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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[PROGRAM ANNOUNCEMENT 01020]

CHILDHOOD LEAD POISONING PREVENTION PROGRAMS (CLPPP)

NOTICE OF AVAILABILITY OF FUNDS

A. Purpose

The Centers for Disease Control and Prevention (CDC) announces the availability of fiscal year (FY) 2001 funds for a cooperative agreement program for new State and competing continuation State programs to develop and improve Childhood Lead Poisoning Prevention activities which include building Statewide capacity to conduct surveillance of blood lead levels in children. CDC is committed to achieving the health promotion and disease prevention objectives of A Healthy People, a national activity to reduce morbidity and mortality and improve the quality of life. This announcement is related to the focus area of Environmental Health. For the copy of “Healthy People," (Full Report: Stock No. 017-001-00547-9) or write or call: Superintendent of Documents Government Printing Office, Washington, DC 20402-9325, telephone (202) 512-1800 or visit the Internet site: http://www.health.gov/healthypeople/.

The purpose of this program is to provide the impetus for the development, implementation, expansion, and evaluation of State and local childhood lead poisoning prevention program activities which include Statewide surveillance capacity to determine areas at high-risk for lead exposure. Also, this cooperative agreement is to carry out the core public health functions of *Assessment, Policy Development, and Assurance* in childhood lead poisoning prevention programs.

Funding for this program will be to:

1. Develop and/or enhance a surveillance system that monitors all blood lead levels (BLLs).
2. Assure screening of children who are at high-risk of lead exposure and follow-up care for children who are identified with elevated BLLs.
3. Assure awareness and intervention for the general public and affected professionals in relation to preventing childhood lead poisoning.
4. Expand primary prevention of childhood lead poisoning in high-risk areas in collaboration with appropriate government and community-based organizations.

As programs have shifted emphasis from providing direct screening and follow-up services to the core public health functions, cooperative agreement funds may be used to support and emphasize health department responsibilities to ensure high-risk children are screened and receive appropriate follow-up services. This includes developing and improving coalitions and partnerships; conducting better and more sophisticated assessments; and developing and evaluating new and existing policies, program performance, and effectiveness based on established goals and objectives.

B. Eligible Applicants

Applicant eligibility is divided into Part A (New Applicants), Part B (Competing Continuation), and Part C (Supplemental Studies) defined in the following section: In FY 2000, CDC shifted its program emphasis from the direct funding of local programs with jurisdictional populations of 500,000 to the funding of State programs. However, the top five metropolitan statistical areas (SMSAs)/largest cities in the United States based on census data will be eligible for direct funding for childhood lead poisoning prevention activities indefinitely. **They are New York City, Los Angeles, Chicago, Philadelphia, and Houston.**

I. Part A: Eligible applicants are State health departments or

other State health agencies or departments not currently funded by CDC and any eligible SMSA not currently receiving direct funding from CDC for childhood lead poisoning prevention activities. Also eligible are health departments or other official organizational authority (agency or instrumentality) of the District of Columbia, the Commonwealth of Puerto Rico, any territory or possession of the United States, and all federally-recognized Indian tribal governments. **Please note: Local Health Departments are not eligible to apply for cooperative agreement funding under Part A of this program announcement unless they are one of the top five SMSAs.** A*pplicants encouraged to apply under Part A are: Arkansas; Chicago; Florida; Idaho; Kentucky; Mississippi; Nevada; North Dakota; Oregon; Philadelphia; South Dakota; Tennessee; Washington and Wyoming.*

2. Part B: Eligible applicants are those states currently funded by the CDC with a project period that expires June 30, 2001. These applicants are: *Los Angeles; Louisiana; Massachusetts; Missouri; Montana*; *New Jersey; New Mexico; New York City; North Carolina; Ohio; Pennsylvania; Rhode Island; West Virginia and Vermont.* In FY 2000, CDC shifted its program emphasis from the direct funding of local programs with jurisdictional populations of 500,000 to the funding of State programs.

However, the top five metropolitan statistical areas (SMSAs)/largest cities in the United States based on census data will be eligible for direct funding for childhood lead poisoning prevention activities. This includes New York City and Los Angeles. These SMSAs are eligible for direct funding indefinitely under Part B.

3. **Part C: Eligible applicants are those State applicants that apply under Part B or non-competing State applicant programs currently funded under a non-expired project period.** For Part B applicants, funding under Part C will only be considered if the Part B application is successful and chosen for funding. All Part C applicants must meet the program requirement of submitting data to CDC's national surveillance database. **Please Note:** Non-competing applicants currently funded with a Part C award are not eligible.

Additional information for all State applicants

If a State agency applying for grant funds is other than the official State health department, written concurrence by the State health department must be provided (for example, the State Environmental Health Agency).

C. Availability of Funds

Part A: New Applicants

Up to $1,700,000 will be available in FY 2001 to fund up to **six** new applicants. CDC anticipates that awards for the first budget year will range from $75,000 to $800,000.

Part B: Competing Continuations

Up to $10,000,000 will be available in FY 2001 to fund up to 14 competing continuation applicants. CDC anticipates that awards for the first budget year will range from $250,000 to $1,500,000.

Part C: Supplemental Studies

Up to $400,000 will be awarded in FY 2001 to fund up to four assessment/evaluation studies with a two-year project period or not to exceed the current established project period. These funds will be awarded to support the development of alternative surveillance assessments and/or to conduct evaluation of the impact of lead screening recommendations. Awards are expected to range from $70,000 to $100,000, with the average award being approximately $85,000. Funds will be awarded for assessment/evaluation studies that address one of the following:

1. Alternative Surveillance Assessment - Assessment of lead exposure in a jurisdictional population or sub-population using an approach to surveillance that differs from the Statewide Childhood Blood Lead Surveillance (CBLS) system described in this announcement.
2. Screening Recommendation Evaluation - Evaluation of the impact

of lead screening recommendations on screening for high-risk children.

Funding for State applicants: To determine the type of program activities and the associated level of funding for an *individual State applicant* for Part A or Part B, please refer to the table below. These are funding limits which should be used to determine program funding levels. Addendum 2 in the application package provides an explanation of the factors used to develop categorical funding limits.

Funding Categories Based on Projected Level of Effort Required to Provide Lead Poisoning Activities to a State Population

Alabama	2	Montana	3
Alaska	3	Nebraska	2
Arizona	3	Nevada	3
Arkansas	2	N. Hampshire	3
California*	1	New Jersey	2
Colorado	3	New Mexico	3
Connecticut	2	New York*	2
Delaware	3	N. Carolina	2
Florida*	3	North Dakota	3
Georgia	2	Ohio	1
Hawaii	3	Oklahoma	2
Idaho	3	Oregon	3
Illinois	1	Pennsylvania	1
Indiana*	3	Rhode Island	2
Iowa	2	S. Carolina	2
Kansas	2	South Dakota	2
Kentucky*	3	Tennessee	2
Louisiana	2	Texas*	1
Maine	3	Utah*	3
Maryland	2	Vermont	3
Mass.	2	Virginia	2
Michigan*	2	Washington	2
Minnesota	2	West Virginia	2
Mississippi	2	Wisconsin	2
Missouri	2	Wyoming	3

* Projected level of effort adjusted to account for currently funded locales.

NOTE:Please see section entitled “Funding Level for SMSA Applicants”.

Funding State Applicants - Part A or Part B: Determine your funding category (Category 1, 2, or 3) and associated program activities by category using the descriptions below. Funding levels are associated with category type and level of program activity to be supported by CDC. R**egardless of category type**, all programs are required to develop and implement screening plans and have a surveillance system designed to monitor all blood lead levels in children. Following are the minimum requirements for each category and the range and average awards for each category.

Category 1: $800,000-$1,500,000, average award $1,000,000
Applicants are to use CDC funding to: implement and evaluate screening plans; submit and analyze data from a Statewide surveillance system; ensure screening and follow-up care; provide public and professional health education and health communication; conduct program impact evaluation; and implement primary prevention activities.

Category 2: $250,000-$800,000, average award $520,000
Applicants are to use CDC funding to: implement and evaluate screening plans; submit and analyze data from a Statewide surveillance system; assure screening and follow-up care; provide public and professional health education and health communication; and conduct program impact evaluation.

Category 3: $75,000-$250,000, average award $150,000
Applicants are to use CDC funding to: implement and evaluate screening plans; submit and analyze data from a Statewide surveillance system; assure screening and follow-up care; and conduct program impact evaluation.

Funding Levels for SMSA Applicants (under Part B only): The range of awards for eligible SMSAs is $250,000 to $800,000.

Additional Information on Funding for all Applicants for Part A, Part B, and Part C New awards are expected to begin on or about July 1, 2001, and are made for 12-month budget periods within a project period not to exceed two-years for State programs. Estimates

outlined above are subject to change based on the actual availability of funds and the scope and quality of applications received. Continuation awards within the project period will be made on the basis of satisfactory progress and availability of funds. A*wards cannot supplant existing funding for CLPP or Supplemental Funding Initiatives.* Funds should be used to enhance the level of expenditures from State, local, and other funding sources.

NOTE:

- **Funds may not be expended for medical care and treatment or for environmental remediation of sources of lead exposure. However, the applicant must provide a plan to ensure that these program activities are carried out.**
- **Not more than 10 percent (exclusive of Direct Assistance) of any cooperative agreement or contract through the cooperative agreement may be obligated for administrative costs. This 10 percent limitation is in lieu of, and replaces, the indirect cost rate.**

D. Program Requirements

1. SPECIAL REQUIREMENT regarding Medicaid provider status of applicants: Pursuant to section 317A of the Public Health Service Act (42 U.S.C. 247b-1), as amended by Sec. 303 of the "Preventive Health Amendments of 1992" (Public Law 102-531),

applicants AND current grantees must meet the following requirements: For CLPP program services which are Medicaid-reimbursable in the applicant's State:

- Applicants who directly provide these services must be enrolled with their State Medicaid agency as Medicaid providers.
- Providers who enter into agreements with the applicant to provide such services must be enrolled with their State Medicaid agency as providers. An exception to this requirement will be made for providers whose services are provided free of charge and who accept no reimbursement from any third-party payer. Such providers who accept voluntary donations may still be exempted from this requirement.

In order to satisfy this program requirement, please provide a copy of a Medicaid provider certificate or statement as proof that you meet this requirement. Failure to include this information will result in your application being returned. Please place this information immediately behind the budget and budget justification pages.

2. Assure that income earned by the CLPP program will be returned to the program for its use.

Cooperative Activities

Part A and Part B: New and Competing Continuations

To achieve the purpose of this cooperative agreement program, the recipient will be responsible for the activities listed under **1. Recipient Activities** and CDC will be responsible for the activities listed under **2. CDC Activities**.

1. Recipient Activities

a. Establish, maintain, or enhance a **statewide surveillance system** in accordance with legislation. *For eligible SMSAs (under Part B),* enhance a data management system that links with the State's surveillance system or develop an automated data management system to collect and maintain laboratory data on the results of blood lead analyses and data on follow-up care for children with elevated BLLs. State recipients should ensure receipt of data from local programs. Local recipients should transfer relevant data to the appropriate State entity in a timely manner for annual submission to CDC.

b. Manage, analyze and interpret individual State surveillance data, and present and disseminate trends and other important public health findings.

c. Develop, implement and evaluate a statewide/jurisdiction-wide childhood blood lead screening plan consistent with CDC guidance provided in *Screening Young Children for Lead*

Poisoning: Guidance for State and Local Public Health Officials. (A copy of this document can be obtained at the following internet address **http://www.cdc.gov/nceh/lead/guide/guide97.htm***). For eligible SMSAs,* participate in the Statewide planning process. Make screening recommendations and appropriate local screening strategies available and known to health care providers.

d. Assure appropriate follow-up care is provided for children identified with elevated BLLs.

e. Establish effective, well-defined working relationships within public health agencies and with other agencies and organizations at national, State, and community levels (e.g., housing authorities; environmental agencies; maternal and child health programs; State and local Medicaid agencies and programs such as Early Periodic Screening, Diagnosis, and Treatment (EPSDT); community and migrant health centers; community-based organizations providing health and social services in or near public housing units, as authorized under Section 330(i) of the PHS Act; State and local epidemiology programs; State and local housing rehabilitation programs; schools of public health and medical schools; and environmental interest groups).

f. Provide managerial, technical, analytical, and program

evaluation assistance to local agencies and organizations in developing or strengthening CLPP program activities.

2. CDC Activities

a. Provide technical, and scientific assistance and consultation on program development, implementation and operational issues.

b. Provide technical assistance and scientific consultation regarding the development and implementation of all surveillance activities including data collection methods and analysis of data. Specifically assist with improving data linkages with Federally-funded means-tested public benefit programs (WIC, Head start, etc.)

c. Assist with data analysis and interpretation of individual State surveillance data and release of national reports. Reports will include analysis of national aggregate data as well as state-specific data on Federally-funded means-tested public benefit programs (WIC, Head start, etc).

d. Assist Part B recipients with communication and coordination among Federal agencies, and other public and private agencies and organizations.

e. Conduct ongoing assessment of program activities to ensure the use of effective and efficient implementation strategies.

Part C: Supplemental Studies

To achieve the purpose of this program, the recipient will be responsible for the activities listed under **1. Recipient Activities** and CDC will be responsible for the activities listed under **2. CDC Activities**.

1. Recipient Activities

a. Develop and implement a study protocol to include the following: methodology, sample selection, field operation, and statistical analysis. Applicants must provide a means of assuring that the results of the study will be published.

b. Revise, refine, and carry out the proposed methodology for conducting *Supplemental Studies.*

c. Monitor and evaluate all aspects of the assessment activities.

d. Publish and disseminate study findings in scientific journals, as appropriate.

2. CDC Activities

a. Provide technical and scientific consultation on activities related to overall program requirements of

supplemental funding activities.

b. Provide technical assistance to program manager and/or principal investigator regarding revision, refinement, and implementation of study design and proposed methodology for conducting supplemental funding activities.

c. Assist program manager and/or principal investigator with data interpretation and analysis issues.

E. Application Content

Use the information in the *Program Requirements, Other Requirements, and Evaluation Criteria* sections to develop the application content. Each applicant should identify Part A, Part B or Part C on their application. Your application will be evaluated on the criteria listed, so it is important to follow them in laying out your program plan:

Applications must be developed in accordance with PHS Form 5161-1.

Part B applicants also competing for Part C funds must submit two separate applications.

Application pages must be clearly numbered, and a complete index to the application and its appendices must be included.

The original and two copies of the application sets must be submitted UNSTAPLED and UNBOUND. All material must be typewritten, double spaced, printed on one side only, with un-reduced font (10 or 12 point font only) on 8 1/2-inch by 11-

inch paper, and at least 1-inch margins and header and footers. All graphics, maps, overlays, etc., should be in black and white and meet the above criteria.

A one-page, single-spaced, typed abstract must be submitted with the application. The heading should include the title of the program, project title, organization, name and address, project director, telephone number, facsimile number, and e-mail address.

The main body of the CLPP program application (Parts A or B) must include the following: budget/budget justification; Medicaid certification; progress report (Part B applicants only); understanding the problem; surveillance/data-management activities; statewide/jurisdiction-wide planning and collaboration; core public health functions; goals and objectives; program management and staffing; and program evaluation.

The main body of the supplemental studies application (Part C) must include the following: study protocol, project personnel, and project management.

Each application should not exceed *75 pages*. The abstract, budget narrative, and budget justification pages are not included in the 75 page limit. Supplemental information should be placed in appendices and is not to exceed 25 pages.

Part B applicants must submit a progress report in their

competing continuation application. This report is not included in the 75 page limit and should not exceed 10 pages. **The report should be placed immediately after the budget and budget justification.**

F. Submission and Deadline

Submit the original and two copies of the PHS 5161-1 (OMB Number 0937-0189) on or before March 19, 2001. Forms are in the application kit.

Submit the application to:

Mattie B. Jackson, Grants Management Specialist
Grants Management Branch, Procurement and Grants Office
Program Announcement 01020
Centers for Disease Control and Prevention (CDC)
2920 Brandywine Road, Room 3000
Atlanta, GA 30341-4146
Internet address **mij3@cdc.gov**

Applications shall be considered as meeting the deadline if they are either: (1) received on or before the deadline date, or (2) sent on or before the deadline date and received in time for submission to the objective review. Applicants must request a legibly dated receipt from a commercial carrier or U. S Postal Service. Private metered postmarks shall not be acceptable as proof of timely mailing.

Applications which do not meet the criteria above are considered late applications. Late applications will not be considered in the current competition and will be returned to the applicant.

G. Evaluation Criteria

The review of applications will be conducted by an objective review panel as they relate to the applicant's response to either Part A, Part B, or Part C. The applications will be evaluated according to the following criteria:

PART A: New Applicants

1. Understanding of the Problem (10 points)

The extent to which the applicant's description and understanding of the burden and distribution of childhood lead exposure or elevated BLLs in their jurisdiction, using available evidence of incidence and/or prevalence and demographic indicators; including a description of the Medicaid population.

2. Surveillance Activities (20 points)

The applicant's ability to develop a childhood blood lead surveillance system that includes: (a) a flow chart that describes data transfer, (b) a mechanism for tracking lead screening services to children, especially Medicaid children (as required in Addendum 5 - Children's Health Act of 2000), and (c) a mechanism for reporting data annually to the CDC's

national surveillance database. The extent to which the surveillance approach is clear, feasible and scientifically sound. Also, the extent to which the proposed time table for accomplishing each activity and methods for evaluating each activity are appropriate and clearly defined. The following elements will be specifically evaluated:

a. How laboratories report BLLs, including ability to identify and assure reporting from private laboratories and portable blood lead technology that perform lead testing.

b. How data will be collected and managed.

c. How quality of data and completeness of reporting will be assured.

d. How and when data will be analyzed.

e. How summary data will be reported and disseminated on a regular basis (i.e., newsletters, fact sheets, annual reports).

f. Protocols for follow-up of children with elevated BLLs.

g. Provisions to obtain denominator data (results of all laboratory blood lead tests, regardless of level) as required in the Children’s Health Act of 2000.

h. Time line and methods for evaluating the Childhood Blood Lead Surveillance (CBLS) approach.

i. Plans to convert paper-based components of the surveillance system to electronic data manipulation.

j. Use of data including evaluation of prevention activities, especially to target screening and prevention efforts.

k. Ability to link environmental data.

3. Statewide Planning and Collaboration (20 points)

The applicant's ability to develop statewide screening recommendations, including appropriate local strategies. The following elements will be specifically evaluated:

a. The proposed approach to developing and carrying out an inclusive state- wide screening plan as outlined in *Screening Young Children for Lead Poisoning: Guidance for State and Local Health Officials*.

b. The extent to which the applicant plans to utilize surveillance and program data to produce a statewide screening recommendation, with specific attention given to the Medicaid population, as required in the Children's Health Act of 2000.

c. The ability of the applicant to involve collaborators in the development of a screening plan and implementation of strategies to strengthen childhood lead poisoning prevention activities.

d. The applicant's demonstrated ability to collaborate with principal partners, including managed-care organizations, the State Medicaid agency, child health-care providers and provider groups, insurers, community-based organizations, housing agencies (especially HUD funded programs), and

banking, real-estate, and property-owner interests, must be demonstrated by letters of support, memoranda of understanding, contracts, or other documented evidence of relationships.

4. Capacity to Carry out Public Health Core Functions (10 points)

The applicant's ability to describe the approach and activities necessary to achieve a balance in the health department's roles in CLPP, including assessment, program and policy development, and monitoring, evaluating, and ensuring the provision of all CLPP activities within their respective categories (for example, Category 3 requires screening plans, surveillance systems, assure follow-up care, and evaluation).

5. Goals and objectives (15 points)

The extent to which the applicant's goals and objectives relate to the CLPP activities as described in the category under which they applied. Objectives must be relevant, specific, measurable, achievable, and time-framed and must be provided for the first budget year. There must be a formal work plan with a description of methods, a timetable for completing the proposed methods, identification of the program staff responsible for accomplishing each objective, and process evaluation measures for each proposed objective. Also include a tentative work plan and timetable for the remaining years of

the proposed project.

6. Project management and staffing (10 points)

The extent to which the applicant has documented the skills and ability to develop and carry out CLPP activities within their respective categories. Specifically, the applicant should:

a. Describe the proposed health department staff roles in CLPP, their specific responsibilities, and their level of effort and time. Include a plan to expedite filling of all positions and provide assurances that such positions will be authorized to be filled by the applicant's personnel system within reasonable time after receiving funding.

b. Describe a plan to provide training and technical assistance to health department personnel and consultation to collaborators outside the health department, including proposed design of information-sharing systems.

7. Program evaluation (15 points)

The extent to which the applicant describes a systematic assessment of the operations and outcomes of the program as a means of contributing to the overall improvement of the program. Specific criteria should include:

a. An evaluation plan which describes useful and appropriate strategies and approaches to monitor and improve the quality, effectiveness, and efficiency of the program;

b. Description of how evaluation findings will be used to assess changes in public policy and measure the program’s effectiveness of collaborative activities; and

c. Description of how the program will document progress made in childhood lead poisoning prevention which result from planned health department strategies.

8. Budget justification (not scored)

The extent to which the budget is reasonable, clearly justified, and consistent with the intended use of funds.

PART B: Competing Continuations

1. Understanding of the Problem (10 points)

The extent to which the applicant's description and understanding of the burden and distribution of childhood lead exposure or elevated BLLs in their jurisdiction, using available evidence of incidence and/or prevalence and demographic indicators, including a description of the Medicaid population, as required in the Children’s Health Act of 2000.

2. Surveillance activity (20 points)

The applicant’s ability to enhance its childhood blood lead surveillance system that includes: (a) a flow chart that describes data transfer and (b) a mechanism that tracks lead screening for Medicaid children (as required in the Children’s Health Act of 2000), evaluating the existing system, and

reporting data to the CDC’s national surveillance database. Also, the extent to which the proposed time table for accomplishing each activity is appropriate and clearly defined. The following elements will be specifically evaluated:

a. How laboratories report BLLs, including ability to identify and assure reporting from private laboratories and portable blood lead technology that perform lead testing.
b. How data are collected and managed.
c. How quality of data and completeness of reporting are assured.
d. How and when data are analyzed.
e. How summary data are reported and disseminated on a regular basis (i.e., newsletters, fact sheets, annual reports).
f. Protocols for follow-up of individuals with elevated BLLs.

g. Provisions to obtain denominator data (results of all laboratory blood lead tests, regardless of level) as required in the Children’s Health Act of 2000.
h. Time line and methods for evaluating the Childhood Blood Lead Surveillance (CBLS) approach.
i. Process used to convert paper-based components of the system to electronic data.
j. Use of data including evaluation of prevention activities,

especially to target screening and prevention efforts.

k. Ability to link environmental data.

For eligible SMSAs (Part B only): The applicant's ability to expand their data management system, including the approach to participating in the State CBLS. The clarity, feasibility, and scientific soundness of the approach to data management. Also, the extent to which the proposed schedule for accomplishing each activity and method for evaluating each activity are clearly defined and appropriate. Please note: The elements (a-k) detailed under No. 2 Surveillance Activities in the section immediately preceding this one all apply to eligible SMSAs.

3. Statewide/Jurisdiction-wide Planning and Collaboration (20 points)

The applicant's demonstrated ability to implement and evaluate statewide/jurisdiction-wide screening recommendations with appropriate local strategies. The following elements will be specifically evaluated:

a. The approach used to develop, carry out, and evaluate an inclusive State- or jurisdiction-wide screening plan as outlined in *Screening Young Children for Lead Poisoning: Guidance for State and Local Health Officials*.

b. The extent to which the applicant utilized surveillance and program data to produce statewide/jurisdiction-wide screening recommendations and target the Medicaid

population, as required in the Children's Health Act of 2000.

c. Description of how collaborations facilitated the development of a screening plan and strengthened childhood lead poisoning prevention strategies.

d. Evidence of collaboration with principal partners, including managed-care organizations, State Medicaid agency, child health-care providers and provider groups, insurers, community-based organizations, housing agencies, and banking, real-estate, and property-owner interests. These collaborations must be demonstrated by letters of support, memoranda of understanding, contracts, or other documented evidence of relationships.

Note: For applicants under Part B, describe progress in implementing the screening plan based upon each of the elements listed above.

4. Capacity to carry out public-health core functions (10 points)

The ability to describe the approach and activities taken to achieve a balance in the health department's roles in CLPP, including assessment, program and policy development, and monitoring, evaluating, and ensuring the provision of all CLPP activities within their respective categories (for example, Category 3 requires screening plans, surveillance systems, assure follow-up care, and evaluation).

5. Goals and objectives (10 points)

The extent to which the applicant's goals and objectives relate to the CLPP activities as described in the category under which they applied. Objectives must be relevant, specific, measurable, achievable, and time-framed and must be provided for the first budget year. There must be a formal work plan with a description of methods, a timetable for completing the proposed methods, identification of the program staff responsible for accomplishing each objective, and process evaluation measures for each proposed objective. Also include a tentative work plan and timetable for the remaining years of the proposed project.

6. Project management and staffing (10 points)

The extent to which the applicant has the skills and ability to develop and carry out CLPP activities within their respective category/ies. Specifically the applicant should:

a. Describe the proposed health department staff roles in CLPP, their specific responsibilities, and their level of effort and time. Include a plan to expedite filling of all positions and provide assurances that such positions will be authorized to be filled by the applicant's personnel system within reasonable time after receiving funding.

b. Describe a plan to provide training and technical assistance to health department personnel and consultation

to collaborators outside the health department, including proposed design of information-sharing systems.

7. Program evaluation (15 points)

The extent to which the applicant describes a systematic assessment of the operations and outcomes of the program as a means of contributing to the overall improvement of the program. Specific criteria should include:

a. An evaluation plan which describes useful and appropriate strategies and approaches to monitor and improve the quality, effectiveness, and efficiency of the program;

b. Description of how evaluation findings will be used to assess changes in public policy and measure the program's effectiveness of collaborative activities; and

c. Description of how the program will document progress made in childhood lead poisoning prevention which result from planned health department strategies.

8. Budget justification (not scored)

The extent to which the budget is reasonable, clearly justified, and consistent with the intended use of funds.

PART C: SUPPLEMENTAL STUDIES - Factors to be Considered

1. Study protocol (45 points)

The applicant's ability to develop a scientifically sound

protocol (including adequate sample size with power calculations), quality, feasibility, consistency with project goals, and soundness of the evaluation plan (which should provide sufficient detail regarding the way the protocol will be implemented). The degree to which the applicant has met the CDC policy requirements regarding the inclusion of women, ethnic, and/or racial groups in the proposed project. This includes: (a) the proposed plan to include of both sexes and racial and ethnic minority populations for appropriate representation; (b) the proposed justification when representation is limited or absent; (c) a statement as to whether the design of the study is adequate to measure differences when warranted; and (d) a statement as to whether the plan for recruitment and outreach for study participants includes establishing partnerships with community-based agencies and organizations. Benefits of the partnerships should be described.

2. Project personnel (20 points)

The extent to which personnel involved in this project are qualified, including experience in conducting relevant studies. In addition, the applicant’s ability to commit appropriate staff time needed to carry out the study.

3. Project management (35 points)

The applicant’s ability to implement and monitor the proposed study to include specific, attainable, and realistic goals and

objectives, and an evaluation plan.

4. Budget justification (not scored)

The extent to which the budget is reasonable, clearly justified, and consistent with the intended use of cooperative agreement funds.

5. Human subjects (not scored)

The extent to which the applicant complies with the Department of Health and Human Services regulations (45 CFR Part 46) on the protection of human subjects.

H. Other Requirements

Technical Reporting Requirements

Provide CDC with the original plus two copies of:

1. Quarterly progress reports, which are required of all grantees. **The quarterly report narrative should not exceed 15 pages.** Time lines for the quarterly reports will be established at the time of award, but are typically due 30 days after the end of each quarter.
2. Calendar-year surveillance data must be submitted annually to CDC in the approved OMB format between March - June. In addition to CDC, a written surveillance summary must be disseminated to State and local public health officials, policy makers, and others.
3. Financial Status Reports are due within 90 days of the end of the budget period.

4. Final financial reports and performance reports are due within 90 days after the end of the project period.

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

NOTE: Data collection initiated under this cooperative agreement program has been approved by the Office of Management and Budget under OMB number (0920-0337), “National Childhood Blood Lead Surveillance System”, Expiration Date: March 31, 2001.

The following additional requirements are applicable to this program. For a complete description of each, see Addendum 1 in the application package.

AR-1 Human Subjects Requirement
AR-2 Requirements for Inclusion of Women and Racial and Ethnic Minorities in Research
AR-7 Executive Order 12372 Review
AR-9 Paperwork Reduction Act Requirements
AR-10 Smoke-Free Workplace Requirements
AR-11 Healthy People 2010
AR-12 Lobbying Restrictions

I. Authority and Catalog of Federal Domestic Assistance Number

This program is authorized under sections 301(a), 317A and 317B of the Public Health Service Act [42 U.S.C. 241(a), 247b-1, and 247b-3], as amended by the Children's Health Act of 2000. Program regulations are set forth in Title 42, Code of Federal Regulations, Part 51b to State and local health departments. The Catalog of Federal Domestic Assistance number is 93.197.

J. Pre-Application Workshop for New and Competing Continuation Applicants

For interested applicants, a telephone conference call for pre-application technical assistance will be held on Wednesday, February 14, 2001, from 1:30 p.m. to 3:30 p.m. Eastern Standard Time. **The bridge number for the conference call is 1-800-311-3437, and the pass code is 907844.** For further information about all workshops, please contact Claudette Grant-Joseph at 404-639-2510.

K. Where to Obtain Additional Information:

This and other CDC announcements may be downloaded through the CDC homepage on the Internet at http://www.cdc.gov. Please refer to program announcement number 00033 when requesting information. To receive additional written information and to request an application kit, call 1-888-GRANTS4 (1-888-472-6874). You will be asked to leave your name, address, and phone number and will need to refer to Announcement 00033. You will receive a complete program description,

information on application procedures, and application forms. CDC will not send application kits by facsimile or express mail.

If you have questions after reviewing the contents of all documents, business management technical assistance may be obtained from:

Mattie B. Jackson, Grants Management Specialist
Grants Management Branch, Procurement and Grants Office
Centers for Disease Control and Prevention (CDC)
2920 Brandywine Road, Room 3000
Atlanta, GA 30341-4146
telephone (770) 488-2718
Internet address **mij3@cdc.gov**

For programmatic technical assistance, contact:

Claudette A. Grant-Joseph, Chief,
Program Services Section, Lead Poisoning Prevention Branch
Division of Environmental Hazards and Health Effects
National Center for Environmental Health
Centers for Disease Control and Prevention (CDC)
1600 Clifton Road, NE, Mailstop E-25
Atlanta, GA 30333
telephone (404) 639-2510
Internet address **cag4@cdc.gov**

Dated:

_____

John L. Williams

Director, Procurement & Grants Office

Addendum 1

DEPARTMENT OF HEALTH AN HUMAN SERVICES
Centers for Disease Control and Prevention
Program Announcement 00033
Childhood Lead Poisoning Prevention Programs

AR-1

Human Subjects Requirements

If the proposed project involves research on human participants, the applicant must comply with the Department of Healthand Human Services Regulations (45 CFR 46) regarding the protection of human research participants. Assurance must be provided to demonstrate that the project will be subject to initial and continuing reviews by an appropriate institutional review board. The applicant will be responsible for providing evidence of this assurance in accordance with the appropriate guidelines and forms provided in the application kit.

In addition to other applicable committees, Indian Health Service (IHS) institutional review committees also must review the project if any component of IHS will be involved with or will support the research. If any American Indian community is involved, its tribal government must also approve that portion of the project applicable to it.

Unless the awardee holds a Multiple Project Assurance, a Single Project Assurance is required, as well as an assurance for each subcontractor or cooperating institution that has immediate responsibility for human participants.

The Office for Protection from Research Risks (OPRR) at the National Institutes of Health (NIH) negotiates assurances for all activities involving human participants that are supported by the Department of Health and Human Services.

AR-2

Requirements for Inclusion of Women and Racial and Ethnic Minorities in Research

It is the policy of the Centers for Disease Control and Prevention (CDC) and the Agency for Toxic Substances and Disease Registry (ATSDR) to ensure that individuals of both sexes and the various

racial and ethnic groups will be included in CDC/ATSDR-supported research projects involving human subjects, whenever feasible and appropriate. Racial and ethnic groups are those defined in OMB Directive No. 15 and include American Indian or Alaska Native, Asian, Black or African American, Hispanic or Latino, Native Hawaiian or Other Pacific Islander. Applicants shall ensure that women, racial and ethnic minority populations are appropriately represented in applications for research involving human subjects. Where clear and compelling rationale exist that inclusion is inappropriate or not feasible, this situation must be explained as part of the application. This policy does not apply to research studies when the investigator cannot control the race, ethnicity, and/or sex of subjects. Further guidance to this policy is contained in the Federal Register, Vol. 60, No. 179, pages 47947-47951, and dated Friday, September 15, 1995.

AR-7

Executive Order 12372 Review

Applications are subject to Intergovernmental Review of Federal Programs, as governed by Executive Order (E.O.) 12372. The order sets up a system for State and local governmental review of proposed Federal assistance applications. Applicants should contact their State single point of contact (SPOC) as early as possible to alert the SPOC to prospective applications and to receive instructions on the State process. For proposed projects serving more than one State, the applicant is advised to contact the SPOC for each State affected. (The application kit contains a current list of SPOCs.) SPOCs who have recommendations about the State process for applications submitted to CDC should send them, in a document bearing the program announcement number, no more than 60 days after the application deadline date, to:

Mattie B. Jackson, Grants Management Specialist
Grants Management Branch, Procurement and Grants Office
Announcement Number 00033
Centers for Disease Control and Prevention
2920 Brandywine Road, Room 3000
Atlanta, GA 30341

Indian tribes must request tribal government review of their applications.

If Indian tribes are eligible for the program, change the sentence about SPOC recommendations as follows:

SPOCs or tribal governments that have recommendations about an

application submitted to CDC should send them, in a document bearing the program announcement number, no more than 60 days after the application deadline date, to:

Mattie B. Jackson, Grants Management Specialist
Grants Management Branch, Procurement and Grants Office
Announcement Number 00033
Centers for Disease Control and Prevention
2920 Brandywine Road, Room 3000
Atlanta, GA 30341

CDC does not guarantee to accept or justify its nonacceptance of recommendations that are received more than 60 days after the application deadline.

AR-9

Paperwork Reduction Act Requirements

Projects that involve data collection from 10 or more persons and that are funded by grants and cooperative agreements will be subject to review and approval by the Office of Management and Budget (OMB).

Data collection initiated under this grant/cooperative agreement) has been approved by the Office of Management and Budget (OMB) under OMB number 0920-0337 for CDC), National Childhood Blood Lead Surveillance System, expiration date March 31, 2001.

AR-10

Smoke-Free Workplace Requirements

CDC strongly encourages all recipients to provide a smoke-free workplace and to promote abstinence from all tobacco products. Public Law 103-227, the Pro-Children Act of 1994, prohibits smoking in certain facilities that receive Federal funds in which education, library, day care, health care, or early childhood development services are provided to children.

AR-11

Healthy People 2001

CDC is committed to achieving the health promotion and disease prevention objectives of A Healthy People 2001,@ a national activity to reduce morbidity and mortality and improve the quality of life.

For a copy of "Healthy People 2001" (Full Report: Stock No. 017-001-00474-0) or "Healthy People 2001" (Summary Report: Stock No. 017-001-00473-1), write or call:

Superintendent of Documents

Government Printing Office

Washington, DC 20402-9325

Telephone (202) 512-1800

AR-12

Lobbying Restrictions

Applicants should be aware of restrictions on the use of HHS funds for lobbying of Federal or State legislative bodies. Under the provisions of 31 U.S.C. Section 1352, recipients (and their subtier contractors) are prohibited from using appropriated Federal funds (other than profits from a Federal contract) for lobbying congress or any Federal agency in connection with the award of a particular contract, grant, cooperative agreement, or loan. This includes grants/cooperative agreements that, in whole or in part, involve conferences for which Federal funds cannot be used directly or indirectly to encourage participants to lobby or to instruct participants on how to lobby.

In addition no part of CDC appropriated funds, shall be used, other than for normal and recognized executive-legislative relationships, for publicity or propaganda purposes, for the preparation, distribution, or use of any kit, pamphlet, booklet, publication, radio, television, or video presentation designed to support or defeat legislation pending before the Congress or any State or local legislature, except in presentation to the Congress or any State or local legislature itself. No part of the appropriated funds shall be used to pay the salary or expenses of any grant or contract recipient, or agent acting for such recipient, related to any activity designed to influence legislation or appropriations pending before the Congress or any State or local legislature.

Addendum 2

Background on CDC's estimate of number and proportion of children at high risk for lead exposure by State

To provide States with general guidance about the appropriate amount of funding to request under this Program Announcement, CDC estimated the number and percentage of children with elevated BLLs for each State. CDC used a logistic-regression model to estimate the contribution of four major risk factors to the probability that an individual child would have a blood lead level (BLL) of at least 10 µg/dL. The selected risk factors were based on data from Phase 2 of the Third National Health and Nutrition Examination Survey (NHANES III, Phase 2) and included the age and race of children, age of housing, and family income. The model established a relative contribution or "coefficient" for each of these factors. These coefficients were then applied to the relevant categories of 1990 census data for each State to produce an estimate of both *the number* and *the percentage* of children with elevated BLLs in the State.

CDC's purpose in estimating the number and percentage of children with EBLLs in each State is to approximate the level of effort that may be required to provide prevention services to the entire population of a State. In accordance with this purpose, CDC adjusted the level of effort projected for State-level CLPP Programs in States with one or more locales currently receiving separate funding under this grant program.

To derive the funding category for each State, CDC gave twice as much weight to the estimated percentage of children with elevated BLLs as to the estimated number of children with elevated BLLs.

Note 1: The categorization scheme developed for use in this Program Announcement is likely to be of only limited usefulness for other purposes. The use of an approximation is necessary because of the wide variation among States in the extent to which their pediatric populations are exposed to lead.

Note 2: Applicants are encouraged to use the funding category that is suggested for the applicant's State; however, note these are suggested funding guidelines and should not be regarded as absolute funding limits.

Addendum 3

BACKGROUND AND DEFINITIONS

Background:
In the last few years, there have been three major changes in the context within which CLPP and CBLS programs function. These are:

- **Changing functions of health departments.** Many health departments have ceased to be major providers of direct screening and follow-up care services, as Medicaid beneficiaries who formerly received preventive health care in health departments have enrolled in managed-care organizations. A decrease in funding has occurred in many health departments.

- **Renewed emphasis on accountability of government agencies.** A renewed call for accountability in government agencies requires that health departments document both the need for and the impact of their programs.

- **Continuing declines in BLLs of the entire U.S. population, resulting in wide variation among jurisdictions with regard to the magnitude of their childhood lead poisoning problems.**

Resource limitations and the demand for public accountability have made it increasingly important for health departments to perform the core functions of public health as outlined in *The Future of Public Health* (IOM, 1988). These core functions are assessment, policy development, and assurance. Health department personnel must also accomplish their missions through others, by deepening relationships among new and old partners both in and outside of the health department. Also, the widening disparity among jurisdictions with regard to the magnitude of the childhood lead poisoning problem has focused attention on State and local health departments, as opposed to the Federal government, as the appropriate decision-makers for lead screening. Taken together, these changes are having a profound impact on CLPP programs, necessitating a change in programmatic emphasis.

CLPP and CBLS programs are positioned to bring about improved screening and follow-up care for children with elevated BLLs, improved public and professional awareness of the problem of childhood lead poisoning, and improved childhood blood lead surveillance, by performing the three core public health functions related to childhood lead poisoning prevention.

Definitions

- *Assessment:* Activities organized by a health department for the purpose of determining the risk for lead exposure among the children in its jurisdiction and the adequacy of programmatic activities to address this risk.
- *Assurance:* Activities organized by a health department for the purpose of 1) monitoring the provision of CLPP services including screening, follow-up care, and public and professional education; and 2) ensuring, as a provider of last resort, the availability of necessary services.
- *High-risk:* A term used to designate areas, populations, and individuals with risk for lead exposure that is assessed or demonstrated to be higher than average.
- *Lead hazard:* Accessible paint, dust, soil, water, or other source or pathway that contains lead or lead compounds that can contribute to or cause elevated BLLs.
- *Lead hazard remediation:* The elimination, reduction, or containment of known and accessible lead sources.
- *Policy development:* Activities organized by a health department for the purpose of framing the CLPP problem and establishing the response to it in its jurisdictions; includes development, oversight, and evaluation of necessary programs, relationships, and policies that will support CLPP.
- *Primary prevention:* The prevention of elevated BLLs in an individual or population, usually by reducing or eliminating lead hazards in the environment.
- *Program:* A designated unit within an agency responsible for implementing and coordinating a systematic and comprehensive approach to CLPP and CBLS.
- *Surveillance:* A process which 1) systematically collects information over time about children with elevated BLLs using laboratory reports as the data source; 2) provides for the follow-up of cases, including field investigations when necessary; 3) provides timely and useful analysis and reporting of the accumulated data, including an estimate of the rate of elevated BLLs among all children receiving blood tests; and 4) reports data to CDC in the appropriate format.

Addendum 4

Childhood Lead Poisoning Prevention Program Components

Major goals and objectives should be developed for each component required in the applicant's funding category. These are the goals and objectives identified in evaluation criteria #5 (goals and objectives).

Component 1. **Statewide/Jurisdiction-wide Screening Plan (Required activity for all funded applicants).** Development or implementation and evaluation of a childhood blood lead screening plan consistent with CDC guidance provided in *Screening Young Children for Lead Poisoning: Guidance for State and Local Public Health Officials.*

Component 2. **Statewide Surveillance System (Required activity for all funded State applicants).** Development or enhancement of a CBLS system that includes collection, analysis, and dissemination of data on: screening, prevalence of elevated BLLs, sources of lead exposure, and follow-up care among children. Inclusion of surveillance data in the national CBLS database maintained by CDC. [Funded locales also need to engage in planning, data management, and surveillance, but it is likely that these activities will take place within the context of State activities.]

Component 3. **Assurance of screening and follow-up care (Required activity for all funded applicants).** Development, improvement, and oversight of lead-related policies and services associated with: a) screening; b) follow-up care for those with elevated BLLs, including care coordination, family education about lead exposure, and environmental investigation; and c) remediation of lead hazards. *Of particular interest*

are efforts to develop policies and to convene and coordinate concerned and responsible parties to bring about these activities.

Component 4. Public and professional health education and health communication (Required for Funding Categories 1 & 2) Development, improvement, and oversight of strategies to perform health education and health communication about CLPP for a variety of target audiences. [Note: The ability to communicate CLPP program goals effectively and to educate community members about CLPP underlie all other aspects of the CLPP program.]

Component 5. Evaluation of program impact (Required activity for all funded applicants). Monitoring and evaluation of the effectiveness of screening, follow-up, education and communication, lead-hazard remediation, and primary prevention activities to ensure that programs are consistent with plans and policies, and revision of programmatic efforts as necessary on the basis of evaluation findings. (For example: What is your program's expected outcome as a result of all program activities implemented)

Component 6. Primary prevention (Required for Funding Category 1). Development, improvement, and oversight of policies and strategies to bring about primary prevention.

Addendum 5

CHILDREN'S HEALTH ACT OF 2000

H.R. 4365

Title XXV - Early Detection & Treatment Regarding Childhood Lead Poisoning

- The Secretary, acting through CDC, shall develop national guidelines for the uniform reporting of all blood lead test results to State and local health departments.

- CDC shall: 1) assist with the improvement of data linkages between State and local health departments and between State health departments and the Centers for Disease Control and Prevention; 2) assist States with the development of flexible, comprehensive State-based data management systems for the surveillance of children with lead poisoning that have the capacity to contribute to a national data set; 3) assist with the improvement of the ability of State-based data management systems and federally-funded means-tested public benefit programs (including the special supplemental food program for women, infants and children (WIC)) and the early head start program to respond to ad hoc inquiries and generate progress reports regarding the lead blood level screening of children enrolled in those programs; 4) assist States with the establishment of a capacity for assessing how many children enrolled in the medicaid, WIC, early head start, and other federally-funded means-tested public benefit programs are being screened for lead poisoning at age-appropriate intervals; 5) use data obtained as result of activities under this section to formulate or revise existing lead blood screening and case management policies; and 6) establish performance measures for evaluating State and local implementation of these requirements.