

of interventions that together have a high degree of community reach and participation.

c. The feasibility of the plan from a program implementation perspective, and from a cost/economic perspective. Included in this should be an estimate of how long it will take to fully implement the plan, with the idea that the quicker the intervention can be implemented effectively and efficiently, the better.

d. The degree to which pilot testing, previous community experience, and/or the science of effective asthma interventions were used/are being used to create the plan and its details.

e. The degree to which the plan reflects and builds on a mature and comprehensive understanding of the assets, attributes, and deficiencies of the communities of focus including non-CAACP asthma activities completed or ongoing in these communities.

f. The degree of community participation in the plan. The following questions should be addressed: Is there documentation of community participation in the development of the plan? Does the plan encourage community capacity building and empowerment? Do community partners play a large role in the implementation period and does this empower or build capacity within the community?

g. Approach to sustainability issues. This includes a discussion of what needs to happen to make the intervention strategies sustainable after project funding is finished, how likely it is that this will occur, and what project staff and partners are doing or planning to do to make this happen.

h. The value of the community asthma action plan and the individual intervention strategies from a broader scientific and community public health perspective. In other words, are the strategies innovative and ambitious enough to stretch our understanding of asthma control and community health?

i. Ability to replicate the community asthma action plan in other cities or expand into new neighborhoods within the same city. This includes the degree to which the individual intervention strategies will likely be attractive to other communities (*i.e.*, cost-feasible, resource-feasible, and reproducible).

2. Project organization, staffing, active collaboration and community support (30 percent). Projects will be judged on the following:

a. The diversity of individuals and organizations involved in the project.

b. The competence and community leadership potential of those actively engaged and participating in the project.

c. The depth of expertise (both formal expertise and significant past hands-on experience) in all areas critical to the project's success.

d. The overall competence, leadership, and vision of the principal investigator(s) and project coordinator(s). This is based, in part, on their individual skills/experience with a community-based team approach to decision-making and problem solving.

e. The ability of project staff and collaborators to communicate openly and easily, to understand each other's roles, and to make optimal project-related decisions. This will be based, in part, on the project's organizational structure and decision-making procedures developed and practiced over the two-year planning period.

f. The commitment of the collaborating individuals and especially, organizations. This includes the degree to which project collaborators have taken ownership or plan to take ownership of the project.

g. The effort made by project staff and collaborators to involve grassroots community members and/or representatives in a meaningful way.

h. The project's effectiveness in creating community awareness and interest in asthma and the project, in particular.

i. The prospect of sustaining the collaborative partnership beyond the project period and even beyond childhood asthma as the public health focus. This includes an assessment of how the project interacts with other existing community projects and coalitions in the region.

3. Evaluation Plan (20 percent).

Projects will be judged on the following:

a. Outcome-based Evaluation Strategies. The overall evaluation plan should be designed to measure the impact of the project's activities and interventions as a whole on the targeted communities' population of children and/or teens with asthma. Evaluation strategies aimed at measuring the impact of a single, specific intervention are important but remain secondary to measuring the project's overall population-based impact. Evaluation strategies that incorporate some or all of the following outcome measures (but not necessarily limited to the following) are suggested:

(1) Hospitalization data (ideally starting a minimum of three years prior to the onset of intervention activities to allow for trend analyses, and with comparable data from outside the communities of focus for comparison).

(2) Emergency care data (as above if possible).

(3) School absenteeism (all causes in those identified as having asthma or asthma-specific absenteeism).

(4) Quality of life and/or asthma symptom surveys (if a non-biased sample can be identified and obtained).

(5) Asthma medications (*i.e.*, the ratio of rescue to controller medication prescriptions filled).

(6) Asthma care visits (*i.e.*, ratio of scheduled to unscheduled visits, or number of asthma maintenance visits per year).

(7) Changes in community empowerment and/or active participation in community health (as measured by a validated instrument in a non-biased sample of the community).

b. Comprehensive Evaluation Plan: Applicants will be judged on how well they have articulated an evaluation plan that complements the outcome-based measures described above (section H2a) and is likely to be useful in understanding and/or measuring the following: (1) The dynamics of the collaborative process, including decision making; (2) the general effectiveness of the collaborative in helping to create, implement, and sustain community interventions; (3) the relationship between the project/collaborative and the community it seeks to serve; (4) the reach of project activities in the communities of focus; (5) the effectiveness of specific intervention components; (6) the cost and resource feasibility of specific intervention components; and (7) the impacts of the project and/or collaborative on the community outside of its specific impacts on asthma.

The evaluation plan will be additionally judged on the degree to which: (1) The project's stakeholders have been identified; (2) their perspectives and evaluation needs are reflected in the plan; and (3) the evaluation plan is cost and resource feasible.

c. Baseline comprehensive evaluation data collected, organized, and/or analyzed during the two-year planning phase with an emphasis on the following: (1) The proportion of baseline data needed for the proposed comprehensive evaluation already collected and analyzed; (2) the likelihood that the baseline data not yet collected will be collected and analyzed in the near future; (3) the quality of the data and the data analysis reports already collected and/or analyzed; and (4) the adequacy of the collected or soon-to-be collected data as a baseline for the proposed comprehensive evaluation.

d. Does the application adequately address the CDC Policy requirements