CANCER PREVENTION & RESEARCH INSTITUTE OF TEXAS

REQUEST FOR APPLICATIONS

RFA P-10-CCP1

Community Collaborative Prevention Programs and Services for Breast, Cervical, and Colorectal Cancers

2009–2010

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1. ABOUT CPRIT

The State of Texas has established the Cancer Prevention and Research Institute of Texas (CPRIT); CPRIT may issue $3 billion in general obligation bonds over 10 years to fund grants for cancer research and prevention.

CPRIT is charged by the Texas Legislature to

- Create and expedite innovation in the area of cancer research, thereby enhancing the potential for a medical or scientific breakthrough in the prevention of cancer and cures for cancer;
- Attract, create, or expand research capabilities of public or private institutions of higher education and other public or private entities that will promote a substantial increase in cancer research and in the creation of high-quality new jobs in this State; and
- Continue to develop and implement the Texas Cancer Plan by promoting the development and coordination of effective and efficient statewide public and private policies, programs, and services related to cancer and by encouraging cooperative, comprehensive, and complementary planning among the public, private, and volunteer sectors involved in cancer prevention, detection, treatment, and research.

2. EXECUTIVE SUMMARY

Cancer is the second leading cause of death in the United States and Texas. Several types of cancer can be prevented, and the prospects for surviving cancer continue to improve. CPRIT will foster the prevention and control of cancer in Texas by providing financial support for a wide variety of projects relevant to cancer prevention, risk reduction, early detection, and survivorship. This RFA solicits applications for relatively short-term projects (up to 3 years) that would provide services through development of collaborations that address documented cancer prevention and control challenges from an innovative perspective. This RFA encourages traditional and nontraditional partnerships and leveraging of existing resources and dollars from other sources. CPRIT expects measurable outcomes of supported activities that demonstrate impact on incidence, mortality, or morbidity or interim measures related to the outcomes.

3. FUNDING OPPORTUNITY DESCRIPTION

3.1. Program Objectives

Background: It is estimated that 97,847 persons will be diagnosed with cancer and 37,285 persons will die from cancer in Texas during 2009.[1]

The risk of developing many cancers can be reduced by personal behavior changes (e.g., smoking cessation, improved nutrition, and increased physical activity). Some cancers can be prevented if tissue changes are detected early and the tissues are removed at a precancerous stage (e.g., precancerous colon polyps or precancerous changes in cervical tissue). Research has shown that several types of cancer can be "cured" if detected during early stages of development and treated promptly and appropriately. Other cancers can be controlled for many years with appropriate treatment and support services.

The aim of this RFA is to increase access to and utilization of primary prevention (e.g.., HPV vaccine), early detection/screening and followup services for cancers of breast, cervix, colon, and rectum above current levels and leading to a reduction of cancer incidence, morbidity, and mortality and an increase in quality of life of cancer survivors. The scope of the proposed projects may include education and outreach and survivorship programs and services. Case management and referral to treatment for those diagnosed with cancer must be provided. In addition, system barriers that may limit access to prevention services or affect the patient outcomes for those diagnosed (e.g., followup on abnormal results, ensuring access to timely treatment) should be addressed. *This RFA will not address treatment of cancer.*

Prevention research will not be funded through this award mechanism. Refer to the Centers for Disease Control and Prevention's document titled Guidelines for Defining Public Health Research and Public Health Non-Research as guidance in defining prevention research and nonresearch (http://www.cdc.gov/od/science/regs/hrpp/researchDefinition.htm).

Objectives and Scope: The ultimate goals of this program are to reduce overall cancer incidence and mortality from breast, cervical, and colorectal cancers by stimulating the development of collaborations that address cancer prevention and control challenges in new and/or innovative ways. *The goals of collaborative projects should include reducing barriers and system fragmentation and making the most efficient use of resources in order to increase public education, outreach, provision of services, and detection of cancer at earlier stages, thereby*

leading to increased survival and decreased mortality rates. The ability to reduce cancer death rates depends, in part, on the application of some of the evidence-based clinical and programmatic strategies currently available. *CPRIT is seeking unique projects and partnerships that will apply these evidence-based programs and clinical services in new ways in Texas*

Specifically, CPRIT seeks to fund comprehensive projects that can address the continuum of preventive care from education and outreach, evidence-based primary preventive measures (e.g., vaccines, education), early detection, and diagnostic services as well as patient navigation and other postdiagnosis services if cancer is detected. Furthermore, the projects should

- Offer effective and efficient prevention services based on the existing body of knowledge and evidence for cancer prevention in ways that far exceed current performance in a given geographic service area;
- Provide tailored, culturally appropriate, and accurate information on early detection and prevention to the public that results in a direct health impact that can be measured;
- Provide effective and innovative outreach strategies to educate the public and increase recruitment into appropriate clinical screening and survivorship services that demonstrate increased rates of early-stage cancer diagnosis and improved quality of life;
- Provide access to state-of-the-art preventive services to individuals;
- Target delivery of preventive services to areas and populations in the State with the greatest need; and
- Reduce barriers and system fragmentation and make the most efficient use of resources.

3.2. Award Description

The Community Collaborative Award seeks to support the creation of integrated programs of a collaborative nature based on the concept of the "community of solution," in which a variety of existing community entities contribute and mobilize their resources collectively to solve a community problem. This RFA invites a coordinated submission of a collaborative partnership program where all partners have a substantial role in the proposed project. For example, collaborations among various organizations may be needed in the following areas:

- Overcoming obstacles to the recruitment and delivery of services tailored to priority populations;
- Patient education/outreach and inreach (e.g., workplace partnerships to reach employees);
- Delivery of screening services and followup on abnormal screens;
- Patient case management after diagnosis (e.g., patient navigation and other survivorship services);
- Coordinating program activities;
- Expanding and maximizing resources; and
- Process and outcome evaluation and reporting (e.g., community organizations partnering with academic institutions for evaluation and reporting).

Through the collaborative partnership model, prevention programs should be able to better identify and meet the diverse needs of the priority populations in communities across the State. It will be critical for funded programs to measure outcomes that have the potential to reduce incidence, mortality, and morbidity.

3.2.1. Priority Areas

CPRIT encourages applicants to address critical needs in cancer prevention and control for the following anatomic sites cancer types:

- Breast
- Cervix
- Colon and rectum

There is sufficient evidence that the provision of age-appropriate, comprehensive, preventive services for these cancers to eligible men and women reduces overall disease incidence and mortality. Applicants should follow evidence-based national clinical guidelines (including but not limited to those of the American Cancer Society, The Guide to Community Preventive Services, U.S. Preventive Services Task Force, etc.) and cite the source.[2,3,4,5,6]

In addition to cancer type, the priority populations should be a major focus for preventive services. Priority populations are subgroups who are disproportionately affected by cancer. Priority populations include but are not limited to

- Underinsured and uninsured individuals;
- Geographically or culturally isolated populations;

- Medically unserved or underserved populations; and
- Any populations with low screening rates, high incidence rates, and high mortality rates. (See appendix, section 9 of the RFA.)

The application should seek to serve individuals that are not eligible for other programs or benefits covering the same services proposed in the application.

CPRIT areas of interest and program service examples include but are not limited to those that can demonstrate a significant increase over baseline for the following:

- Coordination and integration of delivery of services for all three—breast, cervical and colorectal—cancers to underserved populations to include education and outreach, provision of cancer screening and diagnostic services, and case management for navigation through the process of diagnosis and referral to treatment;
- Coordination of all the resources in a given geographic service area (funding, service providers, nonprofits, etc.) to focus on a single goal such as reduction in cervical cancer deaths;
- Systematic investigation into the causes of high mortality rates and disparities in a given service or geographic area and development and implementation of plans to address the causes and improve outcomes; and
- Multisector partnerships that address cancer prevention and control in a novel way involving home, school, workplace or some combination of the family, community organizations, schools, and the private and academic sector to expand outreach and delivery of services. Examples are expanding outreach and delivery of services to include workplace wellness programs, faith-based outreach, and outreach for HPV vaccination.

Cervical Cancer Note

The Centers for Disease Control and Prevention report that Texas had the ninth highest mortality rate and seventh highest incidence rate for cervical cancer in 2005 among the 50 States. Accordingly, CPRIT encourages applications that address this critical need in creative and compelling ways.

Breast Cancer Note

CPRIT recognizes the recent debate over when it is most appropriate to begin mammography screening. However, evidence shows that mammography does save lives, including for women in their 40s. Until a more precise screening tool becomes

available, CPRIT funding mechanisms will continue to support recommendations for its use beginning at age 40 for average-risk women. To view a press release issued by CPRIT regarding this topic, please visit www.cprit.state.tx.us.

3.2.2. Outcome Metrics

The applicant will be expected to describe and quantify final outcome measures for the project. Outcome measures should include separate outcomes for different aspects of the collaborative project and services provided. Evaluation of processes and systems improvement as well as data collection and reporting of key system and health outcomes will be of critical importance.

The outcomes should include but are not be limited to the following:

Organizational/System Outcomes

- Qualitative analysis of the identified barriers to the provision of comprehensive preventive services that include target population barriers as well health system barriers;
- Qualitative analysis of specific process(es) implemented to address the identified barriers and their effectiveness in doing so (include target population barriers as well health system barriers); and
- Formative and summative evaluation of processes, system improvements, and their effectiveness on provision of comprehensive preventive services to the target population.

Target Population Health Outcomes

- For Health Education Services
  - Increase over baseline of priority populations who utilize proposed preventive measures after participating in the educational program. In addition, interim measures may include the following:
    - Increase over baseline of persons appropriately counseled about health behaviors and evidence-based screening guidelines;
    - Increase over baseline of persons discussing the pros and cons of screening for cancer with their healthcare provider; and
    - Increase over baseline of persons who access cancer survivorship services.
- For Screening Services
  - Percentage of increase over baseline in provision of age-appropriate, comprehensive

preventive services to eligible men and women in a defined service area, in particular:

- Underinsured and uninsured individuals age 50 years and older who have never been screened for colorectal cancer;
- Women who have never been screened for cervical cancer or have not been screened in the past 5 years; and
- Women age 40 years and older who have not received a screening mammogram within the past 5 years.

  - Percentage of increase over baseline in stage of cancers detected and diagnosed at earlier stages in a defined service area.

- For Case Management Services
  - For those in need of further diagnostic testing: Percentage of increase over baseline in provision of (suspected cancer type appropriate) counseling regarding diagnostic options, and navigation through system for followup diagnostic procedures; and
  - For those diagnosed with cancer: Percentage of increase over baseline in provision of (cancer type and stage appropriate) counseling regarding treatment options and navigation through the system for referral to treatment.
- For Survivorship Services
  - Percentage of increase over baseline in provision of survivorship services in a defined service area; and
  - Percentage of increase over baseline in improvement in quality-of-life measures.

The appendix includes some baseline disease burden data on selected cancers for the State of Texas. However, applicants will be required to provide baseline data for the services and service area that they are proposing and must present a convincing plan describing how CPRIT funds will impact baseline rates. If you are proposing the provision of services to previously unserved population and do not have baseline data, you may contact the CPRIT Prevention Review Office for clarification if needed. (See section 8.2.)

3.3. Eligibility

3.3.1. Institutional Applicant

- Partnerships can be groups of individuals or organizations brought together by an agreement for sharing resources and responsibilities to achieve common goals and derive mutual benefits. The term "partnership" need not imply a formal legal entity.
- The applicants in the partnerships must be Texas-based entities, including a public or private institution of higher education, academic health institution, university, government organization, nongovernmental organization, or other public or private companies such as community organizations (e.g., service clubs, senior services programs, libraries, faith-based organizations, community centers, chambers of commerce); healthcare providers in a variety of settings (hospitals, community health centers, local health departments, clinics, primary care providers, specialists, etc.); local businesses (media representatives, beauty salons and barbershops, etc.); health-related organizations (American Cancer Society, Cancer Information Services, etc.); and government agencies (elected officials, local health departments, etc.).
- A lead agency should be identified to coordinate the program. The partners—or "members" of the partnership—work together to implement the required contract activities and ensure that the eligible priority populations within their service area are recruited for and provided with breast, cervical, and colorectal cancer screening and diagnostic services; case management services; and treatment referrals as needed.
- The lead agency must designate a single Program Director (PD) who will be responsible for the overall performance of the funded project.
- Subcontracting organizations may include public, not-for-profit, and for-profit entities. Such entities may be located outside of the State of Texas, but non-Texas-based organizations are not eligible to receive CPRIT funds.
- CPRIT grants will be awarded by contract to successful applicants. Certain contractual requirements are mandated by Texas law or by administrative rules. Although applicants need not demonstrate the ability to comply with these contractual requirements at the time the application is submitted, applicants should make themselves aware of these standards before submitting a grant application. Significant issues addressed by the CPRIT contract are listed in section 7. All statutory provisions and relevant administrative rules can be found at www.cprit.state.tx.us.

3.3.2. Program Management

- The PD should be designated at the lead agency of the partnership and would be responsible for the overall execution of the proposed project. The PD must have a relevant educational background and an appropriate level of education and management experience. The PD must reside in Texas during the project performance time and must be in a position to organize and manage service sites and various components of the program.
- A Program Coordinator (PC) can also be designated by the lead agency. If proposed, the PC would work under direction of the PD and would coordinate day-to-day efforts of each component of the project executed by different partnering organizations.
- Each partnering organization of the proposed collaborative project can designate a Program Co-coordinator who would be responsible for execution of the project component under that partnering organization.
- The evaluation of the project must be headed by a professional who has demonstrated expertise in the field (e.g., program and outcomes evaluation, epidemiology, statistics) and resides in Texas during the time the project is conducted. One of partnership organizations can be designated as the lead for the evaluation of the project.

3.4. Funding Information

CPRIT will award two types of projects under this RFA, Full Project Award funding and Planning Awards.

For **Full Project Awards**, applicants requesting over $1M are required to submit a Preapplication. The purpose of the Preapplication is to assess whether the application is responsive to the RFA and , if appropriate, to offer suggestions about optimal response to the RFA. Applicants will be invited to submit Full Project Award applications based on review of the Preapplication. The Full Project Award applicants may request up to a maximum of $3 million in total funding over a maximum of 3 years (36 months). The budget should be proportional to the scope of the proposed project; for example, the number of individuals receiving services. Funds for Years 2 and 3 will be contingent on demonstrating successful attainment of goals and reporting on outcomes metrics. The first year may include time for planning and startup but should also include service implementation during the last quarter at a minimum. Years 2 and 3 should be primarily for the delivery and evaluation of the services as well as process and system

improvement. Projects may be modest in size and scope and request smaller amounts of funding or be larger and more complex and request the maximum amount.

Planning Awards are intended for applicants who not do not have a sufficiently developed project for current submission to the RFA but have the basis for a strong collaborative network. In cases of such promising collaborative relationships, the collaborators can submit a application to conduct the planning phase of the partnership project. There must be a specific need for planning beyond the need for additional time to develop the grant application. (That is, there must be a need for the potential partners to select a specific project, gather evidence of need, establish respective partners' roles and responsibilities, etc.) Applicants for Planning Awards can request up to a maximum of $15,000 in total funding. Applicants who receive planning grants must complete their planning and submit a report by August 2010 and a full application at the next release of this RFA, which is anticipated to be in the fall of 2010.

Available Funding

CPRIT's total prevention program budget for FY2010 is $22M. Decisions will be made based on the quality of applications submitted in response to the Community Collaborative RFA, but given the total CPRIT budget, it is anticipated that only two or three projects could be funded if the maximum amount is requested.

Grant funds may be used to pay for salary and benefits, project supplies, equipment (equipment having a useful life of more than 1 year and an acquisition cost of $5,000 or more per unit must be specifically approved by CPRIT), costs for outreach and education of populations, travel of project personnel to project site(s), and clinical costs for screening and case management. CPRIT funds will be distributed on a reimbursement basis. (See the Instructions for Applicants document for budget guidance.) The budget should be proportional to the number of individuals receiving services. Requests for funds for travel to professional meetings are not appropriate for this funding mechanism, nor are requests for funds to support construction, renovation, or any other infrastructure needs.

Applicants should be aware that Texas law limits the amount of indirect costs that may be funded by CPRIT grants. Guidance regarding indirect cost recovery can be found in the administrative rules proposed by CPRIT. While State law does not specifically address a limit on indirect cost recovery for CPRIT-funded prevention programs, it is CPRIT's policy not to allow

recovery of indirect costs for prevention programs except under exceptional circumstances. The rules and the statute can be found at www.cprit.state.tx.us.

4. KEY DATES

RFA

RFA Release	December 7, 2009

Preapplication (if requesting over $1 M)

Online Preapplication opens	December 18, 2009, 7 a.m., central time
Preapplication due	January 18, 2010, 3 p.m., central time
Preapplication review	As soon as possible
Preapplication notification	As soon as possible

Planning Award (in preparation for the next Collaborative Community Award RFA deadline)

Online receipt system opens	December 18, 2009, 7 a.m., central time
Planning Award request due	February 8, 2010, 3 p.m., central time
Planning Award notification	March 10, 2010

Full Application

Online application opens	December 18, 2009, 7 a.m., central time
Application due	March 1, 2010, 3 p.m., central time
Application review	April to May 2010
Award notification	June 2010
Anticipated start date	July/August 2010

5. SUBMISSION GUIDELINES

5.1. Online Registration

Applications will be accepted beginning at 7 a.m., central time, on December 18, 2009, and must be submitted via the CPRIT Application Receipt System (CARS) (https://CPRITGrants.org). **Only applications submitted at this portal will be considered eligible for evaluation.** All applicants must register a user name to start and submit a Preapplication, a Planning Award, and/or a full application.

5.2. Preapplication Components

Projects requesting over $1M are required to submit a Preapplication.

Applicants are advised to follow all instructions to ensure accurate and complete submission of the online Preapplication. Applicants will be required to submit the following information:

i. Application title
ii. Period of performance
iii. Approximate total award requested
iv. Description and major goals of the proposed project (up to 3 pages maximum)
v. For the lead Collaborative Partner
    a. Name of the organization
    b. Name, qualifications, and experience of the PD
    c. Role of the organization in the proposed project
vi. For each Collaborative Partner
    a. Name of the organization
    b. Name of the Program Co-coordinator
    c. Role of the organization in the proposed project

5.3. Planning Award Components

Applicants are advised to follow all instructions to ensure accurate and complete submission of the online Planning Award application. Applicants will be required to submit the following information:

i. Application title
ii. Period of performance
iii. Total award requested (maximum $15,000)
iv. Budget justification (3,000 characters). There must be a specific need for planning funds beyond the usual costs of preparing a grant application. For example, routine secretarial expenses are not an adequate justification.
v. Description and major goals of the proposed project (up to 3 pages). For the lead Collaborative Partner
    a. Name of the organization
    b. Name of the PD

c. Role of the organization in the proposed project

vi. List of potential Collaborative Partners (name and institution) under consideration and their role in the proposed project

5.4. Full Application Components

5.4.1. Contact Information

Enter all required applicant and Application Signing Official (ASO) information along with the application title. In addition to the PD, an ASO (a person authorized to sign for the organization) will need to create an account in CARS. There are two different roles/accounts required (one for the PD and a separate one for the ASO) in order to submit the application.

5.4.2. Abstract (6,000 characters)

Clearly explain the problem(s) to be addressed and the approach(es) to be utilized in addressing the problem(s), including a description of the collaborative project. Describe the need that the proposed project will address and how the project will overcome barriers to the provision of services. Clearly explain why the collaborative approach is stronger/better than the single-institution approach. Clearly outline the goals and/or specific aims of the program, the population that will be served, estimated number of individuals served, and specific services that will be provided as a part of the program.

5.4.3. Significance (3,000 characters)

Clearly address how the proposed project/services, if successful, will have a unique and major impact on the field of cancer prevention and control and reduction of incidence, mortality, and/or morbidity. Describe how the funds from this grant will greatly improve outcomes for Texans compared to the current services being provided.

5.4.4. Project Plan (15 pages; applicants may submit fewer than the maximum allowed pages)

Background: Briefly present the rationale behind the proposed service, emphasizing the critical barrier to current service delivery that will be addressed. Pilot project evaluation data are not required; however, baseline data (e.g., analyses of barriers, screening and detection rates, stage at diagnosis) for the target population and target service area are required. If you are proposing provision of services to previously unserved population and do not have baseline data, please contact the CPRIT Prevention Review Office for clarifications and guidance on accepted baseline.

(See section 8.2.) Clearly demonstrate the ability to provide the proposed service, and describe how expected results will be achieved. Clearly demonstrate the ability to reach the target population.

Specific Project Goals: Concisely state the specific goals of the proposed project that will be pursued and the role and contribution of each partnering organization in the project goals. Cleary describe the target population. Projects should demonstrate knowledge of current system barriers and approaches and propose novel strategies to address/change the system that will result in greatly improved outcomes over the current baseline.

Components of the Project: Clearly describe all components of the project, and provide a plan to integrate multiple processes and components in order to provide seamless comprehensive prevention services to the target population. Similarly, clearly describe the role of the each partnering organization for specific components of the project and a plan to integrate multiple partnering organization processes in a seamless system of preventive care delivery to targeted population.

Evaluation Strategy: Describe the impact on ultimate outcome measures (e.g., reduction of cancer incidence, mortality, or morbidity) and interim outcome measures (e.g., increase in the proportion of individuals receiving cancer screening) as outlined in Section 3.2.2, including data collection and management methods, statistical analyses, anticipated results, potential problems, barriers to achieving the goals, and alternative approaches. Since evaluation and reporting of outcomes are critical components of this RFA and must be headed by a professional who has demonstrated expertise in the field, applicants should budget accordingly for this activity.

5.4.5. Supplemental Documents

References: Provide a concise and relevant list of references cited for the application.

Budget and Justification: Provide a brief outline and justification of the budget for the entire proposed period of support, including salaries and benefits, supplies, education and outreach expenses, equipment, patient care costs (excluding treatment costs), and other expenses, for each Collaborating Partner. Equipment having a useful life of more than 1 year and an acquisition cost of $5,000 or more per unit must be specifically approved by CPRIT. CPRIT funds will be distributed on a reimbursement basis. (See the Instructions for Applicants document for

budget guidance.) Applications requesting more than $3 million (total costs) will be administratively withdrawn from consideration.

Biographical Sketches: The PD for the lead agency should provide a biographical sketch that describes his/her education and training, professional experience, awards and honors, and publications and/or involvement in health programs relevant to cancer prevention and/or service delivery and coordination. Up to two additional biographical sketches for key personnel at the lead agency may be provided. Each Collaborating Partner may include one additional biosketch per partnering organization. Each biographical sketch must not exceed two pages.

Current and Pending Support: For all current and pending awards/grants to each of the partnering organizations, provide the funding source, amount, duration, title of the project/award, and a two-line summary of the goal/use of the funds. Current and pending support may be reported for the PD and Co-coordinators on an individual basis or on an organizational level for the lead and partnering organizations. If relevant, also describe how CPRIT funds will extend or complement the other current and pending awards. Applicants are encouraged to demonstrate how other resources from State, Federal, nonprofit, and other sources will be leveraged.

Letters of Support: Each partnering organization should provide a letter of support from the executive branch of the organization demonstrating the support and commitment of each organization to the proposed collaborative project. Applicants should provide letters of support from community organizations, service providers, or any other component essential to the success of the program. For example, if the goal is to provide screening services to a specific underserved population, the applicant should provide letters of support demonstrating community connections with the targeted population.

Applications that are missing one or more of these components; exceed the specified page, word, or budget limits; or do not meet the eligibility requirements listed above will be administratively rejected without review.

6. APPLICATION REVIEW

6.1. Overview of the Review Process

The review process will be preceded by the submission of Preapplications for projects requesting more than $1M. Following the Preapplication review, selected applications will be

invited to submit a full application. Projects requesting $1M or less can proceed to submit a full application.

Preapplication: Projects requesting over $1M should submit a Preapplication. The purpose of the Preapplication is to evaluate whether the proposed project is responsive to the RFA and, if appropriate, to offer suggestions about an optimal response to the RFA. Preapplications will be reviewed rapidly by the Prevention Review Council, and applicants will be invited to submit a complete application if the proposed project addresses the scope and objectives of the RFA. Preapplications may be submitted until January 18, 2010; however, applicants are urged to submit their Preapplications as soon as possible. CPRIT will respond to Preapplications as they are received and will not wait until the January 18, 2010, date to review them.

Full applications: All full applications will be reviewed using a two-stage process: (1) Peer review and (2) programmatic review. In the first stage, applications will be evaluated by an independent expert review panel using the criteria provided below. In the second stage, applications judged to be most meritorious by review panels will be evaluated and recommended for funding by the Prevention Review Council. The programmatic review process is based on comparisons with applications from all of the merit review panels and programmatic priorities. Each stage of application review is conducted completely confidentially, and all panel members are required to sign nondisclosure statements regarding the contents of the applications. All panel members will be non-Texas residents and operate under strict conflict-of-interest prohibitions. Under no circumstances should institutional personnel and/or individual applicants initiate contact with any member involved in the peer review process (with the exception of staff of the CPRIT Prevention Review Office) regarding the status or substance of the application. Violations of this prohibition will result in the administrative withdrawal of the application.

Planning Awards: The purpose of the Planning Award is to encourage the submission of innovative ideas and collaborations resulting in the submission of outstanding applications at the next release of the Community Collaborative RFA. Planning applications will be evaluated based on the proposed collaboration, description of planning activities, and budget justification/explanation. Planning awards may be submitted until February 8, 2010. The merit of planning applications will be evaluated by the Prevention Review Council, and applicants will

be notified on or before March 10, 2010. Successful applicants must complete their planning processes and submit a report to CPRIT by August 10, 2010. Successful applicants will be required to submit full applications at the next release of the Community Collaborative RFA, which is anticipated to in the fall of 2010.

6.2. Full Application Review Criteria

Peer review of applications will be based on the primary evaluation criteria (scored) and secondary (unscored) criteria identified below. Review panels will evaluate and score each primary criterion and subsequently assign a global score that reflects an overall assessment of the quality of the application. The overall assessment of the application will not be an average of the scores of individual criteria; rather, it will reflect the reviewers' overall impression of the application that included unscored criteria as well.

6.2.1. Primary Evaluation Criteria

The primary evaluation criteria will evaluate the impact on public health, organizational capacity, and innovation of the proposed work contained in the application. Concerns with any of these criteria potentially indicate a major flaw in the significance and/or design of the proposed project.

Impact and Innovation

- Do the proposed strategies and services address an important problem in cancer prevention and control from an organizational/systemic perspective as well as that of targeted population?
- Does the proposed project support desired organizational and system outcomes?
- Is the program innovative and original? For example, does the project take evidence-based services and challenge existing paradigms to accelerate the rates of screening and detection?
- Have Collaborative Partners demonstrated that the collaborative effort will provide greater impact on cancer prevention and control than each individual organization's effort separately?
- Is the proposed program nonduplicative? That is, does the program address known gaps in prevention services and avoid duplication of effort?

- Does the program leverage resources available through the partnership (e.g., negotiating for low-cost or pro bono services or in-kind support including staffing; leveraging and complementing other State, Federal, and nonprofit grants; and leveraging resources to maximize the reach of the services proposed)?

Project Strategy and Feasibility

- Are the proposed objectives and activities feasible within the duration of the award?
- Are the barriers to access to preventive services identified and appropriately addressed? Are alternative approaches considered if proposed solutions fail?
- Is the program design supported by established theory and practice as well as evidence-based preventive services?
- Does the project clearly describe strategies for each component of the services?
- Does the project clearly present a plan for how they would manage and facilitate meaningful collaboration among the separate partners to enable successful completion of the proposed project?

Organizational Capacity

- Does the application clearly designate a lead agency that will coordinate the collaborative program? Does the lead agency have a track record in coordinating collaborative projects and cancer prevention and control?
- Does the application clearly describe the organizational capacity of each partnering organization, and is the role of partnering organizations consistent with their organizational missions?
- Does the application demonstrate that all the partners are involved and committed to work together to develop the project plan and determine the management structure?
- Does the collaborative partnership jointly demonstrate the ability to provide the proposed preventive services? (For example, do facilities have appropriate certifications, equipment, and staff available?) Does it demonstrate a connection to the community and cultural competence? Does the collaborative partnership have the necessary resources and infrastructure for all the components of the proposed project?
- Have the appropriate partnering agencies and personnel been recruited for the proposed project activities as they pertain to organizational ability to implement system

changes and provide outreach, education, preventive services, and case management as well as for the evaluative portion of the project?

Target Population

- Does the project address the needs of an underserved area or population?
- Is the target population clearly described, including but not limited to the following:
    - The demographics of each group?
    - The heterogeneity and/or homogeneity of the groups with regard to each specific group's cancer prevention and control needs, including access barriers to access to prevention services?
- Are culturally appropriate approaches demonstrated in outreach and education as well as in service provision and case management services?

Outcomes Evaluation

- Are the proposed outcome measures appropriate for the services provided, and are the expected changes clinically significant?
- Are the proposed organizational outcome measures appropriate for the identified barriers, and will the expected changes be sufficient for improvement of the delivery of preventive services?
- Are there clear baseline cancer prevention data for the targeted population (screening rates for specific cancers for each targeted population)?
- Is there is a clearly described plan for assessment of the project's organizational success, including solution to barriers and their effect on target population outcomes?
- Is there is a clearly described plan for assessment of the project's success as related to target population outcomes, including outreach and education, screening services, and case management processes as well as of the process outcomes evaluation?
- Does the project provide a clear plan for data collection and management, statistical analyses, and interpretation of results?

Access to Treatment (for screening and diagnostic services)

- Does the applicant demonstrate availability of resources and expertise to provide case management, including followup for abnormal results and access to treatment?

6.2.2. Secondary Criteria

Secondary criteria contribute to the global score assigned to the application.

Budget: Is the budget appropriate and reasonable for the scope and services of the proposed work? Is the cost per person served appropriate and reasonable? Is it a good investment of Texas public funds?

Sustainability: Are there plans for sustainability of the project beyond the funded timeframe of this award?

Potential for Replication: Does the program lend itself to replication by others in the State? If so, does the program describe a plan for doing so?

7. AWARD ADMINISTRATION

Texas law requires that CPRIT awards be made by contract between the applicant and CPRIT. For multicollaborator grants, CPRIT has some discretion regarding how contracts are awarded (e.g., as a single contract to the lead organization or separate contracts with each collaborator). CPRIT will work with the grant award recipients regarding the preferred contracting arrangement. Texas law specifies several components that must be addressed by the award contract, including needed compliance and assurance documentation, budgetary review, and terms relating to intellectual property rights. These contract provisions are specified in CPRIT's administrative rules, which are available at www.cprit.state.tx.us.

All CPRIT awards will be made to institutions, not to individuals. If the Project Director or project Co-coordinators change their institutional affiliations during the time period of the award, partnering institutions may be required to provide evidence of the qualifications of the new Project Director or Co-coordinator in order to maintain awarded funding.

CPRIT requires the Project Director of the award to submit annual progress reports. These reports summarize the progress made toward project goals and address plans for the upcoming year. In addition, fiscal reporting and reporting on selected metrics will be required per the instructions to award recipients. Failure to provide timely and complete reports will constitute an event of default of the award contract, which may result in the early termination of the CPRIT award, reimbursement to CPRIT of award funds, and cessation of future funding. Forms and instructions will be made available at the www.cprit.state.tx.us.

8. CONTACT INFORMATION

8.1. HelpDesk

HelpDesk support is available for questions regarding user registration and online submission of applications. Queries submitted via e-mail will be answered within 1 business day. HelpDesk staff are not in a position to answer questions regarding the scope and focus of applications.

Dates of Operation: December 18, 2009, to March 1, 2010

Hours of Operation: 8 a.m. – 5 p.m., central time

Tel: 866-973-6661

E-mail: PreventionHelp@CPRITGrants.org

8.2. Program Questions

Questions regarding the CPRIT program, including questions regarding this or other funding opportunities, should be directed to the CPRIT Prevention Review Office:

Tel: 512-305-8419

E-mail: PreventionHelp@CPRITGrants.org

Web: www.cprit.state.tx.us

9. APPENDIX

This appendix includes baseline data on selected cancers (breast, cervical, and colorectal) for the State of Texas. Additional data by Councils of Government and by county can be found on CPRIT's Web site at www.cprit.state.tx.us/reportsstats.html. However, applicants will be required to provide baseline data for the specific services and service area that they are proposing. For additional cancer data, please visit the Texas Cancer Registry (TCR) Web site at www.dshs.state.tx.us/tcr/, or call the TCR at 1-800-252-8059.

9.1. Baseline Data: Breast Cancer (Texas)

Breast cancer has the highest incidence rate of all cancers in women in Texas.[7] In 2009, it is estimated that 2,687 women in Texas will die of breast cancer and that another 15,110 will be diagnosed with the disease.[8] In 2007, the estimated direct cost of cancer care for breast cancer in Texas was $923.7 million.[9] Evidence suggests that mammography screening significantly reduces mortality from breast cancer.[4]

9.1.1. Mortality Data

	BASELINE
Population	2006 Mortality Rate
Total	**22.5**
Non-Hispanic White	22.6
Black	33.4
American Indian	~
Asian/Pacific Islander	6.3
Hispanic	17.3
No High School Diploma	5.83
High School Graduate	8.17
Some College	3.57
College +	5.18

a. All rates are per 100,000 females. Rates are age adjusted to the 2000 U.S. Standard Population.

b. ~ Rates are suppressed if fewer than 16 deaths were reported in the specified population.

c. Source: Cancer mortality data provided by the Texas Cancer Registry, Cancer Epidemiology and Surveillance Branch, Texas Department of State Health Services, 1100 W. 49th Street, Austin, Texas 78756, www.dshs.state.tx.us/tcr/default.shtm or 512-458-7523. Cancer mortality data by education level provided by the Texas Department of State Health Services, Center for Health Statistics, August 2009.

9.1.2. Intermediate Measures: Screening

Percentage of women age 40 and over who have received a mammogram within the past 2 years.

	BASELINE
Population	%
Total	**72.6**
White	75.2
Black	67.8
Hispanic	70.7
No High School Diploma	64.4
High School Graduate	68.9
Some College	73.8
College +	80.4

a. Source: Behavioral Risk Factor Surveillance System, Statewide Survey, 2008.

9.1.3. Intermediate Measures: Early Detection

	BASELINE
Stage at Diagnosis	2006 Incidence Rate
In Situ	21.2
Localized	62.1
Regional	34.5
Distant	6.6
Unknown Stage	8.1

a. Rates are per 100,000 and age adjusted to the 2000 U.S. Standard Population (19 age groups, Census P25-1130), User Standard.

b. Source: Texas Department of State Health Services, Cancer Epidemiology and Surveillance Branch, Texas Cancer Registry, Incidence, 1995-2006, NPCR-CSS Sub 11-26-2008, SEER Pop-Adj, SEER*Prep 2.4.0.

9.2. Baseline Data: Cervical Cancer (Texas)

In 2009, it is estimated that 381 women in Texas will die of cervical cancer and another 1,054 will be diagnosed with the disease.[8] For 2007, the estimated direct cost of cancer care for cervical cancer in Texas was $77.4 million.[9] In 2005, Texas had the ninth highest mortality rate and seventh highest incidence rate for cervical cancer among all 50 States.[10] In 2006, the number of new cervical cancer cases in Texas was higher among minority groups.[11]

Evidence suggests that screening reduces both incidence of and mortality from cervical cancer.[2] Almost all deaths due to cervical cancer could be avoided if women followed screening and followup recommendations.[8]

9.2.1. Mortality Data

	BASELINE
Population	2006 Mortality Rate
Total	**3.0**
Non-Hispanic White	2.5
Black	4.0
American Indian	~
Asian/Pacific Islander	~
Hispanic	4.0
No High School Diploma	1.30
High School Graduate	0.88
Some College	0.37
College +	0.45

a. All rates are per 100,000 females. Rates are age adjusted to the 2000 U.S. Standard Population.

b. ~ Rates are suppressed if fewer than 16 deaths were reported in the specified population.

c. Source: Cancer mortality data provided by the Texas Cancer Registry, Cancer Epidemiology and Surveillance Branch, Texas Department of State Health Services, 1100 W. 49th Street, Austin, Texas 78756; www.dshs.state.tx.us/tcr/default.shtm or 512-458-7523. Cancer mortality data by education level provided by the Texas Department of State Health Services, Center for Health Statistics, August 2009.

9.2.2. Intermediate Measures: Screening

Percentage of women age 18 and older who have received a Pap test within the past 3 years.

	BASELINE
Population	%
Total	**81.5**
White	82.4
Black	84.4
Hispanic	81.7
No High School Diploma	76.3
High School Graduate	75.2
Some College	82.0
College +	89.7

Source: Behavioral Risk Factor Surveillance System, Statewide Survey, 2008.

9.2.3. Intermediate Measures: Early Detection

	BASELINE
Stage at Diagnosis	2006 Incidence Rate, by Stage
In Situ	Data Not Collected
Localized	3.7
Regional	2.9
Distant	0.9
Unknown Stage	1.3

Source: Texas Department of State Health Services, Cancer Epidemiology and Surveillance Branch, Texas Cancer Registry, Incidence, 1995-2006, NPCR-CSS Sub 11-26-2008, SEER Pop-Adj, SEER*Prep 2.4.0.

9.3. Baseline Data: Colorectal Cancer (Texas)

Colorectal cancer has the third highest incidence rate of all cancers in both men and women in Texas.[7] In 2009, it is estimated that 3,477 Texans will die of colorectal cancer and another 9,858 will be diagnosed with the disease.[8] For 2007, the estimated direct cost of cancer care for colorectal cancer in Texas was over $1 billion.[9]

Evidence suggests that screening for colorectal cancer with fecal occult blood testing, sigmoidoscopy, or colonoscopy detects early-stage colorectal cancer and adenomatous polyps and reduces colorectal cancer mortality in adults age 50 to 75 years.[3] Data from a survey in Texas, however, showed no improvement between 2006 and 2008 in the number of adults age 50 and older who reported having received a sigmoidoscopy or colonoscopy.[9]

9.3.1. 9.3.1 Mortality Data

	BASELINE
Population	2006 Mortality Rate
Total	**16.7**
Non-Hispanic White	16.3
Black	27.6
American Indian	~
Asian/Pacific Islander	11.1
Hispanic	13.5
No High School Diploma	5.24
High School Graduate	5.96
Some College	2.27
College +	3.52

a. All rates are per 100,000. Rates are age adjusted to the 2000 U.S. Standard Population.

b. ~ Rates are suppressed if fewer than 16 deaths were reported in the specified population.

c. Source: Cancer mortality data provided by the Texas Cancer Registry, Cancer Epidemiology and Surveillance Branch, Texas Department of State Health Services, 1100 W. 49th Street, Austin, Texas 78756; www.dshs.state.tx.us/tcr/default.shtm or 512-458-7523. Cancer mortality data by education level provided by the Texas Department of State Health Services, Center for Health Statistics, August 2009.

9.3.2. Intermediate Measures: Screening

Percentage of adults age 50 and older who have received a blood stool test within the past 2 years (column 1) and percentage of adults age 50 and older who have received a sigmoidoscopy or colonoscopy (column 2).

	BASELINE (Column 1)	**BASELINE (Column 2)**
Population	%	%
Total	**19.3**	**56.2**
White	21.4	63.2
Black	25.3	53.3
Hispanic	12.1	40.8
No High School Diploma	13.5	38.2
High School Graduate	18.5	53.7
Some College	21.0	59.7
College +	21.6	66.2

Source: Behavioral Risk Factor Surveillance System, Statewide Survey, 2008.

9.3.3. Intermediate Measures: Early Detection

	BASELINE
Stage at Diagnosis	2006 Incidence Rate by Stage
In Situ	1.6
Localized	16.4
Regional	14.2
Distant	8.1
Unknown Stage	4.5

Source: Texas Department of State Health Services, Cancer Epidemiology and Surveillance Branch, Texas Cancer Registry, Incidence, 1995-2006, NPCR-CSS Sub 11-26-2008, SEER Pop-Adj, SEER*Prep 2.4.0.

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