reporting System
			Decrease in rate of alcohol-related motor vehicle fatalities	Fatality Analysis Reporting System
			Decrease in rate of motor vehicle occupant fatalities	Vital Statistics Fatality Analysis Reporting System
TBI			Decrease in TBI-related injury for children 0-18	Emergency department data, ICD 10
			Decrease in TBI-related death rate in children 0-18	Emergency department data, ICD 10
			Decrease the rate of MVC-related TBIs (ED visits, hospitalizations, death) in young adults 15–24 years of age	Hospital data, ICD 10 Emergency department data, ICD 10
Enhanced: RNCO	Connect science and practice within the field of violence and injury prevention	Increase in state and local sharing and leveraging of IVP funds and/or resources	Increase in sustainability of injury and violence prevention programs and practices Statewide reduction in focus area injury and violence related morbidity and mortality	Data Sources will be determined by awardee based on case-specific availability and content
Enhanced: SQI	Increase in IVP surveillance data quality, consistency and use (standard definitions, types of analysis)	Increase the development and evaluation of surveillance guidance		

At the conclusion of Year 1, in their annual progress report, awardees will be required to update the evaluation plan. This updated evaluation plan must include:

- Process measures that were developed and agreed to earlier with CDC and which reflect how the implementation of the selected strategies will be tracked. Each selected strategy will be required to have associated implementation measures that can be collected on a regular basis
- A plan for communicating with the implementers about how the implementation is progressing, and a

process to assist implementers in making program improvements throughout each project year, not just at the conclusion of the project year. A description of dissemination channels and audiences (including stakeholder and public dissemination) for relevant products and findings

Required evaluation-related activities are listed below and should align with the state IVP plan and should be coordinated with (enhance, not duplicate) other state and federal funds related to IVP (e.g.: DELTA FOCUS, Rape Prevention and Education [RPE], Essentials for Childhood, Striving to Reduce Youth Violence Everywhere [STRYVE], Prescription Drug Overdose Prevention for States [PDO Prevention for States], National Violent Death Reporting System [NVDRS], Injury Control Research Centers [ICRC], Youth Violence Prevention Injury Center [YVPC].) Evaluation Activities include the following:

YEAR 1

1. Participate with CDC-appointed technical advisors to conduct program evaluation activities, including the submission of annual progress reports using the CDC provided template.
2. Identify implementation measures and refine short term and mid-term (process measures, including risk and protective factors) and long-term (health impact) factors associated with each strategy. For cross-cutting strategies (those selected for more than one focus area), there must be short and long term factors specific to each focus area. For example, if you are implementing Nurse Family Partnership as the strategy for both child abuse and neglect and TBI, you must list short- and long-term measures specific to child abuse and neglect and TBI.
3. Upon completion of the revised evaluation plan, inform implementing organizations about their role in each identified strategy. The implementing organization may be the state health department, a community based organization, university or medical school, another governmental partner, or some combination of these entities.
4. Create a specific plan or work with partners to create a specific plan for the provision of technical assistance related to the implementation of selected evidence-based strategies.

YEARS 2-5

1. Applicant must provide substantial support for evaluation of three strategies that address all four priority focus areas (see IVP Strategies Table for examples). At least one of these strategies must overlap priority focus areas. **Substantial support is defined as direct state health department evaluation of a strategy; providing assistance to partner-evaluation of a strategy; providing surveillance data to inform targeting of strategies or to inform program improvements.**
2. Continuously evaluate (as lead evaluator or in conjunction with partner evaluators) the implementation and monitoring of outcomes of the evidence-based strategies and related activities.
3. Provide regular reports of evaluation results to CDC and stakeholders and use the information for programmatic decisions and continuous program improvement.
4. Participate with CDC-appointed technical advisor and CDC-named evaluation contractor to conduct program evaluation activities.

c. Organizational Capacity of Awardees to Implement the Approach

Applicants must demonstrate the ability to execute the CDC strategies and activities and meet project period outcomes.

Organizational capacity includes skill sets such as: program planning, program evaluation, performance monitoring, financial reporting, budget management and administration, and personnel management

Applicants should demonstrate relevant experience and capacity (management, administrative, and technical) to implement the activities and achieve the project outcomes, experience and capacity to implement the evaluation plan, and a staffing plan and project management structure sufficient to achieve the project

outcomes and which clearly defines staff roles. Applicants must also be fully capable of managing the required procurement efforts, including the ability to write and award contracts in accordance with applicable grants regulations.

Key staff with experience and training in policy, communication, epidemiology, and evaluation should already be in place at start of Year 1 or should be hired/contracted within first 3 months. CORE SVIPP staff should at least equal 1 full time equivalent.

Applicants may describe their current status in applying for public health department accreditation or evidence of accreditation. Information on accreditation may be found at http://www.phaboard.org.

d. Work Plan

Applicants must prepare a detailed work plan for the first year of the award and a high-level plan for subsequent years. If funded, CDC will provide feedback and technical assistance to help finalize the work plan post-award. PLEASE NOTE THAT THIS WORK PLAN IS ESSENTIALLY A RESTATEMENT OF THE INFORMATION ALREADY PRESENTED BY THE AWARDEE IN THE APPROACH SECTION AND THE EVALUATION AND PERFORMANCE MEASUREMENT STRATEGY SECTION. THAT IS, ANY OBJECTIVES OR MEASURES IN THE WORK PLAN SHOULD BE CONSISTENT WITH AND ALIGNED WITH THE WORK DESCRIBED IN THESE OTHER SECTIONS.

Applicants must name this file "Work Plan" and upload it as a PDF file on www.grants.gov. Applicants should organize the work plan according to the Strategies and Activities section of the FOA. The work plan at a minimum should:

- Restate or refer back to the single, state-specific Logic Model describing the comprehensive approach being proposed to work toward the outcomes specified on the overall CDC program logic model.
- Use the model to identify the key short-, mid-, and long-term outcomes to be achieved.
- For each outcome, convert the outcome into Specific, Measurable, Achievable, Relevant, and Time-phased (SMART) objectives for the first 12-month budget period.
- Use the model to identify/describe the activities and sub-activities to be conducted to meet the program outcomes.
- Provide a timeline that identifies key activities and assigns approximate dates for inception and completion.
- Describe the multi-sector collaboration that will be formed to assist in carrying out the proposed activities.
- Describe staff and administrative roles and functions to support implementation of the award, including evaluation functions.
- Explain administration and assessment processes to ensure successful implementation and quality assurance.

e. CDC Monitoring and Accountability Approach

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

- Tracking awardee progress in achieving the desired outcomes.
- Ensuring the adequacy of awardee systems that underlie and generate data reports.
- Creating an environment that fosters integrity in program performance and results.

Monitoring may also include the following activities:

- Ensuring that work plans are feasible based on the budget and consistent with the intent of the award.
- Ensuring that awardees are performing at a sufficient level to achieve outcomes within stated

timeframes.
- Working with awardees on adjusting the work plan based on achievement of outcomes, evaluation results and changing budgets.
- Monitoring performance measures (both programmatic and financial) to assure satisfactory performance levels.

Other activities deemed necessary to monitor the award, if applicable.
These activities may include monitoring and reporting activities that assist grants management staff (e.g., grants management officers and specialists, and project officers) in the identification, notification, and management of high-risk grantees.

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

CDC Activities - BASE:

- Assist with the exchange of information and collaboration among awardees
- Provide awardees with relevant research findings and public health recommendations related to comprehensive injury and violence prevention and control
- Provide ongoing guidance, consultation, and technical assistance in conducting awardee activities, particularly related to the four priority focus areas for this funding announcement (i.e. Dissemination and implementation of best available evidence strategies: child abuse and neglect, intimate partner/sexual violence, motor vehicle crash injury and death, and TBI (in addition, awardees may choose to identify one innovative area – see II. Implementation section above
- Assist with the identification of effective IVP interventions and campaigns/materials that can be integrated into comprehensive violence and injury prevention and control programs
- Provide awardees with instructions and spreadsheets for calculating annual injury indicator data
- Receive, assess, aggregate and disseminate Injury Indicator Data for Multi-state products

ENHANCED COMPONENTS:

CDC Activities – SQI:

- Approve evaluation topics and methodology prior to project initiation
- Provide ongoing guidance, consultation, and technical assistance in conducting awardee activities
- Collaborate with awardees to identify injury surveillance evaluation questions and provide technical assistance regarding methodology
- Participate in the Injury Surveillance Workgroups

CDC Activities – RNCO:

- Assist with the exchange of information and collaboration among the five Regional Network Coordinating Organizations
- Provide guidance and input to the five RNCOs on deciding which national/cross regional collaborative peer learning group will be the focus (child abuse and neglect, TBI, motor vehicle crash injury and death, sexual/interpersonal violence, and one to be determined).
- Provide ongoing guidance, consultation and technical assistance
- Facilitate development and implementation of communication protocols for within and between RNCOs, their participating state entities/members, and CDC
- Facilitate annual meeting with the RNCOs and CDC to review common themes, alignment issues, barriers and facilitators
- Within their means, address the systemic issues identified through regular communications with

the RNCOs, the annual meeting and the customer satisfaction and impact survey

B. Award Information

1. Funding Instrument Type: Cooperative Agreement

CDC's substantial involvement in this program appears in the CDC Program Support to Awardees Section.

2. Award Mechanism: U17

U17 - Applied Methods in Violence-Related or Accidental Injury Surveillance Cooperative Agreements

3. Fiscal Year: 2016

Estimated Total Funding: $30,675,000

4. Approximate Total Fiscal Year Funding: $6,135,000

BASE: $5,160,000

SQI: $600,000

RNCO: $375,000

This amount is subject to the availability of funds.

5. Approximate Project Period Funding: $30,675,000

BASE: $25,800,000

SQI: $3,000,000

RNCO: $1,875,000

6. Total Project Period Length: 5 year(s)

7. Expected Number of Awards: 20

8. Approximate Average Award: $250,000 Per Budget Period

This amount is subject to the availability of funds.

9. Award Ceiling: $475,000 Per Budget Period

BASE: $250,000*
Enhanced Components (only eligible if awarded BASE):
RNCO: $75,000*
SQI: $150,000*
Total (if apply for all components): $475,000*
*(Ceiling amounts include direct and indirect costs. This amount is subject to the availability of funds.)

10. Award Floor: $200,000 Per Budget Period

11. Estimated Award Date: 08/01/2016

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

12. Budget Period Length: 12 month(s)

13. Direct Assistance

Direct Assistance (DA) is not available through this FOA.

C. Eligibility Information

1. Eligible Applicants

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

Additional Eligibility Category:

Government Organizations:

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

2. Additional Information on Eligibility

State Health Departments (States) or their bona fide agents (this includes the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, the Commonwealth of the Northern Marianna Islands, American Samoa, Guam, the Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau) and Federally recognized or state-recognized American Indian/Alaska Native tribal governments (Tribes). A bona fide agent is an agency/organization identified by the State Health Department as eligible to submit an application under the state eligibility in lieu of a state application.

The award ceiling for this FOA is a total of $475,000 (BASE: $250,000, RNCO: $75,000, SQI: $150,000). CDC will consider any application requesting an award higher than this amount as non-responsive and it will receive no further review. CDC will also consider any application requesting an award less than $200,000 for the BASE component non-responsive.

Special Requirements:

Special Requirements – BASE:

• Have a current/existing state injury and violence prevention plan in place. Provide the web link to current state plan and/or provide a copy of the plan as an appendix to this application named " XX State Plan BASE" (XX = 2 letter state abbreviation)

• Have a current, active Injury Community Implementation Group (ICIG) or similar statewide IVP collaborative group in place. Submit minutes of ICIG meetings held in 2015 as an appendix to this application named "XX 15 ICIG Minutes BASE". (XX = 2 letter state abbreviation)

• Submit letters of support from appropriate divisions within the state health department involved with related IVP programs. Specifically, the divisions responsible for other CDC funded IVP programs (e.g., Rape Prevention and Education, Essentials for Childhood, DELTA Focus, NVDRS, NISVS, and

Prescription Drug Overdose) and related federal program areas (e.g., . HRSA's Collaborative Innovation & Improvement Network (CoIIN), National Transportation and Safety Board (NTSB), SAMHSA). Letters of support should be attached as an appendix to this application and named "XX LOS." (XX = 2 letter state abbreviation)

• Submit letters of support from partners that will be implementing and/or assisting in the implementation of the proposed strategies

• Where appropriate, include letters of support that include information related to the roles, duties, and responsibilities of shared staff, resources and/or partnerships. Domestic Violence and Sexual Violence Coalitions exist in all 50 states and must be included in the Injury Community Implementation Group (ICIG). Applicants should also include additional letters of support from partnering agencies for child abuse and neglect, TBI, motor vehicle crash injury and death, and intimate partner/sexual violence. Letters of support should be attached as an appendix to this application and named "XX LOS." (XX = 2 letter state abbreviation)

ENHANCED COMPONENTS

Special Requirements - SQI:

• Applicants must be approved and funded for the BASE to be eligible for review and funding for the Surveillance Quality Improvement Component.

Special Requirements - RNCO:

• Applicants must be approved and funded for the BASE to be eligible for review and funding for the Regional Network Coordinating Organization Component

• Demonstrate evidence of having a state injury and violence prevention program in place for at least five years. As an appendix to the application, provide appropriate supporting documentation (e.g. Notice of Award from CDC or other funding organization, letter from State Health Department official, etc.) and name "XX IVP Program History" (XX = 2 letter state abbreviation).

Appendices described above should be in PDF format and uploaded in Grants.gov under "Other Attachment Forms" and specifically named as described in bullets above.

The award ceiling for each component under Section B. Award Information is $475,000. CDC will not consider any application requesting an award higher than the specified amount. If a pre-application is required, then specify here and include it in the special eligibility requirements section. (http:// www.hhs.gov/ asfr/ ogapa/ aboutog/ hhsgps107.pdf)

3. Justification for Less than Maximum Competition

Competition is limited to States, Territories and Tribes, or their bona fide agents because they maintain public health responsibility for IVP, and their infrastructure and surveillance systems are essential to statewide IVP efforts. Injuries and their consequences, including unintentional and violence-related injuries, are the leading cause of death for the first four decades of life, regardless of gender, race or socioeconomic status. In 2013, more than 192,900 individuals in the United States die each year as a result of unintentional injuries and violence, more than 27 million others suffer non-fatal injuries resulting in emergency department visits each year. The total lifetime medical and work loss costs of injuries and violence in the United States was **$671 billion** in 2013. The costs associated with fatal injuries was $214 billion while nonfatal injuries accounted for over $457 billion. Most events that result in injury and/or death from injury could be prevented if evidence-based public health strategies, practices, and policies were used by SHDs throughout the nation. This program focuses on supporting SHDs in their efforts to ensure widespread adoption of best practices by disseminating and implementing statewide strategies and monitoring their impact. Since 1997 CDC has funded SHDs to establish, build, and enhance injury prevention infrastructure and surveillance programs through cooperative agreements.

This cooperative agreement builds on that work by focusing on the existing infrastructure to implement strategies that address IVP through the lens of shared risk and protective factors are encouraged to promote maximum impact of limited resources. Required strategies will align with NCIPC priorities related to child abuse and neglect, TBI, motor vehicle crash injury and death, and intimate partner/sexual violence.

4. Cost Sharing or Matching

Cost Sharing / Matching Requirement: No

Cost sharing or matching funds are not required for this program. While there is no cost sharing requirement for the BASE component, applicant institutions, including any collaborating institutions, are encouraged to devote resources to the program and cost share at least ten percent (10%) of direct costs. Any non-Federal support (funds or other resources) indicates a greater potential of success and sustainability of the program. Non-federal support will be considered in the scoring of the Evaluation Criteria in the BASE section. Examples of support include donated equipment and space or funded staff time and effort. Applicants that plan to provide support should provide detailed documentation in an appendix outlining specific contributions to the program and the value of those contributions. Although no statutory matching requirement for this FOA exists, leveraging other resources and related ongoing efforts to promote sustainability is strongly encouraged.

Consistent with the cited authority for this announcement and applicable grants regulations, sources for cost sharing or matching may include complementary foundation funding, other U.S. government funding sources including programs supported by HHS or other agencies (e.g., Department of Agriculture, Department of Education, Department of Housing and Urban Development, Department of Transportation, Environmental Protection Agency, U.S. Park Service) and other funding sources. Applicants should coordinate with multiple sectors such as public health, transportation, education, health care delivery, and agriculture.

5. Maintenance of Effort

Maintenance of effort is not required for this program.

D. Required Registrations

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

1. Required Registrations

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

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

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

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

b. System for Award Management (SAM): The SAM is the primary registrant database for the federal government and the repository into which an entity must submit information required to conduct business as an awardee. All applicant organizations must register with SAM, and will be assigned a SAM number. All

information relevant to the SAM number must be current at all times during which the applicant has an application under consideration for funding by CDC. If an award is made, the SAM information must be maintained until a final financial report is submitted or the final payment is received, whichever is later. The SAM registration process can require 10 or more business days, and registration must be renewed annually. Additional information about registration procedures may be found at ***www.SAM.gov***.

c. Grants.gov: The first step in submitting an application online is registering your organization at www.grants.gov, the official HHS E-grant Web site. Registration information is located at the "Get Registered" option atwww.grants.gov.

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

Step	System	Requirements	Duration	Follow Up
1	Data Universal Number System (DUNS)	1. Click on http:// fedgov.dnb.com/webform 2. Select Begin DUNS search/request process 3. Select your country or territory and follow the instructions to obtain your DUNS 9-digit # 4. Request appropriate staff member(s) to obtain DUNS number, verify & update information under DUNS number	1-2 Business Days	To confirm that you have been issued a new DUNS number check online at (http:// fedgov.dnb.com/ webform) or call 1-866-705-5711
2	System for Award Management (SAM) formerly Central Contractor Registration (CRR)	1. Retrieve organizations DUNS number 2. Go to www.sam.gov and designate an E-Biz POC (note CCR username will not not work in SAM and you will need to have an active SAM account before you can register on grants.gov)	3-5 Business Days but up to 2 weeks and must be renewed once a year	For SAM Customer Service Contact www.fsd.gov/US Calls: 866-606-8220
3	Grants.gov	1. Set up an individual account in Grants.gov using organization new DUNS number to become an authorized organization representative (AOR) 2. Once the account is set up the E-BIZ POC will be notified via email 3. Log into grants.gov using the password the E-BIZ POC received and create new password 4. This authorizes the AOR to submit applications on behalf of the organization	Same day but can take 8 weeks to be fully registered and approved in the system (note, applicants MUST obtain a DUNS number and SAM account before applying on grants.gov)	Register early! Log into grants.gov and check AOR status until it shows you have been approved

2. Request Application Package

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

3. Application Package

Applicants must download the SF-424, Application for Federal Assistance, package associated with this funding opportunity at www.grants.gov. If Internet access is not available, or if the online forms cannot be accessed, applicants may call the CDC PGO staff at 770-488-2700 or e-mail PGO PGOTIM@cdc.gov for assistance. Persons with hearing loss may access CDC telecommunications at TTY 1-888-232-6348.

4. Submission Dates and Times

If the application is not submitted by the deadline published in the FOA, it will not be processed. Office of Grants Services (OGS) personnel will notify the applicant that their application did not meet the deadline. The applicant must receive pre-approval to submit a paper application (see Other Submission Requirements section for additional details). If the applicant is authorized to submit a paper application, it must be received by the deadline provided by OGS.

a. Letter of Intent Deadline (must be emailed or postmarked by)

Due Date for Letter of Intent: **03/01/2016**

b. Application Deadline

Due Date for Applications: **04/08/2016**, 11:59 p.m. U.S. Eastern Standard Time, at www.grants.gov. If Grants.gov is inoperable and cannot receive applications, and circumstances preclude advance notification of an extension, then applications must be submitted by the first business day on which grants.gov operations resume.

Date for Informational Conference Call: 02/01/2016

The Informational Conference Call will be held for potential applicants to further understand the conceptual framework of this Funding Opportunity Announcement (FOA). The call will start promptly on Monday (02/01/2016) at 2:00 p.m. Eastern Standard Time. Conference call can be accessed at either: (770) 488-3600 OR (855) 644-0229 and the Conference ID is 1634049.

5. CDC Assurances and Certifications

All applicants are required to sign and submit "Assurances and Certifications" documents indicated at http://wwwn.cdc.gov/ grantassurances/ (S(mj444mxct51lnrv1hljjjmaa)) /Homepage.aspx.
Applicants may follow either of the following processes:

- Complete the applicable assurances and certifications with each application submission, name the file "Assurances and Certifications" and upload it as a PDF file with at www.grants.gov
- Complete the applicable assurances and certifications and submit them directly to CDC on an annual basis at http://wwwn.cdc.gov/ grantassurances/ (S(mj444mxct51lnrv1hljjjmaa))/ Homepage.aspx

Assurances and certifications submitted directly to CDC will be kept on file for one year and will apply to all applications submitted to CDC by the applicant within one year of the submission date.

6. Content and Form of Application Submission

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

7. Letter of Intent

Is a LOI: Recommended but not Required

An LOI is requested but optional. The content of the LOI can be very simple — all CDC is looking for is a letter from the applicant stating the intention to apply and which components they are applying for.

LOI must be sent via U.S. express mail, delivery service, fax, or email to:

Ted Castellanos

CDC, NCIPC

Address: 4770 Buford Hwy NE, MS-62

Atlanta, GA 30341

Telephone number: 770-488-3665

Fax: 770-488-3551

Email address: ipq1@cdc.gov

8. Table of Contents

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

9. Project Abstract Summary

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

Please note that a project abstract must be submitted for **each component** named using the specific component name (e.g. XX {State Initials} Project Abstract BASE), (e.g. XX {State Initials} Project Abstract SQI), and/or (e.g. XX {State Initials} Project Abstract RNCO). If applying for enhanced components (SQI and/or RNCO), upload the Project Abstract Summary as a PDF file under "Other Attachment Forms" at www.grants.gov.

D.10 Project Narrative

If applying for a single component: maximum of 20 pages, single spaced, 12 point font, 1-inch margins, and number all pages.
If applying for more than one component: maximum of 15 pages for the "base" (subsections of the Project Description that the components share with each other, which may include target population, inclusion, collaboration, etc.); and up to 4 additional pages allowed per component for Project Narrative subsections that may be specific to each component.
Text should be single spaced, 12 point font, 1-inch margins, and number all pages.
Page limits include work plan; content beyond specified limits will not be reviewed.

Please note that a project narrative must be submitted for **each component** named using the specific component name (e.g. XX {State Initials} Project Narrative BASE), (e.g. XX {State Initials} Project Narrative SQI), and/or (e.g. XX {State Initials} Project Narrative RNCO). If applying for enhanced components (SQI and/or RNCO), upload the Project Narrative as a PDF file under "Other Attachment Forms" at www.grants.gov.

BASE: Maximum of 25 pages, single spaced, Calibri 12 point, 1-inch margins, number all pages. Content beyond 25 pages will not be considered. The 25 page limit includes the work plan.

SQI: Maximum of 10 pages, single spaced, Calibri 12 point, 1-inch margins, number all pages. Content beyond 10 pages will not be considered. The 10 page limit includes the work plan.

RNCO: Maximum of 10 pages, single spaced, Calibri 12 point, 1-inch margins, number all pages. Content beyond 10 pages will not be considered. The 10 page limit includes the work plan.

a. Background

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

b. Approach

i. Purpose

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

ii. Outcomes

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

iii. Strategies and Activities

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

1. Collaborations

Applicants must describe how they will collaborate with programs and organizations either internal or external to CDC.

Collaborations as indicated in the Strategies and Activities Section #3.

Applicants must file the MOU or MOA, as appropriate, name the file “MOUs/MOAs”, and upload it as a PDF file at www.grants.gov.

Applicants must file letters of support, as appropriate, name the file “Letters of Support”, and upload it as a PDF file at www.grants.gov.

2. Target Populations

Applicants must describe the specific target population(s) in their jurisdiction and explain how such a target will achieve the goals of the award and/or alleviate health disparities. Refer back to the Target Population section in the CDC Project Description.

c. Applicant Evaluation and Performance Measurement Plan

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

- How applicant will collect the performance measures, respond to the evaluation questions, and use evaluation findings for continuous program quality improvement. The Paperwork Reduction Act of 1995 (PRA): Applicants are advised that any activities involving information collections (e.g., surveys, questionnaires, applications, audits, data requests, reporting, recordkeeping and disclosure

requirements) from 10 or more individuals or non-Federal entities, including State and local governmental agencies, and funded or sponsored by the Federal Government are subject to review and approval by the Office of Management and Budget. See Section E (pages 4 and 5) at http://www. hhs.gov/ asfr/ogapa/ aboutog/ogpoe/ gpd2-02.pdf. For further information about CDC's requirements under PRA see http://www.hhs.gov/ ocio/policy/collection/.

- How key program partners will participate in the evaluation and performance measurement planning processes.
- Available data sources, feasibility of collecting appropriate evaluation and performance data, and other relevant data information (e.g., performance measures proposed by the applicant).

Where the applicant chooses to, or is expected to, take on specific evaluation studies, they should be directed to:

- Describe the type of evaluations (i.e., process, outcome, or both).
- Describe key evaluation questions to be addressed by these evaluations.
- Describe other information (e.g., measures, data sources).

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

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

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

d. Organizational Capacity of Applicants to Implement the Approach

Applicant must address the organizational capacity requirements as described in the CDC Project Description.

Applicants must name this file "CVs/Resumes" or "Organizational Charts" and upload it at www.grants.gov.

11. Work Plan

Included in the Project Narrative Page limits:

Multiple components: maximum of 15 pages for the base and up to 4 additional pages per component) Single component: maximum of 20 pages)

Applicants must prepare a work plan consistent with the CDC Project Description Work Plan section. The work plan integrates and delineates more specifically how the awardee plans to carry out achieving the project period outcomes, strategies and activities, evaluation and performance measurement.

Please note that a work plan must be submitted for **each component** named using the specific component name (e.g. XX {State Initials} Work Plan BASE), (e.g. XX {State Initials} Work Plan SQI), and/or (e.g. XX {State Initials} Work Plan RNCO). If applying for enhanced components (SQI and/or RNCO), upload the Work Plan as a PDF file under "Other Attachment Forms" at www.grants.gov.

BASE: Work plan included in the 25 page limit for Project Narrative and Work Plan. Single spaced, Calibri 12 point, 1-inch margins, number all pages. Content beyond 25 pages will not be considered.

SQI: Work plan included in the 10 page limit for Project Narrative and Work Plan. Single spaced, Calibri 12 point, 1-inch margins, number all pages. Content beyond 10 pages will not be considered.

RNCO: Work plan included in the 10 page limit for Project Narrative and Work Plan. Single spaced, Calibri 12 point, 1-inch margins, number all pages. Content beyond 10 pages will not be considered.

12. Budget Narrative

Applicants must submit an itemized budget narrative, which may be scored as part of the Organizational Capacity of Awardees to Implement the Approach. When developing the budget narrative, applicants must consider whether the proposed budget is reasonable and consistent with the purpose, outcomes, and program strategy outlined in the project narrative. The budget must include:

- Salaries and wages
- Fringe benefits
- Consultant costs
- Equipment
- Supplies
- Travel
- Other categories
- Contractual costs
- Total Direct costs
- Total Indirect costs

Indirect costs will not be reimbursed under grants to foreign organizations, international organizations, and foreign components of grants to domestic organizations (does not affect indirect cost reimbursement to the domestic entity for domestic activities).
For guidance on completing a detailed budget, see Budget Preparation Guidelines at:http:// www.cdc.gov /grants /interested in applying /application resources.html .
If applicable and consistent with the cited statutory authority for this announcement, applicant entities may use funds for activities as they relate to the intent of this FOA to meet national standards or seek health department accreditation through the Public Health Accreditation Board (see: http://www.phaboard.org). Applicant entities to whom this provision applies include state, local, territorial governments (including the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, the Commonwealth of the Northern Marianna Islands, American Samoa, Guam, the Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau), or their bona fide agents, political subdivisions of states (in consultation with states), federally recognized or state-recognized American Indian or Alaska Native tribal governments, and American Indian or Alaska Native tribally designated organizations. Activities include those that enable a public health organization to deliver public health services such as activities that ensure a capable and qualified workforce, up-to-date information systems, and the capability to assess and respond to public health needs. Use of these funds must focus on achieving a minimum of one national standard that supports the intent of the FOA. Proposed activities must be included in the budget narrative and must indicate which standards will be addressed.
Applicants must name this file "Budget Narrative" and upload it as a PDF file at www.grants.gov. If requesting indirect costs in the budget, a copy of the indirect cost-rate agreement is required. If the indirect costs are requested, include a copy of the current negotiated federal indirect cost rate agreement or a cost allocation plan approval letter for those Grantees under such a plan. Applicants must name this file "Indirect Cost Rate" and upload it at www.grants.gov.

Applicants submitting activities under optional innovation area cannot use more than 10% of their award to advance that project. Year 1 of activities under innovation area will be dedicated to developing a plan for identifying, selecting, and implementing the innovation area. Years 2-5 of the project period will be dedicated to the implementation of innovation area.

Please note that a Budget Narrative must be submitted for **each component** named using the specific component name (e.g. XX {State Initials} Budget Narrative BASE), (e.g. XX {State Initials} Budget Narrative SQI), and/or (e.g. XX {State Initials} Budget Narrative RNCO). If applying for enhanced components (SQI and/or RNCO), upload the Budget Narrative as a PDF file under "Other Attachment Forms" at www.grants.gov.

13. Tobacco and Nutrition Policies

Awardees are encouraged to implement tobacco and nutrition policies.

Unless otherwise explicitly permitted under the terms of a specific CDC award, no funds associated with this FOA may be used to implement the optional policies, and no applicants will be evaluated or scored on whether they choose to implement these optional policies.

CDC supports implementing evidence-based programs and policies to reduce tobacco use and secondhand smoke exposure, and to promote healthy nutrition. CDC encourages all awardees to implement the following optional recommended evidence-based tobacco and nutrition policies within their own organizations. The tobacco policies build upon the current federal commitment to reduce exposure to secondhand smoke, specifically Pro-Children Act of 2001, 20 U.S.C. Sections 7181-7184, that prohibits smoking in certain facilities that receive federal funds in which education, library, day care, health care,or early childhood development services are provided to children.

Tobacco Policies:

1. Tobacco-free indoors: Use of any tobacco products (including smokeless tobacco) or electronic cigarettes is not allowed in any indoor facilities under the control of the awardee.
2. Tobacco-free indoors and in adjacent outdoor areas: Use of any tobacco products or electronic cigarettes is not allowed in any indoor facilities, within 50 feet of doorways and air intake ducts, and in courtyards under the control of the awardee.
3. Tobacco-free campus: Use of any tobacco products or electronic cigarettes is not allowed in any indoor facilities or anywhere on grounds or in outdoor space under the control of the awardee.

Nutrition Policies:

1. Healthy food-service guidelines must, at a minimum, align with HHS and General Services Administration Health and Sustainability Guidelines for Federal Concessions and Vending Operations. These guidelines apply to cafeterias, snack bars, and vending machines in any facility under the control of the awardee and in accordance with contractual obligations for these services (see: http:// www.gsa.gov/ graphics/ pbs/ Guidelines for Federal Concessions and Vending Operations.pdf).
2. Resources that provide guidance for healthy eating and tobacco-free workplaces are:

http://www.cdc.gov/ nccdphp/dnpao/hwi/ toolkits/ tobacco/index.htm
http://www. thecommunityguide.org/ tobacco/index.html
http:// www.cdc.gov /obesity /strategies /food-serv-guide.html

14. Health Insurance Marketplaces

A healthier country is one in which Americans are able to access the care they need to prevent the onset of disease and manage disease when it is present. The Affordable Care Act, the health care law of 2010, creates new Health Insurance Marketplaces, also known as Exchanges, to offer millions of Americans affordable health insurance coverage. In addition, the law helps make prevention affordable and accessible for Americans by requiring health plans to cover certain recommended preventive services without cost sharing. Outreach efforts will help families and communities understand these new options and provide eligible individuals the assistance they need to secure and retain coverage as smoothly as possible. For more information on the Marketplaces and the health care law, visit: www.HealthCare.gov.

15. Intergovernmental Review

The application is subject to Intergovernmental Review of Federal Programs, as governed by Executive Order 12372, which established a system for state and local intergovernmental review of proposed federal assistance applications. Applicants should inform their state single point of contact (SPOC) as early as possible that they are applying prospectively for federal assistance and request instructions on the state's process. The current SPOC list is available at: http://www.whitehouse.gov/omb/grants_spoc/.

16. Pilot Program for Enhancement of Employee Whistleblower Protections

Pilot Program for Enhancement of Employee Whistleblower Protections: All applicants will be subject to a term and condition that applies the terms of 48 Code of Federal Regulations (CFR) section 3.908 to the award and requires that grantees inform their employees in writing (in the predominant native language of the workforce) of employee whistleblower rights and protections under 41 U.S.C. 4712.

16a. Funds Tracking

Proper fiscal oversight is critical to maintaining public trust in the stewardship of federal funds. Effective October 1, 2013, a new HHS policy on subaccounts requires the CDC to set up payment subaccounts within the Payment Management System (PMS) for all new grant awards. Funds awarded in support of approved activities and drawdown instructions will be identified on the Notice of Award in a newly established PMS subaccount (P subaccount). Grantees will be required to draw down funds from award-specific accounts in the PMS. Ultimately, the subaccounts will provide grantees and CDC a more detailed and precise understanding of financial transactions. The successful applicant will be required to track funds by P-accounts/sub accounts for each project/cooperative agreement awarded. Applicants are encouraged to demonstrate a record of fiscal responsibility and the ability to provide sufficient and effective oversight. Financial management systems must meet the requirements as described 2 CFR 200 which include, but are not limited to, the following:

- Records that identify adequately the source and application of funds for federally-funded activities.
- Effective control over, and accountability for, all funds, property, and other assets.
- Comparison of expenditures with budget amounts for each Federal award.
- Written procedures to implement payment requirements.
- Written procedures for determining cost allowability.
- Written procedures for financial reporting and monitoring.

16b. Copyright Interests Provisions

This provision is intended to ensure that the public has access to the results and accomplishments of public health activities funded by CDC. Pursuant to applicable grant regulations and CDC's Public Access Policy, Recipient agrees to submit into the National Institutes of Health (NIH) Manuscript Submission (NIHMS) system an electronic version of the final, peer-reviewed manuscript of any such work developed under this award upon acceptance for publication, to be made publicly available no later than 12 months after the official date of publication. Also at the time of submission, Recipient and/or the Recipient's submitting author must specify the date the final manuscript will be publicly accessible through PubMed Central (PMC). Recipient and/or Recipient's submitting author must also post the manuscript through PMC within twelve (12) months of the publisher's official date of final publication; however the author is strongly encouraged to make the subject manuscript available as soon as possible. The recipient must obtain prior approval from the CDC for any exception to this provision.

The author's final, peer-reviewed manuscript is defined as the final version accepted for journal publication, and includes all modifications from the publishing peer review process, and all graphics and supplemental material associated with the article. Recipient and its submitting authors working under this award are responsible for ensuring that any publishing or copyright agreements concerning submitted articles reserve adequate right to fully comply with this provision and the license reserved by CDC. The manuscript will be hosted in both PMC and the CDC Stacks institutional repository system. In progress reports for this award, recipient must identify publications subject to the CDC Public Access Policy by using the applicable NIHMS identification number for up to three (3) months after the publication date and the PubMed Central

identification number (PMCID) thereafter.

16c. Reporting of Foreign Taxes (International/Foreign projects only)

A. Valued Added Tax (VAT) and Customs Duties – Customs and import duties, consular fees, customs surtax, valued added taxes, and other related charges are hereby authorized as an allowable cost for costs incurred for non-host governmental entities operating where no applicable tax exemption exists. This waiver does not apply to countries where a bilateral agreement (or similar legal document) is already in place providing applicable tax exemptions and it is not applicable to Ministries of Health. Successful applicants will receive information on VAT requirements via their Notice of Award.

B. The U.S. Department of State requires that agencies collect and report information on the amount of taxes assessed, reimbursed and not reimbursed by a foreign government against commodities financed with funds appropriated by the U.S. Department of State, Foreign Operations and Related Programs Appropriations Act (SFOAA) ("United States foreign assistance funds"). Outlined below are the specifics of this requirement:

1) Annual Report: The grantee must submit a report on or before November 16 for each foreign country on the amount of foreign taxes charged, as of September 30 of the same year, by a foreign government on commodity purchase transactions valued at 500 USD or more financed with United States foreign assistance funds under this grant during the prior United States fiscal year (October 1 – September 30), and the amount reimbursed and unreimbursed by the foreign government. [Reports are required even if the grantee did not pay any taxes during the reporting period.]

2) Quarterly Report: The grantee must quarterly submit a report on the amount of foreign taxes charged by a foreign government on commodity purchase transactions valued at 500 USD or more financed with United States foreign assistance funds under this grant. This report shall be submitted no later than two weeks following the end of each quarter: April 15, July 15, October 15 and January 15.

3) Terms: For purposes of this clause: "Commodity" means any material, article, supplies, goods, or equipment; "Foreign government" includes any foreign government entity; "Foreign taxes" means value-added taxes and custom duties assessed by a foreign government on a commodity. It does not include foreign sales taxes.

4) Where: Submit the reports to the Director and Deputy Director of the CDC office in the country(ies) in which you are carrying out the activities associated with this cooperative agreement. In countries where there is no CDC office, send reports to VATreporting@cdc.gov.

5) Contents of Reports: The reports must contain: a. grantee name; b. contact name with phone, fax, and e-mail; c. agreement number(s) if reporting by agreement(s); d. reporting period; e. amount of foreign taxes assessed by each foreign government; f. amount of any foreign taxes reimbursed by each foreign government; g. amount of foreign taxes unreimbursed by each foreign government.

6) Subagreements. The grantee must include this reporting requirement in all applicable subgrants and other subagreements.

17. Funding Restrictions

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

- Awardees may not use funds for research.
- Awardees may not use funds for clinical care except as allowed by law.
- Awardees may use funds only for reasonable program purposes, including personnel, travel, supplies, and services.
- Generally, awardees may not use funds to purchase furniture or equipment. Any such proposed spending must be clearly identified in the budget.
- Reimbursement of pre-award costs generally is not allowed, unless the CDC provides written approval

to the awardee.

- Other than for normal and recognized executive-legislative relationships, no funds may be used for:
  - publicity or propaganda purposes, for the preparation, distribution, or use of any material designed to support or defeat the enactment of legislation before any legislative body
  - the salary or expenses of any grant or contract recipient, or agent acting for such recipient, related to any activity designed to influence the enactment of legislation, appropriations, regulation, administrative action, or Executive order proposed or pending before any legislative body
- See Additional Requirement (AR) 12 for detailed guidance on this prohibition and additional guidance on lobbying for CDC awardees.
- The direct and primary recipient in a cooperative agreement program must perform a substantial role in carrying out project outcomes and not merely serve as a conduit for an award to another party or provider who is ineligible.

- The direct and primary recipient in a cooperative agreement program must perform a substantial role in carrying out project outcomes and not merely serve as a conduit for an award to another party or provider who is ineligible.

• States proposing PDO readiness activities under the 10% innovation of funding cannot use funds for purchasing naloxone, implementing or expanding drug "take back" programs, or directly funding or expanding substance abuse treatment programs

• Incentives are not allowable expenses

18. Other Submission Requirements

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

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

If Internet access is not available or if the forms cannot be accessed online, applicants may contact the PGO TIMS staff at 770- 488-2700 or by e-mail at pgotim@cdc.gov, Monday through Friday, 7:30 a.m.–4:30 p.m., except federal holidays. Electronic applications will be considered successful if they are available to PGO TIMS staff for processing from www.grants.gov on the deadline date.

b. Tracking Number: Applications submitted through www.grants.gov are time/date stamped electronically and assigned a tracking number. The applicant's Authorized Organization Representative (AOR) will be sent an e-mail notice of receipt when www.grants.gov receives the application. The tracking number documents that the application has been submitted and initiates the required electronic validation process before the application is made available to CDC.

c. Validation Process: Application submission is not concluded until the validation process is completed successfully. After the application package is submitted, the applicant will receive a "submission receipt" e-mail generated by www.grants.gov. A second e-mail message to applicants will then be generated by www.grants.gov that will either validate or reject the submitted application package. This validation process may take as long as two business days. Applicants are strongly encouraged to check the status of

their application to ensure that submission of their package has been completed and no submission errors have occurred. Applicants also are strongly encouraged to allocate ample time for filing to guarantee that their application can be submitted and validated by the deadline published in the FOA. Non-validated applications will not be accepted after the published application deadline date.

If you do not receive a "validation" e-mail within two business days of application submission, please contact www.grants.gov. For instructions on how to track your application, refer to the e-mail message generated at the time of application submission or the Applicant User Guide, Version 1.1, page 102. http:// www.grants.gov /documents /19/18243 /Grantsgov ApplicantUserGuide .pdf /ce754626 -c2aa-44bc-b701 -30a75bf428c8

d. Technical Difficulties: If technical difficulties are encountered at www.grants.gov, applicants should contact Customer Service at www.grants.gov. The www.grants.gov Contact Center is available 24 hours a day, 7 days a week, except federal holidays. The Contact Center is available by phone at 1-800-518-4726 or by e-mail at support@www.grants.gov. Application submissions sent by e-mail or fax, or on CDs or thumb drives will not be accepted. Please note that www.grants.gov is managed by HHS.
e. Paper Submission: If technical difficulties are encountered at www.grants.gov, applicants should call the www.grants.gov Contact Center at 1-800-518-4726 or e-mail them at support@www.grants.gov for assistance. After consulting with the Contact Center, if the technical difficulties remain unresolved and electronic submission is not possible, applicants may e-mail CDC GMO/GMS, before the deadline, and request permission to submit a paper application. Such requests are handled on a case-by-case basis.
An applicant's request for permission to submit a paper application must:

1. Include the www.grants.gov case number assigned to the inquiry
2. Describe the difficulties that prevent electronic submission and the efforts taken with the www.grants.gov Contact Center to submit electronically; and
3. Be received via e-mail to the GMS/GMO listed below at least three calendar days before the application deadline. Paper applications submitted without prior approval will not be considered. If a paper application is authorized, PGO will advise the applicant of specific instructions for submitting the application (e.g., original and two hard copies of the application by U.S. mail or express delivery service).

E. Review and Selection Process

1. Review and Selection Process: Applications will be reviewed in three phases.

a. Phase I Review

All applications will be reviewed initially for completeness by CDC OGS staff and will be reviewed jointly for eligibility by the CDC NCIPC and OGS. Incomplete applications and applications that do not meet the eligibility criteria will not advance to Phase II review. Applicants will be notified that their applications did not meet eligibility or published submission requirements.

b. Phase II Review

A review panel will evaluate complete, eligible applications in accordance with the criteria below.
i. Approach ii. Evaluation and Performance Measurement iii. Applicant's Organizational Capacity to Implement the Approach

Not more than thirty days after the Phase II review is completed, applicants will be notified electronically if their application does not meet eligibility or published submission requirements.

BASE Component Evaluation Criteria	Maximum Points: 100

BASE - Approach (34 points):

Overall (8 points)

- Does the applicant provide goals that are relevant to the purpose of the proposal and feasible to accomplish during the project period? (5 points)
- Does the applicant describe how stated goals will lead to lives saved and injuries prevented? (3 points)

Collaboration (26 points)

- Does the applicant have an established statewide injury and violence prevention collaborative (e.g. Injury Community Implementation Group (ICIG), etc.) that includes key partners and related coalitions? (5 points)
- Does the applicant include a list of current members, meeting minutes, or a memorandum of understanding (or Charter or another guidance document) from the established injury and violence prevention collaborative? (3 points)
- How well does the applicant describe the capacity of the existing injury and violence prevention collaborative in terms of leadership, expertise, community representation, collaborative experience/abilities, and agency representation? (4 points)
- Has the applicant provided evidence that members of the existing injury and violence prevention collaborative have successfully worked together and in collaboration with community leaders to implement broad-based policy, systems, and/or organizational change initiatives (i.e. legislation introduced or passed, organizational policy put in place, industry operations or policy changed, organization of a legislator awareness day, securing a legislative champion, evaluation of impact/outcome of a policy intervention)? (4 points)
- Does the applicant provide examples of past successes? (6 points)
- Does the applicant provide letters of support from key internal and external government leaders and partners, as described earlier in this FOA, indicating support for injury and violence prevention programs? (4 points)

BASE - Evaluation and Performance Management (36 points):

Access to data (12 points)

- Does the applicant demonstrate they have access to timely, electronic statewide centralized, emergency department data as evidenced by data presented in the appendices? (1 point)
- Does the applicant demonstrate they have access to timely, electronic statewide centralized, hospital discharge data as evidenced by data presented in the appendices? (5 points)
- Does the applicant demonstrate they have access to timely, electronic statewide centralized, vital statistics data as evidenced by data presented in the appendices? (5 points)
- Has the applicant provided data to the 2009-20013 State Injury Indicator Reports as evidenced by annual CDC-issued letters of data receipt and do the letters demonstrate submission of both multiple cause-of-death data and hospital discharge data? (1 point)

Goals, Objectives, and Methods: Collect and Analyze Data (5 points)

- Are the data goals and objectives SMART (Specific, Measurable, Achievable, Relevant, Time-framed)? (2 points)
- Does the applicant outline the data activities necessary to accomplish the purpose of the proposal? (2 points)
- Does the applicant provide a reasonable and complete timeline for implementing and completing all data activities and objectives? (1 point)

Support and Evaluate Program and Policy Strategies: (5 points)

- Are the strategy goals and objectives SMART (Specific, Measurable, Achievable, Relevant, Time-Framed)? (2 points)
- Does the applicant outline strategies necessary to accomplish the purpose of the proposal? (2 points)
- Does the applicant provide a reasonable and complete timeline for implementing and completing all strategies and objectives? (1 point)

Program Evaluation: (14 points)

- Does the proposed evaluation address all program goals and objectives? (2 points)
- Does the applicant include a detailed plan for evaluating progress toward meeting goals and objectives? (4 points)
- Will the proposed evaluation effectively evaluate program progress, effectiveness, and impact? (2 points)
- Does the applicant describe the availability of potential data sources for evaluation purposes? (2 points)
- Does the applicant document the availability of staff with the appropriate expertise, experience and capacity to perform program evaluation? (2 points)
- Does the applicant present a feasible plan for reporting evaluation results and for using evaluation information for programmatic decisions and continuous program improvement? (2 points)

BASE - Applicant's Organizational Capacity to Implement the Approach: (30 points)

Current status (5 points)

- Does the applicant describe the current injury and violence prevention programs in the state health department? (2 points)
- Does the applicant provide the current level of agency/inter-agency resources dedicated to implementing injury and violence-related activities? (2 points)
- Does the applicant explain how additional funding will contribute to efforts to integrate as appropriate existing or planned violence- and injury-related activities to address shared risk and protective factors? (1 point)

State plan (9 points)

- Does the applicant provide evidence of a current state injury and violence prevention and control plan? (2 points)
- Does the current injury plan use data to describe the epidemiology of the burden of injury and violence in the state? (2 points)
- Does the current injury plan use data to evaluate the epidemiologic data to determine the critical target areas? (1 point)
- Does the current injury plan use data to establish priorities? (1 point)
- Does the current injury plan use data to select appropriate best available evidence strategies? (1 point)
- Does the current injury plan use data to identify implementing organizations for priority strategies? (1 point)
- Does the current injury plan use data to inform and secure commitments from public health/political leadership? (1 point)

Management and staffing plan (16 points)

- Does the applicant describe the roles of each unit, organization, and/or agency, as well as evidence of coordination, supervision, and degree of commitment (e.g., time, in-kind, financial), involved with IVP activities in the state health department? (2 points)
- Does the applicant provide adequate information to assess the quality of relationships between the

program and other government agencies and health department units? (1 point)
- Does the applicant provide evidence of or plans to establish intra-agency agreements (IAA) outlining roles, duties, and responsibilities (e.g., create IAA with lead of RPE, Essentials for Childhood, DELTA, etc.)? (3 points)
- Does the applicant describe clearly defined roles and abilities of project staff and an appropriate percent of time each is committing to the project? (1 point)
- Does the applicant identify the required staff for the program, including the provision of resumes or CVs for existing staff and position descriptions for proposed positions? (2 points)
- Does the applicant designate a coordinator with the responsibility for coordinating the BASE component of the Core SVIPP? (1 point)
- Does the applicant provide evidence of access to or assignment of epidemiological expertise for performing routine data analysis and providing technical advice by including resumes or CVs for existing staff? (1 point)
- Does the applicant demonstrate staff experience with policy making and briefing political leaders and policy makers by including resumes or CVs for existing staff? (1 point)
- Does the applicant demonstrate staff experience with communications by including the provision of resumes or CVs for existing staff? (1 point)
- Does the applicant demonstrate staff experience with evaluation by including the provision of resumes or CVs for existing staff? (1 point)
- Does the applicant describe a continuation plan in the event that key staff leave the project (including how new staff will be smoothly integrated into the project, and assurance that resources will be available when needed for this project)? (1 point)
- Does the applicant provide evidence of cost sharing (at least ten percent of direct costs)? (1 point)

BASE - Budget and Justification (not scored):

- Does the applicant provide a detailed budget and narrative justification consistent with stated objectives and planned injury prevention program activities?
- Does the applicant include funding for one person to attend at least one annual meeting with CDC (Joint Annual Meeting of the CDC Core SVIPP or other meetings agreed upon by CDC)?

SQI Component Evaluation Criteria	Maximum Points: 100

SQI - Approach (50 points):

Collaboration (20 points)

- Has the applicant provided evidence of collaborative investigations with epidemiologists outside of their own work unit? (5 points)
- Has applicant had meaningful participation in previous Injury Surveillance Workgroups or similar endeavors? (Letters of Support provided stating detail role?) (10 points)
- Are plans for collaboration provided? (5 points)

Access to data (30 points)

- Does the applicant demonstrate they have access to medical records for the purpose of abstraction? (6 points)
- Does the applicant demonstrate they have access to timely, statewide, centralized electronic emergency department data as evidenced by data presented in the appendices? (6 points)
- Does the applicant demonstrate they have access to timely, statewide, centralized electronic hospital discharge data as evidenced by data presented in the appendices? (6 points)
- Does the applicant demonstrate they have access to timely, statewide, centralized electronic multiple-cause-of-death data as evidenced by data presented in the appendices? (6 points)
- Has the applicant provided data to the 2009-2013 State Injury Indicator Reports as evidenced by

annual CDC-issued letters of data receipt and do the letters demonstrate submission of multiple cause-of-death, hospital discharge, and emergency department data? (6 points)

SQI - Evaluation and Performance Management: (25 points):

Topic Selection and Methods Development Process: (5 points)

- Does the applicant propose a plan for topic selection and methods development that will result in feasible investigations? (5 points)

Implementation: (10 points)

- Does the applicant provide goals that are relevant to the purpose of the proposal and feasible to accomplish during the project period? (3 points)
- Are the goals and objectives SMART? (2 points)
- Does the applicant outline the activities necessary to accomplish the purpose of the proposal? (3 points)
- Does the applicant provide a reasonable and complete timeline for implementing and completing all data activities and objectives? (2 points)

Evaluation (10 points):

- Does the applicant include a plan for evaluating progress toward meeting goals and objectives? (3 points)
- Will the proposed evaluation effectively evaluate program progress, effectiveness, and impact? (4 points)
- Does the applicant present a feasible plan for reporting evaluation results and for using evaluation information for programmatic decisions and continuous program improvement? (3 points)

SQI - Applicant's Organizational Capacity to Implement the Approach (25 points):

Current status (10 points)

- Does the applicant describe their current injury and violence surveillance capacity? (3 points)
- Does the applicant demonstrate experience with abstracting medical records? (2 points)
- Has the applicant conducted an evaluation of their state injury and violence surveillance data? (3 points)
- Does the applicant explain how additional funding will contribute to efforts to improve existing or planned injury and violence surveillance activities? (2 points)

Management and staffing plan (15 points)

- Does the applicant describe clearly defined roles and abilities of project staff and an appropriate percent of time each is committing to the project? (3 points)
- Does the applicant identify the epidemiological staff for the program, including the provision of resumes or CVs for existing staff and position descriptions for proposed positions? (3 points)
- Does the applicant identify the medical records abstraction staff for the program, including the provision of resumes or CVs for existing staff and position descriptions for proposed positions? (3 points)
- Does the applicant demonstrate capacity to produce academic and translation products that lead to advancement of injury surveillance as evidenced by inclusion of previous data products? (3 points)
- Does the applicant describe a continuation plan in the event that key staff leave the project (including how new staff will be smoothly integrated into the project, and assurance that resources will be available when needed for this project)? (3 points)

SQI - Budget and Justification (not scored):

- Does the applicant provide a detailed budget and narrative justification consistent with stated objectives and planned injury prevention program activities?
- Does the applicant include funds for one person to attend at least one annual meeting with CDC (Joint Annual Meeting of the CDC Core SVIPP or other meetings agreed upon by CDC).

RNCO Component Evaluation Criteria	Maximum Points: 100

RNCO - Approach (50 points):

Understanding and Need (10 points):

- Does the applicant describe their understanding of the issues faced by state injury and violence prevention programs, and the need for regional state collaboration? (5 points)
- Does the applicant describe their understanding of the importance of a research and practice collaboration? (5 points)

Collaboration (40 points):

- Has the applicant provided evidence that previous coalitions and multi-member groups, to include research organizations, have been successful in working together and in collaboration with other partners to implement goals of the organization? (10 points)
- Does the applicant provide letters of support from other potential regional network member states, national organizations, research institutions, and others in active support of being a Regional Network Coordinating Organization? (10 points)
- Does the applicant provide descriptions of any inter-state collaboration active or inactive and potential lessons learned from those efforts? (10 points)
- Does the applicant provide descriptions of national cross-region collaborative process for establishing National/Cross-Regional Peer Learning Group? (10 points)

RNCO - Evaluation and Performance Management: (30 points):

- Does the applicant provide goals that are relevant to the purpose of the proposal and feasible to accomplish during the project period? (5 points)
- Does the applicant describe how the goals will lead to improved capacity of Regional Network member states? (5 points)
- Are the goals and objectives SMART (Specific, Measurable, Achievable, Relevant, Time-Framed)? (5 points)
- Does the applicant outline the activities necessary to accomplish the purpose of the proposal? (5 points)
- Does the applicant provide a reasonable and complete timeline for implementing and completing all activities and objectives? (5 points)
- Does the applicant provide details on how the needs assessment in year one will inform the direction of the Regional Peer Learning Team? (5 points)

RNCO - Applicant's Organizational Capacity to Implement the Approach: (20 points)

- Does the applicant dedicate adequate staff to manage the Regional Network Coordinating Organization as evidenced by:
    - Providing clear roles and responsibilities of staff? (5 points)
    - Showing evidence of previous experience of assigned staff in developing and maintaining partnerships by including the provision of resumes or CVs for existing staff? (10 points)
- Does the applicant demonstrate support by producing letters of support or commitment from the state health department officer or equivalent? (5 points)

RNCO - Budget (not scored):

- Does the applicant provide a detailed budget and narrative justification consistent with stated objectives and planned injury prevention program activities?
- Does the applicant include funding for one person to attend at least one annual meeting with CDC (Joint Annual Meeting of the CDC Core SVIPP or other meetings agreed upon by CDC)?

Not more than thirty days after the Phase II review is completed, applicants will be notified electronically if their application does not meet eligibility or published submission requirements.

c. Phase III Review

SCORING:

Applications will be funded in order by score and rank determined by the review panel. All components are scored on a maximum score of 100 points each. CDC will review the BASE component of all the applications first. Once that review is complete, only those applicants that rank in the funded category will be eligible to be reviewed/funded for the expanded components (SQI and/or RNCO). For SQI - the four highest scoring proposals will be funded. For RNCO - the highest scoring proposal will be funded within each of the five regions (n=5) to ensure geographic distribution. We expect these will still be in line with the HHS regions (1&2, 3&5, 4&6, 7&8, 9&10).

Successful applicants will anticipate notice of funding by July 1, 2016 with a start date of August 1, 2016.

F. Award Administration Information

1. Award Notices

Awardees will receive an electronic copy of the Notice of Award (NOA) from CDC PGO. The NOA shall be the only binding, authorizing document between the awardee and CDC. The NOA will be signed by an authorized GMO and emailed to the Awardee Business Officer listed in application and the Program Director.

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

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

2. Administrative and National Policy Requirements

Awardees must comply with the administrative and public policy requirements outlined in 45 CFR Part 75 and the HHS Grants Policy Statement, as appropriate.

Brief descriptions of relevant provisions are available at http:// www.cdc.gov/ grants/ additional requirements/ index.html

The HHS Grants Policy Statement is available at http:// www.hhs.gov /asfr /ogapa /aboutog /hhsgps107.pdf.

The following Administrative Requirements (AR) apply to this project: Generally applicable ARs:

- AR-7: Executive Order 12372
- AR-9: Paperwork Reduction Act http://www.hhs.gov/ocio/policy/collection/infocollectfaq.html

The Paperwork Reduction Act of 1995 (PRA): Offerors should be advised that any activities

involving information collection (i.e., posing similar questions or requirements via surveys, questionnaires, telephonic requests, focus groups, etc.) from 10 or more non-Federal entities/persons, including States, are subject to PRA requirements and may require CDC to coordinate an Office of Management and Budget (OMB) Information Collection Request clearance prior to the start of information collection activities. This would also include information sent to or obtained by CDC via forms, applications, reports, information systems, and any other means for requesting information from 10 or more persons; asking or requiring 10 or more entities/persons to keep or retain records; or asking or requiring 10 or more entities/persons to disclose information to a third-party or the general public. For cooperative agreements PRA applicability will depend on the level of CDC involvement with the development, collection, dissemination, and management of information/data.

(CDC OMB package approval in process)

- AR-10: Smoke-Free Workplace
- AR-11: Healthy People 2020
- AR-12: Lobbying Restrictions
- AR-13: Prohibition on Use of CDC Funds for Certain Gun Control Activities
- AR-14: Accounting System Requirements
- AR-16: Security Clearance Requirement
- AR-21: Small, Minority, And Women-owned Business
- AR-24: Health Insurance Portability and Accountability Act
- AR-25: Release and Sharing of Data
- AR-26: National Historic Preservation Act of 1966
- AR-29: Compliance with EO13513, "Federal Leadership on Reducing Text Messaging while Driving," October 1, 2009
- AR-30: Compliance with Section 508 of the Rehabilitation Act of 1973
- AR-33: Plain Writing Act of 2010
- AR-34: Patient Protection and Affordable Care Act (e.g., a tobacco-free campus policy and a lactation policy consistent with S4207)
- AR-35: Nutrition Policies

For more information on the CFR visit http://www.ecfr.gov/cgi-bin/ECFR?page=browse.

3. Reporting

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

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

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

Report	When?	Required?
Awardee Evaluation and Performance Measurement Plan	6 months into award	Yes
Annual Performance Report (APR)	No later than120 days before end of budget period. Serves as yearly continuation application.	Yes
Data on Performance Measures	CDC program determines. Only if program wants more frequent performance measure reporting than annually in APR.	No
Federal Financial Reporting Forms	90 days after end of calendar quarter in which budget period ends	Yes
Final Performance and Financial Report	90 days after end of project period.	Yes

a. Awardee Evaluation and Performance Measurement Plan (required)
With support from CDC, awardees must elaborate on their initial applicant evaluation and performance measurement plan. This plan must be no more than 20 pages; awardees must submit the plan 6 months into the award.

This plan should provide additional detail on the following:

- The frequency that evaluation and performance data are to be collected.
- How data will be reported.
- How evaluation findings will be used for continuous quality and program improvement.
- How evaluation and performance measurement will yield findings to demonstrate the value of the FOA (e.g., improved public health outcomes, effectiveness of FOA, cost-effectiveness or cost benefit).
- Dissemination channels and audiences.
- Other information requested as determined by the CDC program.

b. Annual Performance Report (APR) (required)
The awardee must submit the APR via www.grants.gov 120 days before the end of the budget period. This report must not exceed 45 pages excluding administrative reporting. Attachments are not allowed, but weblinks are allowed.
This report must include the following:

- **Performance Measures:** Awardees must report on performance measures for each budget period and update measures, if needed.
- **Evaluation Results:** Awardees must report evaluation results for the work completed to date (including findings from process or outcome evaluations).
- **Work Plan:** Awardees must update work plan each budget period to reflect any changes in project period outcomes, activities, timeline, etc.
- **Successes**
    - Awardees must report progress on completing activities and progress towards achieving the

project period outcomes described in the logic model and work plan.
    - Awardees must describe any additional successes (e.g. identified through evaluation results or lessons learned) achieved in the past year.
    - Awardees must describe success stories.
- **Challenges**
    - Awardees must describe any challenges that hindered or might hinder their ability to complete the work plan activities and achieve the project period outcomes.
    - Awardees must describe any additional challenges (e.g., identified through evaluation results or lessons learned) encountered in the past year.
- **CDC Program Support to Awardees**
    - Awardees must describe how CDC could help them overcome challenges to complete activities in the work plan and achieving project period outcomes.
- **Administrative Reporting** (No page limit)
    - SF-424A Budget Information-Non-Construction Programs.
    - Budget Narrative – Must use the format outlined in "Content and Form of Application Submission, Budget Narrative" section.
    - Indirect Cost Rate Agreement.

The awardee must submit the Annual Performance Report via www.grants.gov 120 days before the end of the budget period.

For year 2 and beyond of the award, awardees may request that as much as 75% of their estimated unobligated funds be carried over into the next budget period.

c. Performance Measure Reporting (optional)

CDC programs may require more frequent reporting of performance measures than annually in the APR. If this is the case, CDC programs must specify reporting frequency, data fields, and format for awardees at the beginning of the award period.

CDC will require awardees to update and report their performance and evaluation measures 60 days after the end of each funding year.

d. Federal Financial Reporting (FFR) (required)

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

e. Final Performance and Financial Report (required)

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

- Performance Measures – Awardees must report final performance data for all process and outcome performance measures.
- Evaluation Results – Awardees must report final evaluation results for the project period for any evaluations conducted.
- Impact/Results/Success Stories – Awardees must use their performance measure results and their

evaluation findings to describe the effects or results of the work completed over the project period, and can include some success stories.
- Additional forms as described in the Notice of Award (e.g., Equipment Inventory Report, Final Invention Statement).

• CDC program will provide format for this report prior to submission

4. Federal Funding Accountability and Transparency Act of 2006 (FFATA)

Federal Funding Accountability and Transparency Act of 2006 (FFATA), P.L. 109–282, as amended by section 6202 of P.L. 110–252 requires full disclosure of all entities and organizations receiving Federal funds including awards, contracts, loans, other assistance, and payments through a single publicly accessible Web site, http://www.USASpending.gov.
Compliance with this law is primarily the responsibility of the Federal agency. However, two elements of the law require information to be collected and reported by applicants: 1) information on executive compensation when not already reported through the SAM, and 2) similar information on all sub-awards/subcontracts/consortiums over $25,000.
For the full text of the requirements under the FFATA and HHS guidelines, go to:

- http://frwebgate. access.gpo.gov/ cgi-bin/getdoc.cgi ?dbname= 109_ cong_ bills &docid=f:s2590enr .txt.pdf,
- https://www. fsrs.gov/documents /ffata_ legislation_ 110_ 252.pdf
- http://www.hhs.gov /asfr/ogapa/aboutog /Grants%20Management %20Information/ ffata_ guidelines.html.

G. Agency Contacts

CDC encourages inquiries concerning this FOA.

Program Office Contact

For programmatic technical assistance, contact:

Ted Castellanos, Project Officer
Department of Health and Human Services
Centers for Disease Control and Prevention
4770 Buford Highway
MS F-62
Atlanta, GA 30341
Telephone: (770) 488-3665
Email: TCastellanos@cdc.gov

Grants Management Office Information

For **financial, awards management, or budget assistance,** contact:

Barbara René Benyard, Grants Management Specialist
Department of Health and Human Services
CDC Procurement and Grants Office
KOGR Building Stanford Room 2058
MS E-01
Atlanta, GA 303041

Telephone: (770) 488-2757
Email: RBenyard@cdc.gov

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

For all other **submission** questions, contact:
Technical Information Management Section
Department of Health and Human Services
CDC Office of Financial Resources
Office of Grants Services
2920 Brandywine Road, MS E-14
Atlanta, GA 30341
Telephone: 770-488-2700
E-mail: pgotim@cdc.gov

CDC Telecommunications for persons with hearing loss is available at: TTY 1-888-232-6348.

H. Other Information

Following is a list of acceptable attachments **applicants** can upload as PDF files as part of their application at www.grants.gov. Applicants may not attach documents other than those listed; if other documents are attached, applications will not be reviewed.

- Project Abstract
- Project Narrative
- Budget Narrative
- CDC Assurances and Certifications
- Table of Contents for Entire Submission

For international FOAs:

- SF424
- SF424A
- Letters of Support
- Funding Preference Deliverables

Optional attachments, as determined by CDC programs:

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

I. Glossary

Activities: The actual events or actions that take place as a part of the program.
Administrative and National Policy Requirements, Additional Requirements (ARs): Administrative requirements found in 45 CFR Part 75 and other requirements mandated by statute or CDC policy. All ARs are listed in the Template for CDC programs. CDC programs must indicate which ARs are relevant to the FOA; awardees must comply with the ARs listed in the FOA. To view brief descriptions of relevant provisions, see http:// www.cdc.gov/ grants/ additional requirements/ index.html. Note that 2 CFR 200 supersedes the administrative requirements (A-110 & A-102), cost principles (A-21, A-87 & A-122) and audit requirements (A-50, A-89 & A-133).
Award: Financial assistance that provides support or stimulation to accomplish a public purpose. Awards include grants and other agreements (e.g., cooperative agreements) in the form of money, or property in lieu of money, by the federal government to an eligible applicant.
Budget Period or Budget Year: The duration of each individual funding period within the project period.Traditionally, budget periods are 12 months or 1 year.
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DUNS: The Dun and Bradstreet (D&B) Data Universal Numbering System (DUNS) number is a nine-digit number assigned by Dun and Bradstreet Information Services. When applying for Federal awards or cooperative agreements, all applicant organizations must obtain a DUNS number as the Universal Identifier. DUNS number assignment is free. If requested by telephone, a DUNS number will be provided immediately at no charge. If requested via the Internet, obtaining a DUNS number may take one to two days at no charge. If an organization does not know its DUNS number or needs to register for one, visit Dun & Bradstreet at

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Evaluation Plan: A written document describing the overall approach that will be used to guide an evaluation, including why the evaluation is being conducted, how the findings will likely be used, and the design and data collection sources and methods. The plan specifies what will be done, how it will be done, who will do it, and when it will be done. The FOA evaluation plan is used to describe how the awardee and/or CDC will determine whether activities are implemented appropriately and outcomes are achieved.
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Grants.gov: A "storefront" web portal for electronic data collection (forms and reports) for federal grant-making agencies at www.grants.gov.
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Inclusion: Both the meaningful involvement of a community's members in all stages of the program process and the maximum involvement of the target population that the intervention will benefit. Inclusion ensures that the views, perspectives, and needs of affected communities, care providers, and key partners are considered.
Indirect Costs: Costs that are incurred for common or joint objectives and not readily and specifically identifiable with a particular sponsored project, program, or activity; nevertheless, these costs are necessary to the operations of the organization. For example, the costs of operating and maintaining facilities, depreciation, and administrative salaries generally are considered indirect costs.
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proposed federal assistance applications. Contact the state single point of contact (SPOC) to alert the SPOC to prospective applications and to receive instructions on the State's process. Visit the following web address to get the current SPOC list: http://www.whitehouse.gov/omb/ grants_spoc/.
Letter of Intent (LOI): A preliminary, non-binding indication of an organization's intent to submit an application.
Lobbying: Direct lobbying includes any attempt to influence legislation, appropriations, regulations, administrative actions, executive orders (legislation or other orders), or other similar deliberations at any level of government through communication that directly expresses a view on proposed or pending legislation or other orders, and which is directed to staff members or other employees of a legislative body, government officials, or employees who participate in formulating legislation or other orders. Grass roots lobbying includes efforts directed at inducing or encouraging members of the public to contact their elected representatives at the federal, state, or local levels to urge support of, or opposition to, proposed or pending legislative proposals.
Logic Model: A visual representation showing the sequence of related events connecting the activities of a program with the programs' desired outcomes and results.
Maintenance of Effort: A requirement contained in authorizing legislation, or applicable regulations that a recipient must agree to contribute and maintain a specified level of financial effort from its own resources or other non-government sources to be eligible to receive federal grant funds. This requirement is typically given in terms of meeting a previous base-year dollar amount.
Memorandum of Understanding (MOU) or Memorandum of Agreement (MOA): Document that describes a bilateral or multilateral agreement between parties expressing a convergence of will between the parties, indicating an intended common line of action. It is often used in cases where the parties either do not imply a legal commitment or cannot create a legally enforceable agreement.
Nonprofit Organization: Any corporation, trust, association, cooperative, or other organization that is operated primarily for scientific, educational, service, charitable, or similar purposes in the public interest; is not organized for profit; and uses net proceeds to maintain, improve, or expand the operations of the organization. Nonprofit organizations include institutions of higher educations, hospitals, and tribal organizations (that is, Indian entities other than federally recognized Indian tribal governments).
Notice of Award (NoA): The official document, signed (or the electronic equivalent of signature) by a Grants Management Officer that: (1) notifies the recipient of the award of a grant; (2) contains or references all the terms and conditions of the grant and Federal funding limits and obligations; and (3) provides the documentary basis for recording the obligation of Federal funds in the HHS accounting system.
Objective Review: A process that involves the thorough and consistent examination of applications based on an unbiased evaluation of scientific or technical merit or other relevant aspects of the proposal. The review is intended to provide advice to the persons responsible for making award decisions.
Outcome: The results of program operations or activites; the effects triggered by the program. For example, increased knowledge, changed attitudes or beliefs, reduced tobacco use, reduced morbidity and mortality.
Performance Measurement: The ongoing monitoring and reporting of program accomplishments, particularly progress toward pre-established goals, typically conducted by program or agency management. Performance measurement may address the type or level of program activities conducted (process), the direct products and services delivered by a program (outputs), or the results of those products and services (outcomes). A "program" may be any activity, project, function, or policy that has an identifiable purpose or set of objectives.
Plain Writing Act of 2010: Plain Writing Act of 2010, Public Law 111-274 requires federal agencies to communicate with the public in plain language to make information more accessible and understandable by intended users, especially people with limited health literacy skills or limited English proficiency. The Plain Writing Act is available at www.plainlanguage.gov.
Program Strategies: Strategies are groupings of related activities, usually expressed as general headers (e.g., Partnerships, Assessment, Policy) or as brief statements (e.g., Form partnerships, Conduct assessments, Formulate policies).
Program Official: Person responsible for developing the FOA; can be either a project officer, program

manager, branch chief, division leader, policy official, center leader, or similar staff member.
Project Period Outcome: An outcome that will occur by the end of the FOA's funding period.
Public Health Accreditation Board (PHAB): A nonprofit organization that works to promote and protect the health of the public by advancing the quality and performance of public health departments in the U.S. through national public health department accreditation http://www.phaboard.org.
Statute: An act of the legislature; a particular law enacted and established by the will of the legislative department of government, expressed with the requisite formalities. In foreign or civil law any particular municipal law or usage, though resting for its authority on judicial decisions, or the practice of nations.
Statutory Authority: Authority provided by legal statute that establishes a federal financial assistance program or award.
System for Award Management (SAM): The primary vendor database for the U.S. federal government. SAM validates applicant information and electronically shares secure and encrypted data with federal agencies' finance offices to facilitate paperless payments through Electronic Funds Transfer (EFT). SAM stores organizational information, allowing www.grants.gov to verify identity and pre-fill organizational information on grant applications.
Technical Assistance: Advice, assistance, or training pertaining to program development, implementation, maintenance, or evaluation that is provided by the funding agency.
Work Plan: The summary of project period outcomes, strategies and activities, personnel and/or partners who will complete the activities, and the timeline for completion. The work plan will outline the details of all necessary activities that will be supported through the approved budget.
Activities: The actual events or actions that take place as a part of the program.

Administrative and National Policy Requirements, Additional Requirements (ARs): Administrative requirements found in 45 CFR Part 74 and Part 92 and other requirements mandated by statute or CDC policy. All ARs are listed in the Template for CDC programs. CDC programs must indicate which ARs are relevant to the FOA; awardees must comply with the ARs listed in the FOA. To view brief descriptions of relevant provisions, see http://www.cdc.gov/od/pgo/funding/grants/additional_req.shtm. Note that 2 CFR 200 will supersede the administrative requirements (A-110 & A-102), cost principles (A-21, A-87 & A-122) and audit requirements (A-50, A-89 & A-133).

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Best Available Evidence: Best Available Evidence can tell us if a program, practice, or policy did what it was supposed to do. What is considered "best available" differs across IVP topic areas with varying levels scientific evidence that show them to be effective. While some strategies may be evidence-based, others may be in support of an evidence-based strategy or building capacity for them. In this analysis, states using at least one (1) strategy that is best available evidence or an "activity that is supportive of best available evidence" for each BASE Priority Focus Area are considered to have met the evidence requirement. More information about best available evidence can be found at http://vetoviolence.cdc.gov/index.php/understanding-evidence.

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IVP: Injury and Violence Prevention

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SHD: State Health Department

Statute: An act of the legislature; a particular law enacted and established by the will of the legislative department of government, expressed with the requisite formalities. In foreign or civil law any particular municipal law or usage, though resting for its authority on judicial decisions, or the practice of nations.

Statutory Authority: Authority provided by legal statute that establishes a federal financial assistance program or award.

TBI: Traumatic Brain Injury

Technical Assistance: Advice, assistance, or training pertaining to program development, implementation, maintenance, or evaluation that is provided by the funding agency.

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