A. Funding Table for Communities Putting Prevention to Work

(Dollars in millions)

Program/ Project/Activity	Total Appropriated	FY 2009 Actual Obligations	FY 2010 Estimated Obligations
Communities Putting Prevention to Work: Community Initiative	449.4	0.0	449.4
Communities Putting Prevention to Work: State and Territory Initiative	125.0	0.0	125.0
Communities Putting Prevention to Work: Chronic Disease Self-Management Initiative	32.3	0.0	32.3
Communities Putting Prevention to Work: National Prevention Media and National Organization Initiatives	40.00	0.0	40.00
Management and Oversight	3.3	0.0	3.3
Total	650.00	0.0	650.00

B. Objectives

The American Recovery and Reinvestment Act of 2009 (Recovery Act) states that "$650,000,000 shall be provided to carry out evidence-based clinical and community-based prevention and wellness strategies authorized by the Public Health Service Act that deliver specific, measurable health outcomes that address chronic disease rates." The Department of Health and Human Services (HHS) is executing a robust initiative in response to the Act. The goal of this collaborative HHS initiative – ***Communities Putting Prevention to Work*** – is to reduce risk factors and prevent/delay chronic disease and promote wellness in both children and adults. ***Communities Putting Prevention to Work*** (CPPW) will expand the use of evidence-based strategies and programs, mobilize local resources at the community-level, and strengthen the capacity of states.

The initiative has a strong emphasis on creating policy and environmental changes at both the state and local levels that will, in the longer term:

- Increase levels of physical activity;
- Improve nutrition;
- Decrease obesity rates; and
- Decrease smoking prevalence, teen smoking initiation, and exposure to second-hand smoke.

Powerful models of success are expected to emerge to be replicated in other communities. For more information, visit: www.cdc.gov/CommunityHealthResources.

C. Activities

There are three major components to the CPPW initiative:
- Community Program
- States and Territories
- National Prevention Media and National Organizations Initiative

Community and State/Territory recipients will select a package of strategies from the following five groups of strategies ("MAPPS Strategies"). These strategies will be described in obesity, physical activity and nutrition and/or a tobacco plan:

- Use **media** to promote healthy foods/drinks and increase activity; restrict advertising and employ counter-advertising for tobacco and unhealthy foods/drinks;
- Increase **access** to healthy food/drink choices and safe locations to be active and improve the built environment; restrict the availability of tobacco and unhealthy food/drinks; smoke free and tobacco free policies
- Use of **point of decision** labeling/signage/placement to discourage consumption of tobacco, increase consumption of healthy foods/drinks, and prompt physical activity;
- Use **price** to discourage consumption of tobacco and to benefit consumption of healthy foods/drinks; and
- Use **social support/services** to promote tobacco cessation, breastfeeding, and increased activity.

Community Program

The Centers for Disease Control and Prevention (CDC) is supporting intensive community approaches to creating supportive policies and environments that will drive changes in risk behaviors and chronic disease prevention and control in selected communities (urban and rural), to achieve the following prevention goals:

- Increased levels of physical activity;
- Improved nutrition (e.g. increased fruit/vegetable consumption, reduced salt and transfats);
- Decreased overweight/obesity prevalence;
- Decreased smoking prevalence and decreased teen smoking initiation; and
- Decreased exposure to secondhand smoke.

As noted, the five evidence-based groups of MAPPS strategies (Media, Access, Point of decision information, Price, and Social support), when combined, can have a profound influence on improving health behaviors by changing community policies and environments. Communities will implement a focused set of prescribed interventions related to the MAPPS strategies, as outlined in the funding opportunity announcement, in tobacco and/or obesity and related risk factors to achieve broad reach, high impact, and sustainable change. The specific amount of funding per community was determined by mix of interventions, population size, ability to reduce health disparities, and likelihood of success. The official local, state or tribal health department (or its bona fide agent, equivalent, or other fiscal intermediary as designated by the mayor, county executive, or other equivalent governmental official), will serve as the lead/fiduciary

agent on behalf of an effective community-wide consortium. Consortium partners include local and state health departments and other governmental agencies, health centers, schools, businesses, community and faith-based organizations, academic institutions, and health care providers. Mental health/substance abuse organizations, health plans and other community partners working together to promote health and prevent chronic diseases were encouraged.

Communities were encouraged to coordinate with other US Government-funded Recovery Act efforts in multiple sectors, such as transportation, education, health care delivery, agriculture and others, as well as coordinating with HHS Regional Offices. Funded communities demonstrated, through letters of support, that they have political support and connections with other community development and livability efforts, and that they build on and leverage existing place-based revitalization and reform projects funded by the US Government, including HHS, and programs supported by other agencies such as the US Department of Housing and Urban Development, the Environmental Protection Agency, the US Park Service, US Department of Transportation, US Department of Agriculture, the Corporation for National and Community Service, and the US Department of Education.

The Community component also includes a robust support plan to ensure funded communities are successful, and that the agencies are able to evaluate the impact of their efforts. The plan consists of a three-pronged approach:

(1) Community Programmatic Support – intervention design, expertise, implementation support, and national dissemination and training. These activities will occur before, during, and after the program implementation period. Elements of this support will be embedded in communities based on community needs;

(2) Community Mentoring – fund up to 10 communities to provide mentoring to less experienced communities based on their previous success in specific policy strategies; and

(3) Evaluation – through a multi-component evaluation strategy that includes case studies in funded communities and states, cost tracking, and modeling, community and state level risk factor surveillance, and selected community impact evaluations utilizing biometric data collection. The primary emphasis of the evaluation design is on factors and variables that influence successful enactment of the community-level policy and environmental changes that are expected to drive, in the longer-term, the key behavioral outcomes linked to chronic disease.

States and Territories

Three major State and Territory components together support implementation of key evidence-based strategies and interventions at the state level that are expected to create supportive policies and environments that will make healthier choices easier and more affordable, and assist those living with chronic conditions:

(1) Policy and environmental change – under direction of CDC, States and Territories received funding to promote state-wide policy and environmental changes in support of the goals of this initiative. These activities, applying the five MAPPS strategies, will

support and institutionalize healthy behaviors related to nutrition, physical activity, obesity control and tobacco use. Strategies were grounded in evidence. All states and territories were eligible for a base funding amount determined by population, and in addition, thirteen states received competitive funds for special policy initiatives;

(2) Tobacco cessation – under the direction of CDC, all currently funded states and territories received funding to expand tobacco quit lines, in concert with expanded cessation media campaigns. States and territories received funding based on the number of smokers in their jurisdiction. Additional funds are being used for national efforts to support surge capacity, additional quit line monitoring and quality improvement measures; and

(3) Expansion of the chronic disease self-management program (CDSMP) - AoA competitively awarded 45 states, the District of Columbia, and Puerto Rico cooperative agreements to collectively deliver chronic disease self-management programs to 50,000 people with chronic conditions and to build or enhance state evidence based prevention distribution and delivery systems. AoA competitively awarded the National Council on Aging Center for Healthy Living a cooperative agreement to provide technical assistance to the states and territories that received Recovery Act CPPW Chronic Disease Self-Management Program awards. Two million-five hundred thousand dollars ($2.5M) was allocated to the Center for Medicare and Medicaid Services to develop and test a prototype system for using Medicare claims data to track the health care utilization of CDSMP participants and compare it with claims data of a comparable group of Medicare beneficiaries who did not participate in the program.

National Prevention Media and National Organizations Initiative

To complement and reinforce community and State/Territory activities, these initiatives will foster effective and hard-hitting prevention and wellness messages and advertisements, amplified and extended through national organizations.

(1) National Prevention Media - under the direction of CDC, investments will be made in national media to foster effective and hard-hitting prevention and wellness messages and advertisements and to provide communities with high-quality communications expertise to assist in achieving measurable health outcomes. Prevention media materials will be tailored to address the unique needs of communities and will provide materials and templates to give the initiative a powerful brand. The communications component will draw on the full array of materials available across HHS, the Federal Government, and non-governmental organizations, ensure consistency and quality, provide support, and aggregate outreach materials so that they can be easily and widely accessed.

(2) National Organizations - under the direction of the HHS Office of Public Health and Science (OPHS), national organizations will be funded as part of the effort to support community outcomes and focus on community-linked prevention and wellness media. Additionally national organizations will foster community-based linkages with other federally funded and foundation activities to leverage reach and impact of interventions. Linkages may include efforts funded by the US Department of Health and Human

Services and programs supported by other agencies such as the US Department of Housing and Urban Development, the Environmental Protection Agency, the US Park Service, US Department of Transportation, US Department of Agriculture, the Corporation for National and Community Service, and the US Department of Education.

D. Characteristics

All funds will be awarded in accordance with the applicable provisions of the Recovery Act, and all applicable HHS-specific and government-wide policies related to such actions whether the policies are general or specific to Recovery Act funds.

Program Category	Type of Award	Total Funding Amount	Methodology for Award Selection	Recipients
Community Program	Grants and contracts	$449,412,500	New competitive funding opportunity announcement, new and existing contracts, and supplement to existing funding announcements	Official local, state or tribal health department (or its bona fide agent, equivalent, or other fiscal intermediary as designated by the mayor, county executive, or other equivalent governmental official) on behalf of an established community coalition; contracts; and non-profit organizations]
States and Territories	Grants and contracts	$157,337,500	Supplement to existing funding announcements, and new and existing contracts	States/Territories; contracts; National Institute of Health; Center for Medicare and Medicaid Services; non-profit organizations; and Universities.]
National Prevention Media and National Organizations	Grants and contracts	$40,000,000	New and existing contracts and new funding opportunity announcement	Contracts and non-profit organizations
Management and Oversight	Other	$3,250,000	Other	Other
Total	-	$650,000,000	-	-

Community Program

Community Program - CDC competitively awarded funding to 44 eligible local or state health departments and Tribal Governments, Regional Area Indian Health Boards, Urban Indian organizations, and Inter-Tribal Councils (or their bona fide agent, equivalent, or other fiscal intermediary as designated by the mayor, county executive, or other equivalent governmental official). Eligible states included the 50 states, the Commonwealth of Puerto Rico, the Virgin Islands, the Commonwealth of the Northern Marianna Islands, American Samoa, Guam, the Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau.

Community Mentoring - awards will be made as competitive supplemental awards within funded communities.

Community Programmatic Support and Evaluation - activities will be funded through a combination of supplemental awards to existing cooperative agreements and new/existing competitive contract solicitations.

States and Territories

Policy and environmental change - CDC awarded supplemental funding through existing cooperative agreements to eligible grantees including all 50 states, the District of Columbia, Puerto Rico, U.S. Virgin Islands, and the Pacific Islands to promote state- and territory-wide policy and environmental change in support of the goals of this initiative.

Tobacco cessation/quitlines - CDC awarded supplemental funding to all states and those territories currently funded for quit line services to expand tobacco quitlines and support tobacco counter-advertising campaigns. The amount of funding was based on the number of smokers in the state. Funding was also allocated to the National Institute of Health for national quitline efforts.

CDC competitively awarded supplemental funds to thirteen states to implement one or more high impact policy, environmental and/or systems change strategies to eliminate health disparities and achieve health equity related to these individual risk factors or a combination thereof. The funded states are as follows: Colorado, Delaware, Florida, Massachusetts, Michigan, Minnesota, Mississippi, New York, North Carolina, Oregon, Rhode Island, Texas, and Wisconsin.

Expansion of the chronic disease self-management program (CDSMP) - AoA competitively awarded new and supplemental cooperative agreement funding to eligible States. Governors will decide through which state government entity the funding would flow (State Units on Aging or State Health Departments). Funding was also allocated to the Center for Medicare and Medicaid Services to develop and test a prototype system for using Medicare claims data to track the health care utilization of CDSMP participants and comparing it with claims data of comparable groups of Medicare beneficiaries who did not participate in the program.

National Prevention Media and National Organizations

National Prevention Media - CDC will award contracts and/or task orders for media production, media buying, earned-media outreach, and social media activities.

National Organizations - OPHS will award competitive funding through cooperative agreements to support earned-media activities; and competitively award funding to National organizations to leverage the strengths of public, private, and industry efforts into collaborative partnerships in support of community outcomes and focus on community-linked prevention and wellness media.

Management and Oversight

A total of $3.25 million will be used for management and oversight of the entire CPPW initiative. This amount is equal to 0.5% of the $650 million appropriated for the initiative: $3,087,500 for CDC and $162,500 for AoA.

E. Delivery Schedule

Program	Milestone	Expected Date	Responsible Agency
Community Program	Post Funding Opportunity Announcement (FOA)	September 2009	CDC
States and Territories	Issue supplemental guidance (environmental and policy change, Quitline)	September 2009	CDC
Chronic Disease Self Management Program	Post FOA	December 2009	AoA
Community Program	Award various contracts and/or cooperative agreements for evaluation components and support	February 2010 - August 2010	CDC
Media Campaign	Post Request for Proposals	January 2010	CDC
States and Territories	"Base" policy and environmental change awards made; Awards made for Quitline efforts	February 2010	CDC
States and Territories	Awards made for supplemental funding to support environmental and policy change	February 2010	CDC
Chronic Disease Self Management Program	Awards made to State Units on Aging or State Health Departments	March 2010	AoA
National Organizations	Post FOA	March 2010	OPHS
Community Programs	Awards made to communities	March 2010	CDC

Program	Milestone	Expected Date	Responsible Agency
Community Programs	Post Supplemental FOA for Community Mentoring	May 2010	CDC
Media Campaign	Awards made for various contracts for media support	May 2010	CDC
National Organizations	Awards made to National Organizations	June 2010	OPHS
Community Programs	Awards made for Community Mentoring	August 2010	CDC

F. Environmental Review Compliance

The grants and contracts addressed in this program are subject to a National Environmental Policy Act (NEPA) categorical exclusion promulgated by HHS [65 FR 10229 (2/25/2000)] and additional NEPA review is not required.

Categorical exclusions (if applicable) and other environmental reviews will be documented in writing and reported on the Section 1609(c) report.

G. Measures:

Outcome / Achievement	Units	Type	9/30/10 10/Q4	12/31/10 11/Q1	3/31/11 11/Q2	6/30/11 11/Q3	9/30/11 11/Q4	Program End 12/Q2
Tobacco: Increase to 85%[1] the percentage of communities funded under the Communities Putting Prevention to Work program that have enacted new smoke-free policies and/or improved the comprehensiveness of their existing policies.	%	TARGET	5	15	25	50	75	85
		ACTUAL						
Obesity (Nutrition): Increase to 85%[1] the percentage of communities funded under the Communities Putting Prevention to Work program that have enacted new policies or improved the comprehensiveness of existing policies to limit the availability of unhealthy food or drink and/or increase the availability of healthy food or drink.	%	TARGET	5	15	25	50	75	85
		ACTUAL						
Obesity (Physical Activity): Increase to 85%[1] the percentage of communities funded under the Communities Putting Prevention to Work program[2] that have enacted new policies or improved the comprehensiveness of existing policies to increase access to physical education in schools or physical activity in afterschool or daycare settings.	%	TARGET	5	15	25	50	75	85
		ACTUAL						

[1] The HHS high priority in this category shows a 75% target to be achieved by the end of Q4 of FY 2011. The 85% target in the implementation plan for this goal correlates to the end of the project/budget period for funded communities.
[2] For the physical activity measures, percentages are of the total number of funded communities that have included the relevant MAPPS strategies in their workplan.

H. Monitoring and Evaluation

All Recovery Act programs are assessed for risk to ensure that appropriate internal controls are in place throughout the entire lifecycle of the program. These assessments are conducted by operating components to comply with the statutory requirements of the Federal Manager's Financial Integrity Act and the Improper Payments Information Act as well as OMB Circular A-123, "Management's Responsibility for Internal Control" (including Appendices A, B, and C).

CDC, AoA, CMS, HHS/ASPE, and HHS/OPHS's risk management process fits within the overall governance structure established at HHS to address Recovery Act program risks. The HHS Risk Management and Financial Oversight Board provides executive leadership and establishes accountability for the risk assessment process related to internal controls over financial reporting, and the HHS Senior Assessment Team ensures that risk assessment objectives are clearly communicated throughout the Department. CDC, AoA, CMS, HHS/ASPE, and HHS/OPHS Senior Assessment Teams carry out comprehensive annual assessments of this Recovery Act program to identify risks and develop strategies to address them, including those associated with selecting recipients, awarding and overseeing funds, and achieving program goals. They meet at least quarterly to monitor and assess the effectiveness of mitigation strategies and identify emerging risks.

In addition, CDC will present this program's high level risks to the Recovery Act Implementation Team. Chaired by the Deputy Secretary and comprised of senior policy officials from throughout the Department, the Implementation Team convenes monthly to monitor progress in carrying out Recovery Act programs and address the obstacles and risks that could impact on their success.

CDC

Understanding that funds allocated as part of Recovery Act require additional accountability, CDC has established a centralized oversight function, for agency-wide Recovery Act Coordination (RAC), to oversee and coordinate all Recovery Act-funded activities. Quarterly reviews of Recovery Act programs will be conducted by RAC in collaboration with CDC's Financial Management Office (FMO) and Procurement and Grant's Office (PGO), as well as program managers. Potential risks associated with executing Recovery Act funds have been identified and appropriate mitigation strategies have been instituted to ensure Recovery Act funding is effectively and efficiently utilized to achieve program goals. In addition, assurance of adequate staffing levels within FMO, PGO, and within the program has been addressed to provide appropriate oversight and monitoring of recipient activity.

To ensure Recovery Act grantee accountability and performance and to minimize risks associated with the misuse of Recovery Act funds, CDC will perform the following contract and grant management activities for Recovery Act-funded contractors and grantees:

- Coordinate with the Office of the Inspector General (OIG) to ensure that Recipient Capability Assessments are conducted on funded organizations as needed;

- Ensure ongoing technical assistance is provided to contractors and grantees who need assistance in meeting administrative and program requirements;
- Monitor the receipt of financial reports, and review those reports for the purpose of monitoring compliance with financial requirements;
- Monitor the receipt of recipient progress reports, and review those reports for the purpose of monitoring compliance with program requirements;
- Conduct vigorous post-award monitoring to include site visits to grantees;
- Ensure the unique identification of Recovery Act funds in contractual and grant agreements, to include the use of unique Recovery Act CFDA numbers for grants;
- Refer all known instances of suspected fraud, waste, or abuse to the OIG;
- Ensure that timely enforcement actions are taken on any non-performing contractor or grantee;
- Take appropriate enforcement action, such as the disallowance of costs, the recovery of funds, the referral of suspected fraud to the OIG, the implementation of administrative corrective actions by the contractor or grantee, or the termination of funding if CDC determines that a contractor or grantee has misused Recovery Act funds, CDC will; and
- Support the oversight of the Recovery Accountability and Transparency Board, the OIG, and General Accounting Office, to include taking timely action on inquires and recommendations.

There will be frequent communication between grant and contract recipients and program staff, including regular conference calls. Program staff will ensure site visits are conducted according to Recovery Act requirements, and that technical assistance is provided. Recipients may be allowed to charge increased administrative costs to support the frequent and extensive reporting required by the Recovery Act. Allowable and unallowable expenditures will be clearly communicated to recipients and appropriate penalties for misappropriation or misuse of funds will be enforced. The Office of Management and Budget (OMB) Circular A-133, "Audits of States, Local Governments and Non profit Organizations" will set the administrative requirements for these entities. OMB Circular A-87, "Cost Principles for State, Local and Indian Tribal Governments" will set the Federal principles for determining allowable costs.

Development and submission of grantee plans and quarterly updates on progress towards measures and targets will enhance recipient accountability. Specific financial and program performance measures and the frequency for their reporting have been enumerated regarding measures. These indicators will serve as an evaluation of progress in deploying funds and achieving the intended outcomes. Lack of progress will serve as a warning for early intervention to ensure timely mitigation of issues. Monthly and quarterly reporting by recipients will be monitored by project and contract officers and failures to adhere to performance measures will be elevated to supervisory authorities immediately for troubleshooting.

AoA

All AoA Recovery Act programs will be assessed for risk and to ensure the appropriate internal controls are in place through the entire funding cycle. These assessments will be done consistent with the statutory requirements of the Federal Managers' Financial Integrity Act and the Improper Payments Information Act, as well as OMB's Circular A-123 "Managements'

Responsibility for Internal Control." Primary recipients of funds are State governments that have their own established control structures and State audits under Office of Management and Budget (OMB) Circular A-133 "Audits of State, Local Governments and Non profit Organizations" have not generated significant systemic findings.

Cost items are reviewed during the application review process and evaluated for reasonableness, allowability and allocability. Disallowed cost entries are promptly removed from the application prior to issuing an award. All recipients will be governed by the appropriate cost principles (OMB Circular A-87 – "Cost Principles for State, Local and Indian Tribal Governments"). In addition, OMB Circular A-133 requires a stringent audit to be performed with a focus on ARRA expenditures.

AoA has a designated staff person who will coordinate all OPDIV-wide Recovery Act reporting activities. This individual will work with the program officer(s) assigned to manage ARRA recipients, as well as ARRA state level coordinators to ensure reports are submitted in a timely manner and the data is accurate.

AoA's Grants Management Office (GMO) and Recovery Act Program Officer (PO) staff will collect quarterly reports from all ARRA act recipients. This data includes:

- A quarterly quantitative data report, which is accompanied semi-annually by a qualitative narrative; the semi-annual narrative will satisfy the GMO/PO discretionary grants reporting requirements while the quarterly quantitative portion of this report will reflect the program measures required by DHHS and OMB.
- An annual Financial Status Report (FSR 269) to track recipient fiscal expenditures

AoA established and listed the indicators for program development and assessment in the Recovery Act program announcement. Each successful applicant submitted an initial work plan in which the state proposed how it would meet these indicators, which relate to overall programmatic goals. These work plans are undergoing revision in response to AoA's notices of award. States will further refine their work plans in consultation with the technical assistance center and AoA project officers during a grantee meeting in June 2010. The goal is for all states to set their initial target goals no later than November, 2010. Subsequently, AoA project officers and technical assistance center staff will engage in an ongoing assessment of state progress toward meeting their indicators and programmatic goals through periodic conference calls, site visits, and technical assistance calls.

To assist with meeting reporting requirements and program goals, ARRA recipients will have the support of the following types of technical assistance under this funding:

- A national technical assistance center specifically tasked to design and implement tools and strategies to assist the successful implementation of AoA CDSMP grant recipients
- Coordinated AoA Program Officer and Regional Staff technical assistance
- Specific trainings and teleconferences to facilitate timely and accurate ARRA, DHHS and OMB reporting requirements

I. Transparency

CDC, AoA, CMS, ASPE, and OPHS are is open and transparent in all of its contracting and grant competitions and program activities that involve spending of Recovery Act funding consistent with statutory and OMB guidance and published on grants.gov and fbo.gov. CDC ensures that recipient reports required by Section 1512 of the Recovery Act are submitted and reviewed for material omissions and significant errors that would mislead or confuse the public. CDC informs recipients of their reporting obligation through standard terms and conditions, grant announcements, contract solicitations, and other program guidance. In addition, CDC provides key award information to recipients and other technical assistance to grantees and contractors and fully utilizes Project Officers to ensure compliance with reporting requirements.

CDC, AoA, CMS, ASPE, and OPHS will provide technical assistance to grantees and contractors and fully utilize Project Officers to ensure compliance with reporting requirements. CDC will ensure recipient cost and performance requirements are reported on a quarterly basis. All awards issued with Recovery Act will have special accounting numbers and codes to track the funds and awards.

Recipients will report economic indicators of job creation and/or preservation on a quarterly basis directly to a central reporting system in accordance with the provisions of Section 1512. These data will be available at the recipient level. All other indicators will be collected from existing databases, collated by the program staff and then reported to CDC RAC. The customary process for reporting progress on these measures to the Department of Health and Human Services (HHS) and the OMB will be employed. These measures will be reported in aggregate, however the recipient-by-recipient performance on which they are based will be available from the program and its project officers. A CDC point of contact has been established for federalreporting.gov and recovery.gov to receive and answer public inquiries regarding programmatic efforts with Recovery Act funds.

CDC shall ensure merit-based decision-making for Recovery Act grant and contract awards by:

- Promoting competition to the maximum extent practicable;
- Considering the weighting of selection criteria to favor applicants with demonstrated ability to deliver performance;
- Using award methods that allow grantees and contractors to commence activities as quickly as possible;
- Ensuring that receipt of funds is contingent on grantees and contractors agreeing to meet Recovery Act reporting requirements;
- Adapting current applicant evaluation and review processes to reflect Recovery Act needs; and
- Pursuing efforts to overcome impediments to Recovery Act awards.

CDC grant announcements and contract solicitations involving Recovery Act funds shall contain transparent merit-based selection criteria that allow CDC to evaluate an applicant's demonstrated or potential ability to:

- Deliver programmatic results;

- Create economic stimulus, to include the number of jobs created or saved in relation to Federal dollars obligated;
- Achieve long-term public health benefits; and
- Satisfy Recovery Act transparency and accountability objectives, to include all reporting requirements.

CDC shall avoid the funding of imprudent projects by:

- Exercising the formal approval of Agency, Program and Spend Plans;
- Identifying measurable Program and Recovery Act outcomes;
- Reviewing proposed activities and expenditures for imprudent projects; and
- Making the timely obligation of funds.

CDC, AoA, CMS, ASPE, and OPHS will conduct frequent review of the program's progress to identify areas of high risk, high and low performance, and longer-term impact. Performance monitoring in communities and states will focus on effective implementation of the set of chosen interventions/strategies and the status of enactment of the policy/system/environmental changes to be produced by the strategies. In addition, in communities, changes in behavioral outcomes of interest will be monitored through periodic risk factor surveillance, and, in selected communities, community impact evaluations utilizing biometric data collection.

J. Accountability

To ensure that managers are held to high standards of accountability in achieving program goals under the Recovery Act, CDC, AoA, CMS, ASPE, and OPHS has built upon and strengthened existing processes. Senior CDC, AoA, CMS, ASPE, and OPHS officials meet regularly with senior Department officials to ensure that projects are meeting their program goals, assessing and mitigating risks, ensuring transparency, and incorporating corrective actions. The personnel performance appraisal system also incorporates Recovery Act program stewardship responsibilities for program and business function managers.

Centers for Disease Control and Prevention
The CPPW program has developed a CDC-approved Program Implementation Plan containing management and oversight processes. Additionally, a point of contact has been established for Recovery.gov to receive and answer public inquiry regarding programmatic efforts with Recovery Act funds.

CDC will conduct quarterly reviews between Division Directors/Management Officials and project officers prior to the end of the quarter to evaluate progress to date and discuss grantee performance. This information will be provided to the National Center and ultimately CDC's Recovery Act Coordination unit for review. Additionally, National Center and Division Directors will have accountability and performance measurement objectives included in performance plans. Annual reviews will be conducted with CDC leadership to ensure programmatic objectives and grantee accountability measures are being executed and achieved as stated.

K. Barriers to Effective Implementation

Circumstances that could impede the effective implementation of Recovery Act activities have been evaluated. In each of these circumstances, CDC has developed a strategy to identify and take actions to mediate appropriately.

1. Potential delay in the development and implementation of strategies in some states and communities due to lack of staff with appropriate expertise in some states or communities. This issue will be re-evaluated upon review of the Community Action Plans due in the third quarter of 2010.

2. Potential impediments for communities in hiring staff due to hiring freezes and limitations on contracting with out of state entities. CDC, AoA, and HHS OPHS are mindful of this barrier and have authorized the use of Recovery Act funding and although we are unable to affect state restrictions regarding procurement policies and procedures, program officials will provide technical assistance to the extent possible to help mitigate this risk.

L. Federal Infrastructure

Not applicable

Summary of Significant Changes:

- Developed new Implementation plan in alignment with OMB approved spend plans (September 2009).
- Updated all sections to reflect the current status of planned activities.
- Updated the **Delivery Schedule** with revised completion dates and added the following:
- **Measures** – added performance measures for nutrition and obesity. The HHS high priority in this category shows a 75% target to be achieved by the end of Q4 of FY 2011. The 85% target in the implementation plan for this goal correlates to the end of the project/budget period for funded communities.