1 BALDWIN STREET,
MONTPELIER, VT 05633-5701

PHONE: (802) 828-2295
FAX: (802) 828-2483

STATE OF VERMONT
JOINT FISCAL OFFICE

MEMORANDUM

To: James Reardon, Commissioner of Finance & Management

From: Nathan Lavery, Fiscal Analyst

Date: January 6, 2011

Subject: JFO #2545, #2546

No Joint Fiscal Committee member has requested that the following items be held for review:

JFO #2545 – $3,108,800 grant from the U.S. Department of Health and Human Services to the Vermont Department of Health. This grant will be used to strengthen local public health infrastructure in rural areas of Vermont. Two (2) limited service positions are included with this request. This is an Affordable Care Act (ACA) grant.
[*JFO received 12/15/11*]

JFO #2546 – $976,632 grant from the U.S. Department of Health and Human Services to the Vermont Department of Health. This grant will be used to strengthen existing chronic disease prevention programs, including public health and health surveillance efforts. Three (3) limited service positions are included with this request. This is an Affordable Care Act (ACA) grant
[*JFO received 12/15/11*]

The Governor's approval may now be considered final. We ask that you inform the Secretary of Administration and your staff of this action.

cc: Harry Chen, Commissioner

1 BALDWIN STREET,
MONTPELIER, VT 05633-5701

PHONE: (802) 828-2295
FAX: (802) 828-2483

STATE OF VERMONT
JOINT FISCAL OFFICE

MEMORANDUM

To: Joint Fiscal Committee Members

From: Nathan Lavery, Fiscal Analyst

Date: December 16, 2011

Subject: Grant Requests

Enclosed please find two (2) items that the Joint Fiscal Office has received from the administration. Five (5) limited service position requests are included among these items.

JFO #2545 – $3,108,800 grant from the U.S. Department of Health and Human Services to the Vermont Department of Health. This grant will be used to strengthen local public health infrastructure in rural areas of Vermont. Two (2) limited service positions are included with this request. This is an Affordable Care Act (ACA) grant. **Expedited review has been requested. Joint Fiscal Committee members will be contacted by December 30 with a request to waive the balance of the review period and approve this item.**
[*JFO received 12/15/11*]

JFO #2546 – $976,632 grant from the U.S. Department of Health and Human Services to the Vermont Department of Health. This grant will be used to strengthen existing chronic disease prevention programs, including public health and health surveillance efforts. Three (3) limited service positions are included with this request. This is an Affordable Care Act (ACA) grant. **Expedited review has been requested. Joint Fiscal Committee members will be contacted by December 30 with a request to waive the balance of the review period and approve this item.**
[*JFO received 12/15/11*]

Please review the enclosed materials and notify the Joint Fiscal Office (Nathan Lavery at (802) 828-1488; nlavery@leg.state.vt.us) if you have questions or would like an item held for legislative review. Unless we hear from you to the contrary by December 30 we will assume that you agree to consider as final the Governor's acceptance of these requests.

VERMONT

State of Vermont
Department of Finance & Management
109 State Street, Pavilion Building
Montpelier, VT 05620-0401

[phone] 802-828-2376
[fax] 802-828-2428

Agency of Administration

JFO 2545

STATE OF VERMONT
FINANCE & MANAGEMENT GRANT REVIEW FORM

Grant Summary:	This is a five year Affordable Care Act (ACA) Grant from US Centers for Disease Control to strengthen existing local infrastructure for delivery of public health programs.				
Date:	12/8/2011				
Department:	Health Department				
Legal Title of Grant:	Public Prevention Health Fund: Community Transformation Grant--(Affordable Care Act)				
Federal Catalog #:	93.531				
Grant/Donor Name and Address:	Centers for Disease Control and Prevention, U.S. Department of Health and Human Services.				
Grant Period: **From:**	10/1/2011	**To:**	9/30/2016		
Grant/Donation	$3,108,800				

	SFY 1	SFY 2	SFY 3	Total	Comments
Grant Amount:	$333,000	$621,760	$621,760	$3,108,800	Total reflects all five years of grant

	# Positions	Explanation/Comments
Position Information:	2	Limited service positions..

Additional Comments:	Health department has requested that this grant be expedited.

Department of Finance & Management		(Initial)
Secretary of Administration	MC 12/13/11	(Initial)
Sent To Joint Fiscal Office		**Date** 12/15/11

RECEIVED
DEC 15 2011
JOINT FISCAL OFFICE

VERMONT GRANT ACCEPTANCE REQUEST Affordable Care Act (Form AA-1-ACA)	Priority Level (check one box): Expedited 14 Days ☒ Normal 30 days ☐

BASIC GRANT INFORMATION

1. Agency:	Agency of Human Services
2. Department:	Health
3. Program:	Health Promotion & Disease Prevention
4. Legal Title of Grant:	Public Prevention Health Fund: Community Transformation Grant -- (Affordable Care Act)
5. Federal Catalog #:	93.531

6. Grant/Donor Name and Address:
Centers for Disease Control and Prevention, United States Department of Health and Human Services

7. Grant Period:	**From:**	10/1/2011	**To:**	9/30/2016

8. Purpose of Grant:
See summary attached.

9. Impact on existing program if grant is not Accepted:
none

10. BUDGET INFORMATION

	SFY 1	SFY 2	SFY 3	Comments
Expenditures:	**FY** 2012	**FY** 2013	**FY** 2014	
Personal Services	$171,000	$306,760	$306,760	
Operating Expenses	$12,000	$15,000	$15,000	
Grants	$150,000	$300,000	$300,000	
Total	$333,000	$621,760	$621,760	
Revenues:				
State Funds:	$0	$0	$0	
Cash	$0	$0	$0	
In-Kind	$0	$0	$0	
Federal Funds:	$333,000	$621,760	$621,760	
(Direct Costs)	$311,150	$570,117	$570,117	
(Statewide Indirect)	$1,311	$3,099	$3,099	
(Departmental Indirect)	$20,539	$48,544	$48,544	
Other Funds:	$0	$0	$0	
Grant (source)	$0	$0	$0	
Total	$333,000	$621,760	$621,760	

Appropriation No:		**Amount:**	$
	3420021000		$322,730
	3420010000		$10,270
			$
			$
			$
			$
		Total	$333,000

REC'D DEC 0 8 2011

PERSONAL SERVICE INFORMATION

11. Will monies from this grant be used to fund one or more Personal Service Contracts? ☒ Yes ☐ No

If "Yes", appointing authority must initial here to indicate intent to follow current competitive bidding process/policy.

Appointing Authority Name: Dr. Harry Chen Agreed by: _____ (initial)

12. Limited Service Position Information:	**# Positions**	**Title**
	1	Public Health Programs Administrator: General
	1	Public Health Programs Specialist
Total Positions	2	

12a. Equipment and space for these positions: ☐ Is presently available. ☒ Can be obtained with available funds.

13. AUTHORIZATION AGENCY/DEPARTMENT

I/we certify that no funds beyond basic application preparation and filing costs have been expended or committed in anticipation of Joint Fiscal Committee approval of this grant, unless previous notification was made on Form AA-1PN (if applicable):

Signature: Barbara Cimaglio Date: 11-23-2011

Title: Commissioner of Health, Deputy

Signature: Patrick Flood Date: 12/1/11

Title: Deputy Secretary

14. SECRETARY OF ADMINISTRATION

☒ Approved: (Secretary or designee signature) Date: 12/2/11

15. ACTION BY GOVERNOR

☐ Check One Box: Accepted

☐ Rejected (Governor's signature) Date: 12.14.11

16. DOCUMENTATION REQUIRED

Required GRANT Documentation

- ☐ Request Memo
- ☐ Dept. project approval (if applicable)
- ☐ Notice of Award
- ☐ Grant Agreement
- ☐ Grant Budget
- ☐ Notice of Donation (if any)
- ☐ Grant (Project) Timeline (if applicable)
- ☐ Request for Extension (if applicable)
- ☐ Form AA-1PN attached (if applicable)

End Form AA-1

Sponsored not checked; 100% Fed.

STATE OF VERMONT
Joint Fiscal Committee Review
Limited Service - Grant Funded
Position Request Form

This form is to be used by agencies and departments when additional grant funded positions are being requested. Review and approval by the Department of Human Resources must be obtained prior to review by the Department of Finance and Management. The Department of Finance will forward requests to the Joint Fiscal Office for JFC review. A Request for Classification Review Form (RFR) and an updated organizational chart showing to whom the new position(s) would report **must** be attached to this form. Please attach additional pages as necessary to provide enough detail.

Agency/Department: AHS / Health Date: 11/17/11

Name and Phone (of the person completing this request): Leo Clark, CFO 802 863-7284

Request is for:

☑ Positions funded and attached to a new grant.

☐ Positions funded and attached to an existing grant approved by JFO #_____

1. Name of Granting Agency, Title of Grant, Grant Funding Detail (attach grant documents):

   US Department of Health & Human Services, Centers for Disease Control & Prevention; Public Prevention Health Fund: Community Transformation Grant -- (Affordable Care Act); Grant funding detail is attached.

2. List below titles, number of positions in each title, program area, and limited service end date (information should be based on grant award and should match information provided on the RFR) position(s) will be established only after JFC final approval:

Title* of Position(s) Requested	# of Positions	Division/Program	Grant Funding Period/Anticipated End Date
PH Programs Administrator: General	1	HPDP	10/1/11 thru 9/30/16
Public Health Programs Specialist	1	HPDP	10/1/11 thru 9/30/16

*Final determination of title and pay grade to be made by the Department of Human Resources Classification Division upon submission and review of Request for Classification Review.

3. Justification for this request as an essential grant program need:

   The positions are budgeted and approved by the Grantor Agency and necessary for implementation of the program.

I certify that this information is correct and that necessary funding, space and equipment for the above position(s) are available (required by 32 VSA Sec. 5(b).

Barbara Cimaglio, DEPUTY COMMISSIONER 11-23-2011
Signature of Agency or Department Head Date

Molly Paul 12/6/11
Approved/Denied by Department of Human Resources Date

12/11/11
Approved/Denied by Finance and Management Date

12/13/11
Approved/Denied by Secretary of Administration Date

Comments:

DHR – 11/7/05

RECD DEC 0 8 2011

VERMONT

State of Vermont
Department of Health
108 Cherry Street, PO Box 70
Burlington, VT 05402

[phone] 802-863-7200
[fax] 802-865-7754

MEMORANDUM

To: Jim Giffin, AHS CFO

From: Leo Clark, VDH CFO

Re: Grant Acceptance of the Community Transformation grant

Date: 11/23/11

The Department of Health has received a grant from the United States Department of Health & Human Services, Centers for Disease Control and Prevention, providing $621,760 each year for five years to enable the Department to strengthen existing local infrastructure to deliver public health programs.

This is an Affordable Care Act (ACA) grant and we are requesting to expedite its processing. We are also requesting approval to receive these funds and are enclosing: the Grant Acceptance Request (AA1) and attached summary, the justification memo for expedited review, a copy of the grant award document, a copy of the grant application, the Position Request Form, and RFR's for two limited service positions.

It is our understanding, based on the advice of Molly Paulger at the Department of Human Resources (DHR), that the AA-1 packet, once approved by the Secretary of Human Services, should be forwarded in its entirety to DHR. DHR will hold the RFR's and begin the classification process immediately, while transmitting the remaining documents to Finance and Management, along with a copy of each RFR's.

We appreciate your support in moving this request forward. Please let me know if you have questions or need additional information. Thank you.

VERMONT

Department of Health

Division of Health Promotion and Disease Prevention

To: Leo Clark, VDH CFO

From: Garry Schaedel, Division Director
Health Promotion and Disease Prevention

Re: Request for Joint Fiscal Office

Date: November 18, 2011

As you know, the Vermont Department of Health (VDH) is the recipient of a new grant award from the Centers for Disease Control and Prevention (CDC) funded by the Prevention and Public Health Fund of the Affordable Care Act.

The Vermont Community Transformation Grant is a five year $621,760 annual award to implement policy, systems, and environmental change strategies in rural areas of Vermont. Vermont was one of 220 total applicants, and only one of 10 states selected for this grant award. This award has received considerable attention from our congressional delegation, Fletcher Allen and Dartmouth Medical Centers, along with numerous community organizations. Senator Bernie Sanders has met with VDH Commissioner Harry Chen, and me, to assure that Vermont achieves the deliverables proposed in the grant application. The CDC, along with Senator Sanders is very interested in assuring that VDH quickly demonstrate significant outcomes in the reduction of health disparities Vermont. 67% of this grant is required to go to rural areas of Vermont.

Due to the high visibility, political interest, and immediate demands of these grants, it is essential to hire staff as soon as possible. The CDC is looking for immediate results and deliverables. VDH is requesting that the Joint Fiscal review process be expedited so that the VDH can access grant funds to begin implementing the requirements of the grant. In particular, VDH is looking to begin the hiring process for the required staff. This new staff will immediately begin to provide grants funding to communities around the state to work on health promotion and disease prevention functions.

Request for Grant Acceptance
Community Transformation ACA
Summary 11/23/2011

The Department of Health has received a grant from the Department of Health & Human Services, Centers for Disease Control, under the Affordable Care Act, providing $621,760 each year for five years to enable the Department to strengthen existing local infrastructure to deliver public health programs.

This funding will support projects that were chosen based on comprehensive assessments of current needs. The priorities are aligned with the initiatives and goals of VDH, Blueprint for Health and the goals of the integrated Chronic Disease Prevention and Health Promotion efforts and programs (as defined by Healthy People and Healthy Vermonters 2020). The evidence based interventions will be incorporated into funding opportunities made available to communities through these initiatives. The projects build on existing partnerships and programs at the state and local level. They focus on policy, infrastructure, and environmental change to support long term outcomes which assure sustainability beyond the funding period by nature of their effect.

Goals will focus activities within four Strategic Directions to include: (1) Tobacco Free Living; (2) Active Living and Healthy Eating; (3) Increased Use of High Impact Quality Clinical Preventive Services; and (4) Healthy and Safe Physical Environment.

The funds will be used to establish two positions: a Program Administrator and a Public Health Specialist. Funds will also be used for five personal service contracts to provide technical assistance and training to schools, childcare centers, the development of outreach & marketing as well as an evaluator. Six grants will be written to coalitions and/or community groups to provide policy implementation within the four Strategic Directions. Supplies & travel expenditures will also be funded.

The Health Department is hereby seeking approval to receive $333,000 in new Federal funds in State Fiscal Year 2012 and the establishment of two limited service positions. The remainder of the Federal funding will be included in the Department's future budget requests. We have attached the grant award document and a copy of the grant application as well as the Position Request Form.

and other logistical support. The data entry support is necessary to provide information for monitoring coalitions for the status of programmatic activities, completion of objectives and the expenditure of resources.

SECTION 3: FISCAL MANAGEMENT

The Vermont Department of Health will distribute funds from the Community Transformation Grant through a request for proposal (RFP) process to the existing community based prevention coalitions throughout the state. This follows the current process used to distribute state and federal dollars for prevention efforts to their community coalitions and replaces previous, more categorical RFP processes formerly used for funding tobacco, substance abuse and physical activity/obesity prevention. The process to distribute resources in this manner is the result of a progressive effort to create consolidated regional grants that support evidence-based public health interventions addressing nutrition and physical activity, alcohol and drug prevention, tobacco control and chronic disease prevention. The work aligns with the Department's 2010-2012 Strategic Plan goals for institutionalizing prevention efforts at the local level and creating communities with the capacity to respond to public health needs.

The goal of the RFP process is to fund competent, coordinated, established coalitions with a history and capabilities in implementing work of similar scope and nature to the CTG. The RFP will require grantees to describe their ability to meet a series of critical requirements speaking to these qualities and are described below.

Current Coalition/Partnerships. Successful grantees will describe: a brief history of their existing coalition and partnerships with an emphasis on how their current organization and partners are prepared to implement the evidence based strategies set forth in Vermont's Community Transformation Implementation Plan (CTIP); current communication and

management structure, including an example of how initiatives are coordinated; their coalition's ability to maintain and expand current coalition capacity including the sectors involved; a description of the decision making body and decision making processes; and, their experience working with and accessing the target population.

Evidence based strategies and target population. In order to promote cohesion between Vermont's proposed CTIP and local CTIP, coalitions applying for funds under this process will be required to propose a scope of work which adheres to and promotes the statewide CTIP to target low SES and minority populations with evidence based strategies. Applicants will be required to complete a regional CTIP and provide evidence of their experience implementing evidence based strategies among the target population, similar to the Statewide CTIP, grantees will be required to use the CTIP Template found in Appendix G of the CTG FOA.

Experience with coordination of activities within and among Coalitions/Partnerships. Successful grantees will describe the partnerships, management, and communication mechanisms to coordinate prevention efforts; history working with coalitions/partnerships, i.e. what collaborations have been done in the past, any successes or barriers; and, challenges that have been experienced with coordination and how they have been addressed; and, how the partnerships on the coalition are highly positioned to leverage implementation of the proposed intervention among the target population(s). Successful grantees will also be required to discuss how they will participate with other coalitions working on the same strategies and collaboratively leverage technical assistance support. Grantees will also be expected to work collaboratively with Stop Teen Alcohol Risk Teams and other community coalitions engaged in environmental strategies aimed at reducing underage and binge drinking

Management and Staffing Plan. Successful grantees will thoroughly describe specific roles and responsibilities of project staff and/or volunteers for their grant; brief experience, training, and education of all proposed staff; if it is a multiple agency/coalition application, specify each coalitions role and all staff responsibilities; if staff has not yet been hired, submit a job description for the position; identify who will supervise staff, coordinator and all volunteers; discuss how the project will be managed so that it includes input and representation from VDH's Local Health District Offices; and, identify who will be responsible for the submission of the required reports, meetings, fiscal management, and evaluation.

Funds targeted for technical assistance (TA) will also be made available to coalitions. These funds will be allocated separately from implementation funds. Each coalition will describe how they will coordinate and collaborate with other coalitions outside of their region to pool TA resources and leverage TA support not just for their implementation project but across all coalitions implementing the same strategies. This TA will not supplant TA provided directly or facilitated by the Department.

Evaluation: Successful grantees will describe evaluation methods including process, outcome and impact measures; who will be doing the evaluation; what data will be gathered with particular focus on the evaluation measures outlined in the state CTG Plan.

Sustainability: Successful grantees will briefly describe the major components of their plans to sustain their efforts, and providing the specific tasks/steps of that plan.

Budget: A budget and budget narrative describing how the requested funds are linked to the proposed activities will be required. Applicants will be required to report any additional funds leveraged or in kind contributions in their budget and budget narrative.

Selection of Sub awardees

VDH will convene a review committee to make recommendations for distribution of funds to community coalitions and organizations. In scoring and ranking proposals, the committee will take into consideration not only the responses to the areas stated above but also to the anticipated reach of the intervention, with priority given to programs which can reach the largest segment of the population and target population, and the need within the geographic community targeted, including the percent and number of low income or minority within the coalition catchment area.

Financial Oversight

Current financial monitoring includes the submittal and approval of a budget at the same time Coalitions are submitting the documentation for programmatic activities. Financial reporting will include quarterly invoicing with a line item expenditure report based upon an approved budget. This provides the opportunity for the State to monitor all Coalitions and their expenditure of resources as expected, and if necessary to redirect any funds. Actual payment to the Coalitions is based on the expenditure of funds reported and is contingent on addressing and/or completing at least 80% of action steps outlined in approved Capacity Building Work Plan and Implementation Work Plan(s) per quarter. The State reviews and approves all reports before payment or provides technical and programmatic support to facilitate successful completion of proposed objective. If a Coalition does not achieve 80% completion payment denied. This quarterly monitoring provides a continuous feedback loop as part of the process evaluation to ensure successful completion of proposed CTG objectives. Grantees will also be required to report additional funds leveraged (cash or in kind) as part of their activities, including matching funds secured to complete program activities.

SECTION 4: LEADERSHIP TEAM AND COALITIONS

VERMONT DEPARTMENT OF HEALTH

SFY12 Community Transformation ACA Budget

VISION Account	Admin & Support	Public Health	VDH Total
	(3420010000)	(3420021000)	
Employee Salaries	$0	$36,415	$36,415
Fringe Benefits	$0	$12,745	$12,745
3rd Party Contracts	$0	$100,000	$100,000
Total Personal Services	$0	$149,160	$149,160
Equipment	$0	$0	$0
Supplies	$0	$6,000	$6,000
Other	$0	$0	$0
Travel	$0	$6,000	$6,000
Total Operating Expenses	$0	$12,000	$12,000
Subgrants	$0	$150,000	$150,000
Total Direct Costs	$0	$311,160	$311,160
Total Indirect Costs	$10,269	$11,580	$21,849
Total SFY12 Grant Costs	$10,269	$322,740	$333,009

Appropriation Summary

Total Personal Services	$10,269	$160,740	$171,009
Total Operating Expenses	$0	$12,000	$12,000
Total Subgrants	$0	$150,000	$150,000
	$10,269	$322,740	$333,009

VERMONT DEPARTMENT OF HEALTH

SFY13 Community Transformation ACA Budget

VISION Account	Admin & Support	Public Health	VDH Total
	(3420010000)	(3420021000)	
Employee Salaries	$0	$86,071	$86,071
Fringe Benefits	$0	$30,125	$30,125
3rd Party Contracts	$0	$138,922	$138,922
Total Personal Services	$0	$255,118	$255,118
Equipment	$0	$0	$0
Supplies	$0	$7,500	$7,500
Other	$0	$0	$0
Travel	$0	$7,500	$7,500
Total Operating Expenses	$0	$15,000	$15,000
Subgrants	$0	$300,000	$300,000
Total Direct Costs	$0	$570,118	$570,118
Total Indirect Costs	$24,272	$27,371	$51,643
Total SFY13 Grant Costs	$24,272	$597,488	$621,760

Appropriation Summary

Total Personal Services	$24,272	$282,488	$306,760
Total Operating Expenses	$0	$15,000	$15,000
Total Subgrants	$0	$300,000	$300,000
	$24,272	$597,488	$621,760

VERMONT

State of Vermont
Department of Health
Health Promotion & Disease Prevention
108 Cherry Street–PO Box 70
Burlington, VT 05402-0070
HealthVermont.gov

[phone] 802-863-7330
[fax] 802-651-1634

Agency of Human Services

November 14, 2011

Dana Ewing, Grants Management Specialist
Centers for Disease Control and Prevention, Branch III
2920 Brandywine Road, Mail Stop 3719
Atlanta, GA 30341-4146

Re: Award Number 1U58DP003650-01

Dear Ms. Ewing,

The Vermont Department of Health is pleased to receive funding for the Community Transformation Implementation Grant from the Centers for Disease Control and Prevention.

Enclosed is a revised budget with justification and a response to the weaknesses noted in the technical review. We look forward to working closely with CDC on this cooperative agreement.

Sincerely,

Garry Schaedel
Principal Investigator for VT
Division of Health Promotion and Disease Prevention

Karen Kelley
Grants Program Specialist

Vermont Public Prevention Health Fund: Community Transformation Grant
Grant Number 1U58DP003650-01
Year One Budget and Justification
October 1, 2011 - September 30, 2012

	Annual Salary	Percent of time	Total
A. PERSONNEL			
Public Health Programs Administrator	$46,717	100%	$32,702
The Programs Administrator will provide overall direction for the grant including: planning; grants management; coordination with Leadership team; advisory committees; educational needs for coalitions and community groups; and policy development. This position will be responsible for the day to day management, and assurance that funds are directed to rural areas of the state. The position will work under the direction of the Division Director.			
Public Health Specialist	$39,354	100%	$27,548
The Public Health Specialist will provide programmatic support to the community coalitions funded under this initiative. This position is a critical part of the feedback loop in the evaluation process to ensure successful completion of proposed CTG objectives for each strategic direction in rural areas of the state. Responsibilities will include: monitoring all coalitions for status of programmatic activities and objectives; and monitoring the expenditure of resources by coalitions. In addition, will provide programmatic support to facilitate successful completion of proposed objectives, redirection of funding if resources are not being spent as expected and recommending appropriate educational seminars and technical assistance resources available.			
TOTAL SALARIES			**$60,249**
B. FRINGE BENEFITS			**$21,087**
Fringe benefits are calculated at 35% of Personnel costs			
TOTAL PERSONNEL			**$81,337**
C. CONTRACTUAL			**$164,000**
Below is a summary of anticipated awards organized by Strategic Direction.Funds will be awarded to consultants to provide technical assistance and training to coalitions from rural areas of the state.			
Tobacco Free Living	$24,000		
Contractor: American Lung Association Method of Selection: Sole Source Period of Performance: TBD once contract is awarded Scope of Work: to provide training and technical assistance for Smoke Free Housing and Smoke Free Parks targeting rural areas of the state. Method of Accountability: The State uses performances based monitoring for all contracts. Payment is linked to performance			

Active Living and Healthy Eating $40,000

Farm to School

Contractor: VT FEED (Food Education Everyday) *$20,000*

Method of Selection: Sole Source VT FEED is uniquely qualified as the state entity to provide the summer institute and training and assistance to schools on Farm to School Implementation.

Period of Performance: TBD once contract is awarded

Scope of Work: to provide technical assistance and training to schools including regional workshops and an annual summer institute.

Method of Accountability: The State uses performances based monitoring for all contracts. Payment is linked to performance

Early Childcare Policy Development *$20,000*

Contractor: Marla Ianello

Method of Selection: Sole Source-Marla is uniquely qualified as the entity in VT to provide training and technical assistance to childcare centers using NAPSACC.

Period of Performance: TBD once contract is awarded

Scope of Work: to provide technical assistance and training to rural childcare centers for the development of nutrition and physical activity policies using the evidence based NAPSACC tool.

Method of Accountability: The State uses performances based monitoring for all contracts. Payment is linked to performance

Clinical Preventive Services $15,000

Chronic Disease Self Management

Contractor: TBD

Method of Selection: Competitive bid

Period of Performance: TBD once contract is awarded

Scope of Word: For the development of outreach and marketing materials to increase participation of lower SES populations from rural areas of the state in the chronic disease self management workshops.

Method of Accountability: The State uses performances based monitoring for all contracts. Payment is linked to performance

Evaluation Support $85,000

Contracted Evaluation Position for the equivalent of 1FTE

Name of Contractor: TBD

Method of Selection: Competitive Bid

Period of Performance: TBD

Scope of Work : Contracted evaluator will provide a minimum of 40 hours per week to conduct evaluation for all components of the CTG grant.

Method of Accountability: The State uses performances based monitoring for all contracts. Payment is linked to performance

D. EQUIPMENT **$0**

E. SUPPLIES **$13,851**

Posters and displays to support the Healthy Retail Store project $10,000

Additional office supplies (educational materials) are estimated at: $851

The purchase educational materials and supplies are needed for technical assistance and education seminars

2 computers at $1,500 $3,000

Justification: Two new computers will be needed for staff.

F. TRAVEL **$12,423**

Instate Travel $1,223

Justification: Travel to Leadership team meetings, coalition community group meetings by Program Administrator and Public Health Specialist are estimated at 24 trips. Each will make an estimated 12 trips per year.

12 trips x 2 people x 100 r/t x .51 = $1,223

Out-of-State Travel $11,200

Justification: Travel costs for staff and Leadership Team to attend national conferences and trainings.

8 people to Atlanta. Airfare $700 Lodging $450 Transportation $100 Meals $150

G. OTHER YEAR 1 **$314,000**

Below is a summary of subrecipient awards organized by Strategic Direction. The State will award subrecipient grants in the following amounts to multiple coalitions and/or community groups responsible for the four strategic directions listed below. In most cases the state will to use a competitive Request for Proposal (RFP) process for sub-recipient awards. The awards will target rural areas of the state.

Tobacco Free Living $35,000

Grant to 1 organization that has statewide capacity to work with housing associations to create smoke free housing buildings in new and existing units.

Active Living and Healthy Eating $164,000

Farm to School 6 $15,000 implementation grants $90,000

Early Childcare Centers 4 $8,500 grants for policy implementation $34,000

Healthy Retail Stores 4 $10,000 implementation grants $40,000

Clinical Preventive Services		$60,000
Chronic Disease Self Management *$6,000 grants to 4 community health teams, and 6 designated regional housing organizations for implementation of the chronic disease self management programs and collection of aggregate data on health outcomes.*		
Healthy and Safe Environment		$55,000
Fluoride *3 $5,000 grants to communities*	$15,000	
Healthy Community Design *4 $10,000 grants to communities*	$40,000	

H. TOTAL DIRECT CHARGES **$585,611**

I. TOTAL INDIRECT CHARGES **$36,150**

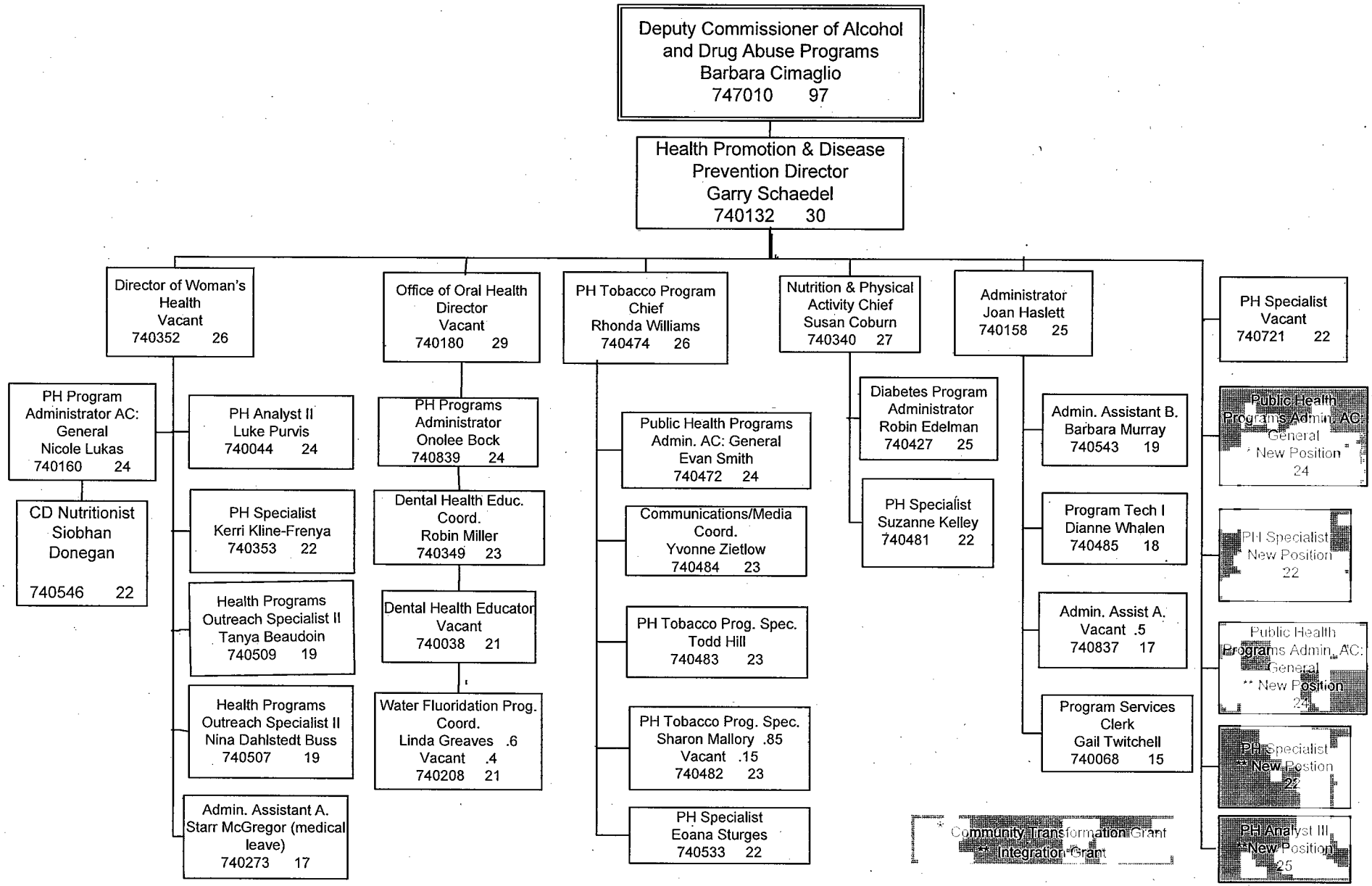
The Vermont Department of Health uses a Cost Allocation Plan, not an indirect rate. The Vermont Department of Health is a department of the Vermont Agency of Human Services, a public assistance agency, which uses a Cost Allocation Plan in lieu of an indirect rate agreement as authorized by OMB Circular A-87, Attachment D. This Cost Allocation Plan was approved by the US Department of Health and Human Services effective October 1, 1987. A copy of the original approval and a copy of the most recent approval letter are attached. The Cost Allocation Plan summarizes actual, allowable costs incurred in the operation of the program. These costs include items which are often shown as direct costs, such as telephone and general office supply expenses, as well as items which are often included in an indirect rate, such as the cost of office space and administrative salaries. These costs are allocated to the program based on the salaries and wages paid in the program. Because these are actual costs, unlike an Indirect Cost Rate, these costs will vary from quarter to quarter and cannot be fixed as a rate. Based on costs allocated to similar programs during recent quarters, we would currently estimate allocated costs at 60% of the direct salary line item.

J. BUDGET TOTAL **$621,760**

VERMONT
DEPARTMENT OF HEALTH

Division of Health Promotion & Disease Prevention

Proposed New Grant Positions



VERMONT DEPARTMENT OF PERSONNEL

Request for Classification Action
New or Vacant Positions
Existing Job Class/Titles ONLY
Position Description Form C

- **This form is to be used by management to request the allocation of a new position, or reallocation of a vacant position, to an EXISTING class title.**
- Employee requests must be submitted on the separate "Position Description Form A."
- Requests for full classification, to determine the appropriate pay grade for any job class must be submitted on "Position Description Form A."
- This form was designed in Microsoft Word to download and complete on your computer. This is a form-protected document, so information can only be entered in the shaded [ ] areas of the form.
- To move from field to field use your mouse, the arrow keys or press Tab. Each form field has a limited number of characters. Use your mouse or the spacebar to mark and unmark a checkbox.
- Where additional space is needed to respond to a question, you will need to attach a separate page, and number the responses to correspond with the numbers of the questions on the form. Please contact your Personnel Officer if you have difficulty completing the form.
- All sections of this form are required to be completed unless otherwise stated.
- The form must be complete, including required attachments and signatures or it will be returned to the department's personnel office.

Request for Classification Action
New or Vacant Positions
EXISTING Job Class/Title ONLY
Position Description Form C/Notice of Action

For Department of Personnel Use Only

Date Received (Stamp)

Notice of Action #_____

Action Taken: _____

New Job Title _____

Current Class Code _____ New Class Code _____

Current Pay Grade _____ New Pay Grade _____

Current Mgt Level____ B/U ____ OT Cat. ____EEO Cat. ____FLSA _____

New Mgt Level _____ B/U ____OT Cat. ____EEO Cat. ____FLSA _____

Classification Analyst_____Date _____ Effective Date: _____

Comments:

Date Processed: _____

Willis Rating/Components: Knowledge & Skills: _____ Mental Demands: _____ Accountability: _____
Working Conditions: _____ Total: _____

Position Information:

Incumbent: **Vacant or New Position**

Position Number: [ ] Current Job/Class Title: [Public Health Specialist AC:General]

Agency/Department/Unit: [AHS/VDH/HPDP] GUC: [74406]

Pay Group: [74A] Work Station: [121] Zip Code: [05401]

Position Type: ☐ Permanent ☒ Limited Service (end date) [ ]

Funding Source: ☐ Core ☒ Sponsored ☐ Partnership. For Partnership positions provide the funding breakdown (% General Fund, % Federal, etc.) [100% federal]

Supervisor's Name, Title and Phone Number: [Garry Schaedel, HPDP Division Director, 802-863-7269]

Check the type of request (new or vacant position) and complete the appropriate section.

☒ **New Position(s):**

a. REQUIRED: Allocation requested: Existing Class Code [441200] Existing Job/Class Title: [Public Health Programs Specialist]

b. Position authorized by:

☒ Joint Fiscal Office – JFO # [ ] Approval Date: [ ]

☐ Legislature – Provide statutory citation (e.g. Act XX, Section XXX(x), XXXX session) [ ]

☐ Other (explain) -- Provide statutory citation if appropriate. [ ]

☐ **Vacant Position:**

a. Position Number: [ ]

b. Date position became vacant: [ ]

c. Current Job/Class Code: [ ] Current Job/Class Title: [ ]

d. REQUIRED: Requested (existing) Job/Class Code: [ ] Requested (existing) Job/Class Title: [ ]

e. Are there any other changes to this position; for example: change of supervisor, GUC, work station? Yes ☐ No ☐ If Yes, please provide detailed information: [ ]

For All Requests:

1. List the anticipated job duties and expectations; include all major job duties: The Public Health Specialist will provide programmatic support to the community coalitions and/or community groups funded under the Community Transformation (CTG) initiative. This position is a critical part of the feedback loop in the evaluation process to ensure successful completion of proposed CTG objectives for each strategic direction. Responsibilities will include: monitoring all coalitions and/or community groups for status of programmatic activities and objectives; and monitoring the expenditure of resources by coalitions and/or community groups. In addition, will provide programmatic support to facilitate successful completion of proposed objectives, redirection of funding if resources are not being spent as expected and recommending appropriate educational seminars and technical assistance resources available.

2. Provide a brief justification/explanation of this request: The scope and responsibility of this position is equivalent to other CDC contract managers within the Division.

3. If the position will be supervisory, please list the names and titles of all classified employees reporting to this position (this information should be identified on the organizational chart as well). N/A

Personnel Administrator's Section:

4. If the requested class title is part of a job series or career ladder, will the position be recruited at different levels? Yes ☐ No ☒

5. The name and title of the person who completed this form: Garry Schaedel, Division Director, HPDP

6. Who should be contacted if there are questions about this position (provide name and phone number):
Garry Schaedel, (802) 863-7269

7. How many other positions are allocated to the requested class title in the department: 2

8. Will this change (new position added/change to vacant position) affect other positions within the organization? (For example, will this have an impact on the supervisor's management level designation; will duties be shifted within the unit requiring review of other positions; or are there other issues relevant to the classification process.) No

Attachments:

☒ Organizational charts are **required** and must indicate where the position reports.

☐ Class specification (optional).

☐ For new positions, include copies of the language authorizing the position, or any other information that would help us better understand the program, the need for the position, etc.

☐ Other supporting documentation such as memos regarding department reorganization, or further explanation regarding the need to reallocate a vacancy (if appropriate).

Personnel Administrator's Signature **(required)*** — 11/14/2011 — Date

G. Schaedel — 11/14/11

Supervisor's Signature **(required)*** — Date

Barbara Cluff — 11-15-11

Appointing Authority or Authorized Representative Signature **(required)*** — Date

* Note: Attach additional information or comments if appropriate.

VERMONT DEPARTMENT OF PERSONNEL

Request for Classification Action
New or Vacant Positions
Existing Job Class/Titles ONLY
Position Description Form C

- **This form is to be used by management to request the allocation of a new position, or reallocation of a vacant position, to an EXISTING class title.**
- Employee requests must be submitted on the separate "Position Description Form A."
- Requests for full classification, to determine the appropriate pay grade for any job class must be submitted on "Position Description Form A."
- This form was designed in Microsoft Word to download and complete on your computer. This is a form-protected document, so information can only be entered in the shaded [ ] areas of the form.
- To move from field to field use your mouse, the arrow keys or press Tab. Each form field has a limited number of characters. Use your mouse or the spacebar to mark and unmark a checkbox.
- Where additional space is needed to respond to a question, you will need to attach a separate page, and number the responses to correspond with the numbers of the questions on the form. Please contact your Personnel Officer if you have difficulty completing the form.
- All sections of this form are required to be completed unless otherwise stated.
- The form must be complete, including required attachments and signatures or it will be returned to the department's personnel office.

Request for Classification Action
New or Vacant Positions
EXISTING Job Class/Title ONLY
Position Description Form C/Notice of Action

For Department of Personnel Use Only

Date Received (Stamp)

Notice of Action #_____

Action Taken: _____

New Job Title _____

Current Class Code _____ New Class Code _____

Current Pay Grade _____ New Pay Grade _____

Current Mgt Level____ B/U ___ OT Cat. ____EEO Cat. ____FLSA _____

New Mgt Level _____ B/U ____OT Cat. ____EEO Cat. ____FLSA _____

Classification Analyst_____Date _____ Effective Date: _____

Comments:

Date Processed: _____

Willis Rating/Components: Knowledge & Skills: _____ Mental Demands: _____ Accountability: _____
Working Conditions: _____ Total: _____

Position Information:

Incumbent: **Vacant or New Position**

Position Number: [ ] Current Job/Class Title: [Public Health Specialist AC:General]

Agency/Department/Unit: [AHS/VDH/HPDP] GUC: [74406]

Pay Group: [74A] Work Station: [121] Zip Code: [05401]

Position Type: ☐ Permanent ☒ Limited Service (end date) [ ]

Funding Source: ☐ Core ☒ Sponsored ☐ Partnership. For Partnership positions provide the funding breakdown (% General Fund, % Federal, etc.) [100% federal]

Supervisor's Name, Title and Phone Number: [Garry Schaedel, HPDP Division Director, 802-863-7269]

Check the type of request (new or vacant position) and complete the appropriate section.

☒ **New Position(s):**

a. REQUIRED: Allocation requested: Existing Class Code [444900] Existing Job/Class Title: [Public Health Programs Administer: General]

b. Position authorized by:

☒ Joint Fiscal Office – JFO # [ ] Approval Date: [ ]

☐ Legislature – Provide statutory citation (e.g. Act XX, Section XXX(x), XXXX session) [ ]

☐ Other (explain) -- Provide statutory citation if appropriate. [ ]

☐ **Vacant Position:**

a. Position Number: [ ]

b. Date position became vacant: [ ]

c. Current Job/Class Code: [ ] Current Job/Class Title: [ ]

d. REQUIRED: Requested (existing) Job/Class Code: [ ] Requested (existing) Job/Class Title: [ ]

e. Are there any other changes to this position; for example: change of supervisor, GUC, work station? Yes ☐ No ☐ If Yes, please provide detailed information: [ ]

For All Requests:

1. List the anticipated job duties and expectations; include all major job duties: The Program administer is responsbile for the overall direction for the Community Transformation Grant: planning; grants management; coordination with Leadership team; advisory committees; educational needs for coalitions and community groups; and policy development. This position will be responsible for the day to day management and will work under the direction from the Division Director. Integrates the goals of Healthy Vermonters 2020, the State Health Plan, and VDH Strategic Priorities. Works with other state agancies to assure that policies within the Department and outside are coordinated. Develops and manages program budgets; writes and monitors sub-recipient grants; Writes grant proposals, monitors funding, and ensures compliance with federal and state policies and program regulations. Works with leadership of medical professionals and community organizations. Represents VDH at state and national meetings. Identifies opportunities, challenges, barriers, and takes steps to address them. Coordinates partnership meetings, plans activities and timelines for the program, and coordinates with partner agencies. Guides development and implementation of a strategic cancer plan including objectives, best practices, strategies, and evaluation methods. Performs other duties as required.

2. Provide a brief justification/explanation of this request: The scope and responsibility of this position is equivalent to other CDC contract managers within the Division.

3. If the position will be supervisory, please list the names and titles of all classified employees reporting to this position (this information should be identified on the organizational chart as well). N/A

Personnel Administrator's Section:

4. If the requested class title is part of a job series or career ladder, will the position be recruited at different levels? Yes ☐ No☒

5. The name and title of the person who completed this form: Garry Schaedel, Division Director, HPDP

6. Who should be contacted if there are questions about this position (provide name and phone number): Garry Schaedel, (802) 863-7269

7. How many other positions are allocated to the requested class title in the department: 2

8. Will this change (new position added/change to vacant position) affect other positions within the organization? (For example, will this have an impact on the supervisor's management level designation; will duties be shifted within the unit requiring review of other positions; or are there other issues relevant to the classification process.) No

Attachments:

☒ Organizational charts are **required** and must indicate where the position reports.

☐ Class specification (optional).

☐ For new positions, include copies of the language authorizing the position, or any other information that would help us better understand the program, the need for the position, etc.

☐ Other supporting documentation such as memos regarding department reorganization, or further explanation regarding the need to reallocate a vacancy (if appropriate).

Personnel Administrator's Signature **(required)***	14/11/2011 Date
Supervisor's Signature **(required)***	11/14/11 Date
Appointing Authority or Authorized Representative Signature **(required)***	11-15-11 Date

* Note: Attach additional information or comments if appropriate.

Notice of Award

COOPERATIVE AGREEMENTS **Issue Date:** 09/25/2011
Department of Health and Human Services
Centers for Disease Control and Prevention
NATIONAL CENTER FOR CHRONIC DISEASE PREV AND HEALTH PROMO

Grant Number: 1U58DP003650-01

Principal Investigator(s):
GARRY SCHAEDEL

Project Title: VERMONT COMMUNITY TRANSFORMATION IMPLEMENTATION APPLICATION-INTEGRATES CLINICAL A

FINANCIAL OFFICER
VERMONT DEPT OF HEALTH
108 CHERRY STREET
BURLINGTON, VT 05402

Budget Period: 10/01/2011 – 09/30/2012
Project Period: 10/01/2011 – 09/30/2016

Dear Business Official:

The Centers for Disease Control and Prevention hereby awards a grant in the amount of $621,760 (see "Award Calculation" in Section I and "Terms and Conditions" in Section III) to VERMONT DEPT OF HEALTH in support of the above referenced project. This award is pursuant to the authority of 301A,311BC,317K2(42USC241A,243BC247BK2) and is subject to the requirements of this statute and regulation and of other referenced, incorporated or attached terms and conditions.

Acceptance of this award including the "Terms and Conditions" is acknowledged by the grantee when funds are drawn down or otherwise obtained from the grant payment system.

If you have any questions about this award, please contact the individual(s) referenced in Section IV.

Sincerely yours,

Mildred Garner

Mildred Garner
Grants Management Officer
Centers for Disease Control and Prevention

Additional information follows

SECTION I – AWARD DATA – 1U58DP003650-01

Award Calculation (U.S. Dollars)	
Salaries and Wages	$108,000
Fringe Benefits	$37,800
Personnel Costs (Subtotal)	$145,800
Supplies	$9,000
Travel Costs	$2,550
Other Costs	$219,610
Consortium/Contractual Cost	$180,000
Federal Direct Costs	$556,960
Federal F&A Costs	$64,800
Approved Budget	$621,760
Federal Share	$621,760
TOTAL FEDERAL AWARD AMOUNT	$621,760
AMOUNT OF THIS ACTION (FEDERAL SHARE)	$621,760

Recommended future year total cost support, subject to the availability of funds and satisfactory progress of the project.

02 $621,760
03 $621,760
04 $621,760
05 $621,760

Fiscal Information:
CFDA Number: 93.531
EIN: 1036000274B8
Document Number: 003650C011

IC	*CAN*	*2011*	*2013*	*2014*	*2015*	*2016*
DP	939ZMNL	$621,760	$621,760	$621,760	$621,760	$621,760

SUMMARY TOTALS FOR ALL YEARS		
YR	**THIS AWARD**	**CUMULATIVE TOTALS**
1	$621,760	$621,760
2	$621,760	$621,760
3	$621,760	$621,760
4	$621,760	$621,760
5	$621,760	$621,760

Recommended future year total cost support, subject to the availability of funds and satisfactory progress of the project

CDC Administrative Data:
PCC: N / OC: 4141

SECTION II – PAYMENT/HOTLINE INFORMATION – 1U58DP003650-01

For payment information see Payment Information section in Additional Terms and Conditions.

INSPECTOR GENERAL: The HHS Office Inspector General (OIG) maintains a toll-free number (1-800-HHS-TIPS [1-800-447-8477]) for receiving information concerning fraud, waste or abuse under grants and cooperative agreements. Information also may be submitted by e-mail to hhstips@oig.hhs.gov or by mail to Office of the Inspector General, Department of Health and Human Services, Attn: HOTLINE, 330 Independence Ave., SW, Washington DC 20201. Such reports are treated as sensitive material and submitters may decline to give their names if they choose to remain anonymous. This note replaces the Inspector General contact information cited in previous notice of award.

SECTION III – TERMS AND CONDITIONS – 1U58DP003650-01

This award is based on the application submitted to, and as approved by, CDC on the above-titled project and is subject to the terms and conditions incorporated either directly or by reference in the following:

a. The grant program legislation and program regulation cited in this Notice of Award.
b. The restrictions on the expenditure of federal funds in appropriations acts to the extent those restrictions are pertinent to the award.
c. 45 CFR Part 74 or 45 CFR Part 92 as applicable.
d. The HS Grants Policy Statement, including addenda in effect as of the beginning date of the budget period.
e. This award notice, INCLUDING THE TERMS AND CONDITIONS CITED BELOW.

Treatment of Program Income:
Other (See Remarks)

SECTION IV – DP Special Terms and Conditions – 1U58DP003650-01

Cooperative Agreement
Funding Opportunity Announcement (FOA) Number: CDC-RFA-DP11-1103PPHF
Award Number: DP003650, Category B: Implementation.

TERMS AND CONDITIONS OF THIS AWARD
NOTE 1. INCORPORATION: Funding Opportunity Announcement Number CDC-RFA-DP11-1103PPHF entitled, U.S. Department of Health and Human Services (HHS), Centers for Disease Control and Prevention (CDC), Patient Protection and Affordable Care Act (ACA), Public Health Prevention Fund: Community Transformation Grants, and the application dated 07/14/2011, are hereby made a part of this ACA award by reference.

NOTE 2. APPROVED FUNDING: Funding in the amount of $621,760 is approved for the Year 01 budget period, which is September 30, 2011 through September 29, 2012. This is the first budget year of a five year project period. This award is funded with Patient Protection and Affordable Care Act (ACA), funds.
The Grantee must adhere to the requirements of Section 4002 and 4201 of the Patient Protection and Affordable Care Act (ACA) www.whitehouse.gov/healthreform/healthcare-overview. All funding for future years will be based on satisfactory programmatic progress and the availability of funds.

NOTE 3. SUMMARY STATEMENT RESPONSE REQUIREMENT: The objective review summary comments on the strengths and weaknesses of the proposal are provided as part of this award. A response to the weaknesses in these statements must be submitted to and approved, in writing, by the Grants Management Specialist as noted in the CDC Contact section of this Notice of Award, not later than October 24, 2011. Should these terms not be satisfactorily adhered to, it may result in denial of your authority to expend additional funds.

NOTE 4. REVISED BUDGET SPECIAL CONDITONS:
You are required to submit a revised budget, detailed narrative justification and work plan by October 24, 2011. You will be contacted within the next ten (10) days via email regarding upcoming budget discussions. Failure to submit the required information in a timely manner may adversely affect the future funding of this project. If the information cannot be provided by the due date, you must submit a letter explaining the reason and state the date by which the Grants Management Specialist noted in Section IV. Staff Contacts will receive the information.

RURAL OR FRONTIER AREAS
Grantee is required to direct a minimum of 20% of total funds awarded to rural or frontier areas. CDC NCCDPHP will ensure that a minimum of 20% of total funds awarded are directed to rural or frontier areas.

PLEASE SEE ATTACHED - ADDITIONAL REQUIREMENTS-

Restricted Costs as stated in the FOA, Section IV, Application and Submission are as follows:

a. No part of any appropriated funds used under this cooperative agreement 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 or proposed before the Congress or any State or local legislature, including city councils or ballot initiatives except in presentation to the Congress or any State or local legislature, including city councils, itself.
b. (b) No part of any appropriated funds used under this cooperative agreement 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 or proposed before the Congress or any State or local legislature or city council.
c. Recipients may not use funds for research.
d. Recipients may not use funds for clinical care.
e. Recipients may only expend funds for reasonable program purposes, including personnel, travel, supplies, and services, such as contractual.
f. Recipients may not generally use HHS/CDC/ATSDR funding for the purchase of furniture or equipment. However, if equipment purchase is integral to a selected strategy, it will be considered. Any such proposed spending must be identified in the budget.
g. Recipients may not use funding for construction.
h. The direct and primary recipient in a cooperative agreement program must perform a substantial role in carrying out project objectives and not merely serve as a conduit for an award to another party or provider who is ineligible.
i. Reimbursement of pre-award costs is not allowed.
j. Recipients may not use funds for abortions in accordance with Executive Order 13535.
k. If requesting indirect costs in the budget, a copy of the indirect cost rate agreement is required. If the indirect cost rate is a provisional rate, the agreement should be less than 12 months of age. The indirect cost rate agreement should be uploaded as a PDF file with ?Other Attachment Forms? when submitting via Grants.gov.

Plans and Due Dates
The following Plans are due to the Project Officer listed under Programmatic contact in NOTE 30:

A. Final Capacity Building Plan due to CDC Project Officer by December 30, 2011 Capacity Building awardees
B. Final Implementation Plan due to CDC Project Officer by January 30, 2011 (Implementation awardees)
C. Final Evaluation Plan due to CDC Project Officer by February 29, 2012 (Implementation awardees)

NOTE 5. PATIENT PROTECTION AND AFFORDABLE CARE ACT (ACA) SUB-ACCOUNT INFORMATION:
(IMPORTANT: There are separate reporting requirements for these funds which are spelled out under the PAYMENT INFORMATION on NOTE 25 of these terms and conditions).
Every grantee has a PIN that is matched to an account number that allows grantees access to funds in the General or ?G? Account and the ?P? Account obligated by the Government to that grantee. The ?G? account contains all funding obligated to that grantee by any governmental agency. In making a payment in response to a grantee request from the ?G? account, the Government is acknowledging that there are enough funds in the sum of available cash from its aggregate awards, to fulfill this request. The ?G? account designation is comprised of the alpha numeric numbers of the award type followed by the grantee award number e.g. U58DP003554. The ?P? Account is a Sub-account created specifically for the purpose of tracking designate types of funding in the Payment Management System. Sub-accounts or ?P? Accounts have been established in the Payment Management System. The ?P? accounts are comprised of the numerical numbers from the original award plus a suffix denoting the separate programmatic obligation.
FOR THIS BUDGET PERIOD FUNDING YEAR, SEPTEMBER 30, 2011 THRU SEPTEMBER 29, 2012, FUNDS WILL BE IN THE ?P? Sub-account. These funds are to be managed on a separate budget from your prior ?G? account. They are not to be co-mingled at any time.
The ACA Sub-Account Title in the DHHS Payment Management System (PMS) is:
CMTYTRANGRANTS11 and must be used by your organization when requesting these funds in PMS.
The ACA Sub-Account Number in the DHHS Payment Management System (PMS) is:
(001234C011) insert 6 digit grantee number plus the subaccount ?document pattern

All funding for future years will be based on satisfactory programmatic progress and the availability of funds.

NOTE 6. INDIRECT COSTS: A current indirect cost rate must be submitted to CDC within 30 days of the receipt of the Notice of Award in order for indirect cost to be approved. Please forward to the Procurement and Grants Office at the address listed in these terms and conditions.

NOTE 7. REPORTING REQUIREMENTS:

CENTRAL CONTRACTOR REGISTRATION AND UNIVERSAL IDENTIFIER REQUIREMENTS:
All recipient organizations must obtain a DUN and Bradstreet (D&B) Data Universal Numbering System (DUNS) number as the Universal Identifier when applying for Federal grants or cooperative agreements. The DUNS number is a nine-digit number assigned by Dun and Bradstreet Information Services. An AOR should be consulted to determine the appropriate number. If the organization does not have a DUNS number, an AOR should complete the US D&B D-U-N-S Number Request Form or contact Dun and Bradstreet by telephone directly at 1-866-705-5711 (toll-free) to obtain one. A DUNS number will be provided immediately by telephone at no charge. Note this is an organizational number. Individual Program Directors/Principal Investigators do not need to register for a DUNS.
Additionally, all recipient organizations must register in the Central Contractor Registry (CCR) and maintain the registration with current information at all times during which it has an application under consideration for funding by CDC and, if an award is made, until a final financial report is submitted or the final payment is received, whichever is later. CCR is the primary registrant database for the Federal government and is the repository into which an entity must provide information required for the conduct of business as a recipient. Additional information about registration procedures may be found at the CCR internet site at www.ccr.gov
If an award is granted, the grantee organization must notify potential sub-recipients that no organization may receive a subaward under the grant unless the organization has provided its DUNS number to the grantee organization.

FEDERAL INFORMATION SECURITY MANAGEMENT ACT (FISMA):
All information systems, electronic or hard copy which contain federal data need to be protected from unauthorized access. This also applies to information associated with CDC grants. Congress and the OMB have instituted laws, policies and directives that govern the creation and implementation of federal information security practices that pertain specifically to grants and contracts. The current regulations are pursuant to the Federal Information Security Management Act (FISMA), Title III of the E-Government Act of 2002 Pub. L. No. 107-347.
FISMA applies to CDC grantees only when grantees collect, store, process, transmit or use information on behalf of HHS or any of its component organizations. In all other cases, FISMA is not applicable to recipients of grants, including cooperative agreements. Under FISMA, the grantee retains the original data and intellectual property, and is responsible for the security of this data, subject to all applicable laws protecting security, privacy, and research. If and when information collected by a grantee is provided to HHS, responsibility for the protection of the HHS copy of the information is transferred to HHS and it becomes the agencys responsibility to protect that information and any derivative copies as required by FISMA. For the full text of the requirements under Federal Information Security Management Act (FISMA), Title III of the E-Government Act of 2002 Pub. L. No. 107-347, visit website:
http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?
dbname=107_cong_public_laws&docid=f:publ347.107.pdf

FEDERAL FUNDING ACCOUNTABILITY and TRANSPARENCY ACT of 2006:

(X) FFATA DOES APPLY: THE GRANTEE MUST FOLLOW THIS SECTION

In accordance with 2 CFR Chapter 1, Part 170 REPORTING SUB-AWARD AND EXECUTIVE COMPENSATION INFORMATION, Prime Awardees awarded a federal grant are required to file a FFATA sub-award report by the end of the month following the month in which the prime awardee awards any sub-grant equal to or greater than $25,000.

A. Reporting of first-tier subawards.
1. Applicability. Unless you are exempt as provided in paragraph D. of this award term, you must report each action that obligates $25,000 or more in Federal funds that does not include Recovery funds (as defined in section 1512(a)(2) of the American Recovery and Reinvestment

Act of 2009, Pub. L. 111?5) for a subaward to an entity (see definitions in paragraph E. of this award term).
2. Where and when to report.
i. You must report each obligating action described in paragraph A.1. of this award term to http://www.fsrs.gov.
ii. For subaward information, report no later than the end of the month following the month in which the obligation was made. (For example, if the obligation was made on November 7, 2010, the obligation must be reported by no later than December 31, 2010).
3. What to report. You must report the information about each obligating action that the submission instructions posted at http://www.fsrs.gov specify.
B. Reporting Total Compensation of Recipient Executives.
1. Applicability and what to report. You must report total compensation for each of your five most highly compensated executives for the preceding completed fiscal year, if-
i. The total Federal funding authorized to date under this award is $25,000 or more;
ii. In the preceding fiscal year, you received-

(a) 80 percent or more of your annual gross revenues from Federal procurement contracts (and subcontracts) and Federal financial assistance subject to the Transparency Act, as defined at 2 CFR 170.320 (and subawards); and
(b) $25,000,000 or more in annual gross revenues from Federal procurement contracts (and subcontracts) and Federal financial assistance subject to the Transparency Act, as defined at 2 CFR 170.320 (and subawards); and
iii. The public does not have access to information about the compensation of the executives through periodic reports filed under section 13(a) or 15(d) of the Securities Exchange Act of 1934 (15 U.S.C. 78m(a), 78o(d)) or section 6104 of the Internal Revenue Code of 1986. (To determine if the public has access to the compensation information, see the U.S. Security and Exchange Commission total compensation filings at http://www.sec.gov/answers/execomp.htm).
2. Where and when to report. You must report executive total compensation described in paragraph A.1. of this award term:
i. As part of your registration profile at http://www.ccr.gov.
ii. By the end of the month following the month in which this award is made, and annually thereafter.
C. Reporting of Total Compensation of Subrecipient Executives.
1. Applicability and what to report. Unless you are exempt as provided in paragraph D. of this award term, for each first-tier subrecipient under this award, you shall report the names and total compensation of each of the sub-recipients five most highly compensated executives for the subrecipients preceding completed fiscal year, if-
i. In the subrecipients preceding fiscal year, the subrecipient received-
(a) 80 percent or more of its annual gross revenues from Federal procurement contracts (and subcontracts) and Federal financial assistance subject to the Transparency Act, as defined at 2 CFR 170.320 (and subawards); and
(b) $25,000,000 or more in annual gross revenues from Federal procurement contracts (and subcontracts), and Federal financial assistance subject to the Transparency Act (and subawards); and
ii. The public does not have access to information about the compensation of the executives through periodic reports filed under section 13(a) or 15(d) of the Securities Exchange Act of 1934 (15 U.S.C. 78m(a), 78o(d)) or section 6104 of the Internal Revenue Code of 1986. (To determine if the public has access to the compensation information, see the U.S. Security and Exchange Commission total compensation filings at http://www.sec.gov/answers/execomp.htm).
2. Where and when to report. You must report subrecipient executive total compensation described in paragraph c.1. of this award term:
i. To the recipient.
ii. By the end of the month following the month during which you make the subaward. For example, if a subaward is obligated on any date during the month of October of a given year (i.e., between October 1 and 31), you must report any required compensation information of the subrecipient by November 30 of that year.
D. Exemptions
If, in the previous tax year, you had gross income, from all sources, under $300,000, you are exempt from the requirements to report:
i. Subawards, and
ii. The total compensation of the five most highly compensated executives of any subrecipient.

E. Definitions. For purposes of this award term:
1. Entity means all of the following, as defined in 2 CFR Part 25:
i. A Governmental organization, which is a State, local government, or Indian tribe;

ii. A foreign public entity;
iii. A domestic or foreign nonprofit organization;
iv. A domestic or foreign for-profit organization;
v. A Federal agency, but only as a subrecipient under an award or subaward to a non-Federal entity.

2. Executive means officers, managing partners, or any other employees in management positions.
3. Subaward:
i. This term means a legal instrument to provide support for the performance of any portion of the substantive project or program for which you received this award and that you as the recipient award to an eligible subrecipient.
ii. The term does not include your procurement of property and services needed to carry out the project or program (for further explanation, see Sec. ___.210 of the attachment to OMB Circular A?133, Audits of States, Local Governments, and Non-Profit Organizations).
iii. A subaward may be provided through any legal agreement, including an agreement that you or a subrecipient considers a contract.
4. Subrecipient means an entity that:
i. Receives a subaward from you (the recipient) under this award; and
ii. Is accountable to you for the use of the Federal funds provided by the subaward.
5. Total compensation means the cash and noncash dollar value earned by the executive during the recipients or subrecipients preceding fiscal year and includes the following (for more information see 17 CFR 229.402(c)(2)):
i. Salary and bonus.
ii. Awards of stock, stock options, and stock appreciation rights. Use the dollar amount recognized for financial statement reporting purposes with respect to the fiscal year in accordance with the Statement of Financial Accounting Standards No. 123 (Revised 2004) (FAS 123R), Shared Based Payments.
iii. Earnings for services under non-equity incentive plans. This does not include group life, health, hospitalization or medical reimbursement plans that do not discriminate in favor of executives, and are available generally to all salaried employees.
iv. Change in pension value. This is the change in present value of defined benefit and actuarial pension plans.
v. Above-market earnings on deferred compensation which is not tax-qualified.
vi. Other compensation, if the aggregate value of all such other compensation (e.g. severance, termination payments, value of life insurance paid on behalf of the employee, perquisites or property) for the executive exceeds $10,000.

NON-DELINQUENCY ON FEDERAL DEBT:
The Federal Debt Collection Procedures Act of 1990 (Act), 28 U.S.C. 3201(e), provides that an organization or individual that is indebted to the United States, and has a judgment lien filed against it, is ineligible to receive a Federal grant. CDC cannot award a grant unless the AOR of the applicant organization (or individual in the case of a Kirschstein-NRSA individual fellowship) certifies, by means of his/her signature on the application, that the organization (or individual) is not delinquent in repaying any Federal debt. If the applicant discloses delinquency on a debt owed to the Federal government, CDC may not award the grant until the debt is satisfied or satisfactory arrangements are made with the agency to which the debt is owed. In addition, once the debt is repaid or satisfactory arrangements made, CDC will take that delinquency into account when determining whether the applicant would be a responsible CDC grant recipient.
Anyone who has been judged to be in default on a Federal debt and who has had a judgment lien filed against him or her should not be listed as a participant in an application for a CDC grant until the judgment is paid in full or is otherwise satisfied. No funds may be used for or rebudgeted following an award to pay such an individual. CDC will disallow costs charged to awards that provide funds to individuals in violation of this Act.
These requirements apply to all types of organizations and awards, including foreign grants.

NOTE 8. ANNUAL FEDERAL FINANCIAL REPORT (FFR, SF 425):
a) ANNUAL FEDERAL FINANCIAL REPORT (FFR) (SF425): is required 90 days after the end of each budget period. The FFR for this budget period is due to the Grants Management Specialist by December 29, 2012. Reporting timeframe is 09/30/2011 through 09/29/2012. The FFR should only include those funds authorized and disbursed during the timeframe covered by the report. If the FFR is not finalized by the due date, an interim FFR must be submitted, marked NOT FINAL, and an amount of un-liquidated obligations must be identified that reflect unpaid expenses. Electronic versions of the form can be downloaded into Adobe Acrobat and completed

on-line by reviewing, http//www.whitehouse.gov/omb/grants/sf425a.pdf (short form) or http//www.whitehouse.gov/omb/grants/sf425.pdf
Failure to submit the required information in a timely manner may adversely affect the future funding of this project. If the information cannot be provided by the due date, you are required to submit a letter explaining the reason and date by which the Grants Officer will receive the information.
b) ANNUAL PROGRESS REPORT:
The Annual Progress Report is due 90 days following the end of the budget period on December 29, 2012. Reporting timeframe is 09/30/2011 through 09/29/2012. The report must include:
- A comparison of actual accomplishments to the goal established for the period;
- The reasons for failure, if established goals were not met; and
- Other pertinent information including, when appropriate, analysis and explanation of performance costs significantly higher than expected.
SEMI-ANNUAL PROGRESS REPORTING

Each funded applicant must provide CDC with a semi-annual Interim Progress Report submitted via www.grants.gov: This report should document progress to meeting programmatic objectives and include success stories related to efforts under the grant.
1. The interim progress report is due no less than 120 days before the end of the budget period. The Interim Progress Report will serve as the non-competing continuation application, and must contain the following elements:
a. Standard Form (?SF?) 424S Form.
b. SF-424A Budget Information-Non-Construction Programs.
c. Budget Narrative.
d. Indirect Cost Rate Agreement.
e. Project Narrative.

Additionally, funded applicants must provide CDC with an original, plus one hard copy of the following reports:
2. Federal Financial Report* (FFR) (SF 425) and annual progress report, no more than 90 days after the end of the budget period.
3. Final performance and Federal Financial Reports*, no more than 90 days after the end of the project period.

Note: An original plus two copies of the reports must be mailed to the Grants Management Specialist for approval by the Grants Management Officer by the due date. All reports must include the Award and Program Announcement numbers shown above.

NOTE 9. AUDIT REQUIREMENT: An organization that expends $500,000 or more in a year in Federal awards shall have a single or program-specific audit conducted for that year in accordance with the provisions of OMB Circular A-133, Audit of States, Local Governments, and Non-Profit Organizations. The audit must be completed along with a data collection form, and the reporting package shall be submitted within the earlier of 30 days after receipt of the auditors report(s), or nine months after the end of the audit period. The audit report must be sent to:
Federal Audit Clearing House
Bureau of the Census
1201 East 10th Street
Jeffersonville, IN 47132

Should you have questions regarding the submission or processing of your Single Audit Package, contact the Federal Audit Clearinghouse at: (301) 763-1551, (800) 253-0696 or email: govs.fac@census.gov
It is very helpful to CDC managers if the recipient sends a courtesy copy of completed audits and any management letters on a voluntary basis to the following address.
Centers for Disease Control and Prevention (CDC)
ATTN: Audit Resolution, Mail Stop E-14
2920 Brandywine Road
Atlanta, GA 30341-4146

The grantee is to ensure that the sub-recipients receiving CDC funds also meet these requirements (if total Federal grant or cooperative agreement funds received exceed $500,000). The grantee must also ensure that appropriate corrective action is taken within six months after receipt of the sub-recipient audit report in instances of non-compliance with Federal law and regulations. The grantee is to consider whether sub-recipient audits necessitate adjustment of

the grantees own accounting records. If a sub-recipient is not required to have a program-specific audit, the Grantee is still required to perform adequate monitoring of sub-recipient activities. The grantee is to require each sub-recipient to permit independent auditors to have access to the sub-recipients records and financial statements. The grantee should include this requirement in all sub-recipient contracts.

NOTE 10. SUBGRANT/SUBRECIPIENT AWARDS: Seed Grants/Sub-Grants ARE NOT authorized under this program or included in Program authorizing legislature. As a result, the recipient is not permitted to fund seed grants or sub-grants. Recipient must issue proposed funding as a procurement requirement per the organizations established procedures.

NOTE 11. TRAVEL COST: In accordance with Health and Human Services (HHS) Grants Policy Statement, travel is only allowable for personnel directly charged and approved on the grant/cooperative agreement. There must be a direct benefit imparted on behalf of the traveler as it applies to the approved activities of the Notice of Award. To prevent disallowance of cost, Recipient is responsible for ensuring that only allowable travel reimbursements are applied in accordance with their organizations established travel policies and procedures. When travel procedures are not in place, the Government Travel Regulations are applicable. The URL for travel is found at:
Per diem: http://policyworks.gov/org/main/mt/homepage/mtt/perdiem/perd01d.html
(add taxes to lodging);Airline Flights: http://www.fedtravel.com/gsa/

Required CDC Travel:
Specific travel requirements for CTG 1 are listed below:

Meeting	# of Staff	# of Days	Dates	Location
CTG Kick-Off Meeting	3-4 Staff Members	3.5 days	October 24-27, 2011	Atlanta
**CTG Action Institute 1	8-10 Team Members	3.5 days	November 29- December 2, 2011	Atlanta
**CTG Action Institute 2	8-10 Team Members	3.5 days	December 5- 8, 2011	Atlanta
**CTG Action Institute 3	8-10 Team Members	3.5 days	December 12-15, 2011	Atlanta

**Action Institutes are content-specific for capacity building and implementation awardees. Awardees are not required to attend all three Action Institutes. CDC will provide additional details about each institute so that awardee can determine which is most appropriate for the organization.

NOTE 12. FOOD AND MEALS: Costs associated with food or meals are NOT permitted unless included with per diem as a part of official travel.
Per HHS Policy food is ?Generally unallowable except for the following: 1.) For subjects and patients under study; 2.) As part of a per diem or subsistence allowance provided in conjunction with allowable travel.

NOTE 13. PRIOR APPROVAL: All requests, which require prior approval, must bear the signature of an authorized official of the business office of the grantee organization as well as the principal investigator or program or project director named on this notice of award. The request must be postmarked no later than 120 days prior to the end date of the current budget period and submitted with an original plus two copies. Any requests received that reflect only one signature will be returned to the grantee unprocessed. Additionally, any requests involving funding issues must include an itemized budget and a narrative justification of the request.
Prior approval is required but is not limited to the following types of requests:
1) Use of unobligated funds from prior budget period (Carryover);
2) Lift funding restriction, withholding, or disallowance,
3) Redirection of funds,
4) Change in Contractor/Consultant;
5) Supplemental funds;
6) Response to Technical Review or Summary Statement,
7) Change in Key Personnel

NOTE 14. CORRESPONDENCE: ALL correspondence (including emails and faxes) regarding this award must be dated, identified with the FOA NUMBER and GRANT AWARD NUMBER, and include a point of contact (name, phone, fax, and email). All correspondence should be addressed to the Grants Management Specialist listed below and submitted with an original plus two copies.
Dana C. Ewing, Grants Management Specialist

Centers for Disease Control, PGO, Branch III
2920 Brandywine Road, Mail Stop 3719
Atlanta, GA 30341-4146
Telephone: (770) 488-2727
Fax: (770) 488-2778
Email: vfa8@cdc.gov

NOTE 15. INVENTIONS: Acceptance of grant funds obligates recipients to comply with the standard patent rights clause in 37 CFR 401.14.

NOTE 16. PUBLICATIONS: Publications, journal articles, etc. produced under a CDC grant support project must bear an acknowledgment and disclaimer, as appropriate, for example: This publication (journal article, etc.) was supported by the Cooperative Agreement Number above from The Centers for Disease Control and Prevention. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the Centers for Disease Control and Prevention.

NOTE 17. CONFERENCE DISCLAIMER AND USE OF LOGOS:
Disclaimer: If a conference is funded by a grant, cooperative agreement, sub-grant and/or a contract the recipient must include the following statement on conference materials, including promotional materials, agenda, and internet sites:

Funding for this conference was made possible (in part) by the Centers for Disease Control and Prevention. The views expressed in written conference materials or publications and by speakers and moderators do not necessarily do not reflect the official policies of the Department of Health and Human Services, nor does the mention of trade names, commercial practices, or organizations imply endorsement by the U.S. Government.

Logos: Neither the HHS nor the CDC logo may be displayed if such display would cause confusion as to the conference source or give false appearance of Government endorsement. Use of the HHS name or logo is governed by U.S.C. 1320b-10, which prohibits misuse of the HHS name and emblem in written communication. A non-federal entity is unauthorized to use the HHS name or logo governed by U.S.C. 1320b-10. The appropriate use of the HHS logo is subject to review and approval of the Office of the Assistant Secretary for Public Affairs (OASPA). Moreover, the Office of the Inspector General has authority to impose civil monetary penalties for violations (42 C.F.R. Part 1003). Neither the HHS nor the CDC logo can be used on conference materials, under a grant, cooperative agreement, and contract or co-sponsorship agreement without the expressed, written consent of either the Project Officer or the Grants Management Officer. It is the responsibility of the grantee (or recipient of funds under a cooperative agreement) to request consent for use of the logo in sufficient detail to ensure a complete depiction and disclosure of all uses of the Government logos. In all cases for utilization of Government logos, the grantee must ensure written consent is received from the Project Officer and/or the Grants Management Officer.

NOTE 18. EQUIPMENT AND PRODUCTS: To the greatest extent practicable, all equipment and products purchased with CDC funds should be American-made. CDC defines equipment as tangible non-expendable personal property (including exempt property) charged directly to an award having a useful life of more than one year AND an acquisition cost of $5,000 or more per unit. However, consistent with recipient policy, a lower threshold may be established. Please provide the information to the Grants Management Officer to establish a lower equipment threshold to reflect your organizations policy.
The grantee may use its own property management standards and procedures provided it observes provisions of the following sections in the Office of Management and Budget (OMB) Circular A-110 and 45 CFR Part 92:
i. Office of Management and Budget (OMB) Circular A-110, Sections 31 through 37 provides the uniform administrative requirements for grants and agreements with institutions of higher education, hospitals, and other non-profit organizations. For additional information, please review: the following website: http://www.whitehouse.gov/omb/circulars/a110/a110.html
ii. 45 CFR Parts 74.32 and 74.34 provides the uniform administrative requirements for grants and cooperative agreements to state, local and tribal governments. For additional information, please review the following website listed:
http://www.access.gpo.gov/nara/cfr/waisidx_03/45cfr92_03.html

NOTE 19. 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 sub-tier 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.
Any activity designed to influence action in regard to a particular piece of pending legislation would be considered "lobbying." That is lobbying for or against pending legislation, as well as indirect or "grass roots" lobbying efforts by award recipients that are directed at inducing members of the public to contact their elected representatives at the Federal or State levels to urge support of, or opposition to, pending legislative proposals is prohibited. As a matter of policy, CDC extends the prohibitions to lobbying with respect to local legislation and local legislative bodies.
The provisions are not intended to prohibit all interaction with the legislative branch, or to prohibit educational efforts pertaining to public health. Clearly there are circumstances when it is advisable and permissible to provide information to the legislative branch in order to foster implementation of prevention strategies to promote public health. However, it would not be permissible to influence, directly or indirectly, a specific piece of pending legislation
It remains permissible to use CDC funds to engage in activity to enhance prevention; collect and analyze data; publish and disseminate results of research and surveillance data; implement prevention strategies; conduct community outreach services; provide leadership and training, and foster safe and healthful environments.
Recipients of CDC grants and cooperative agreements need to be careful to prevent CDC funds from being used to influence or promote pending legislation. With respect to conferences, public events, publications, and "grassroots" activities that relate to specific legislation, recipients of CDC funds should give close attention to isolating and separating the appropriate use of CDC funds from non-CDC funds. CDC also cautions recipients of CDC funds to be careful not to give the appearance that CDC funds are being used to carry out activities in a manner that is prohibited under Federal law.

NOTE 20. PROGRAM INCOME: Any program income generated under this cooperative agreement will be used in accordance with the additional cost alternative. The disposition of program income must have written prior approval from the Grants Management Officer. Additional Costs Alternative--Used for costs that are in addition to the allowable costs of the project for any purposes that further the objectives of the legislation under which the cooperative agreement was made. General program income subject to this alternative shall be reported on lines 10r and 10s, as appropriate, of the FSR (Long Form).

NOTE 21. KEY PERSONNEL: In accordance with 45 CFR 74.25(c) (2) & (3) CDC recipients shall obtain prior approval changes in key persons in cases where specified in an application (1) change in the project director or principal investigator or other key persons specified in the application or award document, and (2) the absence for more than three months, or a 25 percent reduction in time devoted to the project, by the approved project director or principal investigator.

NOTE 22: COMPLIANCE WITH EO13513, FEDERAL LEADERSHIP ON REDUCING TEXT MESSAGING WHILE DRIVING: Effective October 1, 2009 this compliance is required. Grant recipients and sub-recipients to grant funds are prohibited from texting while driving a Government owned vehicle or when using Government furnished electronic equipment while driving any vehicle. This award is subject to the requirements of Executive Order (EO13513). For the full text of the award terms and conditions, please review the following website: http://www.cdc.gov/od/pgo/funding/addtl_Reqmnts.htm.

NOTE 23. TRAFFICKING IN PERSONS: This award is subject to the requirements of Section 106 (g) of the Trafficking Victims Protection Act of 2000, as amended (22 U.S.C. 7104). For the full text of the award terms and conditions, please review the following website: http://www.cdc.gov/od/pgo/funding/grants/Award_Term_and_Condition_for_Trafficking_in_Persons.shtm

NOTE 24. ACKNOWLEDGMENT OF FEDERAL SUPPORT: When issuing statements, press releases, requests for proposals, bid solicitations and other documents describing projects or programs funded in whole or in part with Federal money, all awardees receiving Federal funds, including and not limited to State and local governments and recipients of Federal research grants, shall clearly state (1) the percentage of the total costs of the program or project which will be financed with Federal money, (2) the dollar amount of Federal funds for the project or program, and (3) percentage and dollar amount of the total costs of the project or program that will be financed by nongovernmental sources.

NOTE 25. PAYMENT INFORMATION:
(IMPORTANT: Reference Patient Protection and Affordable Care Act (ACA) Sub-Account Information, NOTE 5)
AUTOMATIC DRAWDOWN (DIRECT/ADVANCE PAYMENTS):
Payment under this award will be made available through the Department of Health and Human Services (HHS) Payment Management System (PMS). PMS will forward instructions for obtaining payments.
a.) PMS correspondence, mailed through the U.S. Postal Service, should be addressed as follows:
Director, Division of Payment Management, OS/ASAM/PSC/FMS/DPM
P.O. Box 6021
Rockville, MD 20852
Phone Number: (877) 614-5533
Email: PMSSupport@psc.gov

Website: http://www.dpm.psc.gov/grant_recipient/shortcuts/shortcuts.aspx?explorer.event=true
Please Note: To obtain the contact information of DPM staff within respective Payment Branches refer to the links listed below:
University and Non-Profit Payment Branch:
http://www.dpm.psc.gov/contacts/dpm_contact_list/univ_nonprofit.aspx?explorer.event=true

Governmental and Tribal Payment Branch:
http://www.dpm.psc.gov/contacts/dpm_contact_list/gov_tribal.aspx?explorer.event=true

Cross Servicing Payment Branch:
http://www.dpm.psc.gov/contacts/dpm_contact_list/cross_servicing.aspx

To expedite your first payment from this award, attach a copy of the Notice of Grant/Cooperative Agreement to your payment request form.
b.) ACA Payment Reporting Requirements ? Expenditures must be reported on the 272 under the grant award number in which funds were obligated. In the ?G? Account, one 272 is required; however, each budget year is considered a new grant award in the ?P? Account, therefore, several 272?s must be reported for this account.
For Example:
Document number 0CCU123456 G-account ? report one cumulative 272 report by document number; A separate 272 report must be reported for EACH document in the P-account.

NOTE 26. ACCEPTANCE OF THE TERMS OF AN AWARD: By drawing or otherwise obtaining funds from the grant payment system, the recipient acknowledges acceptance of the terms and conditions of the award and is obligated to perform in accordance with the requirements of the award. If the recipient cannot accept the terms, the recipient should notify the Grants Management Officer.

NOTE 27. CERTIFICATION STATEMENT: By drawing down funds, Awardee certifies that proper financial management controls and accounting systems to include personnel policies and procedures have been established to adequately administer Federal awards and funds drawn down are being used in accordance with applicable Federal cost principles, regulations and Budget and Congressional intent of the President.

NOTE 28. ADDITIONAL REQUIREMENTS: Awardees must comply with the administrative requirements outlined in 45 Code of Federal Regulations (CFR) Part 74 or Part 92 as appropriate. The Additional Requirements that apply to this grant or cooperative agreement are indicated below. The full text of the Additional Requirements may be found on the CDC web site at: http://www.cdc.gov/od/pgo/funding/grants/additional_req.shtm

? AR-7: Executive Order 12372 Review
? AR-8: Public Health System Reporting Requirements
? AR-9: Paperwork Reduction Act Requirements
? AR-10: Smoke-Free Workplace Requirements
? AR-11: Healthy People 2010
? AR-12: Lobbying Restrictions
? AR-14: Accounting System Requirements
? AR-15: Proof of Non-profit Status
? AR-16: Security Clearance Requirement
? AR-21: Small, Minority, And Women-owned Business
? AR 23: Compliance with 45 C.F.R. Part 87
? AR-26: National Historic Preservation Act of 1966
? AR-27: Conference Disclaimer and Use of Logos
? AR-29: Compliance with EO13513, ?Federal Leadership on Reducing Text Messaging while Driving?, October 1, 2009

NOTE 29. CDC STAFF CONTACTS:
Programmatic Technical Assistance:
Business and Grants Policy Contact
Mildred Garner, Grants Management Officer
Centers for Disease Control, PGO, Branch III
2920 Brandywine Road, Mail Stop E-09
Atlanta, GA 30341-4146
Telephone: (770) 488-2077
Fax: (770) 488-2778
Email: vew4@cdc.gov

Dana C. Ewing, Grants Management Specialist
Centers for Disease Control, PGO, Branch III
2920 Brandywine Road, Mail Stop 3719
Atlanta, GA 30341-4146
Telephone: (770) 488-2727
Fax: (770) 488-2778
Email: vfa8@cdc.gov

Programmatic Contact
Latrece Timmons, Project Officer
Centers for Disease Control
4770 Buford Hwy, NE MS K-30
Atlanta, Georgia 30341
Telephone: 770-488-8636
Email: vhc4@cdc.gov

STAFF CONTACTS
Grants Management Specialist: Dana C Ewing

SPREADSHEET SUMMARY
GRANT NUMBER: 1U58DP003650-01

INSTITUTION: VERMONT DEPARTMENT OF HEALTH

Budget	*Year 1*	*Year 2*	*Year 3*	*Year 4*	*Year 5*
Salaries and Wages	$108,000				

Fringe Benefits	$37,800				
Personnel Costs (Subtotal)	$145,800				
Supplies	$9,000				
Travel Costs	$2,550				
Other Costs	$219,610	$621,760	$621,760	$621,760	$621,760
Consortium/Contractual Cost	$180,000				
TOTAL FEDERAL DC	$556,960	$621,760	$621,760	$621,760	$621,760
TOTAL FEDERAL F&A	$64,800				
TOTAL COST	$621,760	$621,760	$621,760	$621,760	$621,760

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Centers for Disease Control
and Prevention (CDC)
Atlanta, GA 30341-3724

Grantee Name: Vermont Department of Health– 1U58DP003650
Category B: Implementation

Note 4 Revised Budget Special Conditions

Your organization requested $996,550 in funds. The amount awarded to your organization is **$621,760.** We are aware that program activities, goals and accomplishments must be revised to encompass the change in scope based on the available funding.

The budget plan is the financial expression of the program as approved during the award process. It shall be related to performance for program evaluation purposes whenever appropriate. This information is provided to assist your organization in making adjustments to provide assistance in your locality; and to frame your proposed costs within the fiscal and administrative requirements of the Code of Federal regulations and Office of management and budget Circulars. Please refer to the Guidelines for Budget Preparation http://www.cdc.gov/od/pgo/funding /budgetguide.htm in completing your verified budget.

PERSONNEL

All proposed staff salaries shall reflect annual salary rate, level of effort proposed for this award, and total salary requested for position. Appropriate records must be maintained to show actual charges to this award and insure level of effort is charged accurately for employees working on multiple federal projects. Employee effort should not exceed 100%.

NOTE REGARDING VACANT POSITIONS: Grant funds must match the effort. To fund the positions for a proposed 12 months would be considered forward funding and would therefore lead to an unobligated balance. The grantee should notify CDC if the positions have been filled since the submission of the application. If the positions are still vacant the grantee should reduce each position proposed for 12 months by at least 3 months to allow the hiring process to take place.

CONSULTANT /CONTRACTUAL COSTS

Cooperative Agreement recipients must obtain written approval from CDC prior to establishing a third-party contract to perform program activities. Approval to initiate program activities through the services of a contractor requires submission of the following information to CDC:

1. Name of Contractor;
2. Method of Selection;
3. Period of Performance;
4. Scope of Work;
5. Method of Accountability; and
6. Itemized Budget and Justification.

SUPPLIES

Supplies include computers and general office supplies. The request is reasonable, sufficiently justified; however grantee must consider the necessity due to limited funds available.

TRAVEL
In-state travel required additional justification to include estimated mileage, mileage reimbursement rate, per diem

Grantee did not include out-of state travel in budget for required CDC meetings. Grantee should include travel funds for two staff to attend required CDC meetings.

NOTE: In accordance with Health and Human Services (HHS) Grants Policy Statement, travel is only allowable for personnel directly charged and approved on the grant/cooperative agreement.

OTHER
This line item lists proposed sub-recipient costs be grantee. Grantee must follow their procurement procedures in establishing these subawards.

Before Contractual costs can be approved, there are required elements that must be provided before establishing an agreement. See "Guidelines for Budget Preparation" for requirements for entering consultant and contractual agreements.

NOTE: As a recipient of Federal funds you must ensure proper stewardship by ensuring established policies/regulations and procedures are in place for accountability.

Sub Recipient Monitoring
In addition, the Uniform requirements for Non- profit organizations require that a system for contract administration shall be maintained to ensure contractor performance with the terms, conditions and specifications of the contract and to ensure adequate and timely follow up of all purchases. Recipients shall evaluate contractor performance and document, as appropriate whether contractors have met the terms, conditions, and specifications of the contract.

INDIRECT COSTS
Should be in accordance with approved cost allocation plan.

#3650 Annie

CENTERS FOR DISEASE CONTROL AND PREVENTION (CDC)
2011 Public Prevention Health Fund Community Transformation Grants
CDC-RFA-DP11-1103-PPHF11
Objective Review Summary Statement
(Implementation)

Date Reviewed:	August 15, 2011
Applicant/Application #:	Vermont Department of Health/90019650
Principal Investigator/Program Director:	Gary Schaedel
Requested Amount:	$5,017,854

Recommendation:
☑ Approve ☐ Disapprove

Reviewer's Comments on Background and Need

Summary of Strengths:

- The applicant clearly describes the need for support in the target area. Solid data are presented to document the population growth among persons 55-64 years of age; the rural nature of the target area; chronic conditions in the state of Vermont; and disparities attributed to race/ethnicity, poverty, low education, unemployment, and disability. The applicant's data demonstrate higher rates of diabetes, heart disease and stroke, asthma, obesity, and depression among low-income populations (pp. 1-9).
- The applicant describes past successes and activities in supporting the work of tobacco-free community Coalitions; ensuring schools have smoke-free campuses and access to evidence-based tobacco interventions; passing policy initiatives to reduce secondhand smoke and change social norms; and addressing tobacco-related disparities, particularly in the context of low socioeconomic (SES) status (pp. 9-10).
- The applicant describes successes in several CTG focus areas (e.g., clinical preventive services, obesity and physical activity, and tobacco control). The applicant highlights significant progress over the past decade toward reaching its objectives in these focus areas (pp. 10-11).

Summary of Weaknesses:

- None noted.

Reviewer's Comments on Program Infrastructure

Summary of Strengths:

- The applicant documents an experienced team to successfully complete the components of the Community Transformation Implementation Plan (CTIP); attend CDC trainings and meetings; participate in the daily support and implementation of the project; and place emphasis on ensuring that community Coalitions, local organizations, and local health offices are coordinated and supported at the local level. Staff positions are identified to oversee and manage all CTG program activities; develop an overall vision for the health of residents in the state of Vermont and the nutrition and physical activity

goals; coordinate the Coalition and community-based activities and research; and provide leadership for the Maternal and Child Health and oral health activities on a statewide basis. The applicant will hire a Public Health Program Administrator, Public Health Specialist, and Administrative Assistant within 90 days post-award to support its existing staff (pp. 15-22).

Summary of Weaknesses:

- The applicant does not describe plans to recruit and hire new staff. Sufficient details are not provided on how the current small staff of 7 persons will be able to oversee and conduct the CTG program activities.

Recommendations:

- The applicant should describe recruitment plans with sufficient details on how the work will be accomplished with program staff.

Reviewer's Comments on Fiscal Management

Summary of Strengths:

- The applicant describes plans to fund competent, coordinated, and established Coalitions with a history and capacity to implement work that is of a similar scope and nature to the CTG program. The overall CTG program will be aligned with funding to subrecipients by distributing CTG funds through requests for proposals (RFPs) to existing community-based prevention Coalitions throughout the state. This process will create consolidated regional grants to support evidence-based public health interventions that address nutrition and physical activity, alcohol and drug prevention, tobacco control, and chronic disease prevention (pp. 25-26).
- The applicant describes strong sustainability plans in which cohesion between state and local CTIPs will be promoted. Coalitions that apply for funds will be required to propose a scope of work that adheres to and promotes the statewide CTIP with evidence-based strategies to target low SES and minority populations. The applicant will convene a Review Committee to make recommendations for the distribution of funds to community Coalitions and organizations through a process of scoring and ranking proposals. Coalitions and community groups that will be responsible for conducting activities in the 4 Strategic Directions will not be identified until the competitive process is complete. The applicant will submit a revised budget to CDC after the award to reflect these groups (pp. 3-4, 23-26).

Summary of Weaknesses:

- The applicant's RFP and award processes appear to be more stringent than those used by CDC. No approaches are articulated to ensure that the RFP/award processes will be fair and reasonable to the government and awards will be made to the Coalitions and community groups identified in the proposal.

Recommendations:

- The applicant should provide assurances that the award process will be fair and reasonable.

Reviewer's Comments on Leadership Team and Coalition Plan

Summary of Strengths:

- The applicant describes its Leadership Team in detail. The members represent the applicant's senior leadership; national, state, and local professional associations; health department staff; and academia. Previous Coalition activities support the applicant's ability to conduct the CTG program activities. A comprehensive list of the Coalitions, their accomplishments, and appropriate letters of support are included in the proposal; this information clearly documents a commitment to and support of the proposed CTG program activities.

Summary of Weaknesses:

- None noted.

Reviewer's Comments on Community Transformation Implementation Plan (CTIP)

Summary of Strengths:

- The applicant documents a longstanding history of working across local, state, and federal agencies to implement public health strategies and interventions. The applicant describes plans to provide technical assistance and conduct activities at state and local levels to increase the capacity, reach, and effectiveness of community Coalitions and facilitate a stronger local infrastructure to deliver public health programs (pp. 36-38).
- The applicant's CTIP is designed to build on existing partnerships and programs at state and local levels and focus on policy, infrastructure, and environmental change to support long-term outcomes and ensure sustainability beyond the 5-year funding cycle.
- The applicant's CTIP integrates community and clinical components. The outcome objectives meet the SMART requirements, and the milestones represent a logical and realistic plan of action for timely and successful achievement of the outcome objectives.

Summary of Weaknesses:

- The applicant's CTIP does not include an adequate foundation for sustainability of the proposed CTG program activities.

Recommendations:

- The applicant should provide evidence of sustainability for the proposed activities.

Reviewer's Comments on Selection of Strategies and Performance Measures

Summary of Strengths:

- The applicant will focus its CTG program activities on 4 Strategic Directions: Tobacco-Free Living, Active Living and Healthy Eating, Increased Use of High Impact Quality Clinical Preventive Services, and Healthy and Safe Physical Environment. The applicant's allocation of the CTG grant award includes 50% to communities, over 50% to the first 3 Strategic Directions, and over 20% to rural areas of the state. The proposed strategies are aligned with the needs documented in the proposal and the capacity of the Leadership Team and Coalitions (pp. 40-47).
- The applicant's proposed strategies address both area-wide needs and the needs of populations experiencing health disparities. Examples are provided of activities that will be conducted for Strategic Directions 1-4 to address and specifically focus on these

needs (e.g., tobacco cessation, childhood and adult obesity, provision of recommended clinical preventive services, and healthy communities) (pp. 40-47).

- The applicant's proposed strategies strive to maximize the public health impact of CTG funding by effectively impacting and reaching a significant portion of the target population. The applicant selected activities to influence positive outcomes in multiple and diverse settings (e.g., multiunit housing, childcare centers, parks, retail food stores, and physician's offices). Based on past successes of the community Coalitions in changing policy, the applicant's selected strategies are highly likely to result in broad reach and successful implementation (p. 40).
- The applicant documents capacity to collect area-level data on demographics and other key factors in the target area, such as smoking prevalence, income and educational status, poverty, unemployment, racial/ethnic disparities, disability, and the distribution of chronic diseases (e.g., diabetes, heart disease and stroke, asthma, obesity, and depression) (pp. 3-9).

Summary of Weaknesses:

- The applicant's strategies and performance measures are not linked to goals or outcomes to measure a reduction in disease burden or change in behaviors.

Recommendations:

- The applicant should link performance measures to goals and outcomes.

Reviewer's Comments on Performance Monitoring and Evaluation

Summary of Strengths:

- The applicant's CTG program will have a significant focus on formative evaluation at the community level. Quarterly reports from Coalitions and site visits will be used for the applicant to promote a culture of learning, continuous quality improvement (CQI), and information exchange. To some degree, the applicant will participate in overall program evaluation with CDC and other grantees to reinforce existing lines of communication, create a true collaboration among all members, and facilitate the development of effective solutions. The CQI process will be used to expand existing strengths of the Leadership Team, Coalitions, and activities and identify areas that need revision and/or improvement. Relevant data will be collected and analyzed on core measures to assess changes in weight, proper nutrition, physical activity, tobacco use prevalence, and emotional well-being and mental health. The applicant expresses a strong interest in exploring the extent to which other methodologies could be employed to monitor progress (pp. 47, 49).
- The applicant will collect all core measures through Behavioral Risk Factor Surveillance System survies and available data at county and state levels to monitor progress. Measures of effectiveness related to the performance goals are clearly articulated and will be targeted to create healthier communities and build capacity to implement broad evidence- and practice-based policy, environmental, programmatic, and infrastructure changes (PEPI) in large counties and rural areas of the state. The applicant's measures of effectiveness are objective and quantitative and have the ability to measure the intended outcomes of the proposed CTG program. A description of the measures of effectiveness is included in the proposal (pp. 49-50).

Summary of Weaknesses:

- The applicant does not explicitly describe its ability to collect area-level data and evaluate the impact of these data on improving nutrition, physical activity, tobacco prevalence, and emotional well-being.
- The applicant includes no measures of effectiveness related to the performance goals that are documented in the Purpose section of the proposal.

Recommendations:

- The applicant should define its data collection and reporting process as required by CDC.

Reviewer's Comments on Participation in Programmatic Support

Summary of Strengths:

- The applicant will participate in programmatic support activities by developing quarterly briefing documents to provide context to the evaluation process. The applicant will share this information with the Leadership Team, local health departments, Coalitions, and CDC to improve understanding of the processes involved in the CTG program and provide insight for formative evaluation and CQI activities of future CTG implementation grantees (p. 50).

Summary of Weaknesses:

- The applicant does not clearly articulate a dissemination plan for the CTG program activities, successes, and lessons learned.

Recommendations:

- The applicant should include a dissemination plan for activities, successes, and lessons learned.

Reviewer's Comments on Budget and Budget Narrative (Reviewed, not scored)

The applicant's detailed budget narrative, summary, and justification for conducting the project are reasonable and consistent with the stated objectives and planned program activities.

GRANTS.GOV

Grant Application Package

Opportunity Title:	Public Prevention Health Fund: Community Transformation
Offering Agency:	Centers for Disease Control and Prevention
CFDA Number:	93.531
CFDA Description:	The Patient Protection and Affordable Care Act of 2010
Opportunity Number:	CDC-RFA-DP11-1103PPHF11
Competition ID:	NCCDPHP-NR
Opportunity Open Date:	05/13/2011
Opportunity Close Date:	07/15/2011
Agency Contact:	Centers for Disease Control and Prevention (CDC) Procurement and Grants Office (PGO) Technical Information and Management Section (TIMS) E-mail: pgotim@cdc.gov Phone: 770-488-2700

This electronic grants application is intended to be used to apply for the specific Federal funding opportunity referenced here.

If the Federal funding opportunity listed is not the opportunity for which you want to apply, close this application package by clicking on the "Cancel" button at the top of this screen. You will then need to locate the correct Federal funding opportunity, download its application and then apply.

This opportunity is only open to organizations, applicants who are submitting grant applications on behalf of a company, state, local or tribal government, academia, or other type of organization.

*** Application Filing Name:** Vermont Department of Health

Mandatory Documents

Move Form to Complete

Move Form to Delete

Mandatory Documents for Submission

- Application for Federal Assistance (SF-424)
- Disclosure of Lobbying Activities (SF-LLL)
- Budget Information for Non-Construction Program
- Project Narrative Attachment Form
- Project Abstract Summary
- [redacted]
- Budget Narrative Attachment Form

Optional Documents

- Other Attachments Form

Move Form to Submission List

Move Form to Delete

Optional Documents for Submission

Instructions

1 **Enter a name for the application in the Application Filing Name field.**

- This application can be completed in its entirety offline; however, you will need to login to the Grants.gov website during the submission process.
- You can save your application at any time by clicking the "Save" button at the top of your screen.
- The "Save & Submit" button will not be functional until all required data fields in the application are completed and you clicked on the "Check Package for Errors" button and confirmed all data required data fields are completed.

2 **Open and complete all of the documents listed in the "Mandatory Documents" box. Complete the SF-424 form first.**

- It is recommended that the SF-424 form be the first form completed for the application package. Data entered on the SF-424 will populate data fields in other mandatory and optional forms and the user cannot enter data in these fields.

- The forms listed in the "Mandatory Documents" box and "Optional Documents" may be predefined forms, such as SF-424, forms where a document needs to be attached, such as the Project Narrative or a combination of both. "Mandatory Documents" are required for this application. "Optional Documents" can be used to provide additional support for this application or may be required for specific types of grant activity. Reference the application package instructions for more information regarding "Optional Documents".

- To open and complete a form, simply click on the form's name to select the item and then click on the => button. This will move the document to the appropriate "Documents for Submission" box and the form will be automatically added to your application package. To view the form, scroll down the screen or select the form name and click on the "Open Form" button to begin completing the required data fields. To remove a form/document from the "Documents for Submission" box, click the document name to select it, and then click the <= button. This will return the form/document to the "Mandatory Documents" or "Optional Documents" box.

- All documents listed in the "Mandatory Documents" box must be moved to the "Mandatory Documents for Submission" box. When you open a required form, the fields which must be completed are highlighted in yellow with a red border. Optional fields and completed fields are displayed in white. If you enter invalid or incomplete information in a field, you will receive an error message.

3 **Click the "Save & Submit" button to submit your application to Grants.gov.**

- Once you have properly completed all required documents and attached any required or optional documentation, save the completed application by clicking on the "Save" button.
- Click on the "Check Package for Errors" button to ensure that you have completed all required data fields. Correct any errors or if none are found, save the application package.
- The "Save & Submit" button will become active; click on the "Save & Submit" button to begin the application submission process.
- You will be taken to the applicant login page to enter your Grants.gov username and password. Follow all onscreen instructions for submission.

OMB Number: 4040-0004
Expiration Date: 01/31/2009

Application for Federal Assistance SF-424

Version 02

* 1. Type of Submission:
- [ ] Preapplication
- [x] Application
- [ ] Changed/Corrected Application

* 2. Type of Application:
- [x] New
- [ ] Continuation
- [ ] Revision

* If Revision, select appropriate letter(s):

* Other (Specify)

* 3. Date Received: Completed by Grants.gov upon submission.

4. Applicant Identifier:

5a. Federal Entity Identifier:

* 5b. Federal Award Identifier:

State Use Only:

6. Date Received by State:

7. State Application Identifier:

8. APPLICANT INFORMATION:

* a. Legal Name: Vermont Department of Health

* b. Employer/Taxpayer Identification Number (EIN/TIN): 03-6000274

* c. Organizational DUNS: 809376155

d. Address:

* Street1: 108 Cherry Street
Street2:
* City: Burlington
County:
* State: VT: Vermont
Province:
* Country: USA: UNITED STATES
* Zip / Postal Code: 05402

e. Organizational Unit:

Department Name: Vermont Department of Health

Division Name: Health Promotion/Disease Preve

f. Name and contact information of person to be contacted on matters involving this application:

Prefix:
* First Name: Garry
Middle Name:
* Last Name: Schaedel
Suffix:

Title: Division Director, Health Promotion/Disease

Organizational Affiliation:

* Telephone Number: 802 863 7269
Fax Number:

* Email: garry.schaedel@ahs.state.vt.us

OMB Number: 4040-0004
Expiration Date: 01/31/2009

Application for Federal Assistance SF-424

Version 02

9. Type of Applicant 1: Select Applicant Type:

A: State Government

Type of Applicant 2: Select Applicant Type:

Type of Applicant 3: Select Applicant Type:

* Other (specify):

*** 10. Name of Federal Agency:**

Centers for Disease Control and Prevention

11. Catalog of Federal Domestic Assistance Number:

93.531

CFDA Title:

The Patient Protection and Affordable Care Act of 2010 (Affordable Care Act) authorizes Community Transformation Grants

*** 12. Funding Opportunity Number:**

CDC-RFA-DP11-1103PPHF11

* Title:

Public Prevention Health Fund: Community Transformation Grant

13. Competition Identification Number:

NCCDPHP-NR

Title:

14. Areas Affected by Project (Cities, Counties, States, etc.):

*** 15. Descriptive Title of Applicant's Project:**

Vermont Community Transformation Implementation Application - Integrates clinical and community components into a cohesive system targeting areas in the State where health disparities exist.

Attach supporting documents as specified in agency instructions.

Add Attachments

OMB Number: 4040-0004
Expiration Date: 01/31/2009

Application for Federal Assistance SF-424

Version 02

16. Congressional Districts Of:

* a. Applicant: VT-ALL
* b. Program/Project: VT-ALL

Attach an additional list of Program/Project Congressional Districts if needed.

Add Attachment

17. Proposed Project:

* a. Start Date: 10/01/2011
* b. End Date: 09/30/2016

18. Estimated Funding ($):

* a. Federal	5,017,854.00
* b. Applicant	0.00
* c. State	0.00
* d. Local	0.00
* e. Other	0.00
* f. Program Income	0.00
* g. TOTAL	5,017,854.00

*** 19. Is Application Subject to Review By State Under Executive Order 12372 Process?**

☐ a. This application was made available to the State under the Executive Order 12372 Process for review on

☒ b. Program is subject to E.O. 12372 but has not been selected by the State for review.

☐ c. Program is not covered by E.O. 12372.

*** 20. Is the Applicant Delinquent On Any Federal Debt? (If "Yes", provide explanation.)**

☐ Yes ☒ No

21. *By signing this application, I certify (1) to the statements contained in the list of certifications and (2) that the statements herein are true, complete and accurate to the best of my knowledge. I also provide the required assurances** and agree to comply with any resulting terms if I accept an award. I am aware that any false, fictitious, or fraudulent statements or claims may subject me to criminal, civil, or administrative penalties. (U.S. Code, Title 218, Section 1001)**

☒ ** I AGREE

** The list of certifications and assurances, or an internet site where you may obtain this list, is contained in the announcement or agency specific instructions.

Authorized Representative:

Prefix:	Dr.
* First Name:	Harry
Middle Name:	
* Last Name:	Chen
Suffix:	
* Title:	Commissioner of Health
* Telephone Number:	802 863 7282
Fax Number:	
* Email:	harry.chen@ahs.state.vt.us
* Signature of Authorized Representative:	Completed by Grants.gov upon submission.
* Date Signed:	Completed by Grants.gov upon submission.

OMB Number: 4040-0004
Expiration Date: 01/31/2009

Application for Federal Assistance SF-424 Version 02

*** Applicant Federal Debt Delinquency Explanation**

The following field should contain an explanation if the Applicant organization is delinquent on any Federal Debt. Maximum number of characters that can be entered is 4,000. Try and avoid extra spaces and carriage returns to maximize the availability of space.

OMB Number: 0980-0204
Expiration Date: 08/31/2012

Project Abstract Summary

Program Announcement (CFDA)

93.531

Program Announcement (Funding Opportunity Number)

CDC-RFA-DP11-1103PPHF11

Closing Date

07/15/2011

Applicant Name

Vermont Department of Health

Length of Proposed Project

60

Application Control No.

Federal Share Requested (for each year)

Federal Share 1st Year	Federal Share 2nd Year	Federal Share 3rd Year
$ 996,550	$ 995,368	$ 1,001,875

Federal Share 4th Year	Federal Share 5th Year
$ 1,008,579	$ 1,015,482

Non-Federal Share Requested (for each year)

Non-Federal Share 1st Year	Non-Federal Share 2nd Year	Non-Federal Share 3rd Year
$ 0	$ 0	$ 0

Non-Federal Share 4th Year	Non-Federal Share 5th Year
$ 0	$ 0

Project Title

Vermont Community Transformation Implementation Application - Integrates clinical and community components into a cohesive system targeting areas in the State where health disparities exist.

Project Abstract Summary

Project Summary

Vermont's Implementation Application focuses on health disparities which still exist throughout Vermont. The focus of this application would be working on preventing heart attack, strokes, cancer and other leading causes of death or disability through evidence and practice-based policy, environmental, programmatic, and infrastructure changes.

Vermont intends to continue to use a progressive approach to the development of coordinated and integrated prevention activities via the Blue Print for Health, community coalitions, and associated community prevention teams. The Blueprint for Health national model for health care reform. It is a state led program dedicated to achieving well-coordinated and seamless health services, with an emphasis on prevention and wellness. This effort includes transitioning patients from patterns of acute episodic care to preventive health services managed by community prevention teams. Initially, community coalitions developed separately and worked to implement evidence based prevention strategies in the areas of substance abuse, obesity and physical activity, tobacco and other key public health areas. Over time, the Vermont Health Department has made a concerted effort to bring these coalitions together to provide prevention services in a coordinated and cohesive manner. As a result of this work, Vermont is uniquely positioned to integrate clinical and community components. This application proposes to bring the community coalitions, the Blueprint for Health, and the community prevention teams together to provide prevention services in a coordinated and cohesive manner. Vermont's strategy to date has been to engage community coalitions, build their capacity and implement activities which reach a significant portion of the population. Fortunately, the efforts in building local infrastructure can now be leveraged using CTG funds to target populations where health disparities still reside. With CTG funds, we can heighten the sophistication in design and delivery of our local and state systems and therefore, increase our ability to address the persistent disparities within the state.

The strategies selected for the CTIP have been chosen based upon coalition's ability to effectively impact and reach a significant portion of the target population. We have intentionally chosen strategies which speak to the strengths of our coalitions. That is, we picked strategies that coalitions can best use to reach the target population through existing connections with multi-unit housing, child care centers, parks, retail food stores, physician's offices and community water supplies.

The project will have a significant focus on formative evaluation at the community level. Formative evaluation will provide an opportunity to monitor and understand coalitions

Estimated number of people to be served as a result of the award of this grant.

650000

DISCLOSURE OF LOBBYING ACTIVITIES

Complete this form to disclose lobbying activities pursuant to 31 U.S.C.1352

Approved by OMB
0348-0046

1. * Type of Federal Action:
- [ ] a. contract
- [x] b. grant
- [ ] c. cooperative agreement
- [ ] d. loan
- [ ] e. loan guarantee
- [ ] f. loan insurance

2. * Status of Federal Action:
- [ ] a. bid/offer/application
- [x] b. initial award
- [ ] c. post-award

3. * Report Type:
- [x] a. initial filing
- [ ] b. material change

4. Name and Address of Reporting Entity:

[x] Prime [ ] SubAwardee

*Name: not applicable

*Street 1: not applicable Street 2:

*City: not applicable State: Zip:

Congressional District, if known:

5. If Reporting Entity in No.4 is Subawardee, Enter Name and Address of Prime:

6. * Federal Department/Agency:

Centers for Disease Control

7. * Federal Program Name/Description:

The Patient Protection and Affordable Care Act of 2010 (Affordable Care Act) authorizes Community Transformation Grants

CFDA Number, *if applicable:* 93.531

8. Federal Action Number, *if known:*

9. Award Amount, *if known:*

$

10. a. Name and Address of Lobbying Registrant:

Prefix: * First Name: not applicable Middle Name:

*Last Name: not applicable Suffix:

*Street 1: Street 2:

*City: State: Zip:

b. Individual Performing Services (including address if different from No. 10a)

Prefix: * First Name: not applicable Middle Name:

*Last Name: not applicable Suffix:

*Street 1: Street 2:

*City: State: Zip:

11. Information requested through this form is authorized by title 31 U.S.C. section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when the transaction was made or entered into. This disclosure is required pursuant to 31 U.S.C. 1352. This information will be reported to the Congress semi-annually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

*** Signature:** Completed on submission to Grants.gov

***Name:** Prefix: * First Name: not applicable Middle Name:

*Last Name: not applicable Suffix:

Title: **Telephone No.:** **Date:** Completed on submission to Grants.gov

Federal Use Only:

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Standard Form - LLL (Rev. 7-97)

BUDGET INFORMATION - Non-Construction Programs

OMB Approval No. 4040-0006
Expiration Date 07/30/2010

SECTION A - BUDGET SUMMARY

Grant Program Function or Activity (a)	Catalog of Federal Domestic Assistance Number (b)	Estimated Unobligated Funds		New or Revised Budget		
		Federal (c)	Non-Federal (d)	Federal (e)	Non-Federal (f)	Total (g)
1. Community Transformation Implementation	93.531	$	$	$ 996,550.00	$ 0.00	$ 996,550.00
2.						
3.						
4.						
5. Totals		$	$	$ 996,550.00	$	$ 996,550.00

SECTION B - BUDGET CATEGORIES

6. Object Class Categories	GRANT PROGRAM, FUNCTION OR ACTIVITY (1) Community Transformation Implementation	(2)	(3)	(4)	Total (5)
a. Personnel	$ 108,000.00	$	$	$	$ 108,000.00
b. Fringe Benefits	37,800.00				37,800.00
c. Travel	2,550.00				2,550.00
d. Equipment	0.00				
e. Supplies	9,000.00				9,000.00
f. Contractual	254,400.00				254,400.00
g. Construction	0.00				
h. Other	520,000.00				520,000.00
i. Total Direct Charges (sum of 6a-6h)	931,750.00				$ 931,750.00
j. Indirect Charges	64,800.00				$ 64,800.00
k. TOTALS (sum of 6i and 6j)	$ 996,550.00	$	$	$	$ 996,550.00
7. Program Income	$ 0.00	$	$	$	$

SECTION C - NON-FEDERAL RESOURCES

(a) Grant Program	(b) Applicant	(c) State	(d) Other Sources	(e)TOTALS
8.	$	$	$	$
9.				
10.				
11.				
12. TOTAL (sum of lines 8-11)	$	$	$	$

SECTION D - FORECASTED CASH NEEDS

	Total for 1st Year	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
13. Federal	$	$	$	$	$
14. Non-Federal	$				
15. TOTAL (sum of lines 13 and 14)	$	$	$	$	$

SECTION E - BUDGET ESTIMATES OF FEDERAL FUNDS NEEDED FOR BALANCE OF THE PROJECT

(a) Grant Program	FUTURE FUNDING PERIODS (YEARS)			
	(b)First	(c) Second	(d) Third	(e) Fourth
16.	$	$	$	$
17.				
18.				
19.				
20. TOTAL (sum of lines 16 - 19)	$	$	$	$

SECTION F - OTHER BUDGET INFORMATION

21. Direct Charges: 931750

22. Indirect Charges: 64800

23. Remarks:

PHS-5161-1 (7/00)

CHECKLIST

OMB Approval No. 0920-0428

Public Burden Statement:

Public reporting burden of this collection of information is estimated to average 4 hours per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC, Clearance Officer, 1600 Clifton Road, MS D-24, Atlanta, GA 30333, ATTN: PRA (0920-0428). Do not send the completed form to this address.

NOTE TO APPLICANT:

This form must be completed and submitted with the original of your application. Be sure to complete both sides of this form. Check the appropriate boxes and provide the information requested. This form should be attached as the last age of the signed original of the application. This page is reserved for PHS staff use only.

Type of Application: ☒ NEW ☐ Noncompeting Continuation ☐ Competing Continuation ☐ Supplemental

PART A: The following checklist is provided to assure that proper signatures, assurances, and certifications have been submitted.

	Included	NOT Applicable
1. Proper Signature and Date	☐	
2. Proper Signature and Date on PHS-5161-1 "Certifications" page.	☐	
3. Proper Signature and Date on appropriate "Assurances" page, i.e., SF-424B (Non-Construction Programs) or SF-424D (Construction Programs)	☐	
4. If your organization currently has on file with DHHS the following assurances, please identify which have been filed by indicating the date of such filing on the line provided. (All four have been consolidated into a single form, HHS Form 690)		
☐ Civil Rights Assurance (45 CFR 80)		
☐ Assurance Concerning the Handicapped (45 CFR 84)		
☐ Assurance Concerning Sex Discrimination (45 CFR 86)		
☐ Assurance Concerning Age Discrimination (45 CFR 90 & 45 CFR 91)		
5. Human Subjects Certification, when applicable (45 CFR 46)	☐	☐

PART B: This part is provided to assure that pertinent information has been addressed and included in the application.

	YES	NOT Applicable
1. Has a Public Health System Impact Statement for the proposed program/project been completed and distributed as required?	☐	☐
2. Has the appropriate box been checked on the SF-424 (FACE PAGE) regarding intergovernmental review under E.O. 12372 ? (45 CFR Part 100)	☐	
3. Has the entire proposed project period been identified on the SF-424?	☐	
4. Have biographical sketch(es) with job description(s) been attached, when required?	☐	☐
5. Has the "Budget Information" page, SF-424A (Non-Construction Programs) or SF-424C (Construction Programs), been completed and included?	☐	
6. Has the 12 month detailed budget been provided?	☐	☐
7. Has the budget for the entire proposed project period with sufficient detail been provided?	☐	☐
8. For a Supplemental application, does the detailed budget address only the additional funds requested?	☐	☐
9. For Competing Continuation and Supplemental applications, has a progress report been included?	☐	☐

PART C: In the spaces provided below, please provide the requested information.

Business Official to be notified if an award is to be made

Name: Prefix: | * First Name: Karen | Middle Name:

* Last Name: Kelley | Suffix:

Title:

Organization:

Address: * Street1: 108 Cherry Street

Street 2:

* City: Burlington

* State: VT: Vermont | Province:

* Country: USA: UNITED STATES | * Zip / Postal Code: 05402

*** Telephone Number:** 802 657 4258

E-mail Address: karen.Kelley@vdh.state.vt.us

Fax Number:

APPLICANT ORGANIZATION'S 12-DIGIT DHHS EIN (If already assigned)

[ ] - 03-6000274 - [ ]

PART C (Continued): In the spaces provided below, please provide the requested information.

Program Director/Project Director/Principal Investigator designated to direct the proposed project

Name: Prefix: * First Name: Garry Middle Name:

* Last Name: Schaedel Suffix:

Title: Division Director

Organization: VT Dept of Health

Address: * Street1: 108 Cherry Street

Street2:

* City: Burlington

* State: VT: Vermont Province:

* Country: USA: UNITED STATES * Zip / Postal Code: 05402

*** Telephone Number:** 802 863 7269

E-mail Address:

Fax Number:

SOCIAL SECURITY NUMBER

HIGHEST DEGREE EARNED MS

PART D: A private, nonprofit organization must include evidence of its nonprofit status with the application. Any of the following is acceptable evidence. Check the appropriate box or complete the "Previously Filed" section, whichever is applicable.

- ☐ (a) A reference to the organization's listing in the Internal Revenue Service's (IRS) most recent list of tax-exempt organizations described in section 501(c)(3) of the IRS Code.
- ☐ (b) A copy of a currently valid Internal Revenue Service Tax exemption certificate.
- ☐ (c) A statement from a State taxing body, State Attorney General, or other appropriate State official certifying that the applicant organization has a nonprofit status and that none of the net earnings accrue to any private shareholders or individuals.
- ☐ (d) A certified copy of the organization's certificate of incorporation or similar document if it clearly establishes the nonprofit status of the organization.
- ☐ (e) Any of the above proof for a State or national parent organization, and a statement signed by the parent organization that the applicant organization is a local nonprofit affiliate.

If an applicant has evidence of current nonprofit status on file with an agency of PHS, it will not be necessary to file similar papers again, but the place and date of filing must be indicated.

Previously Filed with: ** (Agency)* on ** (Date)*

INVENTIONS

If this is an application for continued support, include: (1) the report of inventions conceived or reduced to practice required by the terms and conditions of the grant; or (2) a list of inventions already reported, or (3) a negative certification.

EXECUTIVE ORDER 12372

Effective September 30, 1983, Executive Order 12372 (Intergovernmental Review of Federal Programs) directed OMB to abolish OMB Circular A-95 and establish a new process for consulting with State and local elected officials on proposed Federal financial assistance. The Department of Health and Human Services implemented the Executive Order through regulations at 45 CFR Part 100 (Inter-governmental Review of Department of Health and Human Services Programs and Activities). The objectives of the Executive Order are to (1) increase State flexibility to design a consultation process and select the programs it wishes to review, (2) increase the ability of State and local elected officials to influence Federal decisions and (3) compel Federal officials to be responsive to State concerns, or explain the reasons.

The regulations at 45 CFR Part 100 were published in *Federal Register* on June 24, 1983, along with a notice identifying the Department's programs that are subject to the provisions of Executive Order 12372. Information regarding PHS programs subject to Executive Order 12372 is also available from the appropriate awarding office.

States participating in this program establish State Single Points of Contact (SPOCs) to coordinate and manage the review and comment on proposed Federal financial assistance. Applicants should contact the Governor's office for information regarding the SPOC, programs selected for review, and the consultation (review) process designed by their State.

Applicants are to certify on the face page of the SF-424 (attached) whether the request is for a program covered under Executive Order. 12372 and, where appropriate, whether the State has been given an opportunity to comment.

Project Narrative File(s)

*** Mandatory Project Narrative File Filename:** _VT_ProjectNarrative.pdf

Add Mandatory Project Narrative File | Delete Mandatory Project Narrative File | View Mandatory Project Narrative File

To add more Project Narrative File attachments, please use the attachment buttons below.

Add Optional Project Narrative File | Delete Optional Project Narrative File | View Optional Project Narrative File

Budget Narrative File(s)

*** Mandatory Budget Narrative Filename:** VT_BudgetNarrative.pdf

[illegible] | Delete Mandatory Budget Narrative | View Mandatory Budget Narrative

To add more Budget Narrative attachments, please use the attachment buttons below.

Add Optional Budget Narrative | Delete Optional Budget Narrative | View Optional Budget Narrative

Budget Narrative

A. Salary and Wages Year 1 **Total $108,000**

Position Title	Name	Time	Months	Amount Requested
Program Administrator	Vacant	100%	12 months	$50,000

Justification - Provides overall direction for the grant including: planning; grants management; coordination with Leadership team; advisory committees; educational needs for coalitions and community groups; and policy development. This position will be responsible for the day to day management and will work under the direction from the Division Director.

Public Health Specialist	Vacant	100%	12 months	$42,000

Justification - Provides programmatic support to the community coalitions and/or community groups funded under this initiative. This position is a critical part of the feed back loop in the evaluation process to ensure successful completion of proposed CTG objectives for each strategic direction. Responsibilities will include: monitoring all coalitions and/or community groups for status of programmatic activities and objectives; and monitoring the expenditure of resources by coalitions and/or community groups. In addition, will provides programmatic support to facilitate successful completion of proposed objectives, redirection of funding if resources are not being spent as expected and recommending appropriate educational seminars and technical assistant resources available.

Administrative Assistant A	Vacant	50%	12 months	$16,000

Justification - Provides administration, financial and clerical support to the grant including record keeping, meeting management, grants and contract administration, processing payments, data entry, and other logistical support. The data entry support is necessary to provide information for monitoring coalitions for the status of programmatic activities, completion of objectives and the expenditure of resources.

Personnel costs are estimated to increase 3% per year for Years 2-5
Year 2 = $111,240, Year 3 = $114,577, Year 4 = $118,015, Year 5 = $121,555

B. Fringe Benefits Year 1 **Total $37,800**

Fringe benefits are calculated at 35% of Personnel Costs.
Fringe benefit rate is expected to remain the same for Years 2-5
Year 2 = $38,934, Year 3 = $40,102, Year 4 = $41,305, Year 5 = $42,544

C. Consultant/Contractual Costs year 1 **Total $254,400**

Below is a summary of anticipated awards organized by Strategic Direction. The state is planning on awarding contracts in the following amounts; funds will be awarded to consultants to provide technical assistance and training to coalitions and/or community groups.

Summary of awards:

Strategic Direction	Technical Assistance and Training
Tobacco Free Living*	$25,000
Active Living and Healthy Eating*	$50,000
Clinical Preventive Services*	$52,500
Healthy and Safe Environment	$45,000
Other: Evaluation support	$81,900
Total	$254,400

*Required strategic directions.

Justification: The state is required to use a competitive Request for Proposal (RFP) process to award contracts. The purpose of the technical assistance and training is to provide support and information so coalitions and/or community groups are successful in achieving the proposed CTG objectives for each strategic direction. At this time detailed information cannot be provided concerning consultants to assist the state with providing technical assistance and training to community coalitions/or community groups. After the competitive process is complete the State will submit a revised budget for approval of selected consultants. When the revision is submitted, the State will provide the names of consultants, organizational affiliation, nature of services to be rendered, relevance of service to the project, and costs or fees for approval. The State uses performances based monitoring for all contracts. Payment is linked to performance. The Program Administrator is responsible for monitoring performance on all contracts.

No Changes for Year 2-5 = $254,400 each year

D. Equipment year 1 **Total $0**

Major equipment purchase are not expected for the duration of the project
Year 2-5 = $0

E. Supplies Year 1 **Total $9,000**

Supplies include 3 computers at $2,500 each	$7,500
Additional office supplies (educational materials) are estimated at	$1,500

Supplies will be reduced to $1,500 per year for Years 2-5

Justification: Three new computers will be needed for staff. In addition, the purchase of educational pamphlets and other educational materials are needed for technical assistance and educational seminars.

F. Travel Year 1 **Total $2,550**

In-State Travel

25 trips x 2 people x 100 r/t x. 51 = $2550
Total $2550

Justification: Travel to Leadership team meetings, coalition community group meetings by Program Administrator and Public Health Specialist are estimated at 50 trips. Each will make an estimated 25 trips per year.

Out-of State Travel Total $0

Justification: Travel costs for staff and Leadership Team to attend national conferences and trainings are not included as per CDC Technical Assistance calls. We anticipate that if costs are not directly paid for by the CDC that our award notification will be adjusted to accommodate additional travel costs.

Travel costs are expected to remain the same for Years 2-5
Year 2 = $2,550, Year 3 = $2,550, Year 4 = $2,550, Year 5 = $2,550,

G. Other Year 1 **Total $520,000**

Below is a summary of sub-recipient awards organized by Strategic Direction. The State is planning on awarding sub-recipient grants in the following amounts to multiple coalitions and/or community groups responsible for the four strategic directions listed below.

Strategic Direction	Community Coalitions/Community Groups
Tobacco Free Living*	$125,000
Active Living and Healthy Eating*	$250,000
Clinical Preventive Services*	$60,000
Healthy and Safe Environment	$85,000
Other: Evaluation support	
Total	$520,000

*Required strategic directions

A total of $435,000 will be awarded to community coalitions/community groups and $127,500 will be awarded to consultants for technical/training for the required strategic directions. This a total of $562,500 allocated to the three required strategic directions or 57% of the State's request.

Justification: In most cases the state will to use a competitive Request for Proposal (RFP) process for sub-recipient awards. The state is not required to use a competitive process but using the competitive process will ensure the states selects coalitions/community groups that are best positioned to achieve the CTG objectives. At this time detailed information cannot be provided concerning which coalitions/community groups will receive sub-recipient awards. After the competitive process is complete the State will submit a revised budget. When the revision is submitted, the State will provide the names and amounts of community coalitions/community groups' receiving awards. The State uses performances based monitoring for grants. Payment is linked to performance. The Public Health Specialist is responsible for monitoring performance on all grants to coalitions and/or community groups.

Other costs will be $520,000 per Year 2 through 5.

Total Direct Charges Year 1 **Total $931,750**

Direct Charges Year 2 = $928,624
Direct Charges Year 3 = $933,129
Direct Charges Year 4 = $937,770
Direct Charges Year 5 = $942,549

Indirect Charges Year 1 **Total $64,800**

Indirect Charges Year 2 = $66,744
Indirect Charges Year 3 = $68,746
Indirect Charges Year 4 = $70,809
Indirect Charges Year 5 = $72,933

The Vermont Department of Health uses a Cost Allocation Plan, not an indirect rate. The Vermont Department of Health is a department of the Vermont Agency of Human Services, a public assistance agency, which uses a Cost Allocation Plan in lieu of an indirect rate agreement as authorized by OMB Circular A-87, Attachment D. This Cost Allocation Plan was approved by the US Department of Health and Human Services effective October 1, 1987. A copy of the original approval and a copy of the most recent approval letter are attached. The Cost Allocation Plan summarizes actual, allowable costs incurred in the operation of the program. These costs include items which are often shown as direct costs, such as telephone and general office supply expenses, as well as items which are often included in an indirect rate, such as the cost of office space and administrative salaries. These costs are allocated to the program based on the salaries and wages paid in the program. Because these are actual costs, unlike an Indirect Cost Rate, these costs will vary from quarter to quarter and cannot be fixed as a rate. Based on costs allocated to similar programs during recent quarters, we would currently estimate these allocated costs at 60% of the direct salary line item.

Total Costs Year 1 **Total $996,550**

Total Costs Year 2 = $995,368
Total Costs Year 3 = $1,001,875
Total Costs Year 4 = $1,008,579
Total Costs Year 5 = $1,015,482

	Year 1	year 2	year 3	year 4	year 5
Salary	$108,000	$111,240	$114,577	$118,015	$121,555
Fringe	$37,800	$38,934	$40,102	$41,305	$42,544
Contractur	$254,400	$254,400	$254,400	$254,400	$254,400
Equipment	$0	$0	$0	$0	$0
Suppleis	$9,000	$1,500	$1,500	$1,500	$1,500
Travel	$2,550	$2,550	$2,550	$2,550	$2,550
other	$520,000	$520,000	$520,000	$520,000	$520,000
Total Direc	$931,750	$928,624	$933,129	$937,770	$942,549
Indirect	$64,800	$66,744	$68,746	$70,809	$72,933
total	$996,550	$995,368	$1,001,875	$1,008,579	$1,015,482

DEPARTMENT OF HEALTH & HUMAN SERVICES

Program Support Center
Financial Management Service
Division of Cost Allocation

26 Federal Plaza, Room 41-122
New York, New York 10278
Phone: (212) 264-2069
Fax: (212) 264-5478

March 15, 2011

Mr. Douglas Racine
Secretary
State of Vermont
Agency of Human Services
103 South Main Street
Waterbury, Vermont 05671-0204

Dear Mr. Racine:

This is to advise you of the approval of the revisions to the Vermont Agency of Human Service (AHS) Cost Allocation Plan, which were submitted under letter dated September 29, 2010 and later revised with letter dated January 11, 2011. The revisions are to reflect continuous changes within the Agency of Human Services due to a department wide reorganization. These revisions, which were submitted in accordance with 45 CFR 95, Subpart E, are effective July 1, 2010 except as noted below.

This approval shall remain in effect until such time as the basis and methods for allocating costs in the plan becomes outdated due to organizational changes, changes in Federal law or regulations, or there is a significant change in program composition that would affect the validity of approved cost allocation procedures.

The plan is approved and costs claimed in conformance with the plan are subject to the following conditions:

1. The approval is based on information provided by the State and is void if the information is later found to be materially incomplete or inaccurate.

2. The costs claimed for Federal financial participation must be allowable under the law, the cost principles contained in OMB Circular A-87 and program regulation.

3. The Department of Children and Families (DCF): Initial review found that incorrect information was provided under submission dated September 29, 2010 for DCF. State provided correct revisions under letter dated January 11, 2011 which is currently under review. We are deferring approval of this section until the review is completed.

4. Vermont Department of Health (VDH), RMTS Time Study Manual for School-Based Medicaid Administrative Service: The Centers for Medicare and Medicaid Services (CMS) has requested VDH to make changes to their RMTS Time Study Manual and resubmit to CMS for review.

We are deferring approval of the RMTS Time Study Manual for School-Based Medicaid Administrative Service, as requested by CMS, until review is conducted and approval is given.

5. Based on CMS letter to Vermont dated May 29, 2007,
   - All current and future PACAP revisions for each AHS Department should comply with Federal regulations regardless of the status of the Global Commitment to Health waiver. The Office of Vermont Health Access administrative expenses and allocation methodologies should comply with Federal regulations at 45 CFR 95.507 (a) and (b) and 42 CFR 433.15.
   - A general reference to the Global Commitment to Health waiver at the beginning of each AHS Department's allocation methodology should be indicated by an asterisk attached to each Plan Department number and allocation methodology that is affected by the waiver.

6. The approved plans are subject to ongoing revisions as the Vermont Agency of Human Services completes the transition to the new organizational and operational structure. These ongoing changes will be addressed in subsequent plan revisions that may impact on currently approved cost allocation methodologies.

Nothing contained herein should be construed as approving activities not otherwise authorized by approved program plans, or Federal legislation or regulations.

The implementation of the cost allocation plan approved by this document may from time to time be revised by authorized Federal staff. The disclosure of inequities during such reviews may necessitate changes to the plan.

Sincerely,

Robert I. Aaronson
Director, Division of
Cost Allocation

cc: Borseti, R., ACF
Johnson, W., CMS
Lubing, L., USDA/FNS

0540/71

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the
Regional Director

Region I
John F. Kennedy Federal Building
Government Center
Boston, MA 02203

March 2, 1989

Ms. Nancy Clermont
Agency Financial Management Specialist
State of Vermont
Agency of Human Services
103 South Main Street
Waterbury, Vermont 05676

Dear Ms. Clermont:

This is to inform you of the approval of the enclosed Administrative Cost Allocation Plan originally submitted on December 30, 1987 and revised May 9, 1988 and September 26, 1988. The approval is effective October 1, 1987 and will remain in effect until such time as the allocation methods contained therein are outdated or otherwise determined to be inappropriate. Responsibility for monitoring the continued accuracy of the plan rests solely with the State.

Approval of this plan is predicated upon conditions that (1) no costs, other than those incurred pursuant to the approved State Plan, are included in claims to HHS and that such costs are legal obligations, (2) the same costs treated as indirect costs have not been claimed as direct costs, and (3) similar types of costs have been accorded consistent treatment.

This approval also presumes the existence of an accounting system with internal controls adequate to protect the interests of both the State and Federal governments. Approval of the cost allocation plan does <u>not</u> constitute the approval of the estimated costs submitted with the plan. The approval relates only to the accounting treatment accorded the costs of your programs, and nothing herein should be construed to approve activities or costs not otherwise authorized by program plans, Federal legislation or regulations.

The operation of the plan may, from time to time, be reviewed by authorized Federal staff, including DCA, OPDIV, HHS Audit and General Accounting Office personnel. The disclosure of inequities during such reviews may necessitate changes to the plan and could result in the disallowance of improperly allocated costs.

Thank you for your cooperation in maintaining an accurate and current cost allocation plan.

Sincerely yours,

Walter M. Boland, Director
Division of Cost Allocation

Enclosure

cc:
Alfred Fuoroli, HCFA
Peter Shanley, USDA

VT Community Coalition Contact Information FY 12

Contact	Community Grantee	Fiscal Agent
Melanie Clark 802-345-9985 melanieclarkvt@gmail.com	Addison County Tobacco Control Roundtable PO Box 191 Vergennes, VT 05491	Community Health Services of Addison County 100 Porter Drive Middlebury, VT 05753 Julie Arel, 802-388-0137 Opendoorclinic1@gmail.com
Beth Shrader 802-257-2175 bapc@sover.net	Brattleboro Area Prevention Coalition (BAPC) PO Box 6008 Brattleboro VT 05301	Youth Services PO Box 6008 Brattleboro VT 05301 Gail Bourque 802-257-0361 Gail.bourque@youthservicesinc.org
Helena Van Voorst 802-735-8324 Helena@burlingtonpartnership.org	Burlington Partnership for a Healthy Community PO Box 1353 Burlington VT 05402	NFI VT 30 Airport Road South Burlington VT 05403 Barby Moore 802-658-0040 barbymoore@nafi.com
Kim Martin 802-223-4949 cvndc@sover.net	Central Vermont New Directions Coalition 73 Main Street#33 Montpelier, VT 05602	Washington Central Friends of Education PO Box 324 Montpelier, VT 05602 Deb Wolf 802-223-3456 dwolfvt@aol.com
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Cindy Hayford 802-464-1698 chayford@myfairpoint.net	Deerfield Valley Comm. Ptnshp PO Box 1688 Wilmington VT 05363	Windham Southwest SU 211 Route 9 West Wilmington VT 05363 Ronda Lackey 802-464-1300 rlackey@whitinghm.k12.vt.us
Ray Coffey 802-878-6982 ray@essexchips.org	Essex CHIPS Inc 2 Lincoln Street Essex Junction, VT 05452	Same
Beth Crane 802-527-5049 beth@fcccp.org	Franklin Cty Caring Communities 67 Fairfield St. 3rd Floor St. Albans, VT 05478	Same

Amy Brewer 802-524-1291 abrewer@nmcinc.org	Franklin Grand Isle Tobacco Prevention Coalition 133 Fairfield Street St. Albans, VT 05478	Northwestern Medical Center 133 Fairfield Street St. Albans, VT 05478 Ted Sirotta 802-524-1088 tsirotta@nmcinc.org
Susan Delattre 802-728-2625 sdellatre@giffordmed.org	Gifford-Ottauquechee-Quintown Combined Tobacco Coalitions 44 South Main Street Randolph, VT 05060	Ottauquechee Community Partnership 32 Pleasant Street Woodstock, VT 05091 Jacqueline Fischer 802-457-2679 jfischer@ocpvt.org
Chad Simmons 802-463-9927 gfpcmedia@gmail.com	Greater Falls Prevention Coalition 44 School Street Bellows Falls, VT 05101	Springfield Area Parent Child Center, 2 Main Street Springfield VT 05150 Betty Kinsman 802-886-5242 bettyk@vermontel.net
Cathy Hazlett 802-457-4780 cathy@myhealthconnections.org	Health Connections of the Upper Valley, Inc PO Box 4 North Pomfret, VT 05053	Same
Joanne Fedele 802-334-3281 jfedele@nchsi.org	HealthWorks ONE Coalition 189 Prouty Drive Newport, VT 05855	North Country Hospital 189 Prouty Drive Newport, Vt 05855 Joanne Fedele, 802-334-3208 jfedele@nchsi.org
Cat Arcangeli 802-334-2839 Cat.arcangeli@neklsvt.org	Health Works ONE Coalition 1 Main Street Newport, VT 05855	Northeast Kingdom Learning Services, 1 Main Street Newport, VT 05855 Michelle Tarryk 802-334-6532 Michelle.tarryk@neklsvt.org
Carol Plante 802-644-1960 carol@ten-towns.com Linda Shaw 802-888-8369 lshaw@chsi.org	Lamoille Prevention Campaign PO Box 51, Cambridge VT 05444 Fit and Healthy Council 528 Washington Highway Morrisville, VT 05661	Copley Health Services, Inc 528 Washington Highway Morrisville, VT 05661 Linda Shaw 802-888-8369 lshaw@chsi.org
Patricia Marshall 802-279-1631 plmarshall@comcast.net	Lamoille Valley Tobacco Task Force PO Box 334 Hyde Park, VT 05655	Community Health Services of Lamoille Valley 530 Washington Highway Morrisville, VT 05661 George Brisson 802-851-8602 gbrisson@chslv.org
Kim Dellinger 802-893-1009 kdellinger@miltonyouth.org	Milton Community Youth Coalition, 165 Route 7, #01 PO Box 543 Milton, VT 05468	Same
Rose Sheehan 802-748-7532 r.sheehan@nvrh.org	Northeastern Vermont Regional Hospital 1315 Hospital Drive St. Johnsbury, VT 05819	Northeastern Vermont Regional Hospital 1315 Hospital Drive St. Johnsbury, VT 05819

		Ella Kelsey 802-748-7508 e.kelsey@nvrh.org
Jackie Fischer 802-457-2679 jfischer@ocpvt.org	Ottauquechee Community Partnership 32 Pleasant Street Woodstock, VT 05091	Same but Elaine Geyer is contact 802-457-2679 Elaine.geyer@gmail.com
Emily Knapp 802-775-4199 eknapp@rmhsccn.org	Rutland Area Prevention Coalition 78 South Main Street Rutland, VT 05701	Rutland Community Programs, Inc. PO Box 222 Rutland, VT 05702 Tom Pour 802-775-4340 tpour@rmhsccn.org
Corey Cenate 802-885-7867 stop@vermontel.net	Springfield Tobacco Options and Prevention 56 Main Street, Suite 208 Springfield, VT 05156	Springfield Prevention Coalition, Inc. 56 Main Street, Suite 208 Springfield, VT 05156 Peter Hayward 802-885-8706 peterh@springfieldprevention.org
Maryann Morris 802-824-4200 maryann@thecollaborative.us	The Collaborative PO Box 32 South Londonderry VT 05155	Mt. Communities Supporting Education dba The Collaborative Same address Jackie Borella 802-824-4200 Jackie@thecollaborative.us
Kiah Morris 802-447-6478 kmorris@bcrj.org	Tobacco-Free Community Partners 100 S. Dewey Street Bennington, VT 05201	Southwestern Vermont Health Care 100 S. Dewey Street Bennington, VT 05201 Kevin Robinson, 802-447-5003 robk@phin.org
Tinalyn Caisse 802-745-1040 spifyinstj@yahoo.com	Together Works! The Carriage House, 107 Eastern Ave. Box 16 (until 8/30), St. J VT 05819	Northeast Kingdom Learning Services, 1 Main Street Newport, VT 05855 Michelle Tarryk 802-334-6532 Michelle.tarryk@neklsvt.org
Melanie Sheehan 802-674-7450 Melanie.Sheehan@mahhc.org	Windsor Area Community Partnership/Mount Ascutney Prevention Partnership 289 County Road Windsor, VT 05089	Mt. Ascutney Hospital & Health Center, 289 County Road Windsor VT 05089 Jill Lord 802-674-7224 Jill.Lord@mahhc.org

Appendix D: Community Transformation Plan Template

Community Transformation Plan – Community Transformation Grant TEMPLATE Date: Year 1					
Site Name	Vermont Department of Health				
Outcome Objective	By Sept 1, 2012, a minimum of 3 towns, cities, housing associations or landlord holdings in the state will adopt a voluntary smoke-free multi-unit housing (MUH) policy that restricts smoking in individual units, including balconies, patios and common areas.				
Population Focus (Check One)	X General/Jurisdiction Wide	Health disparity by – age, urban or rural location, gender, race/ethnicity, education, income, sexual orientation, disability, or other. (specify):			
Strategic Direction	Increase smoke-free multi-unit housing				
Reportable Milestone Activities		Timeline (Initiation-Completion)	Identify the Activity(ies) related to the Health Disparity	Measure	Lead Staff and Key Partners
Update and circulate a recruitment plan among all coalitions to broaden a smoke-free outdoor air community effort among multiple coalitions, partners and housing/tenant associations.		Q1-Q2	Include low income, resettlement groups	Recruitment Plan	Coalition specialist, public health specialist, housing contractor
Create and implement an outreach plan for each coalition to include and educate low income (and immigrant and minorities if applicable) with target of bringing on 3 new coalition members per grantee		Q2 – Q3	Low income in all grantee areas	Outreach plans	Coalition specialist, public health specialist, housing contractor
Recruit 2 or more partners in each funded coalition through one-on-one meetings or phone calls		Q2-Q4	Proportionate representation of low income	Meeting records	Coalition specialist, public health specialist, housing contractor
Facilitate 3 meetings held by each community coalition and ensure representation by low income, native and/or minority populations.		Q1-Q4	Include proportionate representation in communities experiencing HD	Coalition meeting records	Coalition specialist, public health specialist, housing contractor
Provide educational programs at 2 statewide or local public hearings including tenant and housing associations to provide education and information on the smoke-free MUH policy.		Q3-4	Hold in areas that have high need and demand	Meeting records; copies of policies	Program Manager, housing contractor

Community Transformation Plan – Community Transformation Grant
TEMPLATE
Date: _____Year 1_____

Site Name	Vermont Department of Health	
Outcome Objective	By Sept 1, 2012, a minimum of 3 towns or cities will adopt a smoke-free park ordinance.	
Population Focus (Check One)	X☐ General/Jurisdiction Wide	Health disparity by – age, urban or rural location, gender, race/ethnicity, education, income, sexual orientation, disability, or other. (specify):
Strategic Direction	Increase smoke-free parks	

Reportable Milestone Activities	Timeline (Initiation-Completion)	Identify the Activity(ies) related to the Health Disparity	Measure	Lead Staff and Key Partners
Perform statewide assessment of park location, density and smoke-free status	Q1-Q2	Focus on high density, low income	Park Assessment	CTG Manager, VT Recreational Parks Assoc
Create an action plan with and for each coalition grantee	Q1-Q2	Focus on high density, low income	Action Plans	Coalition Specialist
Provide 6 technical assistance calls or webinars on smoke free park best practice and shared successes and challenges	Q2-Q4	Capacity building among all partners	Calls and Webinar Notes	Program Specialist
Provide educational programs at 4 statewide, regional or local public meetings to engage stakeholders on progress to date of smoke free park effort	Q2-Q4	Focus on high density, low income	Educational Program Notes	Program Specialist
Organize 8 community mobilization events (e.g. a rally) to raise public awareness and gain support for smoke-free parks	Q1-Q4	Focus on high density, low income	Community Mobilization Events	Program Specialist, Coalitions
Create and place 4 youth "fellows policy program" positions to assist with smoke free parks	Q2-Q4	Low income youth	Youth Fellows	CTG Director, Program Specialist, Coalitions
Create leadership network involving education, facilities management, medical and coalition membership to learn and share best practice and create momentum	Q2-Q4	Health and community leadership	Leadership Network (1 member from each coalition)	Program Specialist, Coalitions
VDH engage the statewide media on at least 1 occasion and each coalition the local media on at least 1 occasion to raise awareness and support	Q2-Q4	Focus on high density, low income	Media coverage	Program Manager, Media Specialist

Appendix D: Community Transformation Plan Template

Community Transformation Plan – Community Transformation Grant TEMPLATE Date: _____Year 1_____					
Site Name	Vermont Department of Health				
Outcome Objective	Increase by 5% number of fax referrals received by the VT Quit Network from medical providers				
Population Focus (Check One)	☐ General/Jurisdiction Wide	Health disparity by – age, urban or rural location, gender, race/ethnicity, education, income, sexual orientation, disability, or other. (specify):			
Strategic Direction	Increase number of smokers referred from medical settings to Vermont Quit Network (Clinical Preventive Services)				
Reportable Milestone Activities		Timeline (Initiation-Completion)	Identify the Activity(ies) related to the Health Disparity	Measure	Lead Staff and Key Partners
Engage VT Medicaid to provide reimbursement of in-office tobacco cessation counseling		Q1-Q4	Low income	Meetings and phone calls	CTG Director, Tobacco Director, Cessation Manager
Hold Training with all Blueprint Practice Facilitators on electronic health record tobacco referral systems		Q3-4	Low income	Trainings	Tobacco Director, Cessation Manager
Hold meetings every 3 weeks through August 2012 with Blueprint and FAHC on integration of Quit in Person to Blueprint		Q1-Q4	Complex patients	Meetings Held	Tobacco Director, Cessation Manager
Perform 3 media/health information interventions aimed to raise awareness of Medicaid cessation services among patients and providers		Q2-Q4	Low income	Media outcomes	Media specialist, Cessation Manager

Appendix E: Community Transformation Plan Example-May 5

Community Transformation Plan – Community Transformation Grant **Date: _____Year 1_____**				
Site Name	Communities which are selected to implement community water fluoridation.			
Outcome Objective	By Sep 1, 2012, 2 communities selected will have implemented policy change to ensure that the local water system supplies optimally fluoridated water.			
Population Focus (Check One)	☐X General/Jurisdiction Wide	X Health disparity by – age, urban or rural location, gender, race/ethnicity, education, income, sexual orientation, disability or other. (specify): Low SES, rural, minority.		
Strategic Direction	Healthy and Safe Physical Environment			
Reportable Milestone Activities	Timeline (Initiation-Completion)	Identify the Activity(ies) related to the Health Disparity	Measure	Lead Staff and Key Partners
Selection of community coalitions for fluoridation activities based on fluoridation status, ability to address disparities.	Q1-Q2	Include representation of populations experiencing HD in coalition efforts to introduce fluoridation.	Coalition selection.	Outreach Manager; Oral Health Director, Fluoridation Program Coordinator, Community Coalitions.
Develop a coalition taskforce to spearhead coalition activities related to fluoridation. Educate taskforce members on community water fluoridation.	Q1-Q2	Include representation of populations experiencing HD in coalition efforts to introduce fluoridation.	Meeting records	Outreach Manager; Oral Health Director, Fluoridation Program Coordinator, Community Coalitions.
Coalition members conduct # presentations to gain support for the policy campaign and to recruit additional coalition members, ensuring proportionate number of presentations in areas with populations experiencing health disparities.	Q1-Q3	Include representation of populations experiencing HD in coalition efforts to introduce fluoridation.	Presentation materials; meeting notes	Outreach Manager; Oral Health Director, Fluoridation Program Coordinator, Community Coalitions.
Attend # community events (e.g., health fairs) to educate the community about the benefits of community water fluoridation, ensuring proportionate number of events in areas with populations experiencing health disparities.	Q1-Q3	Include representation of populations experiencing HD in coalition efforts to introduce fluoridation.	List of events and dates	Outreach Manager; Oral Health Director, Fluoridation Program Coordinator, Community Coalitions.
Facilitate # community coalition meetings, ensuring proportionate number	Q1-Q3	Include representation	Coalition meeting	Outreach Manager; Oral

of meetings in areas with populations experiencing health disparities.		of populations experiencing HD in coalition efforts to introduce fluoridation.	records	Health Director, Fluoridation Program Coordinator, Community Coalitions.
Provide educational programs at # public hearings of tenant associations to provide education and information on community water fluoridation.	Q4	Include representation of populations experiencing HD in coalition efforts to introduce fluoridation.	Meeting records; copies of policies	Outreach Manager; Oral Health Director, Fluoridation Program Coordinator, Community Coalitions.
Engage local media, on at least # occasions to communicate the campaign's message (e.g., press events, ads/articles in local papers and online news outlets, letters to the editor).	Q2	Include representation of populations experiencing HD in coalition efforts to introduce fluoridation.	Media documentation	Outreach Manager; Oral Health Director, Fluoridation Program Coordinator, Community Coalitions.
Organize # community mobilization events (e.g., a rally), with # in communities experiencing health disparities, to raise public awareness and gain support for community water fluoridation. Engage Policy makers as a part of mobilization efforts.	Q3	Include representation of populations experiencing HD in coalition efforts to introduce fluoridation.	Event documentation	Outreach Manager; Oral Health Director, Fluoridation Program Coordinator, Community Coalitions.
Monitor implementation and enforcement of new policy, ensuring evaluation of implementation and enforcement measures in sub-populations experiencing health disparities.	Ongoing	Comprehensive evaluation		Outreach Manager; Oral Health Director, Fluoridation Program Coordinator, Community Coalitions.

Community Transformation Plan – Community Transformation Grant

Date: _____Year 1_____

Site Name	Vermont Communities, Schools and Early Child Care Centers	
Outcome Objective	By July 2012, a minimum of 6 schools and 6 early childcare centers will implement Farm to institution Programs.	
Population Focus (Check One)	☑ General/Jurisdiction Wide	Health disparity by – age, urban or rural location, gender, race/ethnicity, education, income, sexual orientation, disability, or other. (specify): Low SES
Strategic Direction	Farm to School	

Reportable Milestone Activities	Timeline (Initiation-Completion)	Identify the Activity(ies) related to the Health Disparity	Measure	Lead Staff and Key Partners
Community coalitions recruit a minimum of 6 schools to participate in Farm to School within targeted communities.	Q1	Schools recruited are at least 40% free and reduced	Schools recruited	Prevention Specialist Agency of Agriculture, VT Food Education Everyday (FEED)
Community coalitions recruit a minimum of 6 early childcare centers to participate in Farm to Childcare Activities	Q1	Early Childcare Centers recruited from high need rural communities	Centers recruited	Prevention Specialist Agency of Agriculture, VT Food Education Everyday (FEED)
Conduct a farm to school needs assessment in the schools and childcare centers. The needs assessment will identify the strength of the school wellness team, current farm to school activities and areas for growth.	Q1 Q2	Participating schools are at least 40% free and reduced Childcare Centers recruited from rural communities	Needs assessment findings	Prevention Specialist Agency of Agriculture, VT Food Education Everyday (FEED)
Conduct two regional Workshops for educators, food service directors and public health regional staff with tracks for early childcare and schools.	Q2	Participating schools are at least 40% free and reduced	Workshop evaluations	Prevention Specialist Agency of Agriculture, VT Food Education Everyday (FEED) Educators and Food Service Directors Local Health

				School Liaisons
Conduct an annual summer institute training workshop for new school health teams.	Q4	Participating schools are at least 40% free and reduced	Summer Institute evaluations	Prevention Specialist Agency of Agriculture, VT Food Education Everyday (FEED) School Health Teams Local Health School Liaisons
Provide one technical assistance site visit to each new school.	Q4	Participating schools are at least 40% free and reduced	Site visit records	Prevention Specialist Agency of Agriculture, VT Food Education Everyday (FEED)
Conduct Farm to School and Farm to Child Care Evaluation	Ongoing		Evaluation Reports	Prevention Specialist Agency of Agriculture, VT Food Education Everyday (FEED) Program Evaluator

Appendix D: Community Transformation Plan Template

Community Transformation Plan – Community Transformation Grant **Date: _____Year 1_____**		
Site Name	Vermont Communities	
Outcome Objective	By July 2012, a minimum of 6 early childcare centers will have wellness policies in place and implement best practices based on their policies.	
Population Focus (Check One)	☑ General/Jurisdiction Wide	Health disparity by – age, urban or rural location, gender, race/ethnicity, education, income, sexual orientation, disability, or other. (specify): Rural low income
Strategic Direction	Increase physical activity and healthy eating in early childcare settings.	

Reportable Milestone Activities	Timeline (Initiation-Completion)	Identify the Activity(ies) related to the Health Disparity	Measure	Lead Staff and Key Partners
Community coalitions recruit a minimum of 6 early childcare centers to conduct a policy assessment using the evidence based Nutrition and Physical Activity Self-Assessment for Child Care NAP SACC.	Q1	Centers selected from low-income rural communities	Number of centers selected	Public Health Specialist Department of Children and Families Early Child Care Nutrition and Physical Activity Work Group.
Conduct a web based training for early childcare centers on how to use the NAP SACC tool to assess their environment.	Q3	Centers selected from low-income rural communities	Web based training implemented	Public Health Specialist Department of Children and Families Early Child Care Nutrition and Physical Activity Work Group.
Provide ongoing technical assistance and support to centers for development of policies based on their NAP SACC assessments	Q4-8	Centers selected from low-income rural communities	Training notes	Public Health Specialist Department of Children and Families Early Child Care Nutrition and Physical Activity Work Group.

Evaluate policies implemented in the 6 centers.	Ongoing	Centers selected from low-income rural communities	Policies implemented and evaluation findings.	Public Health Specialist Department of Children and Families Early Child Care Nutrition and Physical Activity Work Group.

Appendix D: Community Transformation Plan Template

Community Transformation Plan – Community Transformation Grant **Date: _____Year 1_____**		
Site Name	Vermont Communities	
Outcome Objective	By July 2012 a minimum of 3 rural, low income (high need) areas of the state will implement evidence based Healthy Community Design strategies to increase access to physical activity and/or healthy eating.	
Population Focus (Check One)	☑ General/Jurisdiction Wide	Health disparity by – age, urban or rural location, gender, race/ethnicity, education, income, sexual orientation, disability, or other. (specify): Rural
Strategic Direction	Healthy Community Design (access to Healthy Eating and Physical Activity)	

Reportable Milestone Activities	Timeline (Initiation-Completion)	Identify the Activity(ies) related to the Health Disparity	Measure	Lead Staff and Key Partners
Recruit three high need communities to participate in Healthy Community Design project.	Q1	Rural, low SES communities identified	Communities recruited	Building Healthy Communities Advisory Committee
Assure curriculum for statewide training, based on Vermont's Healthy Community Design Resource (under development as of July 2011), includes challenges and solutions for high need rural areas.	Q1	Curriculum addresses unique needs of low income, rural communities	High needs, rural areas topic added to training curriculum	Building Healthy Communities Consultant, Building Healthy Communities Advisory Committee
A team consisting of health advocates and town leaders from each of the high need areas attends Healthy Community Design training.	Q2	Teams from high need communities are trained on how these changes positively impact the health of higher need residents	Teams attend training; training evaluations	Building Healthy Communities Consultant, Prevention Specialist
Provide funding to community collations to select high need community teams for funding to build capacity, complete a community assessment, and create an implementation plan to move forward at least one evidence based, healthy community design strategy.	Q2	High need, low resource communities receive funding to support their efforts	Grants to communities	Prevention Specialist
Provide technical assistance and support to each team to help them build capacity and keeps the public informed about the project.	Q2 and 3	High need communities that may have little experience	Reports from grantees on partnerships created,	Building Healthy Communities Consultant, Prevention

Appendix D: Community Transformation Plan Template

		in this area get on-going expert support and TA	meetings held, attendance by 'role" of attendee	Specialist
Provide technical assistance and support to each team for them to complete at least 2 assessments of the community (provided in the Vermont Healthy Community Design Resource), to gather information about resources and gaps related to town supported access to physical activity and/or healthy eating.	Q3	High need communities that may have little experience in this area get on-going support and TA	Assessment results	Building Healthy Communities Consultant, State Health Department Prevention Specialist
Provide technical assistance and support to each team for holding planning session(s) that involve community partners to review results of assessments.	Q3 and 4	High need communities that may have little experience in this area get on-going support and TA	Planning meeting minutes and results	Building Healthy Communities Consultant, Prevention Specialist
Provides technical assistance and support to each team on developing an implementation (using evidence base strategies identified in Vermont's Healthy Community Design Resource), plan to address at least one of the identified areas of improvement.	Q4	High need communities that may have little experience in this area get on-going support and TA	Implementation Plan	Building Healthy Communities Consultant, Prevention Specialist
Fund new low income communities	Annually	High need, low resource communities receive funding to support their efforts.		Prevention Consultant

Appendix D: Community Transformation Plan Template

Community Transformation Plan – Community Transformation Grant **Date: _____Year 1_____**					
Site Name	Vermont Statewide				
Outcome Objective	By September 2012 increase participation of people with low socioeconomic status in the statewide healthier living workshops HLW (evidence based chronic disease self management programs).				
Population Focus (Check One)	☑ General/Jurisdiction Wide	Health disparity by – age, urban or rural location, gender, race/ethnicity, education, income, sexual orientation, disability, or other. (specify): Low socioeconomic status			
Strategic Direction	Increase self efficacy of low SES Vermonters living with chronic conditions.				
Reportable Milestone Activities		Timeline (Initiation-Completion)	Identify the Activity(ies) related to the Health Disparity	Measure	Lead Staff and Key Partners
Remove barriers to participation in the Healthier Living Workshops including transportation services, dependant care and provide incentives to attendance including healthy meals.		Q1-Q2	Target low SES Vermonters	Increased utilization of services	Public Health Specialist, Office of Vermont Health Access,
Gather and disseminate current successful marketing strategies from the 13 health service areas offering the HLW.		Q4	Target low SES Vermonters	Strategies gathered	Public Health Specialist, Office of Vermont Health Access, Blueprint for Health, Diabetes Prevention and Control Program.
Utilize and disseminate marketing tools developed to increase cardiovascular disease screening among low income women.		Q4	Target low SES Vermonters	Materials created and disseminated	Public Health Specialist, Office of Vermont Health Access, Blueprint for Health, Diabetes Prevention and Control Program.
Utilize existing community groups of self management stakeholders to promote participation in HLWs through the dissemination of marketing materials.		Q3	Target low SES Vermonters	Materials disseminated, groups contacted	Public Health Specialist, Office of Vermont Health Access, Blueprint for Health, Diabetes Prevention and Control Program. Community stakeholders
Utilize existing relationships with national		Q2	Target low	Information	Public Health

organizations involved in chronic disease self management to share information and successes.		SES Vermonters	shared	Specialist, Office of Vermont Health Access, Blueprint for Health, Diabetes Prevention and Control Program.

Appendix D: Community Transformation Plan Template

Community Transformation Plan – Community Transformation Grant **Date: _____Year 1_____**		
Site Name	Vermont Communities	
Outcome Objective	By July 2012 increase availability of fresh fruits and vegetables in a minimum of 6 retail stores.	
Population Focus (Check One)	☑ General/Jurisdiction Wide	Health disparity by – age, urban or rural location, gender, race/ethnicity, education, income, sexual orientation, disability, or other. (specify): Rural low income Vermonters
Strategic Direction	Increase accessibility of healthful foods in small stores.	

Reportable Milestone Activities	Timeline (Initiation-Completion)	Identify the Activity(ies) related to the Health Disparity	Measure	Lead Staff and Key Partners
Recruit a minimum of 6 independently owned and operated stores in rural areas to increase access to fresh fruits and vegetables.	Q1	Stores selected from areas of high need designated as food deserts.	Number of stores recruited	Public Health Specialist, Community Coalitions, Store Owners, Vermont Grocers Association
VDH will provide annual funding to community coalitions for implementation of the retail stores project in a minimum of 6 stores.	Q2	Communities selected from rural high need areas	Number of communities funded	Public Health Specialist, Community Coalitions, Local Health Office Prevention Specialists
Provide technical assistance via quarterly conference calls to community coalitions on increasing access to fresh fruits and vegetables.	Q3, and quarterly	Communities selected from rural high need areas	Call agendas and Attendance lists	Public Health Specialist, Community Coalitions, Store Owners
Provide funding to community coalitions to provide equipment grants to stores for displays and refrigeration units to carry fresh fruits and vegetables.	Q2	Stores selected from rural high need areas.	Displays and refrigeration units purchased.	Public Health Specialist, Community Coalitions, Store Owners.
Gather success stories and lesson learned from community coalitions and store owners.	Quarterly	Stories gathered from rural high need areas.	Stories compiled and lessons shared	Public Health Specialist, Community Coalitions, Store Owners

Appendix D: Community Transformation Plan Template

Community Transformation Plan – Community Transformation Grant **Date: _____Year 1_____**					
Site Name	Vermont				
Outcome Objective	Train 100 providers in evidence based screenings such as CRAFFT, Gain SS, MAYSI-2 by July 2012.				
Population Focus (Check One)	x General/Jurisdiction Wide	Health disparity by – age, urban or rural location, gender, race/ethnicity, education, income, sexual orientation, disability, or other. (specify): Low SES			
Strategic Direction	Provide training and technical assistance to health care institutions, providers and provider organizations to effectively implement systems to improve delivery of clinical preventive services				
Reportable Milestone Activities		Timeline (Initiation-Completion)	Identify the Activity(ies) related to the Health Disparity	Measure	Lead Staff and Key Partners
Identify four community coalitions with which to partner and provide regional trainings		Q1	Prioritize communities with high HD	Number of communities selected and HD data	CTG Director, Alcohol and Substance Abuse Director
Contract with a statewide training and technical assistance consultant/organization to provide training.		Q2	RFP for services requires trainers with competency in services for Low SES and minorities	Training contract includes specific deliverables related to substance abuse screening and cultural competency	CTG Director, Alcohol and Substance Abuse Director
Initiate training in four separate communities with key providers attending such as Student Assistance Program Counselors.		Q3	Recruit attendees which serve populations with HD.	Number of attendees and organizational affiliation	CTG Director, Alcohol, Substance Abuse Director and training contractor

Appendix D: Community Transformation Plan Template

Community Transformation Plan – Community Transformation Grant TEMPLATE Date: Year 2					
Site Name	Vermont Department of Health				
Outcome Objective	By Sept 1, 2013, a minimum of 5 additional towns, cities, housing associations or landlord holdings in the state will adopt a voluntary smoke-free multi-unit housing (MUH) policy that restricts smoking in individual units, including balconies, patios and common areas.				
Population Focus (Check One)	X General/Jurisdiction Wide	Health disparity by – age, urban or rural location, gender, race/ethnicity, education, income, sexual orientation, disability, or other. (specify):			
Strategic Direction	Increase smoke-free multi-unit housing				
Reportable Milestone Activities		Timeline (Initiation-Completion)	Identify the Activity(ies) related to the Health Disparity	Measure	Lead Staff and Key Partners
Update an outreach plan for each coalition to include and educate low income (and immigrant and minorities if applicable) with target of bringing on 3 new coalition members per grantee		Q5	Low income in all grantee areas	Outreach plans	Coalition specialist, public health specialist, housing contractor
Recruit 1 or more partners in each funded coalition through one-on-one meetings or phone calls		Q5-Q8	Representation of tenant association leadership	Meeting records	Coalition specialist, public health specialist, housing contractor
Facilitate 4 meetings held by each community coalition and ensure representation by low income, native and/or minority populations.		Q5-Q8	Include proportionate representation in communities experiencing HD	Coalition meeting records	Coalition specialist, public health specialist, housing contractor
Provide educational programs at 2 statewide or local public hearings including tenant and housing associations to provide education and information on the smoke-free MUH policy.		Q5-Q8	Hold in areas that have high need and demand	Meeting records; copies of policies	Program Manager, housing contractor
VDH engage the statewide media on at least 2 occasions and each coalition the local media on at least 1 occasion to communicate the campaign's message (e.g., press events, ads/articles in local papers and online news outlets, letters to the editor).		Q5-Q7	Inclusion of ethnic media outlets to ensure widespread dissemination of message.	Media documentation	Program Manager; Media Specialist;
Organize 2 community mobilization events (e.g., a rally) in communities experiencing health disparities, to raise		Q5-Q8	Include proportionate representation	Event documentation	Outreach Manager; Outreach

public awareness and gain support for the smoke-free outdoor air policy.		of communities experiencing HD		Specialists; Media Specialist;
Educate the public on 3 separate occasions about newly adopted policy (e.g., sponsor a community forum; place an ad in a local newspaper), including the availability of cessation services/resources, with targeted efforts in communities experiencing health disparities.	Q5-Q8	Assist coalition grantees to hold or co-host forums in targeted areas	Supporting documents; copies of relevant media	Outreach Manager; Outreach Specialists; Media Specialist; CBO 1; CBO 2
Monitor implementation and enforcement of new policy, ensuring evaluation of implementation and enforcement measures in sub-populations experiencing health disparities.	Q5-Q8	Comprehensive evaluation	Evaluation plan and outcomes	Evaluation Manager, Outreach manager, specialists

Appendix D: Community Transformation Plan Template

Community Transformation Plan – Community Transformation Grant TEMPLATE Date: _____Year 1_____		
Site Name	Vermont Department of Health	
Outcome Objective	By Sept 1, 2012, a minimum of 3 towns or cities will adopt a smoke-free park ordinance.	
Population Focus (Check One)	X☐ General/Jurisdiction Wide	Health disparity by – age, urban or rural location, gender, race/ethnicity, education, income, sexual orientation, disability, or other. (specify):
Strategic Direction	Increase smoke-free parks	

Reportable Milestone Activities	Timeline (Initiation-Completion)	Identify the Activity(ies) related to the Health Disparity	Measure	Lead Staff and Key Partners
Perform statewide assessment of park location, density and smoke-free status	Q1-Q2	Focus on high density, low income	Park Assessment	CTG Manager, VT Recreational Parks Assoc
Create an action plan with and for each coalition grantee	Q1-Q2	Focus on high density, low income	Action Plans	Coalition Specialist
Provide 6 technical assistance calls or webinars on smoke free park best practice and shared successes and challenges	Q2-Q4	Capacity building among all partners	Calls and Webinar Notes	Program Specialist
Provide educational programs at 4 statewide, regional or local public meetings to engage stakeholders on progress to date of smoke free park effort	Q2-Q4	Focus on high density, low income	Educational Program Notes	Program Specialist
Organize 8 community mobilization events (e.g. a rally) to raise public awareness and gain support for smoke-free parks	Q1-Q4	Focus on high density, low income	Community Mobilization Events	Program Specialist, Coalitions
Create and place 4 youth "fellows policy program" positions to assist with smoke free parks	Q2-Q4	Low income youth	Youth Fellows	CTG Director, Program Specialist, Coalitions
Create leadership network involving education, facilities management, medical and coalition membership to learn and share best practice and create momentum	Q2-Q4	Health and community leadership	Leadership Network (1 member from each coalition)	Program Specialist, Coalitions
VDH engage the statewide media on at least 1 occasion and each coalition the local media on at least 1 occasion to raise awareness and support	Q2-Q4	Focus on high density, low income		Program Manager, Media Specialist

Appendix D: Community Transformation Plan Template

Community Transformation Plan – Community Transformation Grant TEMPLATE Date: _____Year 1_____					
Site Name	Vermont Department of Health				
Outcome Objective	Increase by 5% number of fax referrals received by the VT Quit Network from medical providers				
Population Focus (Check One)	☐ General/Jurisdiction Wide	Health disparity by – age, urban or rural location, gender, race/ethnicity, education, income, sexual orientation, disability, or other. (specify):			
Strategic Direction	Increase number of smokers referred from medical settings to Vermont Quit Network (Clinical Preventive Services)				
Reportable Milestone Activities		Timeline (Initiation-Completion)	Identify the Activity(ies) related to the Health Disparity	Measure	Lead Staff and Key Partners
Engage VT Medicaid to provide reimbursement of in-office tobacco cessation counseling		Q1-Q4	Low income	Meetings and phone calls	CTG Director, Tobacco Director, Cessation Manager
Hold Training with all Blueprint Practice Facilitators on electronic health record tobacco referral systems		Q3-4	Low income	Trainings	Tobacco Director, Cessation Manager
Hold meetings every 3 weeks through August 2012 with Blueprint and FAHC on integration of Quit in Person to Blueprint		Q1-Q4	Complex patients	Meetings Held	Tobacco Director, Cessation Manager
Perform 3 media/health information interventions aimed to raise awareness of Medicaid cessation services among patients and providers		Q2-Q4	Low income	Media outcomes	Media specialist, Cessation Manager

Appendix E: Community Transformation Plan Example-May 5

Community Transformation Plan – Community Transformation Grant **Date: _____Year 2_____**		
Site Name	Communities which are selected to implement community water fluoridation.	
Outcome Objective	By Sep 1, 2012, 2 communities selected will have implemented policy change to ensure that the local water system supplies optimally fluoridated water.	
Population Focus (Check One)	☐X General/Jurisdiction Wide	X Health disparity by – age, urban or rural location, gender, race/ethnicity, education, income, sexual orientation, disability or other. (specify): Low SES, rural, minority.
Strategic Direction	Healthy and Safe Physical Environment	

Reportable Milestone Activities	Timeline (Initiation-Completion)	Identify the Activity(ies) related to the Health Disparity	Measure	Lead Staff and Key Partners
Selection of community coalitions for fluoridation activities based on fluoridation status, ability to address disparities.	Q5-Q6	Include representation of populations experiencing HD in coalition efforts to introduce fluoridation.	Coalition selection.	Outreach Manager; Oral Health Director, Fluoridation Program Coordinator, Community Coalitions.
Develop a coalition taskforce to spearhead coalition activities related to fluoridation. Educate taskforce members on community water fluoridation.	Q5-Q6	Include representation of populations experiencing HD in coalition efforts to introduce fluoridation.	Meeting records	Outreach Manager; Oral Health Director, Fluoridation Program Coordinator, Community Coalitions.
Coalition members conduct # presentations to gain support for the policy campaign and to recruit additional coalition members, ensuring proportionate number of presentations in areas with populations experiencing health disparities.	Q5-Q7	Include representation of populations experiencing HD in coalition efforts to introduce fluoridation.	Presentation materials; meeting notes	Outreach Manager; Oral Health Director, Fluoridation Program Coordinator, Community Coalitions.
Attend # community events (e.g., health fairs) to educate the community about the benefits of community water fluoridation, ensuring proportionate number of events in areas with populations experiencing health disparities.	Q5-Q7	Include representation of populations experiencing HD in coalition efforts to introduce fluoridation.	List of events and dates	Outreach Manager; Oral Health Director, Fluoridation Program Coordinator, Community Coalitions.
Facilitate # community coalition meetings, ensuring proportionate number	Q5-Q7	Include representation	Coalition meeting	Outreach Manager; Oral

of meetings in areas with populations experiencing health disparities.		of populations experiencing HD in coalition efforts to introduce fluoridation.	records	Health Director, Fluoridation Program Coordinator, Community Coalitions.
Provide educational programs at # public hearings of tenant associations to provide education and information on community water fluoridation.	Q7	Include representation of populations experiencing HD in coalition efforts to introduce fluoridation.	Meeting records; copies of policies	Outreach Manager; Oral Health Director, Fluoridation Program Coordinator, Community Coalitions.
Engage local media, on at least # occasions to communicate the campaign's message (e.g., press events, ads/articles in local papers and online news outlets, letters to the editor).	Q6	Include representation of populations experiencing HD in coalition efforts to introduce fluoridation.	Media documentation	Outreach Manager; Oral Health Director, Fluoridation Program Coordinator, Community Coalitions.
Organize # community mobilization events (e.g., a rally), with # in communities experiencing health disparities, to raise public awareness and gain support for community water fluoridation. Engage Policy makers as a part of mobilization efforts.	Q7	Include representation of populations experiencing HD in coalition efforts to introduce fluoridation.	Event documentation	Outreach Manager; Oral Health Director, Fluoridation Program Coordinator, Community Coalitions.
Monitor implementation and enforcement of new policy, ensuring evaluation of implementation and enforcement measures in sub-populations experiencing health disparities.	Ongoing	Comprehensive evaluation		Outreach Manager; Oral Health Director, Fluoridation Program Coordinator, Community Coalitions.

Community Transformation Plan – Community Transformation Grant

Date: _____Year 2_____

Site Name	Vermont Communities, Schools and Early Child Care Centers	
Outcome Objective	By July 2013, a minimum of 6 schools and 6 early childcare centers will implement Farm to institution Programs.	
Population Focus (Check One)	☑ General/Jurisdiction Wide	Health disparity by – age, urban or rural location, gender, race/ethnicity, education, income, sexual orientation, disability, or other. (specify): Low SES
Strategic Direction	Farm to School	

Reportable Milestone Activities	Timeline (Initiation-Completion)	Identify the Activity(ies) related to the Health Disparity	Measure	Lead Staff and Key Partners
Community coalitions recruit a minimum of 6 schools to participate in Farm to School within targeted communities.	Q5	Schools recruited are at least 40% free and reduced	Schools recruited	Prevention Specialist Agency of Agriculture, VT Food Education Everyday (FEED)
Community coalitions recruit a minimum of 6 early childcare centers to participate in Farm to Childcare Activities	Q5	Early Childcare Centers recruited from high need rural communities	Centers recruited	Prevention Specialist Agency of Agriculture, VT Food Education Everyday (FEED)
Conduct a farm to school needs assessment in the schools and childcare centers. The needs assessment will identify the strength of the school wellness team, current farm to school activities and areas for growth.	Q5 Q6	Participating schools are at least 40% free and reduced Childcare Centers recruited from rural communities	Needs assessment findings	Prevention Specialist Agency of Agriculture, VT Food Education Everyday (FEED)
Conduct two regional Workshops for educators, food service directors and public health regional staff with tracks for early childcare and schools.	Q6	Participating schools are at least 40% free and reduced	Workshop evaluations	Prevention Specialist Agency of Agriculture, VT Food Education Everyday (FEED) Educators and Food Service Directors Local Health

				School Liaisons
Conduct an annual summer institute training workshop for new school health teams.	Q6	Participating schools are at least 40% free and reduced	Summer Institute evaluations	Prevention Specialist Agency of Agriculture, VT Food Education Everyday (FEED) School Health Teams Local Health School Liaisons
Provide one technical assistance site visit to each new school.	Q6	Participating schools are at least 40% free and reduced	Site visit records	Prevention Specialist Agency of Agriculture, VT Food Education Everyday (FEED)
Conduct Farm to School and Farm to Child Care Evaluation	Ongoing		Evaluation Reports	Prevention Specialist Agency of Agriculture, VT Food Education Everyday (FEED) Program Evaluator

Appendix D: Community Transformation Plan Template

Community Transformation Plan – Community Transformation Grant **Date: _____Year 2_____**		
Site Name	Vermont Communities	
Outcome Objective	By July 2013, a minimum of 6 early childcare centers will have wellness policies in place and implement best practices based on their policies.	
Population Focus (Check One)	☑ General/Jurisdiction Wide	Health disparity by – age, urban or rural location, gender, race/ethnicity, education, income, sexual orientation, disability, or other. (specify): Rural low income
Strategic Direction	Increase physical activity and healthy eating in early childcare settings.	

Reportable Milestone Activities	Timeline (Initiation-Completion)	Identify the Activity(ies) related to the Health Disparity	Measure	Lead Staff and Key Partners
Community coalitions recruit a minimum of 6 early childcare centers to conduct a policy assessment using the evidence based Nutrition and Physical Activity Self-Assessment for Child Care NAP SACC.	Q5	Centers selected from low-income rural communities	Number of centers selected	Public Health Specialist Department of Children and Families Early Child Care Nutrition and Physical Activity Work Group.
Conduct a web based training for early childcare centers on how to use the NAP SACC tool to assess their environment.	Q7	Centers selected from low-income rural communities	Web based training implemented	Public Health Specialist Department of Children and Families Early Child Care Nutrition and Physical Activity Work Group.
Provide ongoing technical assistance and support to centers for development of policies based on their NAP SACC assessments	Q8	Centers selected from low-income rural communities	Training notes	Public Health Specialist Department of Children and Families Early Child Care Nutrition and Physical Activity Work Group.

Evaluate policies implemented in the 6 centers.	Ongoing	Centers selected from low-income rural communities	Policies implemented and evaluation findings.	Public Health Specialist Department of Children and Families Early Child Care Nutrition and Physical Activity Work Group.

Community Transformation Plan – Community Transformation Grant Date: _____Year 2_____					
Site Name	Vermont Communities				
Outcome Objective	By July 2013 a minimum of 3 rural, low income (high need) areas of the state will implement evidence based Healthy Community Design strategies to increase access to physical activity and/or healthy eating.				
Population Focus (Check One)	☑ General/Jurisdiction Wide	Health disparity by – age, urban or rural location, gender, race/ethnicity, education, income, sexual orientation, disability, or other. (specify): Rural			
Strategic Direction	Healthy Community Design (access to Healthy Eating and Physical Activity)				
Reportable Milestone Activities		Timeline (Initiation-Completion)	Identify the Activity(ies) related to the Health Disparity	Measure	Lead Staff and Key Partners
Recruit three high need communities to participate in Healthy Community Design project.		Q5	Rural, low SES communities identified	Communities recruited	Building Healthy Communities Advisory Committee
Assure curriculum for statewide training, based on Vermont's Healthy Community Design Resource (under development as of July 2011), includes challenges and solutions for high need rural areas.		Q5	Curriculum addresses unique needs of low income, rural communities	High needs, rural areas topic added to training curriculum	Building Healthy Communities Consultant, Building Healthy Communities Advisory Committee
A team consisting of health advocates and town leaders from each of the high need areas attends Healthy Community Design training.		Q6	Teams from high need communities are trained on how these changes positively impact the health of higher need residents	Teams attend training; training evaluations	Building Healthy Communities Consultant, Prevention Specialist
Provide funding to community collations to select high need community teams for funding to build capacity, complete a community assessment, and create an implementation plan to move forward at least one evidence based, healthy community design strategy.		Q6	High need, low resource communities receive funding to support their efforts	Grants to communities	Prevention Specialist
Provide technical assistance and support to each team to help them build capacity and keeps the public informed about the project.		Q6 and 7	High need communities that may have little experience	Reports from grantees on partnerships created,	Building Healthy Communities Consultant, Prevention

		in this area get on-going expert support and TA	meetings held, attendance by 'role" of attendee	Specialist
Provide technical assistance and support to each team for them to complete at least 2 assessments of the community (provided in the Vermont Healthy Community Design Resource), to gather information about resources and gaps related to town supported access to physical activity and/or healthy eating.	Q7	High need communities that may have little experience in this area get on-going support and TA	Assessment results	Building Healthy Communities Consultant, State Health Department Prevention Specialist
Provide technical assistance and support to each team for holding planning session(s) that involve community partners to review results of assessments.	Q7 and 8	High need communities that may have little experience in this area get on-going support and TA	Planning meeting minutes and results	Building Healthy Communities Consultant, Prevention Specialist
Provides technical assistance and support to each team on developing an implementation (using evidence base strategies identified in Vermont's Healthy Community Design Resource), plan to address at least one of the identified areas of improvement.	Q8	High need communities that may have little experience in this area get on-going support and TA	Implementation Plan	Building Healthy Communities Consultant, Prevention Specialist
Create short, in depth (webinar, conference call, half day) trainings on specific Healthy Community Design topics: - Health Impact Assessments - How to Influence the Content of Your Town Plan - Conducting Community Assessments Using Tools in the Vermont Healthy Community Design Resource - Vermont's Complete Streets Policy: What it Means for Your Community	Q7 and 8	Training topic chosen and created will be targeted toward the challenges of low income and rural communities.	Training outlines, power point presentations materials created	Building Healthy Communities Consultant, Prevention Specialist, Building Healthy Communities Advisory Committee

Create and distribute Training Schedule to all grantees, Office Of Local health Prevention Teams, Vermont Planners Association	Q8	Training topic chosen and created will be targeted toward the challenges of low income and rural communities.	Schedule created and distributed	Prevention Specialist

Appendix D: Community Transformation Plan Template

Community Transformation Plan – Community Transformation Grant Date: _____Year 2_____					
Site Name	Vermont Statewide				
Outcome Objective	By September 2013 increase participation of people with low socioeconomic status in the statewide healthier living workshops HLW (evidence based chronic disease self management programs).				
Population Focus (Check One)	☑ General/Jurisdiction Wide	Health disparity by – age, urban or rural location, gender, race/ethnicity, education, income, sexual orientation, disability, or other. (specify): Low socioeconomic status			
Strategic Direction	Increase self efficacy of low SES Vermonters living with chronic conditions.				
Reportable Milestone Activities		Timeline (Initiation-Completion)	Identify the Activity(ies) related to the Health Disparity	Measure	Lead Staff and Key Partners
Remove barriers to participation in the Healthier Living Workshops including transportation services, dependant care and provide incentives to attendance including healthy meals.		Q5-Q6	Target low SES Vermonters	Increased utilization of services	Public Health Specialist, Office of Vermont Health Access,
Gather and disseminate current successful marketing strategies from the 13 health service areas offering the HLW.		Q6	Target low SES Vermonters	Strategies gathered	Public Health Specialist, Office of Vermont Health Access, Blueprint for Health, Diabetes Prevention and Control Program.
Utilize and disseminate marketing tools developed to increase cardiovascular disease screening among low income women.		Q6	Target low SES Vermonters	Materials created and disseminated	Public Health Specialist, Office of Vermont Health Access, Blueprint for Health, Diabetes Prevention and Control Program.
Utilize existing community groups of self management stakeholders to promote participation in HLWs through the dissemination of marketing materials.		Q7	Target low SES Vermonters	Materials disseminated, groups contacted	Public Health Specialist, Office of Vermont Health Access, Blueprint for Health, Diabetes Prevention and Control Program. Community stakeholders
Utilize existing relationships with national		Q6	Target low	Information	Public Health

organizations involved in chronic disease self management to share information and successes.		SES Vermonters	shared	Specialist, Office of Vermont Health Access, Blueprint for Health, Diabetes Prevention and Control Program.
Evaluate effectiveness of marketing tools utilized for similar populations including conducting focus groups of low SES Vermonters at risk for cardiovascular disease to determine effective outreach methods, barrier reduction techniques and participation incentives.	Q6	Target low SES Vermonters	Focus groups conducted	Public Health Specialist, Office of Vermont Health Access, Blueprint for Health, Diabetes Prevention and Control Program.

Appendix D: Community Transformation Plan Template

Community Transformation Plan – Community Transformation Grant **Date: _____Year 2_____**		
Site Name	Vermont Communities	
Outcome Objective	By July 2013 increase availability of fresh fruits and vegetables in a minimum of 6 retail stores.	
Population Focus (Check One)	☑ General/Jurisdiction Wide	Health disparity by – age, urban or rural location, gender, race/ethnicity, education, income, sexual orientation, disability, or other. (specify): Rural low income Vermonters
Strategic Direction	Increase accessibility of healthful foods in small stores.	

Reportable Milestone Activities	Timeline (Initiation-Completion)	Identify the Activity(ies) related to the Health Disparity	Measure	Lead Staff and Key Partners
VDH will provide annual funding to community coalitions for implementation of the retail stores project in a minimum of 6 stores.	Q6	Communities selected from rural high need areas	Number of communities funded	Public Health Specialist, Community Coalitions, Local Health Office Prevention Specialists
Provide technical assistance via quarterly conference calls to community coalitions on increasing access to fresh fruits and vegetables.	Quarterly	Communities selected from rural high need areas	Call agendas and Attendance lists	Public Health Specialist, Community Coalitions, Store Owners
Provide funding to community coalitions to provide equipment grants to stores for displays and refrigeration units to carry fresh fruits and vegetables.	Q6	Stores selected from rural high need areas.	Displays and refrigeration units purchased.	Public Health Specialist, Community Coalitions, Store Owners.
Gather success stories and lesson learned from community coalitions and store owners.	Quarterly	Stories gathered from rural high need areas.	Stories compiled and lessons shared	Public Health Specialist, Community Coalitions, Store Owners

Appendix D: Community Transformation Plan Template

Community Transformation Plan – Community Transformation Grant **Date: _____Year 2_____**					
Site Name	Vermont				
Outcome Objective	Train 100 providers in evidence based screenings such as CRAFFT, Gain SS, MAYSI-2 by July 2013.				
Population Focus (Check One)	x General/Jurisdiction Wide	Health disparity by – age, urban or rural location, gender, race/ethnicity, education, income, sexual orientation, disability, or other. (specify): Low SES			
Strategic Direction	Provide training and technical assistance to health care institutions, providers and provider organizations to effectively implement systems to improve delivery of clinical preventive services				
Reportable Milestone Activities		Timeline (Initiation-Completion)	Identify the Activity(ies) related to the Health Disparity	Measure	Lead Staff and Key Partners
Identify four community coalitions with which to partner and provide regional trainings		Q5	Prioritize communities with high HD	Number of communities selected and HD data	CTG Director, Alcohol and Substance Abuse Director
Contract with a statewide training and technical assistance consultant/organization to provide training.		Q6	RFP for services requires trainers with competency in services for Low SES and minorities	Training contract includes specific deliverables related to substance abuse screening and cultural competency	CTG Director, Alcohol and Substance Abuse Director
Initiate training in four separate communities with key providers attending such as Student Assistance Program Counselors.		Q7	Recruit attendees which serve populations with HD.	Number of attendees and organizational affiliation	CTG Director, Alcohol, Substance Abuse Director and training contractor

Appendix D: Community Transformation Plan Template

Community Transformation Plan – Community Transformation Grant TEMPLATE Date: Year 3					
Site Name	Vermont Department of Health				
Outcome Objective	By Sept 1, 2014, a minimum of 7 additional towns, cities, housing associations or landlord holdings in the state will adopt a voluntary smoke-free multi-unit housing (MUH) policy that restricts smoking in individual units, including balconies, patios and common areas.				
Population Focus (Check One)	X General/Jurisdiction Wide	Health disparity by – age, urban or rural location, gender, race/ethnicity, education, income, sexual orientation, disability, or other. (specify):			
Strategic Direction	Increase smoke-free multi-unit housing				
Reportable Milestone Activities		Timeline (Initiation-Completion)	Identify the Activity(ies) related to the Health Disparity	Measure	Lead Staff and Key Partners
Update an outreach plan for each coalition to include and educate low income (and immigrant and minorities if applicable) with target of bringing on 3 new coalition members per grantee		Q9	Low income in all grantee areas	Outreach plans	Coalition specialist, public health specialist, housing contractor
Facilitate 2 meetings held by each community coalition and ensure representation by low income, native and/or minority populations.		Q9-Q12	Include proportionate representation in communities experiencing HD	Coalition meeting records	Coalition specialist, public health specialist, housing contractor
Provide educational programs at 4 statewide or local public hearings including tenant and housing associations to provide education and information on the smoke-free MUH policy.		Q9-Q12	Hold in areas that have high need and demand	Meeting records; copies of policies	Program Manager, housing contractor
VDH engage the statewide media on at least 2 occasions and each coalition the local media on at least 1 occasion to communicate the campaign's message (e.g., press events, ads/articles in local papers and online news outlets, letters to the editor).		Q9-Q12	Inclusion of alternative media outlets to ensure widespread dissemination of message.	Media documentation	Program Manager; Media Specialist;
Organize 2 regional community mobilization events (e.g., a rally) in communities experiencing higher health disparities, to raise public awareness and gain support for the smoke-free outdoor air policy.		Q9-Q12	Include proportionate representation of communities experiencing HD	Event documentation	Outreach Manager; Outreach Specialists; Media Specialist;
Educate the public on 5 separate occasions (one in each funded coalition		Q9-Q12	Assist coalition grantees to	Supporting documents;	Outreach Manager;

region) about newly adopted policy (e.g., sponsor a community forum; place an ad in a local newspaper), including the availability of cessation services/resources, with targeted efforts in communities experiencing health disparities.		hold or co-host forums in targeted areas	copies of relevant media	Outreach Specialists; Media Specialist; CBO 1; CBO 2
Monitor implementation and enforcement of new policy, ensuring evaluation of implementation and enforcement measures in sub-populations experiencing health disparities.	Q9-Q12	Comprehensive evaluation	Evaluation plan and outcomes	Evaluation Manager, Outreach manager, specialists

Appendix D: Community Transformation Plan Template

Community Transformation Plan – Community Transformation Grant TEMPLATE Date: _____Year 3_____					
Site Name	Vermont Department of Health				
Outcome Objective	By Sept 1, 2014, a minimum of 10 additional towns or cities will adopt a smoke-free park ordinance.				
Population Focus (Check One)	X☐ General/Jurisdiction Wide	Health disparity by – age, urban or rural location, gender, race/ethnicity, education, income, sexual orientation, disability, or other. (specify):			
Strategic Direction	Increase smoke-free parks				
Reportable Milestone Activities		Timeline (Initiation-Completion)	Identify the Activity(ies) related to the Health Disparity	Measure	Lead Staff and Key Partners
Update statewide assessment of park location, density and smoke-free status		Q13	Focus on high density, low income	Park Assessment	CTG Manager, VT Recreational Parks Assoc
Create an action plan with and for each coalition grantee		Q13	Focus on low income	Action Plans	Coalition Specialist
Provide 6 technical assistance calls or webinars on smoke free park best practice and shared successes and challenges		Q13-Q16	Capacity building among all partners	Calls and Webinar Notes	Program Specialist
Provide educational programs at 4 statewide, regional or local public meetings to engage stakeholders on progress to date of smoke free park effort		Q14-Q16	Focus on high density, low income	Educational Program Notes	Program Specialist
Organize 6 community mobilization events (e.g. a rally) to raise public awareness and gain support for smoke-free parks		Q13-Q16	Focus on high density, low income	Community Mobilization Events	Program Specialist, Coalitions
Create and place 4 youth "fellows policy program" positions to assist with smoke free parks		Q14-Q16	Low income youth	Youth Fellows	CTG Director, Program Specialist, Coalitions
Create leadership network involving education, facilities management, medical and coalition membership to learn and share best practice and create momentum		Q14-Q16	Health and community leadership	Leadership Network (1 member from each coalition)	Program Specialist, Coalitions
VDH engage the statewide media on at least 1 occasion and each coalition the local media on at least 1 occasion to raise awareness and support		Q14-Q16	Focus on high density, low income	Media coverage	Program Manager, Media Specialist
VDH work to pass smoke-free language		Q13-Q16	Statewide	Language	CTG Director,

covering all state-funded parks and beaches			Passed	Tobacco Director, VDH staff

Appendix D: Community Transformation Plan Template

Community Transformation Plan – Community Transformation Grant TEMPLATE Date: _____Year 3_____					
Site Name	Vermont Department of Health				
Outcome Objective	Increase by 5% from FY13 baseline the number of fax referrals received by the VT Quit Network from medical providers				
Population Focus (Check One)	x☐ General/Jurisdiction Wide	Health disparity by – age, urban or rural location, gender, race/ethnicity, education, income, sexual orientation, disability, or other. (specify):			
Strategic Direction	Increase number of smokers referred from medical settings to Vermont Quit Network (Clinical Preventive Services).				
Reportable Milestone Activities		Timeline (Initiation-Completion)	Identify the Activity(ies) related to the Health Disparity	Measure	Lead Staff and Key Partners
Deliver social marketing, mailing and radio advertising of VT Medicaid benefit that provides reimbursement of in-office tobacco cessation counseling		Q9-Q12	Low income	Meetings and phone calls	Media specialist, Cessation Manager, Tobacco Director
Hold 2 technical assistance calls with all Blueprint Practice Facilitators on electronic health record tobacco referral systems		Q9-Q12	Low income	Technical Assistance Calls	Tobacco Director, Cessation Manager
Hold meetings every 3 months with Blueprint and FAHC on integration progress of Quit in Person to Blueprint		Q9-Q12	Complex patients	Meetings Held	Tobacco Director, Cessation Manager
Perform 3 media/health information interventions aimed to raise awareness of Medicaid cessation services among patients and providers		Q10-Q12	Low income	Media outcomes	Media specialist, Cessation Manager
Evaluation of referrals and utilization to/of Vermont Quit Network		Q9-Q12	Statewide data	Evaluation Outcomes	Evaluation Manager

Appendix E: Community Transformation Plan Example-May 5

Community Transformation Plan – Community Transformation Grant **Date: _____Year 3_____**		
Site Name	Communities which are selected to implement community water fluoridation.	
Outcome Objective	By Sep 1, 2014, 2 communities selected will have implemented policy change to ensure that the local water system supplies optimally fluoridated water.	
Population Focus (Check One)	☐X General/Jurisdiction Wide	X Health disparity by – age, urban or rural location, gender, race/ethnicity, education, income, sexual orientation, disability or other. (specify): Low SES, rural, minority.
Strategic Direction	Healthy and Safe Physical Environment	

Reportable Milestone Activities	Timeline (Initiation-Completion)	Identify the Activity(ies) related to the Health Disparity	Measure	Lead Staff and Key Partners
Selection of community coalitions for fluoridation activities based on fluoridation status, ability to address disparities.	Q9-Q10	Include representation of populations experiencing HD in coalition efforts to introduce fluoridation.	Coalition selection.	Outreach Manager; Oral Health Director, Fluoridation Program Coordinator, Community Coalitions.
Develop a coalition taskforce to spearhead coalition activities related to fluoridation. Educate taskforce members on community water fluoridation.	Q9-Q10	Include representation of populations experiencing HD in coalition efforts to introduce fluoridation.	Meeting records	Outreach Manager; Oral Health Director, Fluoridation Program Coordinator, Community Coalitions.
Coalition members conduct # presentations to gain support for the policy campaign and to recruit additional coalition members, ensuring proportionate number of presentations in areas with populations experiencing health disparities.	Q9-Q11	Include representation of populations experiencing HD in coalition efforts to introduce fluoridation.	Presentation materials; meeting notes	Outreach Manager; Oral Health Director, Fluoridation Program Coordinator, Community Coalitions.
Attend # community events (e.g., health fairs) to educate the community about the benefits of community water fluoridation, ensuring proportionate number of events in areas with populations experiencing health disparities.	Q9-Q11	Include representation of populations experiencing HD in coalition efforts to introduce fluoridation.	List of events and dates	Outreach Manager; Oral Health Director, Fluoridation Program Coordinator, Community Coalitions.
Facilitate # community coalition meetings, ensuring proportionate number	Q9-Q11	Include representation	Coalition meeting	Outreach Manager; Oral

of meetings in areas with populations experiencing health disparities.		of populations experiencing HD in coalition efforts to introduce fluoridation.	records	Health Director, Fluoridation Program Coordinator, Community Coalitions.
Provide educational programs at # public hearings of tenant associations to provide education and information on community water fluoridation.	Q11	Include representation of populations experiencing HD in coalition efforts to introduce fluoridation.	Meeting records; copies of policies	Outreach Manager; Oral Health Director, Fluoridation Program Coordinator, Community Coalitions.
Engage local media, on at least # occasions to communicate the campaign's message (e.g., press events, ads/articles in local papers and online news outlets, letters to the editor).	Q10	Include representation of populations experiencing HD in coalition efforts to introduce fluoridation.	Media documentation	Outreach Manager; Oral Health Director, Fluoridation Program Coordinator, Community Coalitions.
Organize # community mobilization events (e.g., a rally), with # in communities experiencing health disparities, to raise public awareness and gain support for community water fluoridation. Engage Policy makers as a part of mobilization efforts.	Q11	Include representation of populations experiencing HD in coalition efforts to introduce fluoridation.	Event documentation	Outreach Manager; Oral Health Director, Fluoridation Program Coordinator, Community Coalitions.
Monitor implementation and enforcement of new policy, ensuring evaluation of implementation and enforcement measures in sub-populations experiencing health disparities.	Ongoing	Comprehensive evaluation		Outreach Manager; Oral Health Director, Fluoridation Program Coordinator, Community Coalitions.

Community Transformation Plan – Community Transformation Grant

Date: _____Year 3_____

Site Name	Vermont Communities, Schools and Early Child Care Centers	
Outcome Objective	By July 2014, a minimum of 6 schools and 6 early childcare centers will implement Farm to institution Programs.	
Population Focus (Check One)	☑ General/Jurisdiction Wide	Health disparity by – age, urban or rural location, gender, race/ethnicity, education, income, sexual orientation, disability, or other. (specify): Low SES
Strategic Direction	Farm to School	

Reportable Milestone Activities	Timeline (Initiation-Completion)	Identify the Activity(ies) related to the Health Disparity	Measure	Lead Staff and Key Partners
Community coalitions recruit a minimum of 6 schools to participate in Farm to School within targeted communities.	Q9	Schools recruited are at least 40% free and reduced	Schools recruited	Prevention Specialist Agency of Agriculture, VT Food Education Everyday (FEED)
Community coalitions recruit a minimum of 6 early childcare centers to participate in Farm to Childcare Activities	Q9	Early Childcare Centers recruited from high need rural communities	Centers recruited	Prevention Specialist Agency of Agriculture, VT Food Education Everyday (FEED)
Conduct a farm to school needs assessment in the schools and childcare centers. The needs assessment will identify the strength of the school wellness team, current farm to school activities and areas for growth.	Q9 Q10	Participating schools are at least 40% free and reduced Childcare Centers recruited from rural communities	Needs assessment findings	Prevention Specialist Agency of Agriculture, VT Food Education Everyday (FEED)
Conduct two regional Workshops for educators, food service directors and public health regional staff with tracks for early childcare and schools.	Q10	Participating schools are at least 40% free and reduced	Workshop evaluations	Prevention Specialist Agency of Agriculture, VT Food Education Everyday (FEED) Educators and Food Service Directors Local Health

				School Liaisons
Conduct an annual summer institute training workshop for new school health teams.	Q10	Participating schools are at least 40% free and reduced	Summer Institute evaluations	Prevention Specialist Agency of Agriculture, VT Food Education Everyday (FEED) School Health Teams Local Health School Liaisons
Provide one technical assistance site visit to each new school.	Q10	Participating schools are at least 40% free and reduced	Site visit records	Prevention Specialist Agency of Agriculture, VT Food Education Everyday (FEED)
Conduct Farm to School and Farm to Child Care Evaluation	Ongoing		Evaluation Reports	Prevention Specialist Agency of Agriculture, VT Food Education Everyday (FEED) Program Evaluator

Appendix D: Community Transformation Plan Template

Community Transformation Plan – Community Transformation Grant **Date: _____Year 3_____**				
Site Name	Vermont Communities			
Outcome Objective	By July 2014, a minimum of 6 early childcare centers will have wellness policies in place and implement best practices based on their policies.			
Population Focus (Check One)	☑ General/Jurisdiction Wide	Health disparity by – age, urban or rural location, gender, race/ethnicity, education, income, sexual orientation, disability, or other. (specify): Rural low income		
Strategic Direction	Increase physical activity and healthy eating in early childcare settings.			
Reportable Milestone Activities	Timeline (Initiation-Completion)	Identify the Activity(ies) related to the Health Disparity	Measure	Lead Staff and Key Partners
Community coalitions recruit a minimum of 6 early childcare centers to conduct a policy assessment using the evidence based Nutrition and Physical Activity Self-Assessment for Child Care NAP SACC.	Q9	Centers selected from low-income rural communities	Number of centers selected	Public Health Specialist Department of Children and Families Early Child Care Nutrition and Physical Activity Work Group.
Conduct a web based training for early childcare centers on how to use the NAP SACC tool to assess their environment.	Q11	Centers selected from low-income rural communities	Web based training implemented	Public Health Specialist Department of Children and Families Early Child Care Nutrition and Physical Activity Work Group.
Provide ongoing technical assistance and support to centers for development of policies based on their NAP SACC assessments	Q12	Centers selected from low-income rural communities	Training notes	Public Health Specialist Department of Children and Families Early Child Care Nutrition and Physical Activity Work Group.

Evaluate policies implemented in the 6 centers.	Ongoing	Centers selected from low-income rural communities	Policies implemented and evaluation findings.	Public Health Specialist Department of Children and Families Early Child Care Nutrition and Physical Activity Work Group.

Community Transformation Plan – Community Transformation Grant
Date: _____Year 3_____

Site Name	Vermont Communities	
Outcome Objective	By July 2014 a minimum of 3 rural, low income (high need) areas of the state will implement evidence based Healthy Community Design strategies to increase access to physical activity and/or healthy eating.	
Population Focus (Check One)	☑ General/Jurisdiction Wide	Health disparity by – age, urban or rural location, gender, race/ethnicity, education, income, sexual orientation, disability, or other. (specify): Rural
Strategic Direction	Healthy Community Design (access to Healthy Eating and Physical Activity)	

Reportable Milestone Activities	Timeline (Initiation-Completion)	Identify the Activity(ies) related to the Health Disparity	Measure	Lead Staff and Key Partners
Recruit three high need communities to participate in Healthy Community Design project.	Q9	Rural, low SES communities identified	Communities recruited	Building Healthy Communities Advisory Committee
Assure curriculum for statewide training, based on Vermont's Healthy Community Design Resource (under development as of July 2011), includes challenges and solutions for high need rural areas.	Q9	Curriculum addresses unique needs of low income, rural communities	High needs, rural areas topic added to training curriculum	Building Healthy Communities Consultant, Building Healthy Communities Advisory Committee
A team consisting of health advocates and town leaders from each of the high need areas attends Healthy Community Design training.	Q10	Teams from high need communities are trained on how these changes positively impact the health of higher need residents	Teams attend training; training evaluations	Building Healthy Communities Consultant, Prevention Specialist
Provide funding to community collations to select high need community teams for funding to build capacity, complete a community assessment, and create an implementation plan to move forward at least one evidence based, healthy community design strategy.	Q10	High need, low resource communities receive funding to support their efforts	Grants to communities	Prevention Specialist
Provide technical assistance and support to each team to help them build capacity and keeps the public informed about the project.	Q10 and 11	High need communities that may have little experience	Reports from grantees on partnerships created,	Building Healthy Communities Consultant, Prevention

		in this area get on-going expert support and TA	meetings held, attendance by 'role" of attendee	Specialist
Provide technical assistance and support to each team for them to complete at least 2 assessments of the community (provided in the Vermont Healthy Community Design Resource), to gather information about resources and gaps related to town supported access to physical activity and/or healthy eating.	Q11	High need communities that may have little experience in this area get on-going support and TA	Assessment results	Building Healthy Communities Consultant, State Health Department Prevention Specialist
Provide technical assistance and support to each team for holding planning session(s) that involve community partners to review results of assessments.	Q11 and 12	High need communities that may have little experience in this area get on-going support and TA	Planning meeting minutes and results	Building Healthy Communities Consultant, Prevention Specialist
Provides technical assistance and support to each team on developing an implementation (using evidence base strategies identified in Vermont's Healthy Community Design Resource), plan to address at least one of the identified areas of improvement.	Q12	High need communities that may have little experience in this area get on-going support and TA	Implementation Plan	Building Healthy Communities Consultant, Prevention Specialist
Create short, in depth (webinar, conference call, half day) trainings on specific Healthy Community Design topics: - Health Impact Assessments - How to Influence the Content of Your Town Plan - Conducting Community Assessments Using Tools in the Vermont Healthy Community Design Resource - Vermont's Complete Streets Policy: What it Means for Your Community	Q11 and 12	Training topic chosen and created will be targeted toward the challenges of low income and rural communities.	Training outlines, power point presentations materials created	Building Healthy Communities Consultant, Prevention Specialist, Building Healthy Communities Advisory Committee

Create and distribute Training Schedule to all grantees, Office Of Local health Prevention Teams, Vermont Planners Association	Q12	Training topic chosen and created will be targeted toward the challenges of low income and rural communities.	Schedule created and distributed	Prevention Specialist
Conduct Trainings	Q9-12	Training topic chosen and created will be targeted toward the challenges of low income and rural communities.	Training attendance and evaluations	Building Healthy Communities Consultant, Prevention Specialist Building Healthy Communities Advisory Committee

Appendix D: Community Transformation Plan Template

Community Transformation Plan – Community Transformation Grant Date: _____Year 3_____		
Site Name	Vermont Statewide	
Outcome Objective	By September 2014 increase participation of people with low socioeconomic status in the statewide healthier living workshops HLW (evidence based chronic disease self management programs).	
Population Focus (Check One)	☑ General/Jurisdiction Wide	Health disparity by – age, urban or rural location, gender, race/ethnicity, education, income, sexual orientation, disability, or other. (specify): Low socioeconomic status
Strategic Direction	Increase self efficacy of low SES Vermonters living with chronic conditions.	

Reportable Milestone Activities	Timeline (Initiation-Completion)	Identify the Activity(ies) related to the Health Disparity	Measure	Lead Staff and Key Partners
Remove barriers to participation in the Healthier Living Workshops including transportation services, dependant care and provide incentives to attendance including healthy meals.	Q9-Q10	Target low SES Vermonters	Increased utilization of services	Public Health Specialist, Office of Vermont Health Access,
Gather and disseminate current successful marketing strategies from the 13 health service areas offering the HLW.	Q10	Target low SES Vermonters	Strategies gathered	Public Health Specialist, Office of Vermont Health Access, Blueprint for Health, Diabetes Prevention and Control Program.
Utilize and disseminate marketing tools developed to increase cardiovascular disease screening among low income women.	Q10	Target low SES Vermonters	Materials created and disseminated	Public Health Specialist, Office of Vermont Health Access, Blueprint for Health, Diabetes Prevention and Control Program.
Utilize existing community groups of self management stakeholders to promote participation in HLWs through the dissemination of marketing materials.	Q11	Target low SES Vermonters	Materials disseminated, groups contacted	Public Health Specialist, Office of Vermont Health Access, Blueprint for Health, Diabetes Prevention and Control Program. Community stakeholders
Utilize existing relationships with national	Q10	Target low	Information	Public Health

organizations involved in chronic disease self management to share information and successes.		SES Vermonters	shared	Specialist, Office of Vermont Health Access, Blueprint for Health, Diabetes Prevention and Control Program.

Appendix D: Community Transformation Plan Template

Community Transformation Plan – Community Transformation Grant **Date: _____Year 3_____**		
Site Name	Vermont Communities	
Outcome Objective	By July 2014 increase availability of fresh fruits and vegetables in a minimum of 6 retail stores.	
Population Focus (Check One)	☑ General/Jurisdiction Wide	Health disparity by – age, urban or rural location, gender, race/ethnicity, education, income, sexual orientation, disability, or other. (specify): Rural low income Vermonters
Strategic Direction	Increase accessibility of healthful foods in small stores.	

Reportable Milestone Activities	Timeline (Initiation-Completion)	Identify the Activity(ies) related to the Health Disparity	Measure	Lead Staff and Key Partners
VDH will provide annual funding to community coalitions for implementation of the retail stores project in a minimum of 6 stores.	Q10	Communities selected from rural high need areas	Number of communities funded	Public Health Specialist, Community Coalitions, Local Health Office Prevention Specialists
Provide technical assistance via quarterly conference calls to community coalitions on increasing access to fresh fruits and vegetables.	Quarterly	Communities selected from rural high need areas	Call agendas and Attendance lists	Public Health Specialist, Community Coalitions, Store Owners
Provide funding to community coalitions to provide equipment grants to stores for displays and refrigeration units to carry fresh fruits and vegetables.	Q10	Stores selected from rural high need areas.	Displays and refrigeration units purchased.	Public Health Specialist, Community Coalitions, Store Owners.
Gather success stories and lesson learned from community coalitions and store owners.	Quarterly	Stories gathered from rural high need areas.	Stories compiled and lessons shared	Public Health Specialist, Community Coalitions, Store Owners

Appendix D: Community Transformation Plan Template

Community Transformation Plan – Community Transformation Grant **Date: _____Year 3_____**					
Site Name	Vermont				
Outcome Objective	Train 100 providers in evidence based screenings such as CRAFFT, Gain SS, MAYSI-2 by July 2014.				
Population Focus (Check One)	x General/Jurisdiction Wide	Health disparity by – age, urban or rural location, gender, race/ethnicity, education, income, sexual orientation, disability, or other. (specify): Low SES			
Strategic Direction	Provide training and technical assistance to health care institutions, providers and provider organizations to effectively implement systems to improve delivery of clinical preventive services				
Reportable Milestone Activities		Timeline (Initiation-Completion)	Identify the Activity(ies) related to the Health Disparity	Measure	Lead Staff and Key Partners
Identify four community coalitions with which to partner and provide regional trainings		Q9	Prioritize communities with high HD	Number of communities selected and HD data	CTG Director, Alcohol and Substance Abuse Director
Contract with a statewide training and technical assistance consultant/organization to provide training.		Q10	RFP for services requires trainers with competency in services for Low SES and minorities	Training contract includes specific deliverables related to substance abuse screening and cultural competency	CTG Director, Alcohol and Substance Abuse Director
Initiate training in four separate communities with key providers attending such as Student Assistance Program Counselors.		Q11	Recruit attendees which serve populations with HD.	Number of attendees and organizational affiliation	CTG Director, Alcohol, Substance Abuse Director and training contractor

Community Transformation Plan – Community Transformation Grant Date: Year 4	
Site Name	Vermont Department of Health
Outcome Objective	By Sept, 2015, a minimum of 7 additional towns, cities, housing associations or landlord holdings in the state will adopt a voluntary smoke-free multi-unit housing (MUH) policy that restricts smoking in individual units, including balconies, patios and common areas.
Outcome Objective	By Sept, 2015, a minimum of 10 additional towns or cities will adopt a smoke-free park ordinance.
Outcome Objective	Increase by 5% from FY14 baseline the number of fax referrals received by the VT Quit Network from medical providers
Outcome Objective	By Sept, 2015, 2 communities selected will have implemented policy change to ensure that the local water system supplies optimally fluoridated water.
Outcome Objective	By July 2015, a minimum of 6 schools and 6 early childcare centers will implement Farm to institution Programs.
Outcome Objective	By July 2015, a minimum of 6 early childcare centers will have wellness policies in place and implement best practices based on their policies.
Outcome Objective	By July 2015 a minimum of 3 rural, low income (high need) areas of the state will implement evidence based Healthy Community Design strategies to increase access to physical activity and/or healthy eating.
Outcome Objective	By Sept, 2015 increase participation of people with low socioeconomic status in the statewide healthier living workshops HLW (evidence based chronic disease self management programs).
Outcome Objective	By July 2015 increase availability of fresh fruits and vegetables in a minimum of 6 retail stores.
Outcome Objective	Train 100 providers in evidence based screenings such as CRAFFT, Gain SS, MAYSI-2 by July 2015.

Community Transformation Plan – Community Transformation Grant Date: Year 5	
Site Name	Vermont Department of Health
Outcome Objective	By Sept , 2016, a minimum of 7 additional towns, cities, housing associations or landlord holdings in the state will adopt a voluntary smoke-free multi-unit housing (MUH) policy that restricts smoking in individual units, including balconies, patios and common areas.
Outcome Objective	By Sept , 2016, a minimum of 10 additional towns or cities will adopt a smoke-free park ordinance.
Outcome Objective	Increase by 5% from FY15 baseline the number of fax referrals received by the VT Quit Network from medical providers
Outcome Objective	By Sept , 2016, 2 communities selected will have implemented policy change to ensure that the local water system supplies optimally fluoridated water.
Outcome Objective	By July 2016, a minimum of 6 schools and 6 early childcare centers will implement Farm to institution Programs.
Outcome Objective	By July 2016, a minimum of 6 early childcare centers will have wellness policies in place and implement best practices based on their policies.
Outcome Objective	By July 2016 a minimum of 3 rural, low income (high need) areas of the state will implement evidence based Healthy Community Design strategies to increase access to physical activity and/or healthy eating.
Outcome Objective	By Sept, 2016 increase participation of people with low socioeconomic status in the statewide healthier living workshops HLW (evidence based chronic disease self management programs).
Outcome Objective	By July 2016 increase availability of fresh fruits and vegetables in a minimum of 6 retail stores.
Outcome Objective	Train 100 providers in evidence based screenings such as CRAFFT, Gain SS, MAYSI-2 by July 2016.

Vermont's Implementation Application focuses on health disparities which still exist throughout Vermont. The focus of this application would be working on preventing heart attack, strokes, cancer and other leading causes of death or disability through evidence and practice-based policy, environmental, programmatic, and infrastructure changes.

Vermont intends to continue to use a progressive approach to the development of coordinated and integrated prevention activities via the Blue Print for Health, community coalitions, and associated community prevention teams. The Blueprint for Health national model for health care reform. It is a state led program dedicated to achieving well-coordinated and seamless health services, with an emphasis on prevention and wellness. This effort includes transitioning patients from patterns of acute episodic care to preventive health services managed by community prevention teams. Initially, community coalitions developed separately and worked to implement evidence based prevention strategies in the areas of substance abuse, obesity and physical activity, tobacco and other key public health areas. Over time, the Vermont Health Department has made a concerted effort to bring these coalitions together to provide prevention services in a coordinated and cohesive manner. As a result of this work, Vermont is uniquely positioned to integrate clinical and community components. This application proposes to bring the community coalitions, the Blueprint for Health, and the community prevention teams together to provide prevention services in a coordinated and cohesive manner. Vermont's strategy to date has been to engage community coalitions, build their capacity and implement activities which reach a significant portion of the population. Fortunately, the efforts in building local infrastructure can now be leveraged using CTG funds to target populations where health disparities still reside. With CTG funds, we can heighten the sophistication in design and delivery of our local and state systems and therefore, increase our ability to address the persistent disparities within the state.

Vermont will focus their activities within four Strategic Directions. Strategic Direction #1 Tobacco Free Living will target the promotion of smoke-free housing units, parks, and increase the numbers of smokers referred to the VT Quit Network. Strategic Direction #2 Active Living and Healthy Eating will focus on the development of Farm-to-Institution initiative, policy changes at early child care setting and encourage retailers to provide access and availability of healthier foods in food desert locations. Strategic Direction #3 Increased Use of High Impact Quality Clinical Preventive Services will leverage Vermont's nationally recognized Blueprint for Health infrastructure to address clinical preventive services for substance abuse and mental health conditions, tobacco cessation and promote the Healthier Living Workshops. Strategic Direction #4 Healthy and Safe Physical Environment will promote: mixed use development, bicycle and pedestrian friendly communities, access to parks, recreational facilities, open space, and access to healthy foods.

The strategies selected for the CTIP have been chosen based upon coalition's ability to effectively impact and reach a significant portion of the target population. We have intentionally chosen strategies which speak to the strengths of our coalitions. That is, we picked strategies that coalitions can best use to reach the target population through existing connections with multi-unit housing, child care centers, parks, retail food stores, physician's offices and community water supplies.

The project will have a significant focus on formative evaluation at the community level. Formative evaluation will provide an opportunity to monitor and understand coalitions

experiences implementing evidence based strategies and assisting them in adhering to the program. In addition, the evaluation can identify barriers to the process of implementation. It will also provide feedback loops to the Leadership team so necessary adjustments can be made to ensure success of the project.

GARRY SCHAEDEL

EXPERIENCE

2010-Present ***Division Director,*** **Health Promotion and Disease Prevention**

Leadership, planning and consultative work for the professional staff (30 FTEs) and programs of the Division of Health Promotion and Chronic Disease Prevention ($6 million budget) This involves the development, implementation, and evaluation of chronic disease prevention and control efforts to ensure that the health department's approach to reducing the Chronic Disease burden on all Vermonters is timely, effective, efficient and successful and that VDH's approach is improving the public's health at both the individual and community levels to assure optimum well-being.

1996-2010 ***EPSDT Director,*** **Vermont Department of Health**

EPSDT (Early, Periodic, Screening, Diagnosis, and Treatment) is the federal mandate requiring states to ensure that all children on Medicaid receive the full scope of services as required under federal law. Responsibilities involve policy development and coordination, program administration including Medicaid Administrative claiming in schools, dental and mental health pilots; contract administration and management with the Vermont Chapters of the American Academy of Pediatrics and Family Practice; Liaison work with the Vermont Children's Health Improvement Project (VCHIP).

1995-1996 ***Managed Care Administrator*****, Department of Vermont Health Access**

1994-1995 ***Policy Analyst*****, Vermont Health Care Authority**

1993-1995 ***Director*****, Vermont Health Care Purchasing Pool**

1988-1993 ***Director Employee Benefits*****, State of Vermont**

1985-1988 ***Director of Public Information*****, Office of Governor Madeleine M. Kunin**

1984-1984 ***Director of Field Operations*****, Kunin for Governor Campaign**

1983-1984 ***Restitution Coordinator,*** **Vermont Department of Corrections**

1981-1983 ***Volunteer Services Coordinator,*** **Vermont Department of Corrections**

1979-1981 ***Recruiter,*** **Peace Corps/VISTA**

1977-1978 ***VISTA Volunteer,*** **Montana Human Rights Division**

EDUCATION

B.A. **St. Michael's College,** *Winooski, VT*
M.H.S. **Southern New Hampshire University,** *Manchester, NH*

BREENA W. HOLMES, MD

breena.holmes@ahs.state.vt.us

Vermont Department of Health, 108 Cherry Street, Burlington, VT 05401

EXPERIENCE

2010-present — **Vermont Department of Health** — **Burlington, VT**
- Director: Maternal and Child Health

2009-present — **American Academy of Pediatrics Council on School Health**
- National Council Member advising health policy in schools

1997-present — **University of Vermont College of Medicine** — **Burlington, VT**
- Associate Clinical Professor of Pediatrics
- Youth Health Improvement Initiative Team Member (VCHIP)
- Medical Student Leadership Group Mentor
- Pediatric Resident Preceptor

2008-2010 — **Middlebury Union High School** — **Middlebury, VT**
- Health Educator: Health Literacy and Decision Making
- School Physician
- Coordinated School Health Team
- Health Curriculum Revision Committee
- Facilitator, Lecturer, Workshop Creator: School Age Health Topics

2008-2010 — **Vermont Department of Education** — **Montpelier, VT**
- Comprehensive Health Education and Wellness Committee

1997-2008 — **Middlebury Pediatric and Adolescent Medicine** — **Middlebury, VT**
- Pediatrician: Adolescent-Focused Clinical Practice
- Physician Practice Leader
- Chair: Department of Pediatrics Porter Hospital

EDUCATION

1993 M.D. University of Massachusetts Medical School
1988 B.A. *(Biology)* Dartmouth College

POSTDOCTORAL TRAINING

1996-1997 Chief Pediatric Resident: University of Massachusetts Medical School
1993-1996 Pediatric Resident: Seattle Children's Hospital and Medical Center

LICENSURE AND CERTIFICATION

2008 Vermont Standards Board for Professional Educators; Health Education License: Pre K-12
1997 Medical License: State of Vermont
1996 American Board of Pediatrics
1994 National Board of Medical Examiners

PROFESSIONAL AFFILIATIONS

American Academy of Pediatrics
- Member: Section on Adolescent Health
- Elected Member: National Council on School Health

American Public Health Association
MVP Health Care Quality Improvement Committee

SUSAN ELIZABETH COBURN, MPH, RD

susan.coburn@ahs.state.vt.us

Vermont Department of Health, 108 Cherry Street, Burlington, VT 05401 | (802) 951-5151

EXPERIENCE

Jan 2008-Present ***Adjunct Faculty (non-salaried)***
Department of Nutrition and Food Sciences, University of Vermont

Coordinates the Community Public Health rotation, and acts as preceptor for students in the Masters of Nutrition in Dietetics program. Provides annual seminars on Public Health Nutrition for masters and undergraduate student classes.

Oct 2006-Present ***Public Health Nutrition and Physical Activity Chief***
Vermont Department of Health

Provide policy, direction, planning and consultative work for nutrition and physical activity within the Vermont Department of Health and in collaboration with partner agencies and organizations. Provide oversight and direction for the Fit and Healthy Vermonters obesity prevention program. Coordinate and collaborate to integrate prevention services across Department of Health programs. Supervise staff and provide shared leadership for the Public Health Prevention work for the Division of Health Promotion and Disease Prevention. January 2008-January 2011 duties included administration of the Centers for Disease Control and Prevention WISEWOMAN cardiovascular disease prevention program.

May 2005-Oct 2006 ***Obesity Prevention Program Administrator***
Vermont Department of Health

Oversee the development and implementation of the obesity prevention grant from the Centers for Disease Control and the Fit and Healthy initiative; develop a state plan for the prevention of obesity and related chronic conditions; lead a staff of nutrition and physical activity professionals to develop and implement populations based interventions to prevent obesity and coordinate nutrition and physical activity functions for health department programs and external partners.

May 2004-May 2005 ***Interim Obesity Prevention Program Administrator***

Jan 2002-May 2005 ***Chronic Disease Nutritionist***
Vermont Department of Health

Developed and implemented the lifestyle intervention program to reduce chronic disease among limited income women ages 40-64 in the Ladies First program. Coordinated the implementation of nutrition and physical activity education programs; assured collaboration and integration with other programs, departments and nutrition groups and provided expert technical assistance on chronic disease nutrition to all chronic disease programs.

Jan 2001-Jan 2003 ***Weight Loss Group Facilitator***
University of VT Behavioral Weight Control

Co-facilitated behavioral, nutrition and lifestyle weight control groups with University psychologist. Counseled adult and teen groups on dietary behaviors for weight control.

Jun 1999-Jan 2002 *Cooking for Life Coordinator*
Vermont Campaign to End Childhood Hunger

Developed and coordinated a new statewide cooking and nutrition education program for low-income families. Participated in development and ongoing evaluation of program curriculum; managed grants including maintaining budgets, statistical data, and preparing reports; developed and pilot tested a curriculum for teen populations; collaborated with partner agencies throughout Vermont; supervised University of Vermont community nutrition practicum students and solicited donated goods and services to offset program costs.

Dec 1999-May 2001 *State Legislative Liaison*
Vermont Dietetics Association

Disseminated information in the state legislature related to the profession of dietetics to dietitians throughout Vermont; provided testimony to House and Senate committees to advocate for services pertaining to the practice of dietetics in Vermont and attended the American Dietetics Association public policy workshop in Washington, DC. March 2000.

EDUCATION

1997	*Bachelor of Science in Nutritional Sciences and Dietetics* University of Vermont
1998	*Dietetic Internship* St. Luke's Hospital, New Bedford, MA
2001-2002	*Graduate course work in mental health counseling* University of Vermont
2005	*Masters degree in Public Health in Leadership* University of North Carolina at Chapel Hill

CERTIFICATION

Feb 1999	*"Serve Safe Food Protection Manager Certification Course"*
Dec 2002	*Certificate of Training in Adult Weight Management* American Dietetics Association

PROFESSIONAL AFFILIATIONS

1997-Present	**American Dietetics Association,** *Member*
1999-2004	**Society of Nutrition Education,** *Member*
2002-Present	**State and Territorial Public Health Nutrition Directors,** *Member*

AWARDS

2002	*Recognized Young Dietitian of the Year,* **VT Dietetics Association**
2002	*Betsy Hiser Memorial Scholarship,* **VT Dietetics Association**
2005	*Delta Omega Book Award Recipient,* **University of North Carolina**

PATRICK L. ROWE, DDS, MPH *patrick.rowe@ahs.state.vt.us*

PROFESSIONAL OBJECTIVE

To serve the public through promoting and improving oral health.

EXPERIENCE

Aug 2009-Present ***Director, Office of Oral Health,*** **Vermont Department of Health, Office of Oral Health,** Burlington, VT

- Program administration and management of Office of Oral Health Staff.
- Assessment and implementation of evidence based recommendations.
- Liaison to stakeholder organizations and communities statewide for oral health.

Jun 2008 ***Summer Policy Fellow*****, American Dental Education Association, Center for Public Policy and Advocacy**, Washington, D.C.

- Advocacy for clinical oral health programs and regulatory change.

Jul 2007- Jun 2008 ***Dental Anatomy Faculty,*** **University of the Pacific, Arthur A. Dugoni School of Dentistry,** San Francisco, CA

Mar 2005-Jan 2007 ***Staff Dentist,*** **Dientes Community Dental Care,** Santa Cruz, CA

- Treated culturally diverse, underserved populations of Santa Cruz and its surrounding counties. Provided the full scope of dentistry including patient education on preventative strategies in oral health. Coordinated treatment plans for medically compromised patients among clinics, physicians and hospital staff.
- Direct supervision of dental auxiliary staff.

Dec 2004-Mar 2005 ***Associate Dentist,*** **University Dental,** Albany, CA

- Provided services in a high-volume practice with multiple operatories and assistants.

Aug 2004-Dec 2004 ***Associate Dentist,*** **General Practice of Claudia Yu, DDS** Oakland, CA

- Practiced the full scope of general dentistry with a diverse patient base. Responsibilities included training auxiliary staff.

Jul 2003-Jun 2004 ***General Practice Resident,*** **Veterans Affairs Medical Center** San Francisco, CA

- Received advanced training in general dentistry and surgical procedures.
- Patient care provided in outpatient, nursing home, and operating room settings.
- Provision of care primarily involving disabled veterans.

Oct 1998-Jul 1999 ***Research Assistant to Stewart Moss, Ph.D.*****, Center for Research on Reproduction and Women's Health, University of Pennsylvania School of Medicine,** Philadelphia, PA

- Investigated sperm tail protein development.

EDUCATION

Dec 2009	*Masters of Public Health in Health Services Organization* **University of California, Los Angeles School of Public Health**
May 2003	*Doctor of Dental Surgery* **State University of New York at Buffalo** **School of Dental Medicine**
May 1998	*Bachelor of Arts* **Colgate University**, Hamilton, NY

AWARDS

2008-2009	**Hershel Horowitz Scholarship** for a dentist entering public health
2002-2003	**Tucker Scholarship** for advanced class standing
1998	**Leo H. Speno Award** for a senior entering a medical field
1998	**Charles J. Tegtmeyer Scholarship** for a senior entering a medical field

CERTIFICATIONS

November 2003	**Dental Board of California**: Dental license issued
February 2006	**New York State Department of Education**: Dental license issued

PROFESSIONAL AFFILIATIONS

2010-Present	**Vermont Public Health Association**
2009-Present	**American Association of Public Health Dentistry**
2009-Present	**Association of State and Territorial Dental Directors**
2008-2009	**UCLA Health Services Student Association**
2007-2009	**American Dental Education Association**
1999-2009	**American Dental Association**
2004-2009	**California Dental Association**
2001-2003	**American Student Dental Association, Buffalo Chapter,** *Treasurer*
2001-2003	**Sub-Board I, Inc.,** *Board of Directors*

RESEARCH

1997-1998	*Projected Distribution of Health Care Need in New York State, by County, 2000-2020.* **Senior Project in Geography at Colgate University**
1997	*Population Projections for New York State, by County, 2000-2020.* **Research Grant at Colgate University**

RHONDA K. WILLIAMS **rhonda.williams@ahs.state.vt.us**

EXPERIENCE

Tobacco Chief, State of Vermont
Burlington, VT, 2/11-present

- Provide administrative, supervisory, planning and consultative work for the Department of Health involving the development, implementation and evaluation of a comprehensive tobacco control program.
- Directs grant and contract development, performance and evaluation; researches and evaluates current and potential tobacco control best practices and reports on program performance.
- Responsible for multiple streams of funding and budgets related to community, policy, cessation and media addressing tobacco control and prevention.
- Oversees the Asthma Program and its CDC work plan, contracts and grant funded efforts statewide.

Grant Writer & Non-Profit Consultant
Vergennes, VT, 1/07-present

- Provide health and environmental non-profits with program development & grant-writing services.
- Coordinate member and communication services for Acorn Energy Co-op, Middlebury.
- Project and writing consultant with the Addressing Asthma in Englewood Project, Chicago.

President
Vergennes Farmers Market
Vergennes, VT, 6/10-present

- President and coordinator of the non-profit market; doubled number of vendors over last season.

Co-Primary Investigator of Addressing Asthma in Englewood Project
Respiratory Health Association of Metropolitan Chicago (formerly the American Lung Association of Metropolitan Chicago)
Chicago, IL 12/05-6/30/10

- Responsible for the design, implementation, budgeting and reporting of evidence-based outcomes related to multi-year, multi-site $2 million pediatric asthma project.
- Coordinated over a dozen partners on their participation and outcomes related to the project.

Deputy Executive Director, Policy, Programs and Medical Education
American Lung Association of Metropolitan Chicago (ALAMC)
Chicago, IL 3/03-7/06

- Managed 30 staff in programs, policy and medical education. Built vibrant team & intern corps.

- Directed our federal, state and local policy agenda on air quality and lung disease.
- Oversaw multiple programs, initiatives and campaigns. Managed 80 budgets, including projects addressing asthma, clean diesel/clean energy, Smoke-free Chicago, smoking cessation, tobacco prevention and control, and numerous lung health initiatives.
- Co-author and co-PI of $2 million grant to implement collaborative model on pediatric asthma.
- Developed new, innovative health initiatives which are still ongoing, including:
    - COPD Initiative: a nationally recognized outreach and research program on chronic obstructive pulmonary disease (COPD) with an annual budget of $550,000.
    - Stakeholders Collaboration to Improve Student Health: a large initiative to coordinate and amplify efforts among non-profits to increase student health in the Chicago Public Schools.
    - Asthma Action Plan for the City of Chicago: a citywide blueprint for reducing asthma's impact.
- Oversaw grant funding for health, research and programmatic initiatives.
- Secured funding to research methodologies for addressing health disparities in asthma and air pollution.

Director, Farm to School Initiative
The Illinois Healthy Schools Campaign
Chicago, IL 10/02-3/03

- As strategy consultant to the Campaign's Founding Director, developed a statewide Farm to School Initiative and spearheaded successful NIEHS funding application for $1 million on asthma and obesity.
- Wrote white papers on farm to school issues, developed a producer network and directed annual event.

Instructor, English as a Second Language
Yunnan Province, China 9/01-5/02

- Founded a private tutoring school for adults and children.

Senior Project Administrator
Chicago Housing Authority (CHA), Environmental Unit
Chicago, IL 10/98-6/01

- Directed and supervised 5 staff in the Healthy Homes Initiative to remediate and prevent environmental health concerns including asthma, pesticides, lead and demolition dust.
- Managed award-winning Chicago Housing Buy-Back Recycling Program that provided services to 100,000 housing residents and generated annual returns exceeding $150,000.
- Collaborated with non-profit and academic sectors to attract funding for improving environmental health in housing. Co-writer of awarded $800,000 NIEHS healthy homes grant.
- Demolition Program Administrator on one of the nation's largest demolition programs.

Committee Coordinator
Chicago City Council's Committee on Energy, Environmental Protection and Public Utilities
Chicago, IL 1/97-10/98

- Responsible for the management of the Chicago City Council committee handling

environmental and energy issues. Performed research, prepared briefs for council members and issued reports.
- Initiated and coordinated multi-governmental task forces to address environmental issues.

Teacher, English as a Second Language
Japan Exchange and Teaching Programme (JET)
Akkeshi, Japan 7/92-7/94
- Instructed English (ESL) as part of competitive JET Programme at secondary school level. Served as JET Hokkaido Representative. Organized "Japan and the Environment" Conference with 150 attendees.

EDUCATION
Yale University, School of Forestry and Environmental Studies
MASTERS OF ENVIRONMENTAL STUDIES, Social Ecology concentration
New Haven, CT 8/94-6/96
- Co-founder of the Yale Coalition for Environmental Ethics & lead organizer of lecture series.
- Teacher's Assistant, "Social Theory." Research Intern, Mineral Policy Center, Washington DC.
- Assistant Organizer, '96 Yale Corporate Environmental Leadership Seminar (CELS).

University of Kansas
BACHELOR OF ARTS, English
Lawrence, KS 8/88-12/89

Publications, Presentations and Volunteer Activities Available Upon Request

Vermont Community Transformation Implementation Application

SECTION 1: BACKGROUND AND NEED

Demographic Summary: From 2000 to 2009 there was an increase of 12,933 people, or 2.1 percent. The highest growth rates occurred in rural areas in the state including Lamoille, Grand Isle, and Franklin Counties. The four rural southernmost counties all show a small decline in population since 2000, as does Essex County. The fastest growing segment of the Vermont population is the 55-64 year old age group. There has been a decline since the Census in the under 18 population, as well as in the 30-44 age group.

Racial and Ethnic Composition : In 1990, the United States Census estimated Vermont's racial and ethnic minority populations to be about 2 percent of the total population. By 2007, that same figure had doubled to 4 percent, representing about 24,500 Vermonters. Vermont's racial and ethnic populations are growing at a much faster rate than the population overall. Between 1990 and 2007, Blacks or African Americans have been the fastest growing population in Vermont, with their numbers more than tripling in the past 18 years. The second fastest growing racial groups are Asians, including Native Hawaiian and other Pacific Islanders–with populations increasing from 0.5 percent of the total population in 1990, to 1.2 percent in 2007. Many recent residents are refugees, some are immigrants, and all may have varying health needs and concerns. Vermont's Refugee Resettlement Program welcomed 353 people from countries throughout Africa and Asia in 2008. Since 1994, more than

Vermont Population, by Racial & Ethnic Category

	1990 U.S. Census –		2007 Estimate –	
	Total #	Percent	Total #	Percent
White Non-Hispanic	552,413	98.2%	596,777	96.0%
Hispanic or Latino	5,687	1.0%	8,170	1.3%
Asian*	3,215	0.5%	7,573	1.2%
Black/African American	1,951	0.3%	6,485	1.0%
American Indian/ Alaskan Native	1,696	0.3%	2,839	0.5%
Total Population	562,758	100%	621,254	100%

* This category also includes Native Hawaiian/Other Pacific Islander

4,000 refugees have resettled in the state. More than half of all the state's racial and ethnic minority populations, and two-thirds of the Hispanic population, live outside of its only urban county (Chittenden County).

Rurality

Population, Income, Education, Employment, and Federal Funds			
	Rural	**Urban**	**Total/Avg**
Population 2010	414,480	211,261	625,741
Per-capita income 2009 (dollars)	37,980	41,641	39,205
100% Federal Poverty rate 2009	49,738	22,182	71,920
Percent not completing high school 2000	14.5	11.5	13.6
Percent completing college 2000	27	34.8	29.4
Unemployment rate 2010 (percent)	6.7	5.4	6.2
Federal funding (dollars per person)	9,499	12,507	10,505

In 2010, the USDA reported that 66.2% of the population resided in rural areas with the balance of 33.8% in urban areas. Characteristics of rural areas of Vermont differ greatly from urban areas. The majority of Vermont's population resides in rural areas in the state and experience lower per-capita incomes; higher poverty and unemployment; fewer complete college and more drop out of high school. While the majority of the population experiencing disparities are in rural areas, urban areas of the state receive 31.7% more federal funds per person.

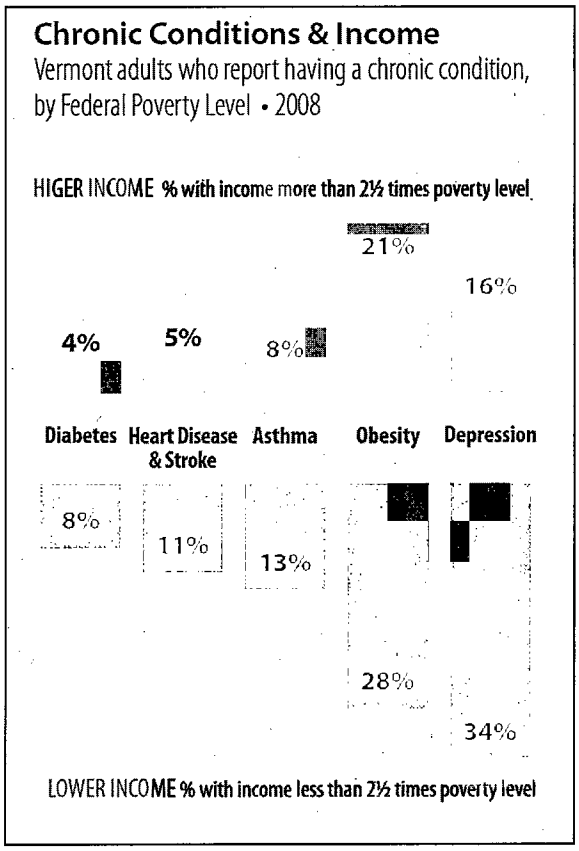
Disparities: Low Socioeconomic Status (SES): Income is the most common measure of socioeconomic status and a strong predictor of the health of an individual or community. Given Vermont's rurality and preponderance of low income, the health outcomes status follow suit. A supply of fresh and nutritious foods, access to reliable and quality medical care, safe housing, communities that encourage play and physical activity, social and civic interaction, and the discouragement of smoking and other unhealthy behaviors – these are all income-related predictors of optimal health.

Studies in the U.S. and Europe show a distinct relationship between income and health. The greater the income, the more likely a person will enjoy more years of healthy life. The lower the income, the greater the likelihood a person will suffer from chronic conditions such as diabetes, heart disease and stroke, and face untimely death. Lower income is more closely associated with rurality, which in itself also creates challenges to adopting healthy behaviors.

Chronic Conditions

In Vermont, low income people are most often:

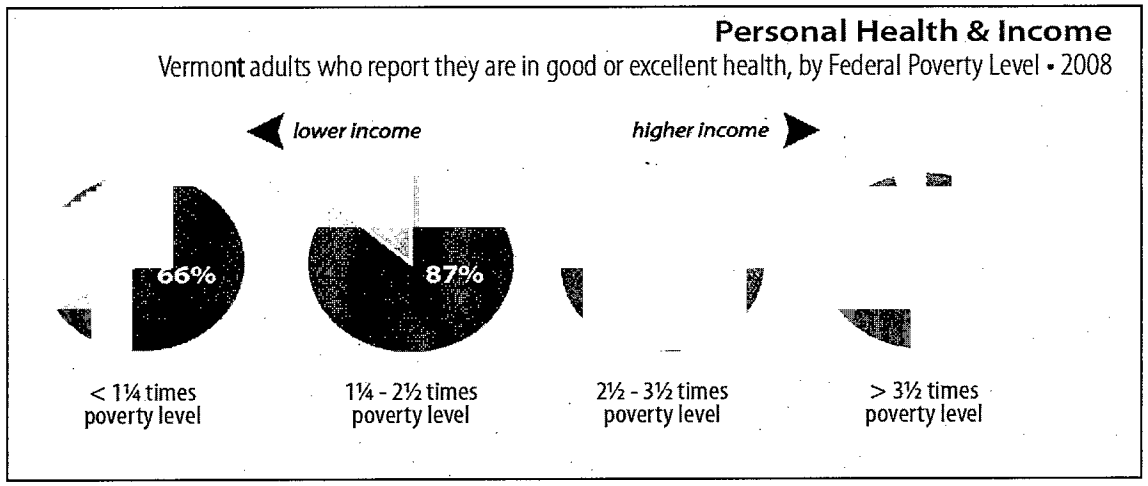
- young (18 to 34 years old)
- less educated
- unemployed or unable to work
- female
- a member of a racial or ethnic minority
- residing in a rural area of the state
- a person with a disability



Vermont ranks high nationally (2nd) in its per capita Medicaid spending due to the needs of its residents and to the generous benefits package it offers. Lower income Vermonters report higher rates of depression and chronic conditions such as obesity, asthma, heart disease, stroke, and diabetes. Fifteen percent of low income Vermont adults have two or more chronic conditions, compared to 7% of higher income Vermonters.

Health Status Indicators

Perceived health status has shown to be an accurate indicator of overall health status. According to Vermont's Behavioral Risk Factor Surveillance Survey (BRFSS), the percent of individuals reporting good or excellent health decreases with decreasing income. This self reported health status coincides with many findings of the BRFSS which indicates that Vermonters with lower socioeconomic status (SES) experience poor health at a greater rate than their higher SES counterparts.



Oral health

About half of children covered by Medicaid have dental decay, compared to one-third of children with private insurance. Twice as many Medicaid-covered children have 3 or more teeth with decay or fillings than children with private dental insurance. They are also less likely to have a regular dental visit. Vermont ranks 37th among states in terms of community water fluoridation. While workforce issues are of great concern, a more focused approach on prevention will not only improve oral health status but reduce the demand for oral health preventive services.

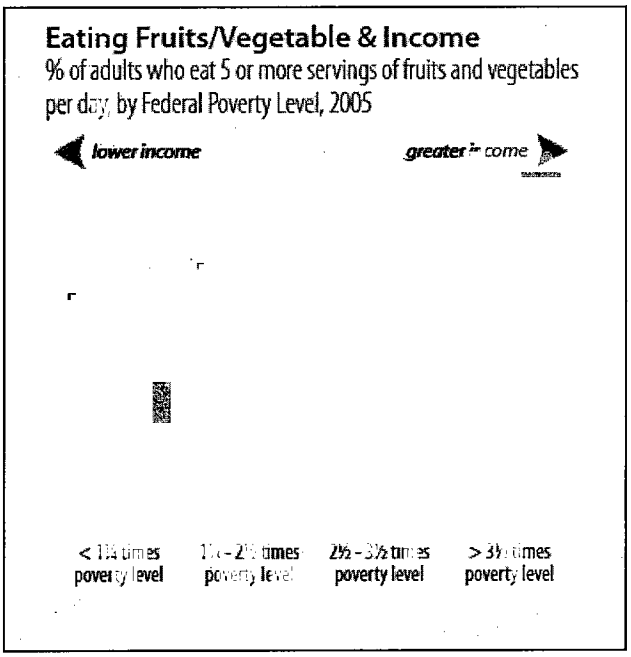
Cholesterol and hypertension

According to the Vermont BRFSS in 2009, respondents from the lowest income category were

more likely to have been told that their blood pressure was high as compared to respondents from the highest income category (36% vs. 22.5% respectively). Similarly, low income respondents were more likely to report having been told their cholesterol was high (of those for which it was checked) as compared to high income respondents (48.7% vs 32.5% respectively).

Health Behaviors

People without food security must too often compromise quality for quantity, eating higher-calorie but lower cost and nutritionally deficient foods. Over time, food insecurity can lead to malnutrition, obesity and chronic illness. According to BRFSS data 16% of low income Vermonters eat less than they feel they should because there is not enough food, or money to buy food; fruit and vegetable consumption decreases with decreasing income and 28% of Vermonters who earn less than 250% of the poverty level are obese.



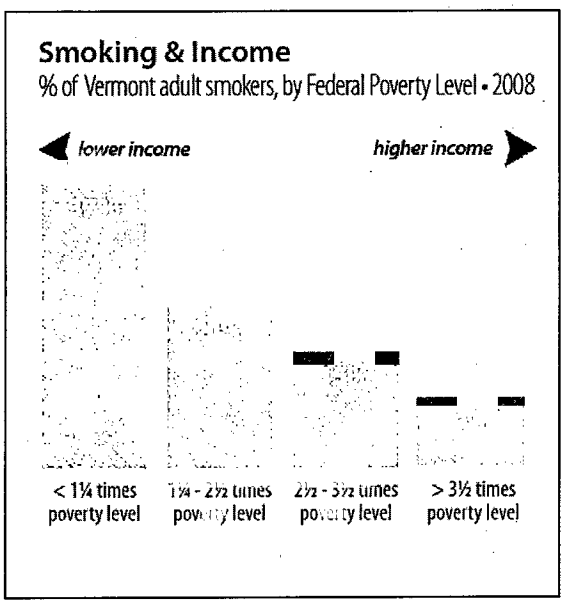
Physical inactivity and obesity

Low-income people are less likely to have regular physical activity and more likely to become obese than people with higher incomes–and this trend starts in early childhood. Thirty nine percent of low income adult Vermonters engage in regular physical activity, compared to 47% of those who are not low income.

Tobacco use

The most important reason for getting into prenatal care early, and continuing with regular visits, is to identify medical risks and behavioral risks (such as smoking) – or other health issues that need to be addressed early in pregnancy. Seven times as many low income women (as represented by enrollment in WIC) smoke during pregnancy, compared to other women. While rates of smoking during pregnancy have decreased over the last decade among women not in WIC, smoking rates have stayed the same among low income women. Not surprisingly 8% of low income women have low birth weight babies, compared to 5.5% of other women.

The percent of adult smokers increases with increasing poverty. Similar trends for low income Vermonters persist regarding second hand smoke at home and the workplace in that second hand smoke exposure is higher among low income Vermonters. For example low income Vermonters were less likely to ban smoking in their home as compared to middle or high income households; 69%, 79% and 92% banned smoking in their home respectively. Among Vermonters with children, smoking was less often prohibited by those with lower incomes as compared to middle or high income households; 85%, 90% and 100% banned smoking in their vehicle respectively. Those with low incomes more often reported breathing someone else's cigarette smoke in their workplace as compared to middle or high income; 50%, 22% and 11% reported breathing second hand smoke respectively.

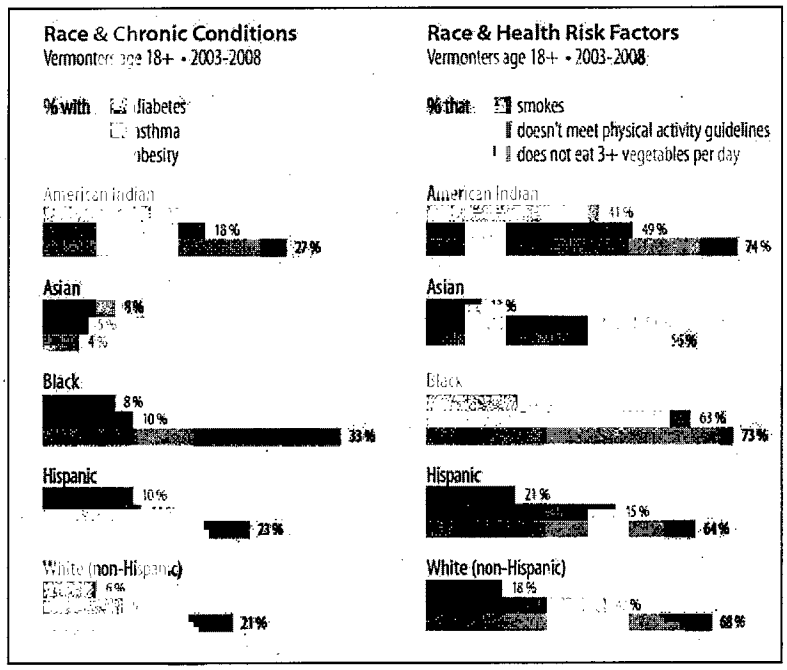


Clinical and preventive guidelines

In 2008, smokers who saw a health care provider in the last year indicated that four out of five of those providers asked whether the individual smoked (85%). Approximately two-thirds reported their health care professional talked with them about smoking (63%) and /or advised them to quit (66%). A third (34%) were recommended a specific quit program by their doctor, and 15% were asked to set a quit date by their health care provider. Low income Vermonters were also less likely to have had their cholesterol checked in the last five years.

Disparities: Racial and Ethnic Minorities: In Vermont, racial disparities that relate to income also exist. Based on the 2000 Census in Vermont, approximately one in 10 White non-Hispanics and Asians were living below the poverty level, one in four American Indians fell into that category.

Perceived health status has shown to be an accurate indicator of overall health status. According to Vermont's Behavioral Risk Factor Surveillance Survey (BRFSS), the percent of individuals reporting good or excellent health varied by race and ethnicity. This self reported health status coincides with many findings of the BRFSS which indicates that racial and ethnic minority populations experience poor health at a greater rate than their White, non-Hispanic counterparts.



There are measurable disparities by race in prevalence of chronic disease and overall reported health status. Rates for prevalence of diabetes, asthma and obesity all vary by race.

Data from 2003 to 2008 indicates that 12% of American Indians have diabetes, compared to 6% of White non-Hispanics; 18% of American Indians have asthma, compared to 10% of Blacks, 11% of Hispanics, 9% of White, non-Hispanics, and 5% of Asians; 33% of Blacks are obese, compared to 4% of Asians.

Tobacco use

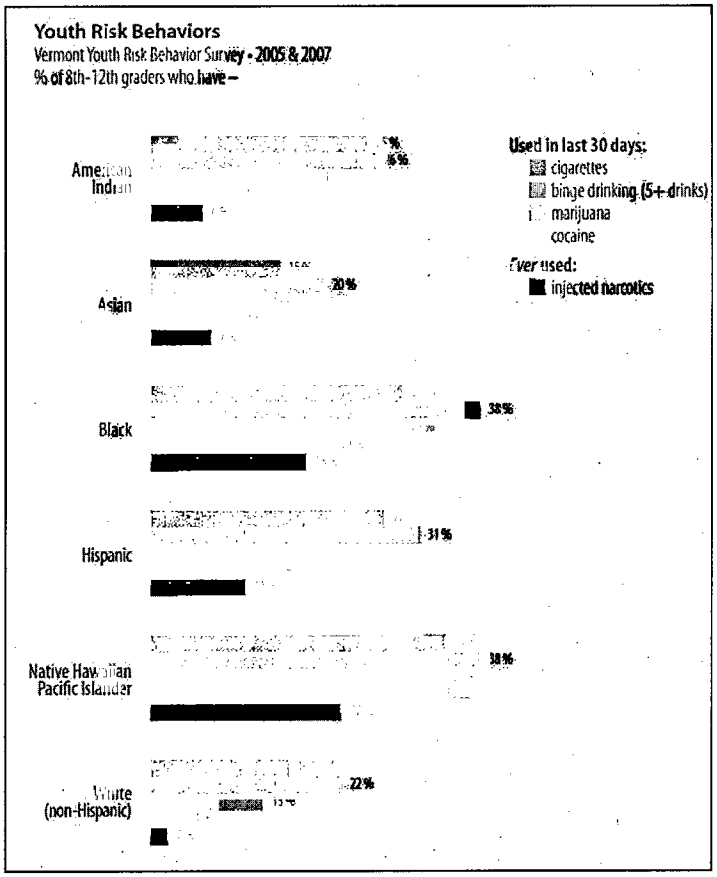
From 2003 to 2008:

- 13% of Asians and 41% of Indians smoke, compared to 18% of White non-Hispanics.

Physical activity and nutrition

From 2003 to 2008:

- 63% of Blacks do not get the recommended amount of physical activity, compared to 43% of White non-Hispanics.
- 56% of Asians reported that they do not eat at least three servings of vegetables a day, compared to nearly three-quarters of Blacks and American Indians.



Minority youth smoking, drinking and drug use

Youth risk behaviors also vary greatly by race and ethnicity. Among Vermont eighth through 12th graders from 2005 to 2007 students of Native Hawaiian/ Pacific Islander descent have the highest rates of smoking,

drinking and other drug use, while White non-Hispanics and Asians often have the lowest rates for the same behaviors. Approximately one in five Black students has ever injected narcotic drugs and 21% reported using cocaine in the past 30 days. Among American Indians, while use of injected narcotics is lower than that of most other race and ethnic groups, they have high rates of smoking, binge drinking and marijuana use.

Data from 2005 to 2007 also highlight racial disparities in maternal and child health:

- 6% of White non-Hispanic mothers have low birth weight babies, compared to 11% of Black mothers, and 8% of Asian/Pacific Islander mothers.
- 9% of White non-Hispanic mothers have pre-term births, compared to 15% of Black mothers, and 7% of Asian/Pacific Islander mothers.
- 64% of Black mothers receive adequate prenatal care compared to 88% of White non-Hispanic mothers.

Past Successes and Activities: (*See also Section 4: Leadership Team and Coalition and Section 6: Selection of Strategies and Performance Measures)*

The Vermont Department of Health (VDH) Fit and Healthy Vermonters Obesity Prevention Program, Tobacco Control Program and Alcohol and Drug Abuse Program all support community partners and coalitions working to implement policy and environmental changes to improve health behaviors and health outcomes. Their ultimate goal is to reduce the burden of health care cost by creating communities that are healthier places to live. The Department has provided technical assistance and financial support for the development of local coalitions and their efforts in assessment, capacity building, planning, implementation and evaluation of the systems approach to best practice implementation. In Section 4: Leadership Team and Coalitions we provide an overview of the activities and successes of community coalitions. Given the

history of state and coalition work in past evidence based policy, environmental, programmatic and infrastructure activities, Vermont has significantly advanced in improving health status of its constituents. Having said this, we also recognize that further progress needs to be made in order to reach Healthy People and Healthy Vermonter goals.

Vermont's strategy to date has been to engage community coalitions, build their capacity and implement activities which reach a significant portion of the population yet are feasible to accomplish. Fortunately, our efforts in building local infrastructure can now be leveraged using Community Transformation Grant (CTG) funds to target populations where health disparities still reside. These populations are more difficult to reach and require a strengthened and integrated approach through policy, environmental, programmatic, and infrastructure activities. With CTG funds, we can heighten the sophistication in design and delivery of our local and state systems and therefore, increase our ability to address the persistent disparities within the state. See Section 6: Selection of Strategies and Performance Measures for additional information describing how selected strategies are best suited to meet the context and needs of communities and target population.

Focus: Past Success Tobacco Control: Vermont models its program around the five components outlined in the 2007 *Best Practices for Comprehensive Tobacco Control Programs* from the Centers for Disease Control and Prevention (CDC). In particular, our interventions have focused on supporting the work of tobacco-free community coalitions; ensuring schools have smoke-free campuses and access to evidence based tobacco interventions; working on passing policy initiatives to reduce secondhand smoke which can change social norms; and addressing tobacco-related disparities especially as it relates to low socioeconomic status.

Since the Tobacco Control Program began in 2001, we have been evaluating the progress

towards our long-term goals, and have adapted interventions to meet the challenges and changing needs of the state. We have made significant progress in the last decade towards our objectives:

- In 2009, the youth prevalence rate dropped to 16%, reaching Vermont's Healthy People 2010 goal.
- In 2010, the adult smoking rate reached an all-time low of 15.4%. While this is a significant reduction from the 22% rate in 2000, there is still work to do in further reducing smoking prevalence.
- As of 2010, Vermont saw an all time high in smoking bans, with 71% of smokers with children not allowing smoking in the home and 83% of smokers not allowing smoking in the car with children.

State & Community Interventions: Over the last decade the tobacco-free community coalitions have been working at the local level to support the overarching goals of the tobacco program. Through changes in grant requirements, and supported by training and technical assistance, these organizations have shifted their direction to include more policy advocacy and less community education, especially in the area of youth prevention. This policy shift reflects research into best practice and focuses on creating smoke-free environments that will protect citizens from exposure, and ultimately change the community norm around tobacco.

The grant changes resulted, in fiscal year (FY) 2010, that 42% of the coalition activities addressed secondhand smoke, compared to only 19% in FY 2007. In FY10 community coalitions also worked on 59 separate policies, with nearly half of them resulting in a smoke-free policy implementation. In the last two years, the youth leadership groups have also shifted their focus to more policy work in conjunction with tobacco-free coalitions.

Health Communications Interventions: Vermont has adopted a comprehensive strategy of statewide counter marketing efforts which incorporates complimentary activities being done at the local level. These "common theme campaigns" utilize a consistent media message, concentrated over a sustained period of time (two months), and support the three main objectives of the Tobacco Control Program: Tobacco Cessation, Youth Prevention and Secondhand Smoke Reduction. To ensure that these campaigns are executed with continuity, community partners (tobacco-free coalitions and youth groups) are required through their grant agreements to take part in the campaigns. The use of common theme campaigns has been well received by partners, and Vermont has seen success in changing youth social norms and in driving smokers to cessation services.

Cessation Interventions: The Vermont Quit Network offers smokers a range of proven options to support their desire to become smoke-free. Vermont has been successful in driving smokers to cessation resources using media, but has also recognized that the majority of smokers prefer to quit on their own. To this end, the "Your Quit Your Way" campaign and "Quit Your Way" tools were developed. With the launch of the "Your Quit Your Way" campaign in FY 2009, the Vermont Quit Network provided thousands of quitting tools to smokers, and saw an 83% increase in use over the previous year. Since then Vermont has continued to see a high proportion smokers enter into services, while at the same time reducing the per-person counseling cost through efficiencies. The success of the Network is also due to the connection to the tobacco-free community coalitions and youth groups, who are also tasked with promoting the Vermont Quit Network at the local level.

Focus: Past Success Obesity and Physical Activity Program

Fit and Healthy Vermonters: Since its inception VDH's Fit and Healthy Vermonters Nutrition and Physical Activity Program have implemented proven public health practices and policies that make the healthy choice the easy choice for all Vermonters. The Fit and Healthy Vermonters program advanced the state obesity prevention plan through the statewide Fit and Healthy Coalitions and work groups across priority target areas. Key partners include the Agencies of Agriculture, and Transportation, the Vermont Departments of: Education; Children and Families; Economics Housing and Community Development, the Farm to School Network, Town Planning Organizations, Community Coalitions and a wide variety of public and private partners including those representing lower-income and vulnerable populations. Active work groups include schools, worksites, early childcare and community.

The Small Change Big Impact Healthy Retailer Project: To maximize efficiencies and improve outcomes, VDH is working to integrate initiatives across the Department and state agencies. These efforts are evident in the developing Healthy Retailer Project funded by a CDC Communities Putting Prevention to Work, economic stimulus grant award. The Healthy Retailer project integrated the work of the Nutrition, Tobacco, and Alcohol Prevention Programs. In collaboration with the Vermont Department of Liquor Control and the Vermont Grocers Association, the project has been providing support to retailers to promote of healthy foods including fresh & local fruits and vegetables, while limiting advertising of tobacco and alcohol products.

Built Environment: VDH developed tools and resources for local policy and environmental changes in support of healthy eating and physical activity. The goal of this initiative is to further obesity prevention by building healthy, vital and walk able communities. A step to accomplishing this is facilitating conversations between community-based health advocates and

planners. Many of the current community coalitions have demonstrated success in including proven strategies that support healthy behaviors town plans.

Worksites and Schools: VDH has provided models for policy and environmental change in the school and worksite settings. The Worksite Wellness Resource has been instrumental in the integration of nutrition, breastfeeding support, physical activity, and tobacco control. The worksite wellness workgroup in collaboration with the Governor's Council on Physical Fitness and Sports has been recognizing employers for the past ten years. In 2010, seventy-nine employers received recognition awards based upon their achievements, an increase from fifty employers in 2009. In 2011, over 40 schools applied for recognition as schools with model policies and practices around healthy eating and physical activity this is an increase from 17 schools in 2009.

Early Childcare: The early childcare workgroup of Fit and Healthy Vermonters has worked to strengthen the nutrition and physical activity best practices by revising childcare licensing regulations. Head Start Centers across the state have been trained in "I am Moving I am Learning" which is an initiative the uses age appropriate physical activity and games to build developmental skills. Head Start centers across the state have been trained and are now working to implement the initiative in home and center based child care settings.

Focus: Past Success Clinical Preventive Services

The Blueprint is a state led program dedicated to achieving well-coordinated and seamless health services, with an emphasis on prevention and wellness, for all Vermonters. This includes transitioning patients from patterns of acute episodic care to preventive health services. The foundation for the success of the Blueprint is the development and expansion of a Learning Health System. The Learning Health System identifies and defines evidence-based clinical

guidelines and incorporates them into the health information technology infrastructure, the central registry's core data dictionary, and evaluation; provides resources and support (funding, facilitation, training opportunities by nationally recognized experts, shared learning, and analytics) for primary care practices, community health teams, and service providers to redefine systems of care; promotes innovation; measures outcomes. By July 2011, the Blueprint is expected to expand to include 79 practices with 388 providers serving 367,751 Vermonters, over 50% of the entire state population.

Evaluation findings of the Blueprint demonstrated that participating communities had significant changes in their ability to deliver preventive services and reduce poor health outcomes. The evaluation consisted of a 4,000 chart reviews and found that 58.6% of patients with diabetes whose medical records were reviewed were having their hemoglobin A1C tested at least twice a year as recommended and 82.8% were having their LDL cholesterol checked at least once as recommended; the mean hemoglobin A1C of patients whose records were reviewed was 7.3 (HgbA1cs should 7.0 or less) and LDL was 97 (LDLs should be 100 or less); 99.1% of patients with hypertension whose records were reviewed had their blood pressure checked at least once at the practice; patients with hypertension had a mean systolic blood pressure of 136 and diastolic blood pressure of 81 (recommendations are for systolic blood pressure less than 140 and diastolic blood pressure less than 90 for patients with hypertension); of records belonging to patients with asthma, 43% had at least one primary care visit at which their asthma control was assessed in some way, of those patients 21% had well-controlled asthma; self-management goals were set by 38% of patients with diabetes, 25.5% of patients with hypertension, and 18% of patients with asthma; and 12.9% of patients with diabetes, 4.4% of patients with hypertension, and 5% of patients with asthma were referred to some sort of self-management resource.

SECTION 2: PROGRAM INFRASTRUCTURE

The VDH has assembled an excellent team with the requisite experience to successfully complete the components of the Community Transformation Implementation Plan (CTIP) outlined in this proposal. Each member described below is committed to attending CDC-sponsored trainings as well as to participate in the day to day support and implementation of the project, with particular emphasis on assuring that the community coalitions, local organizations and local health offices are coordinate and supported at a local level.

Garry Schaedel, MHS, Director, Division of Health Promotion and Disease Prevention:

Mr. Schaedel has over twenty years of experience in health care administration and policy development with the State of Vermont. Prior to his current position as Division Director for Health Promotion and Disease Prevention, he held various positions within state government, ranging from a Benefits Manager for the Vermont State Employee Benefit Plan, to a Policy Analyst for what is now the Banking, Insurance, Securities and Health Care Administration (BISHCA), and Department of Health Access (DVHA, Vermont's Medicaid Agency). For 14 years he was the EPSDT Director in the Division of Maternal and Child Health at the Vermont Health Department.

In his prior role, he was responsible for all aspects of the Department's School Health efforts; management of multimillion dollar grants and contracts (e.g. the Vermont Child Health Improvement Program; every School District in Vermont, the Vermont Chapters of the American Academy of Pediatrics and Family Practice; University of Massachusetts Health Care Financing Agency); he was also the Departments Medicaid Administrative "expert", and sat on

the state's Medicaid Advisory Committee and the Agency of Human Services MMIS transformation team.

In his role as Director of EPSDT, Mr. Schaedel's efforts lead to an update Vermont's hearing/vision law to coincide with the American Academy of Pediatrics Bright Futures Recommendation; working with the National American Academy of Pediatrics he received a distinguished service award for his role in making Bright Futures Recommendations the gold standard for school sports physicals, now a national model. He developed best practice standards for school spending focusing on the delivery of school health services (Vermont has the best nurse: student ratio in the country); continuation and expansion of the CDC Coordinated School Health Program; and, the creation of the Tooth Tutor Program (a national model)

Mr. Schaedel is responsible for the oversight and management of all programs covered under this FOA and will provide overall management support to staff of the project. In addition, Mr. Schaedel will have primary responsibility for chairing the Leadership Team and directing their efforts to facilitating success of the CTG Initiative.

Susan Coburn MPH, RD, Nutrition and Physical Activity Chief: As the Department of Health's Nutrition and Physical Activity Chief, Ms. Coburn is responsible for development of the overall the vision for the health of Vermonters and the goals for nutrition and physical activity. Policies that lead to accomplishment of public health goals for reduction of the ill effects of poor nutrition and inactivity are developed under her direction. It is her primary responsibility to collect, analyze interpret and present information on the health status of Vermonters, current health topics, and effective interventions for improving health status; recommend innovative approaches to maximizing resources, reducing silos and promoting collaboration within the department and among partner organizations.

Throughout her tenure with the Department, Ms. Coburn has been adept at assuring that interventions reflect all dimensions of health including the individual and family, organizations (health care, education, business), community and public policy; responding to requests from the Commissioner's Office regarding nutrition and physical activity; serving as the food, nutrition and physical activity expert for the department; engaging the media to increase awareness and knowledge of public health issues, particularly as related to nutrition and physical activity. Ms. Coburn has over 8 years of public health experience working on policy, environmental and systems changes for obesity prevention. She has experience leading systems change for and was instrumental in the development and implementation of the Vermont Prevention Model as a framework to shift community nutrition and physical activity initiatives to policy and environmental change. She oversees planning and implementation of the Departments Fit and Healthy Vermonters Obesity Prevention program including program design, contract development, grant awards and program evaluation as well as a team of public health professionals including the Physical Activity Coordinator, WISEWOMAN Program Coordinator and Diabetes Prevention and Control Program Administrator.

Rhonda Williams, MES, Tobacco Control Program Chief: Ms. Williams brings expertise in environmental health and policy. Starting with environmental policy and coordination for Chicago City Council, she has coordinated or led projects addressing lead and environmental hazards in housing, tobacco control, asthma health disparities, and community approaches to mitigating air quality impacts on respiratory health. In early 2011 Ms. Williams started as Tobacco Chief with the Vermont Department of Health and also oversees asthma after having been a Co-investigator on a four-year evidence-based project addressing pediatric asthma in Chicago. Recent relevant work includes her role in overseeing Vermont's comprehensive

tobacco control program that increasingly emphasizes population-based policy, addressing health disparities as impacted by tobacco/housing/air pollution, and leading expansion of a local farmers market as board president.

Previous to working at the Department of Health, Ms. Williams held the position as Deputy Director of the American Lung Association of Metropolitan Chicago where she oversaw policy, programming and medical education to improve respiratory outcomes. She was responsible for starting new initiatives focused on improving student health in Chicago Public Schools, addressing chronic obstructive pulmonary disease, and incorporating community health educators as part of Chicago's asthma care coordination approach. Ms. Williams served as a consultant and board member with the Healthy Schools Campaign and as a Senior Administrator with the Chicago Housing Authority where she developed new management policies to reduce exposure to pesticides.

Across the course of her career, Ms. Williams' work has honed her skills in stakeholder collaboration, integration, and community and institution-based research. She has worked with a number of agencies, evaluators and associations including CDC, EPA, RTI and coalitions on the environment, asthma, tobacco, food policy, school health clinics, maternal health, community economic development, etc. in several states.

Breena Welch Holmes, MD, Director of Maternal and Child Health: As the Director of Maternal Child Health (MCH), Dr. Holmes provides departmental and statewide leadership for all core MCH programs including EPSDT, Children with Special Health Needs, including Child Development Clinic, School Health, Title V Planning and WIC. A key area of responsibility for Dr. Holmes is to lead and directs the ongoing collaboration which occurs between departmental programs that intersect with MCH (Childhood Lead Poisoning, Environmental Health, Epi,

Injury Prevention, Oral Health, etc) as well as agency wide program collaboration (Mental Health, Child Welfare programs) that is necessary to ensure a successful statewide MCH program and to comply with requirements of the Title V block grant. Dr. Holmes serves as a member of the VDH Senior Management Team consisting of the Commissioner, Deputies, other Division Directors, Chief Operations and Financial Officers.

Dr. Holmes is a board certified pediatrician who led a hospital owned primary care practice in rural Vermont for 12 years before joining the Vermont Department of Health as Maternal and Child Health Director in 2010. She was a 10 year member of the Early Childhood Board of Mary Johnson Children's Center and is the school physician for both the elementary and high school in Middlebury, Vermont.. She is the chairman of the Joint School Health Committee, a partnership with the Vermont Department of Health and the Department of Education.

Dr. Holmes will apply her knowledge of health care delivery systems in direct support of Vermont's activities related to clinical and preventive services. She will work closely with the Leadership Team, Blueprint for Health and the Commissioner's Office to assure cross program support for these activities.

Patrick Rowe, DDS, MPH, Oral Health Director: As the Oral Health Director, Dr. Rowe plans, organizes and directs the work of staff engaged in comprehensive approaches to oral health activities on a statewide basis. He visits schools to evaluate field operations and to discuss department programs with school officials; oversees the inspection of fluoridation installations and consults with local personnel to maintain optimum levels of fluoridation; reviews treatment plans of dental consultants to monitor appropriate treatment of needy clients who qualify for assistance under various dental assistance programs. Major public health functions include the oversight of data collection and monitoring of services provided by individual dentists in the

state and develops programmatic changes based on data analysis; development of guidelines for school dental hygienists and evaluation of other state and local dental health programs and recommends any appropriate changes.

Dr. Rowe completed a General Practice Residency at the Veteran's Affairs Medical Center in San Francisco, CA where he received first hand knowledge of the challenges faced by disabled veterans in maintaining optimal health. Dr. Rowe spent time as an associate in private dental practice in the San Francisco bay area before accepting a staff dentist position at a Federally Qualified Health Center in Santa Cruz, CA. The experience gained while working in the community clinic setting has strengthened, and continues to inform, his understanding of the real life challenges of underserved populations.

Dr. Rowe gained exposure to the policy environment through the American Dental Education Association while teaching at the University of the Pacific Arthur A. Dugoni School of Dentistry. He completed a post-doctoral public health program at the University of California, Los Angeles, and received his Masters of Public Health in 2009. Dr. Rowe joined the Vermont Department of Health as Director of the Office of Oral health in August 2009. Dr. Rowe has experience across the spectrum of healthcare delivery, from provision of clinical care in diverse settings to policy analysis, technical scientific analysis, and public health program management and will apply his expertise in this area to oral health activities outlined in the CTIP.

Additional Staffing Support: In addition, 2.5 additional FTE will be hired in support of the CTG activities. These staff will be brought into the project within 90 days of award. The Division has a fully staffed operations unit to focus on recruitment activities for these positions. Currently the State has been successful in recruiting. In the Division, for each vacant position, managers have had an average of 20 qualified candidates. An evaluator will be obtained through

a request for proposal process and may consist of several collaborative organizations with expertise in formative, process and outcome evaluation in the topic areas proposed within the Community Transformation Implementation Plan (CTIP). The position descriptions for new staff are listed below.

Public Health Programs Administrator: This position will be responsible for the day to day management and all aspects of the program planning, administration, implementation and evaluation working under direction of the Division Director. This includes planning, administrative and policy development work at a professional level, and implementation of programs to promote development of integrated systems in the community through evidence and practice-based policy, environmental, programmatic and infrastructure changes in Vermont. In addition, the program administrator will monitor performance on all contracts.

Public Health Specialist: This position will provide programmatic support and direct support to the community coalitions/groups funded under this initiative. This position is a critical part of the feed back loop in the evaluation process to ensure successful completion of proposed CTG objectives for each strategic direction. Responsibilities will include: monitoring all coalitions and/or community groups for status of programmatic activities and objectives; and monitoring the expenditure of resources by coalitions and/or community groups. In addition, this position will provide programmatic support to facilitate successful completion of proposed objectives, redirection of funding if resources are not being spent as expected and recommending appropriate educational seminars and technical assistant resources available.

Administrative Assistant: This position will assist with administration of the program including grants and contract administration, processing payments and logistics support. In addition, this position provides clerical support including record keeping, meeting management, data entry,

The Leadership Team consists of the Leadership of the Vermont Chapters of the American Academy of Pediatrics and the Vermont Chapter of the American Academy of Family Physicians, along with three Division Directors from the Vermont Health Department (Health Promotion and Disease Prevention; Maternal and Child Health; Office of Local Health); they will be joined by a representative of the Vermont Medical Society; and the head of government relations of the University of Vermont's Vermont Child Health Improvement Program (VCHIP). The original group has been meeting for over 20 years. Over the years, the group has expanded to its current configuration but has been nimble in creating ad hoc committees for projects as needed. This leadership group has been chaired or joined by leaders known both within the Vermont health community but nationally as well. The editors of the most recent Bright Futures Recommendations include three Vermonters, Dr. Joseph Hagan and Paula Duncan, along with VCHIP Executive Director, Judy Shaw who have each participated on this team.

Current members bring to the table the contacts and connections with the Leadership of the Vermont College of Medicine; The Leadership of Vermont Schools; The Tobacco Review Board; Community and Statewide coalitions that work on obesity prevention, asthma, substance abuse, oral health. Over the years, this group has worked on a variety of projects and systems changes which resulted in improvements in: lead screening for children; breastfeeding and laws to support women who do; access to health insurance and medical and dental homes for children; standards for transforming so called "sports physicals" into Bright Futures wellness exams in order to play school sports. Finally this group was the impetuous for the creation of VCHIP which has expanded nationally to NIPN (the National Improvement Partnership Network).

While Team member Garry Schaedel will have oversight of all staff involved in the CTG activities, we will also include the CTG Project Manager in the Leadership Team meetings and activities. Below is a brief description of current membership, as CTG needs dictate, additional members may be added.

Stephanie Winters, Vermont Medical Society - The mission of VMS is to serve the public by facilitating and enhancing physicians' individual and collective commitments, capabilities, and efforts to improve the quality of life for the people of Vermont through the provision of accessible and appropriate health care services. In addition to representing the perspectives of physicians who are practicing or in training, as part of the Leadership Team Ms. Winters is also key to disseminating information and leveraging participation in Department initiatives.

Dr. Lou DiNicola, American Academy of Pediatrics, Vermont Chapter (VT AAP) and Dr. Robert Penny, American Academy of Family Practitioners, Vermont Chapter (VT AAFP) - Drs. DiNicola and Penny have had a longstanding history of participation with the VT AAP and VT AAFP. As part of the Leadership Team Drs. DiNicola and Penny work with the Department to provide insight into community practice patterns, challenges and priorities and are instrumental in identification of needs and strategic planning to guide the Leadership Team and their activities.

Dr. Breena Holmes, Maternal and Child Health Director, VDH - As a Leadership Team member Dr. Holmes leads and directs the ongoing collaboration which occurs between departmental programs that intersect with MCH (Childhood Lead Poisoning, Environmental Health, Epi, Injury Prevention, Oral Health, etc), agency wide program collaboration (Mental Health, Child Welfare programs), and community engagement that is necessary to ensure a successful statewide MCH program.

Garry Schaedel, Division Director, Health Promotion and Disease Prevention, VDH - Mr. Schaedel provides leadership, planning and consultative work for the professional staff and programs of the Division of Health Promotion and Chronic Disease Prevention. His participation in the Leadership Team is critical to ensure that the needs of minority Vermonters and others at higher risk for under service and poor outcomes are addressed in all processes. In addition, he is the direct liaison with the Department of Education, Regional Planning Commissions and other key stakeholders to assure their perspectives are represented at Leadership Team meetings.

Alison Reagan, Division Director, Office of Local Health - Ms. Reagan plays a critical role in representing Vermont's local health offices. As key participants in community coalitions, the local health offices impart essential knowledge and information regarding community needs and capacity. Ms. Reagan leverages her role with local health offices to support Leadership Team efforts to promote a cohesive and coordinated system of community coalitions able to implement evidence based prevention efforts.

Patricia Berry, Vermont Child Health Improvement Project (VCHIP) - VCHIP is a trusted partner helping health care professionals improve the care they provide to children and families. Their primary purpose is to undertake measurement-based assessments of current care delivery, offer evaluation support to identify specific and achievable improvements in systems of care, actively collaborate with public and private entities seeking to spread improvement partnerships, and inform policy across larger health care systems. As part of the Leadership Team, Ms. Berry provides important insight regarding the system of healthcare and how to leverage activities to support and adapt community based infrastructure to achieve desired health outcomes.

Dr. Lisa Dulsky-Watkins, Vermont Blueprint for Health - The Blueprint is designed to promote the seamless coordination of care. It places an emphasis on preventive health – engaging people

when they are well, as well as giving patients the tools to help them manage their chronic conditions. Dr. Watkins will work in her capacity to coordinate clinical preventive services with the Blueprint and facilitate integration of these activities into Blueprint activities to assure effectiveness and sustainability.

Denis Barton, Bi-State Primary Care Association - Bi-State Primary Care Association (Bi-State) s an organization whose members provide and/or support community-based primary health care services. A "voice" for the medically underserved, Bi-State members include community health centers, rural health clinics, private and hospital-supported primary care practices, community action programs, health care for the homeless programs, area health education centers, clinics for the uninsured, and social service agencies. Bi-State works with federal, state, and regional health policy organizations and policymakers, foundations, and payers to develop strategies, policies, and programs that promote and sustain community-based, primary health care services.

Sarah Wendell Launderville, Vermont Center for Independent Living (VCIL) - VCIL is directed and staffed by individuals with disabilities, works to promote the dignity, independence and civil rights of Vermonters with disabilities. Like other independent living centers across the country, VCIL is committed to cross-disability services, the promotion of active citizenship and working with others to create services that support self-determination and full participation in community life.

Community Coalitions: As previously stated, Vermont has taken a progressive approach to the development of coordinated and integrated prevention activities among community coalitions. Our efforts in this area began as three major prevention initiatives which have converged. These initiatives include the Community Tobacco Coalitions, Strategic Prevention Framework (SPF)

State Incentive Grant (SIG), and the Coordinated Healthy Activity, Motivation and Prevention Programs (CHAMPPS). Separately they have each worked to implement evidence based prevention strategies in the areas of substance abuse, obesity and physical activity, tobacco and other key public health areas. Over time VDH has made a concerted effort through capacity building, technical assistance and strategic funding to bring these coalitions together to provide prevention services in a coordinated and cohesive manner. A brief history of the initiatives and the associated coalitions is described below.

Coalition Activities: Tobacco: With grants to local groups, and through direct community services, the Health Department's Tobacco Control Program and Local Health Offices has had a history of bringing statewide tobacco control efforts to the local level. Vermont's funded coalitions coordinate events, conduct outreach and media campaigns, refer community members to quit resources, support local policy changes, and more. Coalitions also provide support to schools, hospitals, health care providers, non-profit organizations, businesses, local media, and law enforcement, in their efforts to promote the reduction of tobacco use.

General coalition activities across the state include helping a community to make town parks smoke-free; organizing cessation classes at local businesses to encourage employees to quit tobacco; collaborating with youth groups like OVX (Our Voices Xposed, a high school-aged programs) and VKAT (Vermont Kids Against Tobacco, a middle school program) to host media literacy education activities; working with retailers to reduce/remove tobacco advertising and displays; partnering with mental health providers to support tobacco cessation among their clients; and helping local businesses set smoking policies, like making building entrances smoke-free.

VDH's Tobacco Control Program provides community coalitions with training and technical assistance to support its emphasis on the use of research-based prevention programs and strategies.

Coalition Activities: SPF SIG: The Vermont SPF SIG began as a federally funded cooperative agreement with the Substance Abuse and Mental Health Administration (SAMHSA), Center for Substance Abuse Prevention (CSAP) and the State of Vermont. The SPF process enables Vermont's coalitions to develop substance abuse prevention infrastructure and through the awarding and evaluation of community grants implementation of prevention programs, practices and strategies necessary to achieve population based positive outcomes.

The SPF is a public health, outcomes-based prevention approach that uses assessment and evaluation to continually move communities forward toward their goals of reducing substance abuse and its consequences. The funded coalitions of Vermont utilize strong collaborations between the private sector, public health, academic partners, non-profit services providers and others to implement the VT SPF-SIG, develop prevention expertise and infrastructure to sustain the process, and generate evidence to support replication of the process across the state.

Coalition Activities: CHAMPPS: Act 215 created the CHAMPPS Program to provide coalitions with technical assistance and sustainable funding to carry out prevention and wellness initiatives. In addition to the funding for wellness initiatives such as obesity prevention and lead poisoning prevention, the initial round of grantees included coalitions working on substance abuse prevention, using federal Strategic Prevention Framework (SPF) and tobacco cessation funding to support these efforts. The CHAMPPS Program represented a significant milestone in the Department of Health's strategic efforts to align community coalition activities in order to converge cross-issue efforts while strengthening local public health infrastructure.

The CHAMPPS Program now serves as the foundation for community wellness initiatives within the Department of Health (VDH) by awarding comprehensive, substantial multi-year grants to communities for health and wellness projects. In support of this approach, VDH has developed internal operational processes to manage funding streams and ensure that all locally-funded initiatives are as coordinated and integrated as possible. VDH will continue to leverage this past work and fund community coalitions to fulfill the requirements of the CTIP set forth by the Department.

Coalition Past Performance: Initial activities for which coalitions were funded focused primarily on capacity building. During this time coalitions were funded to convene new coalitions; promote coalition membership; develop coalition charters, bylaws and operating procedures; develop regional plans for community health including needs assessments and strategic planning; and build coalition capacity in targeted health areas, particularly through training and technical assistance. Capacity building efforts have focused on the areas of alcohol, tobacco and other drug abuse prevention; physical activity; lead poisoning and, nutrition with varying emphasis on youth and adults.

Since the beginning of Vermont's efforts to develop local capacity to implement evidence based public health programs, the number of coalitions has proliferated. A comprehensive list of coalitions is included in the Appendix. These coalitions have had support and representation from a broad base of stakeholders including: city and regional planning, health care providers, child care providers, hospitals and wellness centers, teen centers, senior centers, schools, parents, youth, business, boards of health or health officers, advocates, transportation and planning, Federally Qualified Health Centers, Girl Scouts, United Way, WIC, community centers, youth camps and more. As the network of coalitions has matured and grown in both scope and number,

they have continued to expand their membership to include stakeholders critical to their ongoing success.

While the Department continues to foster additional capacity building when needed, over time coalition activities have shifted to implementation. With their needs assessment, community plans and strategic initiatives identified, coalitions have been very eager and successful in the implementation of programs and initiatives. Because of the large number of coalitions and coalition activities, a representative sample of their activities and accomplishments are listed below. As expected many coalitions across the state are engaging in similar efforts even though it may be listed only once.

- Increased lead poisoning testing among children.
- Training of landlords and contractors in essential maintenance practices and lead-safe renovation practices
- Lead prevention outreach and education for medical providers, social service providers, city government, legislators and the community at large
- Building community capacity for lead case consultation.
- Community outreach and education for physical activity and healthy eating
- Advocacy and education for policymakers regarding the creation of built environments to support physically active lifestyles
- Ongoing physical activity events and programs
- Training providers on physical activity and nutrition, with focus on a lifespan approach
- Coalition awards to cities and towns to implement physical activity and nutrition activities
- Working with schools to adopt an "active recess" program to promote physical activity
- Working with farmer's markets

- Removal of unhealthy foods from "school snack carts" and provide healthy alternatives
- Collaborations with town Recreation Departments, garden centers and families to make available space for community gardens
- Incorporating physical activity opportunities into a Brownfield redevelopment project
- Working with emergency food shelves to accept fresh produce from farmers and community gardens to improve access to healthier foods for low income Vermonters
- Working with school superintendents and school nurses to continue with the implementation of school wellness policies
- Helping a community to make town parks smoke-free through policy change
- Organizing cessation classes at local businesses to encourage employees to quit tobacco
- Collaborating with youth groups to host media literacy education activities
- Working with retailers to invoke policies to reduce/remove tobacco advertising and displays
- Partnering with mental health providers to support tobacco cessation among their clients
- Helping local businesses set smoking policies, like making building entrances smoke-free
- Alcohol media campaigns
- Support and collaborate with law enforcement to conduct sobriety checkpoints
- Support Department of Liquor Control to conduct Responsible Beverage Server Training
- Promote the adoption of alcohol curriculum and education such as Botvin's Life Skills, Challenging College Alcohol Abuse, Project Northland
- Social marketing and policy change with Job Corps
- School policy development and policy change regarding alcohol and drug abuse programming
- Diversion/TASP (Teen Alcohol Safety Program) policy review

- Workplace alcohol-free policy change and campaigns
- Restricting or limiting alcohol outlet density or location
- Social host liability alcohol ordinances
- Land use ordinances regarding the use of alcohol in public places

SECTION 5: COMMUNITY TRANSFORMATION IMPLEMENTATION PLAN (CTIP)

Vermont is uniquely positioned to integrate clinical and community components into a cohesive whole because of the work the state has done to create the Blueprint, community teams and community coalitions.

The Vermont Department of Health is the state's lead agency for public health policy, planning, surveillance, intervention and advocacy. Essential public health and disease prevention services are available across Vermont through VDH's 12 local health district offices (due to our size, Vermont does not have a county government structure). The local health district offices are overseen by VDH Central Office and work in partnership with local health care providers, voluntary agencies, municipalities, schools, businesses and community organizations to improve health and extend statewide initiatives in local communities throughout the state. As the state's lead agency for public health, VDH has had a longstanding history of working across local, state and federal agencies to implement public health strategies and interventions. A major function of the Department will be to facilitate and convene stakeholders and assure the delivery of adequate technical assistance.

In 2004, all funded CDC chronic disease programs in VDH including Surveillance, and Tobacco Control began meeting monthly with the Chronic Disease Director and Blueprint staff, to educate each other about our surveillance, community assessments, interventions, common stakeholders,

evaluation efforts, and key relationships within the state, region, and with the CDC. This group worked collaboratively and its work culminated in the development and adoption of, to adopt the Vermont Prevention Model (social ecological model) and Strategic Prevention Framework, as an integrated approach to community assessment, planning and capacity-building efforts. From these meetings, a need for a team approach to supporting integrated programs at the local level was initiated.

The primary methods for assuring successful implementation of the proposed strategies are through the support of community coalitions and their capabilities to add to the local public health infrastructure. As such, the goal of VDH at a state and local health office level is to facilitate coordination and communication across stakeholders as well as assure that community coalitions have adequate technical assistance resources.

At the state level, the project Leadership Team and management staff will engage key stakeholders from across state government and statewide organizations, including membership organizations. The state Leadership Team will convene partners critical to the success of this project to help increase the capacity, reach and effectiveness of the community coalitions. VDH and the Leadership Team will work with local health district offices and community coalitions to provide technical assistance (TA). VDH's approach to TA has been its cornerstone in its success engaging community coalitions and helping to facilitate a stronger local infrastructure to deliver public health programs. It is focused around the development of productive two-way communication to build a collaborative relationship that engages community coalitions to identify needs as well as solutions. The provision of TA is grounded in the concept that the coalition is an integral participant in developing action plans and has itself intrinsic expertise in

its understanding of the regional context in which public health programs occur. In this way TA is an exchange of expertise and support and fosters a trusting reciprocal relationship.

VDH TA: supports coalition activities with training on research based best practices; provides information on various strategies and resources available to the community coalitions; provides insight to guide the development of program improvement goals; offers peer networking opportunities for coalitions; helps to manage conflict (when appropriate) among project partners; and, promotes the coalition leadership skills. VDH is able to achieve this by engaging its own contacts from local, state, and federal partners who provide assistance through a variety of approaches, techniques, strategies and resources.

This approach is similarly carried out at the local level. At the local health district offices, Public Health Prevention Specialists coordinates work with the Blueprint for Health Community Health Teams and community partners to develop and implement evidence based public health chronic disease prevention initiatives. This approach leverages state and local resources that further supports these services and creates a public health infrastructure to strengthen an integrated system of health.

Sustainability: The projects outlined in this application build on existing partnerships and programs at the state and local level. It focuses on policy, infrastructure and environmental change to support long term outcomes which assure sustainability beyond the funding period by nature of their effect. VDH will continue to provide state level support including grant funding (when available), technical assistance, resources, and best practice guidelines. The tools, resources, and training materials developed, will be maintained and require "manageable" updating in the future.

The projects outlined in this proposal were chosen based on comprehensive assessments of current needs. The priorities are aligned with the initiatives and goals of VDH, Blueprint for Health and the goals of the integrated Chronic Disease Prevention and Health Promotion efforts and programs (as defined by Healthy People and Healthy Vermonters 2020). The evidence based interventions will be incorporated into funding opportunities made available to communities through these initiatives.

VDH will partner with state level advocates for public health to discuss how best to sustain gains made by community coalitions engaged in each of the projects. These partners include but are not limited to: American Heart Association of Vermont, American Lung Association of Vermont, American Cancer Society of Vermont, Coalition for Tobacco Free Vermont, Fit and Health Advisory Committee, AARP, Smart Growth Vermont, Vermont League of Cities and Towns, Vermont Tobacco Evaluation and Review Board, the Vermont Superintendents Association, The Vermont Principals Association, and the Vermont School Board Association. These partners will assess capacity for statewide policy change across physical activity, nutrition, and tobacco use.

The plan to acquire funding and resources from non-federal sources to sustain these policy efforts include: Vermont Tobacco Evaluation and Review Board and Coalition for Tobacco Free Vermont educating and advocating for state funds to support tobacco control program efforts; VDH supporting public health efforts through the Blueprint for Health Initiative blending health care reform with prevention efforts; identifying new funds and resources from health foundations or other organizations developing proposals; and sustaining the CHAMPPS community grant funding for coalitions working on chronic disease prevention.

SECTION 6: SELECTION OF STRATEGIES AND PERFORMANCE MEASURES

Vermont will focus their activities within four Strategic Directions including: Strategic Direction #1: Tobacco Free Living: Strategic Direction #2: Active Living and Healthy Eating; Strategic Direction #3: Increased Use of High Impact Quality Clinical Preventive Services, and Strategic Direction #4: Healthy and Safe Physical Environment. As Section 1 describes, Vermont continues to have poor health status indicators and outcomes in these areas with disparities existing among low SES and minority populations. In the budget narrative we have described that over 50% of all funds will be distributed to communities, over 50% of all funds will be dedicated to Strategic Directions #1, #2, and #3 and over 20% of funds will be distributed to rural areas of the state.

The strategies selected for the CTIP have been chosen based upon their ability to effectively impact and reach a significant portion of the target population. While community coalitions, through their membership have access to the broad array of stakeholders to make the CTG initiative successful, we have also chosen strategies which reach the target population. Specifically we have chosen ways to influence positive outcomes such as multi-unit housing, child care centers, parks, retail food stores, physician's offices. Given the past success of community coalitions in changing policy (see Section 4: Leadership Team and Coalitions) we have chosen strategies with high likeliness of successful implementation as well as reach. Given what we know regarding the evidence base on each of these strategies, they will also be greatly effective and assist the state in reaching the improvement in health outcomes required under FOA.

Tobacco

As described in Section 1: Background and Need, Vermont has not yet reached its goals for tobacco cessation and continues to show that the population of people of lower SES and racial

and ethnic minorities experience disparities and justifies the selection of Strategic Direction #1, Tobacco Free Living: The selection of specific evidence based strategies will target the promotion of smoke-free housing units, parks and increase the number of smokers referred to the VT Quit Network. As data from the Adult Tobacco Survey indicates, the percent of adult smokers increases with increasing poverty. In response, our strategies focus on increasing the likeliness that they will be referred by their doctor to the VT Quit Network. There are similar trends regarding second hand smoke in that second hand smoke exposure is higher among low income Vermonters. Low income Vermonters are less likely to ban smoking in their home as compared to middle or high income households. Among Vermonters with children, smoking is less often prohibited by those with lower incomes as compared to middle or high income households. Low SES is also the demographic for multi-unit housing in the state and as such, we will focus on second hand exposure policy in this setting. Banning smoking in public parks and other areas will also be a focus of our efforts.

Active Living and Healthy Eating

Vermont will expand strategies to promote active living and healthy eating building on the current successful model of state level content experts development and dissemination of best practice programs for local implementation.

As stated in *Section 1: Need and Background*: Childhood and adult obesity is a statewide epidemic, but with significant disparities existing in particular populations. In response, the state will focus on development of Farm to Institution initiatives, policy changes at early child care settings, and encouraging retailer to provide access and availability of healthier foods in food desert locations. Three key driving issues have directed us to selecting these strategies.

Lasting behavioral change to correct and prevent obesity requires a holistic, systems-based food education intervention that works on multiple levels to reconnect people to their food. Vermont is experiencing a rapid attrition of small, local farms. Many Vermonters have lost, or in many cases, never experienced a basic connection to their food. They have little, to no personal experience, on which to build healthy eating behaviors. Given that many low income Vermonters rely upon institution-based meal programs – such as reduced and free school meals – the Farm-to-Institution strategy is ideally suited for this purpose.

Interventions aimed at children, particularly those of low SES, have been an ongoing challenge. According to www.Childtrends.org, 24% of children in Vermont are below 150% of the federal poverty level, of those children 74% use center based child care. Efforts to change policies in child care are more likely to reach a larger number of targeted children and be sustainable well past the funding period. Given the broad use of center based services, this will also have a significant reach to the general population.

Finally, given the rural nature of Vermont, the distribution of retail food stores where dependable and adequate selections of fresh fruits and vegetables are available is very poor. Vermonters often have to travel long distances to shop for food staples. While local retail convenience stores fulfill an important role, they often lack the willingness or infrastructure to supply fresh fruits and vegetables on a regular basis. As a result "food deserts" often exist in Vermont's rural and frontier areas. We plan to encourage retailers to provide access and availability of healthier foods so a larger number of rural residents have healthier food choices. Given the poverty disparities in rural areas, and the distribution of minority residents, this strategy will have a broad reach within the general population as well as the target populations.

Quality Clinical Preventive Services

Vermont has had a longstanding commitment to promoting behavior change through developing activated and engaged patient – provider teams. One example of this work is the Blueprint for Health (described further in Section 1: Background and Need). The Vermont Blueprint's Expansion and Quality Improvement Program (EQuIP) translates visionary policy into real world operations and sustainable change. Components of EQuIP include a team of Blueprint quality improvement practice facilitators who provide general ongoing support to practices and providers, additional facilitators from other organizations that offer targeted expertise as needed (for example on IT implementation and workflow), analytic support from the University of Vermont, the health information infrastructure that feeds them, and a wide range of quality improvement activities. They are trained to work with the practices on data guided cycles of improvement and access comparative effectiveness and performance reporting to help guide their activities.

Community Health Teams are key to Blueprint activities. They are locally-based multi-disciplinary teams that bridge the gaps and drive change towards a community system of integrated health services. They connect health care providers with health services and community based program to transform the way care and preventive health services are delivered. The design and personnel structure of the CHTs are created at the local level. Community health teams are embedded in advanced primary care practices (APCPs). Their focus is to enhance access and shift the focus from acute care to population management and delivery of evidence based preventive health services. APCPs are formally recognized by the National Committee for Quality Assurance (NCQA) Physician Practice Connection – Patient Centered Medical Home program (PPC-PCMH) as patient centered medical homes. NCQA PPC-PCMH standards require primary care practice to enhance access and continuity; identify and

manage patient populations; plan and manage care; provide self-care support; track and coordinate care; and, measure and improve performance. Enhanced self-management support and informed decision making is also embedded in the Blueprint model. The presence of CHTs, working closely with APCPs, provides resources and supports (e.g. counseling & education) that are essential for many patients to achieve personal goals, live healthier lifestyles, and improve their health status.

While the Blueprint for health provides a strong infrastructure Vermont data still shows that we still have significant gaps in our ability to assure patients receive recommended clinical preventive services (See Section 1, Background and Need). In support of the CTG the Blueprint for Health infrastructure will be leveraged in the grant period to address clinical preventive services for substance abuse and mental health conditions, tobacco cessation and promote the Healthier Living Workshops (described below). The Blueprint will provide training to facilitators, community health teams, advanced primary care practices, and community based health service providers; provide facilitation in advanced primary care practices to integrate screening tools into their clinical workflow; host learning sessions with each community team to share best practices and strategies for further quality improvement; provide community based self-management programs and in person tobacco cessation.

Healthier Living Workshops: Healthier Living Workshops (HLWs) are Vermont's version of the Stanford Chronic Disease Self Management programs. These six week long evidence-based programs teach patients self-management skills and provide a peer support network for individuals with chronic conditions. HLWs empower individuals as self-managers through education, support and skill-building exercises, notably, goal setting, action planning, and problem-solving. As of December 2010, over 2070 Vermonters have completed the program,

participating in 350 workshops, representing every (14) health service area in the state. Capacity exists to serve more individuals who may be engaged through CTG activities.

Oral Health: According to the CDC "water fluoridation reaches all residents of communities and generally is not dependent on individual behavior." This is a key factor in the selection of water fluoridation as a prevention strategy to reach the broad population as well as target areas of high health disparities. In Vermont, only 58% of community water systems use optimal levels of fluoride. Vermont ranks 37th among all states for the percent of population reached by this key prevention measure. Under the CTG community coalitions will be funded to provide education to the public and policymakers regarding the importance of fluoridation.

According to a study published in the January/February 2010 issue of *General Dentistry*, the Academy of General Dentistry's (AGD) peer-reviewed clinical journal, the controlled addition of a fluoride compound to public water supplies is considered to be the most cost-effective way to prevent cavities and fight tooth decay. The Centers for Disease Control and Prevention (CDC) states that studies show that for every $1 invested in the prevention measure of water fluoridation, it yields $38 of savings in dental treatment costs.

Healthy and Safe Physical Environment

Vermont has a number of initiatives under way that support creating healthy communities in the state, such as the Designated Downtown Program: This program provides state incentives for communities to develop downtowns and reduce sprawl; Statewide Safe Route to School: This efforts assists communities to create and support safe walking and biking around schools; Agricultural programs that support local farms and farmers, farmers markets, and Farm-to-Institution programs; The recently legislatively passed, "Complete Streets Policy" which creates a strong partnerships between the Vermont Agencies of Transportation and Agriculture and the

Departments Health, , Economic Housing and Community Development; Forest Parks and Recreation. The policy focuses on various initiatives that support "healthy community design"; CHAMPPS funding over the past four years that supports local communities to develop and implement healthy community design strategies. All nine grantees are in the process of developing and/or implementing healthy community design projects.

Designing communities so that physical activity and access to healthy food is part of our regular daily routine ensures that healthy options are available to all regardless of age and income. Peer reviewed studies demonstrate a 35% increase in physical activity (e.g., number of walkers or percent of active individuals) in communities with more inviting and safer outdoor environment for activity. Examples of "healthy community design" which will be promoted as part of this project include:

Mixed Use Development where residential, retail, office, industry, medical and educational facilities are built close to each other and in higher densities help to create a walkable community that provides opportunities for people of all ages and abilities to engage in routine physical activity and creates a greater market for and access to healthy food options, cuts down on commute times, concentrates infrastructure investments, and promotes social interaction among community members.

Bicycle and Pedestrian Friendly Communities promote active daily living through biking and walking, addressing safety, comfort and aesthetics by providing amenities such as bicycle parking, sidewalks, cross walks, shared use paths, lighting, benches and street trees.

Access to Parks, Recreational Facilities and Open Space provides residents with safe places to connect and play. Access to recreation facilities— such as parks and green space, outdoor sports fields and facilities, walking and biking trails, public pools, and community playgrounds – is

affected by proximity to homes or schools, cost, hours of operation, and transportation.

Access to Healthy Foods is essential to a healthy diet. Local land-use policies, zoning and ordinances can increase access to healthy food and local food production by utilizing public spaces for farmers markets, expanding community garden programs, supporting community-based agricultural enterprises, providing incentives to food retailers to offer healthier foods and zoning for supermarket and restaurant locations.

SECTION 7: PERFORMANCE MONITORING AND EVALUATION

The project will have a significant focus on formative evaluation at the community level. Formative evaluation will provide an opportunity to monitor and understand coalitions experiences implementing evidence based strategies and assisting them in adhering to the fidelity or identifying the facilitating and obstructive facets to implementing them. The evaluation process will include both quarterly reporting from coalitions to describe the challenges and successes as well as site visits to gain perspective from all coalition members and other community partners. This approach will give the CTG staff an opportunity to promote a culture of learning and continuous quality improvement within the coalitions and, by documenting and sharing this information with other coalitions will create a learning community and promote inter-coalition communication and collaboration. The evaluator will work with coalitions to assure that the experiences gained through this project are widely shared and understood. Coalitions' payment is based on successful completion and implementation of the required programmatic activities. Currently Vermont's Coalitions are required to submit the following documentation for programmatic activities: Coalition/Partnership Capacity Building Work Plan; Assessment Report(s); Prevention Implementation Work Plan(s); any required National Outcome

Measures (NOMs); completion of Capacity Building Work Plan; Status of Prevention Implementation Work Plan(s); and provide additional relevant information such as any promotional items distributed. In addition, Coalitions report two times per year on a programmatic success story. This reporting format is well established and all Coalitions will continue to use this format for any funding awarded through this grant. This quarterly and semi-annual reporting will provide the basis for the projects process evaluation.

Financial monitoring includes the submittal and approval of a budget at the same time Coalitions are submitting the documentation for programmatic activities. Financial reporting will include quarterly invoicing with a line item expenditure report based upon an approved budget. This provides the opportunity for the State to monitor all Coalitions and their expenditure of resources as expected, and if necessary to redirect any funds. Redirection could be within the Coalition's budget or redirected to another Coalition if appropriate. This ongoing monitoring and management will assist in redirecting funds and ensuring grants funds are spent timely and appropriately.

Actual payment to the Coalitions is based on the expenditure of funds reported and is contingent on addressing and/or completing at least 80% of action steps outlined in approved Capacity Building Work Plan and Implementation Work Plan(s) per quarter. The State reviews and approves all reports before payment or provides technical and programmatic support to facilitate successful completion of proposed objective. If a Coalition does not achieve 80% completion payment denied. This quarterly monitoring provides a continuous feed back loop as part of the process evaluation to ensure successful completion of proposed CTG objectives.

At the state level, the CTG staff will convene all relevant topic-based programmatic staff to review overall CTG progress as well as progress in each topical area. Continuous Quality

Assurance and Improvement (CQI) are integral to the performance monitoring and evaluation of multifaceted and complex initiatives. Vermont's CQI process will take form in a Plus/Delta. Plus/Delta is a process used by many organizations to build upon the strengths of a team, coalition or activity (+) while identifying areas that need to be changed (△). Ideally, a Plus/Delta should be conducted at important junctions of a project but will be conducted at least quarterly to raise issues or concerns regarding the methodologies, workplans or project management and identify strategies to address these issues. Primarily, the team will review the input from the evaluator and findings of the formative and process evaluation. This will provide the basis from which the Plus/Delta can draw information and quality improvement strategies be identified. It will be the responsibility of the CTG staff to monitor the general progress of the entire project, and ensure that any issues identified during a Plus/Delta were appropriately addressed. CTG staff not only invites, but strongly encourages a representative(s) from the Leadership Committee to participate in the Plus/Delta meetings. Participation in these meetings will reinforce already established lines of communication and create a true collaboration between all members and facilitate the development of effective solutions when needed.

In addition to ongoing formative and process evaluation and performance monitoring through the CQI process described above, CTG staff will work with VDH statisticians to assure that relevant data on core measures (changes in weight, proper nutrition, physical activity, tobacco use prevalence and emotional well-being and mental health) are collected and analyzed according to program needs. At this time, VDH statisticians collect all core measures through the Behavioral Risk Factor Surveillance Survey (completed both for youth and adults). This data can be made available at the county and state level to monitor progress. As well, staff has the ability to combine years of data to evaluate progress towards outcomes at a more granular level such as

town or village. This will be of particular importance when targeting improvements in less populated rural areas of the state. The purpose of the evaluation will be: to understand the extent to which community coalitions are adhering to the fidelity of evidence-based programs (formative evaluation); to understand the facilitators and barriers to community coalition implementation of evidence-based programs (formative evaluation); to understand the number of policies, environmental, programmatic and infrastructure changes accomplished through local and state CTG activities (process evaluation); and, to understand changes to core measures (changes in weight, proper nutrition, physical activity, tobacco use etc.) in each of the participating communities and statewide (outcome evaluation).

Given Vermont's ability to monitor core measures on a granular level, we would be very interested in exploring the extent to which other methodologies could be employed to monitor progress. We welcome and encourage participation in national evaluation activities and feel that as a whole state applicant we can contribute to the body of knowledge in this area.

SECTION 8: PARTICIPATION IN PROGRAMMATIC SUPPORT

As part of programmatic monitoring and the CQI process, CTG staff will develop quarterly briefings which describe and provide context to the evaluation process. This information will be shared with the Leadership Team, Local Health Departments, coalitions as well as the CDC and will provide a foundation for better understanding the processes involved in this work as well as provide insight to formative evaluation and CQI activities of future CTG Implementation grantees. We would welcome and encourage participation in regional calls with other CTG awardees to discuss the briefings developed by the CTG team and as requested can provide more formal presentations to the national cohort of CTG awardees (such as through Webinars) as well as national CTG trainings and conferences.