Connecticut Community Transformation Grant

SECTION A. BACKGROUND AND NEED

1. Current Capacity to Support Activities in Draft Capacity Building Plan The Connecticut Department of Public Health (DPH) has a long history of funding health promotion and disease prevention activities in communities with high-need populations, evidenced by the federal Centers for Disease Control and Prevention's (CDC) continuous support for Connecticut's Asthma; Comprehensive Cancer; Colorectal Cancer; Cardiovascular Disease and Stroke; Diabetes; Nutrition, Physical Activity and Obesity (NPAO); Oral Health; Breast and Cervical Cancer; WISEWOMAN; Tobacco Control, and Patient Navigation programs. In 2010, program staff led a statewide collaborative effort involving public and private stakeholders to develop an integrated chronic disease plan. The plan focuses on shared modifiable risk factors for chronic diseases, with an emphasis on policy, systems, and environmental changes, and addresses health disparities and health equity. The work completed to date will serve as a resource for the Community Transformation Grant (CTG) project.

Strong support and leadership from DPH Commissioner, Dr. Jewel Mullen, will increase the state's capacity to conduct CTG activities. She helped gain support and input from partners for addressing all five Strategic Directions. She also selected strong, experienced DPH and Leadership Teams to oversee the state's CTG efforts (see Sections B and D).

The area in which DPH proposes to work, is the five Connecticut counties with populations <500,000: Litchfield, Middlesex, New London, Tolland and Windham. Three of these counties have successful Action Communities for Health, Innovation, and Environmental Change (ACHIEVE) Initiatives (see Section D, #2 Community Coalitions) that have been part of the CTG planning process and have agreed to work directly with the CTG Coalitions in each county.

2. Support Needed (CDC & Experts): Connecticut county- and town-level data are not readily accessible to consumers, even within DPH. The CTG Team needs the support of CDC and other national experts to identify or develop strategies to make such data available to County Coalitions for needs assessments and monitoring trends in health outcomes and risk factors (see Section G). DPH also needs CDC support to review the compiled lists of tools, toolkits, and resources for capacity building and implementation activities for recommended and possible use by CTG County Coalitions.

3. Potential Partnerships & Linkages: Past and present statewide partnerships that can be reestablished or enhanced include Communities Putting Prevention to Work (CPPW); ACHIEVE; CT Breastfeeding Coalition; Mobilizing against Tobacco for Connecticut's Health (MATCH) Coalition; Asthma Advisory Council; Connecticut Childhood Obesity Council; Department of Social Services Healthy Aging Program; the Connecticut Health Foundation, and the Connecticut Health Disparities Project. Strong ties also exist with local health departments/districts through the CDC Preventive Health and Health Services Block Grant (PHHSBG). These partnerships involve community-based coalitions, using traditional and non-traditional partners from both the public and private sectors to create sustainable population-based systems, policy, and environmental change initiatives.

4. Past Policy, Environmental, Programmatic, & Infrastructure Successes/Lessons Learned

Past successes within the five counties include a nationally recognized community garden, an award winning walking/biking trail, creation of bicycle lanes, establishment of a Food Policy Council, start the school day with a walk initiative, comprehensive employee wellness initiatives, Clean Indoor Air Act laws, and smoking bans throughout the state in restaurants, bars, cafes, and workplaces. Lessons learned include: the importance of recruiting non-traditional stakeholders;

early education of the public about the benefits of policies; and the need to address distinctions between Spanish and English educational efforts through culturally appropriate initiatives.

5. Area Description & Need: The three large urban counties in Connecticut (Fairfield, Hartford, and New Haven) have multiple resources available for addressing well-documented health disparities, whereas the remaining five counties, comprising mostly small or rural towns, have limited resources for use across a larger geographic area, and have limited access to data with which to document need. Lacking the population density, these five counties are often overlooked when funds are distributed in the state, and their unique needs largely remain unmet.

a. ***Population Size, Demographics, and Socioeconomic Disparities.*** This proposal covers the five Connecticut counties with populations below 500,000. The division of Connecticut's 169 towns into eight counties is an artifact, as county governments do not exist, and towns are the units of local government. Local health infrastructure comprises 75 independent health departments. (Appendix A, Table 1). About 25% of Connecticut's population or 889,239 people live in the five-county, 90-town area proposed to be served. Nearly one-third (31%) of this population resides in 58 rural towns. The area population is predominantly white non-Hispanic (county range, 80% to 92%), as is the U.S. (84%) and Connecticut (88%), with county percentages of blacks ranging from 0.8% to 5% and Hispanics from 4% to 9%. County-level racial and ethnic data do not reflect the composition of all constituent towns, however. The town of New London for example, is 17% black and 25% Hispanic, in contrast to New London County (5% black, 7% Hispanic); and the town of Windham is 31% Hispanic, compared to Windham County (9% Hispanic) (Appendix A, Table 2).

Connecticut has the highest personal per capita income, third highest median household income, and third lowest poverty rate in the U.S., and except for Windham County, residents of

the five counties have higher education levels and per capita income and lower poverty rates compared to the nation. However, county numbers also obscure marked differences in socioeconomic status across town lines. These differences are so striking that the state's 169 towns have been categorized by the State Data Center into "Five Connecticuts,"(Appendix A. Table 3) ranging from "wealthy" to "urban core". The five-county area contains only one of Connecticut's 23 "wealthy" towns, and from 2000 to 2009, the ratings of 13 area towns worsened. In 2009, 29% (257,825) of the area's population lived in towns with the two lowest ratings. Some of Connecticut's towns are among the deepest pockets of poverty in the nation. In 2005-2009, the state poverty rate was 8.7%, and the rates for four of the five counties were even lower. In contrast, poverty rates for many county subdivisions were as much as six times greater than the county rates (Appendix A, Table 4).

b. ***Burden of Chronic Diseases and Conditions.*** Heart disease, stroke, cancer, diabetes, and chronic lower respiratory diseases are among the leading causes of death in Connecticut and the five counties, accounting for over half of all resident deaths. In 2002-2006, the death rates for these diseases were significantly higher than the state rates in several towns within the five-county area, with some more than double the state rate (Appendix A, Table 5), and many others were higher though not significantly so.

c. ***Chronic Disease Risk Factors.*** The prevalence rates of modifiable risk factors among residents of the five counties are not significantly different from statewide rates. According to the 2011 County Health Rankings, Windham County ranks last in Connecticut for health behaviors, along with clinical care, social & economic factors, and physical environment; Litchfield and New London counties also rank poorly for many factors. In 2007-2009, an estimated 25% of Connecticut adults had high blood pressure (HBP); 34% had high blood cholesterol (HBC), 17%

had never had their cholesterol level tested, and 6% had diagnosed diabetes. About 46% did not meet the CDC recommendations for physical activity, 72% consumed less than five servings of fruits and vegetables daily, and 16% were current smokers. Obesity prevalence in the area was about 21%, except for Windham County (28%).

In 2009, an estimated 18% of Connecticut high school students were current smokers, 10% were obese, and during the week before the survey, 75% did not have physical activity for 60 minutes or more every day, and only 21% reported eating five servings of fruits and vegetables a day. County-level data on youth risk behavior are not available; however, DPH will seek guidance from CDC to establish methods of determining such data.

d. ***Disparities by Race and Ethnicity*****.** Connecticut's racial and ethnic minorities experience disparities in chronic diseases and their risk factors, and in the rural towns comprising nearly two-thirds of the five-county area, this is compounded by poor access to health care, transportation, and jobs. Data for subpopulations in the area are limited by small sample sizes and the lack of systematically collected local health data. Statewide, compared to white residents, blacks have higher age-adjusted death rates for heart disease, stroke, cancer, and diabetes, and higher prevalence rates for diabetes, HBP, obesity, and physical inactivity (Appendix A, Table 6). Hispanics have higher rates of diabetes, obesity, and physical inactivity, whereas their heart disease and cancer mortality rates are significantly lower.

e. ***Disparities by Age and Socioeconomic Status***. From 2007 to 2009, rates of obesity, physical inactivity, HBP, and HBC increased with age. This is noteworthy, because the five-county population is older relative to the Connecticut and U.S. populations. The 2009 median age in Litchfield County was greater than that for the U.S. and state by seven and four years, respectively. An aging population has far-reaching implications for state and federal

expenditures for health care and insurance, education, and transportation. Educational attainment, income, and poverty are recognized determinants of health, and Connecticut residents with lower socioeconomic status tend to have more risk behaviors and worse health outcomes. Compared to college graduates, for example, state residents with less than a high school education were more likely to smoke, be obese, physically inactive, to have HBP, HBC, diabetes, and not ever had their cholesterol tested (Appendix A, Table 7).

f. ***Disparities in Other Vulnerable Populations.*** In Connecticut, persons with disabilities, the medically underserved, sexual/gender minorities, and residents of rural areas also experience health disparities. Disability status increases with age and county values do not represent all towns. The percent of the population with disabilities in New London County and town , for example, were: New London County, age 5+, 18%, age 65+, 38%; New London town, age 5+, 24%, age 65+, 45% (2000 data). All five counties contain numerous federally designated medically underserved populations and/or areas and health professional shortage areas and populations (Appendix A, Table 8). Similarly, the health care system of Connecticut's rural communities has insufficient capacity to provide services in areas such as mental health, dental services, specialty services, transportation, and coordination of care. Except for HIV/AIDS statistics, little information is available on lesbian, gay, bisexual and transgender health.

Capacity-building efforts will include defining more clearly and accurately the health status of the five counties and their subpopulations, through increased community collaboration.

SECTION B. PROGRAM INFRASTRUCTURE

1. Staff: DPH is currently organized as eight branches with Chiefs who report directly to the DPH Commissioner (see Appendix B for DPH Organization Chart). The Public Health Initiatives Branch, led by **Lisa Davis**, consists of four multidisciplinary sections. **Renee**

Coleman-Mitchell, Section Chief, Health Education, Management and Surveillance Section (HEMS), will serve as the CTG Principal Investigator. Currently, she is responsible for the overall management of the HEMS Section, including fiscal and programmatic oversight of seven programs totaling over $73 million. Eight ACHIEVE Communities and the American Recovery and Reinvestment Act "Communities Putting Prevention to Work" (CPPW), are administered in and/or work directly with the HEMS Section. CPPW includes a Hospital Baby-Friendly Initiative, a partnership with the Y's afterschool programs, and tobacco cessation Quit Line. The Asthma; Cancer; Tobacco; and the Nutrition, Physical Activity and Obesity Programs also are housed in the HEMS Section. **Eugene Nichols**, CTG Project Director, is an Associate in the HEMS NPAO Program. He is currently responsible for all PHHSBG programs focusing on nutrition, physical activity, and obesity; all eight ACHIEVE Communities; and the CPPW. He participated in national ACHIEVE training opportunities that included a Coaches Meeting and Action Institute, and is the State Health Department ACHIEVE Expert Advisor at DPH, providing technical assistance in the development of the Community Health Action and Response Team Coalitions, Community Health Assessment and Group Evaluation tool (CHANGE), and assisting in local level implementation of policy, systems, and environmental change strategies. **Lisa McCooe**y, MPH, will serve as CTG Epidemiologist. She is Supervising Epidemiologist in the HEMS Cancer and WISEWOMAN Programs and is proficient in SAS, Excel, Sigma Plot, GIS Mapping and survey tools for needs assessment and evaluation activities. She is the DPH liaison to the Connecticut Cancer Partnership, collaborates with the Connecticut Tumor Registry, and serves in a lead capacity on the Connecticut Chronic Disease Workgroup. Upon receipt of the award, the DPH staff listed above (i.e., the CTG Team) will transition to

provide in-kind overall grant management, project operations, and evaluation. Position role and responsibilities for the CTG grant are listed below. (See also Appendix C, Staff Resumes.)

Name and Position	Position Funding	CTG-related Position Duties and Responsibilities
Lisa Davis, RN, BSN, MBA, Chief , Public Health Initiatives Branch	5% In-kind, State Funded	Serve as the CTG liaison to the DPH Executive Administration and Commissioner
Renee Coleman-Mitchell, MPH, Section Chief, HEMS Section	10% In-kind, State Funded	Serve as the Principal Investigator with overall management of the CTG Grant; serve on and work directly with Leadership Team and serve as the liaison between the DPH, the Leadership Team, CTG County Coalitions, and CDC.
Eugene Nichols, Health Program Assistant, Nutrition, Physical Activity & Obesity Program, HEMS Section	100% In-kind, State Funded	Serve as Project Director with overall day-to-day grant operations; provide oversight for the implementation and monitoring of all grant activities; coordinate with other agencies, community organizations, coalitions, and partners; coordinate state and local training; provide technical assistance as the State Health Department Expert Advisor; ensure required reports and documentation are submitted to CDC.
Lisa McCooey, MPH Epidemiologist 4, HEMS Section	50% In-kind, State Funded	Develop and implement plan for CTG performance monitoring and evaluation at state and local levels; develop evaluation materials; provide technical assistance to CTG County Coalitions conducting community health assessments; identify data sources and data collection strategies; serve on the Leadership Team.
Rolinda Williams, Secretary of the Comprehensive Cancer Program in the HEMS Section	10% In-kind, State Funded	Provide overall clerical support to all CTG positions.

Pamela Kilbey-Fox, Chief of the Local Health Administration Branch (LHAB), has been active in the CTG planning and will serve on the Leadership Team. The LHAB is the primary interface between DPH and Connecticut's 75 local Health Departments and Districts. Lead staff from DPH's Chronic Disease Programs will work directly with the CTG Team.

2. Barriers to Trainings/Meeting Attendance: DPH is under a new administration that supports and understands the importance of attending CDC-sponsored trainings and other required meetings. We do not anticipate barriers to attending these meetings.

SECTION C. FISCAL MANAGEMENT

1. Funding Distribution to Sub-recipients: DPH demonstrates readiness to disseminate funds to sub-recipients and will assign a dedicated Contract Specialist to work directly with the CTG Program Director to develop and monitor processes for all CTG related contracts. This will include executing contracts with the five County area fiduciary agents. Sole source status of the five County area fiduciary agents will be requested from the Connecticut Office of Policy and Management (OPM), precluding the-request-for-proposal process, thus accelerating contract execution. Only one contract template will be needed. Also, OPM has granted approval for DPH to execute multi-year contracts to expedite the contract execution process and allow for continuity of activities.

2. Alignment of Funding with Goals: All CTG proposed funding allocations are aligned with the goals of this grant. The majority of funds (91%) will be directly allocated to the County Coalitions to support capacity building activities related to the five Strategic directions. In addition, funds will be directed to 31% of the population in these five counties that live in rural areas. The remaining funds will be used at DPH to support capacity building and training needs for the CTG and Leadership Teams, and County Coalitions including under-represented groups.

3. Fiscal Management Procedures & Reporting: DPH will apply existing fiscal management practices to CTG activities. All CTG fiscal correspondence, applications, reports, purchases, contracts, and other financial processes will be recorded with a CTG-specific funding code upon entry into CORE CT (Connecticut's statewide electronic fiscal management system). This unique coding system enables the tracking of expenditures and budget management functions for CTG activities, distinct from other federal- and/or state-funded programs and/or cooperative agreements. In addition, a reporting mechanism has been established to assure thoroughness and

accuracy for all CTG programming and fiscal management. Upon receipt of a Notice of Grant Award, DPH will assign a Chief Accountability Officer to the CTG fiscal management processes, who will issue the unique funding code, monitor all related expenditures, and provide financial reports in compliance with state and federal requirements.

4. Funds Leveraged from Other Sources: DPH will capture funds leveraged from other local sources by including this information on the quarterly report templates developed for County Coalitions to meet reporting requirements. As noted by CTG partners, many existing community coalitions have been working together and obtained an abundance of local resources from which to draw on. Within DPH, funds will be leveraged with the National Public Health Improvement Initiative for proposed needs assessments and training. DPH will submit information regarding funds leveraged to CDC in accordance with recommended reporting requirements.

SECTION D. LEADERSHIP TEAM AND COALITIONS

1. Leadership Team: Connecticut has begun to establish multi-sector organizational teams and coalitions at both the state and local levels to support CTG goals. DPH recruited 23 agencies, organizations and consumers to serve as members of the CTG Leadership Team. Members represent areas suggested in the FOA: DPH executive staff, the CTG PI and Program Director, and a representative from each of the five County Coalitions. (See Appendix D for Leadership Team Members and Affiliations and Appendix E for Leadership Team Letters of Support). Additional members will be recruited as needed to meet CTG goals. DPH and parent organizations have conducted outreach to identify consumer representation.

Leadership Team members will participate in CTG-related training opportunities, provide overall grant guidance, and, most importantly, meet the identified needs of the five County Coalitions. The Team will provide ongoing support, guidance, and resources to Coalitions as

they conduct the following capacity building activities: (1) establish multi-sector community coalitions; (2) identify relevant training needs; (3) collect and use community health and health assessment data to identify population subgroups experiencing health disparities and inequities; and (4) develop and implement local plans for counties that have established sufficient readiness to pilot and/or implement policy, environmental, and infrastructure changes related to the five Strategic Directions.

The Leadership Team will be informed quarterly about progress made by each County Coalition toward accomplishing CTG capacity-building objectives (see Section G). Information presented to the Leadership Team will include County Coalition quarterly progress report summaries; annual county health needs assessment data; and other data collection activities and relevant findings.

After County Coalitions have completed capacity building activities, the Leadership Team's responsibilities will shift to assisting counties to address indicators of health in under-represented communities, reducing barriers to implementation, and addressing sustainability issues by recommending specific policy, environmental, programmatic, and infrastructural approaches. They will review all evaluation reports, identify strategies for midcourse corrections, will continue to assist DPH in improving overall CTG grant management.

2. Community Coalitions: Numerous state and local partners have agreed to collaborate with and support Connecticut's CTG county-level efforts. DPH invited over 350 partners, who are already involved in activities related to the five Strategic Directions, to participate on a CTG Partnership Conference Call on June 1, 2011. The call was led by Commissioner Jewel Mullen and Renee Coleman-Mitchell, Principal Investigator. During the call, DPH: (1) provided an overview of the FOA; (2) provided a rationale for the DPH decision to apply for capacity

building; (3) solicited input from key partners regarding the State's proposed FOA response; (4) discussed potential collaboration with state and local partners; and, (5) presented the newly established DPH CTG web page and e-mail address to provide partners with an easy venue for input, comments, suggestions, and questions. (See Appendix F for documentation of Questions and Answers)

Given the great enthusiasm and synergy expressed by Connecticut communities and partners regarding the CTG collaborative opportunity, DPH convened a Connecticut CTG Partners' Meeting on June 13, 2011. The meeting objectives were to share the DPH proposed county approach to implement capacity building activities at the community level, and to begin county-specific dialogues regarding community coalitions, local chronic disease and chronic disease risk factor data, health needs assessments, community engagement of populations in need, and identification of policies and policy gaps in relation to the five Strategic Directions. The county-specific dialogues occurred in breakout sessions in which participants were grouped with fellow county partners to discuss community-specific issues. (See Appendix G for The Community Transformation Partners Meeting Summary). On July 6, 2011, DPH convened a conference call with Connecticut ACHIEVE communities. Discussions focused on established ACHIEVE communities mentoring newly awarded ACHIEVES counties.

A list of interested partners who have agreed to serve at the county level has been assembled. (See Appendix H for potential coalition member list by county and state). Although several of the agencies and organizations that have agreed to participate represent the interests of all state residents, they have agreed to assist counties requiring their expertise. (See Appendix I for letters of support from county partners.) This will be determined by each county's data, needs assessment, and policy scan findings.

Numerous community-based coalitions have been identified within the five counties, and they have agreed to expand existing coalitions and/or work collaboratively as CTG County Coalitions. Examples of such coalitions and their successes include the following.

a) Windham County-The Northeast District Department of Health (NDDH) HealthQuest (HQ) Coalition is a 2009 ACHIEVE community funded by the National Association of Chronic Disease Directors and comprises policymakers, stakeholders, community coaches and consumers. Working in an underserved, food insecure, and predominantly rural population, Coalition successes include school policies affecting over 4,400 elementary school children who now receive an extra 50 minutes of physical activity each week. This no-cost *WriteSteps School Walking Initiative* has decreased disciplinary referrals, improved writing scores, and significantly increased the percentage of students passing the physical fitness component of the Connecticut Mastery Tests. A Food Policy Council was established and is engaging producers and changing procurement practices in numerous settings. Smoke-free campuses and worksite wellness initiatives also were accomplished. This coalition's 2009 application for a federal CPPW grant was *recommended for approval* but went unfunded.

b) Tolland County-The Eastern Highlands ACHIEVE Coalition has brought together key decision makers committed to improving the health outcomes of residents. Successes include: establishing a pre-K healthy snack policy; adopting lactation protocols to accommodate lactating women during the work day; implementing healthy snack policy and developing protocols for enhanced opportunities for active living in Parks and Recreational Department activities; and reviewing planning regulations related to increasing physical activity opportunities in open spaces, trails, and sidewalks.

c) New London County-The New London Coalition, led by the Ledge Light Health District, received funding through the National Association of County and Health Officials to engage in a 2-year process to improve health by adopting new policies, improving ways of working together to leverage resources, and making sustainable changes in the community environment. Successes include: increasing community gardens in school and neighborhoods; improving access to farmers markets; recruiting large supermarkets in underserved areas; creating and maintaining a network of walking routes with signage; opening schools after hours for physical activity opportunities for families; implementing traffic-calming measures; promoting stairwell use in all public buildings; and requiring a health impact assessment for all new zoning and transportation proposals.

d) New London County - African American Health Council of Southeastern Connecticut (AAHC) In 2006, Ledge Light Health District established the AAHC as an advisory body for the African American Heart Disease and Stroke Risk Reduction Program engaging community members in a dialogue about the impact of health disparities and heightening community awareness about diseases that predominately plague the minority community. Over almost five years, Council membership has expanded to local hospitals and medical providers, human service agencies, emergency response teams, businesses, civic and faith-based organizations, educators, and concerned citizens. Currently, the AAHC is conducting a community survey on physical health outcomes and economic, spiritual, and emotional health. As part of an effort to bring attention to health equity in the community-at-large, the AAHC co-hosts a series called "Conversations for Change," where community members of all backgrounds and ages view a documentary (such as "Unnatural Causes" or "Race: the Power of an Illusion") together and then have a dialogue about race and health equity.

SECTION E. COMMUNITY HEALTH ASSESSMENT & PLANNING

1. Assessing Burden of Chronic Disease & Identifying Target Populations: To achieve the goal of full readiness for program implementation, a coordinated approach is needed that allows all five county areas the maximum amount of autonomy. Some county needs will be shared among all the County Coalitions, and some will be unique to one or two counties. The CTG Team will assess and respond to specific needs of each Coalition, coordinate Coalition activities to address common needs, and work individually with Coalitions that have unique needs. Each County Coalition will work separately to conduct grant activities, and will combine resources and share strategies where appropriate. The CTG Team will help to make shared opportunities available to the Coalitions, and to facilitate steady and strong progress toward grant objectives.

The CTG and Leadership Teams will convene the County Coalitions and establish timelines and benchmarks for area needs assessments. The NDDH HealthQuest Coalition is expected to leverage an existing Community Health Assessment in Windham County for a consortium of six medical centers and hospitals. The Eastern Highlands Coalition is expected to combine data into the Connecticut Health Equity Index and establish baselines for health outcomes. The CTG Team will respond to requests for state health data, where available, to help these and other County Coalition activities. Quarterly and annual evaluation activities (described in Section G) will document progress toward completion of area needs assessments and policy scans, barriers will be identified quickly, and rapid midcourse correction strategies will be developed in close consultation with the County Coalitions.

Some County Coalitions with existing ACHIEVE communities have successfully completed the CDC CHANGE Tool in limited areas. Whereas the Windham and Tolland County Coalitions will only need to include a few additional towns, the ACHIEVE community in New London

County is currently focused only in the city of New London and will need to expand to include other towns. The Litchfield and Middlesex County Coalitions, which are newly awarded ACHIEVE communities, could profit from the experiences of the other counties, and may require more time to reach an equivalent level of success. The five County Coalitions will begin capacity building exercises at different initial benchmarks and are expected to progress at different rates. Some Coalitions may achieve full readiness for implementation within 1-2 years, while others may require more time. Although the Coalitions are at various stages of readiness for implementation, none has yet fulfilled all criteria for readiness. The primary goal of this proposal is that, by the end of the grant period, all five Coalitions will have completed capacity building activities and will be ready for program implementation.

In a recent preliminary survey among the County Coalitions about their anticipated needs, each indicated a need for activities directed at each of the five steps toward readiness. All indicated a particular need to: establish or broaden multi-sectorial coalitions; receive training in coalition retention and recruitment, coalition sustainability, and policy impact and outcome measures; conduct or broaden policy scans throughout the counties and across sectors. The five Coalitions also indicated that membership by under-represented groups is a high priority, which may include racial/ethnic minorities, farmers and migrant farming workers, representatives of American Indian tribes, teens and young adults, and families of incarcerated inmates.

The survey findings indicated that the current and past activities were variably directed at the five Strategic Directions that are mandatory for this grant opportunity. All three ACHIEVE communities conducted activities on Active Living and Health Eating, two focused on High Impact Quality Clinical and Preventive Services, and only one focused on Tobacco-free Living. In addition to the grant-mandated Strategic Directions, two of the three existing ACHIEVE

communities have conducted activities on Healthy and Safe Physical Environment, and one indicated an anticipated need to expand into this strategic direction. Two ACHIEVE communities anticipate expanding activities to include Social and Emotional Wellness to build provider and system capacity, and promote effective parenting strategies and positive youth development.

The needs assessment and planning processes for the five County Coalitions, therefore, will need to be specific in content, allowing the Coalitions to leverage and expand existing initiatives. Further, existing funds for the two active ACHIEVE communities are currently focused on strategic directions that will not fully meet the objectives of this grant opportunity, requiring an expansion of activities. Existing needs assessments conducted by these County Coalitions, therefore, will likely not include information about all the required strategic directions, necessitating focused activities in these topics. The CTG Team will assist County Coalitions with chosen strategic directions, helping to foster collaboration with existing programs within DPH such as Tobacco Cessation, Healthy Homes, Environmental Tracking, Chronic Disease, and Cancer Screening. The Team will also facilitate collaboration with programs managed by other State agencies, such as The Connecticut Partnership for Success Initiative (Department of Mental Health and Addictive Services), which consists of multiple federally-funded local coalitions working together to improve mental and social well-being. Members of the Leadership Team may help foster additional collaborative activities.

Several tools are available to assist County Coalitions as they conduct area need assessments and policy scans. One such tool is the CDC CHANGE Tool. The Ledge Light Coalition used this tool to identify needs for a variety of sectors, including schools, worksites, community organizations, health care providers, and the community-at-large. They found that schools lacked

nutrition curricula, and that worksites lacked clear smoking policies. The Eastern Highlands Coalition used the tool to determine that environmental conditions at worksites do not support physical activity. All three of the ACHIEVE communities who used the CDC CHANGE tool indicated that it was relatively easy to use for conducting area needs assessments. These three communities may continue to use the tool, and will also be a good resource for those County Coalitions that have not yet conducted area needs assessments. The CTG Team will assist, as needed, and will be previously trained in the use of the CHANGE tool.

Tools developed by the existing ACHIEVE communities may also be useful for the County Coalitions. The 2010 Health Resident Survey, recently developed by the Ledge Light ACHIEVE community, used Internet, local newspapers, and drop boxes to assess resident opinions about accessibility and affordability of prevention opportunities and services in New London, and the degree of support for public policy and environmental changes. The Ledge Light Coalition also conducted Neighborhood Health-Friendliness Quotients at the census tract level, and conducted walking tours, bus tours, and bicycle tours of their neighborhoods. Other tools used previously by the ACHIEVE communities include State surveillance reports and contracted assessments such as: 1) a Health Resource Capacity Assessment (Ellen Andrews, 2003); 2) the Community Food Security in CT: An Evaluation and Raking of 169 Towns (September, 2005); and a Joint Report by CT Food Policy Council (University of Connecticut and the Hartford Food System). In addition, a Needs Assessment Tool Kit developed by Applied Research and Environmental Systems may be useful for some County Coalitions. These options will be made available to all County Coalitions.

The preliminary survey described above indicated that the County Coalitions are diverse, with anticipated common and unique needs, and that health data needs may also differ. Important criteria for health outcome and risk factor trends are availability at regular intervals, inclusion of

subpopulations, and population-based. The data should also be available at county, health district, and town levels.

To explore population-based estimates of health outcome and risk factors for use by the County Coalitions, cross Branch collaborations within DPH will occur (See Appendix J - Data Workgroup. Epidemiologists in the DPH Public Health Initiatives and Planning Branches provide epidemiological support to the chronic disease programs within DPH, and manage the Behavioral Risk Factor Surveillance Survey (BRFSS) and the Youth Risk Behavioral Survey (YRBS). Birth and death records are managed by the Planning Branch. A Data Workgroup comprising the CTG Team, epidemiologists who support the chronic disease programs, and those who manage other statewide surveillance systems, is proposed that will explore how population-based data could be used to support the specific needs of the five County Coalitions. Epidemiologic membership from external partners, such as local health districts, the County Coalitions, and public health researchers, will also be invited. The workgroup will make project-specific recommendations on how best to respond to County Coalition needs. It will also be a core contact for training opportunities that increase competency skills among epidemiologists within DPH and across the state, including opportunities made available through the Epidemic Intelligence Service Case Studies initiative at CDC. The Workgroup will also collaborate with CDC experts to identify or develop statistically valid methods for local health data using BRFSS, YRBS, birth, death, and hospitalization records.

In addition, national surveys, such as the National Health Interview Survey could be explored for use within Connecticut. The Workgroup will identify or develop novel strategies that make available to the County Coalitions the outcome data needed to monitor trends in health outcomes and risk factors. The Workgroup will also explore, with needed input from CDC experts, ways

for County Coalitions to develop a survey instrument similar to the BRFSS with enough statistical power to achieve valid local results.

Of particular interest for this proposal are the health indicators and risk factors of subpopulations that contribute significantly to health disparities in the state. Tracking measures of disparities in these subpopulations are important to the goals of this proposal. The Connecticut Association of Directors of Health recently developed a Health Equity Index to monitor trends in health equity, and some health districts have adopted this measure. The Index, which is a composite score based on available town-level data, is one of several measures that could be used by the County Coalitions to monitor disparities. It is expected that health equity measures will be easier to develop for some subpopulations, and more challenging for others, necessitating a variety of approaches.

A potentially exciting strategy for monitoring trends in health outcomes and risk factors is simulation modeling, such as that recently developed to predict prevalence of diabetes within the United States l.). Predictions are made with inputs such as diagnosed prevalence, initial onset, and death and recovery information. If local data are available, this technique could be used by County Coalitions to develop community plans and prioritize existing action plans. The CTG Team, in collaboration with the Workgroup, proposes to work in cooperation with experts at CDC to develop these skills for assistance with County Coalition needs.

Connecticut Capacity Building Plan – Community Transformation Grant Date: July 15, 2011				
Site Name	State of Connecticut Department of Public Health			
Outcome Objective	By October 31, 2011, finalize state-level infrastructure necessary to carryout Connecticut's CTG Years 01 - 05 capacity building activities.			
Population Focus (Check One)	☐ General/Jurisdiction Wide	X Health disparity by – age, urban or rural location, gender, race/ethnicity, education, income, sexual orientation, disability, or other. (specify):		
Reportable Milestone Activities	Timeline (Initiation-Completion)	Identify the Activity(ies) related to the Health Disparity	Measure	Lead Staff and Key Partners
Further define DPH & CTG Team roles and responsibilities, including designation of CTG contract and fiscal management staff.	Q1	Strong emphasis on minority and rural community engagement	CTG Team roles and responsibilities documented and distributed Support staff assigned	DPH Executive Staff; Principal Investigator (PI); CTG Project Director (CTG PD); Epidemiologist 4 (Epi 4); Fiscal and Contract Units
Set Year 01 DPH & CTG Team bi-weekly meeting schedule; define all internal and external reporting requirements and timelines, including reporting templates for CTG County Coalitions; and establish communication methods and schedules between DPH and CDC, Leadership Team, and CTG County Coalitions.	Q1	Reporting templates to include participation and engagement of minority and rural communities	Bi-weekly meetings scheduled reporting schedule and templates disseminated, communication schedule and methods established	PI; CTG PD; Epi 4
Finalize Leadership Team member list, including agencies, organizations, consumer representatives of the populations experiencing health disparities, and minority and rural communities.	Q1	Minority and rural populations represented	Leadership Team Membership Roster Completed	DPH Executive Staff; PI; CTG PD
Elect Leadership Team chair(s); refine Team roles and responsibilities, including support, guidance, and resources to support CTG County Coalitions and overall grant management.	Q1	Minority and rural populations represented	Chair(s) elected, roles and responsibilities distributed, listing of resources and best practices disseminated to Coalitions	CTG Leadership Team Members; PI; CTGPD
Establish Leadership Team operating rules or bylaws, quarterly meeting schedule, and	Q1	Communication methods which reach targeted	Operating rules defined, quarterly meetings scheduled,	Leadership team elected officers and members

communication methods with DPH, CTG County Coalitions, populations experiencing health disparities, and minority and rural communities.		populations and population subgroups included	and communication schedule and methods established	
Revise Connecticut's Capacity Building Plan for submission to and approval by CDC.	Q2 – Q3	Plan includes minority and rural community involvement	Plan approved by CDC	PI CTGPD Epi 4 CTG Leadership
Outcome Objective	By November 30, 2011, finalize local-level infrastructure in the five countries necessary to carryout Connecticut's CTG Years 01 - 05 capacity building activities.			
Population Focus (Check One)	☐ General/Jurisdiction Wide	X Health disparity by – age, urban or rural location, gender, race/ethnicity, education, income, sexual orientation, disability, or other. (specify):		
Reportable Milestone Activities		Timeline (Initiation-Completion)	Identify the Activity(ies) related to the Health Disparity	Measure	Lead Staff and Key Partners
Identify lead/fiduciary agent for each of the five CTG County Coalitions.		Q1		Agents selected	County Partners; Community Coalitions; Local Health Departments/Districts(LHD/D)
Execute contracts with identified lead/fiduciary agents for each of the five CTG County Coalitions.		Q1 - Q2	Contract to include representation for all CTG Capacity Building Activities	Contracts executed	CTG PD; Lead/Fiduciary Agents; Fiscal Accountant; Contract Specialist
Conduct local scans of existing coalitions, partnerships, workgroups, and task forces involved in the five Strategic Directions for inclusion in the CTG County Coalitions.		Q2 – Q3	Include representation of organized groups	Existing coalitions join CTG County Coalitions and support efforts	Lead/Fiduciary Agents; Community Partners & Coalitions; LHD/D
Establish or strengthen County Coalitions to support CTG efforts, including agencies, organizations, or consumers that represent populations experiencing health disparities, and minority and rural communities.		Q2 – Q3	Minority and rural communities and subgroups represented	CTG County Coalition Membership Rooster	Lead/Fiduciary Agents; Community Partners and Coalitions; LHD/D ; Leadership Team
Elect CTG County Coalition Chair(s).		Q2		Chair(s) Elected	CTG County Coalitions
Conduct introductory meeting with		Q2	Input and	Meeting results	CTG County

consumers and representatives from the CTG minority, low income and rural communities for Coalition membership recruitment.		Representation of populations and subgroups experiencing Health Inequities	included in quarterly report submission, new members added to Coalition Rooster	Coalition Officers
Set Year 01 CTG County Coalition meeting schedules; define all internal and external reporting requirements and timelines; establish operating rules or bylaws; establish communication methods with stakeholders and county residents.	Q2	Communication methodologies which reach targeted populations and population subgroups included	Meetings Scheduled, operating rules defined, communication methods established	CTG County Coalition officers and members
Develop a written county-specific Capacity Building Plan to define plans to conduct all contractual mandated CTG capacity building activities including those that have been previously conducted, those which must be expanded on, and those newly initiated ensuring representation of all towns.	Q3	Impact on populations and subgroups experiencing health inequities	Capacity Building Plan approved by DPH for inclusion in a Revised State Capacity Building Plan	CTG County Coalitions
Develop and implement an ACHIEVE Mentoring Program for two of the three counties without ACHIEVE activities.	Q4 – End of Project Period		Non ACHIEVE County Coalitions supported by peers	Leadership Team Three CTG County Coalitions with ACHIEVE

Outcome Objective	By January 1, 2012, enhance capacity building skills and knowledge of DPH CTG Team, Leadership Team, and CTG County Coalition members necessary to accomplish CTG capacity building and implementation activities				
Population Focus (Check One)	☐ General/Jurisdiction Wide	X Health disparity by – age, urban or rural location, gender, race/ethnicity, education, income, sexual orientation, disability, or other. (specify):			
Reportable Milestone Activities		Timeline (Initiation-Completion)	Identify the Activity(ies) related to the Health Disparity	Measure	Lead Staff and Key Partners
Establish a list of national, state, and local training resources and best practices relevant to capacity building activities such as coalition recruitment and retention, health needs assessments, minority community engagement, health data collection, and policy scans.		Q1	Best practices for minority community engagement and reducing health disparities	List of training resources and best practices	CTG PD Leadership Team County Coalitions National and State Training Experts
Develop and disseminate survey instrument(s) to assess state and local CTG staff capacity building and policy, environmental, programmatic, and infrastructure change implementation training needs.		Q2	Includes minority community engagement and reducing health disparities	Training needs data collected	Epi 4 Leadership Team County Coalitions

Analyze survey data to determine multi-level training needs.	Q2 Q3	Determine skills/knowledge related to minority community engagement and reducing health disparities	Identified Training needs	Epi 4
Work collaboratively with the DPH Public Health Quality Improvement Project to leverage resources to meet joint identified training needs.	Q3- End of Project Period		Training funds leveraged	CTG PD DPH Public Health Quality Improvement Project Director
Coordinate, conduct and evaluate training education sessions to meet identified needs.	Q3 – Q4	Includes best practices for minority community engagement and reducing health disparities	Trainings Evaluated	CTG PD DPH Public Health Quality Improvement Project Director Epi 4

Outcome Objective	By February 1, 2012, identify communities, populations, and population subgroups in the five countries experiencing the greatest burden of chronic disease and health inequities to target implementation of policies which address the five strategic directions			
Population Focus (Check One)	☐ General/Jurisdiction Wide	X Health disparity by – age, urban or rural location, gender, race/ethnicity, education, income, sexual orientation, disability, or other. (specify):		
Reportable Milestone Activities		Timeline (Initiation-Completion)	Identify the Activity(ies) related to the Health Disparity	Measure	Lead Staff and Key Partners
Establish criteria to assist County Coalitions to evaluation completeness and accuracy of existing health data in relation to CTG goals.		Q2	Data includes populations and subgroups experiencing health inequities	Criteria established	Epidemiologist 4 Leadership Team
Conduct scan of existing national, state, and local level health data which includes the burden of chronic diseases, chronic disease risk factors, and identification of population subgroups experiencing health disparities and inequities.		Q2	Includes Data representative of minority populations and subgroups	Data sources identified	Epi 4 Leadership Team CTG County Coalitions
Obtain and analyze existing health data from identified data sources and identify gaps.		Q2	Identify populations/areas experiencing health disparities	Gaps in existing data sources identified	Epi 4 National Experts
Determine data collection methodology for data not currently captured and/or methodology to use existing national or state data for local-level planning.		Q3-Q4	Identify populations/areas experiencing health disparities	Local-level data obtained	Epi 4 National Experts
Obtain local data not currently captured, analyze and use for County CTG planning		Q3-Q4	Identify populations/areas	Local-level data estimates	Epi 4 National Experts

and implementation purposes.		experiencing health disparities		
Outcome Objective	By March 1, 2012, identify barriers to health care access and health care needs of communities, populations, and population subgroups experiencing the greatest burden of chronic disease for policy development and implementation planning purposes.			
Population Focus (Check One)	☐ General/Jurisdiction Wide	X Health disparity by – age, urban or rural location, gender, race/ethnicity, education, income, sexual orientation, disability, or other. (specify):		
Reportable Milestone Activities	Timeline (Initiation-Completion)	Identify the Activity(ies) related to the Health Disparity	Measure	Lead Staff and Key Partners
Establish criteria to assist regions/communities to evaluation completeness of existing health needs assessment in relation to CTG goals.	Q3	health needs represented	Criteria established	Epi 4 Leadership Team
Establish a list of national, state, and local tools, toolkits, surveys; to assist regions/communities in conducting local health needs assessments.	Q3	Representation included	List of resources	CTG PD Leadership Team County Coalitions National Experts
Conduct scan of and compile existing, local health assessment data including the burden of chronic diseases and identification of population subgroups experiencing health disparities and inequities.	Q3-Q4	Representation included	Data submitted to DPH	County Coalitions Epi 4
Identify gaps in existing local health assessment data using criteria established by CTG Leadership Team which meet CTG goals.	Q3-Q4	Representation Included	Gaps documented	County Coalitions Epi 4
Select a collection methodology and obtain regional/community health assessment data not currently captured in existing regional/community data sources to include barriers to access care, venues in the community for physical activity, safe environments such as parks or playgrounds, etc.	Q3-Q4	Representation Included	Comprehensive local health assessment data	County Coalitions Epi 4
Outcome Objective	By December 31, 2011, ensure that minority communities are engaged in the Connecticut CTG process with representation on the Connecticut CTG Leadership Team and each of the five CTG County Coalitions			
Population Focus (Check One)	☐ General/Jurisdiction Wide	X Health disparity by – age, urban or rural location, gender, race/ethnicity, education, income, sexual orientation, disability, or other. (specify):		
Reportable Milestone Activities	Timeline	Identify the	Measure	Lead Staff and Key

	(Initiation-Completion)	Activity(ies) related to the Health Disparity		Partners
Meet with Leadership member organizations representing minority populations to determine methods of engagement and community organizations that should be represented on CTG County Coalitions.	Q1 – Q2	Inclusion and input of minority populations	Minority representation	CTG Community Coalition Officers
Identify 1- 3 minority communities in each region and conduct local meetings to build buy-in for CTG goals and solicit community input for pilot testing and implementation plan development.	Q1- Q2	Inclusion and input of minority populations	Minority representation	CTG Community Coalition Officers

Outcome Objective	By July 1, 2012, use local policy scan findings to develop state plan to pilot test select polices under Capacity Building and to develop a CTG Implementation Plan for submission to and approval by CDC.			
Population Focus (Check One)	☐ General/Jurisdiction Wide	X Health disparity by – age, urban or rural location, gender, race/ethnicity, education, income, sexual orientation, disability, or other. (specify):		
Reportable Milestone Activities	Timeline (Initiation-Completion)	Identify the Activity(ies) related to the Health Disparity	Measure	Lead Staff and Key Partners
Establish criteria to assist County Coalitions to evaluation completeness and data accuracy of existing policy scans in relation to CTG goals.	Q4	Includes policies addressing health disparities	Criteria established	Epi 4 Leadership Team
Compile and disseminate list of national, state, and local resources, e.g., tools, toolkits, and/or surveys to Coalitions to assist counties in conducting policy scans.	Q4	Includes policies addressing health disparities	Policy scan tools selected, and utilized and/or modified to meet county needs	CTG PD Leadership Team
Conduct policy scans, analyze scan data, and identify gaps in existing policies, environments, programs, and infrastructures for pilot testing and implementation CTG phases.	Q4 – Year 02	Identify policy gaps in targeted populations	Policy scan findings use to develop local policy pilot testing and implementation plans	CTG County Coalitions CTG PD Epi 4

Year 02 – 04, County Coalition readiness will be determined for pilot testing and implementation of policies.

SECTION G. PERFORMANCE MONITORING & EVALUATION

1. Core Plan: The proposed core Performance Monitoring and Evaluation Plan is shown below.

Community Transformation Evaluation
Time and Frequency, by Assessment Group

Assessment Group	Update Reports	Focus Groups	Point-in-time Group Surveys	Point-in-time Population Surveys	Population-based Health Outcomes
CTG Team	Bi-weekly*				
Leadership Team	Quarterly*	Annual*	Annual*		
Five County Coalitions	Quarterly*	Annual*	Annual*		
Under-represented Subpopulations		Annual*	Annual*		
General Community				Annual**	Annual**

* Conducted and assessed by DPH; ** Conducted and assessed by Coalitions.

It includes qualitative and quantitative benchmarks to track progress toward grant objectives. The CTG Team, Leadership Team, and County Coalitions will be evaluated using quarterly reports, surveys, and focus groups. The plan will be revised with CDC within 150 days post-award, and approved by the DPH Human Investigations Committee.

CTG Team Evaluation and Role. To ensure a thorough and unbiased evaluation, a contractor may be hired to assist the CTG Team with focus groups and the assessment of the CTG Team. Alternatively, evaluation of the CTG Team may be assumed by the County Coalitions. The CTG team will meet biweekly to monitor progress toward achieving grant objectives and to discuss topics such as: staff workload; training needs; fiscal and/or grants performance; the degree to which funds are aligned with grant objectives; type and nature of County needs (including specific data requests) and capacity to respond to them; and appropriateness of Leadership Team membership; and inclusion of under-represented groups. The CTG Team will also assign roles as needed and discuss ways to make midcourse corrections. Findings will be communicated through periodic written reports for presentation to the Leadership Team and County Coalitions.

Leadership Team Evaluation. The effectiveness and membership involvement of the Leadership Team will be evaluated. The CTG Team will maintain notes from the quarterly Leadership Team meetings and monitor attendance. Annually, a focus group and group survey

will be conducted to better understand the unique perspective of the Leadership Team. Topics to be explored include: funding alignment with state and local needs; perceived progress of each County Coalition and strategies for addressing barriers; satisfaction toward implementation of the CBP, and how the Leadership Team can assist in the selection on policy, environmental, programmatic, and infrastructural approaches to address identified indicators of health in its under-represented communities. The Leadership Team will also explore ways in which issues of sustainability and implementation can be achieved among the five County Coalitions.

County Coalition Evaluation. Quarterly reports using a single template will be used to evaluate the County Coalitions, and results, including trend data, will be compiled for presentation to the Leadership Team. Each County Coalition will track and enter its progress in an ACCESS database and will provide information about readiness for CTIP implementation. The reports will also include: fiscal expenditures; frequency, attendance, and content of Coalition meetings; degree of responsiveness to issues identified in Coalition meetings; Coalition membership; needs assessment status; identification and recruitment of under-represented subpopulations; needs (expert consultants, data, etc.); and participation in CTG trainings. Comparisons across County Coalitions will be used to identify how CTG Team resources can be focused, common barriers, and how Coalitions overcome the barriers.

One annual group survey and follow-up 90-minute focus group will be conducted for each County Coalition to provide in-depth information about the topics described above. Additional topics may include: satisfaction with CTG Team; training needs; degree to which funding is aligned with County Coalition needs; assessment of the Leadership Team; perceived barriers toward CTG implementation and sustainability, and factors that contribute to disease burden. The evaluation strategy will explore the degree to which under-represented groups are recruited

and involved in the County Coalitions, and will identify other under-represented groups for recruitment.

Additionally, each of the five County Coalitions will develop evaluation strategies to monitor community attitudes and needs of their representative towns. The fully implemented community evaluation strategy may be expanded from existing CHANGE or other tool activities. Common topics adopted by the County Coalitions may include: community awareness of County Coalitions, and CTG activities; the potential impact of existing or proposed policies on the community; community health needs and perceived barriers; and perceived factors that contribute to disease burden. The community evaluation will be implemented annually, and summary reports will be developed by County Coalitions and presented at County Coalition and Leadership Team meetings.

Evaluation of Incorporation and Empowerment of Under-represented Groups. A single group survey and follow-up focus group involving members of the Leadership Team and County Coalitions who represent subpopulations will be conducted. Topics will include: perceived needs of under-represented groups; degree to which CTG activities are meeting under-represented group needs; degree of satisfaction, inclusion, comfort level, perceived discrimination, and empowerment experienced through CTG membership; and factors that contribute to disease burden among subpopulations. To offset transportation and childcare costs, each subpopulation participant will receive a $25 gift card.

Evaluation Instruments and Analysis. Evaluation surveys and focus groups will be conducted with no identifying information beyond zip codes. Evidence-based and field-tested questions will be incorporated into surveys when feasible, and novel survey questions will be field-tested before use. Where possible, survey questions will include Likert scales to capture strength of feeling, and checklist options to minimize response variability.

All surveys will use SurveyMonkey,®. Preliminary and descriptive statistics and inferential analyses will be conducted using SAS® 9.2. Surveys with a small number of respondents and simple analysis needs may be analyzed with Microsoft® Excel 2010. Analyzed data will be summarized in tables with Excel or visualized with graphs created with SigmaPlot® 12.0. Data available at sub-geography levels (counties, health districts, and towns) may be visualized with ArcGIS 10 software. All software tools described above are routinely used within DPH and among the CTG Team. Funds are requested to support annual shared license fees.

To build capacity for qualitative analysis, DPH will purchase Atlas Software, which compiles written transcripts into recurrent themes of discussion within focus groups with limited bias. Focus group discussions analyzed by the CTG Team will be incorporated into written reports with accompanying survey summaries.

Communication. Annual reports containing trends in quarterly reports and the findings of surveys and focus groups will be developed, distributed at Leadership Team and County Coalition meetings, and submitted to CDC staff. All reports will be placed on the DPH CTG web site and made publicly available for County Coalition distribution. Templates for quarterly and annual reports will be included in the CTG evaluation plan. In addition, success stories and evaluation results that demonstrate highly effective activities will be submitted for consideration in peer-reviewed journals and other publications.

2. National Evaluation: The CTG epidemiologist will participate in CDC led national evaluation activities. She will lead the evaluation and draw in other staff content experts as appropriate and incorporate common measures established by CDC.