**FY 2020 NOFO COAG Checklist**

NOTE: Italicized statements are considerations or potential topics to address for the section or subsection.

|  |  |
| --- | --- |
| **Section or Subsection** |  |
| **Required Registrations** | [ ]  |
| * Data Universal Numbering System (DUNS)

May request a DUNS number by telephone at 1-866-705-5711 or <http://fedgov.dnb/com/webform/displayHomePage.do> | [ ]  |
| * System for Award Management (SAM)

Additional information about registration procedures at <https://www.sam.gov/SAM/>  | [ ]  |
| * Grants.gov
 | [ ]  |
| **Request Application Package**May request application package at [www.grants.gov](http://www.grants.gov) | [ ]  |
| **Application Package**Must download the SF-424, Application for Federal Assistance, package associated with this NOFO at www.grants.gov | [ ]  |
| **CDC Assurances and Certifications** | [ ]  |
| * Sign and submit “Assurances and Certifications” documents indicated at [http://www.cdc.gov/grantassurances/(S9mj444mxct51lnrvhljjjmaa))/Homepage.aspx](http://www.cdc.gov/grantassurances/%28S9mj444mxct51lnrvhljjjmaa%29%29/Homepage.aspx)
 | [ ]  |
| * Risk Assessment Questionnaire Requirement
 | [ ]  |
| * Duplication of Efforts
 | [ ]  |
| **Table of Contents** | [ ]  |
| **Project Abstract Summary** | [ ]  |
| * Project Abstract Summary ≤1 page
 | [ ]  |
| **Project Narrative** | [ ]  |
| * Background
 | [ ]  |
| * + Does the Background provide a description of relative background information that includes the context of the problem?
 | [ ]  |
| * Approach
 | [ ]  |
| * + Purpose
 | [ ]  |
| * + - 2-3 sentences that describe how your application will address the public health problem as described in the CDC Background section?
 | [ ]  |
| * + Outcomes
 | [ ]  |
| * + - Outcomes you expect to achieve by the end of the project period clearly defined?
 | [ ]  |
| * + - Outcomes indicate the intended direction of change (e.g., increase or decrease)?
 | [ ]  |
| * + Strategies and Activities
 | [ ]  |
| * + - Provide a clear and concise description of the strategies and activities you will use to achieve the period of performance outcomes?
 | [ ]  |
| * + - Select existing evidence-based strategies that meet your needs or did you describe in the Applicant Evaluation and Performance Measurement Plan how these strategies will be evaluated over the course of the project period?
 | [ ]  |
| * + - Strategy 1: Diagnosis/treatment of persons with TB disease

REQUIRED for both high and low incidence jurisdictions | [ ]  |
| How will you: |  |
| * + - * Ensure case management and treatment of persons with active TB through the use of adherence-promoting measures such as case review/cohort analysis, outreach staff who are culturally competent, extensive application of conventional and electronic DOT, incentives, and enablers
 | [ ]  |
| * + - * Assess adequacy and appropriateness of therapy for each patient by reviewing initial regimen, susceptibility results, adherence, and response to therapy
 | [ ]  |
| * + - * Seek expert consultation for treatment of MDR TB and other complex cases from TB experts
 | [ ]  |
| * + - * Seek expert consultation regarding laboratory results for molecular detection of drug resistance or interpretation of other laboratory results when needed

*DTBE lab developed a table of tests and how they are currently named to help distinguish between culture and NAA—utilize and provide to regional staff* | [ ]  |
| * + - * Collaborate with HIV/AIDS and STD programs to ensure that all newly diagnosed TB cases are tested for HIV and referred for HIV services if infected with HIV
 | [ ]  |
| * + - * Collaborate with partners are correctional facilities, homeless shelters, and substance abuse settings to ensure that all newly diagnosed TB cases are treated to completion

*Establish a jurisdictional correctional liaison* *Establish meeting schedule with these partners**Include these partners on a TB Advisory Committee* | [ ]  |
| * + - * Utilize, promote, and promulgate effective binational referral mechanisms for patient who may receive care along the U.S.-Mexico border or who may cross the border while taking treatment for TB

*This could be a potential job duty if you have established and interjurisdictional point-of-contact for your jurisdiction—consider adding to this person’s job plan**Consider attending the monthly binational TB ECHO. Contact Diana Fortune for more information*  | [ ]  |
| * + - * Partner with CDC Division of Global Migration and Quarantine (DGMQ) to support international and binational quarantine efforts

*Communicate with DGMQ regarding what information should be provided to them if a TB case traveled during his/her infectious period**Develop a checklist of information that is required by DGMQ for a patient that traveled during his/her infectious period* | [ ]  |
| * + - * Establish a process to review case management activities routinely to ensure optimal patient care
 | [ ]  |
| * + - * Formulate and implement a plan for the elimination and interruption of transmission of *M. tuberculosis*. DUE AT END OF YEAR 1
 | [ ]  |
| * + - Strategy 2a: Conduct contact investigations for infectious TB cases

*Send staff that perform contact investigations to a contact investigation and interviewing skills course at one of the TB Centers of Excellence (COE)*REQUIRED for both high and low incidence jurisdictions | [ ]  |
| How will you: |  |
| * + - * Ensure that contact investigation activities are initiated and completed promptly

*How are contact investigations prioritized in your jurisdiction?**Have you established timeframes for completion of certain activities during a contact investigation?* | [ ]  |
| * + - * Assess reasons for cases with fewer than 3 contacts elicited, for delays in interviewing cases or examining contacts, and for lower rates of completion of LTBI treatment, and devise strategies for improvement.

*How can you use epidemiologic data and TB genotyping data to confirm or identify previously unidentified transmission links between TB cases?**How can you use TB genotyping data to evaluate the completeness of contact investigations?* | [ ]  |
| * + - * Submit data from contact investigations in the Aggregate Reports for Tuberculosis Program Evaluation: Follow-up and Treatment of Contacts to Tuberculosis Cases

*If you have the capacity, develop a contact investigation database* | [ ]  |
| * + - Strategy 2b: Examination of immigrants and refugees with TB or LTBI

REQUIRED for both high and low incidence jurisdictions | [ ]  |
| How will you: |  |
| * + - * Ensure that immigrants and refugees classified as A, B1, or B2 are located promptly and examined and treated appropriately

*Establish internal timeframes from date of notification**Establish a spreadsheet with date deadlines (i.e., 30 days from date of notification—evaluation should be initiated; 90 days from date of notification—evaluation should be completed (Tennessee can provide template)**Add clinic level users to EDN, if applicable* | [ ]  |
| * + - * Report examination results of domestic TB follow-up activities including treatment outcomes for TB and LTBI to the Electronic Disease Notification (EDN) system

*Establish timeframes for when data should be entered into EDN once data are received* *Example: Tennessee has health department developed a TB Supplemental Follow-up worksheet that is returned once the evaluation is initiated so this date can be entered into EDN* | [ ]  |
| * + - Strategy 2c: Targeted testing and treatment of LTBI in high-risk populations

REQUIRED for high incidence jurisdictionsSTRONGLY ENCOURAGED for low incidence jurisdictions | [ ]  |
| How will you: |  |
| * + - * Ensure that effective interventions are implemented to identify non-U.S.-born and locally-determined high-risk populations for developing TB, and that they are evaluated and treated for TB and LTBI if recommended
 | [ ]  |
| * + - * Ensure partnerships with HIV, diabetes, and/or other non-communicable disease program staff (e.g., smoking, alcohol abuse) to promote testing for LTBI and referral for TB services among those with HIV, diabetes, or other behavioral risk factors which increase the risk of progressing from LTBI to TB disease

*Develop a database of organizations that provide services for people with the risk factors that increase the risk of progressing from LTBI to TB disease. Determine if these organizations provide testing for TB infection? Do these organizations provide treatment for TB infection? Do these organizations know where to refer patients with positive tests for TB infection?* | [ ]  |
| * + - * Partner with primary care providers serving high-risk populations to expand LTBI testing and treatment

*Determine if these providers have an annual meeting? If so, provide education material or present at this meeting?**Provide in-services to these providers**Invite these providers to TB meetings* | [ ]  |
| * + - * Report targeted testing and treatment data using the Aggregate Reports for Tuberculosis Program Evaluation (ARPE): Targeted Testing and Treatment of Patients with Latent TB Infection Form
 | [ ]  |
| HIGH INCIDENCE JURISDICTIONS MUST: |  |
| * + - * Identify a process to choose local high-risk population(s) that is more site-specific than the general requirements of Strategies 2a and 2b. Establish a baseline for testing individuals identified as high-risk of having LTBI and/or progressing to TB disease within the FIRST YEAR of the CoAg, and identify a goal and strategy for scaling up targeted testing for LTBI
 | [ ]  |
| * + - * Establish a baseline for initiating and completing treatment for individuals diagnosed with LTBI who are recommended for treatment within the FIRST YEAR of the CoAg and identify a goal and strategy for increasing LTBI treatment initiation and completion rates
 | [ ]  |
| LOW INCIDENCE JURISDICTIONS ARE ENCOURAGED TO: |  |
| * + - * Implement or maintain targeted testing and treatment activities in populations at high risk for LTBI and/or progression to TB disease, and to report outcomes as described above
 | [ ]  |
| * + - Strategy 3: Program planning, evaluation, and improvement

REQUIRED for both high and low incidence jurisdictions | [ ]  |
| * + - * Identify a program evaluation focal point

Responsibilities of the evaluation focal point include:1. Serve as point of contact for program evaluation activities in their jurisdiction
2. Provide leadership and serve as a resource for building program evaluation capacity within their jurisdictions
3. Share program evaluation experiences and lessons learned with partners and colleagues
4. Work closely with CDC TB program staff, including program evaluation consultants
5. Participate in TB Program Evaluation Network (TB PEN) activities including bimonthly conference calls and the TB PEN/TB ETN biennial conference
 | [ ]  |
| * + - Strategy 4: Epidemiologic surveillance and reporting
 | [ ]  |
| * + - * Enhance identification, reporting, and follow-up of persons with confirmed or suspected TB by establishing collaborative relationships with appropriate reporting sources including:
1. Hospitals and clinics (e.g., TB and HIV/AIDS and STD clinics)
2. Laboratories performing testing for mycobacteria
3. Healthcare providers (e.g., pulmonary and infectious disease subspecialists)
4. Correctional facilities
5. Homeless shelters
6. Community and migrant health centers
7. Pharmacies
8. Other public and private facilities providing care to populations at risk for TB

*If hospitals do not have an in-house laboratory, determine what commercial laboratories each hospital uses**Identify what mycobacterial tests are performed by laboratories who report (e.g., smear, culture, NAAT, susceptibilities)* | [ ]  |
| * + - * Ensure complete, accurate, and timely reporting of persons with confirmed or suspected TB by:
1. Maintaining TB disease as a mandatory reportable condition as required by state and local laws
2. Enhancing awareness among healthcare providers of the requirement to report TB cases
3. Maintaining a passive surveillance data collection system that includes at least the data elements contained in the CDC Report of Verified Case of TB (RVCT)
4. Conducting active surveillance for TB when warranted because of a known or suspected TB outbreak, or when there is reason to believe that passive surveillance is insufficient to identify all cases of TB
5. Ensuring that testing and reporting of co-morbid conditions associated with TB (e.g., HIV, diabetes, viral hepatitis) is provided to all persons with TB disease at time of diagnosis
6. Following CDC data security and confidentiality guidelines
7. Creating/updating and submitting to CDC at least annually a TB surveillance quality assurance protocol as described CDC Quality Assurance for TB Surveillance Data Guide and Toolkit ftp://ftp.cdc.gov/pub/Software/TIMS/2009%20RVCT%20Documentation/RVCT%20Training%20Materials/Quality%20Assurance%20Materials/QA%20Manual/0a%20-%20Front%20Cover%20and%20Inside%20front%20cover%20FINAL.pdf

*How are reportable conditions communicated to providers in your jurisdiction?**Are patients with suspected or confirmed TB disease tested for HIV, diabetes and viral hepatitis? Can patients opt out of these tests?* | [ ]  |
| * + - * Notify CDC of TB cases in a complete, accurate, and timely manner by:
1. Maintaining an electronic data system for verified TB cases that is compatible with the National Electronic Disease Surveillance System (NEDSS) standards
2. Reporting to CDC complete and accurate data on all TB cases (regardless of whether cases are considered “countable” in official case counts) using the Report of Verified Case of Tuberculosis (RVCT)
3. Transmitting TB case notification messages via the National Notifiable Disease Surveillance System (NNDSS) or other CDC-approved system for all verified TB cases to CDC in a timely manner (within 1 week for newly verified cases and within 1 month for previously verified cases with updated information)
4. Ensuring that all RVCT data for a TB case, including treatment completion and outcome information, are submitted within 2 years of the initial case report

*Ensure that all cases, countable and non-countable cases are transmitted to CDC**When data are updated in your surveillance system, when are those data updates transmitted to CDC—what is the schedule for transmission to CDC?* | [ ]  |
| * + - * Ensure prompt identification and investigation of TB genotype clusters by:
1. Submitting at least one isolate from persons with culture-positive TB to a CDC-designated laboratory for genotyping in a timely manner
2. Linking genotyping result to surveillance data as soon as possible and within 8 weeks of genotype results becoming available, either through the TB Genotyping Information Management System (TB GIMS) or by entering the genotyping laboratory accession number in the appropriate field on the RVCT according to best practices for TB genotyping
3. Promptly reviewing (within 1 week of receiving notification) and collaborating with CDC to investigate TB genotype cluster alerts generated by TB GIMS to determine whether a TB outbreak is occurring

*Ensure access by staff to TB GIMS**How are genotyped results linked to surveillance data in your jurisdiction?**How are genotyping data reported to local staff?**How are clusters prioritized in your jurisdiction?* | [ ]  |
| * + - * Ensure appropriate response to large TB outbreaks (≥10 cases diagnosed in a 3-year period that are related by recent transmission) by:
1. Conducting timely and appropriate epidemiologic investigation of, and response to, TB outbreaks
2. Reporting outbreak investigation and response activities to CDC at least monthly, including epidemiologic data and ongoing or planned interventions to control transmission (e.g., line lists or outbreak-related cases, epidemiologic links identified among patients, and results of contact investigations, including TB and LTBI treatment outcomes)
 | [ ]  |
| * + - * IF FEASIBLE, promote standardized collection and reporting of case-level LTBI surveillance data by:
1. Evaluating what steps are needed to make LTBI a reportable condition in the recipient’s jurisdiction (for those jurisdictions where LTBI is not already reportable)
2. Conducting a needs assessment and gap analysis to establish what actions need to be taken to implement case-level LTBI surveillance using CDC LTBI case reporting form and protocol by the end of the performance period

*What would it take to make LTBI a reportable condition?* |  |
| * + - * IF FEASIBLE, provide data on case-based surveillance for LTBI by:
1. Collecting data on all contacts of infectious TB patients who are diagnosed with LTBI consistent with data elements contained in the CDC RVCT
2. Collecting data on all persons diagnosed with LTBI in public health department clinics consistent with data elements contained in the CDC RVCT
3. Transmitting LTBI case notification messages via NEDSS or other CDC-approved system for all verified LTBI cases to CDC in a timely manner (within 1 week for newly verified cases and within 1 month for previously verified cases with updated information)

*Is LTBI already a reportable condition in your jurisdiction? If so, who is required to report (e.g., health departments only, all providers, etc.)**If LTBI is reportable, are you collecting the same surveillance elements as contained in the RVCT?**Are you able or would you be able to transmit LTBI surveillance data to CDC?* | [ ]  |
| * + - Strategy 5: Human Resource Development (HRD) and partnerships

REQUIRED for both high and low incidence jurisdictions | [ ]  |
| * + - * Designate a focal point for training and education

Areas of responsibility for the focal point include:1. Serve as primary contact in your respective Tb program for CDC and COE education and training activities, including needs assessments, capacity building, and resource development/sharing
2. Ensure development and implementation of annual training and HRD activities specific to your TB program
3. Provide an annual update of progress-to-date on HRD activities in the performance report
4. Attend the biennial focal point meeting and the biennial TB ETN conference
 | [ ]  |
| * + - * Identify training and HRD needs

*Survey your jurisdictions to determine what training is needed**Look at quality of data being submitted and identify any needs around understanding of data variables**Look at completion of contact investigations to determine if additional training is needed* | [ ]  |
| * + - * Provide competency-based in-serve TB training and human resource development
 | [ ]  |
| * + - * Establish evaluation strategies to improve existing training and to identify ongoing training and HRD needs
 | [ ]  |
| * + - * Improve patient education and communications capacity within the program
 | [ ]  |
| * + - * Collaborate with organizations and providers serving high-risk populations, including:
				+ Coordinating trainings related to TB control with training for other disease control interventions, such as HIV/AIDS, viral hepatitis, and STD
				+ Targeting TB training to other health care providers or organizations serving high-risk populations
 | [ ]  |
| * + - Strategy 6: Public Health Laboratory Strengthening
 | [ ]  |
| * + - * Ensuring availability of reliable, timely laboratory services and use of recommended growth-based and molecular methodologies for the detection of, isolation of, identification of, and susceptibility testing for *M. tuberculosis* complex (MTBC) appropriate to individual laboratory’s workload and experience
 | [ ]  |
| * + - * Developing, implementing, monitoring, and reporting on strategies and activities to meet CDC recommended turn-around times (TATs) by establishing internal laboratory-specific goals, strategies/activities to improve TATs for specimen receipt, acid-fast bacillus (AFB) smear, nucleic acid amplification, identification of MTBC, and drug susceptibility testing (DST)
 | [ ]  |
| * + - * Ensuring that testing methods and algorithms selected are the most efficient and eliminate redundancies for workload volume of specimens received and laboratory capacity
 | [ ]  |
| * + - * Processing fewer than 20 specimens/week (the recommended minimum level of activity to maintain proficiency) in a laboratory should prompt consideration of collaboration with another laboratory. Performing first-line DST for <50 patient isolates per year should prompt consideration of referral to isolates to the National DST Reference Center or another laboratory
 | [ ]  |
| * + - * Continuing to provide access to nucleic acid amplification testing (NAAT) for detection of MTBC directly from clinical specimens
 | [ ]  |
| * + - * Ensuring rpoB mutations detected by Xpert MTB/RIF (or other probe-based methods, as applicable) are confirmed by DNA sequencing
 | [ ]  |
| * + - * Ensuring information about reference services including testing algorithms of CDC’s Molecular Detection of Drug Resistance (MDDR) Service and the National DST Reference Center are in place for rapid reflex when applicable

*Do you or you lab have a “protocol” regarding when to send specimens to CDC for MDDR testing (e.g., patient with previous treatment of TB, patient from a country with high rates of drug resistance, etc.)?* | [ ]  |
| * + - * Ensuring at least one isolate from all persons with culture-confirmed TB is submitted for genotyping in a timely manner

*How frequently are isolates sent for genotyping in your jurisdiction?* | [ ]  |
| * + - * Supporting as applicable, dependent on patient population, the use of interferon gamma release assays (IGRA) in mutual agreement with the TB Program to aid in diagnosing TB disease and LTBI
 | [ ]  |
| * + - * Monitoring and assessing local data (i.e., laboratory-specific data) to guide decisions regarding testing algorithms, improving TAT, laboratory services, and business practices for gained efficiencies and rapid reporting of results

*Do you have a policy for implementing a false-positive or cross-contamination investigation (e.g., if a patient has a single positive culture and no other positives, matching genotypes with no obvious epi-links)?* | [ ]  |
| * + - * Implementing when practical, state of the art technologies and approaches as become available to improve test results, turnaround times, efficiency of test methods and staff and patient management
 | [ ]  |
| * + - * Strengthening collaboration with partners, including TB programs, clinicians, TB nurses, CDC Laboratory Consultants, and other laboratories, to ensure optimal use of laboratory services and timely flow of information

*Does your TB program have a lab liaison that serves as a point-of-contact for the lab to your program?**Does your TB program have regular meetings with your lab?* | [ ]  |
| * + - Collaborations
 | [ ]  |
| * + - * Describe how you will collaborate with programs and organizations either internal or external to CDC?

*Examples could include HIV/STD/Viral Hepatitis Program, departments within your jurisdiction such as mental health, substance abuse, etc.* | [ ]  |
| * + - * + With other CDC programs and CDC-funded organizations

Other partners that TB programs should collaborate with include those funded by:1. Division of Viral Hepatitis
2. Division of Sexually Transmitted Disease Prevention
3. Division of HIV/AIDS Prevention
4. Division of Diabetes Translation
5. Division of Global Migration and Quarantine
6. Immunization Services Division

Also partner with CDC-funded TB Centers of Excellence for Training, Education, and Medical Consultation (COEs) | [ ]  |
| * + - * + With organizations not funding by CDC
1. Private providers
2. Medical and nursing schools and related teaching hospitals, public health schools and associations
3. Regional TB controllers association
4. TB advisory councils
5. U.S. panel physicians and civil surgeons (as guided by CDC)
6. STD/HIV Prevention and Training Centers
7. Viral Hepatitis Education and Training Centers
8. Health Resources and Services Administration (HRSA) primary care centers
9. AIDS Education and Training Centers
10. Substance Abuse and Mental Health Services Administration (SAMSHA)
11. Addiction Technology Transfer Centers
12. Refugee Resettlement Assistance Agencies
13. Indian Health Service and Tribal Organizations
 | [ ]  |
| Each recipient will designate at least one liaison for locally determined high-risk populations. Liaisons will be responsible for ensuring a process is in place to foster collaborations between programs and agencies | [ ]  |
| Each recipient will collaborate with HIV/AIDS and STD programs, community planning groups, HIV care consortiums, and other local groups that influence funding and programmatic activities to ensure that all newly diagnosed TB cases are tested for HIV and referred to STD and hepatitis services if found to be HIV-positive. Rapid HIV testing should be offered to patients in TB clinics*If you use QFT-Plus and a butterfly collection kit, consider using the red-top purge tube (used to prime the tubing) as an HIV test.* | [ ]  |
| * + - * + In addition, applicants are STRONGLY encouraged to collaborate with external organizations:
1. Seek collaboration between health departments and Medicaid agencies at Federal and State levels and collaborate with community health centers (CHCs), including Federally Qualified Health Centers (FQHCs) and schools of Public Health to integrate primary care and public health efforts
2. Collaborate with US Immigration and Customs Enforcement (ICE) officials to implement processes to ensure coordination of TB patients discharged from healthcare facilities in accordance with applicable state laws or regulations
3. Communicate with Health Care for the Homeless Council as potential partners to address TB control among the homeless
4. Collaborate on trainings with HIV/AIDS, STD, and viral hepatitis training partners to integrate disease content as appropriate in courses as outlines by NCHHSTP’s Program Collaboration and Service Integration (PCSI) Strategy
5. Enroll in Health Resources and Services Administration’s (HRSA) 340B Drug Pricing Program, which would enable the purchase of TB medication at reduced drug prices
6. Collaborate with other laboratory professionals (state, local, clinical, commercial) and laboratory organizations (APHL)
7. Memoranda of Understanding (MOUs)/Memoranda of Agreement (MOAs) are not required for the NOFO but are strongly recommended if a TB program determines that formalization of collaboration is needed with an organization. Submit MOUs and MOAs as attachments
8. STRONGLY recommended that relevant TB program staff attend the CDC program managers’ course (local public health staff should attend a COE Fundamentals of TB Control Programs Course)
 | [ ]  |
| * + - Target Populations and Health Disparities
 | [ ]  |
| * + - * Describe the specific population(s) in your jurisdiction?
 | [ ]  |
| * + - * Explain how such a target will achieve the goals of the award or alleviate health disparities?
 | [ ]  |
| * + - * Address how you will include specific populations that can benefit from the program that is described in the Approach section?
 | [ ]  |
| * + - * Targeted TB prevention and control efforts should focus on the following populations:
1. All persons with TB disease
2. Persons having recent contact to infectious TB, especially children <5 years of age
3. Non-U.S.-born persons from countries with elevated TB rates who reside in, or are traveling to, the United States
4. Racial and ethnic minority populations
5. Persons living with HIV and others who are immunocompromised
6. Persons with diabetes with additional risk factors for TB
7. Persons working or residing in congregate settings (e.g., correctional facilities, homeless shelters)
8. Persons with substance abuse disorders (i.e., excessive alcohol use, injection-drug use, non-injection-drug use)
9. Persons ≥65 years of age
10. Persons with multiple medical and social risk factors
 | [ ]  |
| * Evaluation and Performance Measurement Plan—Programmatic Focus
 | [ ]  |
| * + Describes how you will collect performance measures, respond to the evaluation questions, and use evaluation findings for continuous program quality improvement?
 | [ ]  |
| * + Describes how key partners will participate in the evaluation and performance measurement planning processes?
 | [ ]  |
| * + Describes available data sources, feasibility of collecting appropriate evaluation and performance data, data management plan (DMP), and other relevant data information?
 | [ ]  |
| * + Plans for updating the Data Management Plan (DMP), if applicable, for accuracy throughout the lifecycle of the project

DMP is required if your application involves data collection  | [ ]  |
| * + - Components of a DMP
1. Description of the data to be collected or generated in the proposed project
2. Standards to be used for the collected or generated data
3. Mechanisms for or limitations in providing access to and sharing of the data (include a description of provisions for the protection of privacy, confidentiality, security, intellectual property, or other rights); should address access to identifiable and de-identified data
4. Statement of the use of data standards that ensure all released data have appropriate documentation that describes the method of collection, what the data represent, and potential limitations for use
5. Plans for archiving and long-term preservation of the data, or explaining why long-term preservation and access are not justified; this section should address archiving and preservation of identifiable and de-identified data
 | [ ]  |
| * + Components of the Evaluation and Performance Measurement Plan
 |  |
| * + - Background
1. Describe rationale for selecting the program evaluation focus area (identify which NTIP indicator or other data source was used to determine the focus area and why this area was chosen)
2. Describe how you intend to use findings and the expected impact on the program
 | [ ]  |
| * + - Program Evaluation Plan
1. Define the evaluation objectives and/or key evaluation questions. Each objective should be Specific, Measurable, Achievable, Realistic, and Time-bound (SMART)
2. For each program evaluation objective, describe the methods and timelines for data collection and analyses
 | [ ]  |
| * + Cohort Review Plan
 | [ ]  |
| * + - Describe plans to perform systematic reviews of case management activities
 | [ ]  |
| * Evaluation and Performance Measurement Plan—Laboratory Focus—**Public Health Laboratory Strengthening**
 | [ ]  |
| * + Organizational chart with staff members
 | [ ]  |
| * + Designate a point of contact
 | [ ]  |
| * + Description of testing methods and algorithm
 | [ ]  |
| * + Laboratory Element 1—Ensure the availability of high-quality and prompt core laboratory services for TB
 | [ ]  |
| * + - Lab-specific measurable goals for improving each TAT (specimen receipt, AFB smear, ID, DST, and NAAT). Lab-specific goals should be chosen to strive to achieve or exceed national targets. If the lab is currently meeting national targets, maintaining the current TAT or a new measurable goal should be listed
 | [ ]  |
| * + - Updates from subsequent annual performance reports should describe progress made towards achieving previously stated goals
 | [ ]  |
| * + - Description of specific strategies and activities for achieving the state goals
 | [ ]  |
| * + - Explanation of potential obstacles to meeting the stated goals
 | [ ]  |
| * + - In tabular form, report the lab’s data for workload and TAT indicators for the previous calendar year and year-to-date
 | [ ]  |
| * + Laboratory Element 2—Labs will implement process improvements during the 5-year project period and report on gained efficiencies from these changes in practice

Labs receiving ≤ 1,000 clinical specimens each year should provide at least one measurable outcome for Laboratory Element 2Labs receiving 1,001 – 5,000 clinical specimens should provide at least two measurable outcomes for Laboratory Element 2Labs receiving ≥ 5,001clinical specimens should provide at least three measurable objectives for Laboratory Element 2 | [ ]  |
| * + - Measurable objectives appropriate for your lab testing volume and level of service should be chosen and described
 | [ ]  |
| * + - Specific strategies and activities related to improvements should be described
 | [ ]  |
| * + - Progress, obstacles, and outcomes related to gained-efficiencies to previously stated objectives should be updated in subsequent annual performance reports
 | [ ]  |
| * + - Once objectives are achieved, either the next phase of an objective or a new objective must be chosen for the upcoming year
 | [ ]  |
| * + Laboratory Element 3—Labs will communicate and collaborate with partners (e.g., healthcare providers, TB Programs, and other laboratories) to ensure optimal use of laboratory services and timely flow of information

Labs receiving ≤ 1,000 clinical specimens each year should provide at least one measurable outcome for Laboratory Element 3Labs receiving 1,001 – 5,000 clinical specimens should provide at least two measurable outcomes for Laboratory Element 3Labs receiving ≥ 5,001clinical specimens should provide at least three measurable objectives for Laboratory Element 3 | [ ]  |
| * + - Measurable objectives appropriate for your lab testing volume and level of service should be chosen and described
 | [ ]  |
| * + - Specific strategies and activities to improve communication and collaboration should be described
 | [ ]  |
| * + - Progress, obstacles, and outcomes related to previously stated objectives should be updated in subsequent annual performance reports
 | [ ]  |
| * + - Once objectives are achieved, either the next phase of the objective or a new objective must be chosen for the upcoming year
 | [ ]  |
| * Organizational Capacity of Applicants to Implement the Approach
 | [ ]  |
| * + Describe you state or local TB program(s), including infrastructure, workforce competence, data systems, and electronic information systems
 | [ ]  |
| * + Provide evidence of adequate program management, planning and development of policy, performance measurement, workforce development and training, and capacity to manage the required priority driven activities
 | [ ]  |
| **Work Plan**INCLUDED in the Project Narrative’s 20-page limit | [ ]  |
| **Budget Narrative**[**https://www.cdc.gov/grants/documents/Budget-Preparation-Guidance.pdf**](https://www.cdc.gov/grants/documents/Budget-Preparation-Guidance.pdf) | [ ]  |
| * Salaries and wages
 | [ ]  |
| * Fringe benefits
 | [ ]  |
| * Consultant costs
 | [ ]  |
| * Equipment
 | [ ]  |
| * Supplies
 | [ ]  |
| * Travel
 | [ ]  |
| * Other categories
 | [ ]  |
| * Contractual costs
 | [ ]  |
| * Total Direct costs
 | [ ]  |
| * Total Indirect costs

Total indirect costs include the cost of collecting, managing, sharing and preserving data | [ ]  |
| **Human Resources Development (budget)** | [ ]  |
| * Line-item budget to specify how funds will be used to achieve your program-specific HDR objectives and activities stated in your application
 | [ ]  |
| **Public Health Laboratory Strengthening (budget)** | [ ]  |
| * Line-item budget to specify how funds will be used to achieve laboratory-specific objectives and activities stated in your application
 | [ ]  |