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**State Board of Health**

**December 8, 2022**

**11:00AM-1:30PM**

**Minutes**

Meeting can be viewed here: [Cisco Webex Meetings – Replay Recorded Meeting](#)

Minutes

1. Call to Order – 11:03 AM

- a. SBOH members present: Damon Arnold, Rashmi Chugh, John Herrmann, Angela Oberreiter, Karen Phelan, Janice Phillips, Julie Pryde, Erica Salem, Esther Sciammarella, Susan Swider
- b. SBOH members absent: Pilar Guerrero, Nathan Hoffman, Joe O'Connor
- c. IDPH staff present: Tyler Bohannon, Sean Dailey, Sara Ettinger, Noah Franklin, Allen Griffy, Don Jones, Lisa Masinter, Allison Nickrent, Amaal Tokars
- d. Guests: Dr. Jerrold Leikin

2. Public Comment – Dr. Jerrold Leikin

- a. I believe a comprehensive cannabis approach is required to avoid a cannabis epidemic and can include (my opinions in no particular order):
  - Recreational cannabis dispensaries should not be considered or designated as an "essential business" by public health or governmental entities (as was done by approximately 22 states early in the COVID pandemic).
  - State Medical Cannabis laws should distinguish between all cannabis analogues (CBD, Delta 9 THC, Delta 8 THC, etc.).
  - Standard product labeling should occur for all medicinal and recreational cannabis products.
  - Consumer education as to the hazards of cannabis (THC) use: A licensed clinician should be available for consumer questions at all medical cannabis dispensaries (as mandated in New York State).
  - Quality control and validation of precise doses should occur prior to selling all cannabis products to consumers. This should include analytical measurement of possible contaminants (especially herbicides and pesticides).
  - Banning all edible cannabis products. (This was passed by the Illinois State Medical Society or ISMS a few years ago.) We have been teaching for decades that medicine is not candy.
  - Discourage use of inhalation products (smoking or vaping) as a delivery method.
  - Encouraging medical examiners & coroners to do their job! That is obtaining and interpreting postmortem cannabis concentrations and list cannabis intoxication as a contributing cause of death in traumatic or medical deaths when appropriate.

- Stop the overpromotion by state public health agencies of cannabis for medical issues - no drug is effective for dozens of divergent medical conditions.
  - Encourage the rapid serum or urine quantitation of THC (and its metabolites) by hospitals/medical centers for clinical use.
  - Develop rapid qualitative urine tests for identification of synthetic cannabis exposure. (This is the next phase of the cannabis epidemic.)
  - Adoption of strict but reasonable cannabis DUI laws (Blood/serum THC < 1 ng/ml as adopted in most of Europe).
  - Stop the elimination of urine cannabis assays in occupational drug testing.
  - Promote the education of adolescents in secondary schools regarding the hazards of cannabis.
  - Promote potency limits for medical and recreational cannabis.
  - Improving access for adolescents to addiction medicine services in this state (which are virtually nonexistent).
- b. These are just a few suggestions that I have been advocating for in Illinois for about a decade to minimize the effects of the coming cannabis epidemic. Attached are relevant references and some of my previous resolutions (all passed through ISMS).
- c. Link to an article published recently about the hazards of recreational cannabis: <https://bmjopenrespres.bmj.com/content/9/1/e001216>

### 3. Updates

- a. IDPH Director's Office Update—Dr. Amaal Tokars
- i. Want to highlight three emerging public health issues.
1. There has been an ongoing Ebola virus outbreak for the last several months in Uganda.
    - a. Preparations continue to be made in the U.S. in the event of an outbreak.
  2. Monkeypox abbreviations have changed. WHO and CDC now refer to as Mpox.
    - a. Exponential increase in cases during summer.
    - b. Cases have decreased to a modest level as of December.
    - c. Illinois experienced the same peak the nation experienced.
  3. Respiratory surge is also an emerging concern.
    - a. Serious illness associated with surge is increasing.
    - b. Overarching role of public health is to provide risk mitigation.
    - c. Important to recognize risk factors and when to take corrective action.
    - d. Unvaccinated population poses a persistent risk.
    - e. Importance of vaccination cannot be overstated.
    - f. Crowded places with high community transmission are an ongoing concern.
    - g. One dozen counties in Illinois experienced high community levels in December.
    - h. Persons should be agile whenever appropriate.
- ii. Grateful to members of the board for their contributions in 2022.

### 4. Old Business

- a. Review of 9/8/22 State Board of Health Minutes—Karen Phelan, State Board of Health Chair
  - i. Approved with amendments.
- b. Review of 11/10/22 Rules Committee Minutes—Karen Phelan, Rules Committee Chair
  - i. Approved with amendments.
- c. Review of 11/17/22 Rules Committee Minutes—Karen Phelan, Rules Committee Chair
  - i. Approved with amendments.

5. New Business

- a. CDC Infrastructure Grant—Noah Franklin
  - i. *(See PowerPoint presentation)*
- b. Rule Review—77 IAC 590—Don Jones
  - i. This is in accordance with amendment to Public Act 102-0888.
  - ii. That amendment made changes to the Underserved Physician Workforce Act
  - iii. Provided educational loan repayment assistance to physicians and IDPH managed the program.
  - iv. Eligible providers were expanded to include not only physicians but physician’s assistants and APRN’s.
  - v. Hospitals and rural health clinics now qualify as a site where eligible health care providers can qualify for educational loan repayment assistance.
  - vi. Rulemaking conforms to statutory changes and other cleanups.
  - vii. \$1 million appropriation.
  - viii. Approved for filing with the Secretary of State for first notice.
- c. Rule Review—77 IAC 955 – Allen Griffy
  - i. Rulemaking is for the Health Care Worker Background Check Code.
  - ii. Public Act 102-1063 recently passed allowing for an individual’s taxpayer ID in addition to social security number to be entered on registry.
  - iii. Incorporates conforming language to Health Care Worker Background Check Code to be in compliance with statute.
  - iv. Other cleanup associated with references throughout the Code.
  - v. Approved for filing with the Secretary of State for first notice.
- d. Rules Presentation—Allison Nickrent
  - i. Postponed
- e. Rules Status Update—Tracey Trigillo
  - i. Postponed
- f. Infant Mortality CBO Efforts—Dr. Lisa Masinter
  - i. *(See PowerPoint presentation)*
- g. SIREN Review—Karen Phelan
  - i. Department provides the opportunity for members to utilize SIREN notifications.
- h. Elections—Karen Phelan
  - i. Motion to elect Dr. Damon Arnold State Board of Health Policy Committee Chairman, 2023, unanimous consent.
  - ii. Vice-chair John Herrmann in the Chair
  - iii. Motion to elect Karen Phelan State Board of Health Rules Committee Chair, 2023, unanimous consent.

- iv. Motion to elect Karen Phelan State Board of Health Chair, 2023, unanimous consent.
  - v. Chairwoman Karen Phelan in the Chair.
  - vi. Motion to elect John Herrmann State Board of Health Vice-chair, 2023, unanimous consent.
- i. Bylaw Review—Karen Phelan
  - i. Bylaws shall be annually reviewed by members of the Board.
  - ii. No concerns raised regarding current bylaws.
- 6. Proposed 2023 Meetings
  - a. **STATE BOARD OF HEALTH 11:00 - 1:30 PM**
    - i. March 9
    - ii. June 8
    - iii. September 7
    - iv. December 7
  - b. **STATE BOARD OF HEALTH RULES COMMITTEE 1:00 – 3:00 PM**
    - i. February 16
    - ii. May 11
    - iii. August 17
    - iv. November 9
  - c. **STATE BOARD OF HEALTH POLICY COMMITTEE 1:00 - 3:00 PM**
    - i. February 23
    - ii. May 18
    - iii. August 24
    - iv. November 16
- 7. Adjournment – 1:31 PM

# How Physicians Can Combat the Cannabis Epidemic

The medical community can mitigate the societal implications of THC toxicity through a variety of interventions **By Jerrold B. Leikin, MD**

**With the explosion of cannabis use primarily due to the enacting of recent medical and recreational cannabis legislation, physicians will be at the forefront to recognize, prevent, and manage its adverse medical effects.**

**T**HE STATISTICS are staggering and indicative of a drug related epidemic. The YouGov study commissioned by the Chicago-based Cresco Labs estimated that 25% of Americans used cannabis in some form within the past year (an increase from 16% when studied in 2018). Last year, Illinois ranked fourth in per capita sales of adult use cannabis (\$52.81) according to Marijuana Business Daily (Oregon ranked first with \$87.38 per capita sales). In June 2021 alone, there were 2,513,676 individual cannabis sales (in a state of 12.7 million) for adult use, according to the Illinois Department of Financial and Professional Regulation.

With the explosion of cannabis use primarily due to the enacting of recent medical and recreational cannabis legislation, physicians will be at the forefront to recognize, prevent, and manage its adverse medical effects. As such, recognition and following basic medical principles are essential tools in mitigating the population, societal, and collateral effects of widespread cannabis use.

Through the binding of the psychoactive component delta-9-tetrahydrocannabinol (THC) to endocannabinoid (CB1) receptors in the brain, THC can cause a myriad of acute and chronic effects that are primarily neurologically mediated (see Table). This can be manifested as neurobehavioral, cardiac, and gastrointestinal presentations to the primary care physician, emergency department, critical care units, and psychiatry.

The medical community can mitigate the societal implications of THC toxicity through a variety of interventions:

- **Identify THC toxicity in a patient.** Toxicity can be determined when there is awareness of possible presenting clinical signs as described in Table 1 (with analytical drug test confirmation). Appropriate diagnosis of marijuana use disorder (with suitable referrals as needed) can then be made. Patient education about THC's adverse effects must be prioritized by any practitioner involved in authorizing or dispensing cannabis.
- **Prevention of accidents caused by THC use.** Since the legalization of recreational cannabis in January 2020, traffic fatalities have increased in the year 2020 in Chicago and Illinois by 45% and 16%, respectively. Due to its prolonged half life, the neurobehavioral effects of THC can last for several hours after the subjective effects dissipate, thus leading to prolonged times of

impairment. Furthermore, due to the complicated pharmacokinetics of THC, the duration of toxicity is not predictable. This is different than with ethanol (which is metabolized in the liver at a rate of 10 to 30 mg/dl/hour to inactive metabolites through zero-order kinetics) and therefore any analogies to ethanol-induced impairment (particularly "per-se" thresholds) are not applicable.

- **Identification of cannabis as a contributing cause of death by coroners, medical examiners, and pathologists.** Medical examiners and coroners have not followed any specific guidelines as to death determination and contribution by THC. Certainly, the hyper-adrenergic effects of THC (which peak within 20 minutes of inhalation use) can contribute to myocardial ischemia in individuals with underlying coronary artery disease, leading to myocardial infarctions. Furthermore, any postmortem blood THC concentration over one ng/ml must receive consideration as a contributing factor to any acute traumatic accident death, due to the neurobehavioral effects (as described in Table). Additionally, since the half-life of THC is several hours and this substance is highly lipophilic, multiple times of use on a daily basis can lead to accumulation and thus chronic toxic effects.
- **Monitor THC levels for toxicity.** A qualitative urine drug screen only indicates the use of THC within approximately a week (assuming use once or twice weekly). The peak concentration of urinary cannabis metabolite (Carboxy-Tetrahydrocannabinol or THC-COOH) after one dose use of inhalational (vaping or smoking) THC is approximately 50 ng/ml. One must suspect acute toxic effects if the urinary THC-COOH level exceeds 100 ng/ml. This urinary concentration marker may also be the optimum metric for cannabis accumulation and its resultant chronic toxicity.
- **Be aware of vulnerable population exposures.** Prenatal exposures have been associated with increased risk of anemia, low birth weight, and neonatal intensive care unit placement. Inadvertent exposures to toddlers and the elderly can lead to adverse cardiac, neurological, and psychiatric effects that necessitate hospitalization. There was a 13.6-fold increase in pediatric edible exposures from 2018 to 2020 called into the Illinois Poison Center (IPC). 150 exposures (with five patients exhibiting severe

effects) to edible marijuana products in children younger than 6 years were reported to the IPC in 2020; this is an increase from 11 edible exposures in 2018 and 35 in 2019.

- **If THC is authorized for any medical rationale, monitor for THC toxicity and inform patients about its side effects and toxic profile.** Drug interactions have not been fully studied and there is limited data on the significance of such interactions. Furthermore, titration is very difficult due to the unpredictability of cannabis kinetics and the possibility of accumulation. It is known that cannabis has significant synergistic effects with ethanol (as to impairment), and other central nervous system depressants—therefore drug interactions may be a consideration in susceptible patients.
- **Be aware of synthetic cannabinoid use.** Escalating use of cannabis may indicate tolerance to its psychogenic effects. The plant-based product can only provide a certain percentage of active psychogenic chemical concentration. Tolerant users may attempt to increase the potency of cannabis by spraying or mixing the plant material with a synthetic product (often known as K2, spice, Kush, fake weed). This will increase the neurotoxicity of cannabis, often causing agitation, violent behavior, seizures, and psychosis. Additionally, newer analogues and isomers of THC (such as delta-8-tetrahydrocannabinol) will be appearing, each with its own unique pharmacodynamics and toxicity profile.
- **Do not over promote the benefits of cannabis.** There are virtually no drugs that are medically useful for dozens of diverse conditions. It should be remembered that cannabis directly modifies the pathophysiology of only one disease process - glaucoma. (The official statement of the American Glaucoma Society is: Although marijuana can lower the intraocular pressure (IOP), its side effects and short duration of action, coupled with a lack of evidence that its use alters the course of glaucoma, preclude recommending this drug in any form for the treatment of glaucoma at the present time. Found at <https://www.americanglaucomasociety.net/about/statement>).
- **Consider contaminants.** Within the past four

years, we have already witnessed two extensive outbreaks of contamination in illicit cannabis products. In 2018, brodifacoum-laced synthetic cannabis resulted in major bleeding events in over 150 cases. Additionally, in the fall/winter of 2019/2020, almost 3,000 individuals were hospitalized with severe bilateral pneumonitis from e-cigarette vaping use-associated lung injury (EVALI). This was eventually linked to a contaminant (Vitamin E acetate) found in illicit vaping cartridges—particularly illicit THC containing products. Both of these outbreaks were centered in the Midwest.

## Conclusion

Physicians, public health leaders, and legislators should remember the primary principle in toxicology as articulated by the alchemist Paracelsus (1493-1534): “dosis sola facit venenum”—it is the dose that makes the poison. There is no exception to this fundamental concept in medical toxicology. Therefore, it is incumbent upon all leaders to recognize and possibly implement a THC potency cap (as has been proposed in Florida (HB 1455), Massachusetts (HD 2841), Montana (SB 341), Washington State (HB 1463), and will be implemented in Vermont starting in 2022. Unlimited and unrestricted use of THC (whether medicinal or recreational) will lead to collateral adverse societal effects as we have seen with the continuing opioid epidemic. The medical community will be required to identify and intervene at the patient care level in order to mitigate this legislatively iatrogenic toxic surge that we are just beginning to experience.

Disclaimer: The views and opinions expressed in this article are those of the author and do not necessarily reflect the official policy or position of any institution. The author has no financial conflicts of interest to disclose.

For a list of references, please email [esidney@cmsdocs.org](mailto:esidney@cmsdocs.org) or [jerroldleikin@gmail.com](mailto:jerroldleikin@gmail.com).

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**There are virtually no drugs that are medically useful for dozens of diverse conditions.**

## Medical Effects of Cannabis Use

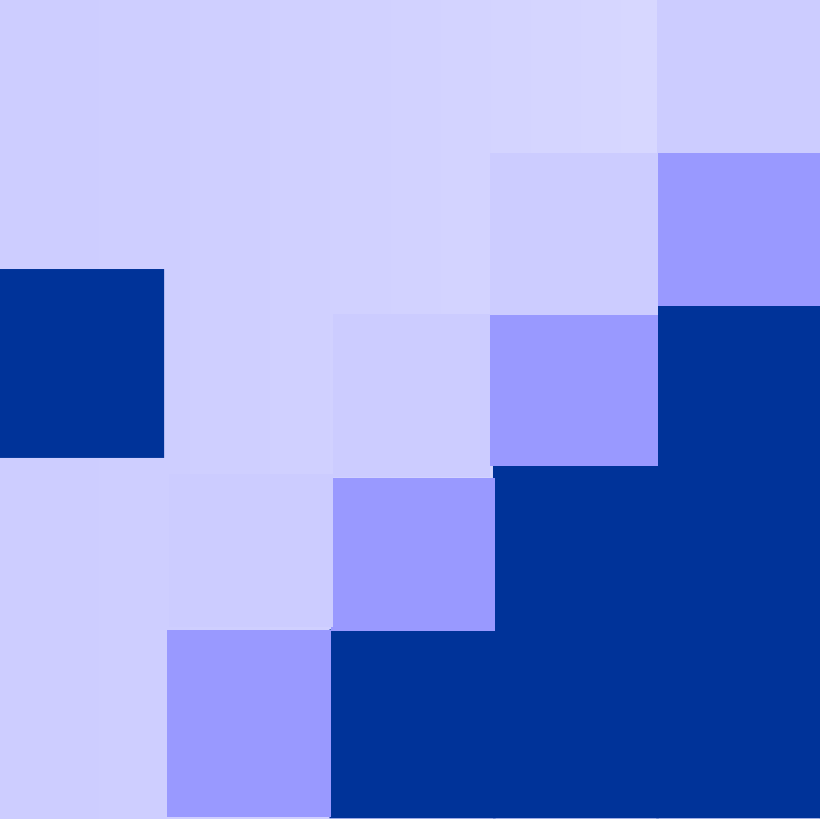
### Acute

- Hyperadrenergic symptoms (tachycardia for up to 3 hours, elevated systolic blood pressure, agitation)
- Orthostatic hypotension
- Dizziness

- Impaired judgement and problem solving
- Impaired balance/ataxia
- Increase in reaction time
- Visual perceptual abnormalities
- Increase in appetite and thirst
- Urinary frequency
- Anxiety
- Paranoia
- Acute dysphoria/panic attacks
- Visual hallucinations

### Chronic

- Psychosis
- Paranoid delusions
- Exacerbation of psychiatric disorders
- Cannabinoid hyperemesis syndrome
- Cognitive impairment
- Withdrawal syndrome (approximately 10%)



Illinois Department of Public Health

Federal Grant Project Title:  
“Strengthening Illinois’s  
Public Health  
Administration (SIPA)”

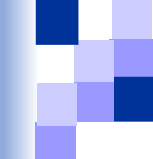
**Noah Franklin, MPA**

**Project Manager, Office of the Director**

# Overview

- Submitted in August for IDPH's proposed infrastructure program, ***"Strengthening Illinois's Public Health Administration (SIPA)"***. **Received \$88 million for the first year**, and future four years of funding will be based on satisfactory programmatic progress and the availability of funds. **We had proposed to:**
  - Create **65 new positions**
  - Implement **23 major activities** & achieve **100 milestones**
  - Improve ***Workforce and Foundational Capacities***





# CDC Infrastructure Grant: High Level

- **What the grant is:**
  - An opportunity to invest in and rebuild the public health workforce
  - An opportunity to build public health departments' capacities
  - An opportunity to improve our functions and systems
  - An opportunity to create pipelines to institutions to recruit and grow new staff from underrepresented communities, fields, or backgrounds.

# Grant Priorities/ Requirements

- Funding to be used for *short-term critical infrastructure & workforce needs, & long-lasting strategic investments*. Needed to allocate for positions & activities to *strengthen internal operations* to support all offices:
  - **Workforce- Hire, retain, support & train the workforce**
    - Key activities include **creating a workforce development plan**, retaining/recruiting staff, addressing staff wellness, providing training/professional development opportunities, improving systems and capacity related to workforce development & management
  - **Foundational Capabilities- Improve operational & administrative capabilities**
    - Key activities include strengthening communications, policy development, improving organizational competencies, connecting data and health equity, addressing emergency preparedness/response, improving community partnership development, and strengthening accountability/performance management

# Grant Priorities/ Requirements (cont.)

## ■ Grant also prioritized other areas:

- Provide ***technical assistance & support for LHDs*** in accreditation & environmental health
- Sustain ***programs/positions created for 5 existing IDPH CDC grants*** expiring in next two years
- Support programs to ***improve department's ability to advance health equity***
- Address ***health disparities for populations at higher risk & in medically underserved communities***

# Major Strategies Planned

## Workforce

We've proposed to:

- 1) Increase partnerships with institutions to create pipelines into positions to grow the workforce
- 2) Improve job descriptions to better attract qualified candidates
- 3) Offer training on implicit bias to those involved in the hiring process
- 4) Create upward mobility within position series
- 5) Conduct a workforce development assessment, which will inform a workplan that will identify critical vacancies
- 6) Provide a variety of training opportunities to staff to enhance their skillset
- 7) Offer more opportunities for feedback & input into workforce & engagement opportunities

# Major Strategies Planned (cont.)

## Foundational Capabilities

We plan to:

- 1) Assess where we can make improvements in fiscal systems & grantmaking
- 2) Invest in developing department-wide quality improvement system
- 3) Increase ability to use data through an equity lens to make programmatic decisions

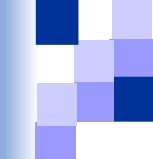
For LHDs, proposed to:

- 1) Create learning community for unaccredited LHDs for PHAB accreditation & providing technical assistance for LHDs facing accreditation
- 2) Train LHDs on assessment/planning models
- 3) Support LHDS & community organizations to execute initiatives to address health inequities
- 4) Provide LHDs with technical advice, education & training for inspecting food industry
- 5) Provide LHDs with training on using environmental health data through health equity lens

# Workforce Funding

## Workforce

- Funding amount: \$83,321,024 for five years to be awarded all at once
  - \$49,992,614 or approximately \$10m/year total available to IDPH
  - **\$33,328,409 or approximately \$6.6m/year total available to all Illinois Local Health Departments** (LHDs) who did not apply/are not funded
- **LHD Workforce Development Grants- Funding to support 67 LHDs:**
  - Recruiting, hiring, or retaining public health staff
  - Training new and existing staff
  - Strengthening workforce planning, systems, processes, and policies
  - Efforts to support and sustain the public health workforce



# Key Grant Positions

**Chief Operating Officer-** Principal Investigator (PI)

**Workforce Director-** Oversee implementation of workforce activities

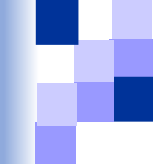
**Project Director-** Support PI, External Evaluator (UIC), & coordination of implementation of all activities

**Project Coordinator-** Assist Project Director

**External Evaluator (UIC)-** Implement evaluation & collaborate with CDC evaluation contractors

**Program Evaluator-** Support UIC in evaluation & performance management

**Program Manager-** Support UIC & Program Evaluator



# Next Steps

- We plan to attend CDC meetings today and tomorrow for grant recipients to learn more about the award, including expectations, roles & responsibilities, timelines, and technical assistance.
- We also plan to meet next week with our CDC Grant Project Officer to discuss our work plan and budget revisions and answer specific questions we have.
- In addition, we plan to meet next week with LHDs discuss how will proceed to provide 40% of our total workforce funding to LHDs to ensure that these funds are dispersed to LHDs within the first year of the grant.





**Centers for Disease Control and Prevention**

Center for Surveillance, Epidemiology, and Laboratory Services

Strengthening U.S. Public Health Infrastructure, Workforce, and Data Systems

CDC-RFA-OE22-2203

08/15/2022

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### Part I. Overview

Applicants must go to the synopsis page of this announcement at [www.grants.gov](http://www.grants.gov) and click on the "Subscribe" button link to ensure they receive notifications of any changes to CDC-RFA-OE22-2203. Applicants also must provide an e-mail address to [www.grants.gov](http://www.grants.gov) to receive notifications of changes.

#### A. Federal Agency Name:

Centers for Disease Control and Prevention (CDC)

#### B. Notice of Funding Opportunity (NOFO) Title:

Strengthening U.S. Public Health Infrastructure, Workforce, and Data Systems

#### C. Announcement Type: New - Type 1:

This announcement is only for non-research activities supported by CDC. If research is proposed, the application will not be considered. For this purpose, research is defined at <https://www.gpo.gov/fdsys/pkg/CFR-2007-title42-vol1/pdf/CFR-2007-title42-vol1-sec52-2.pdf>. Guidance on how CDC interprets the definition of research in the context of public health can be found at <https://www.hhs.gov/ohrp/regulations-and-policy/regulations/45-cfr-46/index.html> (See section 45 CFR 46.102(d)).

New - Type 1

#### D. Agency Notice of Funding Opportunity Number:

CDC-RFA-OE22-2203

#### E. Assistance Listings Number:

93.967

#### F. Dates:

##### 1. Due Date for Letter of Intent (LOI):

06/30/2022

Recommended but not Required  
LOI due date: 6/30/2022  
Project Officer: Jonathan Carlson  
Email address: PHInfrastructure@cdc.gov

## **2. Due Date for Applications:**

08/15/2022

11:59 p.m. U.S. Eastern Standard Time, at [www.grants.gov](http://www.grants.gov).

## **3. Due Date for Informational Conference Call:**

June 29, 2022

**Applicant Informational calls:** CDC will host 2 informational calls for interested applicants. The content of both calls will be identical. The 2 times are offered as a way to help accommodate the schedules of interested applicants and their locations in varying time zones. Due to limited space, we ask that interested applicants only register for Webinar A or B, but not both.

When: June 29, 2022 3:00 to 4:00 PM Eastern Time (U.S. and Canada)

Topic: OE22-2203 Applicant Informational Call A

Register in advance for this webinar:

[https://cdc.zoomgov.com/webinar/register/WN\\_V5iIgBryTBCUwpp1xxgDqA](https://cdc.zoomgov.com/webinar/register/WN_V5iIgBryTBCUwpp1xxgDqA)

When: June 29, 2022 6:00 to 7:00PM Eastern Time (U.S. and Canada)

Topic: OE22-2203 Applicant Informational Call B

Register in advance for this webinar:

[https://cdc.zoomgov.com/webinar/register/WN\\_jrPD018uQMCydBMi6d9vew](https://cdc.zoomgov.com/webinar/register/WN_jrPD018uQMCydBMi6d9vew)

## **F. Executive Summary:**

### **Summary Paragraph**

The COVID-19 pandemic has led to a historic investment in the infrastructure of U.S. public health agencies. This NOFO is drafted to provide support for core infrastructure improvements that include, but are not limited to, these agencies' workforce, foundational capabilities, and data infrastructure. Stronger infrastructure will serve immediate needs to respond to the ongoing COVID-19 pandemic and other public health outcomes that worsened or stalled during the COVID-19 pandemic. The investments will have sustained effects that position these agencies to better meet the ongoing and future public health needs of the communities and populations they serve.

All recipients under Component A will receive workforce and foundational capabilities funding and recipients of Component B will also be funded. Only some recipients, to be determined, under Component A will receive data modernization initiative funding. All awards are subject to availability of funds.

### **a. Eligible Applicants:**

Open Competition

### **b. NOFO Type:**

G (Grant)

**c. Approximate Number of Awards**

116

**Component A:** 111

**Component B:** 5

**d. Total Period of Performance Funding:**

\$3,945,000,000

**e. Average One Year Award Amount:**

\$21,938,000

**Component A**

Strategy A1 Workforce: \$20,000,000

Strategy A2 Foundational capabilities: \$1,260,000

Strategy A3 Data modernization: \$678,000

**Component B:** \$9,000,000

These amounts are subject to the availability of funds.

**f. Total Period of Performance Length:**

5

**g. Estimated Award Date:**

November 01, 2022

**h. Cost Sharing and / or Matching Requirements:**

No

**Part II. Full Text**

**A. Funding Opportunity Description**

**1. Background**

**a. Overview**

The COVID-19 pandemic emphasized the critical importance of a robust public health system. Public health departments and other public health partners need to continue their work to respond to COVID-19 and prepare for future public health emergencies. The pandemic also accentuated long-standing weaknesses and created new challenges to the U.S. public health infrastructure. Moreover, COVID-19 affected nearly every aspect of healthcare and public health, laying bare disparities and gaps in some conditions and worsening others. Public health partners need the capacity to regain their footing in these areas and then accelerate their efforts.

This funding is intended to help meet critical infrastructure needs in the short-term; it should also make possible strategic investments that will have lasting effects on public health agencies across the United States. To that end, Component A will support strategically strengthening public health infrastructure and systems related to the workforce, foundational capabilities, and data infrastructure. Component B will support Component A recipients to implement key strategies more efficiently and effectively, by providing technical assistance, evaluation leadership and support, and mechanisms for communication and coordination across all recipients.

Maximum flexibility will be provided to the recipients to carry out this work consistent with the purpose of the funding and the scope of this NOFO. The scope of possible workforce investments is wide, including hiring, retaining, supporting, and training the workforce; there will be no restrictions on the types of positions that can be hired for public health capacity building. Other investments and improvements to foundational capabilities will help modernize public health agencies and position them to be even better service providers and partners. Investments and improvements to modernize the data infrastructure will serve to improve efficiency and effectiveness of those organizations' operations and public health work, including their ability to partner in a complex health and health care environments. These outcomes will lead to public health services being improved, and in turn public health outcomes including COVID-19 will be better addressed.

Across areas, this should be part of a transformation of public health agencies needed to meet the evolving and complex needs of the U.S. population. This transformation will improve public health internal systems and operations. This will necessarily involve creating and strengthening partnerships at all levels. This funding also recognizes a history of underinvestment in U.S. communities that have been economically or socially marginalized, are located in rural geographic areas, are composed of people from racial and ethnic minority groups, are medically underserved, and are disproportionately affected by COVID-19 or other priority public health problems. This program also should support larger efforts to rebalance these investments and serve communities and populations in a more equitable way.

All recipients will receive workforce and foundational capabilities funding under Component A and recipients of Component B will also be funded. Only some recipients, to be determined, requesting A3 Data modernization funding will be funded.

All awards and funding are subject to availability of funds.

#### **b. Statutory Authorities**

Section 317(k)(2) of the Public Health Services Act [42 USC 247b(k)(2), as amended]; the American Rescue Plan 2021 Subtitle F—Public Health Workforce, SEC. 2501

#### **c. Healthy People 2030**

The "*Healthy People 2030*" focus areas of:

- [Public Health Infrastructure](#)
- [Health Conditions](#) (such as [Respiratory Diseases](#))
- [Health Behaviors](#) (such as [Emergency Preparedness](#) or [Vaccinations](#))
- Social Determinants of Health (such as [Health Care Access and Quality](#))
- Healthcare [Workforce](#)
- [Hospital and Emergency Services](#)

#### **d. Other National Public Health Priorities and Strategies**

- [HHS Action Plan to Reduce Racial and Ethnic Health Disparities: A Nation Free of Disparities in Health and Health Care](#)
- [CDC CSTLTS and NACCHO's Public Health Infrastructure and Systems](#)

- [HRSA's Health Workforce Strategic Plan](#)
- [ASPR/PHE's US Health Security National Action Plan](#)
- [National Institute of Health's Workforce Planning Toolkit](#)
- [Data Modernization Initiative Strategic Implementation Plan](#)

#### e. Relevant Work

This NOFO is complementary and non-duplicative of many CDC program activities, public health priorities, and strategies, in particular:

- [CDC-RFA-OT21-2103](#): National Initiative to Address COVID-19 Health Disparities Among Populations at High-Risk and Underserved, Including Racial and Ethnic Minority Populations and Rural Communities
- [CDC-RFA-CK19-1904](#): Epidemiology and Laboratory Capacity for Prevention and Control of Emerging Infections Diseases (ELC)
- [ELC Enhancing Detection Emerging Issues Project](#): Funding for the Enhanced Detection, Response, Surveillance, and Prevention of COVID-19
- [Accelerating Data Modernization in Public Health Departments | DMI Support | CDC](#): funding under the ELC cooperative agreement for data modernization, electronic case reporting, and vital statistics systems strengthening
- [CDC-RFA-PS19-1901](#): Strengthening Sexually Transmitted Disease Prevention and Control for Health Departments - Supplement for Disease Intervention Services (DIS) Workforce Development
- [CDC-RFA-TP22-2201](#): Public Health Crisis Response Cooperative Agreement
- [CDC RFA-OT18-1803](#): Tribal Public Health Capacity Building and Quality Improvement
- [CDC-RFA-OT20-2004](#): Supporting Tribal Public Health Capacity in Coronavirus Preparedness & Response

## 2. CDC Project Description

### a. Approach

**Bold** indicates period of performance outcome.

Logic Model: Strengthening US Public Health Infrastructure, Workforce, and Data Systems (Components A and B)

| Strategies                                                   | Short-Term Outcomes                                | Intermediate-Term Outcomes                                            | Long-Term Outcomes                                      |
|--------------------------------------------------------------|----------------------------------------------------|-----------------------------------------------------------------------|---------------------------------------------------------|
| Component A: Strengthening public health (PH) infrastructure |                                                    |                                                                       |                                                         |
| Strategy A1: Workforce                                       | <b>ST1. Increased hiring of diverse staff (A1)</b> | <b>I1. Increased size and capabilities of the PH workforce (A1-2)</b> | LT1. Accelerated prevention, preparedness, and response |
| Strategy A2: Foundatio                                       | <b>ST2. Improved organizational systems &amp;</b>  | <b>I2. Stronger PH</b>                                                |                                                         |

|                                                                |                                                                                                                        |                                                                                                                                        |                                                                  |
|----------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------|
| nal capabilities                                               | <b>processes (A2)</b>                                                                                                  | <b>foundational capabilities (A1-3)</b>                                                                                                | to emerging threats (A1-3)                                       |
| Strategy A3: Data modernization                                | <b>ST3. More modern and efficient data infrastructure (A3)</b><br><br><b>ST4. Increased data interoperability (A3)</b> | <b>I3. Increased availability and use of PH data (A3)</b><br><br>I4. Increased reach of PH services (A1-3)                             | LT2. Improved other public health outcomes (A1-3)                |
| Component B: Technical assistance for public health agencies   |                                                                                                                        |                                                                                                                                        |                                                                  |
| Strategy B1: Training and technical assistance for Component A | ST1. Increased grant implementation knowledge & skills among Component A recipients (B1, B2)                           | I1. Increased effectiveness of strategy implementation among Component A recipients (B1, B2)                                           | LT1. Increased achievement of Component A grant outcomes (B1-B3) |
| Strategy B2: Grant program evaluation                          | <b>ST2. Increased hiring &amp; retention mechanisms available to Component A recipients (B1)</b>                       | I2. Increased efficiency of strategy implementation among Component A recipients (B1, B2)                                              | LT2. Strengthened capacity of Component A recipients (B1-B3)     |
| Strategy B3: Grant coordination & communication                | ST3. Increased knowledge about grant processes & outcomes among Component A recipients, CDC, & other partners (B2, B3) | <b>I3. Improved sharing of lessons learned &amp; evidence among Component A recipients, CDC, and other interested partners (B1-B3)</b> |                                                                  |

### i. Purpose

Component A will serve many purposes. First, it will enable recipients to hire, retain, sustain, and train the public health workforce, and strengthen their foundational capabilities. Also, with investments in data modernization, public health services will be expanded, improved, and accelerated, and in turn public health concerns including COVID-19 will be better addressed. The purpose of Component B is to support successful implementation of Component A, by providing technical assistance, evaluation support, and coordination and communication support among relevant partners.

### ii. Outcomes

Under Component A, strategy A1 Workforce, the key outcomes that recipients are expected to achieve by the end of the period of performance include increased hiring of diverse staff and increased size and capabilities of the public health workforce with improved wages and protections. For strategy A2 Foundational capabilities, the key outcomes include improved organizational systems and processes and evidence of stronger public health foundational capabilities. For strategy A3 Data modernization, key outcomes include a more modern and efficient data environment, increased data interoperability, and increased availability and use of

public health data. Key outcomes specific to Component B include increased hiring and retention mechanisms available to Component A recipients and, in the longer term, improved sharing of lessons learned and evidence among Component A recipients, CDC, and other interested partners.

### **iii. Strategies and Activities**

#### **Component A: Strengthening Public Health Infrastructure**

##### **Key principles**

All work under Component A should be grounded in three key principles:

- The need for data and evidence to drive planning and implementation
- The critical role that partnerships will play in success, and
- The imperative to direct these resources in a way that supports health equity

All planning for investments in workforce, foundational capabilities, and data modernization must be driven by careful, strategic thinking, relevant data and evidence, and engagement with key partners. Recipients should take the time needed to plan these investments in ways that meet their needs and contexts. Strategic, data-driven planning should help maximize the benefits of these investments to public health agencies and the populations they serve. This approach should continue throughout implementation, to guide any needed course corrections and generate evidence about the effectiveness of strategies implemented through this grant.

Across the strategies below, recipients will need to collaborate and coordinate with a wide range of partners, to support planning, implementation, and evaluation. Those partners may vary across strategies and across recipients, but the need to devote significant funding and staff time toward building and strengthening old and new partnerships will be a common thread.

Across the strategies below, recipients are expected to approach planning and implementation with health equity, diversity, equity, inclusion, and accessibility in mind. How this looks may vary by strategy. For example, workforce investments should include dedicated efforts to recruit staff from the communities they serve and continue to create a public health workforce that can meet the needs of all communities. Investments in the data should be directed in ways that help strengthen ties with, and services in U.S. communities that have been economically or socially marginalized, are located in rural geographic areas, are composed of people from racial and ethnic minority groups, are medically underserved, and are disproportionately affected by COVID-19 or other priority public health problems.

#### **Strategy requirements for recipients of Component A**

Applicants are encouraged to apply for all Strategies A1-A3 and to propose work under some or all Key Activities, to benefit from this opportunity. Applicants that apply for Strategy A1 must include Key Activity 6: at a minimum, this includes: supporting a fulltime Workforce Director and evaluation staff. Applicants may support a Data Modernization Director under strategy A1 Workforce, but this is not required.

#### **Additional strategy requirements for statewide recipients of Component A**



No less than 40% of the funding provided to state health department recipients for Strategy A1 Workforce should be distributed among the local health departments that have not received direct funding from this grant. All recipients should demonstrate how they will reduce or eliminate the administrative requirements and reporting burden put upon local public health departments and nonprofit organizations supporting grant activities. No recipient should request or require additional programmatic reports, work plans, or expenditure information from local health departments beyond what is required by the grant, unless otherwise required by law. State health departments should ensure that these funds are dispersed to their jurisdictional local health departments within the first year of the grant. (This guidance does not supersede state, and local rules, and regulations, or official funding agreements between state and local public health agencies.) These items should be described in the project and budget narrative.

### **Flexibility for recipients of Component A**

The strategies and activities outlined below are broad by design and intended to provide recipients with maximum flexibility to meet their needs. Applicants can apply for one or more of the Strategies A1-A3 below, and within any selected Strategy, applicants can apply for one or more of the Key Activities. Applicants can also propose Key Activities not listed under a strategy, so long as they clearly align under the broader strategy ([Appendix 1\\_Sample Activities for Component A.docx](#))

Strategies A1-A3 overlap to some extent, and recipients can fund and organize their proposed activities under whichever strategy they wish, given their program's priorities and budget. For example, workforce can be supported under all strategies as appropriate, and work related to data infrastructure can be supported under Strategy A2 Foundational capabilities and under Strategy A3 Data modernization. Similarly, activities to strengthen human resource and workforce related systems and processes can be supported under Strategy A1 Workforce or A2 Foundational capabilities.

### **Guidance for applicants to Component A**

In the narrative portion of the application, for each strategy for which they are applying, applicants should explain why they are applying for that strategy and describe the organizational transformations they expect to accomplish in 5 years under this grant. When information or data are lacking to support the rationale for a particular strategy, applicants should outline the purpose and timeframe for any new assessments or analyses that need to be conducted to guide work under this NOFO. Under each strategy, applicants should describe the Key Activities that they plan to implement in year one, if funded, and the reasons or evidence that make those activities both feasible and effective in the applicant's public health system and context. Applicants are encouraged to provide a description of their current state, key barriers or constraints to moving forward, and how these funds would be used to overcome or circumvent those barriers.

Each strategy being applied for should have a clear separate Abstract Narrative, Project Narrative and Budget Narrative with the following verbatim titles identifying each strategy: A1 Workforce, A2 Foundational capabilities, and A3 Data modernization.

### **Strategy A1 Workforce**

The intent of the strategy is to reinforce and expand the public health workforce by hiring, retaining, supporting, and training the workforce and by strengthening relevant workforce planning, systems, processes, and policies. The public health workforce that can be supported includes the full range of public health positions, across levels of workforce tenure and seniority, public health topic or program areas, and competencies. Positions may include those that are inherently public health in nature and those that are inherently cross-cutting or foundational in nature. The staff may work directly for the recipient or work for a governmental or non-governmental partner organization. ([Appendix 2\\_Example Workforce Positions and Position Descriptions.docx](#))

Under the strategy, recipients can fill vacancies and create new positions, and they can retain staff who are on term appointments, whom they wish to extend employment. Recipients can also make significant new investments in workforce engagement, well-being, and other related programs and services, to assist with retention and help improve emotional, mental, and physical health outcomes of the workforce. New and existing staff always need training, whether to refresh skills and knowledge or to learn new skills, given a dynamic public health work environment. Under this strategy, recipients can expand and strengthen training programs across focus or topic areas, intended audiences, methodologies, and formats. All trainings should strive to adhere to CDC's Quality Training Standards [[Quality Training Standards | Training Development | CDC](#)] and, when appropriate, to be made available through [CDC TRAIN](#).

Recipients also can use this grant to strengthen their own workforce and human resource related planning, systems, processes, and policies. Improving recipients' organizational administrative competencies related to human resource services may be necessary to accomplish the other Key Activities under this strategy. Some modifications and improvements may be put in place to assist directly with rapidly hiring, retaining, supporting, and training staff, but recipients may also pursue longer-term system or process improvements whose effects may not be felt immediately. As noted above, no less than 40% of the funding provided to state health department recipients for Strategy A1 Workforce should be distributed among the local health departments that have not received direct funding from this grant.

Across work in the strategy, recipients and their partners should prioritize recruiting and hiring staff who are from the communities and populations served. Recipients and their partners also should demonstrate a commitment to diversity, equity, inclusion, and accessibility in their workforce recruitment and selection processes, communication, and outcomes. Moreover, recipients and partners should strive to create high quality jobs with benefits, flexibilities, and salary levels that are attractive and provide job protection and security.

Some costs associated with recruitment and hiring are allowable, including supplies and equipment needed to perform their jobs, personal protective equipment, data management, and other necessary supplies. 45 CFR part 75 outlines the parameters related to allowable costs that might be implicated in proposed activities.

### **Strategy A1 Workforce: Specific requirements**

In addition to adhering to the three cross-cutting principles and the requirements outlined for all of Component A, applicants under Strategy A1 Workforce must also adhere to these requirements:

- Any applicant to this strategy should include significant work under Key Activity 1, Recruit and hire. Applicants are encouraged to apply to conduct work under all five Key Activities.
- Applicants must include Key Activity 6 related to supporting a Workforce Director, and evaluation staff. Supporting a DMI Director is an encouraged option, but not required.

**Strategy A1 Workforce: Key activities** (Refer to Appendix 1\_Sample Activities for Component A and Appendix 2\_Example Workforce Positions and Position Descriptions)

1. **Recruit and hire new public health staff.** For example, this could include expanding recruitment efforts, creating new positions, improving hiring incentives, and creating new hiring mechanisms.
2. **Retain public health staff.** For example, this could include strengthening retention incentives, creating promotional opportunities, and transitioning staff to other hiring mechanisms.
3. **Support and sustain the public health workforce.** For example, this could include strengthening workplace well-being programs and expanding engagement with the workforce to address their mental, emotional, and physical well-being.
4. **Train new and existing public health staff.** For example, this could include improving the quality and scope of training and professional development opportunities for all staff.
5. **Strengthen workforce planning, systems, processes, and policies.** For example, this could include maintaining and upgrading human resource systems, identifying ways to better collect and use workforce data, and identifying policies that could facilitate more efficient and effective workforce development and management.
6. **Strengthen support for implementation of this grant.** At a minimum, applicants must:
  - Support a full-time Workforce Director who has sufficient authority and seniority to effectively manage the work under this grant. This individual must report to the highest level of the recipient organization, be able to represent the recipient organization, and participate actively in discussions and meetings with other recipients and CDC about the grant and their experiences under it. (Required)
  - Dedicate at least 1.0 full-time employee to program evaluation and performance measurement for all work proposed under Strategies A1-A3. These evaluation staff will facilitate progress reporting, use of grant performance measures, internal evaluation activities, collaboration with national partners from Component B on evaluation of the grant, and participation in relevant national organizational and workforce assessments. (Required)
  - Successful applicants may choose to use A1 Workforce funding to hire a Data Modernization Director. This is an encouraged option, not a requirement.

**Strategy A2 Foundational Capabilities**

The intent of this strategy is to strengthen recipients' overall systems, processes, and policies to ensure a strong core infrastructure needed to protect health and provide fair opportunities for all. The Foundational Public Health Services (FPHS) [FPHS | PHNCI](#) framework defines a minimum set of capabilities and areas that must be available in every community. The FPHS framework aligns well to the core capabilities that CDC itself seeks to strengthen and supports advancement in delivering [Essential Public Health Services](#). The framework includes eight (8) public health infrastructure foundational capabilities, which are the cross-cutting skills and capacities needed to support basic public health protections and other programs and activities that are key to ensuring the community's health and achieving equitable health outcomes.

These capabilities include: 1) Assessment/Surveillance, 2) Emergency Preparedness and Response, 3) Policy Development and Support, 4) Communications, 5) Community Partnership Development, 6) Organizational Competencies, 7) Accountability/Performance Management, and 8) Equity.

Effectively managing a public health agency implicates every aspect of these foundational capabilities <https://phnci.org/transformation/fphs>. It also includes strengthening the public health agency's ability to meet or exceed the standards and measures outlined in the national consensus accreditation standards for health departments, which are aligned with the foundational capabilities and ensure that these are in place. [Version 2022 - Public Health Accreditation Board \(phaboard.org\)](#) Recipients should consider how to meet or exceed the public health accreditation standards and measures that align to these foundational capabilities.

As jurisdictions transition from COVID-19 emergency response footing to long-term, sustainable approaches to delivering the essential public health services, A2 funding will focus on supporting those core foundational capabilities that are not directly funded by other sources but are nonetheless important to underlying public health infrastructure. All the foundational capabilities may be supported by this funding. However, to reduce the duplication of effort specific to foundational capabilities funded through other sources, such as surveillance, epidemiology, laboratory capacity, and vital records, work under Strategy A2 should focus on the following crosscutting activities that do not have a direct source of CDC funding.

**Strategy A2 Foundational capabilities:** Key activities ([Appendix 1\\_Sample Activities for Component A.docx](#))

1. Strengthen accountability/Performance management, including accreditation.
2. Strengthen organizational competencies addressing information technology, data modernization human resources, financial management, contract, and procurement services.
3. Enhance communications.
4. Enhance or increase policy development and legal services and analysis.
5. Strengthen community partnership development and engagement.
6. Improve equity and organizational competencies addressing leadership, governance, and strategic planning.

7. As appropriate, implement plans to transition from COVID-19 emergency response and other emergency response and preparedness projects.

### **Strategy A3 Data modernization**

This funding supports jurisdictions to develop and deploy scalable, flexible, and sustainable technologies, policies, and methods to implement world-class data and analytical capabilities to support the Essential Public Health Services. Public health data infrastructure should have clear governance structures that are inclusive (e.g., consider the needs of counties and cities as well as states) and technically enforceable (i.e., written into the infrastructure's code). The data infrastructure should be able to scale rapidly, be flexible to accommodate changing needs in public health surveillance and response, ensure bidirectional data flow, and provide predictive ability to identify emerging public health risks and concerns. All activities undertaken should reduce burden on health care and public health partners reporting data, while enhancing data sharing at all levels. This effort also aims to accelerate modernization through enhancing the public health data workforce and encourages the use of shared data and health information services and infrastructure offered via CDC or partner organizations. The goal is to enhance the data and information infrastructure used by public health.

Governance processes should assure that state level activities consider the needs of counties and cities, and that city and county level initiatives do not duplicate services, systems, or other resources available from the state public health agency. Strategies should ensure the ability to exchange and integrate data among public health systems and agencies, and with health care and other public health partners, including tribal entities as appropriate. Recipients will be expected to demonstrate step-wise progress in assessing current functionalities and prioritizing modernization needs prior to making investments. Every effort should be made to ensure the sustainability by leveraging procurement approaches that support modern service design and development.

This funding opportunity builds on and is expected to coordinate with and leverage, but not duplicate, the workforce, laboratory system, and data-related progress made via Epidemiology and Laboratory Capacity for Prevention and Control of Emerging Infectious Diseases (ELC), Public Health Emergency Preparedness (PHEP), and other funding opportunities and investments.

Recipients of this funding are required to coordinate with and leverage, but not duplicate, the workforce, laboratory system, and data-related activities in Epidemiology and Laboratory Capacity for Prevention and Control of Emerging Infectious Diseases (ELC), Public Health Emergency Preparedness (PHEP), and other funding opportunities and investments. Applicants of A3 must specify in their proposals as to whether or not they are a current recipient of data modernization funding through the CDC Epidemiology and Laboratory Capacity for Prevention and Control of Emerging Infectious Diseases (ELC) supplemental funding.

### **Strategy A3 Data modernization: Requirements**

- Investments in stand-alone, monolithic systems with limited interoperability are not allowed.

- Investment in new system design/configurations will require sign-off from CDC DMI program prior to jurisdictional procurement to ensure alignment with the North Star Architecture strategy.
- Key Activities 2-4 below are required.

**Strategy A3 Data modernization:** Key activities ([Appendix 1 Sample Activities for Component A.docx](#))

1. **Identify** a data modernization director and supporting team that will be responsible for ensuring the jurisdiction takes an agile, enterprise-wide approach in assessment, planning, and incremental implementation of modernization activities. The director may be funded through this award or other sources. This position is strongly recommended as part of Strategy A1 Workforce.
2. **Assess and report** the current capacity, gaps, and opportunities to modernize the public health data infrastructure and workforce. For jurisdictions who have recently completed a data modernization assessment (e.g., within the past 2 years) previous assessments should be reviewed and updated. This is a required activity.
3. **Create implementation plans** for 1) modernization of public health data environment to support public health work that includes forward-looking use of flexible, scalable, sustainable infrastructure that leverages shared services and cloud-native technology and 2) workforce development to address existing gaps, build capacity within the current workforce and sustain modernization gains. Implementation plans should be based on assessment results. Initial implementation plans should be developed by the end of Year 1, and must demonstrate collaboration across city, county, and state public health agencies and not duplicate systems and services. This is a required activity. Workforce needs may be addressed through Strategy A1 Workforce or Strategy A3 Data modernization, and while it is an encouraged option to include hiring a DMI director, it is not required.
4. **Implement** developed work plans to realize data infrastructure enhancements and improvements. Implemented activities should be aligned with national efforts and national standards. As part of implementation, recipients will be required to 1) attend an annual Data Modernization Workshop; 2) participate in a CDC-sponsored Data Modernization Learning Community and 3) participate in other established and relevant communities of practice as appropriate. This is a required activity.
5. **Accelerate implementation** by proposing innovative modernization projects to enhance data quality, exchange, dissemination, and use. Acceleration projects will only be approved after progress on activities 1-4 has been demonstrated.

For Strategies A3 Data modernization CDC may develop additional supplemental guidance that outlines additional work plan and budget requirements tailored to the jurisdictional public health infrastructure needs and congressional language in appropriations specific to this strategy that could include specific data modernization activities not listed in the activities section of this funding opportunity.

**Component B: Technical Assistance for Component A**

The purpose of Component B is to support Component A recipients to implement Strategies A1-A3 more efficiently and effectively. Component B recipients will do this by providing technical assistance, evaluation leadership and support, and mechanisms for communication and coordination across all recipients and CDC.

Applicants to Component B can apply for one or more **Strategies** below.

All recipients of Component B will be expected to communicate and coordinate with one another, to support and streamline engagement with Component A recipients, with the assistance of the recipient of Strategy B3. Regardless of strategy in which they work, Component B recipients are encouraged to help Component A recipients build and strengthen partnerships with academic institutions including minority-serving institutions (e.g., HBCUs, HACUs, etc.) and other technical organizations operating in recipients' project areas, to support more sustainable access to technical assistance and expertise.

### **Strategy B1 Training and technical assistance for Component A Strategies A1, A2, and A3**

The intent of this strategy is to assist recipients of Component A more efficiently and effectively plan and implement their grant activities. Recipients of Strategy B1 should facilitate collection and use of relevant data, expedite access to information and mechanisms that help recipients meet their grant goals, and increase recipients' skills and capacity to retain some of the gains of the grant in the longer term. The training and technical assistance offered should be driven by Component A recipients' needs. The training and technical assistance should be of such high quality and value to Component A recipients, that voluntary uptake will be high.

Applicants to Strategy B1 can choose to propose one or more Key Activities.

#### **Key activity 1: Evidence-driven planning for Strategy A1 Workforce and Strategy A2 Foundational capabilities**

One or more Component B recipients should support Component A recipients by providing cross-cutting and ongoing planning activities, through providing technical assistance with:

- Conducting foundational capabilities and workforce needs assessments
- Synthesizing and using data related to the workforce to guide work under Strategy A1
- Synthesizing and using data related to foundational capabilities to guide work under Strategy A2
- Analyzing and using the above types of data for program improvement and decision-making
- Creating and strengthening partnerships with academic institutions including minority-serving institutions (e.g. HBCUs, HACUs, etc.), academic organizations, and other technical organizations to support implementation of Strategies A1-A2 and to increase student rotations at public health departments.

Assistance related to workforce and foundational capabilities planning should be made available as soon as possible after awards are made to Component A recipients, particularly for those recipients that do not have recent strategies or needs assessment data to drive planning for their Component A grant application. This assistance should help recipients revise and strengthen

their work plans during the period of performance under A1 and A2 of this grant. This kind of assistance should continue during the grant period. For example, with continuation applications to the grant and other ongoing planning needs at the recipient level.

**Key activity 2: Evidence-driven implementation for Strategy A1 Workforce and Strategy A2 Foundational capabilities**

One or more Component B recipients should also support Component A recipients by identifying and providing access to evidence and information about best practices and models for recipients to draw from for implementation, such as:

- Model job descriptions, personnel sharing agreements, scopes of work, and requests for proposals
- Conducting regional and national pay and salary reviews
- Guidance on how to identify, develop, and evaluate high quality programs to implement under A1 Workforce and A2 Foundational capabilities (e.g., workforce training programs, strategic planning approaches)
- Model policies and legislation, including those related to hybrid workplaces, teleworking policies, hiring caps, and workforce surge capability
- Access to new evidence and tools that support implementation
- Access to human resource, workforce development, and foundational capability expertise, which recipients could access for tailored assistance
- Direct support for peer-to-peer learning on best practices, with travel support or honorariums
- Development of a peer-to-peer exchange program between CDC and state, local and territorial public health agencies (e.g., providing a 4-week experiential on-site learning opportunity)

**Key activity 3: Data modernization**

One or more Component B recipients should support Component A recipients through assessing training needs and providing training opportunities to support the use of flexible, scalable, sustainable infrastructure that leverages shared services and cloud-native technology and is focused on data standards and technologies. Example training topics may include, but are not limited to, the following: software as a service, HL7 standards including V2, V3 and FHIR, machine learning, trust frameworks (e.g., TEFCFA), USCDI and USCDI plus, and national initiatives, as they are announced. Partners will be responsible for

- Understanding jurisdiction training needs
- Identifying and contracting with vendor partners to deliver trainings in a variety of modalities
- Promoting available training offerings to recipients
- Maintaining a repository of developed trainings that is accessible to jurisdictions for training on demand, and



- Conducting other activities associated with expanding access to standards-based trainings.

Training topics and delivery methods will be developed in coordination with CDC. Training topics that do not support the use of flexible, scalable, sustainable infrastructure by jurisdictions will not be approved.

#### **Key activity 4: Accessing staffing solutions and contracts to facilitate implementation of Strategies A1, A2, and A3**

One or more Component B recipients should support Component A recipients by providing direct access to hiring, retention, training, and systems strengthening mechanisms. These may include coordinated access to:

- National, regional, or multi-state recruitment and hiring campaigns, platforms, or hubs
- Staffing solutions and direct mechanisms for hiring staff, or multi-state hiring contracts and mechanisms, particularly for positions that are hard to fill
- Multi-state or national contracts for training support
- Information technology agencies and contractors to introduce or modify human resource or related workforce, administration, and other data systems

#### **Strategy B2 Grant program evaluation**

A comprehensive evaluation of this grant is important to further build the evidence base around workforce development, foundational capabilities, and data modernization and to identify best practices and lessons that the public health sector could take forward, after this grant is over. To that end, one or more partners will be funded to take on an evaluation leadership role. This role will include development and management of a comprehensive evaluation plan involving multiple evaluation methods and ongoing dissemination and reflection on results obtained. Various audiences will need to be served by the evaluation activities, including the Component A recipients, CDC, the public health sector, and Congress. The primary aim of this strategy is to evaluate the grant, not to build evaluation capacity of the recipients, though some capacity-building is encouraged. The recipient(s) of Strategy B2 can subgrant to various evaluation partners, as they see fit, to accomplish the evaluation goals.

One or more Component B recipients will, in collaboration with CDC and Component A recipients:

- Design and implement an evaluation plan for the grant, which will likely include multiple case studies, surveys, focus groups, and triangulation with other existing data sources, performance measures, and other process and grant activity tracking
- Synthesize evaluation results, along with work plan and CDC performance measure data
- Support Component A recipients with participating in, analyzing, and using existing national initiatives that are related to describing the public health workforce and foundational capabilities, such as the [PHWINS](#), [ASTHO Profile](#), [NACCHO Profile](#), [Lab Testing Capacity](#), [Epidemiology Capacity Assessments](#), and health department accreditation efforts [www.phaboard.org](http://www.phaboard.org). Coordinate with and support, as appropriate, key

partners involved in existing national initiatives that are related to describing the public health workforce and foundational capabilities

- Prepare briefs that highlight notable programmatic experiences for recipients as well as other audiences
- Assist Component A recipients with preparing and reporting performance measures to CDC
- Disseminate and promote use of preliminary and final evaluation results, to Component A recipients, CDC, other partners, and the peer-reviewed literature

### **Strategy B3 Grant coordination and communication**

This grant will have numerous recipients that reflect a wide range of capacity, needs, and strategic approaches. However, they will share many characteristics and will be working towards similar goals. Communication among Component A recipients about their experiences, plans, questions, and findings is key to helping each one move forward with their work in efficient and effective ways. The recipient(s) of Strategy B3 will facilitate this communication and should adopt multiple means for doing so, from annual meetings to regular webinars and other online ways to share information and questions in real time. This recipient(s) will also help coordinate communication between the Component A recipient community and CDC, to complement the work of project officers and other CDC staff supporting implementation.

#### **Key Activity 1: Crosscutting coordination and communication**

One or more Component B recipients will, in collaboration with CDC and Component A recipients:

- Create, host, and maintain one or more communities of practice for recipients to exchange information and resources
- Hold regular informational webinars for recipients
- Organize annual recipient meetings (virtual and in-person, as appropriate)
- Facilitate communication between CDC and the recipient community, including identification and maintenance of relevant online platforms for sharing
- Facilitate communication and coordination among the other Component B partners to support and streamline engagement with the Component A recipients
- Facilitate communication and coordination between Component B partners and the recipient community, including maintenance of a system for managing and tracking TA requested from and provided to recipients
- Obtain feedback from the recipient community as needed

#### **Key Activity 2: Data modernization**

In collaboration with CDC, one Component B recipient with a strong understanding of modern public health data systems and informatics principles and practices should support recipients of Strategy A3 Data modernization through planning, organizing, and convening a yearly two-day

Public Health Data Modernization Workshop. Attendance at this workshop will be a required activity for all recipients funded for Strategy A3. Data modernization includes technologies, processes, strategies, and workforce capacity building that accelerate improvements to data quality, exchange management and use.

- The purpose of the workshop will be to convene the recipient data modernization directors and at least one supporting team member to improve their ability to modernize the data infrastructure and enhance data capabilities in their jurisdiction.
- The content of the workshop will be developed in coordination with CDC and should include training, sharing and discussions about data modernization topics (e.g. data standards, analytics, shared services, effective technologies), and strategies for conducting workforce development in these areas.

One Component B recipient with a strong understanding of modern public health data systems and informatics principles and practices will be selected to support all recipients through planning and convening a monthly or bi-monthly jurisdiction data modernization community of practice that will allow for more regular discussion of lessons learned and promotion of peer-to-peer learning across funded jurisdictions. Regular participation in this learning community will be a required activity for all recipients funded for data modernization.

- The purpose of the learning community will be convening DMI Directors and other jurisdictional colleagues on a routine basis to promote sharing of lessons learned and peer-to-peer learning opportunities.
- The convened learning community will be developed in coordination with CDC and should include a monthly or bi-monthly schedule of virtual learning community gatherings, as well as an online collaboration space.

Applicants are to only apply to Component A or to Component B of this Notice of Funding Opportunity, but not both.

### **1. Collaborations**

Please see sections a and b below.

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

Recipients of Component A and B are expected to collaborate, as appropriate, with CDC programs and centers, institutes, and offices (CIOs) to ensure that activities and funding are coordinated with, complementary of, and not duplicative of efforts supported under other CDC programs that support the public health workforce, data modernization, or the COVID-19 response. Given that this grant can serve nearly any aspect of a public health system, recipients will need to coordinate with nearly every CDC-funded grant or cooperative agreement that they receive or work with. The points of coordination and collaboration are numerous. Thus, we encourage the recipient to place the management for this grant in direct line of the office of the public health director and preferably under public health department leadership that has experience with managing crosscutting and flexible resources meant to improve the entire organization.

Specific to this grant, recipients of Component A should receive training and technical assistance from recipients of Component B1. Component A and Component B recipients are expected to

collaborate around the identification of training and technical assistance needs, sharing of best practices, lessons learned, and other communications.

All recipients of Component B will be expected to communicate and coordinate with one another, to support and streamline engagement with Component A recipients, with the assistance of the recipient of Strategy B3. Regardless of strategy in which they work, Component B recipients are encouraged to help Component A recipients build and strengthen partnerships with academic institutions including minority-serving institutions (e.g., HBCUs, HACUs, etc.) and other technical organizations operating in recipients' project areas, to support more sustainable access to technical assistance and expertise.

**b. With organizations not funded by CDC:**

The areas for collaboration with organizations not funded by CDC are also numerous and will extend across a recipient's public health system and program areas. These collaborations fall into two categories: those that relate to the internal operations of recipients' own organizations and those that relate to the areas and populations that these agencies serve. Data infrastructure-related collaborations should include existing and new partners to advance data exchange and modern data architectures and processes.

Specifically, Component A applicants should describe the primary collaborations that will help them implement their respective strategies. Applicants are encouraged to strengthen or establish new funding relationships with national, regional, or local partners, academic institutions, and community organizations that 1) have experience with aspects of public health infrastructure planning, development, and staffing, systems improvement, etc. or 2) can collaborate on data standardization, exchange, dissemination, and use; shared services and infrastructure; and data infrastructure design, planning and implementation.

Applicants of Component A should also acknowledge and focus this grant's efforts towards supporting U.S. communities that have been economically or socially marginalized, are located in rural geographic areas, are composed of people from racial and ethnic minority groups, are medically underserved, and are disproportionately affected by COVID-19 or other priority public health problems. This area for collaboration will require strong relationships and partnerships with existing community or social service delivery programs for African American, Hispanic, Asian American, Pacific Islander, Native American and other racial and ethnic minority groups and people living in rural communities. Specifically for Strategy A1 Workforce, this work also includes hiring staff who reflect the communities in which they will serve and enhancing the public health-related data available for those communities.

Such key partners may include the following:

- Community-based and civic organizations
- Federally recognized tribes, or tribal-serving organizations
- Academic institutions, and universities (e.g., minority serving institutions – Historically Black Colleges and Universities (HBCUs), Hispanic Association of Colleges and Universities (HACUs), American Indian Higher Education Consortium (AIHEC), Tribal Colleges and Universities (TCUs)
- Asian American and Pacific Islander Serving Institutions (AAPI)

- Organizations associated with the [Public Health AmeriCorps](#) program
- Faith-based organizations
- Local governmental agencies and community leaders
- Local businesses and business community networks and organizations, (e.g., employers, local chambers of commerce, or small business community groups)
- Social services providers and organizations, including those that address social determinants of health (e.g., community transportation; anti-discrimination organizations; legal services)
- Health care providers, including community health centers (e.g., federally qualified health centers [FQHCs])
- Health-related organizations, (e.g., pharmacies, testing centers, or community health workers)
- State Offices of Rural Health (SORH) or equivalent, State Rural Health Associations (SRHAs)
- Rural Health Clinics (RHCs) and Critical Access Hospitals (CAHs)

Component A applicants should describe in the application their primary collaborations that further the intent of this grant. Specifically, they should demonstrate their commitment to local partnerships and to using those partnerships to strengthen their infrastructure in ways that reflect the populations being served and that direct those infrastructure investments to areas of greatest public health need.

Relevant memoranda of understanding (MOUs), memoranda of agreement (MOAs), or letters of support are acceptable, but not required. Please use naming convention “ApplicantName\_Collaborations\_MOU\_YYYYMMDD,” and upload to [www.grants.gov](http://www.grants.gov).

This section only applies to Component A applicants.

## **2. Target Populations**

The populations to be served by this grant will vary across recipients and depend on local needs. The population this grant serves are those that use public health services including, U.S. communities that have been economically or socially marginalized, located in rural geographic areas, are composed of people from racial and ethnic minority groups, are medically underserved, and those disproportionately affected by COVID-19 or other priority public health problems. Applicants should describe how they will use infrastructure investments to advance health equity in their jurisdictions. This should include involving relevant communities in the planning, implementation, and evaluation of applicants’ current and future infrastructure goals, as appropriate.

### **a. Health Disparities**

Component A recipients are expected to direct this grant effort toward reducing the burden of COVID-19 and other public health problems among disproportionately affected populations and medically underserved communities. Component B recipients should fully support this among the Component A recipients.

Component A applicants should describe the specific public health problems, groups, and geographic areas towards which they plan to direct the grant effort. They should describe how this plan should serve the aim of reducing health disparities and promoting health equity in the jurisdiction. Component B applicants should describe their commitment to supporting these goals among Component A recipients they will serve.

#### **iv. Funding Strategy**

##### **Coronavirus Disease 2019 (COVID-19) Funds**

A recipient of a grant or cooperative agreement awarded by the Department of Health and Human Services (HHS) with funds made available under the Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020 (P.L. 116-123); the Coronavirus Aid, Relief, and Economic Security Act, 2020 (the “CARES Act”) (P.L. 116-136); the Paycheck Protection Program and Health Care Enhancement Act (P.L. 116-139); and/or the Consolidated Appropriations Act and the Coronavirus Response and Relief Supplement Appropriations Act, 2021 (P.L. 116-260) and/or the American Rescue Plan of 2021 [P.L. 117-2] agrees as applicable to the award, to: 1) comply with existing and/or future directives and guidance from the Secretary regarding control of the spread of COVID-19; 2) in consultation and coordination with HHS, provide, commensurate with the condition of the individual, COVID-19 patient care regardless of the individual’s home jurisdiction and/or appropriate public health measures (e.g., social distancing, or home isolation); and 3) assist the United States Government in the implementation and enforcement of federal orders related to quarantine and isolation.

In addition, to the extent applicable, Recipient will comply with Section 18115 of the CARES Act, with respect to the reporting to the HHS Secretary of results of tests intended to detect SARS-CoV-2 or to diagnose a possible case of COVID-19. Such reporting shall be in accordance with guidance and direction from HHS and/or CDC. HHS laboratory reporting guidance is posted at: <https://www.hhs.gov/sites/default/files/covid-19-laboratory-data-reporting-guidance.pdf>.

Further, consistent with the full scope of applicable grant regulations (45 C.F.R. 75.322), the purpose of this award, and the underlying funding, the recipient is expected to provide to CDC copies of and/or access to COVID-19 data collected with these funds, including but not limited to data related to COVID-19 testing. CDC will specify in further guidance and directives what is encompassed by this requirement.

This award is contingent upon agreement by the recipient to comply with existing and future guidance from the HHS Secretary regarding control of the spread of COVID-19. In addition, recipient is expected to flow down these terms to any subaward, to the extent applicable to activities set out in such subaward.

Applicants are to only apply to Component A or to Component B of this Notice of Funding Opportunity, but not both.

#### **Component A**

The funding strategy aims to distribute these funds in a transparent, data-driven way that ensures that they are available to areas with the greatest need. Funding for Component A will be

allocated by strategy based on the funding available for each strategy, based on a formula that establishes a funding floor and then allocates the remainder based on the size of the entire population served by the recipient, with an adjustment for community vulnerability, based on the Census Bureau's [Community Resilience Estimate](#). This adjustment serves to help direct additional resources towards areas with greater need, and recipients are encouraged to adopt similar principles when allocating funding within their coverage areas or jurisdiction. Statewide recipients' population sizes (and thus awards) will be adjusted to remove the populations of any funded countywide and citywide recipients within those statewide recipients.

All recipients may receive Strategy A1 Workforce and A2 Foundational capabilities funding. For A1 Workforce strategy, CDC determined a base amount of \$2,500,000 and ceiling of \$150,000,000. For A2 Foundational capabilities strategy, CDC determined a base amount of \$250,000 and ceiling of \$8,000,000. For A3 Data modernization strategy, CDC determined a base amount of \$175,000 and ceiling of \$3,600,000. Please see "Attachment A\_Funding Strategy" for a funding strategy formula.

For Strategies A3 Data modernization CDC may develop additional supplemental guidance that outlines additional work plan and budget requirements tailored to the jurisdictional public health infrastructure needs and congressional language in appropriations specific to this strategy that could include data modernization activities not listed in the activities section of this funding opportunity. Award amounts may be established by population-based formula, geographic overlap and unnecessary redundancies and other criteria specified in the appropriations legislation.

## **Component B**

Approximately \$45,000,000 will be made available to recipients under Component B. There is no award floor and no ceiling. No formula will be used for determining funding to each recipient.

### **b. Evaluation and Performance Measurement**

#### **i. CDC Evaluation and Performance Strategy**

Evaluation and performance measurement help demonstrate achievement of project outcomes; build a stronger evidence base for specific interventions; clarify applicability of the evidence base to different populations, settings, and contexts; and drive continuous improvement. CDC and recipients will use evaluation results to assess progress and to document program impact, sustainability, and continued program improvement recommendation that can be shared with decision makers and other partners.

To that end, recipients should allocate a portion of their award to support evaluation activities (i.e., including data collection and use of monitoring and evaluation data) and are encouraged to work with evaluators to do so.

## **Component A**

Component A recipients will work with CDC and Component B recipients to develop an evaluation and performance measurement plan that outlines their approach to addressing

common evaluation questions, reporting on evaluation results and performance measures, and sharing successes and challenges.

CDC and Component B2 Grant evaluation recipients will collaborate with Component A recipients to manage and analyze performance measure data and synthesize evaluation findings across recipients. CDC and Component B2 Grant evaluation recipients will also identify and conduct additional evaluation projects (e.g., analytic studies, and case studies) to evaluate program activities and outcomes.

### **Strategy A1 Workforce: Performance Measures**

Performance measures may include (but are not limited to) the following, with bolded outcomes from the logic model also bolded below.

#### Process measures

- Number and type of current vacancies overall and by Job Type/Classification and Program Area
- Number and type of hiring mechanisms used to hire new staff
- Number and type of incentives or programs used to retain existing public health staff
- Number and type of workplace programs or services newly available and used by staff
- Number and type of workforce, training, and other assessments conducted to guide workforce development and related programs
- Number and type of improvements to workforce systems and processes
- Number and type of innovations to workforce systems and processes
- Successes and challenges to implementation

#### Short-term outcome measures

##### **Increased hiring of diverse public health staff**

- Number of diverse staff hired overall and by job type or classification, program area, and hiring mechanism or employment status

##### **Increased retention of existing public health staff**

- Staff retention rate by job type (i.e., Retention rate =  $(A-B)/C$  where A = # of staff on last day of reporting period, B = # of new hires during reporting period, and C = # of staff on Day-1 of reporting period)
- Percent increase in salary ranges pre-pandemic to current date
- Number of positions with a salary range at or above \$15 an hour

##### **Improved workforce systems and processes**

- Percent improvement on jurisdiction's organizational administrative competency assessment from baseline
- Mean position vacancy duration in working days (average time to hire)

#### Intermediate outcome measures

##### **Increased size of the public health workforce**



- Number of staff employed overall and by job type or classification, program area, and hiring mechanism or employment status
- Total size of the workforce, over time, by job type or classification, program area, and hiring mechanism or employment status

### **Increased job satisfaction**

- Proportions of public health staff who report being satisfied with their job, their organization, the workplace environment, their pay, and their job security

### **Strategy A2 Foundational capabilities: Performance measures**

Performance measures may include (but are not limited to) the following, with bolded outcomes from the logic model also bolded below.

#### Process measures

- Number of recipients that apply for public health accreditation or re-accreditation
- Number and type of improvements to foundational systems and processes
- Number and type of innovations to foundational systems and processes
- Successes and challenges to implementation

#### Short-term outcome measures

### **Improved organizational systems and processes**

- Number and type of quality improvements to organizational systems and processes

#### Intermediate outcome measures

### **Stronger public health foundational capabilities**

- Number of recipients that receive public health accreditation or re-accreditation
- Number of recipients that meet or exceed accreditation standards and measures
- Number of recipients that report “full” or “sufficient” capability on organizational administrative competency assessments

### **Strategy A3 Data modernization: Performance measures**

Performance measures may include (but are not limited to) the following, with bolded outcomes from the logic model also bolded below.

#### Process measures

- Identified dedicated agency staff to lead and coordinate data modernization efforts
- Clearly established data, health information system and workforce capabilities, needs, and opportunities
- Extent of demonstrated utilization of shared services to enhance existing systems or data exchange
- Extent of enhanced workforce capacities and capabilities to accelerate data and health information system modernization

#### Short-term outcome measures

##### **More modern and efficient data infrastructure**

- Improved public health data infrastructure, data science, and informatics capabilities and capacities
- Increased capacity to quickly analyze, interpret, and act on data

##### **Increased data interoperability**

- Improved public health data sharing and interoperability among partners (e.g., public health agencies, healthcare, laboratories, and other partners)
- Reduced data reporting burden among partners
- Increased efficiencies, timeliness and completeness of data

#### Intermediate outcome measures

##### **Increased availability and use of public health data**

- Increase in availability of real-time, linked public health data that provide better, faster, and more coordinated data to recognize changes that may signal a threat and respond to emerging public health threats.

#### Performance Measures shared with ELC

The following are shared measures with ELC. Monitoring and data collection will continue to be carried out under ELC for ELC recipients. For non-ELC recipients, monitoring and data collection will be carried out through grant monitoring processes.

1. Document and understand workforce, data, and HIS needs and opportunities
  - Completed assessment and identified opportunities using recommended tool or equivalent in first 90 days of award (Y/N).
  - If yes, provide summary of key finding and opportunities identified.
  - If no, describe barrier and challenges to completing the assessment.
  - Was assessment data used to develop the workforce development plan or data modernization plan? (Y/N)
  - If yes, describe data used and how the plans were modified.
2. Implement workforce enhancement to accelerate data and HIS modernization
  - Did trainings and other workforce activities address workforce competency gaps identified in the assessment? (Y/N).
  - Describe how the trainings and workforce activities address identified competency gaps.
  - Number of trainings:

- Provide a list of the trainings presented to include title of the training, intended audience, mode of delivery, number of participants, proportion of evaluations completed, and feedback provided.
3. Provide details on peer-to-peer learning (if applicable) via trip report; and workforce enhancement through fellows, technical assistance, or shared consultative services.
  4. Accelerate improvements to data quality, exchange, management, and use
    - List of shared services used or created to enhance existing systems or data exchange.

### **Component B: Performance measures**

Evaluation and performance measurement of Component B recipients will largely be focused on process measures. The proposed measures below will be further defined and finalized with Component A and Component B recipients after award and will complement data and information from ongoing progress reporting from the Component B partners.

Performance measures may include (but are not limited to) the following, with bolded outcomes from the logic model also bolded below.

#### Process measures

##### Strategy B1 Training and technical assistance

- Number and percent of recipients served, intensity of engagement with each recipient, topics covered, nature of TA provided
- Number of direct hiring and other contract mechanisms made available to Part A recipients, number and percent of Component A recipients that participate in those, and (for workforce related contracts) number of staff contracted through those mechanisms
- Extent of Component A recipients' satisfaction with the work of Component B TA partner(s)

##### Strategy B2 Grant evaluation

- Number of evaluation results products produced and disseminated, to whom, and when
- Number and percent of Component A recipients' that participate in evaluation activities conducted by the Evaluation partner
- Extent of Component A recipients' satisfaction with the work of Component B evaluation partner(s)

##### Strategy B3 Coordination and communication

- Number and percent of Component A recipients engaged in any communities of practice and major meetings and group events held for that group
- Extent of Component A recipients' satisfaction with the work of Component B coordination and communication partner(s)

#### Outcome measures

##### Strategy B1 Training and technical assistance

##### **Increased hiring & retention mechanisms available to Component A recipients**

- Number and scope of workforce hiring and retention mechanisms made available to Component A recipients
- Number of Component A recipients that use those mechanisms
- Among Component A recipients that use those mechanisms, number and type of staff hired or retained

#### Strategy B2 Grant evaluation

##### **Improved sharing of lessons learned and evidence among Component A recipients, CDC, and other interested partners**

- Number and type of dissemination products based on evaluation findings disseminated to Component A recipients and to broader public health audiences
- Number and percent of Component A recipients that report significant learning from evaluation results shared

#### **CDC's evaluation approach**

CDC will work with Component A recipients and Component B recipients to finalize NOFO performance measures and an overarching evaluation plan for this work. All partners will be expected to submit a comprehensive Evaluation and Performance Measurement Plan within 6 months of award. CDC will provide additional guidance for this plan after award.

The performance measures will complement ongoing progress and financial reporting. CDC will use these and other information and data sources to address key evaluation questions. CDC will collect information on a regular basis through the end of the period of performance using standardized templates. As described below, there will be six-month progress reporting submitted via the Research Electronic Data Capture, or otherwise known as REDCap. CDC will provide training and technical assistance for recipients on REDCap post-award.

The Component B2 Evaluation Partner(s) will further add to the evaluation approach, by complementing these data sources and other data reported directly to CDC. These evaluation activities may include case studies of Component A recipients' experiences, focus groups and individual interviews with recipients, and other assessment tools. The evaluation plan that the Component B2 Evaluation Partner(s) will create at the start of their award will guide this approach.

Recipients also are encouraged to dedicate additional program evaluation and analytic expertise towards enhanced internal evaluation of their work under this grant. Recipient-driven evaluation may include additional monitoring, analysis, and use of related data, as well as targeted evaluation projects or quality improvement initiatives that support grant implementation or further develop the evidence base related to public health infrastructure investments.

#### **CDC's evaluation approach for Strategies A1 Workforce and A2 Foundational Capabilities**

When appropriate and as applicable, recipients should devote grant resources towards participating in relevant national public health agency capability and workforce assessments and those related to health department accreditation. Recipients should also devote resources towards using the data from those assessments to guide planning and implementation under this grant. CDC plans to conduct secondary analyses of aggregate data from these existing assessments and use that information to track progress towards key outcomes over the course of the period of

performance. By relying on existing assessment and accreditation programs, CDC seeks to reduce the burden of data collection and reporting on recipients and reinforce the value of those existing efforts. Recipients that do not opt to participate in these assessments may be required to submit similar data elements separately to CDC. Current key infrastructure assessments include (but are not limited to) the following: [PHWINS](#), [ASTHO Profile](#), [NACCHO Profile](#), [Lab Testing Capacity](#), or [Epidemiology Capacity Assessments](#), and [the Public Health Accreditation Board's accreditation measures](#).

### **Data Management Plan and the Paperwork Reduction Act**

Given the flexible nature of this grant and diversity of allowable activities, a Data Management Plan (DMP) is not required unless a recipient chooses to allocate funding to an activity that involves the collection, generation, or analysis of data. The DMP may be submitted as a checklist, paragraph, or other format. To help guide applicants in developing a DMP, a sample plan is provided via the following link:

<http://www.icpsr.umich.edu/icpsrweb/content/datamanagement/dmp/plan.html>

As a result of the declared public health emergency (PHE), COVID-19, CDC's COVID-19 related data collections currently fall under a PHE Paperwork Reduction Act (PRA) Waiver as part of the 21st Century Cures Act. PRA requirements for most information collection activities that support the investigation of, and response to the COVID-19 pandemic, which would normally require submission of a PRA package, can be waived. If information collection activities continue beyond the period of the declared PHE or beyond the termination PHE PRA Waiver, all collections will become subject to requirements of the PRA. Awardees will receive additional guidance from CDC on how to address these PRA requirements.

### **ii. Applicant Evaluation and Performance Measurement Plan**

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

- How the 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)
- Plans for updating the Data Management Plan (DMP) as new pertinent information becomes available. If applicable, throughout the lifecycle of the project. Updates to DMP should be provided in annual progress reports. The DMP should provide a description of the data that will be produced using these NOFO funds; access to data; data standards ensuring released data have documentation describing methods of collection, what the data represent, and data limitations; and archival and long-term data preservation plans. For more information about CDC's policy on the DMP, see <https://www.cdc.gov/grants/additional-requirements/ar-25.html>.

Where the applicant chooses to, or is expected to, take on specific evaluation studies, the applicant 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).

Recipients will be required to submit a more detailed Evaluation and Performance Measurement plan, including a DMP, if applicable, within the first 6 months of award, as described in the Reporting Section of this NOFO.

### **Component A**

A comprehensive Evaluation and Performance Measurement plan is not required in the Component A applications to this NOFO. Specifically, for this NOFO, in the Evaluation and Performance Measurement section of the application, Component A applicants should focus on proposed evaluation and performance measurement around Strategy A1 Workforce and Strategy A2 Foundational capabilities. Specifically, they should describe

- Their past participation in relevant national workforce and foundational capabilities assessments including PH-WINS, ASTHO or NACCHO Profiles, PHAB Accreditation, and others they consider relevant to the proposed work.
- Their intention to participate in those national assessments during the period of performance.
- The status of their ability to report on the A1 Workforce and A2 Foundational Capabilities outcome performance measures outlined above, including whether any measure would represent a large burden to report and why, and
- Their intention and ability to collaborate with the national partner focused on evaluation to do additional evaluation, including case studies and interviews.

Additional performance metrics may be required in the future.

### **Component B**

A comprehensive Evaluation and Performance Measurement plan is not required in the Component B applications to this NOFO at this time. Specifically, for this NOFO, in the Evaluation and Performance Measurement section of the application, applicants may focus on describing this limited approach to developing a plan to:

- Collect data on the process and outcome performance measures specified by CDC in the project description.
- Describe how performance measurement and evaluation findings will be reported and used to demonstrate the outcomes of the NOFO and for continuous program quality improvement.
- Explain how evaluation and performance measurement will contribute to developing an evidence base for programs that lack a strong effectiveness evidence base.

- Describe your organization experience with conducting evaluation studies and include key evaluation questions, data sources and analysis methods used in the study. Describe past participation in relevant national workforce and foundational capabilities assessments including PH-WINS, ASTHO or NACCHO Profiles, PHAB Accreditation, and others they consider relevant to the proposed work.

Component A and Component B recipients will be required to submit a more detailed Evaluation and Performance Measurement plan, including a DMP, if applicable, within the first 6 months of award, as described in the Reporting Section of this NOFO.

### **c. Organizational Capacity of Recipients to Implement the Approach Component A**

Given the scope and intent of this grant, applicants must demonstrate the organizational capacity needed to carry out and coordinate strategies across the full range of Foundational Public Health Services [FPHS Factsheet FINAL \(phnci.org\)](https://www.phnci.org/fphs-factsheet-final) and across all Ten Essential Services [CDC - 10 Essential Public Health Services - CSTLTS](https://www.cdc.gov/10essential/). In short, applicants should demonstrate that they manage a comprehensive public health system. Acceptable documentation includes, but is not limited to, a signed letter by the public health agency leadership or their designees on organizational letterhead explaining the existing capacity and capability to address public health workforce strategies and foundational capabilities; organizational charts; and resumes or CVs for key personnel positions that are currently filled (include position descriptions for vacant positions). Applicant must name this file “Organizational Capacity\_Component A\_Services” and upload it as a PDF to [www.grants.gov](https://www.grants.gov).

To demonstrate existing capacity to provide comprehensive public health services, applicants must submit documentation that indicates the applicant has legal authority to make hiring decisions on behalf of the public health agency in their jurisdiction. Documentation could include a signed letter from the public health agency leadership or their designee on organizational letterhead. If these documents are not submitted, the application will be considered non-responsive and will receive no further review. Applicant must name this file “Organizational Capacity\_Component A\_Hiring” and upload it as a PDF to [www.grants.gov](https://www.grants.gov).

All applicants must be able to describe their current status in applying for public health department accreditation or evidence of accreditation or reason for not applying. Information on accreditation may be found at <http://www.phaboard.org>. This should include describing how the applicant is meeting, exceeding, or working on the standards and measures for maintaining a competent public health workforce and data infrastructure to support public health activities, as described in the accreditation standards. [Public Health Accreditation Board Standards and Measures, Version 1.5 \(phaboard.org\)](https://www.phaboard.org/public-health-accreditation-board-standards-and-measures-version-1.5) Please note that the new version of the standards was just approved and will go into effect in July 2022 for anyone seeking accreditation or reaccreditation in the future -- [Version 2022 - Public Health Accreditation Board \(phaboard.org\)](https://www.phaboard.org/public-health-accreditation-board-version-2022). Acceptable documentation includes, but is not limited to, a signed letter by the public health agency leadership or their designees on organizational letterhead providing evidence of accreditation or reaccreditation, or actively taking steps to pursue accreditation, or explanation as to why your agency is not pursuing accreditation. Applicant must name this file “Organizational

Capacity\_Component A\_Accreditation” and upload it as a PDF to [www.grants.gov](http://www.grants.gov).

Applicants also must demonstrate capacity to reach a broad population of 400,000 or greater throughout a large coverage area. Specifically, they should be a statewide public health system, or a large countywide public health system, large citywide public health system, or territorial and freely associated state system. Applicants must submit documentation that provides the accurate population size served by the public health authority based on the 2020 U.S. Census. Sources may be updated as census data change over time. Documentation could include a signed letter from the public health agency leadership or their designee on organizational letterhead stating the population size served. If this documentation is not submitted, the application will be considered non-responsive and will receive no further review. Applicant must name this file “Organizational Capacity\_Component A\_Population Size” and upload it as a PDF to [www.grants.gov](http://www.grants.gov).

Populations for county and city jurisdictions are based on the following 2020 U.S. Census resources:

- Counties: <https://www.census.gov/programs-surveys/popest/technical-documentation/research/evaluation-estimates/2020-evaluation-estimates/2010s-counties-total.html>
- Cities: <https://www.census.gov/programs-surveys/popest/technical-documentation/research/evaluation-estimates/2020-evaluation-estimates/2010s-cities-and-towns-total.html>

(Only for those applying for A3 Data modernization funding) Identify as a current or previous recipient of data modernization funding through the CDC Epidemiology and Laboratory Capacity for Prevention and Control of Emerging Infectious Diseases (ELC) supplemental funding. Documentation must include a signed letter from the public health agency leadership or their designee on organizational letterhead stating the organization’s current status of receiving ELC data modernization supplemental funding. If documentation of your current ELC funding status is not submitted, the application will be considered non-responsive and will receive no further review. Applicant must name this file “Organizational Capacity\_Component A\_ELC\_Support” and upload it as a PDF to [www.grants.gov](http://www.grants.gov).

## **Component B**

Applicants must demonstrate organizational capacity that is pertinent to the specific strategies and activities under Component B for which they apply (e.g., relevant evaluation experience if applying for Strategy B2 Grant evaluation). Applicants must also

- Demonstrate their experience and expertise in providing relevant technical assistance
- Demonstrate a successful track record of collaborating successfully with governmental public health agencies across the US, of varying sizes and geographic regions, including (but not limited to) the technical assistance areas in which they propose to work under this grant



- Demonstrate the capacity to quickly engage a large number Component A recipients soon after award and have the relevant staffing, established contact list, administrative systems, and partnerships in place to do so. It is acceptable for this broad reach and capacity to be obtained through sub-awards or consortia of organizations working together, under a prime recipient.

Acceptable documentation must include signed letters by multiple public health government agency leaders or their designees on organizational letterhead describing experience with receiving technical assistance from Component B applicants on key public health workforce strategies, foundational capabilities, and/or data modernization initiatives; organizational charts; and resumes or CVs for key personnel positions that are currently filled (include position descriptions for vacant positions). Applicant must name this file “Organizational Capacity\_Component B” and upload it as a PDF to [www.grants.gov](http://www.grants.gov).

#### **d. Work Plan**

Applicants must provide a detailed work plan for the first year of the project and a high-level work plan for subsequent years. The work plan must be organized by strategy and outline key objectives per strategy and include select activities or milestones that applicants will implement towards achieving those objectives. Applicants are to only apply to Component A or to Component B of this Notice of Funding Opportunity, but not both. Therefore, applicants will only complete either the Component A work plan or the Component B work plan.

Component A Work Plan: Please use the template Attachment B\_PHI Workplan\_Component A

Component B Work Plan: Please use the template Attachment B\_PHI Workplan\_Component B

#### **Activity Table Structure**

| Activity Title:                       |                   |                                              |          |                     |
|---------------------------------------|-------------------|----------------------------------------------|----------|---------------------|
| Activity Focus (select one):          |                   |                                              |          |                     |
| Other Activity Focus (if applicable): |                   |                                              |          |                     |
| Milestone Description                 | Party Responsible | Key Contracts, Subawards, and Collaborations | Due Date | Measures of Success |
|                                       |                   |                                              |          |                     |
|                                       |                   |                                              |          |                     |
|                                       |                   |                                              |          |                     |

Applicants must name the file “ApplicantName\_PHIWorkplan\_CompA\_YYYYMMDD” or “ApplicantName\_PHIWorkplan\_CompB\_YYYYMMDD” and upload it as part of their application package to [www.grants.gov](http://www.grants.gov).

#### **e. CDC Monitoring and Accountability Approach**

Monitoring activities include routine and ongoing communication between CDC and recipients, site visits, and recipient 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 recipient progress in achieving the desired outcomes.
- Ensuring the adequacy of recipient 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 deemed necessary to monitor the award:

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

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 recipients.

CDC will collect recipient financial and progress reporting data every 6 months through the end of the period of performance. CDC will also conduct a virtual compliance visit after six months, but before the end of the first year, from date of the award. The virtual compliance visit will be a telephone call and/or video conference to ensure the recipient's compliance with using the funding for the approved activities and to identify technical assistance needs. CDC may conduct additional in-person site or virtual visits as needed to best facilitate grants management and oversight duties.

## **B. Award Information**

### **1. Funding Instrument Type:**

G (Grant)

### **2. Award Mechanism:**

E11

### **3. Fiscal Year:**

2023

Estimated Total Funding:

\$3,945,000,000

### **4. Approximate Total Fiscal Year Funding:**

\$3,225,000,000

**Component A**

Strategy A1 Workforce: \$3,000,000,000

Strategy A2 Foundational capabilities: \$140,000,000

Strategy A3 Data modernization: \$40,000,000

**Component B**

- \$45,000,000

Specific amounts of funding described herein may be increased or decreased as they are subject to the availability of funds.

This amount is subject to the availability of funds.

**5. Approximate Period of Performance Funding:**

\$3,945,000,000

**Component A**

Strategy A1 Workforce: \$3,000,000,000

Strategy A2 Foundational capabilities: \$700,000,000

Strategy A3 Data modernization: \$200,000,000

**Component B: \$45,000,000**

This period of performance funding is an estimate for both components. All awards are contingent upon the availability of funding and stipulations of appropriations.

Over a five-year period of performance, CDC will award a total of approximately \$3.945 billion. All \$3 billion for strategy A1 Workforce will be disbursed during FY23. \$140 million for strategy A2 Foundational capabilities will be disbursed each budget year starting in FY23 for the five-year period of performance. \$40 million for strategy A3 Data modernization will be disbursed each budget year starting in FY23 for the five-year period of performance. The Component B funding of \$45 million will be disbursed during year one of FY23.

Specific amounts of funding described herein may be increased or decreased as they are subject to the availability of funds.

**6. Total Period of Performance Length:**

5

year(s)

**7. Expected Number of Awards:**

116

**Component A:** 111

**Component B:** 5

**8. Approximate Average Award:**

\$21,938,000

Per Project Period

**Component A**

Strategy A1 Workforce: \$20,000,000

Strategy A2 Foundational capabilities: \$1,260,000

Strategy A3 Data modernization: \$678,000

**Component B: \$9,000,000**

These amounts are subject to the availability of funds.

**9. Award Ceiling:**

\$161,600,000

Per Project Period

**Component A**

Strategy A1 Workforce: \$150,000,000

Strategy A2 Foundational capabilities: \$8,000,000

Strategy A3 Data modernization: \$3,600,000

**Component B**

\$0

**10. Award Floor:**

\$2,925,000

Per Project Period

**Component A**

Strategy A1 Workforce: \$2,500,000

Strategy A2 Foundational capabilities: \$250,000

Strategy A3 Data modernization: \$175,000

**Component B**

\$0

**11. Estimated Award Date:**

November 01, 2022

Throughout the project period, CDC will continue the award based on the availability of funds, the evidence of satisfactory progress by the recipient (as documented in required reports), and the determination that continued funding is in the best interest of the federal government. 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 period of performance comprises the initial competitive segment and any subsequent non-competitive continuation award(s).

**12. Budget Period Length:**

60 month(s)

Over a five-year period of performance, CDC will award a total of approximately \$3.945 billion. All \$3 billion for strategy A1 Workforce will be disbursed during FY23. \$140 million for

strategy A2 Foundational capabilities will be disbursed each budget year starting in FY23 for the five-year period of performance. \$40 million for Strategy A3 Data modernization will be disbursed each budget year starting in FY23 for the five-year period of performance. The Component B funding of \$45 million will be disbursed during year one of FY23.

### **13. Direct Assistance**

Direct Assistance (DA) is available through this NOFO.

DA is available through this NOFO. Applicants may request federal personnel, equipment, or supplies, including SAS licenses, as Direct Assistance (DA) to support any of the approved strategies and activities, in lieu of a portion of financial assistance (FA). To address staffing and/or program expertise deficits, applicant may convert FA to DA to recruit staff with the requisite training, experience, expertise (e.g., Public Health Associate Program [PHAP]). For information on Direct Assistance for Assigning CDC Staff to State, Tribal, Local, and Territorial Health Agencies, refer to:

[https://www.cdc.gov/publichealthgateway/grantsfunding/direct\\_assistance.html](https://www.cdc.gov/publichealthgateway/grantsfunding/direct_assistance.html)

If you are successful and receive a Notice of Award, in accepting the award, you agree that the award and any activities thereunder are subject to all provisions of 45 CFR Part 75, currently in effect or implemented during the period of the award, other Department regulations and policies in effect at the time of the award, and applicable statutory provisions.

## **C. Eligibility Information**

### **1. Eligible Applicants**

Eligibility Category:

00 (State governments)

01 (County governments)

02 (City or township governments)

04 (Special district governments)

25 (Others (see text field entitled "Additional Information on Eligibility" for clarification))

99 (Unrestricted (i.e., open to any type of entity above), subject to any clarification in text field entitled "Additional Information on Eligibility")

Additional Eligibility Category:

Government Organizations:

State (includes the District of Columbia)

Local governments or their bona fide agents

Territorial governments or their bona fide agents in the Commonwealth of Puerto Rico, the Virgin Islands, the Commonwealth of the Northern Mariana Islands, American Samoa, Guam, the Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau

## 2. Additional Information on Eligibility

Bona fide agents are eligible to apply.

Webpage <https://www.cdc.gov/publichealthgateway/grantsfunding/expediting.html#Q2>.

### Component A

- State governments (including District of Columbia)
- Special district governments
- Local governments (includes county, city, and townships) serving a
  - County population of 2,000,000 or more
  - City population of 400,000 or more
- U.S. territories and freely associated-state governments

### Component B

Open

#### Additional Eligibility Information

Strategy A1/Component B are open to entities eligible under 317(k)(2) (States, political subdivisions of States, and other public and nonprofit private entities). Strategies A2 and A3 are intended for states, political subdivisions of states, and other public entities as specified in section 317(a) of the Public Health Services Act (42 USC: 247(b)). It targets public health organizations which are constitutionally empowered to protect the health and welfare of their respective communities, through public health infrastructure, programs and services.

To demonstrate existing capacity providing comprehensive public health services, applicants must submit documentation indicating legal authority to make hiring decisions on behalf of the public health agency in their jurisdiction. Documentation includes signed letter from agency leadership or designee on organizational letterhead. If not submitted, the application will be considered non-responsive and will receive no further review.

Local government's public health agency or their bona fide agents must: Serve a county population of 2 million or more or serve a city population of 400,000 or more. Populations for county and city jurisdictions are based on the 2020 U.S. Census resources. Applicants must submit documentation providing accurate population size served by the public health authority based on the 2020 U.S. Census. Documentation includes a signed letter from public health agency leadership or their designee on organizational letterhead stating the population size served. If not submitted, the application will be considered non-responsive and will receive no further review.

## 3. Justification for Less than Maximum Competition

N/A

## 4. Cost Sharing or Matching

Cost Sharing / Matching Requirement:

No

## 5. Maintenance of Effort

Maintenance of effort is not required for this program.

### D. Required Registrations

#### 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](http://www.grants.gov).

**PLEASE NOTE: Effective April 4, 2022, applicants must have a Unique Entity Identifier (UEI) at the time of application submission (SF-424, field 8c).** The UEI is generated as part of SAM.gov registration. Current SAM.gov registrants have already been assigned their UEI and can view it in SAM.gov and Grants.gov. Additional information is available on the [GSA website](https://www.gsa.gov), [SAM.gov](https://sam.gov), and [Grants.gov- Finding the UEI](https://www.grants.gov).

##### a. Unique Entity Identifier (UEI):

All applicant organizations must obtain a Unique Entity Identifier (UEI) number by registering in SAM.gov prior to submitting an application. A UEI number is a unique twelve-digit identification number assigned to the registering organization.

If funds are awarded to an applicant organization that includes sub-recipients, those sub-recipients must provide their UEI 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 a recipient. All applicant organizations must register with SAM, and will be assigned a SAM number and a Unique Entity Identifier (UEI). 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 [SAM.gov](https://sam.gov) and the [SAM.gov Knowledge Base](https://sam.gov).

**c. [Grants.gov](https://www.grants.gov):** The first step in submitting an application online is registering your organization at [www.grants.gov](https://www.grants.gov), the official HHS E-grant Web site. Registration information is located at the "Applicant Registration" option at [www.grants.gov](https://www.grants.gov).

All applicant organizations must register at [www.grants.gov](https://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 | System for Award Management (SAM) | 1. Go to <a href="https://sam.gov">SAM.gov</a> and designate an E-Biz POC (You will need to have an active SAM account before you can register on grants.gov). The UEI is generated as part of your registration.                                                                                                                                                                                    | 3-5 Business Days but up to 2 weeks and must be renewed once a year                                                                                                                   | For SAM Customer Service Contact <a href="https://fsd.gov/">https://fsd.gov/</a> <a href="https://fsd-home.do">fsd-home.do</a> Calls: 866-606-8220 |
| 2 | Grants.gov                        | 1. Set up an individual account in Grants.gov using organization's new UEI number to become an Authorized Organization Representative (AOR)<br>2. Once the account is set up the E-BIZ POC will be notified via email<br>3. Log into grants.gov using the password the E-BIZ POC received and create new password<br>4. This authorizes the AOR to submit applications on behalf of the organization | It takes one day (after you enter the EBiz POC name and EBiz POC email in SAM) to receive a UEI (SAM) which will allow you to register with Grants.gov and apply for federal funding. | Register early! Applicants can register within minutes.                                                                                            |

## 2. Request Application Package

Applicants may access the application package at [www.grants.gov](https://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](https://www.grants.gov).

## 4. Submission Dates and Times

If the application is not submitted by the deadline published in the NOFO, 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)

Due Date for Letter Of Intent 06/30/2022

06/30/2022



LOI due date: 6/30/2022  
Project Officer: Jonathan Carlson  
Email address: PHInfrastructure@cdc.gov

## **b. Application Deadline**

Due Date for Applications 08/15/2022

08/15/2022

11:59 pm U.S. Eastern Time, at [www.grants.gov](http://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.

June 29, 2022

### **Due Date for Information Conference Call**

**Applicant Informational calls:** CDC will host 2 informational calls for interested applicants. The content of both calls will be identical. The 2 times are offered as a way to help accommodate the schedules of interested applicants and their locations in varying time zones. Due to limited space, we ask that interested applicants only register for Webinar A or B, but not both.

When: June 29, 2022 3:00 to 4:00 PM Eastern Time (U.S. and Canada)

Topic: OE22-2203 Applicant Informational Call A

Register in advance for this webinar:

[https://cdc.zoomgov.com/webinar/register/WN\\_V5iIgBryTBCUwpp1xxgDqA](https://cdc.zoomgov.com/webinar/register/WN_V5iIgBryTBCUwpp1xxgDqA)

When: June 29, 2022 6:00 to 7:00PM Eastern Time (U.S. and Canada)

Topic: OE22-2203 Applicant Informational Call B

Register in advance for this webinar:

[https://cdc.zoomgov.com/webinar/register/WN\\_jrPD018uQMCydBMi6d9vcw](https://cdc.zoomgov.com/webinar/register/WN_jrPD018uQMCydBMi6d9vcw)

## **5. Pre-Award Assessments**

### **Risk Assessment Questionnaire Requirement**

CDC is required to conduct pre-award risk assessments to determine the risk an applicant poses to meeting federal programmatic and administrative requirements by taking into account issues such as financial instability, insufficient management systems, non-compliance with award conditions, the charging of unallowable costs, and inexperience. The risk assessment will include an evaluation of the applicant's CDC Risk Questionnaire, located at <https://www.cdc.gov/grants/documents/PPMR-G-CDC-Risk-Questionnaire.pdf>, as well as a review of the applicant's history in all available systems; including OMB-designated repositories of government-wide eligibility and financial integrity systems (see 45 CFR 75.205(a)), and other sources of historical information. These systems include, but are not limited to: FAPIIS (<https://www.fapiis.gov/>), including past performance on federal contracts as per Duncan Hunter National Defense Authorization Act of 2009; Do Not Pay list; and System for Award Management (SAM) exclusions.

CDC requires all applicants to complete the Risk Questionnaire, OMB Control Number 0920-1132 annually. This questionnaire, which is located

at <https://www.cdc.gov/grants/documents/PPMR-G-CDC-Risk-Questionnaire.pdf>, along with supporting documentation must be submitted with your application by the closing date of the Notice of Funding Opportunity Announcement. If your organization has completed CDC's Risk Questionnaire within the past 12 months of the closing date of this NOFO, then you must submit a copy of that questionnaire, or submit a letter signed by the authorized organization representative to include the original submission date, organization's EIN and UEI.

When uploading supporting documentation for the Risk Questionnaire into this application package, clearly label the documents for easy identification of the type of documentation. For example, a copy of Procurement policy submitted in response to the questionnaire may be labeled using the following format: Risk Questionnaire Supporting Documents \_ Procurement Policy.

### **Duplication of Efforts**

Applicants are responsible for reporting if this application will result in programmatic, budgetary, or commitment overlap with another application or award (i.e. grant, cooperative agreement, or contract) submitted to another funding source in the same fiscal year. Programmatic overlap occurs when (1) substantially the same project is proposed in more than one application or is submitted to two or more funding sources for review and funding consideration or (2) a specific objective and the project design for accomplishing the objective are the same or closely related in two or more applications or awards, regardless of the funding source. Budgetary overlap occurs when duplicate or equivalent budgetary items (e.g., equipment, salaries) are requested in an application but already are provided by another source. Commitment overlap occurs when an individual's time commitment exceeds 100 percent, whether or not salary support is requested in the application. Overlap, whether programmatic, budgetary, or commitment of an individual's effort greater than 100 percent, is not permitted. Any overlap will be resolved by the CDC with the applicant and the PD/PI prior to award.

Report Submission: The applicant must upload the report in Grants.gov under "Other Attachment Forms." The document should be labeled: "Report on Programmatic, Budgetary, and Commitment Overlap."

## **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](http://www.grants.gov).

## **7. Letter of Intent**

Is a LOI:

Recommended but not Required

The purpose of an LOI is to allow CDC program staff to estimate the number of and plan for the review of submitted applications. LOI are strongly encouraged, but not required.

LOI should indicate the applicant's intention to submit an application to this Notice of Funding Opportunity.

Send LOI via email to:

Project Officer: Jonathan Carlson  
Email address: PHInfrastructure@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](http://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](http://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](http://www.grants.gov).

## **10. Project Narrative**

Multi-component NOFOs may have a 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 per component for Project Narrative subsections that are 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 may not be reviewed.

Applicants should use the federal plain language guidelines and Clear Communication Index to respond to this Notice of Funding Opportunity Announcement. Note that recipients should also use these tools when creating public communication materials supported by this NOFO. Failure to follow the guidance and format may negatively impact scoring of the application.

The project narrative may have a maximum of 50 pages total. Background, Organizational Capacity of Applicants to Implement the Approach, the Workplan, and an abbreviated version of the Applicant Evaluation and Performance Measurement Plan (to be updated in 6 months) are required. Applicants will either apply for Component A or Component B, but not both.

### **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 period of performance. 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 period of performance 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 period of performance. (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. Applicants must address the Collaboration requirements as described in the CDC Project Description.

### **2. Target Populations and Health Disparities**

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. The applicants must also address how they will include specific populations that can benefit from the program that is described in the Approach section. Applicants must address the Target Populations and Health Disparities requirements as described 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 recipient will fulfill the requirements described in the CDC Evaluation and Performance Measurement and Project Description sections of this NOFO. 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. For further information about CDC's requirements under PRA see <https://www.cdc.gov/od/science/integrity/reducePublicBurden/>.
- 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, data management plan (DMP), 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).

Recipients will be required to submit a more detailed Evaluation and Performance Measurement plan (including the DMP elements) within the first 6 months of award, as described in the Reporting Section of this NOFO.

#### **d. Organizational Capacity of Applicants to Implement the Approach**

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

### **11. Work Plan**

(Included in the Project Narrative's page limit)

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 recipient plans to carry out achieving the period of performance outcomes, strategies and activities, evaluation and performance measurement.

### **12. Budget Narrative**

Applicants must submit an itemized budget narrative. 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 could include the cost of collecting, managing, sharing and preserving data.

Indirect costs on grants awarded to foreign organizations and foreign public entities and performed fully outside of the territorial limits of the U.S. may be paid to support the costs of

compliance with federal requirements at a fixed rate of eight percent of MTDC exclusive of tuition and related fees, direct expenditures for equipment, and subawards in excess of \$25,000. Negotiated indirect costs may be paid to the American University, Beirut, and the World Health Organization.

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 NOFO 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 Mariana 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 NOFO. Proposed activities must be included in the budget narrative and must indicate which standards will be addressed.

Vital records data, including births and deaths, are used to inform public health program and policy decisions. If applicable and consistent with the cited statutory authority for this NOFO, applicant entities are encouraged to collaborate with and support their jurisdiction's vital records office (VRO) to improve vital records data timeliness, quality and access, and to advance public health goals. Recipients may, for example, use funds to support efforts to build VRO capacity through partnerships; provide technical and/or financial assistance to improve vital records timeliness, quality or access; or support vital records improvement efforts, as approved by CDC.

Applicants must name this file "Budget Narrative" and upload it as a PDF file

at [www.grants.gov](http://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 Recipients under such a plan. Applicants must name this file "Indirect Cost Rate" and upload it at [www.grants.gov](http://www.grants.gov).

Applicants must include high-level object class budgets for each Strategy in Component A that they wish to be considered for current or future funding. The budget narrative should be categorized by the following verbatim titles identifying each strategy: A1 Workforce, A2 Foundational capabilities, and A3 Data modernization. Please see "Attachment D\_SF424\_A Guidance" for an example of how these verbatim titles must be utilized as labels for each section of the budget narrative and for the SF424A.

### **13. Pilot Program for Enhancement of Employee Whistleblowers 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 recipients 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.

#### **13a. 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). Recipients will be required to draw down funds from award-specific accounts in the PMS. Ultimately, the subaccounts will provide recipients 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 45 CFR 75 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.

#### **13b. 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.

### **13c. Data Management Plan**

As identified in the Evaluation and Performance Measurement section, applications involving data collection or generation must include a Data Management Plan (DMP) as part of their evaluation and performance measurement plan unless CDC has stated that CDC will take on the responsibility of creating the DMP. The DMP describes plans for assurance of the quality of the public health data through the data's lifecycle and plans to deposit the data in a repository to preserve and to make the data accessible in a timely manner. See web link for additional information: <https://www.cdc.gov/grants/additional-requirements/ar-25.html>.

## **14. Funding Restrictions**

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

- Recipients may not use funds for research.
- Recipients may not use funds for clinical care except as allowed by law.
- Recipients may use funds only for reasonable program purposes, including personnel, travel, supplies, and services.
- Generally, recipients 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 recipient.
- 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 recipients](#).
- 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.

See the unallowable costs included in [2 CFR 200 Subpart E - Cost Principles](#).



45 CFR part 75 outlines the parameters related to allowable costs that might be implicated in proposed activities.

## 15. Other Submission Requirements

**a. Electronic Submission:** Applications must be submitted electronically by using the forms and instructions posted for this notice of funding opportunity at [www.grants.gov](http://www.grants.gov). Applicants can complete the application package using Workspace, which allows forms to be filled out online or offline. All application attachments must be submitted using a PDF file format. Instructions and training for using Workspace can be found at [www.grants.gov](http://www.grants.gov) under the "Workspace Overview" option.

**b. Tracking Number:** Applications submitted through [www.grants.gov](http://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](http://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](http://www.grants.gov). A second e-mail message to applicants will then be generated by [www.grants.gov](http://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 NOFO. 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](http://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 Grants.gov Online User Guide.

<https://www.grants.gov/help/html/help/index.htm?callingApp=custom#t=GetStarted%2FGetStarted.htm>

**d. Technical Difficulties:** If technical difficulties are encountered at [www.grants.gov](http://www.grants.gov), applicants should contact Customer Service at [www.grants.gov](http://www.grants.gov). The [www.grants.gov](http://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@grants.gov](mailto:support@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](http://www.grants.gov) is managed by HHS.

**e. Paper Submission:** If technical difficulties are encountered at [www.grants.gov](http://www.grants.gov), applicants should call the [www.grants.gov](http://www.grants.gov) Contact Center at 1-800-518-4726 or e-mail them at [support@grants.gov](mailto:support@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](http://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](http://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, OGS will advise the applicant of specific instructions for submitting the application via email.

## **E. Review and Selection Process**

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

#### **a. Phase 1 Review**

All applications will be initially reviewed for eligibility and completeness by the Office of Grants Services. Complete applications will be reviewed for responsiveness by Grants Management Officials and Program Officials. Non-responsive applications will not advance to Phase II review. Applicants will be notified that their applications did not meet eligibility and/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.

#### **i. Approach**

**Maximum Points: 40**

**Component A and Component B Approach are scored separately by reviewers. Each Component is worth a maximum of 40 points.**

#### **Component A (Maximum Points: 40)**

Evaluate the extent to which the applicant:

- Presents outcomes that are consistent with the period of performance outcomes described in the CDC Project Description.
- Describes an overall strategy and activities consistent with the CDC Project Description.
- Describes strategies and activities that are achievable, appropriate to achieve the outcomes of the project, and evidence-based (to the degree practicable).
- Shows that the proposed use of funds is an efficient and effective way to implement the strategies and activities and attain the period of performance outcomes.

- Presents a work plan that is aligned with the strategies and activities, outcomes, and performance measures and is consistent with the content and format proposed by CDC.
- Describes strategies and activities to support and provide sub-awards to local health departments or other public health agencies or organizations that are not direct recipients of this award to cover the entire jurisdiction the applicant is proposing to serve

#### **Component B (Maximum Points: 40)**

Evaluate the extent to which the applicant:

- Presents outcomes that are consistent with the period of performance outcomes described in the CDC Project Description.
- Describes an overall strategy and activities consistent with the CDC Project Description.
- Describes strategies and activities that are achievable, appropriate to achieve the outcomes of the project, and evidence-based (to the degree practicable).
- Shows that the proposed use of funds is an efficient and effective way to implement the strategies and activities and attain the period of performance outcomes.
- Presents a work plan that is aligned with the strategies/activities, outcomes, and performance measures in the approach and is consistent with the content and format proposed by CDC.

#### **ii. Evaluation and Performance Measurement**

**Maximum Points: 25**

**Component A and Component B Evaluation and Performance Measurement are scored separately by reviewers. Each Component is worth a maximum of 25 points.**

#### **Component A (Background) (Maximum Points: 25)**

Evaluate the extent to which the applicant:

- Describes past participation in relevant national assessments
- Describes intention to participate in relevant assessments in the future
- Reacts to proposed outcome performance measures specified by CDC in the project description for Strategy A1 Workforce
- Describes their evaluation and performance measurement capacity
- Describes their intentions to collaborate with the Component B2 Grant evaluation recipient

#### **Component B (Maximum Points: 25)**

Evaluate the extent to which the applicant:

- Shows and affirms the ability to collect data on the process and outcome performance measures specified by CDC in the project description and presented by the applicant in their approach, including information on the feasibility of reporting on the measures and barriers to reporting.
- Describes how performance measurement and evaluation findings will be reported, and used to demonstrate the outcomes of the NOFO and for continuous program quality improvement.

- Describes how evaluation and performance measurement will contribute to developing an evidence base for programs that lack a strong effectiveness evidence base.
- Describes any evaluation studies they are to undertake. Describe in sufficient detail to identify the key evaluation questions, and data sources and analysis methods.

**iii. Applicant's Organizational Capacity to Implement the Approach**

**Maximum Points: 35**

**Component A - Strategy A1 and A2, Component A - Strategy A3, and Component B Organizational Capacity to Implement the Approach are scored separately by reviewers. Component A (A1 Workforce and A2 Foundational capabilities), Component A (Strategy A3 Data modernization), and Component B are each worth a maximum of 35 points.**

**Component A (Maximum Points: 35)**

**A1 Workforce and A2 Foundational capabilities**

Evaluation for Strategy A1 and A2 will assess the extent to which applicants:

- Implement a comprehensive public health program, including all the Public Health Services.
- Maintain a comprehensive public health infrastructure, including all Public Health foundational capabilities, including a robust human resources capacity.
- Are accredited or provide evidence of active pursuit of accreditation by the Public Health Accreditation Board (PHAB) or explains why their organization chooses not to apply for accreditation.
- Have an established public health presence across their jurisdiction, including evidence of serving medically underserved areas within their jurisdiction.
- Demonstrated ability to manage a large state, or county, or city public health agency that services a population of 400,000 or greater or demonstrated ability to manage a U.S. Territory or freely associated state health agency.

**A3 Data modernization (Maximum Points: 35)**

Evaluation for Strategy A3 will assess the extent to which applicants:

- Implement a comprehensive public health program, including all the Public Health Services.
- Maintain a comprehensive public health infrastructure, including all Public Health foundational capabilities, including a robust human resources capacity.
- Are accredited or provide evidence of active pursuit of accreditation by the Public Health Accreditation Board (PHAB) or explains why their organization chooses not to apply for accreditation.
- Have an established public health presence across their jurisdiction, including evidence of serving medically underserved areas within their jurisdiction.
- Demonstrated ability to manage a large state, or county, or city public health agency that services a population of 400,000 or greater or demonstrated ability to manage a U.S. Territory or freely associated state health agency.

- Have an established understanding and authority to implement DMI standards and practices across their identified level of government (i.e., States and Territories (including Freely Associated States) or eligible city or eligible county).
- Have identified as a current recipient of data modernization funding through the CDC Epidemiology and Laboratory Capacity for Prevention and Control of Emerging Infectious Diseases (ELC) supplemental funding.

### **Component B (Maximum Points: 35)**

Evaluation will assess the extent to which applicants:

- Have a wide reach across the United States, alone or in combination with key partners also included in the grant application.
- Could begin substantive work with many Component A recipients soon after award
- Have recent experience working with governmental public health agency related to the parts of Component B to which they are applying.

### **Budget**

**Maximum Points: 0**

The budget is not scored. However, applicants should describe in the budget narrative how budget items are related to the various strategies for which they are applying. There should be a way for CDC and reviewers to understand approximately how much of the funding will be applied to each strategy in the proposal. Please use the verbatim strategy titles A1 Workforce, A2 Foundational capabilities, and A3 Data modernization to label budget narrative sections. Thus, applicants will need to have a separate budget line for each strategy identified on the SF-424A under the headings referred to as “Grant Program Function or Activity” for Strategies A1-A3. Please see “Attachment D\_SF424\_A Guidance” for an example, and utilize the verbatim titles provided.

## **c. Phase III Review**

### **Component A**

An objective review with field reviewers will be used to examine these applications and inform award decisions. The following factors also may affect the funding decision: geographic diversity. The purpose of this grant is to support public health agencies across the United States. As such, CDC does not plan to fund more than one recipient to serve the same geographic area, for example, two applicants that work statewide in the same state, two applicants that work countywide in the same county, or two applicants that work citywide in the same city. In those situations, rank order will be used to determine which of the competing applicants will be funded, and the remaining applicant(s) for that geographic area may not be funded, even if other applicants had lower total scores. Statewide applicants will not be responsible for working in any city or county jurisdictions that receive funding from this grant to avoid geographical overlap. It may also be necessary for CDC to fund only specific levels of government such as all states and territories or all eligible cities or all eligible counties for specific strategies such as DMI to avoid geographical overlap and unnecessary redundancies. Finally, applicants that demonstrate plans to devote more grant effort towards the needs in medically underserved areas may be funded above those that might score higher but do not have that same geographic emphasis.

## **Component B**

An objective review with field reviewers will be used to examine these applications and inform award decisions. The following factors also may affect the funding decision: organizations with documented associations with many state, or local or Territorial government public health agencies, and scope of strategies that an applicant proposes to cover. Applicants that seek to cover more of the strategies included in Component B may be funded over those that cover fewer strategies, but which have higher total scores. Maximizing coordination and streamlining among these Component B partners is in the best interest of the grant and the Component A recipients they are intended to serve.

### **Review of risk posed by applicants.**

Prior to making a Federal award, CDC is required by 31 U.S.C. 3321 and 41 U.S.C. 2313 to review information available through any OMB-designated repositories of government-wide eligibility qualification or financial integrity information as appropriate. See also suspension and debarment requirements at 2 CFR parts 180 and 376.

In accordance 41 U.S.C. 2313, CDC is required to review the non-public segment of the OMB-designated integrity and performance system accessible through SAM (currently the Federal Recipient Performance and Integrity Information System (FAPIIS)) prior to making a Federal award where the Federal share is expected to exceed the simplified acquisition threshold, defined in 41 U.S.C. 134, over the period of performance. At a minimum, the information in the system for a prior Federal award recipient must demonstrate a satisfactory record of executing programs or activities under Federal grants, cooperative agreements, or procurement awards; and integrity and business ethics. CDC may make a Federal award to a recipient who does not fully meet these standards, if it is determined that the information is not relevant to the current Federal award under consideration or there are specific conditions that can appropriately mitigate the effects of the non-Federal entity's risk in accordance with 45 CFR §75.207.

CDC's framework for evaluating the risks posed by an applicant may incorporate results of the evaluation of the applicant's eligibility or the quality of its application. If it is determined that a Federal award will be made, special conditions that correspond to the degree of risk assessed may be applied to the Federal award. The evaluation criteria is described in this Notice of Funding Opportunity.

In evaluating risks posed by applicants, CDC will use a risk-based approach and may consider any items such as the following:

- (1) Financial stability;
- (2) Quality of management systems and ability to meet the management standards prescribed in this part;
- (3) History of performance. The applicant's record in managing Federal awards, if it is a prior recipient of Federal awards, including timeliness of compliance with applicable reporting requirements, conformance to the terms and conditions of previous Federal awards, and if applicable, the extent to which any previously awarded amounts will be expended prior to future awards;
- (4) Reports and findings from audits performed under subpart F 45 CFR 75 or the reports and findings of any other available audits; and

(5) The applicant's ability to effectively implement statutory, regulatory, or other requirements imposed on non-Federal entities.

CDC must comply with the guidelines on government-wide suspension and debarment in 2 CFR part 180, and require non-Federal entities to comply with these provisions. These provisions restrict Federal awards, subawards and contracts with certain parties that are debarred, suspended or otherwise excluded from or ineligible for participation in Federal programs or activities.

## **2. Announcement and Anticipated Award Dates**

The anticipated publication date is June 16, 2022, on [www.grants.gov](http://www.grants.gov). Applicants will have up to 60 days, or August 15, 2022, to respond. Applicants are encouraged to apply early. The anticipated award date(s) may vary by each component and strategy. Component A and Component B may be funded on or near November 1, 2022.

## **F. Award Administration Information**

### **1. Award Notices**

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

Any applicant awarded funds in response to this Notice of Funding Opportunity will be subject to annual 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.

## **2. Administrative and National Policy Requirements**

Recipients 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 <https://www.cdc.gov/grants/additional-requirements/index.html>.

The HHS Grants Policy Statement is available at <http://www.hhs.gov/sites/default/files/grants/grants/policies-regulations/hhsgps107.pdf>.

The following Administrative Requirements (AR) apply to this NOFO:

- *AR-7: Executive Order 12372 Review*
- *AR-8: Public Health System Reporting Requirements*
- *AR-9: Paperwork Reduction Act Requirements*
- *AR-10: Smoke-Free Workplace Requirements*
- *AR-11: Healthy People 2030*
- *AR-12: Lobbying Restrictions*
- *AR-13: Prohibition on Use of CDC Funds for Certain Gun Control Activities*
- *AR-8: Public Health System Reporting Requirements*
- *AR-15: Proof of Non-profit Status*

- AR-23: Compliance with 45 CFR Part 87
- 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 Requirements
- AR-25: Data Management and Access
- 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: Information Letter 10-006, - Compliance with Section 508 of the Rehabilitation Act of 1973
- AR-32: Enacted General Provisions
- AR-34: Language Access for Persons with Limited English Proficiency
- AR-37: Prohibition on certain telecommunications and video surveillance services or equipment for all awards issued on or after August 13, 2020

The full text of the Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards, 45 CFR 75, can be found at: <https://www.ecfr.gov/cgi-bin/text-idx?node=pt45.1.75>

Should you successfully compete for an award, recipients of federal financial assistance (FFA) from HHS must administer their programs in compliance with federal civil rights laws that prohibit discrimination on the basis of race, color, national origin, disability, age and, in some circumstances, religion, conscience, and sex (including gender identity, sexual orientation, and pregnancy). This includes taking reasonable steps to provide meaningful access to persons with limited English proficiency and providing programs that are accessible to and usable by persons with disabilities. The HHS Office for Civil Rights provides guidance on complying with civil rights laws enforced by HHS. See <https://www.hhs.gov/civil-rights/for-providers/provider-obligations/index.html> and <https://www.hhs.gov/civil-rights/for-individuals/nondiscrimination/index.html>.

- Recipients of FFA must ensure that their programs are accessible to persons with limited English proficiency. For guidance on meeting your legal obligation to take reasonable steps to ensure meaningful access to your programs or activities by limited English proficient individuals, see <https://www.hhs.gov/civil-rights/for-individuals/special-topics/limited-english-proficiency/fact-sheet-guidance/index.html> and <https://www.lep.gov>.
- For information on your specific legal obligations for serving qualified individuals with disabilities, including providing program access, reasonable modifications, and taking appropriate steps to provide effective communication, see <http://www.hhs.gov/ocr/civilrights/understanding/disability/index.html>.
- HHS funded health and education programs must be administered in an environment free of sexual harassment, see <https://www.hhs.gov/civil-rights/for-individuals/sex-discrimination/index.html>.



- For guidance on administering your project in compliance with applicable federal religious nondiscrimination laws and applicable federal conscience protection and associated anti-discrimination laws, see <https://www.hhs.gov/conscience/conscience-protections/index.html> and <https://www.hhs.gov/conscience/religious-freedom/index.html>.

### 3. Reporting

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

- Helps target support to recipients;
- Provides CDC with periodic data to monitor recipient progress toward meeting the Notice of Funding Opportunity outcomes and overall performance;
- Allows CDC to track performance measures and evaluation findings for continuous quality and program improvement throughout the period of performance 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 NOFO.

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 NOFO copying the CDC Project Officer.

These apply to both Component A and Component B recipients.

| Report Type                                                                                                | When?                                                                                                          | Required? |
|------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------|-----------|
| Recipient Evaluation and Performance Measurement Plan, including Data Management Plan (DMP)(if applicable) | 6 months into award                                                                                            | Yes       |
| Annual Performance Report (APR)                                                                            | No later than 120 days before end of budget period. Services as a yearly continuation application.             | Yes       |
| Progress Reporting                                                                                         | 6-month reports are due 60 days after each fiscal 6-month mark; thereafter, through the period of performance. | Yes       |
| Federal Financial Reporting Forms                                                                          | Due 90 days after the end of the budget period                                                                 | Yes       |

|                                        |                                                |     |
|----------------------------------------|------------------------------------------------|-----|
| Final Performance and Financial Report | Due 90 days after end of period of performance | Yes |
|----------------------------------------|------------------------------------------------|-----|

There may be flexibility in reporting deadlines. CDC will communicate updates or revisions to reporting requirements as appropriate. Performance measures and progress reports will be submitted via the Research Electronic Data Capture, or otherwise known as REDCap. Recipients will also update workplans in REDCap. CDC will provide training and technical assistance for recipients on REDCap post-award.

**a. Recipient Evaluation and Performance Measurement Plan (required)**

With support from CDC, recipients must elaborate on their initial applicant evaluation and performance measurement plan. This plan must be no more than 20 pages; recipients must submit the plan 6 months into the award. HHS/CDC will review and approve the recipient's monitoring and evaluation plan to ensure that it is appropriate for the activities to be undertaken as part of the agreement, for compliance with the monitoring and evaluation guidance established by HHS/CDC, or other guidance otherwise applicable to this Agreement.

Recipient Evaluation and Performance Measurement Plan (required): This plan should provide additional detail on the following:

Performance Measurement

- Performance measures and targets
- The frequency that performance data are to be collected.
- How performance data will be reported.
- How quality of performance data will be assured.
- How performance measurement will yield findings to demonstrate progress towards achieving NOFO goals (e.g., reaching target populations or achieving expected outcomes).
- Dissemination channels and audiences.
- Other information requested as determined by the CDC program.

Evaluation

- The types of evaluations to be conducted (e.g. process or outcome evaluations).
- The frequency that evaluations will be conducted.
- How evaluation reports will be published on a publicly available website.
- How evaluation findings will be used to ensure continuous quality and program improvement.
- How evaluation will yield findings to demonstrate the value of the NOFO (e.g., effect on improving public health outcomes, effectiveness of NOFO, cost-effectiveness or cost-benefit).
- Dissemination channels and audiences.

HHS/CDC or its designee will also undertake monitoring and evaluation of the defined activities within the agreement. The recipient must ensure reasonable access by HHS/CDC or its designee

to all necessary sites, documentation, individuals and information to monitor, evaluate and verify the appropriate implementation the activities and use of HHS/CDC funding under this Agreement.

**b. Annual Performance Report (APR) (required)**

The recipient must submit the APR via [www.Grantsolutions.gov](http://www.Grantsolutions.gov) no later than 120 days prior to the end of the budget period. This report must not exceed 45 pages excluding administrative reporting. Attachments are not allowed, but web links are allowed.

This report must include the following:

- **Performance Measures:** Recipients must report on performance measures for each budget period and update measures, if needed.
- **Evaluation Results:** Recipients must report evaluation results for the work completed to date (including findings from process or outcome evaluations).
- **Work Plan:** Recipients must update work plan each budget period to reflect any changes in period of performance outcomes, activities, timeline, etc.
- **Successes**
  - Recipients must report progress on completing activities and progress towards achieving the period of performance outcomes described in the logic model and work plan.
  - Recipients must describe any additional successes (e.g. identified through evaluation results or lessons learned) achieved in the past year.
  - Recipients must describe success stories.
- **Challenges**
  - Recipients must describe any challenges that hindered or might hinder their ability to complete the work plan activities and achieve the period of performance outcomes.
  - Recipients must describe any additional challenges (e.g., identified through evaluation results or lessons learned) encountered in the past year.
- **CDC Program Support to Recipients**
  - Recipients must describe how CDC could help them overcome challenges to complete activities in the work plan and achieving period of performance 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 recipient must submit the Annual Performance Report via <https://www.grantsolutions.gov> 120 days prior to the end of the budget period.

The recipients must submit the Annual Performance Report via [www.Grantsolutions.gov](http://www.Grantsolutions.gov) no later than 120 days prior to the end of the 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 recipients at the beginning of the award period.

CDC will require 6-month reporting on some performance measures, and others will be required annually. The final reporting schedule will be determined after award.

**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 budget period through the Payment Management System (PMS). 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, recipients are required to submit a letter of explanation to OGS and include the date by which the Grants Officer will receive information.

No additional information.

**e. Final Performance and Financial Report (required)**

The Final Performance Report is due 90 days after the end of the period of performance. The Final FFR is due 90 days after the end of the period of performance and must be submitted through the Payment Management System (PMS). CDC programs must indicate that this report should not exceed 40 pages. This report covers the entire period of performance and can include information previously reported in APRs. At a minimum, this report must include the following:

- Performance Measures – Recipients must report final performance data for all process and outcome performance measures.
- Evaluation Results – Recipients must report final evaluation results for the period of performance for any evaluations conducted.
- Impact/Results/Success Stories – Recipients must use their performance measure results and their evaluation findings to describe the effects or results of the work completed over the period of performance, and can include some success stories.
- A final Data Management Plan that includes the location of the data collected during the funded period, for example, repository name and link data set(s)
- Additional forms as described in the Notice of Award (e.g., Equipment Inventory Report, Final Invention Statement).

No additional information.

#### **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:

- <https://www.gpo.gov/fdsys/pkg/PLAW-109publ282/pdf/PLAW-109publ282.pdf>,
- [https://www.frs.gov/documents/ffata\\_legislation\\_110\\_252.pdf](https://www.frs.gov/documents/ffata_legislation_110_252.pdf)
- <http://www.hhs.gov/grants/grants/grants-policies-regulations/index.html#FFATA>.

#### **5. 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 recipient 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 recipient did not pay any taxes during the reporting period.]

2) Quarterly Report: The recipient 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](mailto:VATreporting@cdc.gov).

5) Contents of Reports: The reports must contain:

a. recipient 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 recipient must include this reporting requirement in all applicable subgrants and other subagreements.

## **6. Termination**

CDC may impose other enforcement actions in accordance with 45 CFR 75.371- Remedies for Noncompliance, as appropriate.

The Federal award may be terminated in whole or in part as follows:

(1) By the HHS awarding agency or pass-through entity, if the non-Federal entity fails to comply with the terms and conditions of the award;

(2) By the HHS awarding agency or pass-through entity for cause;

(3) By the HHS awarding agency or pass-through entity with the consent of the non-Federal entity, in which case the two parties must agree upon the termination conditions, including the effective date and, in the case of partial termination, the portion to be terminated; or

(4) By the non-Federal entity upon sending to the HHS awarding agency or pass-through entity written notification setting forth the reasons for such termination, the effective date, and, in the case of partial termination, the portion to be terminated. However, if the HHS awarding agency or pass-through entity determines in the case of partial termination that the reduced or modified portion of the Federal award or subaward will not accomplish the purposes for which the Federal award was made, the HHS awarding agency or pass-through entity may terminate the Federal award in its entirety.

## **G. Agency Contacts**

CDC encourages inquiries concerning this NOFO.

### **Program Office Contact**

**For programmatic technical assistance, contact:**

First Name:

Jonathan

Last Name:

Carlson

Project Officer

Department of Health and Human Services

Centers for Disease Control and Prevention

Address:

Department of Health and Human Services

Centers for Disease Control and Prevention

Center for Surveillance, Epidemiology, and Laboratory Services

Division of Scientific Education and Professional Development

2400 Century Center Blvd., Mailstop V24-5

Atlanta, GA 30345

Telephone:

Email:

phinrastructure@cdc.gov

### **Grants Management Office Information**

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

First Name:

Rhonda

Last Name:

Latimer

Grants Management Specialist

Department of Health and Human Services

Office of Grants Services

Address:

Department of Health and Human Services

Centers for Disease Control and Prevention

Office of Grants Services

2939 Flowers Road

Atlanta, GA 30341

Telephone:

770-488-1647

Email:

ito1@cdc.gov

For assistance with **submission difficulties related to** [www.grants.gov](http://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.

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](http://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
- Report on Programmatic, Budgetary and Commitment Overlap
- Table of Contents for Entire Submission

For international NOFOs:

- SF424
- SF424A
- 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

Applicants are encouraged to upload public health agency leadership letters, MOUs/MOAs, and any documents requested to demonstrate responsiveness. Applicants are encouraged to visit this website more for guidance and answers to questions they may have: <https://www.cdc.gov/workforce/resources/infrastructuregrant.html>

## **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 NOFO; recipients must comply with the ARs listed in the NOFO. To view brief descriptions of relevant provisions, see <https://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).

**Approved but Unfunded:** Approved but unfunded refers to applications recommended for approval during the objective review process; however, they were not recommended for funding by the program office and/or the grants management office.

**Assistance Listings:** A government-wide collection of federal programs, projects, services, and activities that provide assistance or benefits to the American public.

**Assistance Listings Number:** A unique number assigned to each program and NOFO throughout its lifecycle that enables data and funding tracking and transparency.

**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 period of performance. Traditionally, budget periods are 12 months or 1 year.

**Carryover:** Unobligated federal funds remaining at the end of any budget period that, with the approval of the GMO or under an automatic authority, may be carried over to another budget period to cover allowable costs of that budget period either as an offset or additional authorization. Obligated but liquidated funds are not considered carryover.

**Continuous Quality Improvement:** A system that seeks to improve the provision of services with an emphasis on future results.

**Contracts:** An award instrument used to acquire (by purchase, lease, or barter) property or services for the direct benefit or use of the Federal Government.

**Cooperative Agreement:** A financial assistance award with the same kind of interagency relationship as a grant except that it provides for substantial involvement by the federal agency funding the award. Substantial involvement means that the recipient can expect federal programmatic collaboration or participation in carrying out the effort under the award.

**Cost Sharing or Matching:** Refers to program costs not borne by the Federal Government but by the recipients. It may include the value of allowable third-party, in-kind contributions, as well as expenditures by the recipient.

**Direct Assistance:** A financial assistance mechanism, which must be specifically authorized by statute, whereby goods or services are provided to recipients in lieu of cash. DA generally involves the assignment of federal personnel or the provision of equipment or supplies, such as vaccines. DA is primarily used to support payroll and travel expenses of CDC employees assigned to state, tribal, local, and territorial (STLT) health agencies that are recipients of grants and cooperative agreements. Most legislative authorities that provide financial assistance to

STLT health agencies allow for the use of DA. <https://www.cdc.gov/grants/additional-requirements/index.html>.

**Evaluation (program evaluation):** The systematic collection of information about the activities, characteristics, and outcomes of programs (which may include interventions, policies, and specific projects) to make judgments about that program, improve program effectiveness, and/or inform decisions about future program development.

**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 NOFO evaluation plan is used to describe how the recipient and/or CDC will determine whether activities are implemented appropriately and outcomes are achieved.

**Federal Funding Accountability and Transparency Act of 2006 (FFATA):** Requires that information about federal awards, including awards, contracts, loans, and other assistance and payments, be available to the public on a single website at [www.USAspending.gov](http://www.USAspending.gov).

**Fiscal Year:** The year for which budget dollars are allocated annually. The federal fiscal year starts October 1 and ends September 30.

**Grant:** A legal instrument used by the federal government to transfer anything of value to a recipient for public support or stimulation authorized by statute. Financial assistance may be money or property. The definition does not include a federal procurement subject to the Federal Acquisition Regulation; technical assistance (which provides services instead of money); or assistance in the form of revenue sharing, loans, loan guarantees, interest subsidies, insurance, or direct payments of any kind to a person or persons. The main difference between a grant and a cooperative agreement is that in a grant there is no anticipated substantial programmatic involvement by the federal government under the award.

**Grants.gov:** A "storefront" web portal for electronic data collection (forms and reports) for federal grant-making agencies at [www.grants.gov](http://www.grants.gov).

**Grants Management Officer (GMO):** The individual designated to serve as the HHS official responsible for the business management aspects of a particular grant(s) or cooperative agreement(s). The GMO serves as the counterpart to the business officer of the recipient organization. In this capacity, the GMO is responsible for all business management matters associated with the review, negotiation, award, and administration of grants and interprets grants administration policies and provisions. The GMO works closely with the program or project officer who is responsible for the scientific, technical, and programmatic aspects of the grant.

**Grants Management Specialist (GMS):** A federal staff member who oversees the business and other non-programmatic aspects of one or more grants and/or cooperative agreements. These activities include, but are not limited to, evaluating grant applications for administrative content and compliance with regulations and guidelines, negotiating grants, providing consultation and technical assistance to recipients, post-award administration and closing out grants.

**Health Disparities:** Differences in health outcomes and their determinants among segments of the population as defined by social, demographic, environmental, or geographic category.

**Health Equity:** Striving for the highest possible standard of health for all people and giving special attention to the needs of those at greatest risk of poor health, based on social conditions.

**Health Inequities:** Systematic, unfair, and avoidable differences in health outcomes and their determinants between segments of the population, such as by socioeconomic status (SES), demographics, or geography.

**Healthy People 2030:** National health objectives aimed at improving the health of all Americans by encouraging collaboration across sectors, guiding people toward making informed health decisions, and measuring the effects of prevention activities.

**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.

**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 activities; 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.

**Period of performance –formerly known as the project period - :** The time during which the recipient may incur obligations to carry out the work authorized under the Federal award. The start and end dates of the period of performance must be included in the Federal award.

**Period of Performance Outcome:** An outcome that will occur by the end of the NOFO’s funding period

**Plain Writing Act of 2010:** The Plain Writing Act of 2010 requires that federal agencies use clear communication that the public can understand and use. NOFOs must be written in clear, consistent language so that any reader can understand expectations and intended outcomes of the funded program. CDC programs should use NOFO plain writing tips when writing NOFOs. **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 NOFO; can be either a project officer, program manager, branch chief, division leader, policy official, center leader, or similar staff member.

**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>.

**Social Determinants of Health:** Conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

**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](http://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.

**UEI:** The Unique Entity Identifier (UEI) number is a twelve-digit number assigned by SAM.gov. When applying for Federal awards or cooperative agreements, all applicant organizations must obtain a UEI number as the Universal Identifier. UEI number assignment is free. If an organization does not know its UEI number or needs to register for one, visit [www.sam.gov](http://www.sam.gov).

**Work Plan:** The summary of period of performance 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.

**Health equity** (2) is achieved when every person has the opportunity to “attain his or her full health potential” and no one is “disadvantaged from achieving this potential because of social position or other socially determined circumstances.”

**Underserved communities** refers to populations sharing a particular characteristic, as well as geographic communities, which have been systematically denied a full opportunity to participate in aspects of economic, social, and civic life. Populations can include but are not limited to: African American, Latino, and Indigenous and Native American persons, Asian Americans and Pacific Page 50 of 50 Islanders and other persons of color; members of religious minorities; lesbian, gay, bisexual, transgender, and queer (LGBTQ+) persons; persons with disabilities; persons who live in rural communities; and persons otherwise adversely impacted by persistent poverty or inequality (Definition modified from the Executive Order On Advancing Racial Equity and Support for Underserved Communities Through the Federal Government, January 20, 2021).



## *Infant mortality and Title V*

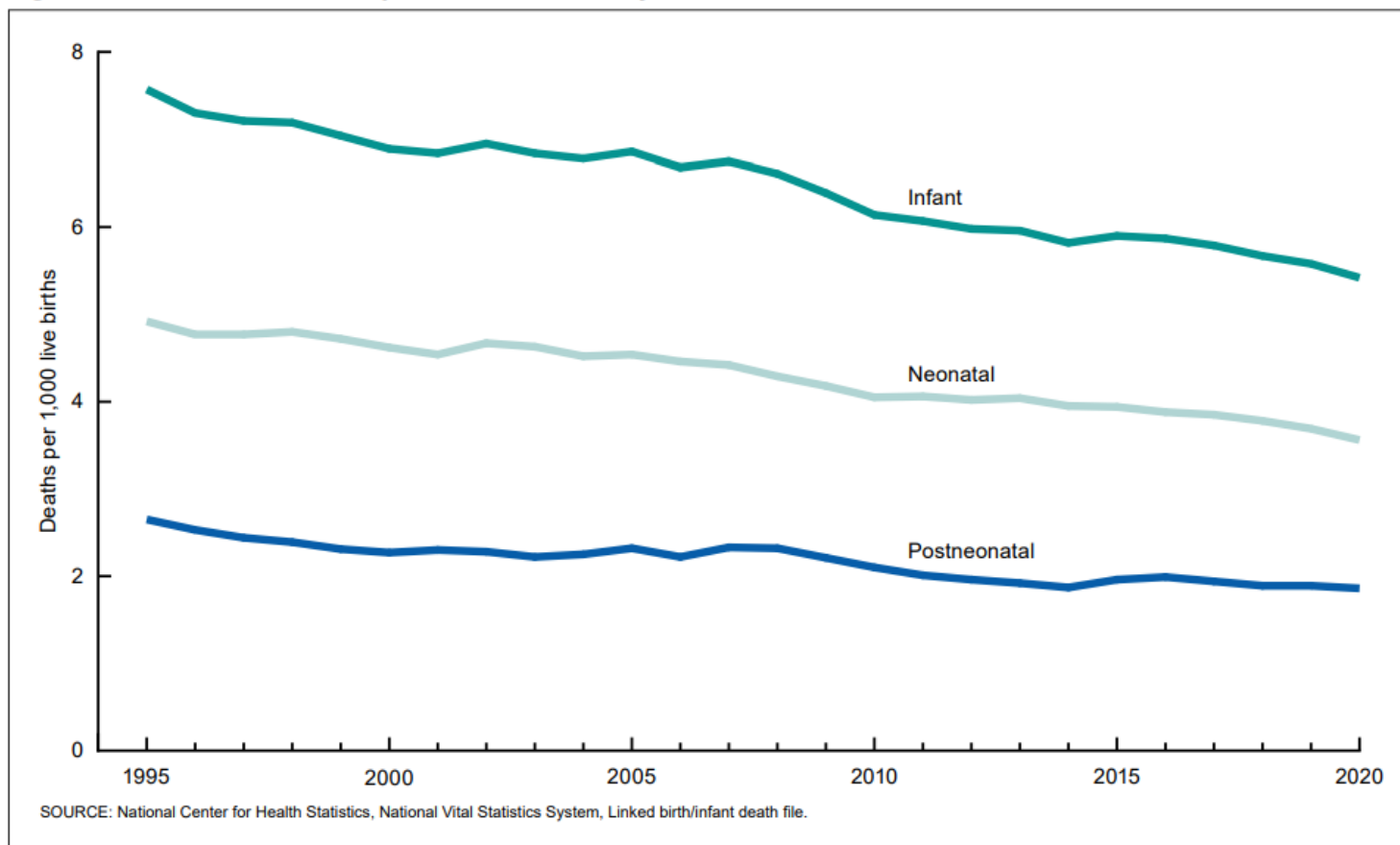
**Lisa Masinter, MD, MPH, MS, FACOG (she/her)**

*Deputy Director*

*Office of Women's Health and Family Services*

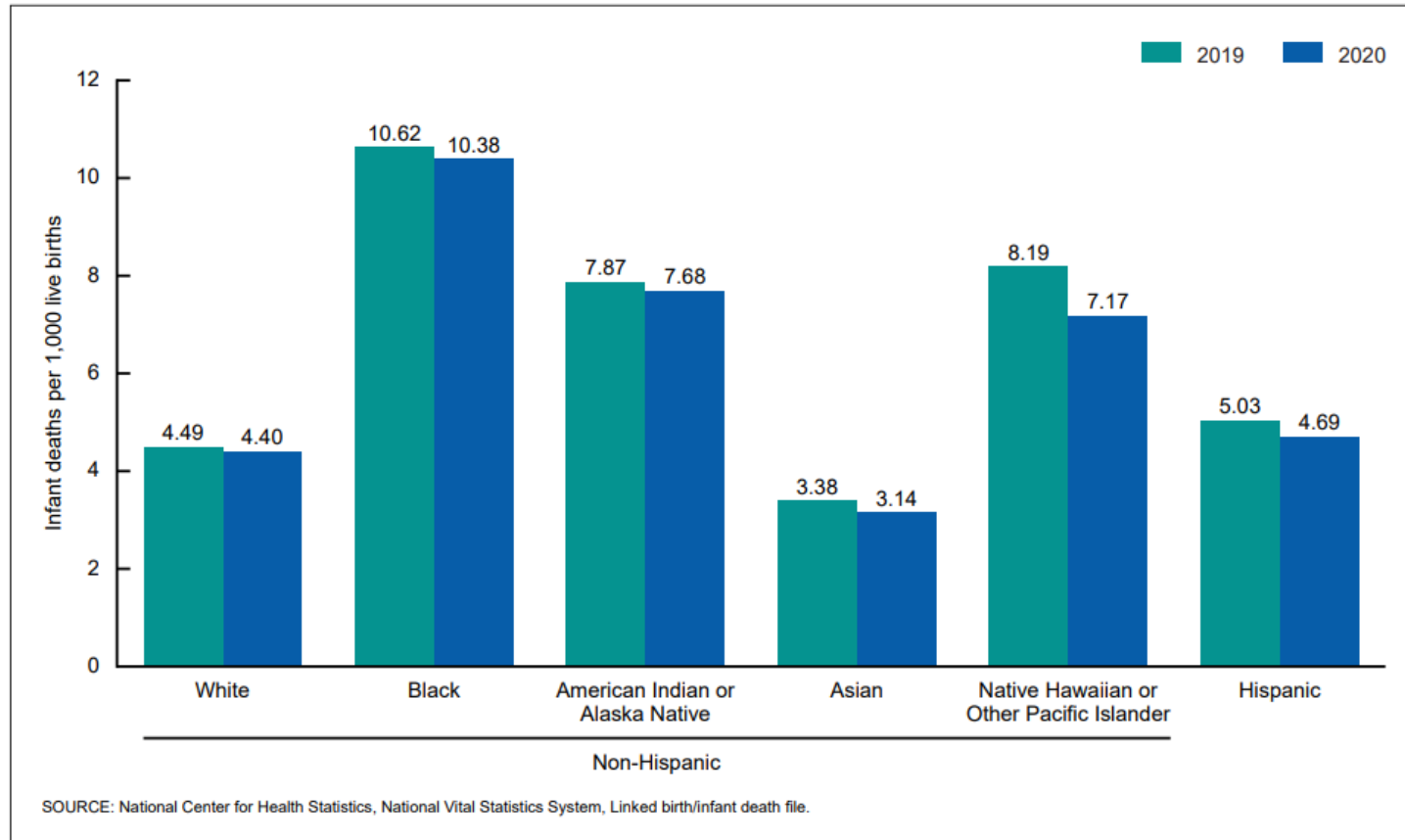
# Infant Mortality trends

**Figure 1. Infant, neonatal, and postneonatal mortality rates: United States, 1995–2020**



# A deeper look into the data: Disparities

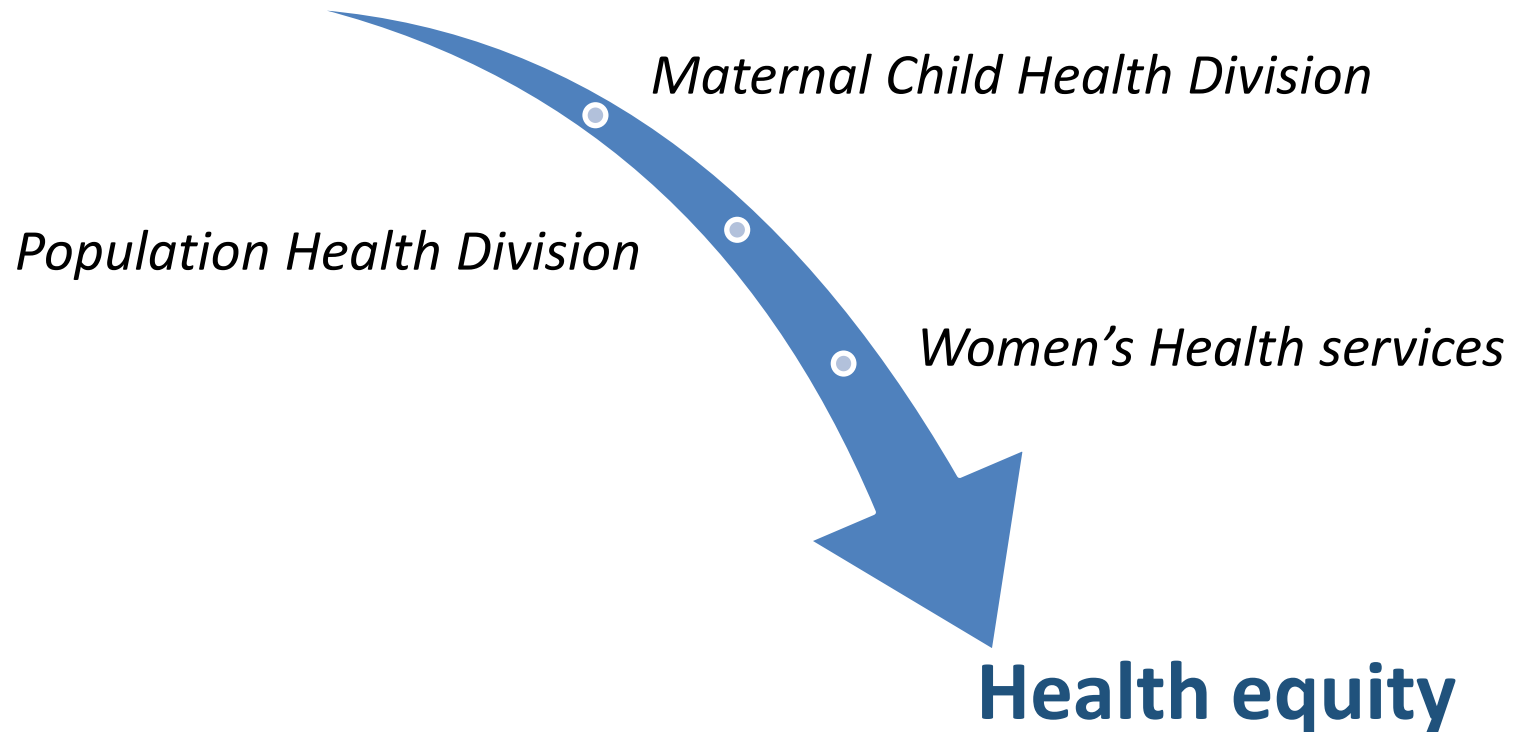
**Figure 2. Infant mortality rate, by maternal race and Hispanic origin: United States, 2019 and 2020**





# Office of Women's Health and Family Services

## Health Disparities



# Maternal Child Health Division

- Title V Maternal and Child Health Block Grant
- Clinical Oversight and Regulation
  - Hospital Birthing Facility Regionalized Perinatal Program (77 IAC 640)
  - School based Health Centers (77 IAC 641)

# Maternal Child Health Division

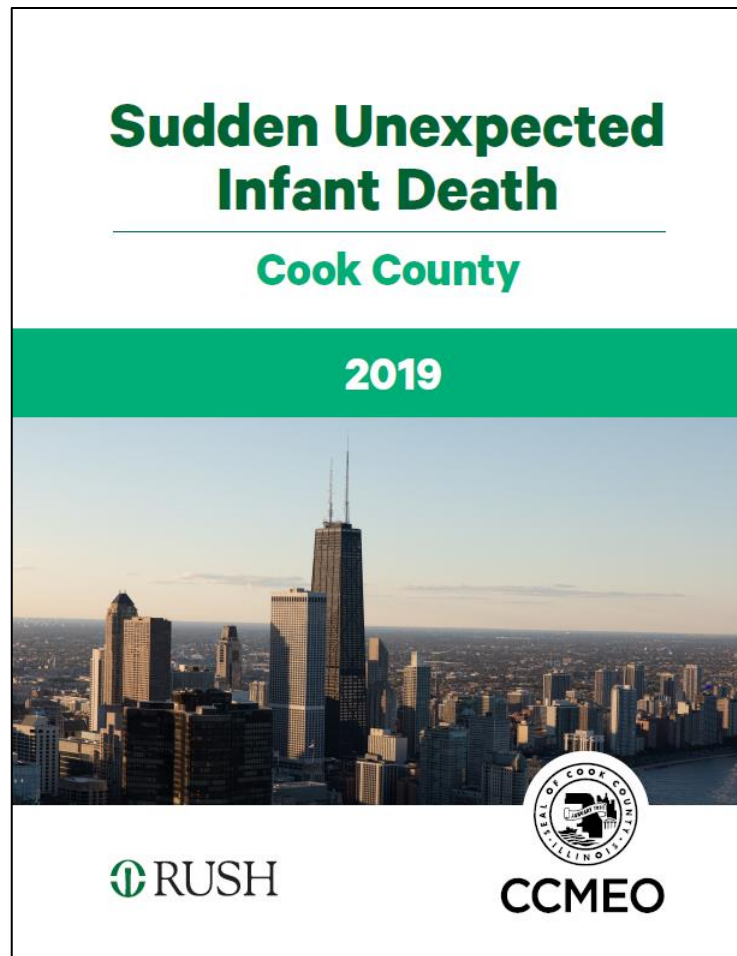
- **Title V Maternal and Child Health Block Grant**
- Clinical Oversight and Regulation
  - Hospital Birthing Facility Regionalized Perinatal Program (77 IAC 640)
  - School based Health Centers (77 IAC 641)

# Title V Maternal Child Block Grant

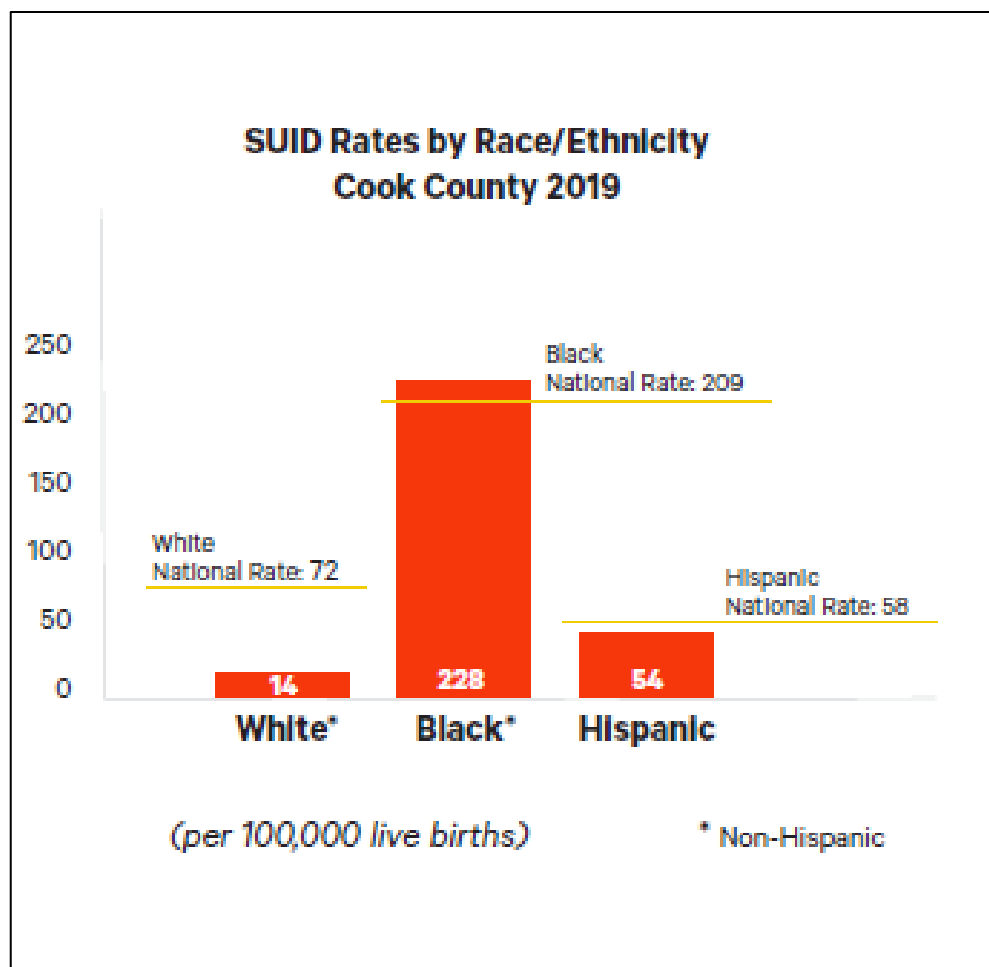
- Created in 1935; Title V of Social Security Act
- Focuses on improving the health and well-being of the nation's mothers, infants, children (including those with special needs), and their families
- Administered by the Health Resources and Services Administration (HRSA)
- Funds 59 states and jurisdictions



# Back to infant mortality disparities: *Sudden Unexpected Infant Death*



# *SUID disparities in Cook Cty*



# What is IL doing?

**Keep your baby safe,  
even when they're sleeping**



Being a new parent is exhausting. We spend so much time and energy taking care of our babies when they are awake, we sometimes forget it is just as important to make sure they are safe while they sleep.



◀ To learn about how to safely use swaddles and sleep sacks, go to our website.

★ Go to [InfantSafeSleep.illinois.gov](https://InfantSafeSleep.illinois.gov) to learn about ★  
how to keep your baby safe while sleeping

# Who is Title V Funding

- Baby Zzzzzs 
  - Amplify messaging campaign
  - Training and education/acknowledge families' existing practices
  - Identify social determinants of health/ barriers to safe sleep practices
  - Current grantee: Sinai Community Institute



# Who is Title V Funding?

- Fetal Infant Mortality Review
  - Systematically review fetal and neonatal deaths within targeted communities of the state
  - Identify non-medical factors that contribute to fetal and neonatal loss
  - Community Action Team (CAT) of diverse community leaders. design and implement key interventions based on the recommendations generated by the review committee.
  - Current Grantees: University of Chicago, St Louis Healthcare Foundation



Thank you!  
Questions?

[lisa.masinter@illinois.gov](mailto:lisa.masinter@illinois.gov)

# Sudden Unexpected Infant Death

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Cook County

2019



CCMEO

# Executive Summary

## Background

Each year in the United States, approximately 3,500 infants die suddenly and unexpectedly before their first birthday. These Sudden Unexpected Infant Deaths (SUID) are the leading threat to life between 1 month and 1 years old. For the past two decades there has been little progress in preventing these deaths. However, beginning in 2019, SUIDs in Cook County were added to a national surveillance system to shed light on the circumstances of these deaths and provide information that could aid in prevention. This is the first annual report of the Sudden Unexpected Infant Death Case Registry for Cook County.

## Conclusion

About once a week in Cook County, an infant dies unexpectedly, typically in an unsafe sleep situation. There is a large racial and ethnic disparity among these deaths, with Black and Hispanic infants dying at rates 16 and 4 times that of white infants respectively. Much work is needed to raise awareness of these tragedies and effectively promote safe infant sleep practices to help prevent them.

## Findings

In 2019, 49 infants who resided in Cook County died suddenly and unexpectedly. Of these, 45 deaths were sleep-related. Here are a few key findings:

- All sleep-related deaths involved the baby being in an unsafe sleep situation.\*
- In Cook County, SUID occurred 16 times more often in Black infants, and nearly 4 times more often in Hispanic infants when compared with white infants.\*\*
- SUID were more frequently seen on the West and South sides.
- Forty-one out of the 45 infants (91%) died with soft bedding or items in their sleeping environment.
- Twenty-two out of 45 infant deaths (50%) died while sleeping in a bed with another person.
- Eight of the sleep-related deaths (18%) were from suffocation.\*\*\*
- Thirty-five out of 45 infants (78%) died before the age of 6 months with a peak at 2 months.
- Nine out of 45 infants (20%) had a history of prematurity.

*\*Forty-three babies died in unsafe sleep situations. There were two sleep-related deaths that did not have complete case information.*

*\*\*Throughout this report, Black non-Hispanic and white non-Hispanic infants are referred to as Black and white infants respectively.*

*\*\*\*Thorough review of these deaths in the Cook County Child Death Review System determined they were caused by “possible suffocation” or “suffocation.”*

## What is SUID? And what happened to SIDS?

SUID is the term used to describe **S**udden **U**nexpected **I**nfant **D**eaths. These deaths used to be called SIDS. The causes of unexpected infant deaths in Cook County are now more accurately described as either due to suffocation, or undetermined, if no cause can be determined after thorough investigation. Most SUIDs occur during sleep and these are commonly referred to as sleep-related infant deaths.

## Nearly every week in Cook County an infant dies suddenly and unexpectedly.

In Cook County today, the greatest threat to the lives of infants ages 30 days old to 1 year is SUID. These deaths typically occur during sleep and frequently involve an unsafe sleep environment. In 2009, the Centers for Disease Control and Prevention began funding work across the U.S. to collect detailed information on the circumstances of these deaths to help prevent them. In 2019, this work began in Cook County, and this report details Cook County’s 2019 SUID data to inform communities, providers and families of this public health threat to infants and to encourage potential prevention strategies.



# The Sleep Environment

## Safe sleep

Placing infants on their back to sleep has been the cornerstone of preventing SIDS since 1994. Greater understanding of other hazards in an infant’s sleep environment have emerged over the past two decades — including sleeping with another person, sleeping with soft bedding, and sleeping on a sleep surface that is not a safety approved mattress. All of these situations have been found to be risks associated with SUID.

An infant sleeping safely is defined as:

- On their back
- In their own crib or bassinet
- With nothing in the crib or bassinet



# 2019 Cook County SUID

In 2019, 49 infants younger than 12 months died suddenly and unexpectedly. Forty-five of these deaths occurred during sleep. This report details the circumstances of these 45 sleep-related infant deaths.

Of the 45 sleep-related infant deaths, eight occurred due to suffocation and 37 were undetermined. All sleep-related infant deaths with complete\* case information had one or more unsafe sleep factors.

\*Two out 45 sleep-related deaths had incomplete case information

Total deaths: 49

Sleep related deaths: 45

- Suffocation: 8
- Undetermined: 37

100%  
All 45 sleep-related SUIDs occurred in an unsafe sleep environment.

## 2019 Calendar

The red circles on the calendar represent the days that infants died suddenly and unexpectedly in 2019.



Sleep-Related Infant Deaths (45)  
Unsafe sleep factors

33%

Or 15 infants were found on their stomach in their sleep space.



78%

Or 35 infants were found in places NOT approved for infant sleep.

Number of infants found in each location:

- 24 Adult beds
- 4 Couches
- 1 Car seat
- 2 Inclined sitting/sleeping products\*
- 4 Other

*\*Inclined sleep products for infants have been recalled. See this article from Consumer Reports: [bit.ly/inclined-sleeper-safety](https://bit.ly/inclined-sleeper-safety)*



Sleep-Related Infant Deaths (45)  
Unsafe sleep factors

49%

Or 22 infants were sleeping with another person, increasing their risk of suffocation.



91%

Or 41 infants were found with soft bedding in their sleep space.

Soft bedding includes pillows, quilts, comforters, sheepskins, blankets, bumper pads, plush toys or stuffed animals.

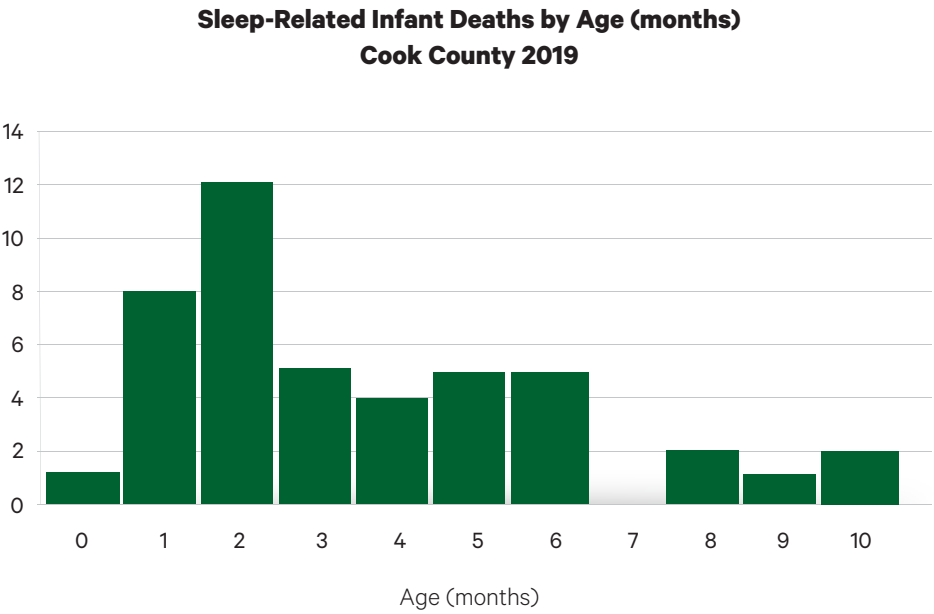


# Sleep-Related Infant Deaths (45)

## Demographics

### Age

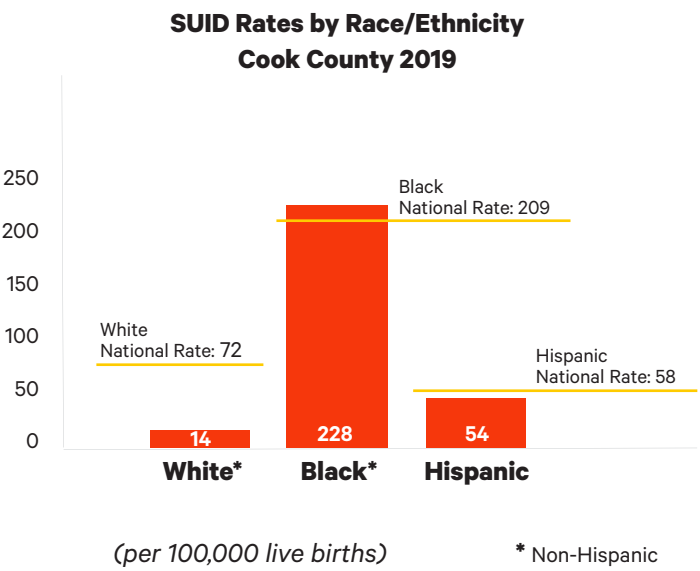
Though SUID may occur any time between birth and one year, there is a peak in SUID between the ages of 1 month and 3 months.



### Race and ethnicity

Nationally, SUID occurs more than twice as often among Black, non-Hispanic infants, and about half as often among Hispanic infants, as compared to white, non-Hispanic infants.

**In Cook County, SUID occurred 16 times more often in Black infants, and nearly 4 times more often in Hispanic infants when compared with white infants.**



### 2019 SUID Disparities

|                                           | Cook County |        |          | United States |         |          |
|-------------------------------------------|-------------|--------|----------|---------------|---------|----------|
|                                           | White*      | Black* | Hispanic | White*        | Black*  | Hispanic |
| Sleep-related SUID                        | 3           | 33     | 9        | 1,425         | 1,214   | 575      |
| Births                                    | 21,627      | 14,468 | 16,770   | 1,972,635     | 580,525 | 983,479  |
| Rate<br>(per 100,000 births)              | 14          | 228    | 54       | 72            | 209     | 58       |
| Rate Ratio<br>(compared to white infants) | Referent    | 16.4   | 3.9      | Referent      | 2.9     | 0.8      |

\* Non-Hispanic

# Sleep-Related Infant Deaths (45)

## Risk factors

Prematurity and tobacco smoke exposure increase the risk of SUID.

20%

Nine SUIDs occurred among infants who were born prematurely.

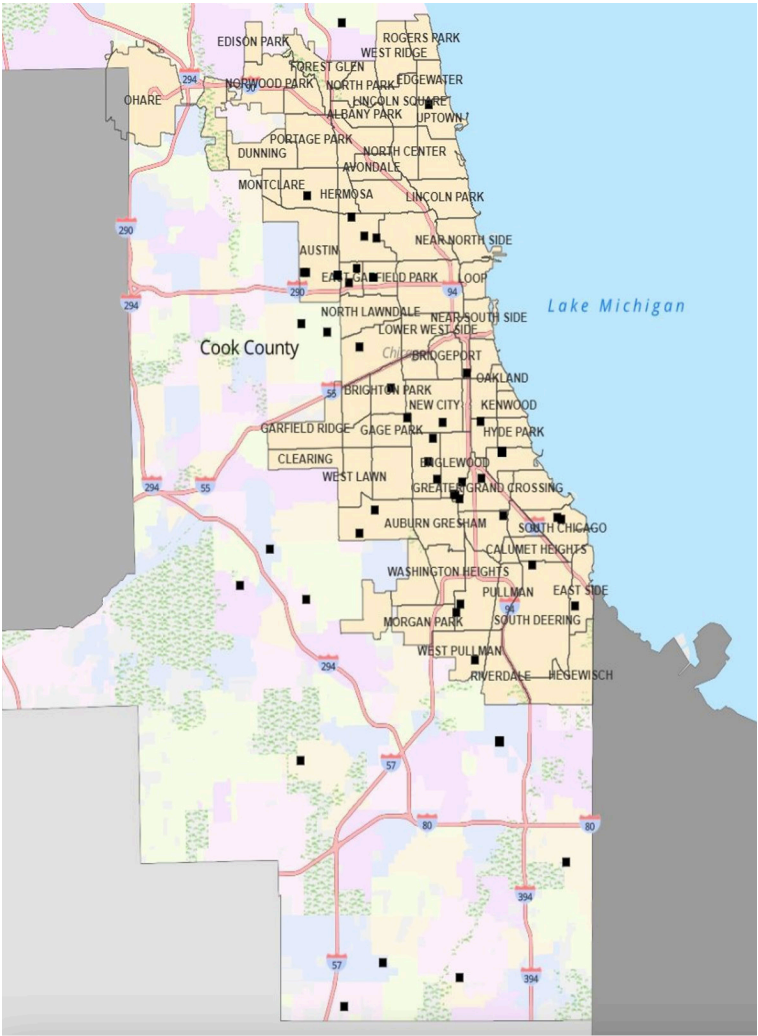
33%

Fifteen SUIDs occurred among infants who had prenatal and/or current smoke exposure.

## Geographic distribution

Though SUID occurs throughout Cook County, mapping cases in 2019 reveals a clustering of SUID on the county’s West and South sides.

Map to the right:  
Sudden Unexpected Infants Deaths  
Cook County 2019  
Each square represents an infant death



# Prevention Efforts

There has been very little progress in preventing SUID over the past 20 years. SUID rates in the U.S. have remained nearly unchanged. In Cook County, that means one infant dies suddenly and unexpectedly every week.

Cook County’s SUID typically occurred when infants were not in a safe sleep environment: infants were often bed-sharing with one or more adults or children, and soft bedding was frequently used. What is not known, however, is how often these sleep circumstances occur on a routine basis for all infants in Cook County — and why many infants survive in an “unsafe” sleep environment while those who died from SUID did not.

Cook County’s SUIDs occurred disproportionately among Black and Hispanic infants on the city’s South and West sides, and within neighborhoods with historical disinvestment and high economic hardship. Prematurity, and prenatal and household cigarette smoke exposure are known risk factors for SUID, and these occurred frequently among Cook County SUIDs. The intersection of these circumstances coupled with an unsafe sleep environment only partially explains the substantially higher rate of SUID for Black and Hispanic infants.

Community health is the collective well-being of its people, and disparities in health indicators across communities are typically driven by inequitable access to necessary resources. We must understand and address that the health of a community that is home to an infant is also part of the environment that may place an infant at risk for — or protect them from — SUID. SUID prevention must include addressing the root causes of health inequities — alongside promoting safe sleep strategies that work — to protect our infants, families and communities.



IT MIGHT NOT BE PRETTY.  
BUT IT CAN BE PEACEFUL.

Getting sleep with a newborn is not easy. But when babies are put to bed in their own, clutter-free space, it’s safer for them and offers peace of mind for you.

Help baby sleep safely so you can sleep soundly.  
[healthychildren.org/safesleep](https://healthychildren.org/safesleep)

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## Partnering for prevention

Preventing SUID starts with information sharing and collaborating with communities that hold a disproportionate burden of SUID. Continuing the work of the Cook County SUID Case Registry is an important step in identifying, collecting and analyzing SUID data. Communicating this data in partnership with public health departments, health care entities, community organizations and other networks, will be essential to enabling collaboration with communities in efforts towards prevention. By initiating dialogue with families and those who support them, we can gain a deeper understanding of the circumstances within our communities, and can help create better pathways to prevention efforts.

### Chicago resources

**Everthrive Illinois** is a champion for health equity, focused on advocating for access to high-quality health care for women, children and families in Illinois. Through campaigns, strategic partnerships and community engagement, Everthrive continues to advance maternal-infant health equity. [everthriveil.org](http://everthriveil.org)

**Family Connects Chicago** is a public health, nurse home visit service available to Chicago families with newborns. Currently in its pilot phase, Family Connects led by the Chicago Department of Public Health, provides a comprehensive spectrum of in-home support, guidance and connections to resources that offer family support inclusive of safe sleep guidance. [healthychicagobabies.org/family-connects/](http://healthychicagobabies.org/family-connects/)

**The Fetal Infant Mortality Review (FIMR)** study in Chicago is a community-based approach to identifying services and support system issues families experienced that may have contributed to fetal and infant losses. FIMR interviews families who have lost an infant, analyzes those experiences, and makes system recommendations to promote better outcomes in the future. FIMR's Interdisciplinary Community Action Team works to create meaningful change by addressing gaps in services and programs, and advocates for supportive policies. [ncfrp.org/fimr/](http://ncfrp.org/fimr/)

**HealthConnect One** advances equitable, community-based, peer-to-peer support for pregnancy, birth, breastfeeding and early parenting. They provide breastfeeding peer counselors and community based doula support — promoting protective factors for healthy babies and families. [healthconnectone.org](http://healthconnectone.org)

**Kids In Danger (KID)** is a nonprofit organization dedicated to protecting children by fighting for product safety. KID was founded in 1998 by the parents of 16-month-old Danny Keysar, who died when a recalled portable crib collapsed around his neck in his Chicago child care home. KID's mission is to save lives by enhancing transparency and accountability through safer product development, better education and stronger advocacy for children. KID disseminates its monthly recall digest to share accurate and timely child product recall information. [kidsindanger.org](http://kidsindanger.org)

**The Fussy Baby Network** provides in-home or virtual support from infants specialists, who support families struggling with infant crying, feeding and sleeping. [erikson.edu/services/fussy-baby-network/](http://erikson.edu/services/fussy-baby-network/)

**Westside Healthy Start** program at ACCESS supports families from Chicago's West Side neighborhoods of North Lawndale, Austin, Humboldt Park, East and West Garfield Park, providing expecting and parenting families with preconception, prenatal and postpartum services to improve the health outcomes of the mother, baby and family. With the support of a dedicated care team, they partner with community members to reduce the infant mortality rate and empower families to create stronger, healthier communities. [achn.net/services-programs/westside-healthy-start/](http://achn.net/services-programs/westside-healthy-start/)

### Regional resources

**Illinois' Home Visiting** programs support healthy, thriving pregnant and parenting families with young children through support services that include parent coaching, education and connections to infant and early childhood health and early learning resources. Home Visiting programs routinely incorporate safe sleep education for families with infants, and the Illinois Maternal Infant Early Childhood Home Visiting program has supported infant safe sleep through the development and tracking of safe sleep benchmarks since 2018. [igrowillinois.org](http://igrowillinois.org)

**SIDS of Illinois, Inc.**, offers a range of services including grief and bereavement support, educational programs and materials for families and professionals, and supports research efforts to eradicate SUID. [sidsillinois.org](http://sidsillinois.org)

### National resources

**AAP Safe Sleep Toolkit:** [safetosleep.nichd.nih.gov/resources/sids-awareness-toolkit](http://safetosleep.nichd.nih.gov/resources/sids-awareness-toolkit)

**AAP policy statement:** Find the latest recommendations for infant sleep from the AAP's Task Force on SIDS. [bit.ly/aap-policy](http://bit.ly/aap-policy)

**Cribs for Kids:** Find cribettes and safe sleep education resources for families in your communities, as well as information on how to become a safe sleep champion at this resource for health care and community providers. [cribsforkids.org/](http://cribsforkids.org/)

**Healthychildren.org:** Find information on your infant's sleep concerns from this AAP web resource. [healthychildren.org/English/ages-stages/baby/sleep/Pages/default.aspx](http://healthychildren.org/English/ages-stages/baby/sleep/Pages/default.aspx)

**Safe to Sleep:** Find education resources and campaign materials at this NIH web resource for organizations. [safetosleep.nichd.nih.gov/](http://safetosleep.nichd.nih.gov/)



The data in this report are from the Sudden Unexpected Infant Death-Case Registry (SUID-CR) system for Cook County, which is housed at Rush University Medical Center in close affiliation with the Cook County Medical Examiner’s Office. The details of each case are extracted from the Medical Examiner’s Lablynx data system. The categorization of each case with regards to cause (e.g., Suffocation, Possible Suffocation or Undetermined with Unsafe Sleep Factors) was determined in a CDC-defined process during the discussion of the case at the Child Death Review.

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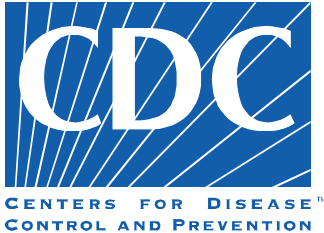
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