CANCER PREVENTION & RESEARCH INSTITUTE OF TEXAS

REQUEST FOR APPLICATIONS
RFA P-20.1-TCL

Tobacco Control and Lung Cancer Screening

> **Please also refer to the Instructions for Applicants document,**
> **which will be posted on June 6, 2019**

Application Receipt Opening Date: June 6, 2019
Application Receipt Closing Date: September 4, 2019

FY 2020
Fiscal Year Award Period
September 1, 2019-August 31, 2020

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RFA VERSION HISTORY

Rev   5/9/2019 RFA release

1. ABOUT CPRIT

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

CPRIT is charged by the Texas Legislature to do the following:

- Create and expedite innovation in the area of cancer research and enhance the potential for a medical or scientific breakthrough in the prevention of or 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 the State of Texas; and
- Develop and implement the Texas Cancer Plan.

1.1. Prevention Program Priorities

Legislation from the 83rd Texas Legislature requires that CPRIT's Oversight Committee establish program priorities on an annual basis. The priorities are intended to provide transparency in how the Oversight Committee directs the orientation of the agency's funding portfolio. The Prevention Program's principles and priorities will also guide CPRIT staff and the Prevention Review Council on the development and issuance of program-specific Requests for Applications (RFAs) and the evaluation of applications submitted in response to those RFAs.

Established Principles:

- Fund evidence-based interventions and their dissemination
- Support the prevention continuum of primary, secondary, and tertiary (includes survivorship) prevention interventions

Prevention Program Priorities

- Prioritize populations disproportionately affected by cancer incidence, mortality, or cancer risk prevalence
- Prioritize geographic areas of the state disproportionately affected by cancer incidence, mortality, or cancer risk prevalence
- Prioritize underserved populations

2. FUNDING OPPORTUNITY DESCRIPTION

2.1. Summary

The ultimate goals of the CPRIT Prevention Program are to reduce overall cancer incidence and mortality and to improve the lives of individuals who have survived or are living with cancer.

The ability to reduce cancer death rates depends in part on the application of currently available evidence-based technologies and strategies.

People who use tobacco products or who are regularly around [environmental tobacco smoke](#) have an increased risk of cancer because tobacco products and secondhand smoke contain many chemicals that damage DNA. Tobacco use causes many types of cancer, and there is no safe level of tobacco use. People who quit smoking, regardless of their age, have substantial gains in life expectancy compared with those who continue to smoke. Also, quitting smoking at the time of a cancer diagnosis reduces the risk of death.[1]

Tobacco use accounts for at least 30% of all cancer deaths, causing 83% of lung cancer deaths in men and 76% of lung cancer deaths in women.[2] Lung cancer is the leading cause of cancer-related mortality in Texas; in 2016 there were an estimated 9,438 deaths.[3]

The **Tobacco Control and Lung Cancer Screening (TCL)** award mechanism seeks to fund programs on tobacco prevention and cessation, as well as screening for early detection of lung cancer. Through release of this RFA, CPRIT's goal is to stimulate more programs across the state, thereby providing greater access for underserved populations and reducing the incidence and mortality rates of tobacco-related cancers.

This RFA seeks to promote and deliver evidence-based programming designed to significantly increase tobacco cessation among adults and/or prevent tobacco use by youth. In addition to evidence-based interventions for tobacco prevention and cessation, screening to detect cancer early, before it has spread, can reduce lung cancer mortality. For the early detection of lung cancer, the US Preventive Services Task Force (USPSTF) recommends annual lung cancer screening with low-dose computerized tomography (LDCT) for persons between the ages of 55 and 80 years old who have a history of heavy smoking (30 pack years or more) and who currently smoke or have quit within the past 15 years. The Centers for Medicare and Medicaid Services (CMS) has approved coverage and reimbursement for lung cancer screening for

individuals 55 to 77 years of age that meet their criteria. CMS also has eligibility criteria for radiologists and facilities delivering the screening services (https://www.cms.gov/medicare-coverage-database/details/nca-decision-memo.aspx?NCAId=274).

CPRIT will support programs screening individuals aged 55 to 77 that follow the CMS criteria for screening, radiologists, and facilities. CMS also requires delivery of smoking cessation counseling if LCDT screening is offered; however, for funding through this mechanism, CPRIT requires that robust evidence-based cessation interventions that go beyond offering only a referral or provision of information about smoking cessation interventions be delivered (see section 2.3 for details).

Programs proposed under this mechanism should be designed to reach and serve as many people as possible. Partnerships with other organizations that can support and leverage resources are strongly encouraged. A coordinated submission of a collaborative partnership program in which all partners have a substantial role in the proposed project is preferred.

Applicants with currently or previously funded CPRIT Tobacco Control and Lung Cancer Screening projects are required to expand current services into additional counties or to include additional types of prevention clinical services. In either case, the expansion must include the delivery of services to nonmetropolitan (rural) and/or medically underserved counties in the state. These may be identified via Web-based tools from the Texas Department of State Health Services and US Department of Health and Human Services respectively.

Health Facts Profiles
Non-Metropolitan Counties, 2013

Demography / Population

Estimated Total Population
3,054,751

Number of Counties
172

Area in Square Miles
184,738.9

Population per Square Mile
16.5
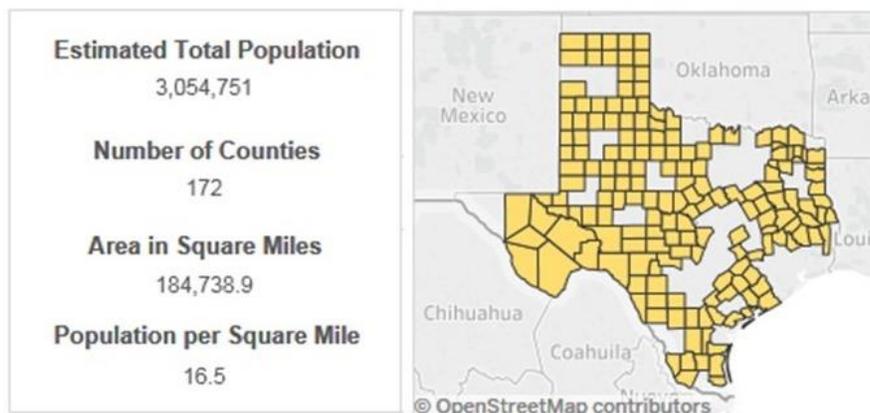
Data source: Center for Health Statistics, Texas Department of State Health Services

Texas Medically Underserved Areas (MUA) and Populations (MUP)
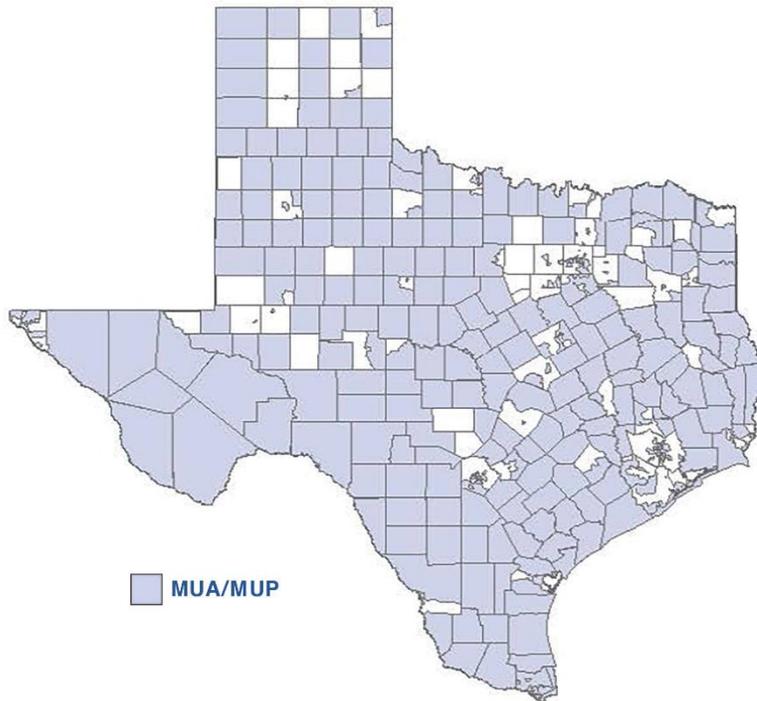
Data source: US Health Resources and Services Administration Data Warehouse, October 2017

Currently funded projects must be in their final year, and programs must have at least 1 full year of data to report before applying for an expansion.

2.2.   Project Objectives

CPRIT seeks to fund **new** projects that will address objectives listed under Option A **or** Option B. **Expansion** projects may address objectives under both Options A **and** B.

A. Tobacco Prevention and Cessation for any age group

- Promote and deliver evidence-based programming designed to significantly increase tobacco cessation among adults and/or prevent tobacco use by youth including

combustible cigarettes, oral tobacco products, and/or electronic devices that deliver nicotine.

- Increase the adoption and sustained implementation of evidence-based strategies by state and local public health agencies designed to reduce tobacco use.
- Increase the adoption and implementation of evidence-based strategies designed to mobilize communities, improve systems and programs to influence societal norms, and encourage and support individuals in adoption of tobacco prevention and cessation behaviors.
- Increase the adoption and sustained implementation of evidence-based strategies by clinicians designed to reduce tobacco use.
- Stimulate the creation, adoption, and implementation of evidence-based strategies and policies designed to significantly improve the effectiveness of health care or other systems in reducing tobacco use among the patients and employees of those systems.
- Implement policy changes and/or system improvements that are sustainable over time.
- Focus on underinsured and uninsured population groups by implementation of strategies and activities that may significantly reduce tobacco use and cancer-related disparities.

B. **Lung Cancer Screening, Early Detection, and Cessation for individuals 55 to 77 years of age**

- Develop, implement, and evaluate strategies to significantly increase use of LDCT screening for earlier detection of lung cancer following the USPSTF criteria and definition of high-risk populations (history of 30 pack years of smoking, individuals between 55 and 77 years of age who currently smoke or who have quit smoking within the past 15 years), as well as meet CMS eligibility criteria for radiologists and facilities.
- Deliver evidence-based programming designed to significantly increase tobacco cessation among adults 55 to 77 years old that are being screened or considered for screening.
- Deliver education for health care providers that includes, but is not limited to, earlier detection of lung cancer, diagnosis and treatment of lung cancer, shared decision-

making about eligibility, risks and benefits of lung LDCT screening, tobacco cessation programming, and comprehensive behavioral health change initiatives.

- Increase shared decision-making between the health care provider and patients about eligibility, risks, and benefits of lung LDCT screening.

- Stimulate the creation, adoption, and implementation of evidence-based strategies and policies designed to significantly improve the effectiveness of health systems in reducing tobacco use among the patients being screened or considered for screening.

- Implement policy changes and/or system improvements that are sustainable over time.

- Focus on underinsured and uninsured population groups by implementation of strategies and activities that may significantly reduce tobacco use and cancer-related disparities.

2.3. Award Description

The Tobacco Control and Lung Cancer Screening RFA solicits applications for eligible projects that may be up to 36 months in duration that will deliver evidence-based interventions focused on tobacco prevention (prevent tobacco use or sustained abstinence) and tobacco cessation among youth and/or adults. This RFA will also support LDCT screening for populations eligible for this intervention as defined by CMS if paired with evidence-based cessation interventions for the population to be screened.

As detailed below, **new** projects may propose comprehensive tobacco cessation programs for youth and/or adults, **(Option A)**, **or** projects may propose programs that include comprehensive tobacco cessation programs plus LDCT lung cancer screening for eligible participants aged 55 to 77, **(Option B)**, **but not both**.

Expansion projects: Expansion to nonmetropolitan/medically underserved area (MUA) counties and/or offering additional clinical services is required for currently or previously funded tobacco control and lung cancer screening projects. To qualify, CPRIT requires these applicants to either expand to additional nonmetropolitan and/or MUA counties or to add the delivery of 1 or more of the following clinical services to their project.

- LDCT lung cancer screening - Expansion of project to include Option B for lung cancer screening if current or previously funded project included only Option A.

- Tobacco Prevention and Cessation – Expansion of project to include Option A for tobacco prevention and cessation program for any age group, in addition to the required cessation services in Option B, if current or previously funded project included only Option B.

- Screenings for breast, cervical, colorectal cancers, hepatitis C virus, and genetic risk factors.

- Vaccinations against HPV and hepatitis B virus.

CPRIT's priorities include a focus on underserved populations and the targeting of areas and populations where significant disparities exist. Projects should propose to develop, adopt, and implement strategies and activities that have the potential to significantly reduce tobacco use and cancer-related disparities and serve underinsured and uninsured population groups. If addressing worksites, projects should focus on worksites that are likely to have limited or no health insurance; eg, part-time or hourly workers. (See priority populations, section 2.4).

Proposals are encouraged to incorporate evidence-based interventions such as those found in Community Guide to Reducing Tobacco Use and Secondhand Smoke Exposure; CDC Policies and Practices for Cancer Prevention: Lung Cancer Screening Programs; CDC Best Practices for Comprehensive Tobacco Control Programs; and American College of Chest Physicians/American Thoracic Society Policy statement on Components Necessary for High- Quality Lung Cancer Screening. In addition, USPSTF guidelines and CMS criteria must be met if providing LDCT screening.

The following are required components of the project:

Option A. Tobacco Prevention and Cessation Services

Projects under this option for tobacco prevention and cessation services without LDCT screening must provide the following:

- Evidence-based tobacco prevention and tobacco cessation education and services for adults and/or youth that include behavioral as well as pharmacotherapy interventions (if such interventions are indicated for youth). Effective cessation interventions include individual, group, and telephone counseling as well as FDA-approved cessation medications. Programs may include prevention and cessation of any product that delivers nicotine, including combustible cigarettes, oral tobacco products, and/or electronic devices.

In addition, projects should include SOME combination of the following:

- Evidence-based strategies delivered by public health officials (eg, state or local public health agencies) designed to reduce tobacco use and increase the adoption and sustained implementation of tobacco control programs.

- Evidence-based strategies designed to mobilize communities, improve systems and programs to influence societal norms, and encourage and support individuals in adoption of prevention and cessation behaviors (eg, NCI RTIPS interventions).

- Evidence-based strategies designed to improve the knowledge, skills, and effectiveness of health care providers in providing direct tobacco cessation interventions (eg, 5 A's approach); and

- Evidence-based strategies designed to improve the efficacy/effectiveness of health systems in tobacco cessation, including changes in how health systems approach tobacco cessation (eg, integration into EMRs, clinical workflows, well visit protocols).

Option B. Lung Cancer screening and early detection services plus cessation services

Projects under this option that includes lung cancer LDCT screening and relevant diagnostic interventions in addition to robust evidence-based tobacco cessation interventions must include **ALL** of the following:

- LDCT lung cancer screening <u>must</u> be provided according to CMS and USPSTF guidelines.

- LDCT lung cancer screening facilities and radiologists <u>must</u> meet CMS requirements.

- Education for health care providers that includes, but is not limited to, earlier detection of lung cancer, diagnosis and treatment of lung cancer, tobacco cessation programming, and more comprehensive behavioral health change initiatives.

- Strategic educational initiatives for both the health care provider and patients focused on patient-centered health care that involves shared decision-making about eligibility, risks and benefits, and implementation of lung LDCT.

- The development, adoption, and implementation of robust evidence-based tobacco cessation interventions for individuals 55 to 77 years of age before screening as well as after LDCT screening. In cases where screening results are normal, cessation interventions begun before the results of screening are received may increase the motivation to continue with cessation treatments.

- Cessation interventions must be comprehensive and robust and integrated with the screening program. Cessation interventions must involve more than handing out educational materials or referral to either the Quitline or other cessation resources and include behavioral as well as pharmacotherapy interventions. Cessation services offered outside the clinic setting require a formal agreement/memorandum of understanding for patient follow-up and confirmation of behavioral changes for the patients referred. Patient cessation outcomes are to be reported to CPRIT.

- The development, adoption, and implementation of enhancements and improvements in health and health care systems and/or policy that can increase the effectiveness of tobacco and cancer control (ie, integration into EMRs, clinical workflow, and well visit protocols).

- The development, adoption, and implementation of procedures and protocols for frequent follow-up of patients to assess not only participation but also successful outcomes regarding accessing cessation services, sustained abstinence, and outcomes known to be related to sustained cessation.

- The development, adoption, and implementation of system policies and protocols that include but are not limited to who should be offered screening within the USPSTF guidelines, frequency of screening, who should be followed, and who should proceed to surgical resection.

- Recognizing that there are false positives and false negatives in LDCT screening, the development, adoption, and implementation of evidence-based protocols for abnormal LDCT results.

- Patient navigation into treatment when cancer is diagnosed. Applicants must describe the resources available for treatment of uninsured/underinsured patients.

CPRIT's services grants are intended to fund prevention interventions that have a demonstrated evidence base and are culturally appropriate for the priority population.

CPRIT recognizes that evidence-based services have been developed but not implemented or tested in all populations or service settings. In such cases, other forms of evidence (eg, preliminary evaluation or pilot project data) that the proposed service is appropriate for the population and has a high likelihood of success must be provided. The applicant must fully

describe the base of evidence and any plans to adapt and evaluate the implementation of the program for the specific audience or situation.

CPRIT encourages traditional and nontraditional collaborative partnerships as well as leveraging of existing resources and dollars from other sources. A collaborative partnership is one in which all partners have a substantial role in the proposed project. Letters of commitment describing their role in the partnership are required from all partners.

CPRIT expects measurable outcomes of supported activities, such as a significant increase over baseline (for the proposed service area) in the provision of evidence-based services, changes in provider practice, systems changes, and cost-effectiveness. Applicants must demonstrate how these outcomes will ultimately impact incidence, mortality, morbidity, or quality of life.

Under this RFA, CPRIT **will not** consider the following:

- **Projects focusing solely on case management/patient navigation services.** Case management/patient navigation services must be paired with tobacco prevention or cessation services. Furthermore, while navigation to the point of treatment of cancer is required when cancer is discovered through a CPRIT-funded project, applications seeking funds to provide coordination of care while an individual is in treatment are not allowed under this RFA.
- **Projects focusing on tobacco prevention and cessation education without the delivery of cessation or other clinical services.**
- **Projects requesting CPRIT funding for Quitline services.** Applicants proposing the utilization of Quitline services should communicate with the Tobacco Prevention and Control program prior to submitting a CPRIT grant application to discuss the services currently offered by the Texas Department of State Health Services (DSHS).
- **Projects involving prevention/intervention research.** Applicants interested in prevention research should review CPRIT's Academic Research RFAs (available at http://www.cprit.texas.gov).[4]

2.4. Priorities

Types of Cancer: Only projects proposing tobacco control interventions and lung cancer screening will be considered for funding. See section 2.5 for specific areas of emphasis.

The Prevention Program's priorities for funding include the following:

1) Populations disproportionately affected by cancer incidence, mortality, or cancer risk prevalence:

CPRIT programs must address underserved populations. Underserved populations are subgroups that are disproportionately affected by cancer. CPRIT-funded efforts <u>must address</u> 1 or more of these priority populations:

- Underinsured and uninsured individuals;
- Medically unserved or underserved populations;
- Racial, ethnic, and cultural minority populations;
- Populations with low screening rates, high incidence rates, and high mortality rates, focusing on individuals never before screened or who are significantly out of compliance with nationally recommended screening guidelines.

The age of the priority population and frequency of screening for provision of clinical services described in the application must comply with established and current national guidelines (eg, USPSTF, CMS, and American Cancer Society).

2) Geographic areas of the state disproportionately affected by cancer incidence, mortality, or cancer risk prevalence:

While disparities and needs exist across the state, CPRIT will also prioritize applications proposing to serve geographic areas of the state disproportionately affected by cancer incidence, mortality, or cancer risk prevalence. In addition, projects addressing areas of emphasis (see section 2.5) will receive priority consideration.

<u>Geographic and Population Balance in Current CPRIT portfolio</u>

At the programmatic level of review conducted by the Prevention Review Council (see section 5.1), priority will be given to projects that target geographic regions of the state and population subgroups that are not adequately covered by the current CPRIT Prevention project portfolio (see https://www.cprit.state.tx.us/our-programs/prevention/portfolio-maps and https://www.cprit.state.tx.us/grants-funded?search=prevention).

2.5. Specific Areas of Emphasis

CPRIT has identified the following areas of emphasis for this cycle of awards.

Primary Prevention
Tobacco Prevention and Control
• Vulnerable and high-risk populations, including people with mental illness, history of substance abuse, youth, and pregnant women, that have higher tobacco usage rates than the general population.
• Areas that have higher smoking rates per capita than other areas of the state. Public Health Regions (PHR) 4, 5, and 9 have significantly higher tobacco use among adults than in other regions of the state.
Secondary Prevention - Screening and Early Detection Services
Lung Cancer
• Decreasing disparities in incidence and mortality rates of lung cancer in racial/ethnic populations. Blacks have higher mortality rates than Hispanics and non-Hispanic whites.
• Increasing screening/detection rates in PHR 2, 4, and 5, where the highest rates of cancer incidence and mortality are found.

2.6. Outcome Metrics

Applicants are required to clearly describe their assessment and evaluation methodology. The applicant is required to describe final outcome measures for the project. Output measures that are associated with the final outcome measures should be identified in the project plan and will serve as a measure of program effectiveness. Planned policy or system changes should be identified and the plan for qualitative analysis described. **Baseline data for each measure proposed are required.** In addition, applicants should describe how funds from the CPRIT grant will improve outcomes over baseline. If the applicant is not providing baseline data for a measure, the applicant must provide a well-justified explanation and describe clear plans and method(s) of measurement to collect the data necessary to establish a baseline. Applicants are required to fully describe any planned systems, policy changes, or improvements.

Reporting Requirements

Funded projects are required to report quantitative output and outcome metrics (as appropriate for each project) through the submission of quarterly progress reports, annual reports, and a final report.

If clinical services are being paid for and provided by others, the applicant is required to report on the number of clinical services and patient outcomes (eg, cancers detected) that are delivered to the people navigated by the program.

- Quarterly progress report sections include, but are not limited to, the following:
  - Summary page, including narrative on project progress (required);
  - Services, other than clinical services, provided to the public/professionals;
  - Actions taken by people/professionals as a result of education or training;
  - Clinical services provided (county of residence of client is required); and
  - Precursors and cancers detected.

- Annual and final progress report sections include, but are not limited to, the following:
  - Key accomplishments, **including qualitative analysis of policy change and/or lasting systems change** and;
  - Progress toward goals and outcome objectives, including percentage increase over baseline in provision of age- and risk-appropriate education and navigation services to eligible individuals in a defined service area;
  - Materials produced and publications;
  - Economic impact of the project.

2.7. Eligibility

- The applicant must be a Texas-based entity, such as a community-based organization, health institution, government organization, public or private company, college or university, or academic health institution.
- The applicant is eligible solely for the grant mechanism specified by the RFA under which the grant application was submitted.
- The designated Program Director (PD) will be responsible for the overall performance of the funded project. The PD must have relevant education and management experience and must reside in Texas during the project performance time.
- The evaluation of the project must be headed by a professional who has demonstrated expertise in the field and who resides in Texas during the time that the project is conducted.

- An applicant is not eligible to receive a CPRIT grant award if the applicant PD, any senior member or key personnel listed on the grant application, or any officer or director of the grant applicant's organization or institution is related to a CPRIT Oversight Committee member.

- The applicant may submit more than 1 application, but each application must be for distinctly different services without overlap in the services provided. Applicants who do not meet this criterion will have all applications administratively withdrawn without peer review.

- If an organization has a current CPRIT grant that is the same or similar to the prevention intervention being proposed, the applicant must explain how the projects are nonduplicative or complementary.

- If the applicant or a partner is an existing Department of State Health Services (DSHS) contractor, CPRIT funds may not be used as a match, and the application must explain how this grant complements or leverages existing state and federal funds. DSHS contractors who also receive CPRIT funds must be in compliance with and fulfill all contractual obligations within CPRIT. CPRIT and DSHS reserve the right to discuss the contractual standing of any contractor receiving funds from both entities.

- Collaborations are permitted and encouraged, and collaborators may or may not reside in Texas. However, collaborators who do not reside in Texas are not eligible to receive CPRIT funds. Subcontracting and collaborating 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.

- An applicant organization is eligible to receive a grant award only if the applicant certifies that the applicant organization, including the PD, any senior member or key personnel listed on the grant application, or any officer or director of the grant applicant's organization (or any person related to 1 or more of these individuals within the second degree of consanguinity or affinity), has not made and will not make a contribution to CPRIT or to any foundation created to benefit CPRIT.

- The applicant must report whether the applicant organization, the PD, or other individuals who contribute to the execution of the proposed project in a substantive, measurable way, (whether slated to receive salary or compensation under the grant award or not), are

currently ineligible to receive federal grant funds because of scientific misconduct or fraud or have had a grant terminated for cause within 5 years prior to the submission date of the grant application.

- CPRIT grants will be awarded by contract to successful applicants. CPRIT grants are funded on a reimbursement-only basis. 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 6. All statutory provisions and relevant administrative rules can be found on the CPRIT website.

2.8. Resubmission Policy

- **One resubmission** is permitted. An application is considered a resubmission if the proposed project is the same project as presented in the original submission. A change in the identity of the PD for a project or a change of title for a project that was previously submitted to CPRIT does not constitute a new application; the application would be considered a resubmission.

- Applicants who choose to resubmit should carefully consider the reasons for lack of prior success. Applications that received overall numerical scores of 5 or higher are likely to need considerable attention. All resubmitted applications should be carefully reconstructed; a simple revision of the prior application with editorial or technical changes is not sufficient, and applicants are advised not to direct reviewers to such modest changes. A 1-page summary of the approach to the resubmission should be included. Resubmitted applications may be assigned to reviewers who did not review the original submission. Reviewers of resubmissions are asked to assess whether the resubmission adequately addresses critiques from the previous review. **Applicants should note that addressing previous critiques is advisable; however, it does not guarantee the success of the resubmission**. All resubmitted applications must conform to the structure and guidelines outlined in this RFA.

2.9.   Expansion Policy

- A grant recipient that has previously been awarded grant funding from CPRIT may submit an application under this mechanism to be considered for an expansion grant if expansion of current services into additional counties and/or additional types of prevention clinical services have been included. The eligibility criteria described in section 2.7 also apply to expansion applications. Before submitting an application for this award, applicants should consult with the Prevention Program Office (see section 7.2) to determine whether it is appropriate for their organization to seek expansion funding at this time.

- Expansion grants are intended to fund expansion of currently or previously funded projects that have demonstrated exemplary success, as evidenced by progress reports and project evaluations, and desire to further enhance their impact on priority populations. Detailed descriptions of **results, barriers, outcomes, and impact of the currently or previously funded project are required** (see outline of Most Recently Funded Project Summary, section 4.4.12).

- Proposed expansion projects should NOT be new projects but should closely follow the intent and core elements of the currently or previously funded project. Established infrastructure/processes and fully described prior project results are required. Expansion of current projects into geographic areas not well served by the CPRIT Prevention portfolio (see maps at http:// www.cprit.state.tx.us/our-programs/prevention/portfolio-maps) will receive priority consideration.

- CPRIT expects measurable outcomes of supported activities, such as a significant increase over baseline (for the proposed service area). It is expected that baselines will have already been established and that continued improvement over baseline is demonstrated in the current application. However, in the case of a proposed expansion where no baseline data exist for the priority population, the applicant must present clear plans and describe method(s) of measurement used to collect the data necessary to establish a baseline. Applicants must demonstrate how these outcomes will ultimately impact cancer incidence, mortality, morbidity, or quality of life.

- CPRIT also expects that applications for continuation **will not** require startup time, that applicants can demonstrate that they have overcome barriers encountered, and that

applicants have identified **lasting systems changes** that improve results, efficiency, and sustainability. Leveraging of resources and plans for dissemination are expected and should be well described.

2.10. Funding Information

Applicants may request any amount of funding up to a maximum of $1 million in total funding for new projects or up to a maximum of $2 million in total funding for expansion projects over a maximum of 36 months. Grant funds may be used to pay for clinical services, navigation services, salary and benefits, project supplies, equipment, costs for outreach and education of populations, and travel of project personnel to project site(s). Requests for funds to support construction, renovation, or any other infrastructure needs or requests to support lobbying will not be approved under this mechanism. Grantees may request funds for travel for 2 project staff to attend CPRIT's conference. Applicants offering screening services must ensure that there is access to treatment services for patients with cancers that are detected as a result of the program and must describe access to treatment services in their application.

While this mechanism will fund diagnostic workup of abnormal LDCT results, applicants are encouraged to find additional sources to support the costlier diagnostic tests that may be needed. Proposed programs should be designed to reach and serve as many people as possible, and costly diagnostic tests could limit the reach of the program. Review of the proposals includes budget considerations such as the average cost per service and whether the budget is appropriate and reasonable and a good investment of Texas public funds.

The budget should be proportional to the number of individuals receiving programs and services, and a significant proportion of funds is expected to be used for program delivery as opposed to program development. In addition, CPRIT seeks to fill gaps in funding rather than replace existing funding, supplant funds that would normally be expended by the applicant's organization, or make up for funding reductions from other sources.

State law limits the amount of award funding that may be spent on indirect costs to no more than 5% of the **total** award amount.

2.11. Opportunity for Applied Research

Since lung cancer screening has only recently become an approved screening tool and may occur in a variety of settings, there remain many questions and opportunities for continued study to optimize the pairing of smoking cessation services with lung cancer screening and to improve the outcomes of lung cancer screening. CPRIT encourages successful applicants to consider how they might leverage a Prevention grant award and the population being screened to address these or other research questions and apply to CPRIT's Academic Research Program.

Examples of potential research questions follow:

- What are the most effective components of outreach and education strategies designed to influence underserved populations to make good decisions about their health and participate in shared decision-making and lung cancer screening?
- What are the most formidable barriers influencing the initiation of tobacco cessation counseling and lung cancer screening among underserved population groups?
- What are the most effective components of evidence-based cessation interventions delivered in conjunction with LDCT screening?
- What are effective shared decision-making interventions for LDCT?
- What is the cost-effectiveness of LDCT alone and/or in conjunction with various evidence-based interventions for tobacco cessation?
- What are the most effective evidence-based protocols for diagnostic work up of lung nodules in community settings?
- Can risk models be developed to define subgroups that might disproportionately benefit or be harmed with LDCT screening?
- What is the role of biomarkers in LDCT screening?

3. KEY DATES

RFA release	May 9, 2019
Online application opens	June 6, 2019, 7 AM central time
Application due	September 4, 2019, 4 PM central time
Application review	October 2019-January 2020
Award notification	February 2020

Anticipated start date   March 1, 2020

Applicants will be notified of peer review panel assignment prior to the peer review meeting dates.

4.   APPLICATION SUBMISSION GUIDELINES

4.1.   *Instructions for Applicants* document

It is imperative that applicants read the accompanying instructions document for this RFA that will be available June 6, 2019 (https://CPRITGrants.org). Requirements may have changed from previous versions.

4.2.   Online Application Receipt System

Applications must be submitted via the CPRIT Application Receipt System (CARS) (https://CPRITGrants.org). **Only applications submitted through this portal will be considered eligible for evaluation.** The PD must create a user account in the system to start and submit an application. The Co-PD, if applicable, must also create a user account to participate in the application. Furthermore, the Application Signing Official (a person authorized to sign and submit the application for the organization) and the Grants Contract/Office of Sponsored Projects Official (an individual who will help manage the grant contract if an award is made) also must create a user account in CARS. Applications will be accepted beginning at 7 AM central time on June 6, 2019, and must be submitted by 4 PM central time on September 4, 2019. Detailed instructions for submitting an application are in the *Instructions for Applicants* document, posted   in CARS. **Submission of an application is considered an acceptance of the terms and conditions of the RFA.**

4.3.   Submission Deadline Extension

The submission deadline may be extended for 1 or more grant applications upon a showing of good cause. All requests for extension of the submission deadline must be submitted via email to the CPRIT Helpdesk within 24 hours of the submission deadline. Submission deadline extensions, including the reason for the extension, will be documented as part of the grant review process records.

4.4. Application Components

Applicants are advised to follow all instructions to ensure accurate and complete submission of all components of the application. Refer to the *Instructions for Applicants* document for details.

Submissions that are missing 1 or more components or do not meet the eligibility requirements may be administratively withdrawn without review.

4.4.1. Abstract and Significance (5,000 characters)

Clearly explain the problem(s) to be addressed, the approach(es) to the solution, and how the application is responsive to this RFA. In the event that the project is funded, the abstract will be made public; therefore, no proprietary information should be included in this statement. Initial compliance decisions are based in part upon review of this statement.

The abstract format is as follows (use headings as outlined below):

- **Need:** Include a description of need in the specific service area. Include rates of incidence, mortality, and screening in the service area compared to overall Texas rates. Describe barriers, plans to overcome these barriers, and the priority population to be served.
- **Overall Project Strategy:** Describe the project and how it will address the identified need. Clearly explain what the project is and what it will specifically do, including the services to be provided and the process/system for delivery of services and outreach to the priority population.
- **Specific Goals:** State specifically the overall goals of the proposed project; include the estimated overall numbers of people (public and/or professionals) reached, unique people (public and/or professionals) served and the number of services.
- **Significance and Impact:** Explain how the proposed project, if successful, will have a major impact on cancer prevention and control for the population proposed to be served and for the State of Texas.

4.4.2. Goals and Objectives (700 characters each)

List only major **outcome goals** and **measurable objectives** for each year of the project. **Do not include process objectives**; these should be described in the project plan only. Include the proposed metric within both the stated objective and the measure. Refer to the *Instructions for*

Applicants document for details. The maximum number is 3 goals with 3 objectives each. Projects will be evaluated annually on progress toward **outcome** goals and objectives. See <u>Appendix B</u> for instructions on writing outcome goals and objectives.

A baseline and method(s) of measurement are required for each objective. Provide both raw numbers and percent changes for the baseline and target. If a baseline has not been defined, applicants are required to explain plans to establish baseline and describe method(s) of measurement.

4.4.3. Project Timeline (2 pages)

Provide a project timeline for project activities that includes deliverables and dates. Use Years 1, 2, 3, and Months 1, 2, 3, etc, as applicable (eg, Year 1, Months 3-5) instead of specific months or years. Month 1 is the first full month of the grant award.

4.4.4. Project Plan (12 pages, fewer pages permissible)

The required project plan format follows. Applicants must use the headings outlined below.

Background: Briefly present the rationale behind the proposed service, emphasizing the critical barriers to current service delivery that will be addressed. Identify the evidence-based service to be implemented for the priority population. Describe the race, ethnicity, age, and other defining characteristics of the population to be served.

If evidence-based strategies have not been implemented or tested for the specific population or service setting proposed, provide evidence that the proposed service is appropriate for the population and has a high likelihood of success.   Baseline data for the target population and target service area are required where applicable.

Reviewers will be aware of national and state statistics, and these should be used only to compare rates for the proposed service area. Describe the geographic region of the state that the project will serve; maps are encouraged.

Goals and Objectives: Process objectives should be included in the project plan. Outcome goals and objectives will be entered in separate fields in CARS. However, if desired, outcome goals and objectives may be fully repeated or briefly summarized here. See <u>Appendix B</u> for instructions on writing goals and objectives.

Components of the Project: Clearly describe the need, delivery method, and evidence base (provide references) for the services as well as anticipated results. Be explicit about the base of evidence and any necessary adaptations for the proposed project. Describe why this project is nonduplicative. If an organization has a current CPRIT grant that is the same or similar to the prevention intervention being proposed, the applicant must explain how the projects are nonduplicative or complementary.

It is important to distinguish between Texas counties where the project proposes to deliver services and counties of residence of population served (see Appendix A for definitions and *Instructions for Applicants*). Only counties with service delivery should be listed in the Geographic Area to be Served section of the application. Projecting counties of residence of population served is not required but may be described in the project plan.

Clearly demonstrate the ability to provide the proposed service and describe how results will be improved over baseline and the ability to reach the priority population. If clinical services are being paid for and provided by others, the applicant must explain and report on the number of clinical services and patient outcomes that are delivered to the people navigated by the program. Applicants must also clearly describe plans to **ensure access to treatment services** should cancer be detected.

Evaluation Strategy: A strong commitment to evaluation of the project is required. Describe the plan for outcome and output measurements, including qualitative analysis of policy and system changes. Describe data collection and management methods, data analyses, and anticipated results. Evaluation and reporting of results should be headed by a professional who has demonstrated expertise in the field. If needed, applicants may want to consider seeking expertise at Texas-based academic cancer centers, schools/programs of public health, or the like. Applicants should budget accordingly for the evaluation activity and should involve that professional during grant application preparation to ensure, among other things, that the evaluation plan is linked to the proposed goals and objectives.

Organizational Qualifications and Capabilities: Describe the organization and its track record and success in providing programs and services. Describe the role and qualifications of the key collaborators/partners in the project. Include information on the organization's financial stability and viability. To ensure access to preventive services and reporting of services outcomes,

applicants should demonstrate that they have provider partnerships and agreements (via memoranda of understanding) or commitments (via letters of commitment) in place.

Program Sustainability: CPRIT funds projects that target needs not sufficiently covered by other funding sources. As CPRIT approaches the end of its funding authority in 2022, program sustainability is of paramount importance. CPRIT acknowledges that full maintenance and sustainability of CPRIT funded projects may not be feasible, especially in cases involving the delivery of clinical services. Educational and other less costly interventions may be more readily sustained. Full maintenance of a project, the ability of the grantee's setting or community to continue to deliver the health benefits of the intervention as funded, is not required; however, efforts toward sustainability are expected and must be described. Program sustainability capacity is defined as the ability to maintain a program and its benefits over time.

Washington University in St. Louis has developed a useful tool (Program Sustainability Assessment Tool) to assess program capacity for sustainability. They describe several factors that contribute to program sustainability. These factors include environmental support, funding stability, partnerships, organizational capacity, program evaluation, program adaptation, communication, and strategic planning. Applicants are not required to use this tool; however, it provides practical guidance on factors that should be considered and should be included in the application to describe a program's capacity for sustainability.

It is expected that steps toward building sustainability capacity for the program will be taken and plans for such be fully described in the application. For new programs, the applicant should describe the factors that will contribute to the program's sustainability and plans for sustainability beyond the project end date. For expansion projects, the applicant should assess and describe their current activities and capacity for sustainability and plans for sustainability beyond the project's end date.

Important factors to include in describing plans for sustainability include integration of the evidence-based intervention within the culture of the grantee's setting or community through policies and practices; plans for systems change that are sustainable over time (eg, improve provider practice, efficiency, cost-effectiveness); and activities (eg, training, identification of alternative resources, building internal assets) that build durable resources and enable the grantee's

setting or community to continue the delivery of some or all components of the evidence-based intervention.

Dissemination and Replication:

Dissemination of project results and outcomes, including barriers encountered and successes achieved, is critical to building the evidence base for cancer prevention and control efforts in the state. Dissemination efforts should consider the message, source, audience, and channel (Brownson, R.C., et al. *J Pub Health Manag Pract*. 24(2):102-111, March/April 2018). Dissemination methods may include, but are not limited to, presentations at workshops and seminars, one-on-one meetings, publications, news media, social media, etc.

While passive dissemination methods are common (eg, publications, presentations at professional meetings), plans should include some active dissemination methods (eg, meetings with stakeholders, blogs, social media). Applicants should describe their dissemination plans. The plans should include the kinds of audiences to be targeted and methods for reaching the targeted audiences.

Replication by others is an additional way to disseminate the project. For applicable components, describe how the project or components of the project lend themselves to application by other communities and/or organizations in the state or expansion in the same communities. Describe what components of this project can be adapted to a larger or lower resource setting. Note that some programs may have unique resources and may not lend themselves to replication by others.

4.4.5. People Reached (Indirect Contact)

Provide the estimated overall number of people (members of the public and professionals) to be reached by the funded project. The applicant is required to itemize separately the types of indirect noninteractive education and outreach activities, with estimates, that led to the calculation of the overall estimates provided. Refer to Appendix A for definitions.

4.4.6. Number of Services Delivered (Direct Contact)

Provide the estimated overall number of services directly delivered to members of the public and to professionals by the funded project. Each individual service should be counted, regardless of the number of services one person receives. The applicant is required to itemize separately the

education, navigation, and clinical activities/services, with estimates, that led to the calculation of the overall estimate provided. Refer to Appendix A for definitions.

4.4.7. Number of Clinical Services Delivered

Provide the estimated overall number of clinical services directly delivered to members of the public by the funded project. Each individual clinical service should be counted, regardless of the number of services one person receives. Separately itemize the clinical services, with estimates, that led to the calculation of the overall estimate provided. Refer to Appendix A for definitions.

4.4.8. Number of Unique People Served (Direct Contact)

Provide the estimated overall number of unique members of the public and professionals served by the funded project. One person may receive multiple services but should only be counted once here. Refer to Appendix A for definitions.

4.4.9. References

Provide a concise and relevant list of references cited for the application. The successful applicant will provide referenced evidence and literature support for the proposed services.

4.4.10. Resubmission Summary

Use the template provided on the CARS (https://CPRITGrants.org). Describe the approach to the resubmission and how reviewers' comments were addressed. Clearly indicate to reviewers how the application has been improved in response to the critiques. Refer the reviewers to specific sections of other documents in the application where further detail on the points in question may be found. When a resubmission is evaluated, responsiveness to previous critiques is assessed.

The summary statement of the original application review, if previously prepared, will be automatically appended to the resubmission; the applicant is not responsible for providing this document.

4.4.11. Expansion Application Documents

If the project proposed is being submitted as an expansion project, the additional document described in section 4.4.12 is required.

4.4.12. Most Recently Funded Project Summary, if Applicable (3 pages)

Upload a summary that outlines the progress made with the most recently funded CPRIT award. Applicants must describe results and outcomes of the most recently funded award and demonstrate why further funding is warranted.

Please note that a different set of reviewers from those assigned to the previously funded application may evaluate this application. Applicants should make it easy for reviewers to compare the most recently funded project with the proposed continuation/expansion project.

In the description, include the following:

- Describe the evidence-based intervention, its purpose, and how it was implemented in the priority population. Describe any adaptations made for the population served.
- List approved goals and objectives of the most recently funded grant.
- For each objective, provide the following:
  - Milestones/target dates and target metrics
  - Actual completion dates and metrics
- For the most recently funded project, describe major activities; significant results, including major findings, developments or conclusions (both positive and negative); and key outcomes. If the project has not yet ended, provide projections for completion dates and final metrics. Include a discussion of objectives not fully met. Explain any barriers encountered and strategies used to overcome these.
- Describe steps taken toward sustainability for components of the projects. Fully describe systems or policy improvements and enhancements.
- Describe how project results were disseminated or plans for future dissemination of results.

4.4.13 CPRIT Grants Summary

Use the template provided on CARS (https://CPRITGrants.org). Provide a listing of **all** projects funded by the CPRIT Prevention program for the PD or Co-PD, regardless of their connection to this application.

4.4.14 Budget and Justification

Provide a brief outline and detailed justification of the budget for the entire proposed period of support, including salaries and benefits, travel, equipment, supplies, contractual expenses, services delivery, and other expenses. CPRIT funds will be distributed on a reimbursement basis. Applications requesting more than the maximum allowed cost (total costs) as specified in section 2.10 will be administratively withdrawn.

- **Average Cost per Person:** The average cost per person will be automatically calculated from the total cost of the project divided by the total number of unique people served (refer to Appendix A).

- **Average Cost per Service:** The average cost per service will be automatically calculated from the total cost of the project divided by the total number of services delivered (refer to Appendix A). A significant proportion of funds is expected to be used for program delivery as opposed to program development and organizational infrastructure.

- **Average Cost per Clinical Service:** The average cost per clinical service will be automatically calculated from the total cost of the project divided by the total number of clinical services delivered (refer to Appendix A).

- **Personnel:** The individual salary cap for CPRIT awards is $200,000 per year. Describe the source of funding for all project personnel where CPRIT funds are not requested.

- **Travel:** PDs and related project staff are expected to attend CPRIT's conference. CPRIT funds may be used to send up to 2 people to the conference.

- **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. An applicant does not need to seek this approval prior to submitting the application. Justification must be provided for why funding for this equipment cannot be found elsewhere; CPRIT funding should not supplant existing funds. Cost sharing of equipment purchases is strongly encouraged.

- **Services Costs:**
  - ○ CPRIT reimburses for services using Medicare reimbursement rates. Describe the source of funding for all services where CPRIT funds are not requested. If clinical services are being paid for and provided by others, the applicant is required to explain and report on the number of clinical services and patient outcomes that are delivered to the people navigated by the program.
  - ○ CPRIT does not allow recovery of costs related to tests that have not been recommended by the USPSTF.
- **Other Expenses:**
  - ○ **Incentives:** Use of incentives or positive rewards to change or elicit behavior is allowed; however, incentives may only be used based on strong evidence of their effectiveness for the purpose and in the priority population identified by the applicant. CPRIT will not fund cash incentives. The maximum dollar value allowed for an incentive per person, per activity or session, is $25.
  - ○ **Costs Not Related to Cancer Prevention and Control:** CPRIT does not allow recovery of any costs for services not related to cancer (eg, health physicals, HIV testing).
- **Indirect/Shared Costs:** Texas law limits the amount of grant funds that may be spent on indirect/shared expenses to no more than 5% of the total award amount (5.263% of the direct costs). Guidance regarding indirect cost recovery can be found in CPRIT's Administrative Rules.

4.4.15 Current and Pending Support and Sources of Funding

Use the template provided on the CARS (https://CPRITGrants.org). Describe the funding source and duration of **all** current and pending support for the proposed project, including a capitalization table that reflects private investors, if any.

4.4.16 Biographical Sketches

The designated PD will be responsible for the overall performance of the funded project and must have relevant education and management experience. The PD/Co-PD(s) must provide a biographical sketch that describes his or her education and training, professional experience,

awards and honors, and publications and/or involvement in programs relevant to cancer prevention and/or service delivery.

- Use the Co-PD biographical sketch section ONLY if a Co-PD has been identified.
- The evaluation professional must provide a biographical sketch in the Evaluation Professional Biographical sketch section.
- Up to 3 additional biographical sketches for key personnel may be provided in the Key Personnel Biographical sketch section.

Each biographical sketch must not exceed 2 pages and should use the "Prevention Programs: Biographical Sketch" template provided on the CARS (https://CPRITGrants.org). Only biographical sketches will be accepted; do not submit resumes and/or CVs. If a position is not yet filled, please upload a job description.

4.4.17 Collaborating Organizations

List all key participating organizations that will partner with the applicant organization to provide 1 or more components essential to the success of the program (eg, evaluation, clinical services, recruitment to screening).

4.4.18 Letters of Commitment (10 pages)

Applicants should provide letters of commitment and/or memoranda of understanding from community organizations, key faculty, or any other component essential to the success of the program. Letters should be specific to the contribution of each organization.

5.   APPLICATION REVIEW

5.1 Review Process Overview

All eligible applications will be reviewed using a 2-stage peer review process: (1) evaluation of applications by peer review panels and (2) prioritization of grant applications by the Prevention Review Council. In the first stage, applications will be evaluated by an independent review panel using the criteria listed below. In the second stage, applications judged to be meritorious by review panels will be evaluated by the Prevention Review Council and recommended for funding based on comparisons with applications from all of the review panels and programmatic priorities. Programmatic considerations may include, but are not limited to, geographic distribution, cancer

type, population served, and type of program or service. The scores are only 1 factor considered during programmatic review. At the programmatic level of review, priority will be given to proposed projects that target geographic regions of the state or population subgroups that are not well represented in the current CPRIT Prevention project portfolio.

Applications approved by Review Council will be forwarded to the CPRIT Program Integration Committee (PIC) for review. The PIC will consider factors including program priorities set by the Oversight Committee, portfolio balance across programs, and available funding. The CPRIT Oversight Committee will vote to approve each grant award recommendation made by the PIC. The grant award recommendations will be presented at an open meeting of the Oversight Committee and must be approved by two-thirds of the Oversight Committee members present and eligible to vote. The review process is described more fully in CPRIT's Administrative Rules, chapter 703, sections 703.6 to 703.8.

Each stage of application review is conducted confidentially, and all CPRIT Peer Review Panel members, Review Council members, PIC members, CPRIT employees, and Oversight Committee members with access to grant application information are required to sign nondisclosure statements regarding the contents of the applications. All technological and scientific information included in the application is protected from public disclosure pursuant to Health and Safety Code §102.262(b).

Individuals directly involved with the review process operate under strict conflict-of-interest prohibitions. All CPRIT Peer Review Panel members and Review Council members are non-Texas residents.

An applicant will be notified regarding the peer review panel assigned to review the grant application. Peer Review Panel members are listed by panel on CPRIT's website. **By submitting a grant application, the applicant agrees and understands that the only basis for reconsideration of a grant application is limited to an undisclosed Conflict of Interest as set forth in CPRIT's Administrative Rules, chapter 703, section 703.9.**

Communication regarding the substance of a pending application is prohibited between the grant applicant (or someone on the grant applicant's behalf) and the following individuals: an Oversight Committee member, a PIC member, a Review Panel member, or a Review Council member. Applicants should note that the CPRIT PIC comprises the CPRIT Chief Executive Officer, the

Chief Scientific Officer, the Chief Prevention and Communications Officer, the Chief Product Development Officer, and the Commissioner of State Health Services. The prohibition on communication begins on the first day that grant applications for the particular grant mechanism are accepted by CPRIT and extends until the grant applicant receives notice regarding a final decision on the grant application. The prohibition on communication does not apply to the time period when preapplications or letters of interest are accepted. Intentional, serious, or frequent violations of this rule may result in the disqualification of the grant application from further consideration for a grant award.

5.2 Review Criteria

Peer review of applications will be based on primary scored criteria and secondary unscored criteria, identified below. Review panels consisting of experts in the field and advocates will evaluate and score each primary criterion and subsequently assign an overall score that reflects an overall assessment of the application. The overall evaluation score will not be an average of the scores of individual criteria; rather, it will reflect the reviewers' overall impression of the application and responsiveness to the RFA priorities.

5.3 Primary Evaluation Criteria

Impact

- Do the proposed services address an important problem or need in cancer prevention and control? Do the proposed project strategies support desired outcomes in cancer incidence, morbidity, and/or mortality? Do the proposed project strategies reach a priority population (eg, low income, minority, rural) at high risk of cancer?

- For expansion projects, does the proposed project build on its initial results (baseline)? Does it go beyond the initial project to address what the applicant has learned or explore new partnerships, new audiences, or improvements to systems?

- Will the project reach and serve/impact an appropriate number of people based on the budget allocated to providing services and the cost of providing services?

- If applicable, have partners demonstrated that the collaborative effort will provide a greater impact on cancer prevention and control than the applicant organization's effort separately?

- Does the program address adaptation, if applicable, of the evidence-based intervention to the priority population? Is the base of evidence clearly explained and referenced?

Project Strategy and Feasibility

- Does the proposed project provide services specified in the RFA?

- Are the overall program approach, strategy, and design clearly described and supported by established theory and practice? Are the proposed objectives and activities feasible within the duration of the award? Has the applicant convincingly demonstrated the short- and long-term impacts of the project?

- Has the applicant proposed policy changes and/or system improvements?

- Are possible barriers addressed and approaches for overcoming them proposed?

- Are the priority population and culturally appropriate methods to reach the priority population clearly described?

- If applicable, does the application demonstrate the availability of resources and expertise to provide case management, including followup for abnormal results and access to treatment?

- Does the program leverage partners and resources to maximize the reach of the services proposed? Does the program leverage and complement other state, federal, and nonprofit grants?

Outcomes Evaluation

- Are specific goals and measurable objectives for each year of the project provided?

- Are the proposed outcome measures appropriate for the services provided, and are the expected changes clinically significant?

- If clinical services are being paid for and provided by others, does the applicant explain the methods used to collect data and report on these clinical services and outcomes?

- Does the application provide a clear and appropriate plan for data collection and management and data analyses?

- Are clear baseline data provided for the priority population, or are clear plans included to collect baseline data?

- If an evidence-based intervention is being adapted in a population where it has not been implemented or tested, are plans for evaluation of barriers, effectiveness, and fidelity to the model described?

- Is the qualitative analysis of planned policy or system changes described?

Organizational Qualifications and Capabilities

- Do the organization and its collaborators/partners demonstrate the ability to provide the proposed preventive services? Does the described role of each collaborating organization make it clear that each organization adds value to the project and is committed to working together to implement the project?

- Have the appropriate personnel been recruited to implement, evaluate, and complete the project?

- Is the organization structurally and financially stable and viable?

Program Sustainability

- For new projects, does the applicant describe **some** factors that will help ensure their program's sustainability (eg, strong environmental support, partnerships, organizational capacity, etc) and their plans to build capacity for sustainability?

- For expansion projects, does the applicant describe their current activities and capacity for sustainability and plans for sustainability beyond the project's end date?

- Does the applicant describe steps that will be taken and components of the project that will be integrated into the organization through policies and practices?

- Does the applicant describe a plan for systems changes that are sustainable over time; eg, improve results, provider practice, efficiency, cost-effectiveness?

- Does the applicant describe steps that the applicant organization or other entities will take or components of the project that will remain (eg, trained personnel, identification of alternative resources, building internal assets) to continue the delivery of some or all components of the evidence-based intervention once CPRIT funding ends?

5.4 Secondary Evaluation Criteria

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 the proportion of the funds allocated for direct services reasonable?

- Is the project a good investment of Texas public funds?

Dissemination and Replication

- Are plans for dissemination of the project's results and outcomes, including target audiences and methods, clearly described?

- Are active dissemination strategies included and described in the plan?

- Does the applicant describe whether and/or how the project lends itself to replication of all or some components of the project by others in the state?

6.   AWARD ADMINISTRATION

Texas law requires that CPRIT grant awards be made by contract between the applicant and CPRIT. CPRIT grant awards are made to institutions or organizations, not to individuals. Award contract negotiation and execution will commence once the CPRIT Oversight Committee has approved an application for a grant award. CPRIT may require, as a condition of receiving a grant award, that the grant recipient use CPRIT's electronic Grant Management System to exchange, execute, and verify legally binding grant contract documents and grant award reports. Such use shall be in accordance with CPRIT's electronic signature policy as set forth in chapter 701, section 701.25.

Texas law specifies several components that must be addressed by the award contract, including needed compliance and assurance documentation, budgetary review, progress and fiscal monitoring, and terms relating to revenue sharing and intellectual property rights. These contract provisions are specified in CPRIT's Administrative Rules. Applicants are advised to review CPRIT's administrative rules related to contractual requirements associated with CPRIT grant awards and limitations related to the use of CPRIT grant awards as set forth in chapter 703, sections 703.10, 703.12.

Prior to disbursement of grant award funds, the grant recipient organization must demonstrate that it has adopted and enforces a tobacco-free workplace policy consistent with the requirements   set forth in CPRIT's Administrative Rules, chapter 703, section 703.20.

CPRIT requires the PD of the award to submit quarterly, annual, and final progress reports. These reports summarize the progress made toward project goals and address plans for the upcoming year and performance during the previous year(s). In addition, quarterly fiscal reporting and reporting on selected metrics will be required per the instructions to award recipients. Continuation

of funding is contingent upon the timely receipt of these reports. Failure to provide timely and complete reports may waive reimbursement of grant award costs and may result in the termination of the award contract.

7. CONTACT INFORMATION

7.1 Helpdesk

Helpdesk support is available for questions regarding user registration and online submission of applications. Queries submitted via email will be answered within 1 business day. Helpdesk staff are not in a position to answer questions regarding the scope and focus of applications. Before contacting the helpdesk, please refer to the *Instructions for Applicants* document (posted on June 6, 2019), which provides a step-by-step guide to using CARS.

Hours of operation:	Monday through Friday, 8 AM to 6 PM central time
Tel:	866-941-7146
Email:	Help@CPRITGrants.org

7.2 Program Questions

Questions regarding the CPRIT Prevention Program, including questions regarding this or any other funding opportunity, should be directed to the CPRIT Prevention Program Office.

Tel:	512-305-8417
Email:	Help@CPRITGrants.org
Website:	www.cprit.texas.gov

8. RESOURCES

- The Texas Cancer Registry. https://www.dshs.texas.gov/tcr or contact the Texas Cancer Registry at the Department of State Health Services.

- The Community Guide. http://www.thecommunityguide.org/index.html

- Cancer Control P.L.A.N.E.T. http://cancercontrolplanet.cancer.gov

- Guide to Clinical Preventive Services: Recommendations of the U.S. Preventive Services Task Force. http://www.ahrq.gov/professionals/clinicians-providers/guidelines-recommendations/guide/

- Brownson, R.C., Colditz G.A., and Proctor, E.K. (Editors). *Dissemination and Implementation Research in Health: Translating Science to Practice.* Oxford University Press, March 2012

- Program Sustainability Assessment Tool, copyright 2012, Washington University, St. Louis, MO, https://www.sustaintool.org/about-us/

- Getting the Word Out: New Approaches for Disseminating Public Health Science Ross C. Brownson, PhD; Amy A. Eyler, PhD; Jenine K. Harris, PhD; Justin B. Moore, PhD, MS; Rachel G. Tabak, PhD, RD, **Journal of Public Health Management & Practice.** 24(2):102-111, March/April 2018. (https://journals.lww.com/jphmp/Fulltext/2018/03000/Getting_the_Word_Out___New_Approaches_for_4.aspx)

- Centers for Disease Control and Prevention: The Program Sustainability Assessment Tool: A New Instrument for Public Health Programs. http://www.cdc.gov/pcd/issues/2014/13_0184.htm

- Centers for Disease Control and Prevention: Using the Program Sustainability Tool to Assess and Plan for Sustainability. http://www.cdc.gov/pcd/issues/2014/13_0185.htm

- Cancer Prevention and Control Research Network: Putting Public Health Evidence in Action Training Workshop. http://cpcrn.org/pub/evidence-in-action/

- Centers for Disease Control and Prevention. Distinguishing Public Health Research and Public Health Nonresearch. http://www.cdc.gov/od/science/integrity/docs/cdc-policy-distinguishing-public-health-research-nonresearch.pdf

9. REFERENCES

1. National Cancer Institute, https://www.cancer.gov

2. American Cancer Society, Cancer Facts and Figures 2016, http://www.cancer.org/research/cancerfactsstatistics/cancerfactsfigures2016

3. Texas Cancer Registry, Cancer Epidemiology and Surveillance Branch, Texas Department of State Health Services. https://www.cancer-rates.info/tx/

4. Centers for Disease Control and Prevention. Distinguishing Public Health Research and Public Health Nonresearch. http://www.cdc.gov/od/science/integrity/docs/cdc-policy-distinguishing-public-health-research-nonresearch.pdf

APPENDIX A: KEY TERMS

- **Activities:** A listing of the "who, what, when, where, and how" for each objective that will be accomplished.

- **Capacity Building**: Any activity (eg, training, identification of alternative resources, building internal assets) that builds durable resources and enables the grantee's setting or community to continue the delivery of <u>some or all</u> components of the evidence-based intervention.

- **Clinical Services:** Number of clinical services such as screenings, diagnostic tests, vaccinations, counseling sessions, or other evidence-based preventive services delivered by a health care practitioner in an office, clinic, or health care system. Other examples include genetic testing or assessments, physical rehabilitation, tobacco cessation counseling or nicotine replacement therapy, case management, primary prevention clinical assessments, and family history screening.

- **Counties of Residence of Population Served:** Counties where the project does not plan to have a physical presence but people who live in these counties have received services. This includes counties of residence of people or places of business of professionals who participate in or receive education, navigation, or clinical services. Examples include people traveling to receive services as a result of marketing and programs accessible via the website or social media. These counties may be described in the project plan and must be reported in the quarterly progress report.

- **Counties with Service Delivery:** Counties where an activity or service will occur and the project has a physical presence for the services provided. Examples include onsite outreach and educational activities and delivery of clinical services through clinics, mobile vans, or telemedicine consults. These counties must be entered in the Geographic Area to be Served section of the application.

- **Education Services:** Number of evidence-based, culturally appropriate cancer prevention and control education and outreach services delivered to the public and to health care professionals. Examples include education or training sessions (group or individual), focus groups, and knowledge assessments. One individual may receive multiple education services.

- **Evidence-Based Program:** A program that is validated by some form of documented research or applied evidence. CPRIT's website provides links to resources for evidence-based strategies, programs, and clinical recommendations for cancer prevention and control. To access this information, visit https://www.cprit.state.tx.us/our-programs/prevention.

- **Goals:** Broad statements of general purpose to guide planning. Outcome goals should be few in number and focus on aspects of highest importance to the project. (Appendix B)

- **Integration:** The extent the evidence-based intervention is integrated within the culture of the grantee's setting or community through policies and practice.

- **Navigation Services:** Number of activities/services that offer assistance to help overcome health care system barriers in a timely and informative manner and facilitate cancer screening and diagnosis to improve health care access and outcomes. Examples include patient reminders, transportation assistance, and appointment scheduling assistance. One individual may receive multiple navigation services.

- **Number of Clinical Services:** Number of clinical services delivered directly to members of the public by the funded project. One individual may receive multiple clinical services.

- **Number of Services (Direct Contact):** Number of services delivered directly to members of the public and/or professionals—direct, interactive public or professional education, outreach, training, navigation service, or clinical service, such as live educational and/or training sessions, vaccine administration, screening, diagnostics, case management/navigation services, and physician consults. One individual may receive multiple services.

- **Objectives:** Specific, **measurable,** actionable, realistic, and timely projections for outcomes; example: "Increase screening service provision in X population from Y% to Z% by 20xx." Baseline data for the priority population must be included as part of each objective. (Appendix B) The proposed metric should be included in **both** the objective and the measure.

- **People Reached (Indirect contact):** Number of members of the public and/or professionals reached via indirect noninteractive public or professional education and outreach activities, such as mass media efforts, brochure distribution, public service announcements, newsletters, and journals. (This category includes individuals who would

be reached through activities that are directly funded by CPRIT as well as individuals who would be reached through activities that occur as a direct consequence of the CPRIT-funded project's leveraging of other resources/funding to implement the CPRIT-funded project.)

- **Unique People Served (Direct Contact):** Number of unique members of the public and/or professionals served via direct, interactive public or professional education, outreach, training, navigation service, or clinical service. This category includes individuals who would be served through activities that are directly funded by CPRIT as well as individuals who would be served through activities that occur as a direct consequence of the CPRIT-funded project's leveraging of other resources/funding to implement the CPRIT-funded project.

APPENDIX B: WRITING GOALS AND OBJECTIVES

List only major **outcome goals** and **measurable objectives** for each year of the project. **Do not include process objectives**; these should be described in the project plan only. Include the proposed metric within **both** the stated objective and the measure. The maximum number is 3 goals with 3 objectives each. Projects will be evaluated annually on progress toward **outcome** goals and objectives.

The following guide has been adapted with permission from Appalachia Community Cancer Network, NIH Grant U54 CA 153604:

Develop well-defined outcome goals and objectives.

Goals provide a roadmap or plan for where a group wants to go. Goals can be long term (over several years) or short term (over several months). Goals should be based on needs of the community and evidence-based data.

Goals should be:

- Believable – situations or conditions that the group believes can be achieved
- Attainable – possible within a designated time
- Tangible – capable of being understood or realized
- On a timetable – with a completion date
- Win-Win – beneficial to individual members and the coalition

Objectives are measurable steps toward achieving the goal. They are clear statements of specific activities required to achieve the goal. The best objectives have several characteristics in common – S.M.A.R.T. + C:

- Specific – they tell how much (number or percent), who (participants), what (action or activity), and by when (date)
  - Example: 115 uninsured individuals age 50 and older will complete colorectal cancer screening by March 31, 2018.
- Measurable – specific measures that can be collected, detected, or obtained to determine successful attainment of the objective
  - Example: How many screened at an event? How many completed pre/post assessment?

- Achievable – not only are the objectives themselves possible, it is likely that your organization will be able to accomplish them
- Relevant to the mission – your organization has a clear understanding of how these objectives fit in with the overall vision and mission of the group
- Timed – developing a timeline is important for when your task will be achieved
- Challenging – objectives should stretch the group to aim on significant improvements that are important to members of the community

Evaluate and refine your objectives

Review your developed objectives and determine the type and level of each using the following information:

There are 2 types of objectives:
- Outcome objectives – measure the "what" of a program; should be in the Goals and Objectives form (see section 4.4.2)
- Process objectives – measure the "how" of a program; should be in the project plan only (see section 4.4.4)

There are 3 levels of objectives:
- Community-level – objectives measure the planned community change
- Program impact – objectives measure the impact the program will have on a specific group of people
- Individual – objectives measures participant changes resulting from a specific program, using these factors:
  - Knowledge – understanding (know screening guidelines; recall the number to call for screening)
  - Attitudes – feeling about something (will consider secondhand smoke dangerous; believe eating 5 or more fruits and vegetable is important)
  - Skills – the ability to do something (complete fecal occult blood test)
  - Intentions – regarding plan for future behavior (will agree to talk to the doctor, will plan to schedule a Pap test)
  - Behaviors (past or current) – to act in a particular way (will exercise 30+ minutes a day, will have a mammogram)

Well-defined outcome goals and objectives can be used to track, measure, and report progress toward achievement.

Summary Table

	Outcome – Use in Goals and Objectives	**Process – Use in Project Plan only**
Community-level	WHAT will change in a community *Example: As a result of CPRIT funding, FIT (fecal immunochemical tests) will be available to 1,500 uninsured individuals age 50 and over through 10 participating local clinics and doctors.*	HOW the community change will come about *Example: Contracts will be signed with participating local providers to enable uninsured individuals over age 50 have access to free colorectal cancer screening in their communities.*
Program impact	WHAT will change in the target group as a result of a particular program *Example: As a result of this project, 200 uninsured women between 40 and 49 will receive free breast and cervical cancer screening.*	HOW the program will be implemented to affect change in a group/population *Example: 2,000 female clients, between 40 and 49, will receive a letter inviting them to participate in breast and cervical cancer screening.*
Individual	WHAT an individual will learn as a result of a particular program, or WHAT change an individual will make as a result of a particular program *Example: As a result of one-to-one education of 500 individuals, at least 20% of participants will participate in a smoking cessation program to quit smoking.*	HOW the program will be implemented to affect change in an individual's knowledge or actions *Example: As a result of one-to-one counseling, all participants will identify at least 1 smoking cessation service and 1 smoking cessation aid.*