

## (e) Updated Community Action Plans

Within the first eight months, finalize a five-year community action plan, based on the guidelines of this announcement, the preliminary plan submitted with this application, input from the application review process, newly available community information, HHS agencies and other sources of technical support, and continuing discussions with the community consortium. Base your revised action plan on a logic model that serves as the foundation for prioritizing, planning, and budgeting interventions, program management, and program sustainability (See Attachment B for references regarding logic model development and use). Review and update the community action plan annually to reflect community needs, opportunities, resources, and program evaluation findings.

## (f) Project Monitoring and Evaluation

i. *Risk Factor Surveillance.* Work with the state health department and CDC to expand existing surveillance mechanisms to collect representative Behavioral Risk Factor Surveillance System (BRFSS) baseline data for 1,500 to 2,000 adults within the intervention area, and repeat such assessments on an annual basis. (<http://www.cdc.gov/brfss/>)

Work with the state education agency and CDC to collect representative baseline data from the Youth Risk Behavior Surveillance System (YRBSS) (including, at a minimum, information on nutrition, physical activity, asthma, and tobacco) for 1,500 to 2,000 middle and/or high school students within the intervention area, and repeat such assessments on at least a biennial basis. ([http://www.cdc.gov/nccdphp/dash/yrbbs/about\\_yrbbs.htm](http://www.cdc.gov/nccdphp/dash/yrbbs/about_yrbbs.htm))

ii. *Existing Data Sources.* Identify existing data sources that can be used to design and monitor STEPS interventions, including hospital discharge data; medical care practice data; vital statistics data; Women, Infants, and Children (WIC) data; community health centers data; Medicaid and Medicare data; school data such as absentee rates, academic, health, and risk information; and other sources of information about individual, group, or community health status, needs, and resources.

iii. *Common Performance Measures.* STEPS recipients will participate in establishing a common set of core performance measures to track the number and types of persons served by various intervention strategies and the

achievement of related short-term, intermediate, and long-term outcomes. Recipients must agree to collect and report on core performance measures using standardized methodology to document how intervention strategies are being implemented and are successfully addressing STEP priorities. Performance goals should show the link between program activities and the achievement of the initiative's overarching goals. See Attachment A for selected "Healthy People 2010" objectives that are anticipated to form part of the core performance measures.

iv. *Comprehensive Evaluation Plan.* Agree to participate fully in a STEPS-wide independent, external evaluation to examine and document the effectiveness of this cooperative agreement program. An important mechanism for changing behavior and implementing effective practices in a variety of settings is the ability to examine and act on successes, barriers to success, and failures. The recipients are expected to be full partners in the evaluation of this initiative by actively gathering and submitting data on selected outcome and performance measures. Grantees will also participate in other evaluation activities that may include regular debriefings, descriptive case studies, special analyses, and mid-course adjustments.

v. *Data-Based Decision Making.* Projects are expected to use all the information above, in consultation with their Project Officer, to design and modify intervention strategies and the community action plan; revise budgets and subcontracts; request technical assistance from HHS agencies and/or contracted experts; recruit new members to the consortium; and/or change the structure of the consortium to improve project participation and outcomes.

## (g) Information Sharing

Actively promote the sharing of experiences, strategies, and results with both funded and unfunded cities, communities, and interested partners. Ensure effective, timely communication and exchange of information, experiences, and results through the use of the internet; management information systems; other electronic approaches and formats; workshops; site visits to and between communities and cities; and other activities.

## 2. Tribal Recipient Activities

Recipient activities are the same as the activities outlined under sections E.1. (a) through (g) for Large Cities and Urban Communities.

## 3. State-Coordinated Small City and Rural Community Recipient Activities

## (a) State Fiduciary Responsibilities

i. *Lead Agency.* Establish the lead/fiduciary agency to be the state health department (its bona fide agent) or its equivalent as designated by the Governor.

ii. *Allocate Funds.* Allocate and disperse funds to communities, the state education agency, other key partners to implement recipient activities at the community level. Include adequate funds to participate fully in the substantial data collection and evaluation activities associated with this award.

iii. *Contract Services.* Contract for services, as needed, to accomplish the objectives of this program announcement.

iv. *Link Budget to Performance.* Provide integrated progress and financial reports that link the performance and expenditures of the communities and all key partners.

v. *Sustainability.* If funded for years three through five, engage in efforts that will sustain successful community programs on a long-term basis.

## (b) Small City and Rural Community Responsibilities

Each of the two to four identified communities is expected, with state assistance, to assume the responsibilities identified under Large City and Urban Community Recipient Activities section E.1. (a) through (g).

## (c) Leadership/Coordination/Management

In support of the communities, the state health department should establish and coordinate a State-Community Management Team, including participation from the funded communities, the state health department, education agency, Office of Rural Health, any city or large community that is funded within the state borders under this program announcement, and other key public and private sector partners.

i. *Coordinate community objectives with state health plans.* Ensure that, community, and city objectives, activities, and interventions are consistent with, and are supportive of state plans and activities for the prevention and control of diabetes, asthma, and obesity.

ii. *Collaboration.* Ensure collaboration between the community and city programs funded under this program announcement and other state and local chronic disease prevention and control programs.