December 12, 1989

NATIONAL CANCER INSTITUTE

STANDARDS FOR COMPREHENSIVE SMOKING PREVENTION AND CONTROL

RFP-56

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INTRODUCTION

The National Cancer Institute (NCI) has set a goal of reducing cancer mortality rates by 50 percent by the end of the century. Accomplishing this goal will require, among other things, the implementation of aggressive smoking cessation and prevention activities to reduce smoking prevalence in adults.

This document presents an organizational framework for a comprehensive smoking prevention and control intervention and enumerates the activities and strategies that make up such an intervention.

Throughout these standards the term "smoking prevention and control" is used to represent total tobacco use prevention and control. It should be noted that smoking accounts for the vast majority of tobacco use-related disease and death in the United States; these standards are directed primarily toward smoking prevention and control. The use of smokeless tobacco, although less prevalent, poses a significant threat to health for those populations with high use. The planning model and standards presented here should be used to implement interventions to prevent and control the use of smokeless tobacco, particularly in those regions and populations with higher patterns of use (e.g., adolescent males and Native American populations).

BACKGROUND

In 1982 NCI redefined the Smoking, Tobacco, and Cancer Program (STCP) and launched an intervention research effort through the new Division of Cancer Prevention and Control. Because the link had been established between tobacco use and chronic disease, including 139,000 cancer deaths per year, the purpose of STCP was to identify, develop, and evaluate interventions to reduce tobacco use. The focus of the research was defined through a systematic planning process involving hundreds of experts in the disciplines related to smoking prevention and control. Intervention trials were started from 1984 to 1986 to examine school-based, self-help, and minimal intervention strategies; physician/dentist-delivered brief counseling; mass media approaches; and comprehensive community-based programs. Populations given priority include youth, minority ethnic groups, women, smokeless tobacco users, and heavy smokers. As these trials are completed, they provide a systematic data base to define effective public health approaches to deal with tobacco use behavior.

These standards present the organization and the critical elements that constitute an aggressive comprehensive initiative for smoking prevention and control. These standards are based on the STCP research data base, the comprehensive body of smoking and behavior change literature, and the

experience of public health professionals and activists. As such, the standards represent the current state of the science in smoking prevention and control.

GOALS

The desired endpoint of a comprehensive smoking prevention and control initiative is to dramatically reduce smoking and its consequences (including elimination of exposure of nonsmokers to tobacco smoke) throughout an identified site (city, county, metropolitan area, state, and Nation). This endpoint requires the simultaneous pursuit of four main goals within a defined site:

- Raise the priority of smoking as a public health concern.
- Improve communities' abilities to change smoking behavior.
- Increase the influence of existing legal and economic factors that discourage smoking.
- Strengthen social norms and values supporting nonsmoking.

To achieve these goals, local, state, regional, and national organizations must implement a concerted program of tobacco control measures that are effective, acceptable to the public, cost-effective, and self-perpetuating.

ASSUMPTIONS

A comprehensive smoking prevention and control initiative is based on several important facts and assumptions:

1. Smoking is one of the primary causes of death and disease in the United States and should be treated as an urgent health issue by allocating adequate resources.
2. National smoking trends show a decrease in smoking rates; however, the decline is unevenly distributed across the population. Smoking rates among adults with a high school education or less remain stable, whereas smoking rates among more educated segments of the U.S. population are rapidly declining.
3. A significant reduction in smoking prevalence in this country can best be achieved by presenting persistent and inescapable cues to smokers to stop smoking and nonsmokers not to start, accompanied by readily available support to achieve these goals.

4. Research in behavior change, smoking prevention, and smoking control has led to the development and evaluation of effective strategies to reduce smoking. The dissemination and widespread use of such strategies throughout the population at large and particularly among target groups of smokers are feasible and will result in a significant reduction in smoking prevalence.

These standards serve as guidelines for the ideal comprehensive smoking prevention and control initiative. Political and economic constraints may prevent the full implementation of parts of the standards. Priorities must include those activities and strategies that result in a significant reduction in smoking prevalence.

PLANNERS AND PARTICIPANTS

A comprehensive smoking prevention and control initiative should be planned and led by organizations and institutions with a mandate to protect the health of the public. Activities should be carried out by existing organizations, agencies, and groups and individuals that a) have access to smokers through their membership or constituency and b) can use their authority and expertise to enhance smoking prevention and control efforts.

There are many roles to be played in such a comprehensive initiative. Although some roles are more appropriately played by specific organizations and individuals, a successful effort will identify and include all who might be useful.

By its nature, a comprehensive smoking prevention and control initiative requires extensive planning, support, and coordination. Central to the development of a successful smoking prevention and control initiative is the recognition that each participating organization can make a unique contribution to smoking prevention and control. By identifying the nature of the contribution, enabling effective performance, coordinating that performance with other activities, and recognizing each organization's effort, the initiative can build a permanent capacity within a site for effective action on smoking or other public health issues.

THE PLANNING MODEL

A smoking prevention and control initiative is based on successful worldwide examples that show that a widespread change in social acceptability of smoking is required to significantly reduce smoking prevalence. To achieve this change, two main educational goals must be met:

1. The general public must recognize the threat to public health posed by smoking and must endorse its restriction.

2. Smokers must be presented with persistent and inescapable cues that support nonsmoking while simultaneously being offered a variety of appropriate cessation tools.

This planning model provides a means for organizing the many diverse activities that make up a comprehensive initiative. The standards for smoking prevention and control presented in succeeding chapters describe the universe of activities that have been shown to be critical to the success of such an effort.

A comprehensive smoking prevention and control initiative consists of interrelated elements. These elements include the groups targeted for intervention, the channels through which they can be reached, and the interventions to reach them. Figure 1 represents these elements and these relationships and provides a useful structure for planning a comprehensive initiative.

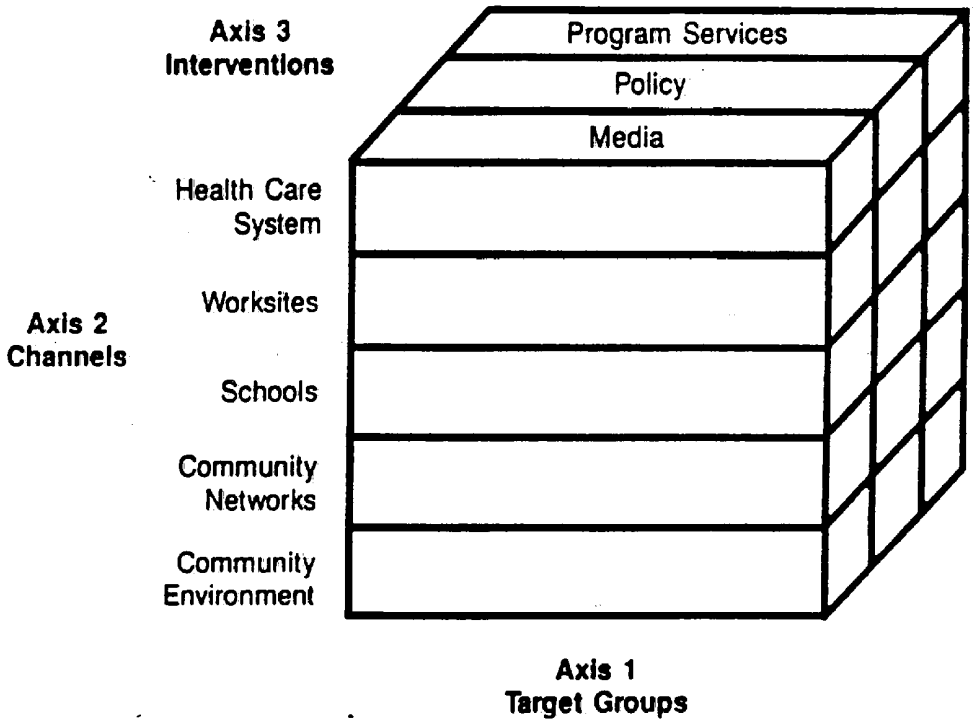

Figure 1. Planning Model for Smoking Prevention and Control

Axis 1: Target Groups

The goal of a comprehensive initiative is to reach all smokers, all adolescents at risk for becoming smokers, and all nonsmokers who may influence the behavior of smokers. For maximum efficacy, the total population is divided into the following target groups. (These groups are not specifically identified in figure 1 because they will vary by site.)

- Smokers and those at risk for smoking

  --Groups with relatively high smoking and smokeless tobacco use rates (e.g., blue-collar workers, people who have not completed high school).

  --Groups with secondary risk factors (e.g., occupational exposure to asbestos).

  --Groups with limited access to information about smoking and cessation services (e.g., ethnic minority populations, uninsured families).

  --All youth, particularly adolescents at elevated risk for starting to smoke (e.g., those at risk for dropping out of school and those whose parents smoke).

- Other groups

  --Groups and individuals who can affect policy changes in relation to smoking as it affects nonsmokers and smokers.

  --Groups and individuals able to amplify and extend effective smoking control as it affects smokers and nonsmokers in other ways.

Axis 2: Channels To Reach Target Populations

The channels for smoking prevention and control are the organizational frameworks through which specific intervention program activities reach targeted individuals and groups. The major channels are:

- The health care system.
- Worksites.
- Schools.
- Community networks.
- Community environment.

These standards describe each of these channels, set goals, specify critical activities, and recommend the optimal level of effort that should occur during a multiyear intensive intervention. A comprehensive smoking prevention and control initiative requires a high level of activity within each of these channels.

Axis 3: Categories of Interventions for Smoking Prevention and Control

The interventions along axis 3 represent the three major categories of interventions--media, policy, and program services--that constitute a comprehensive smoking prevention and control initiative.

Each category of interventions includes a variety of specific intervention strategies, some that can be delivered through all five channels (e.g., self-help materials or large community-based magnet events such as the Great American Smokeout) and some that are most appropriately delivered within a specific channel (e.g., brief counseling by health care providers or school-based smoking prevention programs). The standards describe various intervention activities within each intervention category and suggest the means of incorporating them within each channel.

USING THE MODEL FOR PLANNING

The planning model poses questions and identifies issues that must be addressed in planning a comprehensive smoking prevention and control initiative. The first step in planning is to identify target groups within a site (axis 1). For each target group, planners should assess the unique relationship between that target group and each of the elements along the other two dimensions of the model (axes 2 and 3). For example (figure 2), in a site where blue-collar workers are the main target group, the following is a possible sequence of questions to be addressed:

1. How do blue-collar workers use the health care system; what clinics, HMO's, hospitals, and health care providers serve this group?

   a. What types of media are available in these settings to reach workers and their health care providers? What types of available media are appropriate for smoking-related intervention?

   b. What policies exist to control smoking in these settings? What additional policies are appropriate for these settings to implement?

   c. What program services are available in these settings? What program services can be effectively delivered in these settings?

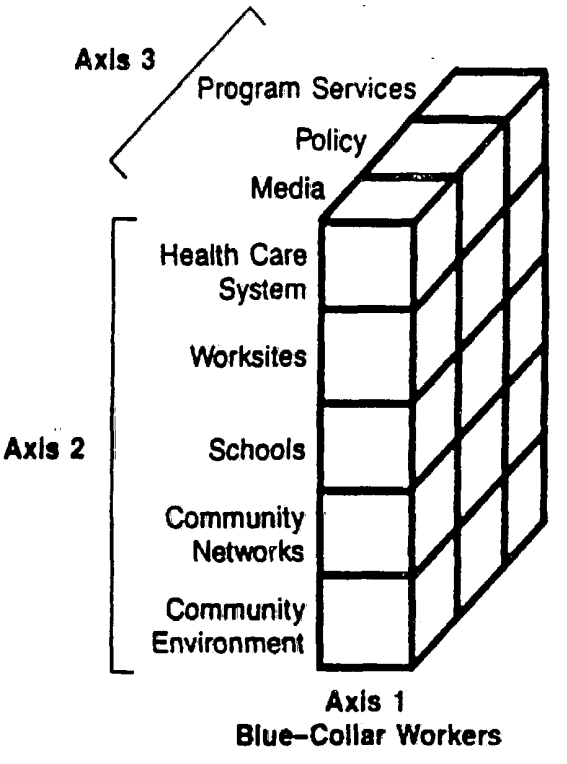

Figure 2. Cross Section of Planning Model for Single Target Group (Blue-Collar Workers)

2. Where are blue-collar workers employed?

   a. What types of media are available in these settings to reach employees in the worksite? What types of available media are appropriate for smoking-related intervention?

   b. What policies exist to control smoking in these settings? What policies are appropriate for these settings to implement?

   c. What program services are available in these settings? What program services can be effectively delivered in these settings?

3. Where are blue-collar workers involved in schools as staff members, parents, or students (primary, secondary, and vocational schools, community colleges, etc.)?

   a. What types of media are available in these settings to reach employees? What types of available media are appropriate for smoking-related intervention?

b. What policies exist to control smoking through schools? What additional policies are appropriate for schools to implement?

c. What program services are available in schools? What program services can be effectively delivered in schools?

4. In which community groups and organizations do blue-collar workers participate?

a. What types of media are available through these networks? What types of available media are appropriate for smoking-related intervention?

b. What policies exist to control smoking in these organizations and networks? What additional policies are appropriate for implementation?

c. What program services are available through these networks? What program services can be effectively delivered through these networks?

5. In which neighborhoods and communities do blue-collar workers live?

a. What types of media are available in these communities and neighborhoods to reach workers and their families? What types of available media are appropriate for smoking-related intervention?

b. What policies exist to control smoking in these settings? What policies are appropriate for these settings to implement?

c. What program services are available in the community? How and where can program services be effectively promoted and delivered?

By answering these questions about each target group, planners can identify large areas of overlap between target groups of smokers and the channels through which they can be reached. For example, many smokers are members of more than one target group. Similarly, several target groups may be reached simultaneously through a single intervention in a specific channel. The identification of such situations will enable the development of a comprehensive plan that avoids duplication of effort and ensures balanced and intensive intervention.

GENERAL CONSIDERATIONS

The above discussion identifies specific elements that are critical to the development of a comprehensive smoking prevention and control initiative, whether it takes place in a small community, city, major metropolitan area, state, or the Nation. When planning such an intervention, the following issues should be considered:

1. Smoking is a public health problem. Participants in a smoking prevention and control initiative must ensure that all communications describe the issue as a problem for all members of a community, not just smokers. Blaming and ostracizing smokers can polarize the public and cause hard feelings that undermine smoking prevention and control efforts.

2. Careful assessment of the site will ensure effective allocation of resources. Such an assessment includes defining the smoking problem; identifying target groups; surveying the current level of program services, policies, and various types of media; and analyzing the potential of the health care system, worksites, schools, community networks, and the community environment to reach smokers.

3. A comprehensive long-term plan must be developed to integrate and coordinate the use of various types of media, develop policies, and deliver program services to the appropriate audiences to achieve significant reductions in smoking prevalence.

TARGET GROUPS

National smoking statistics help define the smoking problems in local sites. Because any comprehensive smoking prevention and control intervention is constrained by limitations in funding and other resources, it is important to identify groups to effectively target with limited resources. Although some smoking control interventions reach all smokers (e.g., restrictive smoking policies, excise taxes, some forms of mass media), other interventions are more appropriately aimed at groups of smokers whose smoking rates are stable or increasing and/or who have limited access to and use of smoking cessation and prevention messages and services.

Recent Government surveys indicate that although smoking in the United States is declining, the rate of decline among some subpopulations has slowed. The subpopulations that are of particular concern, either because of smoking prevalence or access to services, include:

- Youth.
- Ethnic minorities.
- Women.
- Blue-collar workers.
- Less educated individuals.
- Unemployed persons.
- Heavy smokers.
- Smokeless tobacco users.

A single smoker may be a member of more than one group. This should be considered when describing the target populations for a comprehensive effort and when defining the effective strategies to reach smokers.

SMOKERS AND THOSE AT RISK FOR SMOKING

National Trends

- Smoking prevalence for ages 20 and older is 31.7 percent for men (down from 50.2 percent in 1965) and 26.8 percent for females (down from 31.9 percent in 1965).[1]

- There has been a decline in smoking in every age group and at every income level, but the decline has been the greatest among the better educated.[2]

National trend data are available through a series of articles in the Journal of the American Medical Association.[3]

Youth

More than four-fifths of smokers born since 1935 started smoking before age 21, and approximately 90 percent of all smokers started by age 18.[1,4] In addition:

- Age of initiation of smoking is occurring at younger ages among more recent birth cohorts, especially among females.[1]

- An annual high school seniors survey indicates that the prevalence of daily cigarette consumption declined from 29 percent of seniors in 1976 to 21 percent in 1980, after which prevalence leveled off at 18 to 21 percent.[5]

- Smoking among high school senior females has consistently exceeded that among males since 1977.[6]

- During the past 20 years black and white teenagers have started to smoke at similar rates.[1]

Ethnic Minorities

More whites are quitting than blacks, yet in recent years the quit ratio has become similar (no national quit rate data are available for other minorities).[1] Additional quit rate data for minorities include:

- In recent years (1974-1985), black males are quitting smoking at a significantly higher rate than white males.[1]

- Black females smoke fewer cigarettes per day than white females.[1]

- Limited data for Hispanics indicate lower prevalence rates of smoking than among whites and blacks (23.6 percent compared with 28.5 percent and 32.9 percent, respectively).[7]

- These are no reliable national data on American Indians or Alaska Natives, but prevalence ranges from 13 percent to 70 percent depending on the specific population.[1]

- Data on Asian Americans are scarce but are estimated at between 20 to 29 percent, again depending on the specific population.[1]

Pregnant Females

National data on smoking during pregnancy are scarce, especially before 1980. Studies generally indicate that less educated, unmarried, or unemployed women are more likely to smoke during pregnancy than others.[1] The National Natality Surveys show that teenage smoking rates during pregnancy remained fairly constant over time (1967 to 1980): about 39 percent among whites and 27 percent among blacks.[8] In addition:

- Black pregnant females are quitting smoking less frequently (17 percent from 11 percent), whereas white pregnant females are quitting more frequently (11 percent to 16 percent).
- White women with fewer than 12 years of education showed relatively little change in quitting during pregnancy (11 percent to 9 percent), whereas smokers with 16 or more years of education more than doubled their quit rate (12 percent to 27 percent).
- Insufficient numbers of black women were sampled to study trends by education among blacks.

Blue-Collar Workers

Blue-collar workers are smoking more and are quitting less than white-collar workers.[9] Additionally:

- Blue-collar workers have a higher rate of relapse than white-collar smokers (40 percent compared with 28 percent, respectively).
- Proportionally, more white-collar workers are former smokers than blue-collar workers (37 percent compared with 28 percent, respectively).
- Blue-collar workers start smoking earlier than white-collar workers, and the age of initiation coincides with entry into the workforce.
- The majority of participants in worksite smoking programs are young, of middle or upper socioeconomic status (SES), and in occupations that do not place them at increased health risk.
- Few worksite programs are targeted to male blue-collar workers.

Less Educated Individuals

Educational attainment appears to be the best single sociodemographic predictor of smoking.[3] In addition:

- Smoking cessation is increasing across all educational groups, but the rate of increase among the higher educated is twice that of lower educated groups.
- Smoking prevalence has declined across all educational groups, but the decline has occurred five times faster among the higher educated compared with the less educated. Currently 16.3 percent of college graduates smoke compared with 35.7 percent of those without high school diplomas.[2]
- Recent studies indicate that high school dropouts have excessively high smoking rates.
- The bulk of dropouts are from low SES backgrounds and/or from minority groups and may require distinctive and more intensive interventions.

Unemployed Persons

When SES and demographic factors are controlled, unemployed persons are more likely than employed persons to smoke.[1] Additionally:

- Since 1980 smoking prevalence in unemployed persons is decreasing but not as fast as in those who are employed (36 percent compared with 32 percent).
- Employed persons are more likely to quit smoking than unemployed persons.

Heavy Smokers

The proportion of heavy smokers (more than 25 cigarettes per day) has not changed significantly from 1974 through 1985 (25.5 percent and 29.8 percent, respectively).[1] Additionally:

- The proportion of heavy smokers did not change among sex- and race-specific subgroups of the smoking population or in different age groups.
- Heavy smoking has been consistently more common among whites than blacks.
- Heavy smoking is more common among men than women.

Smokeless Tobacco Users

Smokeless tobacco is an issue that must be addressed. Currently there are 6.1 percent of males age 18 and older who use smokeless tobacco.[3] An estimated 8.9 percent, or 1.1 million males, between 18 and 24 years of age use some form of smokeless tobacco. Use of smokeless tobacco follows a pattern similar to cigarette smoking with respect to the measures of SES, education, and income. Prevalence for both products is higher among those with less education and lower income.

Because most of these data are based on national trends, planners in a given site must draw inferences about site-specific SES/demographic factors based on income, education, gender, race/ethnicity, and other distinctive attributes of the target population. Resources should be expanded to reach those populations that have higher prevalence and lower quit rates and that have not been effectively targeted.

OTHER GROUPS

Policymakers

Individuals in positions to make or influence both private and public policies should be targeted for intensive educational efforts. The identification of such individuals and groups depends largely on the specific policy issue being addressed. For example, an effort to implement clean indoor air regulations for food service establishments has a natural audience of restaurant owners and managers.

Community Leaders

Influential health care providers, teachers, school principals, ministers, and business people can provide legitimacy for the issue of smoking control, represent the issue for their constituency, and act as a spokesperson for their constituency's position on the issue to the media. The identification, education, training, and ongoing support of such individuals is critical to gaining grassroots support for the smoking control effort.

Smoking Prevention and Control Intermediaries

The success of a comprehensive smoking control effort depends primarily on building the capacity of thousands of individuals with authority to act in an effective manner to prevent smoking or to counsel smokers to quit. For example, physicians, dentists, nurses, teachers, pharmacists, chiropractors, social workers, firefighters, and youth workers should be trained to deliver brief smoking prevention and cessation counseling. The identification,

training, and support of these individuals is a major part of a successful initiative.

The General Public

Smoking is a public health issue. The general public must understand what this means and that it is important for a number of reasons: to act to protect their own health, to support smokers in their attempts not to smoke, to support measures that encourage youth not to begin smoking, and to ensure that policy measures are upheld and supported. An effort must be made to raise the level of awareness of the general public about all aspects of the smoking issue.

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SMOKING PREVENTION AND CONTROL ACTIVITIES

MEDIA

The education of the public through media is essential to any successful smoking prevention and control program. Two other classes of interventions--policy changes and program services--are described in subsequent chapters. Collectively these three interventions represent axis 3 on the matrix (page 7) and serve as tools to reach the target groups through each of the channels discussed.

The word "media" is used in many different contexts. As used herein, media means the collective system of communication used to disseminate information about smoking and health. The dissemination process and message content are both important in ensuring that the most effective smoking cessation and prevention lessons are shared with the public. The major types of mass media are radio, television, newspapers, and magazines as well as more targeted types of media, including closed-circuit television, organizational newsletters, and neighborhood advertising papers.

Goals

The primary goals of mass media interventions in a comprehensive smoking prevention and control effort are to support nonsmoking behavior, increase motivation to stop smoking, and enhance public support for policy changes that support smoking control.

Media activities facilitate achievement of several important goals in the ongoing effort to control smoking. The specific goals of media-related activities are to:

1. Provide information to the public regarding the facts and issues about smoking, including availability of cessation program services and smoking-related events.

2. Motivate people to stop smoking or prevent them from starting to smoke.

3. Set the public agenda and generate public discussion by placing smoking in its proper perspective as a health issue.

4. Generate broad public support for nonsmoking policies and make policymakers aware of this support.

5. Recruit smokers into treatment programs.

6. Conduct smoking cessation courses.

These goals support the other smoking control activities. Close coordination of each goal with the other program activities is critical to the overall success of any comprehensive smoking control effort.

Role of Media

Media provides important information to the public regarding the facts and issues about smoking. The awareness of the health consequences of tobacco use has increased dramatically among the U.S. population in recent years. The public health campaigns of the past 25 years have been successful, but their task is not complete. Public education initiatives can disseminate smoking control messages, publicize available program services, and inform people of opportunities to strengthen smoking control policies. By using media to transfer information to target groups and the general public, smoking prevention and control messages can be spread widely.

Media motivates people to stop smoking and helps prevent them from starting to smoke. Media is a tool for motivating people to never begin smoking or to quit. Many types of educational activities can be used to convince people that they are at serious risk for health problems and that they can reduce this risk by not smoking. Once people have seen the benefits of quitting and are convinced that this is a wise decision, media can be used to encourage them to seek treatment. In addition, media messages can motivate nonsmokers to support smokers in their efforts to stop.

Media establishes the public agenda with smoking in its proper perspective as a public health issue and generates public discussion. Media strategies are particularly useful because they can reach large audiences to have a broad impact, or they can be targeted toward specific groups to present more individualized messages. By focusing public attention on smoking issues, media can shape personal and corporate decisions as well as public policies. Educational messages can correctly portray smoking as a public health problem rather than a personal decision.

Timing is critical in promoting any public message, and media can facilitate the timely distribution of smoking control information. Furthermore, reporting on an issue often establishes its importance on the public agenda and indicates that it warrants additional discussion or action.

Media generates broad public support for nonsmoking policies and ensures that policymakers are aware of this support. By demonstrating to people all the benefits of a smoke-free society, media activities can expand smoking control policies. Media activities can also highlight and increase public support for smoking control policies. Policymakers are always interested in public opinions and by using media to inform them of this support for smoking control, an environment conducive to policy change will be created.

Media recruits smokers into treatment. The demand for treatment can be increased by promoting no-smoking norms via mass media and other more specialized educational activities. After a person has decided to stop smoking, many types of media activites can be used to inform the person of specific treatment alternatives, including numerous smoking cessation strategies. Media can also be used to market individual smoking cessation programs.

Media conducts smoking cessation clinics. Smoking cessation programs have been effectively conducted through mass media. Both brief and more intensive programs have been conducted or augmented through programs on television and in newspapers. Such a smoking program, even with a relatively low success rate, can translate into large absolute numbers of people stopping, given the large audiences provided by mass media.

Recommended Activities

These activities reach across all target groups and implementation channels and provide the broadest possible smoking control intervention.

1. **Develop and implement a communications plan that codifies a coordinated strategy to disseminate smoking control messages to target groups and the general public.** This plan should consider all programs and media involved within each channel and should describe the messages and strategies that will enhance and support them. It should further describe the resources, target audiences, types of messages, and other site-specific information needed to accomplish the goals of the comprehensive smoking prevention and control initiative.

2. **Promote available program services, including smoking control hotlines.** The availability of program services should be broadly publicized to ensure that they achieve maximum utilization and impact. These services may be promoted to the general public or they may be directed toward specific channels or target groups.

3. **Conduct magnet events on a regular basis.** Magnet events are well-publicized activities (or sets of activities) that take place within a defined area during a specific time and are designed to focus community attention on smoking as a public health issue. More important, magnet events encourage smokers to stop and offer opportunities to do so. Magnet events (such as the American Cancer Society's Great American Smokeout) often are conducted on a nationwide basis with extensive media attention, although local events may also be successful.

4. **Train smoking control advocates in media access and presentation skills.** Messages that promote smoking control can reach smokers

through the news media, as well as through paid and public service advertisements. Gaining access to the news media and using that access effectively require special skills that may not be available in all communities. An effective smoking control program will make use of opportunities in the news media. Local experts in smoking control should be trained to make the best use of news media time when such opportunities arise.

5. **Train reporters and broadcast journalists about the details of smoking issues.** News professionals should be educated about the health implications of smoking and opportunities to control smoking so they can share accurate information with the public.

6. **Establish, maintain, and promote a communication network to enhance local coverage of national, regional, and local smoking issues.** This should include publicizing local smoking success stories of public figures who quit, expanded smoking policies, or new cessation programs. Local news coverage of smoking control is enhanced when local stories involve current issues in the national news. Communication between national, state, and local smoking control advocates will ensure that newsworthy information is widely available and reported. A personal computer bulletin board system allows the instant transfer of information.

7. **Publicize policy issues and community efforts to influence national, state, and local policymaking.** Media can be used to focus attention on policy changes that will help control smoking. These efforts can be targeted broadly to the general public or to specific policymakers.

Integrating the Media Into the Initiative

Media-related activities will prove most successful when:

- Channel-specific media efforts are coordinated with larger mass media messages and programs.
- Channel-specific media initiatives are consistent with each other.
- Mass media and channel-specific media efforts promote available program services and support public policy changes.
- Media approaches combine a planned set of strategies with enough flexibility to allow for timely responses to current news events.

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POLICY

Policies are an important component of a comprehensive community smoking prevention and control program. Although the word "policy" often connotes legislation or regulation, many effective smoking policies result from the voluntary actions of individuals, organizations, and private businesses concerned about the health and well-being of their patients, clients, employees, students, or members.

Perhaps the most common use of the term "policy" is in the context of public policy, which refers to laws passed by a governmental body. However, the words "law" and "policy" are not interchangeable. All laws are forms of policy, but policy is a much broader word, including guidelines or rules made by a variety of groups, including governments, private organizations, and private businesses.*

Goals

The overall goal of a comprehensive smoking prevention and control initiative is to promote and protect public health. This goal can be achieved by successfully implementing the following policy goals:

1. Ensure safe, smoke-free environments for the public and reinforce social norms and values supporting nonsmoking.

2. Provide stimuli and incentives to help smokers stop and offer structural support to help them remain smoke free.

3. Provide incentives for people to never begin smoking.

Types of Policies

1. Clean indoor air.

2. Restricting access to tobacco by minors.

3. Economic incentives and taxation.

4. School-based prevention curricula.

5. Restricting advertising and promotion of tobacco.

*Note: There are a variety of statutory restrictions on the use of funds to lobby legislative bodies or to influence election or referendum results. This chapter does not suggest that these restrictions be violated in any way.

Clean Indoor Air

The most common smoking policies restrict or prohibit smoking in indoor areas. Restaurants, stores, offices, public transportation, worksites, schools, and health care facilities are frequently subject to clean indoor air policies. In 1986 the Surgeon General's report on The Health Consequences of Involuntary Smoking concluded that:

1. Involuntary smoking is a cause of disease, including lung cancer, in healthy nonsmokers.

2. Children of parents who smoke compared with the children of nonsmoking parents have an increased frequency of respiratory infections, increased respiratory symptoms, and slightly smaller rates of increase in lung function as the lung matures.

3. The simple separation of smokers and nonsmokers within the same air space may reduce, but does not eliminate, the exposure of nonsmokers to environmental tobacco smoke.

These conclusions strongly suggest that the prohibition of smoking is the only policy that affords adequate protection from the known carcinogens in tobacco smoke.

Restricting Access to Tobacco by Minors

Because the addictive nature of nicotine makes it very difficult to stop smoking, preventing adolescents from ever beginning to smoke is essential. The Surgeon General's report on The Health Consequences of Smoking: Nicotine Addiction points out that since the early 1900's scientific evidence and historical anecdotes have shown that tobacco use is a form of addiction. Advances in the neurosciences have begun to reveal effects of nicotine in the brain and body that may explain why tobacco use is reinforcing and difficult to stop.

The urgency of restricting access to tobacco becomes quite evident when nicotine addiction is considered in conjunction with evidence indicating that more than 87 percent of people born between 1950-54 who have ever smoked began this habit before age 21. In most states, the sale of tobacco to minors is prohibited by law. The age at which minors can legally purchase tobacco varies among states; however, enforcement of these prohibitions is almost uniformly lacking. In addition, the sale of cigarettes in vending machines is legal and common, and many vending machines are located in places that provide minors unrestricted access to tobacco. Policies to reduce minors' access to tobacco may include the prohibition of sales in vending machines, licensure requirements for tobacco retailers, and harsher penalties for retailers who sell cigarettes to minors.

Economic Incentives and Taxation

Economic incentives influence an individual's decision to consume tobacco. Most people's decisionmaking patterns are directly influenced by the costs they incur. Increased tobacco excise taxes, which increase the cost of cigarettes to consumers, can reduce consumption among some groups of smokers. Teenagers, in particular, may have less disposable income than adults and be more effectively discouraged from purchasing cigarettes by excise tax increases.

Other financial incentives to stop consuming tobacco may be established by employers, insurance companies, and other individuals and organizations with an interest in the health of smokers. Worksite incentive programs are discussed in more detail in the section Program Services, in Smoking Prevention and Control Activities, on page 27.

School-Based Prevention Curriculum

Reducing the demand for cigarettes and other tobacco products, as discussed in the section about schools, may be accomplished through education. To date, school-based smoking prevention programs in the United States have had consistently positive effects. They have been particularly effective in delaying the onset of tobacco use, though less successful in targeting high-risk and minority youth. Policies that mandate the inclusion of effective smoking prevention curriculums in schools ensure that all students receive such instruction.

Restricting Advertising and Promotion of Tobacco

Restrictions on the advertising and promotion of tobacco products are one of the most effective ways to reduce demand. In 1970--the year before cigarette ads were banned from radio and television--the tobacco industry spent $361 million on advertising and promotion, but in 1986, the six major firms spent $2.4 billion on these activities--almost $9 for every man, woman, and child in the United States. Since 1971, when broadcast advertising was banned, expenditures on advertising and promotion of cigarettes have increased fivefold, in constant dollars. Despite these figures, the tobacco industry claims that its advertising has no impact on young people and denies any intentional attempt to recruit young users. These claims are contradicted by their actions, including targeted advertising and promotion and heavy use of image advertising in areas where it will be highly visible to young people.

To counteract the tenacious marketing efforts and the vast financial resources of the tobacco industry, comprehensive smoking prevention and control initiatives should work toward eliminating all advertising and marketing other than price and product advertising, including all free distribution of tobacco products and lifestyle advertising.

Recommended Policies

The following list includes many, but not all, policies that may be included in a comprehensive smoking control program:

Clean Indoor Air

1. All indoor environments accessible to the public are smoke free.

2. All health care and public health facilities are smoke free.

3. All worksites are smoke free.

4. All schools are smoke free. (This prohibits smoking at all school facilities, buildings, athletic fields, or functions by faculty, students, staff, spectators, or visitors.)

Restricting Access to Tobacco by Minors

5. All cigarette vending machines accessible to minors are banned.

6. All tobacco sales to minors are prohibited and this prohibition is enforced.

Economic Incentives and Taxation

7. Cigarette excise taxes are introduced and increased on a regular basis.

8. All health and life insurance carriers should provide differential insurance rates for smokers and nonsmokers.

9. All health insurers should reimburse for smoking cessation services.

School-Based Prevention Curricula

10. Lessons on the dangers of smoking and the addictive properties of nicotine should be a regular component in health and physical education curriculums for all school systems.

Restricting Advertising and Promotion of Tobacco

11. All advertising and marketing other than price and product advertising should be eliminated, including all free distribution of tobacco products and lifestyle advertising.

Integrating Policies Into a Comprehensive Initiative

Each state or community must assess its own current situation to determine which course of action is most appropriate and which policies can be most successful with its particular population. Social, cultural, political, economic, educational, and religious influences are just some of the factors that vary across sites and make each particular environment unique. Before any policy changes can be effectively implemented, public support for them must be generated throughout the community. Policy changes that protect people who are particularly vulnerable to the negative effects of tobacco or that protect youth from becoming addicted often generate broad popular support. These include efforts to protect people with asthma or other respiratory diseases and people with work-related health risks and limitations on advertising directed toward young people and restricting their access to tobacco.

In planning a comprehensive smoking prevention and control initiative, smoking control advocates should do two things: (1) inform policymakers of the importance and benefits of smoking control policies, and (2) provide information to interested individuals on the importance of smoking control policies and techniques they can use to produce needed policy changes.

Smoking control policies complement other strategies to reduce prevalence rates. Although smoking control policies may independently decrease smoking prevalence, when combined with media activities and program services their potential for success is significantly enhanced. It is essential to integrate policy development and implementation into a comprehensive smoking prevention and control plan.

A comprehensive smoking prevention and control program will prove most successful when:

- Media activities are attuned to current policy issues.
- Channel-specific policies are coordinated with broader public policies influencing all channels.
- Channel-specific policy initiatives are consistent with each other.

Recommended Activities

The following is a list of some activities to support the implementation of the recommended policies. Each intervention site should consider which activities will be most useful in its particular environment. This list in not exhaustive.

1. Provide information to policymakers on the hazards of involuntary smoking and smokeless tobacco, the addictive properties of nicotine,

improper or deceptive advertising practices used to promote tobacco use, the potential for excise taxes to reduce consumption, the degree of public support for restricting smoking in public, and the benefits of smoking control policies. This information can be given to policymakers in a variety of ways, including workshops, meetings with individual policymakers, and through testimony, letters, and the media.

2. Inform people working for policy changes of their resources, allies, opponents, scientific support for their policies, and the process of changing policy.

3. Train smoking control advocates how to effectively express their views to the public and present these views to lawmakers. This includes workshops on public speaking, events to generate media attention, and letter-writing campaigns.

4. Use policy changes to broaden the impact that media has on changing individual behavior. By keeping smoking issues in the news and giving them proper coverage, people will be reminded of the health consequences of smoking.

5. Use media to reinforce nonsmoking norms and encourage individuals to actively participate in smoking prevention and control efforts.

PROGRAM SERVICES

The mass media and policy components of a comprehensive smoking and prevention intervention raise awareness of the smoking issue and motivate people to make changes in their behavior relative to smoking. Such efforts must be accompanied by a wide range of program services that guide and support individuals in making those changes. Most program services are delivered via the identified channels for smoking prevention and control, that is, through the health care system, worksites, schools, and community networks.

There are three main kinds of program services in a comprehensive smoking control effort: cessation resources (e.g., brief counseling, self-help strategies, group clinic programs), prevention resources (e.g., school-based smoking prevention curriculums), and smoking education (e.g., workshops for policymakers, programs for the general public about the smoking issue). Although these program services vary widely in source, audience, intensity, structure, and purpose, all share three essential elements: (1) information about smoking, (2) compelling reasons to act, and (3) guidance about how to act effectively.

Goal

The goal of program services in a smoking prevention and control effort is to ensure the high visibility and ready availability of materials and programs that support individual behavior changes consistent with the nonsmoking norms.

Cessation Resources

Smokers vary greatly in their readiness to stop smoking and in their needs for programs to support cessation. A wealth of knowledge exists regarding methods and techniques that can aid smokers with different cessation needs. Resources must be allocated for efforts to motivate more smokers to make serious quit attempts and to use cessation resources. Existing techniques must be made widely available from a variety of authoritative sources for cessation resources to be effective.

It should be noted that most smokers stop smoking in response to broad public education campaigns and with minimal contact with programs or service providers. On the other hand, in any given year, approximately one-third of all smokers try to stop smoking, and only 1 in 10 succeeds. These figures support the promotion and ready availability of self-directed, easy-to-use materials and brief interventions to help these people stop smoking successfully.

A comprehensive smoking prevention and control intervention should identify groups with targeted smokers in their memberships and constituencies and enhance the capacity of these groups to serve as smoking cessation agents. Information about the full range of smoking cessation services should be widely promoted and made available to all smokers, both through the smoking control channels and through the media. These smoking cessation resources include:

- Self-help materials.
- Brief cessation counseling.
- Dedicated stop-smoking telephone hotline.
- Incentive programs.
- Group smoking cessation programs.
- Other methods.

Self-Help Materials

Two decades of research suggest that self-help strategies for smoking cessation may be the preferred means to stop smoking and can produce success rates approximating those of more formal programs, at lower cost and with greater access to target populations.

The NCI consensus document "Essential Elements of Self-Help/Minimal Intervention Strategies for Smoking Cessation" makes the following recommendations about self-help smoking cessation programs:

1. Intervention efforts should focus on increasing smokers' motivations to make serious quit attempts.
2. Programs should be targeted toward all smokers, not just those who request them.
3. Programs should be adapted to serve the needs of special populations of smokers.
4. All programs should include (1) elements that focus on the health and social consequences of smoking and (2) strategies and exercises aimed at quitting, maintenance of nonsmoking, relapse prevention, and recycling.
5. Existing materials and programs should be made widely available rather than developing new ones.

6. Self-help programs should be used in combination with other strategies (e.g., brief smoking counseling by health care providers, telephone hotlines, etc.).

Self-help materials are available through voluntary health agencies, hospitals, health departments, county extension services, and the Federal Government at little or no cost. These materials should be widely and appropriately distributed through the smoking prevention and control channels to ensure that they reach targeted smokers.

Brief Cessation Counseling

Brief smoking cessation techniques can be used by a variety of individuals to help smokers decide to stop and to help them maintain abstinence. Like self-help materials, brief interventions should both motivate the smoker to stop and provide useful information for achieving permanent abstinence. Brief counseling can often be used to augment self-help programs as well as to refer smokers to more intensive cessation programs.

Brief smoking cessation interventions by physicians and dentists have been shown to be effective in randomized, controlled trials. In these studies, smokers received strong, personalized advice to stop from a trusted health professional. This advice included an agreement to set a "quit date," information on withdrawal symptoms and ways to cope with them (usually in a self-help brochure), and pharmacologic aids to help with cessation, if indicated. Followup with the smoker can reduce the incidence of relapse.

Although this type of brief intervention most frequently has been accomplished through personal contact with physicians and dentists, other individuals in different situations may be used, depending on the smokers being targeted. Other health care professionals should be trained to deliver such interventions (e.g., public health nurses, dental hygienists, pharmacists, and occupational health nurses). Some populations may also be reached using individuals who are not health care professionals. Finally, brief interventions have also been done with groups of smokers, rather than individuals, and have even been done through mass media. Each channel and each target population should be considered in designing brief cessation interventions.

Dedicated Stop-Smoking Telephone Hotline

A stop-smoking telephone hotline provides easy access to information on cessation, advice, brief counseling, referral, and printed materials. Such hotlines are particularly critical in areas with few other cessation services.

Calls must be answered by staff and volunteers trained in smoking cessation counseling. Operators should be trained to determine the general level of addiction and nature of the smoker's habit by asking a few questions about smoking patterns and previous quit attempts. Training should also enable operators to address cessation issues such as recordkeeping, setting a quit date, weight control, use of nicotine gum, benefits of quitting, and coping with withdrawal symptoms. Operators should be able to make referrals to community information sources and should send self-help materials to callers. Multilingual operators may be appropriate in some areas.

A telephone hotline serves no purpose unless its existence and services are heavily promoted throughout each channel and in the mass media.

Incentive Programs

Incentive programs are systematic ways of motivating smokers to quit and to stay off cigarettes through awarding a variety of prizes. An attractive, tangible reward for quitting that is available in the near future can help smokers to bridge the gap between the initial pain of withdrawal and the rewards of long-term nonsmoking. There are many kinds of incentive programs. Some award cash to all participants who attain a certain goal and others use a lottery or contest approach. Many use cash rewards; others award services, consumer products, memberships, or other nonmonetary prizes.

Incentive programs are an important tool for smoking control because they provide extra motivation for smokers to stop at a given time; fit naturally into the majority of worksites, hospitals, schools, and other organizations; are especially effective when combined with other stop smoking resources such as self-help materials or classroom instruction; and are cost effective.

Group Smoking Cessation Programs

A wide variety of group smoking cessation programs are available through health voluntary agencies, hospitals and HMO's, schools, and private vendors. Although many such programs have proven to be very helpful to smokers who want to quit, the cost and time involved in the delivery of such programs render them impractical as a means of reaching large numbers of smokers. Nevertheless, such programs provide an option for smokers who need structure and support in quitting, and publicizing the availability of existing group programs through smoking control channels is important.

Other Methods

A glance through the telephone book under "Smoking" or a trip to the drugstore will show a number of other services, devices, and strategies designed to help people stop smoking. The efficacy (and evaluation thereof) and cost of such interventions vary greatly. Most such services have not

been evaluated. Smokers need information to help them identify credible sources of smoking cessation services. Decisions about the promotion of such services through larger smoking prevention and control initiatives must be decided on a community level. National quality-control guidelines are being discussed.

Prevention Services

In light of current statistics on smoking among adolescents, there is a need for improved and more intensive efforts to prevent smoking initiation. For example, there has been no decline in prevalence of adolescent smoking in recent years; more than 3,000 American children begin to use tobacco each day; of those who do not complete high school, 75 percent smoke; and smokeless tobacco is a particular problem among some groups of adolescents.

Through a comprehensive smoking prevention and control program, all children should be regularly reached with basic health education/tobacco use prevention programs; groups at high risk for beginning to smoke should be targeted with more intensive efforts; and smoking cessation support should be widely available to support adolescent quitting.

School-Based Programs

The most common and perhaps convenient place to conduct tobacco use prevention programs is in schools. Several essential elements of school-based smoking prevention education should be considered in any intervention. These include:

- Adequate amount of time devoted to the topic, teacher training.
- Inclusion of theoretically based and field-tested educational models.

Many programs already exist and are available for use in schools. These efforts should be introduced as early as possible, even if a given program predates expected onset of tobacco use by several years, and should be offered consistently over time. Programs should also include cessation programs for teachers, counselors, coaches, health care personnel, and others who work with youth.

Nonschool-Based Programs

Among those youth who are considered to be at increased risk for becoming tobacco users are those who have parents who smoke, who are at risk for dropping out of schools, and/or who are economically disadvantaged.

High-risk youth may be reached by implementing brief cessation counseling and/or educational messages via a number of different avenues:

- Parents, significant adults (e.g., teachers, coaches, counselors), and friends.
- Media (radio and television).
- Treatment agencies (e.g., physicians, substance abuse programs, maternal-child health centers, and other medical clinics).
- Law enforcement agencies.
- Worksites, job training programs, unemployment centers.
- Social organizations, neighborhood centers, church groups.
- Youth service agencies.
- Indian reservations.

Smoking Education

Environmental tobacco smoke affects the health of the general public, and the public must be informed of this risk to protect itself from this hazard. The audience for smoking education, therefore, is the general public. However, resource limitations require that program services for smoking education be carefully aimed toward groups and individuals who can be effective in amplifying or supporting overall smoking prevention and control goals.

Workshops on Policy Development and Implementation

Individuals responsible for smoking policy development and implementation in both the private and public sectors must have current information about the health effects of smoking, the reasons for developing policies, and the effective strategies for doing so. Educational workshops for policymakers from similar settings should include time for problem-solving and examples of successful policy implementation. Such workshops should be available on a regular basis for representatives from groups and organizations within each of the smoking control channels.

Workshops on Smoking and the Media

A successful smoking control media campaign draws heavily on a variety of influential individuals in the community who are able to speak in a clear and compelling manner about the smoking issue. Such individuals should be educated about the terms of the smoking control debate, tobacco industry tactics, basic smoking statistics, and the nature of the smoking control effort in a specific site. In addition, audio/video coaching may be appropriate.

General Smoking Education

Formal, brief (45-minute) presentations of smoking prevention and control should be made available to groups through each smoking control channel and should include:

- Information about smoking as a public health problem.
- Information about the hazards of smoking and the benefits of quitting.
- Description of the magnitude and urgency of the problem.
- Description of what can be done in the group's setting (e.g., in a church: that a restrictive policy can be implemented, self-help material made available, cessation programs offered to adults, and cessation and prevention programs offered to youth).
- Description of what an individual can do (e.g., support a smoker in stopping, support public policy development, become involved in smoking control activities).

Recommended Activities

1. Develop, maintain, and promote a list of site-available program services.
2. Identify, maintain, and support a dedicated stop-smoking hotline.
3. Make the promotion of the current list of program services a part of each intervention in each channel.
4. Include the promotion of the dedicated stop-smoking hotline in all appropriate interventions in each channel.
5. Promote and support the use of incentives for smoking cessation in each channel.
6. Ensure optimal availability of smoking cessation and tobacco education resources during and after magnet events.
7. Promote and deliver tobacco education programs through each channel.
8. Promote the availability of policy and media advocacy education programs in each channel.

December 12, 1989

CHANNELS FOR SMOKING PREVENTION AND CONTROL

THE HEALTH CARE SYSTEM

Description

Health care providers, the staff working with these providers, and the settings in which they work can reach up to 70 percent of all smokers. The activities outlined here focus on encouraging health care providers and their professional organizations to become more involved in smoking cessation and prevention activities both in their practices and as community leaders.

To deliver a comprehensive smoking control intervention through the health care system, two groups of health care providers should be identified. The primary group includes primary care physicians (family and general practitioners, obstetricians, gynecologists, internists, and pediatricians), primary care dentists, nurses, pharmacists, physicians' assistants, and all staff working with these providers. The secondary group includes all other health care providers who can reach particular groups of smokers effectively.

In addition, influential health care providers who are interested and able to play a leadership role in smoking control should be identified and encouraged to influence their colleagues directly through participation in programs to train their peers in smoking intervention techniques and indirectly through discussions at meetings and social events.

Goals

- To influence health care providers to promote smoking interventions and to play a leadership role in community smoking control efforts.
- To establish delivery of a brief smoking cessation intervention as a minimal standard of practice.
- To assist interested professionals in becoming proficient in providing smoking cessation assistance.
- To direct smokers to health care providers who are skilled in smoking cessation techniques.
- To change health care facility and organization norms to support nonsmoking.
- To increase adoption and effective implementation of comprehensive health care facility nonsmoking policies.
- To increase smoking control messages within health care media.

Recommended Activities

1. Develop and maintain a group of health care providers who will train other providers in smoking cessation and prevention techniques.

2. Train influential local health care providers to serve as local smoking control advocates and community resources.

3. Educate health care providers about the health effects of smoking and smoking interventions (1 hour).

4. Provide an opportunity for more intensive education of health care providers in smoking cessation interventions (3 to 4 hours).

5. Maintain health care providers' involvement in smoking control.

6. Establish nonsmoking policies in health care facilities and organizations.

7. Provide self-help materials and promote available program services through all media within health care settings.

See "The Health Care System" section in the chapter "Channel Activities and Strategies" for a complete description of these activities.

WORKSITES

Description

Worksites are an important channel for smoking control because they represent a setting in which large numbers of smokers may be reached and in which smoking control activities may be promoted, cessation programs offered, and cessation attempts encouraged and supported. Worksites also are an important channel for involving nonsmokers in smoking control efforts, particularly through the promotion of nonsmoking policies. Restrictions on smoking in the workplace protect nonsmokers from exposure to the tobacco smoke of others. Thus, successful worksite smoking control programs consist of two major components: (1) motivation and support for smoking cessation attempts and (2) a clear nonsmoking policy that is strictly enforced.

It is important in implementing worksite smoking control programs that employees take responsibility for planning and implementing smoking control policies and programs in their own worksite. Where unions are present, it is critical that they be involved. Working with companies where unions are present requires special sensitivity to the legal aspects of labor management

relations, the status of those relations in a given company, and the concern of unions for protecting the health and rights of their members.

For the purposes of the interventions described here, targeted worksites are defined as those businesses employing 50 or more persons. Worksites that should be emphasized are those businesses whose employees represent target groups such as blue-collar workers and workers whose environment exposes them to carcinogens or other increased health risks. Further, worksites employing large numbers of other target groups should also be considered primary worksites and should receive special attention.

Community businesses vary considerably in size, so gaining access to these businesses and their employees requires a variety of approaches. Smaller businesses often may be reached most efficiently through local business coalitions on health promotion. These coalitions may be established through support from local business organizations such as the Chamber of Commerce, Rotary, Kiwanis, or other local service organizations. Larger businesses provide the opportunity to reach larger numbers of employees within the same setting. However, establishment of nonsmoking policies and cessation resources within larger businesses may require more time than required within smaller businesses. An analysis of business demographics and other resources will help in formulating a strategy for targeting companies.

Goals

- To increase cessation among workers who smoke.
- To increase the capacity for worksites to serve as effective agents of smoking control.
- To increase adoption and effective implementation of comprehensive worksite nonsmoking policies.
- To enhance support for nonsmoking in the business and labor sectors of the community.

Recommended Activities

A. Policy-related activities.

1. Develop and maintain a group of individuals trained to serve as smoking control resources on worksite smoking issues.
2. Provide smoking control policy presentations to business organizations and unions (1 hour).
3. Provide smoking control policy workshops to representatives of business organizations and unions (3 to 4 hours).

4. Promote and implement stop-smoking incentives among worksites with high proportions of employees who smoke.

B. Activities directed toward smokers.

1. Promote participation in smoking or health-related magnet events.

2. Deliver smoking education in the worksite.

3. Provide self-help materials and promote available program services through all media within the worksite.

SCHOOLS

Description

Schools provide another important channel for smoking control because they represent a primary channel for reaching youth and adolescents and provide an opportunity for reaching individuals who may not be reached through other worksites. Schools also provide a forum for reinforcing parental messages delivered through worksite programs. Although school structures and settings may vary widely, several characteristics of schools are particularly conducive to successful smoking prevention and cessation efforts. The school environment is established to support learning and, thus, naturally provides the skills and support for delivery of smoking prevention and cessation programs to students, faculty, and staff. Further, students may be more receptive to learning about the health effects of smoking and smoking cessation. Finally, as self-governing establishments, schools provide important opportunities for implementing nonsmoking policies.

School-based smoking prevention and control activities should be carried out through all private and public primary, secondary, and postsecondary schools. Primary schools include elementary schools; secondary schools include high schools and vocational schools; and postsecondary schools include trade schools, junior colleges, colleges, and universities. The primary emphasis for school-based programs is the identification and intervention within schools with large proportions of target group members--students, faculty, and staff.

Goals

- To delay and decrease the onset of smoking among students.
- To increase smoking cessation among students, faculty, and staff.
- To increase the capacity for schools to serve as effective resources for smoking prevention and cessation.
- To increase adoption and effective implementation of comprehensive school nonsmoking policies.
- To enhance support for nonsmoking in PTA's, school-related unions, and other school-based organizations.

Recommended Activities

1. Identify, recruit, and train influential representatives from school systems and school-related groups to serve as local smoking control resources for schools.
2. Provide smoking prevention and control presentations to school boards, PTA's, teachers, staff unions, and other school-related groups.
3. Aid in establishing nonsmoking policies in all schools.
4. Implement state-of-the-art smoking prevention curriculums in schools.
5. Provide self-help materials and promote available program services through all media available within the schools.

COMMUNITY NETWORKS

Description

Community networks are groups of individuals who gather regularly for some mutually sanctioned purpose. Such networks range in structure from formal (social clubs and some service organizations) to informal (block associations, social clubs, neighborhood centers). Community networks are an important channel for smoking prevention and control because they provide an opportunity to reach individuals who may not be reached through health care settings, worksites, or schools. In addition, the expanded capacity of such networks as active agents of smoking control ensures ongoing support for the norms of nonsmoking at all levels of the community. Community networks

include youth organizations, service and social clubs, and religious and professional organizations.

Because numerous networks exist in each community, program resources may not be sufficient to reach all of them. Thus, two groups of networks, defined by the formality of their structure and their capacity to effect change, should be targeted. The first group includes large organizations that have an active membership (regular attendance, 40 or more adults per meeting), meet six or more times per year, and have a regular meeting place. These networks may be intervention targets themselves and/or their members may be active in the delivery of smoking-related information and services in the community. Such networks may include religious groups, civic organizations, and voluntary health and social service organizations.

The second group of community networks does not meet the above criteria but has the potential to reach groups of targeted smokers. These groups should be enlisted to assist in promoting tobacco prevention and control activities. Such networks may vary greatly in structure and function and may be uniquely able to reach targeted smokers. They include such groups as child care co-ops, block associations, after-school programs, and social clubs.

Goals

- To increase cessation among network members who smoke.
- To build the capacity of community networks to serve as effective agents of smoking prevention and control.
- To increase adoption and effective implementation of comprehensive nonsmoking policies where appropriate.
- To enhance support for nonsmoking in community networks.

Recommended Activities

1. Train influential network members to serve as local smoking control role models and community resources.
2. Provide smoking control policy presentations to community networks and organizations.
3. Provide smoking control policy workshops for representatives of community networks and organizations.
4. Promote participation of community networks in smoking and health-related magnet events.

5. Provide self-help materials and promote available program services through all media used by each community network.

COMMUNITY ENVIRONMENT

Description

All urban areas and regions of the country are made up of various smaller communities that can be geographically, ethnically, or culturally defined. Community environment refers to the general physical and social milieu in identified areas within the intervention site. The community environment as a channel consists of the multiple outlets in a community that reach all citizens regardless of employment, scholastic, health, social, or smoking status. The presence and salience of messages promoting smoking or quitting, the availability (or lack thereof) of cigarettes and smokeless tobacco, and the social norms for smoking in public places all contribute to a community environment that may or may not support smoking.

Although the majority of smoking prevention and control research has concentrated on the delivery of interventions via the other four intervention channels, the importance of the community environment to a comprehensive smoking prevention and control initiative cannot be underestimated because:

1. Targeted smokers cannot all be reached via the four traditional intervention channels. For example, the unemployed, the medically underserved, and the medically indigent within the channels may have limited exposure to smoking prevention and control messages. Such smokers may be more successfully reached through interventions that are directed toward the general public and that occur in public places.

2. Not all smokers are members of groups identified to be targets of intensive intervention. For example, the largest number of smokers in the United States are white males between the ages of 35 and 64. Although some of these smokers may be targeted for intervention as members of one or another of the target groups of smokers, many will not be reached directly. Interventions delivered through the community environment will reach smokers not specifically identified as target groups.

3. One of the goals of a comprehensive smoking prevention and control initiative is to strengthen social norms and values supporting nonsmoking. The persistent and inescapable presence of cues and messages supporting these norms in public places in the community educates and motivates both smokers and nonsmokers to support nonsmoking.

The community environment is similar to other channels for smoking prevention and control in that it refers to a set of institutionalized structures through which smoking-related interventions can reach smokers in particular and the public in general. Media, policy, and program services interventions must all have a strong presence in the community environment in a comprehensive initiative.

The community environment is different from the other channels in that the kinds of structures available to be used for interventions are more heterogeneous and less organized; therefore, the interventions that take place via this channel may be more diverse. For example, the goal of reducing the number of prosmoking cues in the community environment can be accomplished through the regulation of billboard advertising, the institution of well-publicized policies restricting smoking in public places, and curtailing the influence of tobacco-related sponsorship and promotion of sporting and cultural events. The site assessment and planning for intervention through this channel must incorporate the unique characteristics, norms, and opportunities within the site to develop an appropriate long-term plan to achieve channel-specific goals.

Goals

- Reduce the number of prosmoking cues and messages in the community environment, including smoking in public places, cigarette advertising, tobacco-sponsored sporting and cultural events, and the widespread availability and affordability of cigarettes.

- Increase the number of cues and messages supporting nonsmoking in the community environment, including the strategic use of planned media campaigns to promote nonsmoking, quick and effective response to tobacco- and smoking-related news events to present the nonsmoking point of view in the media, and the highly visible promotion of available program services in public places throughout the community.

Recommended Activities

- Identify smoking and nonsmoking cues and messages.

- Identify systems, organizations, and forces that support and perpetuate these cues and messages.

- Identify and enlist relevant groups and individuals with an interest in specific changes in the community environment to advise and participate.

- Develop a long-term strategic plan to increase messages and cues supporting nonsmoking and to decrease messages and cues promoting smoking. This plan must include:

  --Planned media campaigns.

  --Promotion of community-wide magnet events.

  --Public and private policy initiatives.

  --Promotion of available program services.

  --Media advocacy by people who can speak for their community on specific smoking-related issues.

CHANNEL ACTIVITIES AND STRATEGIES

THE HEALTH CARE SYSTEM

Recommended Activities

1. Develop and maintain a group of health care providers who will train other providers in smoking cessation and prevention techniques.

2. Train influential local health care providers to serve as local smoking control advocates and community resources.

3. Educate health care providers about the health effects of smoking and smoking interventions (1 hour).

4. Provide an opportunity for more intensive education of health care providers in smoking cessation interventions (3 to 4 hours).

5. Maintain health care provider involvement in smoking control.

6. Establish nonsmoking policies in health care facilities and organizations.

7. Provide self-help materials and promote available program services through all media within health care settings.

Required Planning Information

- Names, addresses, and telephone numbers of health care providers by specialty.
- Names, addresses, and telephone numbers from health care providers' organizations.
- Names, addresses, telephone numbers, and contact persons from health care facilities.
- Names, addresses, telephone numbers, and contact persons of postsecondary health care schools, including medical, public health, nursing, and vocational schools.
- Names, addresses, and telephone numbers of health care settings with nonsmoking policies, including information about the restrictiveness of each policy.
- Names, addresses, telephone numbers, and contact persons for all media available through local health care settings.

- List of proven smoking control, smoking policy, and smoking advocacy training programs (1 hour and 3 to 4 hours), including information about procedures for and cost of obtaining all materials necessary for implementation.

- List of locally available smoking cessation materials, including procedures for and cost of obtaining materials.

Definition of Primary and Secondary Health Care Providers

To deliver a comprehensive smoking control intervention through the health care system, two groups of health care providers should be identified. The primary group includes primary care physicians (family and general practitioners, obstetricians, gynecologists, internists, and pediatricians), primary care dentists, nurses, pharmacists, physicians' assistants, and all staff working with these providers. The secondary group includes all other health care providers who can reach particular groups of smokers effectively.

Activity 1

Develop and maintain a group of health care providers who will train other providers in smoking cessation and prevention techniques.

Description

Primary identified health care providers who will provide training programs in their communities for their colleagues should attend a workshop designed to develop knowledge and skills in:

- Providing effective smoking cessation and prevention interventions within health care settings.

- Establishing smoke-free office environments and office procedures for screening and monitoring patients who smoke.

- Recruiting and training health care providers to become involved in smoking control.

- Organizing additional training sessions.

- Leading a session, with emphasis on intervention strategies (e.g., role playing) and providing feedback.

- Using smoking cessation resources and services appropriately.

High priority should be given to developing these skills among health care providers within each local community throughout the site.

Suggested Strategies

- Motivate professional organizations to adopt and implement an ongoing program of training for their memberships.
- Use existing training programs that have proven effective.
- Promote training programs through appropriate health care media.
- Formally recognize leadership in implementing training activities and completing training.
- Consider providing incentives for prominent health care providers who participate in training and/or training maintenance programs.

Optimal Level of Activity

- Efforts to train health care providers in the primary identified group should be concentrated in the first 2 years of a 5-year program. At the end of 2 years, one trainer should be trained for each specialty in the target group, and within each specialty there should be at least one trainer for every 50 targeted health care providers.
- Efforts to train health care providers in the secondary group should be initiated when it is clear that a major group of smokers will not be reached by the primary group but can be reached through the secondary group.

Tracking Measures

- Number of health care providers in each specialty of the primary target group trained as trainers.
- Number of health care providers in each specialty of the secondary target group trained as trainers.

Activity 2

Train influential local health care providers to serve as local smoking control advocates and community resources.

Description

Identify, recruit, and train influential health care providers to serve as resources to their communities. Provide them with an indepth knowledge of smoking issues and enable them to serve as community resources on a wide

range of smoking control issues. This training should provide the motivation, knowledge, skills, and ongoing support for these local leaders to become advocates within the community. These health care providers may or may not be the same individuals trained as trainers under activity 1.

Suggested Strategies

- Recruit and train a network of health care providers in each community.
- Train network members in media strategies, testimony presentation, and smoking control advocacy.
- Maintain contact with trained health care providers and supply them with information about scientific and policy developments and smoking control events to enable them to maintain their role as smoking control experts in the community.
- Encourage media coverage of role models' activities in smoking control.
- Ensure that community role models are appropriately identified in the media as local resources.
- Ensure that trained role models are knowledgeable about locally available smoking cessation resources and services.

Optimal Level of Activity

- By the end of 2 years, one influential health care provider should be trained per community of 50,000.
- By the end of 3 years, three influential health care providers should be trained per major media market.

Tracking Measure

- Number of health care providers trained.

Activity 3

Educate health care providers about the health effects of smoking and smoking cessation interventions (1 hour).

Description

Provide brief presentations to health care providers to increase their knowledge of available smoking cessation interventions. These presentations

should seek to enhance the efficacy of smoking cessation interventions delivered by health care providers and to motivate health care providers to deliver interventions more frequently. Presentations should be made at local grand rounds, professional society meetings, hospital departmental meetings, and similar community health care setting events. At a minimum these presentations should include:

- Scientific basis for minimal tobacco intervention as a standard of practice.
- Motivation of health care providers to become involved in smoking cessation, including the health benefits of cessation.
- The importance of keeping records of smoking status and smoking history as well as creating an office environment that supports cessation.
- Brief summary of provider-delivered intervention strategies.
- Identification of factors that interfere with abstinence and guidelines for maintaining abstinence.
- Development of effective clinical skills for delivering smoking interventions.
- Information about locally available smoking cessation resources and services.

Suggested Strategies

- Enlist health care providers who have completed the smoking control training program as speakers.
- Approach major health care provider organizations to solicit support for training targeted providers at local grand rounds, professional society meetings, hospital departmental meetings, and similar community health care setting events.
- Develop strategies for institutionalizing training in smoking cessation and prevention within postsecondary health care schools (e.g., medical, nursing, pharmacy, and dental schools).
- Expand the target audience for presentations at the local level to include licensed practical nurses, nursing home workers, community health nurses, visiting nurses, home health aides, respiratory therapists, and other locally identified groups.

- Arrange for appropriate Continuing Medical Education (CME) and Continuing Education Credit (CEC) for health care providers who attend smoking control presentations.

- Provide formal recognition for individuals who complete smoking control education.

- Solicit endorsement and cosponsorship of education program by health care provider societies and organizations, especially local medical societies, specialty organizations, residency programs, and medical and other health professional schools.

Optimal Level of Activity

- By the end of 5 years, 80 percent of all health care providers in both the primary and secondary target groups will have been trained.

Tracking Measure

- Number of trained health care providers in both the primary and secondary target groups.

Activity 4

Provide an opportunity for more intensive education of health care providers in smoking cessation interventions (3 to 4 hours).

Description

Conduct half-day workshops for health care providers interested in substantially increasing their knowledge about and skills in delivering smoking cessation interventions. Education should build on the content of less intensive education programs (activity 3) and should conform to NCI guidelines for intensive training. For example, training should include practice in delivering smoking intervention counseling. Additional elements include:

- An overview of cessation techniques intended to increase knowledge of smoking intervention counseling.

- Training (through videos, slides, and practice) to increase skills for smoking intervention counseling.

- Materials (e.g., record cards, patient materials) that increase the frequency of cessation interventions, including screening and monitoring smoking patients, assessing readiness for cessation, gathering smoking history and previous cessation attempts, providing personalized planning and suggestions, expressing concern regarding

patients' smoking habits and offering to help, assisting patients in setting a stop-smoking date, providing print resources, referring patients to other sources of help, offering pharmacologic therapy, and offering continuing support.

- Information about locally available smoking cessation resources and services.

Suggested Strategies

- Use health care providers who have completed the smoking control training program.
- Include audiovisual and slide presentations in the program format.
- Provide sample materials for use in health care settings as well as information about how to obtain additional materials.
- Emphasize the importance of incorporating strategies for smoking cessation into everyday practice.
- Invite providers who have successfully incorporated smoking control into their practices to describe the transition.
- Delineate roles for clinical office staff.
- If smoking training is to be presented within a broader chronic disease prevention training program, ensure that at least 2 to 3 hours of the program are devoted to smoking.
- Arrange for appropriate CME and CEC for health care providers who attend the intensive education program.
- Solicit endorsement and cosponsorship of the intensive smoking control education program from health care provider societies and organizations, especially local medical societies, specialty organizations, residency programs, and medical and other health professional schools.
- Ensure that professionals are trained in social service agencies that serve low-income populations (e.g., Women, Infants, and Children (WIC) programs, family planning providers, and maternal and child health (MCH) programs).

Optimal Level of Activity

- By the end of 5 years, 25 percent of all health care providers in the primary group will have been trained.

Tracking Measure

- Number of trained health care providers in both the primary and secondary groups.

Activity 5

Maintain health care provider involvement in smoking control.

Description

Develop a program of regular contact with health care providers' offices to maintain their involvement in smoking control. This program should:

- Facilitate screening, treatment, monitoring, and tracking of smokers by health care providers.
- Facilitate frequent distribution of self-help materials to smoking patients by health care providers.
- Motivate and provide resources for office staff to create nonsmoking offices.

Suggested Strategies

- Develop a newsletter or similar regular mailing to keep the smoking issue alive and to provide information on available materials and smoking cessation and prevention strategies.
- Offer a variety of print materials appropriate for use by health providers and smokers.
- Make available and promote to health care providers a system of telephone and onsite consultation by smoking control experts available in the site.
- Offer opportunities for advanced training in smoking control techniques.

Optimal Level of Activity

- All health care providers should be contacted with additional information about smoking cessation and prevention at least 1 month after training, 6 months after training, and twice annually thereafter.

Tracking Measure

- Number and frequency of contacts to health care providers.

Activity 6

Establish nonsmoking policies in all health care facilities and organizations.

Description

Encourage local health care facilities and organizations to adopt strong nonsmoking policies. Health care facilities include hospitals, private and public clinics, physicians' and dentists' offices, HMO's, and health care training institutions. Creation of smoke-free health care facilities and organizations is a logical extension of measures designed to protect the public health and is consistent with the image health care institutions should have within the community. Influential health care providers should be recruited to promote nonsmoking policies throughout the community, including giving presentations to hospital administrators, facility managers, public officials, and other decisionmakers. Presentations should include information about the benefits of such policies and the methods for their successful implementation.

Suggested Strategies

- Identify influential health care providers who have completed the smoking control training program and provide further training as spokespersons to the health care community about the benefits of nonsmoking policies.

- Use influential health care providers who have completed the smoking control training program and have been specifically trained as spokespersons for their community.

- Conduct regional workshops for policymakers on the development and implementation of nonsmoking policies.

- Urge physicians and dentists to ban smoking in office waiting rooms and provide support for their efforts to implement such a ban.

- Contact nurses, therapists, physicians' assistants, dental hygienists, and other allied health providers to urge their assistance in establishing bans on smoking in their worksites.

- Contact administrators of hospitals, group practices, clinics, HMO's, nursing homes, and other health care facilities with information

about nonsmoking policies and provide assistance in implementing and enforcing nonsmoking policies.

- Contact independent pharmacists and pharmacy owners to encourage establishment of nonsmoking policies in their facilities.

- Contact state and local health care provider associations, societies, and organizations to request assistance in reaching individual members to urge them to advocate for nonsmoking facilities and adoption of a ban on smoking during all official meetings.

- Provide all interested health care providers and facilities with information about locally available smoking cessation and policy materials as well as local health care providers who have completed the smoking control training program.

- Provide media coverage of health care facilities that establish smoking policies.

Optimal Level of Activity

- By the end of 5 years, 90 percent of all targeted physicians and dentists will have implemented nonsmoking office policies for both staff and patients.

- By the end of 5 years, 80 percent of all health care-related systems and facilities will have adopted nonsmoking policies.

Tracking Measures

- Number of policy training programs conducted.

- Number of health care providers participating in policy training programs.

- Number of health care-related systems and facilities that have adopted nonsmoking policies.

Activity 7

Provide self-help materials and promote available program services through all media within health care settings.

Description

Make smoking cessation materials readily available (self-help manuals, pamphlets, information about nicotine gum, buttons, and signs). Availability of these materials in health care settings should be publicized. Liaisons

between voluntary agencies, smoking cessation program providers, and health care facilities should be created and expanded to provide health care facilities with necessary materials and information.

Suggested Strategies

- Promote use of available smoking cessation materials and services.
- Match smoking cessation strategies and informational materials to the target population.
- Reach employee dependents with smoking cessation services and materials through health care settings.
- Promote availability of materials and community services through policy workshops and presentations.
- Enlist appropriate health care providers and their staffs to assist in implementation.
- Promote use of the telephone hotline as a smoking cessation tool.

Optimal Level of Activity

- By the end of 5 years, 100 percent of health care facilities will be contacted at least twice with an offer of materials and advice about available cessation services.
- By the end of 5 years, 90 percent of all identified media in health care settings will have presented information about smoking cessation resources and services.

Tracking Measures

- Number of health care facilities contacted.
- Number of health care media presenting information about smoking cessation resources and services.

WORKSITES

Recommended Activities

A. Policy-related activities.

1. Develop and maintain a group of individuals trained to serve as smoking control resources on worksite smoking issues.

2. Provide smoking control policy presentations to business organizations and unions (1 hour).

3. Provide smoking control policy workshops to representatives of business organizations and unions (3 to 4 hours).

4. Promote the implementation of stop-smoking incentives among worksites with high proportions of employees who smoke.

B. Activities directed toward smokers.

1. Promote participation in smoking or health-related magnet events.

2. Deliver smoking education in the worksite.

3. Promote use of local smoking cessation services and provide support for local smoking cessation services using all media available within the worksite.

Required Planning Information

- Names, addresses, and telephone numbers of all worksites with more than 50 employees by occupation and/or industry.
- Proportion of community workers employed in worksites with fewer than 50 employees.
- Names, addresses, telephone numbers, and contact persons of companies employing significant numbers of targeted smokers.
- Names, addresses, telephone numbers, and contact persons of business organizations, service clubs, unions, and professional human resource and personnel organizations.
- Names, addresses, telephone numbers, and contact information for worksite consultants and trainers.
- Legislation and/or regulations governing worksite smoking policies within the site.
- Names, addresses, and telephone numbers of all worksites with nonsmoking policies, including information about the restrictiveness of each policy.
- Names, addresses, telephone numbers, and contact persons for all media available through local worksites.

- List of proven smoking control, smoking policy, and smoking advocacy training programs (1 and 3 to 4 hours), including information about procedures for and cost of obtaining all materials necessary for implementation.

- List of locally available smoking cessation materials, including procedures for and cost of obtaining materials.

Worksite Policy-Related Activities

Activity A1

Develop and maintain a group of individuals trained to serve as smoking control resources on worksite smoking issues.

Description. Establish a network of speakers in each community who can make presentations on workplace smoking issues and policies to local organizations and businesses. These speakers should be recognized community leaders, local health care providers, or volunteers from local voluntary health organizations.

Suggested Strategies.

- Promote existing local programs that train activists to be effective worksite resources in the development of nonsmoking policies through appropriate community media.

- Tailor presentations to the unique characteristics of the audience and worksites and address factors such as business size, labor relations, and local ordinances.

- Use existing training programs that have been proven effective.

- Motivate local organizations to adopt and implement a program of training for their memberships.

- Formally recognize leadership in implementing training activities and completion of training.

- Consider providing incentives for individuals who participate in training programs.

Optimal Level of Activity.

- By the end of 2 years, one trainer should be trained for every 20 businesses with more than 50 employees.

- By the end of 2 years, one influential individual should be trained per community of 50,000.

- By the end of 2 years, three influential individuals should be trained per major media market.

Tracking Measure.

- The number of individuals trained.

Activity A2

Provide smoking control presentations to business organizations and unions (1 hour).

Description. Make nonsmoking policy presentations to groups of individuals who are in a position to set and enforce nonsmoking policies, including health promotion coalitions of businesses, Chambers of Commerce, service clubs, unions, and professional human resources and personnel organizations. Presentations should be designed to raise awareness about smoking-related health concerns, legal issues, and national and local trends in nonsmoking policies as well as policy and program services. Presentations should emphasize what worksites and individuals can do to control smoking.

Suggested Strategies.

- Enlist individuals who have completed nonsmoking policy training program as speakers.

- Identify and recruit individuals to be trained in presenting nonsmoking policies.

- Promote nonsmoking policy presentations to local business organizations and unions through appropriate local media.

- Tailor presentations to audience and business characteristics.

- Support presentations with information and materials tailored to business perspectives.

- Provide followup support within 1 month of each presentation to offer further assistance or materials as needed.

- Provide incentives for worksites to implement a total ban on smoking in the worksite.

- Arrange for appropriate media coverage before and after presentations.

Optimal Level of Activity.

- By the end of 5 years, 90 percent of primary identified worksites will receive at least one presentation.

Tracking Measure.

- Number of presentations to businesses with 50 or more employees and professional and business organizations.

Activity A3

Provide smoking control policy workshops to representatives of business organizations and unions.

Description. Provide detailed information about smoking control policies and issues by conducting workshops for audiences representing many community businesses. These workshops should provide businesses with an understanding of the rationale for smoking restrictions, including information about the health effects of smoking, laws and regulations about smoking, and options for restricting smoking. Workshops also should provide information about the steps involved in developing and implementing smoking restrictions in the workplace.

Suggested Strategies.

- Enlist individuals who have completed the nonsmoking policy training program as speakers.
- Promote nonsmoking policy workshops among identified worksites, coalitions, and groups of smaller worksites through appropriate community media.
- Provide examples of local businesses that have successfully implemented nonsmoking policies.
- Give local successes and issues prominent attention throughout the worksite and in the public media.
- Address the unique requirements of all local businesses, large and small, by scheduling separate workshops if appropriate.
- Include local community experts as well as outside experts and trainers as workshop speakers.
- Promote locally available smoking cessation resources.

- Promote available policy development and implementation consulting services.

Optimal Level of Activity.

- In each of the 5 years of intervention, every targeted worksite will have access to a smoking control policy workshop at least once each year.

Tracking Measures.

- Number of workshops conducted.
- Number of workshop participants.

Activity A4

Promote the implementation of stop-smoking incentives among worksites with high proportions of employees who smoke.

Description. Encourage smoking cessation and support continued abstinence among employees through use of financial or related benefits. Offer employers information about the value of incentive programs as well as guidelines for structuring incentive programs, including information about ensuring fairness with nonsmokers and the range of possible incentives (e.g., cash, health or life insurance premium discounts, contests and lotteries, vacation packages).

Suggested Strategies. Encourage employers to:

- Identify incentives of proven efficacy.
- Reward nonsmokers with incentives.
- Include stop-smoking incentives in all written company benefits materials where appropriate.
- Promote stop-smoking incentives through all available worksite media (e.g., employee newsletters, payroll enclosures, posters).
- Implement smoking control contests that include smokers and nonsmokers and include cessation followup activities to maintain smoking abstinence.

Optimal Level of Activity.

- Information about incentives will be included in 100 percent of all nonsmoking policy worksite presentations.

- Information about incentives will be included in all communications with identified worksites in which other program services are promoted.

Tracking Measures.

- Records of smoking policy presentations and contacts to offer program services.
- Number of nonsmoking policy consultations that include information about incentives.

Worksite Activities Directed Toward Smokers

Activity B1

Promote participation in smoking or health-related magnet events.

Description. Extensively promote magnet events such as the Great American Smokeout, Community Health Fairs, and Non-Dependence Day to increase participation in worksite and community-wide smoking cessation programs.

Suggested Strategies.

- Identify magnet events.
- Create company-specific events.
- Work with local voluntary health agencies to maximize worksite participation in magnet events and provide incentives to participate.
- Encourage media coverage of worksite magnet events, emphasizing smoking control activities.
- Use magnet events to promote available smoking cessation services in the community.
- Implement worksite smoking restrictions to coincide with magnet events.
- Implement smoking restrictions at magnet events.
- Provide followup services and consultation for smokers and companies who participate in magnet events.

Optimal Level of Activity.

- By the end of 5 years, 90 percent of all identified worksites will participate in at least three magnet events.
- By the end of 5 years, 50 percent of all worksites with fewer than 50 employees will participate in at least three magnet events.

Tracking Measure.

- Number of primary and secondary worksites participating in magnet events.

Activity B2

Deliver smoking education in the worksite.

Description. Provide smoking education to both smokers and nonsmokers. Smoking education should be an important part of a worksite health promotion program and should address the health risks of tobacco smoke, benefits of quitting, and available smoking cessation services.

Suggested Strategies.

- Include in the presentations a discussion of the health effects of tobacco smoke for the smoker and nonsmoker, benefits of smoking cessation, and available smoking cessation methods and resources.
- Schedule presentations to be convenient for employees.
- Promote presentations through appropriate worksite media.
- Have representatives from voluntary organizations or health care providers make presentations if possible.
- Include smoking presentations in all worksite health education programs and screenings.
- Provide information about the location of local smoking information sources, local cessation services, and their costs.
- Promote the availability of self-help and other smoking-related material in the company through appropriate worksite media and promotion.

Optimal Level of Activity.

- By the end of 5 years, 100 percent of the primary identified worksites will have conducted at least two smoking education presentations.

- By the end of 5 years, 50 percent of the secondary identified worksites will have conducted at least two smoking education presentations.

Tracking Measures.

- Number of primary identified worksites in which smoking education presentations have been conducted.

- Number of secondary identified worksites in which smoking education presentations have been conducted.

Activity B3

Promote use of local smoking cessation services and provide support for local smoking cessation services using all media available within the worksite.

Description. Make smoking cessation materials readily available (self-help manuals, pamphlets, information about nicotine gum, and buttons and signs). Availability of these materials at worksites should be promoted through all worksite media. Liaisons between voluntary agencies, smoking cessation program providers, and schools should be created and expanded to provide worksites with necessary materials and information.

Suggested Strategies.

- Promote use of available smoking cessation materials and services through all available worksite media.

- Match smoking control strategies and informational materials to the target populations.

- Reach dependents and retirees with smoking cessation services and materials through worksites.

- Promote availability of materials and community services through policy workshops, presentations, and worksite communications (e.g., newsletters).

- Promote use of the telephone hotline as a smoking cessation tool.

Optimal Level of Activity.

- By the end of 5 years, 100 percent of primary identified worksites will have been contacted at least twice with an offer of materials and advice about available cessation services and the promotion of those services.

- By the end of 5 years, 100 percent of all identified worksite media will have presented information about smoking cessation resources and services.

Tracking Measures.

- Number of worksites contacted.

- Number of worksite media presenting information about smoking cessation resources and services.

SCHOOLS

Recommended Activities

1. Identify, recruit, and train influential representatives from school systems and school-related groups to serve as local smoking control resources for schools.

2. Provide smoking prevention and control presentations to school boards, PTA's, teacher and staff unions, and other school-related groups.

3. Aid in establishing smoke-free policies in all schools.

4. Implement state-of-the-art smoking prevention curriculums in all schools.

5. Provide self-help materials and promote available program services through all media available within schools.

Required Planning Information

- Names, addresses, telephone numbers, and descriptions of schools (e.g., size, type, other relevant identifying characteristics).

- Names, addresses, and telephone numbers of influential representatives from school systems and school-related groups.

- Names, addresses, and telephone numbers of school health nurses, drug counselors, and other school staff appropriate to assist in providing and promoting smoking prevention curriculums.

- Identification of schools meeting primary target group criteria.

- Current status of health education curriculums and smoking cessation and smoking policies in identified schools.

- Identification of school-based and school-related organizations (PTA's, school board associations, staff and teachers unions, etc.).

- List of available, proven smoking prevention curriculums, including information about procedures for and cost of obtaining all materials necessary for implementation.

- List of proven school smoking control, smoking policy, and smoking advocacy resource training programs (1 and 3 to 4 hours), including information about procedures for and cost of obtaining all materials necessary for implementation.

- Names, addresses, telephone numbers, and contact persons for all media available within school settings and related organizations.

- List of locally available smoking prevention and cessation materials appropriate for schools, including procedures for and cost of obtaining materials.

Activity 1

Identify, recruit, and train influential representatives from school systems and school-related organizations to serve as local smoking control resources for schools.

Description

Recruit and train school-related representatives to provide knowledge about the health effects of smoking and other smoking issues and to enable them to serve as a resource to schools on a wide range of smoking prevention and control issues. Training should provide the motivation, knowledge, skills, and ongoing support for these local leaders to become smoking prevention and control educators and advocates for schools in their communities.

Suggested Strategies

- Recruit a network of influential school-related leaders.
- Educate school leaders to knowledgeably represent smoking prevention and control issues to their constituencies and other school-related groups.
- Educate leaders to represent smoking prevention and control issues to the media.
- Use existing training programs that have proven effective.
- Maintain contacts with these leaders and supply them with information about policy and scientific developments and site-specific smoking control events to enable them to maintain their role as smoking control experts within the community.
- Encourage media coverage of leaders' activities in smoking control.
- Ensure that community leaders are appropriately identified as local resources in the media.
- Ensure that trained leaders are knowledgeable about locally available smoking cessation resources and services.

Optimal Level of Activity

- By the end of 2 years, one influential school leader should be trained per community of 50,000.
- Each leader will be contacted at least twice annually with new information about smoking control and offers of support.

Tracking Measures

- Number of school leaders trained.
- Record of contacts with trained leaders.

Activity 2

Provide smoking prevention and control presentations to school boards, PTA's, teacher and staff unions, and other school-related groups.

Description

Make presentations to groups of and individual school officials who can set and enforce nonsmoking policies. This includes professional teachers' organizations, school unions, school boards, PTA's, school counselors, school nurses, and others. Presentations should be designed to raise awareness about smoking-related health concerns, school smoking problems, legal issues, national and local trends in nonsmoking policies, and locally available program services.

Suggested Strategies

- Enlist individuals who have completed school smoking resource training programs as speakers.
- Identify and recruit individuals to be trained to give nonsmoking policy presentations.
- Promote nonsmoking policy presentations to officials of schools and school-related organizations through appropriate local media.
- Tailor presentations to audience and school characteristics.
- Support presentations with materials tailored to school-related issues.
- Provide followup support within 1 month of each presentation to offer further assistance as needed.
- Provide incentives for schools to implement a total ban on smoking.
- Arrange for appropriate media coverage before and after presentations.

Optimal Level of Activity

- By the end of 5 years, 90 percent of identified school-related organizations will receive at least one presentation.

Tracking Measure

- Number of presentations to school organizations.

Activity 3

Aid in establishing smoke-free policies in all schools.

Description

Provide assistance to schools implementing nonsmoking policies. Ensure that restrictions on use of smokeless tobacco are included in these policies. Policies should ultimately seek a total smoking ban on school grounds. Policies may be implemented in stages depending on current school policies and attitudes (e.g., gradually prohibit all student smoking, then smoking in teachers' and staff lounges, followed by smoke-free buildings and finally, smoke-free school grounds).

Suggested Strategies

- Identify school-based policies and their level of effectiveness in reaching the goal of establishing smoke-free schools.
- Enlist individuals who have completed the school smoking resource training program as speakers.
- Identify local consultants who can provide hands-on consultation about nonsmoking policies.
- Contact state and local school associations and unions to solicit their assistance in establishing smoking bans in their schools.
- Ensure that the promotion of drug-free school policies includes information regarding tobacco use.
- Provide information to all interested school personnel about locally available smoking cessation and policy materials as well as local school leaders who have completed the smoking control training program.
- Provide media coverage of schools and school-related organizations that establish smoking policies.

Optimal Level of Activity

- By the end of 5 years, 100 percent of primary target schools will have policies that restrict smoking.
- By the end of 5 years, 90 percent of primary target schools will have policies that prohibit smoking on all school property.

Tracking Measures

- Number of identified schools with policies that restrict smoking.
- Number of identified schools with policies that ban smoking on school grounds.

Activity 4

Implement state-of-the-art smoking prevention curriculums in schools.

Description

Provide training for school personnel and curriculum materials to ensure that effective smoking prevention curriculums are implemented. At a minimum, smoking prevention curriculums should meet NCI guidelines. In some cases, funding for purchase of smoking curriculum materials will need to be obtained. Curriculums may be presented either as part of a comprehensive school health education program or independently, depending on the school's needs and the approach most likely to ensure that adequate attention is given to smoking prevention. The smoking prevention curriculums selected and their implementation should be supported by the entire school system.

Suggested Strategies

- Review current school health curriculums to make sure that smoking prevention components are included and that these components meet NCI guidelines.
- Train teachers in the proper use of the curriculums.
- Enlist support for the curriculums selected and their implementation by the entire school system by involving diverse teacher and parent interest groups.
- Provide continuing support for supplying and updating materials.

Optimal Level of Activity

- By the end of 5 years, 90 percent of identified schools will have implemented state-of-the-art smoking prevention curriculums, as defined by NCI consensus, either as an independent program or within a comprehensive health education program.

Tracking Measure

- Number of identified schools that have implemented smoking prevention curriculums or components.

Activity 5

Provide self-help materials and promote available program services through all media available within the schools.

Description

Make smoking cessation materials readily available (self-help manuals, pamphlets, information about nicotine gum, buttons, and signs). Availability of these materials at the school should be publicized. Liaisons between voluntary agencies, smoking cessation program providers, and schools should be created and expanded to provide schools with necessary materials and information.

Suggested Strategies

- Promote use of available smoking cessation materials and services.
- Match smoking cessation strategies and informational materials to the target population.
- Reach parents and dependents with smoking cessation services and materials through schools.
- Promote availability of materials and community services through policy workshops and presentations.
- Enlist school health nurses, drug counselors, and other appropriate staff members to assist in implementation.
- Promote use of the smoking telephone hotline as a cessation tool.

Optimal Level of Activity

- By the end of 5 years, 100 percent of targeted schools will be contacted at least twice with an offer of materials and advice about available cessation services.
- By the end of 5 years, 90 percent of all identified school-related media will have presented information about smoking cessation resources and services to students, faculty, and staff.

Tracking Measures

- Number of target schools contacted.

- Number of school-related media presenting information about smoking cessation resources and services.

COMMUNITY NETWORKS

Recommended Activities

1. Train influential network members to serve as local smoking control role models and community resources.

2. Provide smoking control policy presentations to community networks and organizations.

3. Provide smoking control policy workshops for representatives of community networks and organizations.

4. Promote participation by community networks in smoking and health-related magnet events.

5. Provide self-help materials and promote available program services through all types of media used by each community network.

Required Planning Information

- Names, addresses, telephone numbers, contact persons, and descriptions (including smoking policy information) of formal and informal community networks with the potential to address smoking prevention and control issues and to reach target groups of smokers through their constituencies or memberships.

- Names, addresses, telephone numbers, and contact persons for all media available through community networks.

- List of smoking control, smoking policy, and smoking advocacy training programs that have proven effective.

- List of available smoking materials, including local hotlines.

Activity 1

Train influential network members to serve as local smoking control role models and community resources.

Description

Recruit and train influential members of networks to provide knowledge about the health effects of smoking and other smoking issues. These people

should serve as role models for other networks and as community resources on a wide range of smoking control issues. Training should provide the motivation, knowledge, skills, and ongoing support for these local leaders to become smoking cessation and prevention educators and advocates within the community.

Suggested Strategies

- Recruit a network of influential community network members.
- Educate them to knowledgeably represent smoking prevention and control issues to their constituencies and other organizations.
- Train network members to effectively represent smoking control issues to the media.
- Use existing training programs that have proven effective.
- Maintain contact with trained network members and supply them with information about policy and scientific developments and site-specific smoking control events to enable them to maintain their role as a smoking control expert in the community.
- Encourage media coverage of network leaders' activities in smoking control.
- Ensure that network leaders are appropriately identified as local resources for the media.
- Ensure that trained leaders are knowledgeable about locally available smoking cessation resources and services.

Optimal Level of Activity

- By the end of 2 years, one influential network representative should be trained for each community of 50,000.
- Each trained representative should be contacted at least twice annually with updated information and offers of support.

Tracking Measure

- Number of influential network representatives trained.

Activity 2

Provide smoking control policy presentations to community networks and organizations.

Description

Make presentations at network meetings or to appropriate network representatives. Presentations should be designed to raise awareness about smoking-related health concerns, legal issues, and national and local trends in nonsmoking policies but should focus mainly on information about what actions the group and individuals can take to prevent and control smoking.

Suggested Strategies

- Recruit and train individuals to give nonsmoking policy presentations.
- Enlist as trainers those individuals who have been prepared to serve as the smoking control resources for community networks.
- Promote nonsmoking policy presentations to local community networks through appropriate local and community media.
- Tailor presentations to audience and network characteristics.
- Support presentations with information and materials tailored to network perspectives.
- Provide followup support within 1 month of each presentation to offer further assistance as needed.
- Provide incentives for community groups to implement a total ban on smoking at their meetings.
- Arrange for appropriate media coverage before and after presentations.

Optimal Level of Activity

- By the end of 5 years, 75 percent of all identified community networks will have received at least one presentation.

Tracking Measure

- Number of presentations made to community networks.

Activity 3

Provide smoking control policy workshops for representatives of community networks and organizations.

Description

Provide detailed information about smoking control policies and issues by conducting workshops for audiences representing many community networks in a conference setting. Workshops should provide organizations with an understanding of the rationale for smoking restrictions, including information about the health effects of smoking for smokers and nonsmokers and laws and regulations about smoking and options for restricting smoking. Workshops should also provide information about the steps involved in developing and implementing smoking restrictions.

Suggested Strategies

- Enlist individuals who have been trained as smoking control resources for community networks to serve as speakers.
- Recruit and train individuals to give nonsmoking policy workshops.
- Promote nonsmoking policy workshops among identified community networks through appropriate local media.
- Provide examples of local community groups that have successfully implemented nonsmoking policies.
- Give prominent media attention to local successes and issues.
- Address the unique requirements of all local community groups by scheduling separate workshops, as appropriate.
- Include local community leaders as well as outside experts and trainers as workshop speakers.
- Introduce network representatives to and promote the use of community smoking prevention and cessation resources and services.

Optimal Level of Activity

- By the end of 5 years, every identified network will have access to a smoking control policy workshop at least once per year.
- In each year of a 5-year program, at least one workshop or seminar will be held annually in every major metropolitan area.

Tracking Measures

- Number of workshops conducted.
- Number of workshop participants.

Activity 4

Promote participation by community networks in smoking or health-related magnet events.

Description

Extensively promote magnet events such as the Great American Smokeout, community health fairs, and Non-Dependence Day to increase awareness of smoking issues and participation in community-wide smoking cessation programs.

Suggested Strategies

- Identify magnet events.
- Create network-specific events.
- Encourage voluntary health agencies to maximize network participation in magnet events.
- Encourage media coverage of worksite magnet events, emphasizing smoking control activities.
- Use magnet events to promote available smoking cessation services in the community.
- Implement network smoking restrictions to coincide with magnet events.
- Provide followup services and consultation for smokers and organizations who participate in magnet events.

Optimal Level of Activity

- By the end of 5 years, 50 percent of identified networks will have participated in a minimum of four magnet events.

Tracking Measures

- Number of networks participating in magnet events.

- Number of magnet events conducted.

Activity 5

Provide self-help materials and promote the use of available program services through all media used by each community network.

Description

Make available smoking cessation information and materials, including self-help pamphlets and manuals, information about nicotine gum, and buttons and signs. Availability of these materials at network meetings and activities should be publicized. Liaisons between community networks and existing local program services should be created and expanded to provide networks with a steady source of information and materials.

Suggested Strategies

- Assist networks in promoting smoking cessation materials and services through all available network media.
- Match smoking cessation strategies and informational materials to the target population.
- Reach dependents and retirees with smoking prevention and cessation services and materials through networks.
- Promote participation by smokers and nonsmokers.
- Develop and distribute information on available cessation services.
- Place information about available cessation services in network communications (e.g., newsletters).
- Schedule presentations about tobacco control and distribute self-help materials periodically at network meetings.
- Promote use of telephone hotline as a smoking cessation tool.

Optimal Level of Activity

- By the end of 5 years, 100 percent of identified networks will be contacted at least twice with an offer of materials and advice about available cessation services.
- By the end of 5 years, 90 percent of all identified media in network settings will have presented information about smoking cessation resources and services.

Tracking Measures

- Number of networks contacted.
- Number of network media presenting information about smoking cessation resources and services.

COMMUNITY ENVIRONMENT

Recommended Activities

1. Identify smoking and nonsmoking cues and messages.
2. Identify systems, organizations, and forces currently supporting and perpetuating these cues and messages.
3. Identify and enlist relevant groups and individuals with an interest in specific changes in the community environment to advise and participate.
4. Develop a long-term strategic plan to increase messages and cues supporting nonsmoking and to decrease messages and cues promoting smoking. This plan must include:
   a. Planned media campaigns.
   b. Promotion of community-wide magnet events.
   c. Public and private policy initiatives.
   d. Promotion of available program services.

Required Planning Information

Because of the heterogeneous nature of the community environment as an intervention channel, it is difficult to specify the particular requirements for planning. The systematic observation and recording of billboard, transit, and print advertising; the clearly marked separation of smokers in restaurants, hotels, and other public places; and numbers and locations of cigarette vending machines all contribute to the place of smoking within the community environment.

Optimal Level of Effort

- 75-percent reduction from baseline in cues and messages supporting smoking within 5 years.
- 75-percent increase from baseline in cues and messages supporting nonsmoking within 5 years.

December 12, 1989

RECOMMENDED RESOURCES

Media

1. Flay BR. Mass media and smoking cessation: a critical review. Am J Public Health 1987;77:153-9

2. Flay, BR. Selling the smokeless society: 56 evaluated mass media programs and campaigns worldwide. Washington, DC: American Public Health Association, 1987

3. Office of Cancer Communications, National Cancer Institute, National Institutes of Health. Making health communication programs work--a planner's guide. NIH publication no. 89-1493, April 1989. Building 31, Room 4B43, Bethesda, Maryland 20892. Free. 1-800-CANCER

4. Office of Cancer Communications, National Cancer Institute, National Institutes of Health. Media strategies for smoking control--guidelines from a consensus workshop. Building 31, Room 10A24, Bethesda, Maryland 20892. Free. 1-800-4-CANCER

Policy

5. Institute for the Study of Smoking Behavior and Policy. The cigarette excise tax: April 17, 1985. Smoking Behavior and Policy Conference Series. Cambridge, Massachusetts: Harvard University, John F. Kennedy School of Government, 1985

6. Legislative Approaches to a Smoke-Free Society. Americans for Nonsmokers Rights.

7. Smoke Fighting. A Smoking Control Movement Building Guide, Michael Pertschuk, Allan Erickson and the Advocacy Institute Staff, 1987. Local ACS. Free

8. Smoke Signals. The Smoking Control Media Handbook, Michael Pertschuk, Allan Erickson and the Advocacy Institute Staff, 1987. Local ACS. Free

9. Taylor P. The smoke ring. New York: Mentor Books, 1985

10. US Public Health Service. The health consequences of involuntary smoking: a report of the Surgeon General. Washington, DC: US Department of Health and Human Services, 1986

11. US Public Health Service. Reducing the health consequences of smoking: 25 years of progress: a report of the Surgeon General. Washington, DC: US Department of Health and Human Services, 1989

12. Warner KE. Smoking and health implications of a change in the federal cigarette excise tax. JAMA 1986;255:1028-32

Program Services

13. Special issue: Cancer education and prevention in the schools. J School Health 1989;59(5). In particular, see Glynn TJ. Essential elements of school-based smoking prevention programs. 181-8

14. Glynn TJ, Boyd GM, Gruman JC. Essential elements of self-help/minimal intervention strategies for smoking cessation. Health Educ Q (in press)

15. Glynn TJ, Manley MW. How to help your patients stop smoking: a National Cancer Institute manual for physicians. Washington, DC: US Public Health Service, US Department of Health and Human Services, 1989; NIH publication no. 89-3064

16. Schwartz JL. Review and evaluation of smoking cessation methods: the United States and Canada, 1978-1985. Washington, DC: US Public Health Service, US Department of Health and Human Services, 1987; (NIH publication no. 87-2940)

17. Stein JA. The Cancer Information Service: evaluation of a large-scale telephone information program. Presented at the 1984 joint meeting of the Evaluation Research Society and the Evaluation Network

The Health Care System

18. American Cancer Society. Tobacco free young America, a guide for the busy practitioner. ACS, 1989

19. American Health Foundation. Stopping smoking: a nurse's guide. American Health Foundation, 320 East 43rd Street, New York, New York 10017, (212) 953-1900, 1989

20. American Hospital Association. Smoking and hospitals. AHA, Chicago, 1988

21. Cohen SJ et al. Helping smokers quit: a randomized controlled trial with private practice dentists. J Am Dent Assoc 1989;118:41-5

22. Glynn TJ, Manley MW. How to help your patients stop smoking: a National Cancer Institute manual for physicians. Washington, DC: US Public Health Service; 1989, NIH publication no. 89-3064

23. Knapp J et al. Clean air health care: a guide to establish smoke-free health care facilities. University of Minnesota, 1986

24. Minnesota Coalition for a Smokefree Society. Respiratory therapists guide

25. National Cancer Institute. Helping smokers quit: a guide for the pharmacist. Washington, DC: US Public Health Service; 1984, NIH publication no. 84-655

Worksites

26. The Bureau of National Affairs, Inc. Where there's smoke: problems and policies concerning smoking in the workplace. 1986. BNA's Customer Service Center, 9435 Key West Avenue, Rockville, Maryland 20850. $35 each. (800) 372-1033; Maryland (800) 352-1400; DC (202) 258-9401

27. Freimuth VS, Stein JA, Kean TJ. Searching for health information: the Cancer Information Service model. Philadelphia: University of Pennsylvania Press, 1989

28. Office of Disease Prevention and Health Promotion, US Public Health Service, US Department of Health and Human Services. A decisionmaker's guide to reducing smoking at the worksite. Summer 1985. Free. (202) 245-7611

29. Office of Disease Prevention and Health Promotion, US Public Health Service, US Department of Health and Human Services. National survey of worksite health promotion activities: a summary. Summer 1987. Free. (202) 245-7611

30. Washington Business Group on Health. Worksite wellness media report: reducing smoking at the workplace. Washington, DC: WBGH, 1987. 229 1/2 Pennsylvania Avenue, S.E., Washington, D.C. 20003. $15. (202) 547-6644

Schools

31. Best JA, Thomson SJ, Santi SM, Smith EA, et al. Preventing cigarette smoking among school children. Ann Rev Public Health 1988;9:161-201

32. Evans RI, Henderson AH, Hill PC, Raines E. Smoking in children and adolescents: psychosocial determinants and prevention strategies. In: US Department of Health and Human Services. Smoking and health: a report of the Surgeon General. Washington, DC: US Government Printing Office, 1979

33. Flay BR. Psychosocial approaches to smoking prevention: a review of findings. Health Psychol 1985;4:449-88

34. Special issue on cancer education and prevention in the schools. J School Health 1989;59(5). In particular, see Glynn TJ. Essential elements of school-based smoking prevention programs. 181-8

35. No smoking. A board member's guide to smoking policies for the schools. National School Boards Association, 1680 Duke Street, Alexandria, Virginia 22314. $3.50. (703) 838-6722

Community Networks

36. DePue JD, Wells BL, Lasater TM, Carleton, RA. Training volunteers to conduct heart health programs in churches. Am J Prev Med 1987;3:51-7

37. Lasater TM. COMMIT project: forming partnerships with religious organizations. 1988

38. Levin, JS. The role of the black church in community medicine. J Natl Med Assoc 1984;76:477-83

39. Winder AE. The mouse that roared: a case history of community organization for health practice. Health Educ Q 1985;353-63

APPENDIX B

Central ASSIST Resources

ASSIST is a demonstration project through which the most current knowledge of smoking prevention and control interventions will be applied in order to reach overall project goals. NCI will support the use of this knowledge by providing a wide variety of resources to be used by demonstration sites throughout the project. These central services and resources will be provided by the Coordinating Center to all ASSIST sites. Following is a preliminary description of the range and type of services expected to be provided to sites:

1. Training
   The following are possible topics for training:

   Phase I:

   i. Training for ASSIST demonstration site project managers in managerial and administrative contractual requirements.

   ii. Training for coalition representatives in the development and use of site analyses.

   iii. Training for coalition representatives in community organization and coalition development.

   iv. Training for coalition representatives to develop the smoking control plan.

   Phase II:

   v. Training for coalition representatives in the instruction of trainers of health professionals

   vi. Training for coalition representatives in the development of effective state-wide and regional prevention programs

   vii. Training for coalition representatives in the development of effective comprehensive worksite programs

   viii. Training for coalition representatives in the instruction of coalition members to deliver prevention programs

   ix. Training for coalition representatives in media advocacy

x. Training for coalition representatives in the instruction of coalition members in interacting with the press

xi. Training for coalition representatives in the instruction of coalition members to write for the media.

xii. Training for coalition representatives in the instruction of coalition members in smoking control advocacy.

The actual topics for training may vary once the training needs of coalitions are assessed.

2. Information Exchange Conferences

It is important that coalition members and staff in each site have the opportunity to share information with colleagues in other sites regarding their experiences relating to coalition organization and management and smoking control. NCI will hold conferences twice a year (fall and spring) in central locations, beginning in Month 8 of Phase I. For each Conference, a topic will be selected and presentations solicited from coalitions. Each coalition will send representatives to information exchange conferences and will disseminate information from these conferences throughout the coalition. Half (6) of these meetings will be held in Bethesda, Maryland, and the other half in a central U.S. city easily accessible by air.

3. Clearinghouse of Existing Intervention Resources

A clearinghouse will be maintained which will contain a copy of all intervention resources (print and audiovisual), both foreign language and English, available for use by ASSIST sites. Materials included in the collection will conform to standards set by NCI and must be readily available in large quantities. A catalog of materials will be developed which includes information about suggested use, audience, price, and availability. This catalog will be up-dated and distributed to sites on an annual basis.

4. Casebooks

A collection of case histories describing innovative smoking control activities occurring in intervention and nonintervention sites will be published annually. Non-ASSIST intervention approaches may also be described and their potential application for use in the study project highlighted. Each casebook will contain a minimum of 10 examples of each of the following: Coalition-wide

Activities; Media Events and Advocacy; Environmental Smoking Control Activities; Smoking Cessation and Control Activities in Target Populations; and Prevention. The first casebook will contain examples of coalition plans.

5. Reports About National Smoking-Related Events

Demonstration sites will be alerted to up-coming smoking-related occurrences, such as the release of new scientific findings, hearings on legislation, Surgeon General's Reports, other government and professional reports and findings and legal developments. Information will include a summary of the event, an analysis of its significance for smoking control, and suggestions for responses by sites. It is anticipated that about 20 such reports will be issued annually starting in Phase I.

6. Calendar of Smoking Control Events

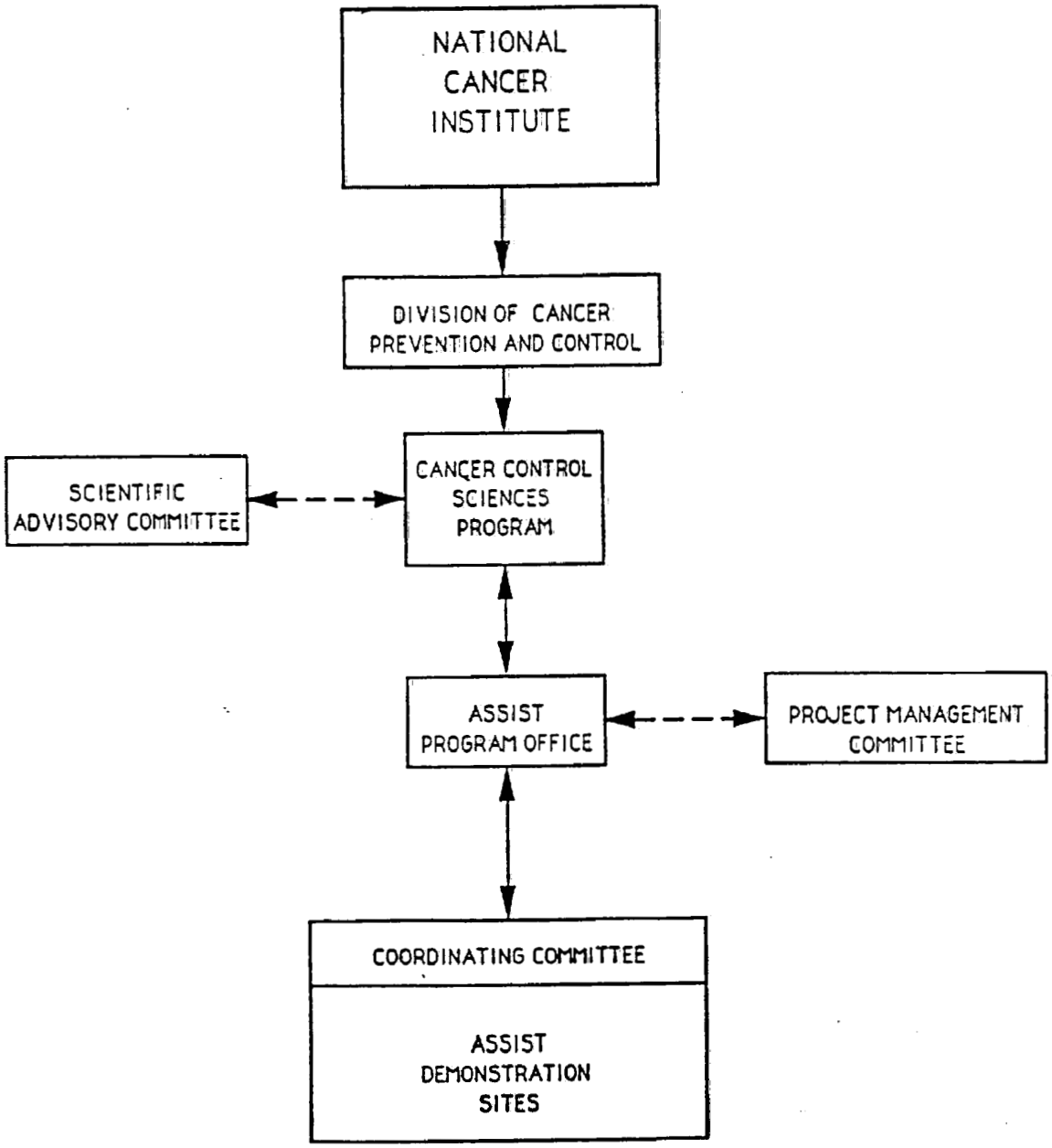
A calendar of significant smoking-related events, including such events as the Great American Smokeout and the release of the Surgeon General's Report will be issued regularly. The calendar will include examples of event-related activities planned by sites, as well as suggested activities. The calendar will be distributed to sites on a regular basis beginning at the start of Phase II.

7. Video Clipping Service

A video clipping service will be provided. The national electronic news media will be monitored for examples of smoking-related coverage, examples will be collected, and a 15 minute video report will be prepared which includes examples of media coverage and analysis of the examples to be used by sites for training in the use of the media for smoking control advocacy. Videotapes shall be distributed to sites regularly throughout Phase II.

APPENDIX C

Organizational chart showing location of ASSIST within NCI



APPENDIX D

Eligible Metropolitan Sites

The following Combined Metropolitan Sampling Areas (CMSA's), Primary Metropolitan Sampling Areas (PMSA's), and Metropolitan Sampling Areas (CMSA's) are eligible to apply for ASSIST awards. Component counties, cities, and towns are shown for each. Proposals must address the entire site. When both a CMSA and one or more of its component PMSA's are eligible, offerors must specify clearly which area is being targetted.

1. Boston-Lawrence-Salem CMSA (MA, NH)
   Boston, MA PMSA
      Central Cities:
       Boston
       Cambridge
       Framingham
       Lynn
       Waltham
      Outside Central Cities:
       Bristol County (part)
           Mansfield town
           Norton town
           Raynham town
       Essex County (part)
           Lynnfield town
           Nahant town
           Saugus town
       Middlesex County (part)
           Acton town
           Arlington town
           Ashland town
           Ayer town
           Bedford town
           Belmont town
           Boxborough town
           Burlington town
           Carlisle town
           Concord town
           Everett city
           Framingham town
           Groton town
           Holliston town
           Hopkinton town
           Hudson town
           Lexington town
           Lincoln town
           Littleton town

Malden city
Marlborough city
Maynard town
Medford city
Melrose city
Natick town
Newton city
North Reading town
Reading town
Sherborn town
Shirley town
Somerville city
Stoneham town
Stow town
Sudbury town
Townsend town
Wakefield town
Waltham city
Watertown town
Wayland town
Weston town
Wilmington town
Winchester town
Woburn city

Norflolk County (part)

Bellingham town
Braintree town
Brookline town
Canton town
Cohasset town
Dedham town
Dover town
Foxborough town
Franklin town
Holbrook town
Medfield town
Medway town
Millis town
Milton town
Needham town
Norfolk town
Norwood town
Quincy city
Randolph town
Sharon town
Stoughton town
Walpole town
Wellesley town
Westwood town
Weymouth town
Wrentham town

Plymouth County (part)

Carver town
Duxbury town
Hanover town
Hanson town
Hingham town
Hull town
Kingston town
Lakeville town
Marshfield town
Middleborough town
Norwell town
Pembroke town
Plymouth town
Plympton town
Rockland town
Scituate town
Suffolk County
Chelsea city
Revere city
Winthrop town
Worcester County (part)
Berlin town
Bolton town
Harvard town
Hopedale town
Lancaster town
Mendon town
Milford town
Southborough town
Upton town

Brockton, MA PMSA
Central City:
Brockton
Outside Central City:
Bristol County (part)
Easton town
Norfolk County (part)
Avon town
Plymouth County (part)
Abington town
Bridgewater town
East Bridgewater town
Halifax town
West Bridgewater town
Whitman town

Lawrence-Haverhill, MA-NH PMSA
Central Cities:
Haverhill, MA
Lawrence, MA
Outside Central Cities:
Essex County, MA (part)
Amesbury town

Andover town
Boxford town
Georgetown town
Groveland town
Merrimac town
Methuen town
Newbury town
Newburyport city
North Andover town
Salisbury town
West Newbury town
Rockingham County, NH (part)
Atkinson town
Brentwood town
Danville town
Derry town
East Kingston town
Hampstead town
Kingston town
Newton town
Plaistow town
Salem town
Sandown town
Seabrook town
Windham town
Lowell, MA-NH PMSA
Central City:
Lowell, MA
Outside Central City:
Middlesex County, MA (part)
Billerica town
Chelmsford town
Dracut town
Dunstable town
Pepperell town
Tewksbury town
Tyngsborough town
Westford town
Hillsborough County, NH (part)
Pelham town
Nashua, NH PMSA
Central City:
Nashua
Outside Central City:
Hillsborough County (part)
Amherst town
Brookline town
Hollis town
Hudson town
Litchfield town
Merrimack town
Milford town

Mont Vernon town
Wilton town
Rockingham County (part)
Londonderry town
Salem-Gloucester, MA PMSA
Central Cities:
Gloucester
Salem
Outside Central Cities:
Essex County (part)
Beverly city
Danvers town
Essex town
Hamilton town
Ipswich town
Manchester town
Marblehead town
Middleton town
Peabody city
Rockport town
Rowley town
Swampscott town
Topsfield town
Wenham town

2. Boston, MA PMSA (see above)

3. Chicago-Gary-Lake Co, Ill-IN-WI CMSA
Aurora-Elgin, IL PMSA
Central Cities:
Aurora (part: Kane County)
Elgin (part: Kane County)
Outside Central Cities:
Kane County
Kendall County
Chicago, IL PMSA
Central Cities:
Aurora (part: DuPage County)
Chicago
Chicago Heights
Elgin (part: Cook County)
Evanston
Outside Central Cities:
Cook County
DuPage County
McHenry County
Gary-Hammond, IN PMSA
Central Cities:
East Chicago
Gary
Hammond
Outside Central Cities:

Lake County
Porter County
Joliet, IL PMSA
Central City:
Joliet
Outside Central City:
Grundy County
Will County
Kenosha, WI PMSA
Central City:
Kenosha
Outside Central City:
Kenosha County
Lake County, IL PMSA
Central Cities:
North Chicago
Waukegan
Outside Central Cities:
Lake County

4. Chicago, IL PMSA (see above)

5. Cleveland-Akron-Lorain, OH CMSA
Akron, PMSA
Central Cities:
Akron
Barberton
Kent
Outside Central Cities
Portage County
Summit County
Cleveland, PMSA
Central City:
Cleveland
Outside Central City:
Cuyahoga County
Geauga County
Lake County
Medina County
Lorain-Elyria PMSA
Central Cities:
Elyria
Lorain
Outside Central Cities:
Lorain County

6. Dallas-Fort Worth TX CMSA
Dallas, PMSA
Central Cities:
Dallas
Denton
Irving

Outside Central Cities:
Collin County
Dallas County
Denton County
Ellis County
Kaufman County
Rockwall County

Fort Worth-Arlington PMSA
Central Cities:
Arlington
Fort Worth
Outside Central Cities:
Johnson County
Parker County
Tarrant County

7. Detroit-Ann Arbor MI CMSA
Ann Arbor PMSA
Central City:
Ann Arbor
Outside Central City
Washtenaw County

Detroit PMSA
Central Cities:
Dearborn
Detroit
Pontiac
Port Huron
Outside Central Cities:
Lapeer County
Livingston County
Macomb County
Monroe County
Oakland County
St. Clair County
Wayne County

8. Houston-Galveston-Brazoria, TX CMSA
Brazoria PMSA
Brazoria County
(no central cities)

Galveston-Texas City PMSA
Central Cities:
Galveston
Texas City
Outside Central Cities:
Galveston County

Houston PMSA
Inside Central Cities:
Baytown (part: Harris County)
Houston
Outside Central Cities:

Fort Bend County
Harris County
Liberty County
Montgomery County
Waller County

9. Los Angeles-Anaheim-Riverside, CA CMSA
   Anaheim-Santa Ana PMSA
      Central Cities:
      Anaheim
      Santa Ana
      Outside Central Cities:
      Orange County
   Los Angeles-Long Beach PMSA
      Central Cities:
      Burbank
      Long Beach
      Los Angeles
      Pasadena
      Pomona
      Outside Central Cities:
      Los Angeles County
   Oxnard-Ventura PMSA
      Central Cities:
      Oxnard
      San Buenaventura (Ventura)
      Outside Central Cities:
      Ventura County
   Riverside-San Bernardino PMSA
      Central Cities:
      Palm Springs
      Riverside
      San Bernardino
      Outside Central Cities:
      Riverside County
      San Bernardino County

10. Los Angeles-Long Beach PMSA (see above)

11. Miami-Fort Lauderdale, FL CMSA
   Fort Lauderdale-Hollywood-Pompano Beach PMSA
      Central Cities:
      Fort Lauderdale
      Hollywood
      Pompano Beach
      Outside Central Cities:
      Broward County
   Miami-Hialeah PMSA
      Central Cities:
      Hialeah
      Miami
      Miami Beach

Outside Central Cities
Dade County

12. New York-Northern New Jersey-Long Island, NY-NJ-CT CMSA
Bergen-Passaic, NJ PMSA
Central City:
Paterson
Outside Central City:
Bergen County
Passaic County
Bridgeport-Milford, CT PMSA
Central Cities:
Bridgeport city
Easton town
Fairfield town
Monroe town
Shelton town
Stratford town
Trumbull town
Milford
Outside Central Cities:
Fairfield County (part)
Bridgeport town
New Haven County (part)
Ansonia town
Beacon Falls town
Derby town
Milford town
Oxford town
Seymour town
Danbury, CT PMSA
Central City:
Danbury
New Fairfield town
Newtown town
Redding town
Ridgefield town
Sherman town
Outsdie Central City:
Fairfield County (part)
Bethel town
Brookfield town
Danbury town
Litchfield County (part)
Bridgewater town
New Milford town
Jersey City, NJ PMSA
Central Cities:
Hoboken
Jersey City
Outside Central Cities:
Hudson County

Middlesex-Somerset-Hunterdon, NJ PMSA
Central Cities:
New Brunswick
Perth Amboy
Outside Central Cities:
Hunterdon County
Middlesex County
Somerset County
Monmouth-Ocean, NJ PMSA
Monmouth County
Ocean County
(no central cities)
Nassau-Suffolk, NY PMSA
Nassau County
Suffolk County
(no central cities)
New York, NY PMSA
Central Cities:
New York City
White Plains
Outside Central Cities:
Bronx County
Kings County
New York County
Putnam County
Queens County
Richmond County
Rockland County
Westchester County
Newark, NJ PMSA
Central Cities:
Elizabeth
Newark
Outside Central Cities
Essex County
Morris County
Sussex County
Union County
Norwalk, CT PMSA
Central City:
Norwalk
Weston town
Westport town
Wilton town
Outside Central City:
Fairfield County (part)
Norwalk town
Orange County, NY PMSA
Orange County
(no central cities)
Stamford, CT PMSA
Central City

Stamford
Outside Central City
Fairfield County (part)
Darien town
Greenwich town
New Canaan town
Stamford town

13. New York, NY PMSA (see above)

14. Newark, NJ PMSA (see above)

15. Philadelphia-Wilmington-Trenton, PA-NJ-DE-MD CMSA
Philadelphia, PA-NJ PMSA
Central Cities:
Camden, NJ
Norristown, PA
Philadelphia, PA
Outside Central Cities:
Burlington County, NJ
Camden County, NJ
Gloucester County, NJ
Bucks County, PA
Chester County, PA
Delaware County, PA
Montgomery County, PA
Philadelphia County, PA
Trenton, NJ PMSA
Central City:
Trenton
Outside Central City:
Mercer County
Vineland-Millville-Bridgeton, NJ PMSA
Central Cities:
Bridgeton
Millville
Vineland
Outside Central Cities:
Cumberland County
Wilmington, DE-NJ-MD PMSA
Central city:
Wilmington
Outside Central City:
New Castle County, DE
Cecil County, MD
Salem County, NJ

16. Philadelphia, PA-NJ PMSA (see above)

17. Philadelphia, PA portion of PMSA

18. Pittsburgh-Beaver Valley, PA CMSA
    Beaver County PMSA
        (No central cities)
    Pittsburgh PMSA
        Central Cities:
            McKeesport
            Pittsburgh
        Outside Central Cities:
            Allegheny County
            Fayette County
            Washington County
            Westmoreland County

19. San Francisco-Oakland-San Jose, CA CMSA
    Oakland PMSA
        Central Cities:
            Berkeley
            Livermore
            Oakland
        Outside Central Cities:
            Alameda County
            Contra Costa County
    San Francisco PMSA
        Central city:
            San Francisco
        Outside Central City:
            Marin County
            San Francisco County
            San Mateo County
    San Jose PMSA
        Central Cities:
            Palo Alto
            San Jose
        Outside Central Cities:
            Santa Clara County
    Santa Cruz PMSA
        Central City:
            Santa Cruz
        Outside Central City:
            Santa Cruz County
    Santa Rosa-Petaluma PMSA
        Central Cities:
            Petaluma
            Santa Rosa
        Outside Central Cities:
            Sonoma County
    Vallejo-Fairfield-Napa PMSA
        Central Cities:
            Fairfield
            Napa
            Vallejo
        Outside Central Cities:

Napa County
Solano County

20. Tampa-St. Petersburg-Clearwater MSA
Central Cities:
Clearwater
St. Petersburg
Tampa
Outside Central Cities:
Hernando County
Hillsborough County
Pasco County
Pinellas County

21. Washington, DC-MD-VA MSA
Central Cities:
Washington, DC
Frederick , MD
Arlington, VA
Outside Central Cities:
District of Columbia
Calvert County, MD
Charles County, MD
Frederick County, MD
Montgomery, County, MD
Prince George's County, MD
Arlington County, VA
Fairfax County, VA
Loudoun County, VA
Prince William County, VA
Stafford County, VA
Alexandria city, VA
Fairfax city, VA
Falls Church city, VA
Manassas city, VA
Manassas Park city, VA

PACKAGING AND DELIVERY OF THE PROPOSAL

Your proposal shall be organized as specified in Section L.1., "Instructions to Offerors" - General Instructions. Shipment and marking shall be as indicated below.

EXTERNAL PACKAGE MARKING

In addition to the address cited below, mark each package as follows:

"RFP NO. NCI-CN-95165-38"

"TO BE OPENED BY AUTHORIZED GOVERNMENT PERSONNEL ONLY"

NUMBER OF COPIES

PLEASE NOTE - THE TECHNICAL PROPOSAL SHALL BE SENT IN SPLIT SHIPMENTS TO TWO LOCATIONS. PLEASE READ THE FOLLOWING INFORMATION CAREFULLY.

A. TECHNICAL PROPOSAL ONLY

ORIGINAL* AND 20 COPIES TO:

If hand-delivered or delivery service	If using U.S. Postal Service
Barbara Mercer Research Contracts Branch National Cancer Institute Executive Plaza South, Room 635 6120 Executive Boulevard Rockville, Maryland 20852	Barbara Mercer Research Contracts Branch National Institutes of Health National Cancer Institute Executive Plaza S., Rm. 635 Bethesda, Maryland 20892

20 COPIES TO:

If hand-delivered or delivery service	If using U.S. Postal Service
O. Jay Arwood Contracts Review Branch National Cancer Institute Westwood Building, Room 803 5333 Westbard Avenue Bethesda, Maryland 20816	O. Jay Arwood Contracts Review Branch National Institutes of Health National Cancer Institute Westwood Building, Room 803 Bethesda, Maryland 20892

B. BUSINESS PROPOSAL

ORIGINAL* AND 20 COPIES TO:

If hand-delivered or delivery service	If using U.S. Postal Service
Barbara Mercer Research Contracts Branch National Cancer Institute Executive Plaza South, Room 635 6120 Executive Boulevard Rockville, Maryland 20852	Barbara Mercer Research Contracts Branch National Institutes of Health National Cancer Institute Executive Plaza S., Room 635 Bethesda, Maryland 20892

*THE ORIGINAL PROPOSAL MUST BE READILY ACCESSIBLE FOR DATE STAMPING.

NOTE: The U.S. Postal Service's "Express Mail" does not deliver to the Rockville, Maryland address. Any package sent to the Rockville address via this service will be held at a local post office for pick-up. The Government is not responsible for picking up any mail at a local post office. If a proposal is not received at the place, date, and time specified herein, it will be considered a "late proposal."

TECHNICAL PROPOSAL COST INFORMATION/SUMMARY OF LABOR AND DIRECT COSTS

DIRECT LABOR:

Labor Category (Title and Name-- use additional pages as necessary)	Rate	Year 1 (Hours)	Year 2 (Hours)	Year 3 (Hours)	Year 4 (Hours)	Year 5 (Hours)	Total
_____							
_____							
_____							
_____							
_____							
Total Hours		_____	_____	_____	_____	_____	_____
DIRECT LABOR COST:		$_____	$_____	$_____	$_____	$_____	$_____
MATERIAL COST:		$_____	$_____	$_____	$_____	$_____	$_____
TRAVEL COST:		$_____	$_____	$_____	$_____	$_____	$_____
OTHER (Specify)		$_____	$_____	$_____	$_____	$_____	$_____
OTHER (Specify)		$_____	$_____	$_____	$_____	$_____	$_____
TOTAL DIRECT COST:		$_____	$_____	$_____	$_____	$_____	$_____

Specific Instructions:

1. Do not include any indirect cost or fee.
2. Do not submit the total amount of proposal.
3. Submit this information as a portion of the Technical Proposal.

20273665868

CONTRACT PRICING PROPOSAL COVER SHEET

1. SOLICITATION/CONTRACT/MODIFICATION NO.

FORM APPROVED OMB NO. 9000-0013

NOTE: This form is used in contract actions if submission of cost or pricing data is required. *(See FAR 15.804-6(b))*

2. NAME AND ADDRESS OF OFFEROR *(Include ZIP Code)*

3A. NAME AND TITLE OF OFFEROR'S POINT OF CONTACT

3B. TELEPHONE NO.

4. TYPE OF CONTRACT ACTION *(Check)*

☐ A. NEW CONTRACT	☐ D. LETTER CONTRACT
☐ B. CHANGE ORDER	☐ E. UNPRICED ORDER
☐ C. PRICE REVISION/ REDETERMINATION	☐ F. OTHER *(Specify)*

5. TYPE OF CONTRACT *(Check)*

☐ FFP ☐ CPFF ☐ CPIF ☐ CPAF

☐ FPI ☐ OTHER *(Specify)*

6. PROPOSED COST *(A+B=C)*

A. COST	B. PROFIT/FEE	C. TOTAL
$	$	$

7. PLACE(S) AND PERIOD(S) OF PERFORMANCE

8. List and reference the identification, quantity and total price proposed for each contract line item. A line item cost breakdown supporting this recap is required unless otherwise specified by the Contracting Officer. *(Continue on reverse, and then on plain paper, if necessary. Use same headings.)*

A. LINE ITEM NO.	B. IDENTIFICATION	C. QUANTITY	D. TOTAL PRICE	E. REF.

9. PROVIDE NAME, ADDRESS, AND TELEPHONE NUMBER FOR THE FOLLOWING *(If available)*

A. CONTRACT ADMINISTRATION OFFICE

B. AUDIT OFFICE

10. WILL YOU REQUIRE THE USE OF ANY GOVERNMENT PROPERTY IN THE PERFORMANCE OF THIS WORK? *(If "Yes," identify)*

☐ YES ☐ NO

11A. DO YOU REQUIRE GOVERNMENT CONTRACT FINANCING TO PERFORM THIS PROPOSED CONTRACT? *(If "Yes," complete Item 11B)*

☐ YES ☐ NO

11B. TYPE OF FINANCING *(√ one)*

☐ ADVANCE PAYMENTS ☐ PROGRESS PAYMENTS

☐ GUARANTEED LOANS

12. HAVE YOU BEEN AWARDED ANY CONTRACTS OR SUBCONTRACTS FOR THE SAME OR SIMILAR ITEMS WITHIN THE PAST 3 YEARS? *(If "Yes," identify item(s), customer(s) and contract number(s))*

☐ YES ☐ NO

13. IS THIS PROPOSAL CONSISTENT WITH YOUR ESTABLISHED ESTIMATING AND ACCOUNTING PRACTICES AND PROCEDURES AND FAR PART 31 COST PRINCIPLES? *(If "No," explain)*

☐ YES ☐ NO

14. COST ACCOUNTING STANDARDS BOARD (CASB) DATA *(Public Law 91-379 as amended and FAR PART 30)*

A. WILL THIS CONTRACT ACTION BE SUBJECT TO CASB REGULATIONS? *(If "No," explain in proposal)*

☐ YES ☐ NO

B. HAVE YOU SUBMITTED A CASB DISCLOSURE STATEMENT *(CASB DS-1 or 2)*? *(If "Yes," specify in proposal the office to which submitted and if determined to be adequate)*

☐ YES ☐ NO

C. HAVE YOU BEEN NOTIFIED THAT YOU ARE OR MAY BE IN NONCOMPLIANCE WITH YOUR DISCLOSURE STATEMENT OR COST ACCOUNTING STANDARDS? *(If "Yes," explain in proposal)*

☐ YES ☐ NO

D. IS ANY ASPECT OF THIS PROPOSAL INCONSISTENT WITH YOUR DISCLOSED PRACTICES OR APPLICABLE COST ACCOUNTING STANDARDS? *(If "Yes," explain in proposal)*

☐ YES ☐ NO

This proposal is submitted in response to the RFP, contract, modification, etc. in Item 1 and reflects our best estimates and/or actual costs as of this date and conforms with the instructions in FAR 15.804-6(b) (2), Table 15-2. By submitting this proposal, the offeror, if selected for negotiation, grants the contracting officer or an authorized representative the right to examine, at any time before award, those books, records, documents and other types of factual information, regardless of form or whether such supporting information is specifically referenced or included in the proposal as the basis for pricing, that will permit an adequate evaluation of the proposed price.

15. NAME AND TITLE *(Type)*

16. NAME OF FIRM

17. SIGNATURE

18. DATE OF SUBMISSION

BREAKDOWN OF PROPOSED ESTIMATED COST (PLUS FEE) AND LABOR HOURS

INSTRUCTIONS FOR USE OF THE FORMAT

1. Refer to Business Proposal Instructions, Section L of this solicitation. The Instructions contain the requirements for proper submission of cost/price data which must be adhered to.

2. This format has been prepared as a universal guideline for all solicitations issued by the National Cancer Institute. It may require amending to meet the specific requirements of this solicitation. For example, this solicitation may require the submission of cost/price data for three years listed on this form. (See Section L.1., General Information for the estimated duration of this project.) If this solicitation is phased, identify each phase in addition to each year. Total each year, phase, and sub-element.

3. This format must be used to submit the breakdown of all proposed estimated cost elements. List each cost element and sub-element for direct costs, indirect costs and fee, if applicable. In addition, provide detailed calculations for all items. For example:

   a. For all personnel, list the name, title, rate per hour and number of hours proposed. If a pool of personnel is proposed, list the composition of the pool and how the cost proposed was calculated. List the factor used for prorating Year One and the escalation rate applied between years.

   b. For all materials, supplies, and other direct costs, list all unit prices, etc., to detail how the calculations were made.

   c. For all indirect costs, list the rates applied and the base the rate is applied to.

   d. For all travel, list the specifics for each trip.

   e. For any subcontract proposed, submit a separate breakdown format.

   f. Justification for the need of some cost elements may be listed as an attachment, i.e., special equipment, above average consultant fees, etc.

4. If the Government has provided "uniform pricing assumptions" for this solicitation, the offeror must comply with and identify each item.

RFP Number: NCI-CN-95165-38
Organization: _____
Date: _____

BREAKDOWN OF PROPOSED ESTIMATED COST (PLUS FEE) AND LABOR HOURS

COST ELEMENT		Year 1	Year 2	Year 3	Year 4	Year 5	Total
DIRECT LABOR:							
Labor Category (Title and Name-- use additional pages as necessary)	Rate	Hours Amt	Hours Amt	Hours Amt	Hours Amt	Hours Amt	Hours Amt
_____							
_____							
_____							
_____							
_____							
DIRECT LABOR COST:		$	$	$	$	$	$
MATERIAL COST:		$	$	$	$	$	$
TRAVEL COST:		$	$	$	$	$	$
OTHER (Specify)		$	$	$	$	$	$
OTHER (Specify)		$	$	$	$	$	$
TOTAL DIRECT COST:		$	$	$	$	$	$
FRINGE BENEFIT COST: (if applicable) ____% of Direct Labor Cost		$	$	$	$	$	$
INDIRECT COST: ____% of Total Direct Cost		$	$	$	$	$	$
FEE: (if applicable) ____% of Total Est. Cost		$	$	$	$	$	$
GRAND TOTAL ESTIMATED COST		$	$	$	$	$	$

DEPARTMENT OF HEALTH AND HUMAN SERVICES
PUBLIC HEALTH SERVICE
NATIONAL INSTITUTES OF HEALTH
PROPOSAL SUMMARY AND DATA RECORD

RFP NUMBER/CONTRACT NUMBER

PROJECT TITLE (Title of RFP or Contract Proposal)

LEGAL NAME AND ADDRESS OF OFFEROR

PLACE OF PERFORMANCE (Full address including ZIP)

TYPE OF CONTRACT PROPOSED

☐ COST-REIMBURSEMENT ☐ FIXED PRICE ☐ COST-PLUS-FIXED-FEE ☐ OTHER

ESTIMATED TIME REQUIRED TO COMPLETE PROJECT

PROPOSED STARTING DATE

ESTIMATED DIRECT COSTS IN PROPOSED YEAR (From budget)

DOES THIS PROPOSAL INCLUDE A SUBCONTRACT ☐ YES ☐ NO (If yes, please furnish name and location of organization, description of services, basis for selection, responsible person employed by subcontractor and cost information.)

NAME AND TITLE OF PRINCIPAL INVESTIGATOR	SOCIAL SECURITY NO.	EST. HOURS WEEKLY	AREA CODE/TEL. NO.
NAME AND TITLE OF CO-INVESTIGATORS (Use attachment if necessary)	SOCIAL SECURITY NO.	EST. HOURS WEEKLY	AREA CODE/TEL. NO.

NAME AND TITLE OF INDIVIDUAL(S) AUTHORIZED TO NEGOTIATE CONTRACTS — AREA CODE/TELEPHONE NUMBER

NAME AND TITLE OF INDIVIDUAL(S) AUTHORIZED TO EXECUTE CONTRACTS — AREA CODE/TELEPHONE NUMBER

DOES THIS PROPOSAL INVOLVE EXPERIMENTS WITH HUMAN SUBJECTS ☐ YES ☐ NO

Institution's General Assurance re Human Subjects — DATE APPROVED _____ ☐ PENDING

Institution's Review Board's approval of this proposal — DATE APPROVED _____ ☐ PENDING

An example of the informed consent for this study is enclosed ☐ YES ☐ NO

A Clinical Protocol is enclosed ☐ YES ☐ NO

OFFEROR'S ACKNOWLEDGEMENT OF AMENDMENTS TO THE RFP (Use attachment if necessary)

ERRATA NUMBER	DATE	ERRATA NUMBER	DATE

NAME, ADDRESS, AND PHONE NUMBER OF COGNIZANT GOVERNMENT AUDIT AGENCY

NUMBER OF EMPLOYEES CURRENTLY EMPLOYED

DOLLAR VOLUME OF BUSINESS PER ANNUM

THIS OFFER EXPIRES _____ DAYS FROM THE DATE OF THIS OFFER. (120 days if not specified)

FOR THE INSTITUTION

SIGNATURE OF PRINCIPAL INVESTIGATOR	SIGNATURE OF BUSINESS REPRESENTATIVE
TYPED NAME AND TITLE	TYPED NAME AND TITLE
EMPLOYER IDENTIFICATION NUMBER	DATE OF OFFER

NIH 2043 (Rev. 6/82)

ATTACHMENT 9

Provision of the Social Security Number is voluntary. Social Security Numbers are requested for the purpose of accurate and efficient identification, review, and management of NIH Extramural Programs. Authority for requesting this information is provided by Title III, Section 301, and Title IV of the Public Health Service Act, as amended.

NIH 2043 (Rev. 6/82) Back

SUMMARY OF RELATED ACTIVITIES

The following specific information must be provided by the offeror pertaining to the Project Director, Principal Investigator, and each of any other proposed key professional individuals designated for performance under any resulting contract.

a. Identify the total amount of all presently active federal contracts/cooperative agreements/grants and commercial agreements citing the committed levels of effort for those projects for each of the key individuals* in this proposal.

Professional's Name and Title/Position

_____

Identifying Number	Agency	Total Effort Committed
1.		
2.		
3.		
4.		

*If an individual has no obligation(s), so state.

b. Provide the total number of outstanding proposals, exclusive of the instant proposal, having been submitted by your organization, not presently accepted but in an anticipatory stage, which will commit levels of effort by the proposed professional individuals.*

Professional's Name and Title/Position

_____

Identifying Number	Agency	Total Effort Committed
1.		
2.		
3.		
4.		

*If no commitment of effort is intended, so state.

c. Provide a statement of the level of effort to be dedicated to any resultant contract awarded to your organization for those individuals designated and cited in this proposal.

Name	Title/Position	Total Proposed Effort
1.		
2.		
3.		
4.		

PROPOSAL INTENT RESPONSE SHEET

RFP No. NCI-CN-95165-38

PLEASE REVIEW THE ATTACHED REQUEST FOR PROPOSAL. FURNISH THE INFORMATION REQUESTED BELOW AND RETURN THIS PAGE BY THE EARLIEST PRACTICABLE DATE. YOUR EXPRESSION OF INTENT IS NOT BINDING BUT WILL GREATLY ASSIST US IN PLANNING FOR PROPOSAL EVALUATION.

==========

[ ] DO INTEND TO SUBMIT A PROPOSAL

[ ] DO NOT INTEND TO SUBMIT A PROPOSAL FOR THE FOLLOWING REASONS:

_____

_____

COMPANY/INSTITUTION NAME:

AUTHORIZED SIGNATURE:

TYPED NAME AND TITLE:

DATE:

==========

RETURN TO:

National Institutes of Health
National Cancer Institute
Attention: Barbara Mercer
Contracting Officer
Executive Plaza South, Room 635
Bethesda, MD 20892

SMALL AND DISADVANTAGED BUSINESS SUBCONTRACTING PLAN

DATE:_____

CONTRACTOR:_____

ADDRESS:_____

CONTRACT NUMBER:_____

LIFE OF CONTRACT (DATES):_____

TOTAL AMOUNT OF CONTRACT:_____

The following, together with any attachments, is hereby submitted as a Subcontracting Plan to satisfy the applicable requirements of Public Law 95-507 as implemented by OFPP Policy Letter 80-2.

1. (a) The following percentage goals (expressed in terms of a percentage of total planned subcontracting dollars) are applicable to the contract cited above or to the contract awarded under the solicitation cited.

(i) Small Business concerns:_____% of total planned subcontracting dollars under this contract will go to subcontractors who are small business concerns.

(ii) Small Disadvantaged Business Concerns:_____% of total planned subcontracting dollars under this contract will go to subcontractors who are small business concerns owned and controlled by socially and economically disadvantaged individuals.

(b) The following dollar values correspond to the percentage goals shown in (a) above.

(i) Total dollars planned to be subcontracted to small business concerns: $_____.

(ii) Total dollars planned to be subcontracted to small disadvantaged business concerns: $_____.

(iii) Total dollars planned to be subcontracted to large business $_____.

(c) The TOTAL amount of dollars awarded for subcontracting $_____.

(d) The following principal products and/or services will be subcontracted under this contract, and the distribution among small and small disadvantaged business concerns is as follows:

(Products/services planned to be subcontracted to: small business concerns are identified by * small disadvantaged concerns are identified by **)

_____

_____

_____

_____

(ADDITIONAL SPACE WILL MOST LIKELY BE NEEDED - ATTACHMENTS MAY BE USED)

(e) The following method was used in developing subcontract goals (i.e., Statement explaining how the product and service areas to be subcontracted were established, how the areas to be subcontracted to small and small disadvantaged business concerns' capabilities were determined, to include identification of source lists utilized in making these determinations)...

_____

_____

_____

_____

_____

Subcontracting Plan
Element 1 continued

(f) Indirect and overhead costs (check one below):

_____ have been _____ have not been

included in the goals specified in 1.(a) and 1.(b), above.

(g) If "have been" is checked, explain the method used in determining the proportionate share of indirect and overhead cost to be allocated as subcontracts to small business concerns and small disadvantaged business concerns.

2. The following individual will administer the subcontracting program:

NAME:_____

TITLE:_____

ADDRESS & TELEPHONE:_____

_____

The individual's specific duties as they relate to the firm's subcontracting program are as follows:

General overall responsibility for this company's Small Business Program, the development, preparation and execution of individual subcontracting plans and for monitoring performance relative to contractual subcontracting requirements contained in this plan, including but not limited to:

(a) Developing and maintaining bidders lists of small and small disadvantaged business concerns from all possible sources.

(b) Ensuring that procurement packages are structured to permit small and small disadvantaged business concerns to participate to the maximum extent possible.

(c) Assuring inclusion of small and SDB concerns in all solicitations for products or services which they are capable of providing.

(d) Reviewing solicitations to remove statements, clauses, etc. which may tend to restrict or prohibit SB and SDB participation.

(e) Ensuring periodic rotation of potential subcontractors on bidders lists.

(f) Ensuring that the bid proposal review board documents its' reasons for not selecting low bids submitted by small and small disadvantaged business concerns.

(g) Ensuring the establishment and maintenance of records of solicitations and subcontract award activity.

(h) Attending or arranging for attendance of company counselors at Business Opportunity Workshops, Minority Business Enterprise Seminars, Trade Fairs, etc.

(i) Conducting or arranging for conduct of motivational training for purchasing personnel pursuant to the intent of P.L. 95-507.

(j) Monitoring attainment of proposed goals.

(k) Preparing and submitting periodic subcontracting reports required.

(l) Coordinating contractor's activities during the conduct of compliance reviews by Federal agencies.

(m) Coordinating the conduct of contractor's activities involving its small and small disadvantaged business subcontracting program.

(n) Additions to (or deletions from) the duties specified above are as follows:

_____

_____

_____

_____

_____

Subcontracting Plan
Element 3

3. The following efforts will be taken to assure that small and small disadvantaged business concerns will have an equitable opportunity to compete for subcontract:

(a) Outreach efforts will be made as follows:

(i) Contacts with minority and small business trade associations

(ii) Contacts with business development organizations

(iii) Attendance at small and minority business procurement conferences and trade fairs

(iv) Sources will be requested from SBA's Procurement Automated Source System (PASS) system.

(b) Small and small disadvantaged business concern source lists, guides and other data identifying small and small disadvantaged business concerns will be maintained and utilized by buyers in soliciting subcontracts.

(c) Additions to (or deletions from) the above listed efforts are as follows:

_____

_____

_____

4. The offeror (contractor) agrees that the clause entitled "Small Business and Small Disadvantaged Business Subcontract Plan" will be included in all subcontracts which offer further subcontracting opportunities, and all subcontractors (except small business concerns) who receive subcontracts in excess of $500,000 will be required to adopt and comply with a subcontracting plan similar to this one. Such plans will be reviewed by comparing them with the provisions of Public Law 95-507, and assuring that all minimum requirements of an acceptable subcontracting plan have been satisfied. The acceptability of percentage goals shall be determined on a case-by-case basis depending on the supplies; services involved, the availability of potential small and small disadvantaged subcontractors, and prior experience. Once approved and implemented, plans will be monitored through the submission of periodic reports, and/or, as time and availability of funds permit, periodic visits to subcontractor's facilities to review applicable records and subcontracting program progress.

5. The offeror (contractor) agrees to submit such periodic reports and cooperate in any studies or surveys as may be required by the contracting agency or the Small Business Administration in order to determine the extent of compliance by the bidder (contractor) with the subcontracting plan and with the clause entitled "Small Business Small Disadvantaged Business Subcontract Plan" contained in the contract.

RE: PERIODIC REPORTS REQUIRED BY P. L. 95.507

The contractor shall submit the original and two copies of "Subcontracting Report for Individual Contracts," SF 294, in accordance with the instructions on the report as referenced in Public Law 95-507, Section 211. Regardless of the effective date of this contract, the report shall be submitted for the entire life of the contract on the following dates:

APRIL 25
OCTOBER 25

The Report shall be sent to the following address:

Contracting Officer
Research Contracts Branch
National Cancer Institute
Executive Plaza South, Room
NIH, Bethesda, Maryland 20892

The contractor shall submit 1 copy of "Summary Subcontract Report," SF-295, in accordance with the instructions on the report as referenced in Public Law 95-507, Section 211.

The Quarterly Report shall be submitted on the following dates:

JANUARY 25
APRIL 25
JULY 25
OCTOBER 25

The first report shall be submitted after the first full quarter of this contract in addition to any fractional part of the quarter in which this contract became effective.

This report shall be mailed to the following address:

Office of Small and Disadvantaged Business Utilization
Department of Health and Human Services
Room 5130
Washington, DC 20201

Subcontracting Plan

Element 6

6. The offeror (Contractor) agrees that he will maintain at least the following types of records to document compliance with this subcontracting plan:

(a) Small and small disadvantaged business concern source lists, guides and other data identifying SD/SDB vendors/concerns.

(b) Organizations contacted for small and disadvantaged business sources.

(c) On a contract-by-contract basis, records on all subcontract solicitations over $100,000, indicating on each solicitation (1) whether small business concerns were solicited, and if not, why not: (2) whether small disadvantaged business concerns were solicited, if not, why not; and (3) reasons for the failure of solicited small or small disadvantaged business concerns to receive the subcontract award.

(d) Records to support other outreach efforts: Contacts with Minority and Small Business Trade Associations, etc. Attendance at Small and Minority business procurement conferences and trade fairs.

(e) Records to support internal activities to guide and encourage buyer Workshops, Seminars, Training Programs, etc. Monitoring activities to evaluate compliance.

(f) On a contract-by-contract basis, records to support subcontract award data to include name and address of subcontractor.

(g) Records to be maintained in addition to the above are as follows:

_____

_____

SIGNED:

TYPED NAME:_____

TITLE:_____

DATE:_____

PLAN ACCEPTED BY: _____
(Contracting Officer)

DATE:_____

NOTE TO CONTRACTING OFFICER: Upon incorporation of a plan into the contract, indicate herein the estimated dollar value of the contract: .

GOVERNMENT NOTICE FOR HANDLING PROPOSALS

This proposal shall be used and disclosed for evaluation purposes only, and a copy of this Government notice shall be applied to any reproduction or abstract thereof. Any authorized restrictive notices which the submitter places on this proposal outside the Government for evaluation purposes shall be made only to the extent authorized by, and in accordance with, the procedures in (cite agency regulation implementing 15.413-2(f).

If agency implementing regulations do not authorize release of proposals outside the Government for evaluation purposes, the last sentence of the foregoing Government notice is to be deleted.

(f) If authorized in agency implementing regulations, agencies may release proposals outside the Government for evaluation, consistent with the following:

(1) Decisions to release proposals outside the Government for evaluation purposes shall be made by the agency head or designee;

(2) Written agreement must be obtained from the evaluator that the information (data) contained in the proposal will be used only for evaluation purposes and will not be further disclosed;

(3) Any authorized restrictive legends placed on the proposal by the prospective contractor or subcontractor or by the Government shall be applied to any reproduction or abstracted information made by the evaluator;

(4) Upon completing the evaluation, all copies of the proposal, as well as any abstracts thereof, shall be returned to the Government office which initially furnished them for evaluation; and

(5) All determinations to release the proposal outside the Government take into consideration requirements for avoiding organizational conflicts of interest and the competitive relationship, if any, between the prospective contractor or subcontractor and the prospective outside evaluator.

(g) The submitter of any proposal shall be provided notice adequate to afford an opportunity to take appropriate action before release of any information (data) contained therein pursuant to a request under the Freedom of Information Act (5 U.S.C. 552); and, time permitting, the submitter should be consulted to obtain assistance in determining the eligibility of the information (data) in question as an exemption under the Act. (See also Subpart 24.2, Freedom of Information Act.) "HHSAR Paragraph 315.608(e)."

INVOICE/FINANCING REQUEST INSTRUCTIONS
FOR NIH COST-REIMBURSEMENT TYPE CONTRACTS, NIH(RC)-1

General: The contractor shall submit claims for reimbursement in the manner and format described herein and as illustrated in the sample invoice/financing request.

Format: Standard Form 1034, Public Voucher for Purchases and Services Other Than Personal; and Standard Form 1035, Public Voucher for Purchases and Services Other Than Personal--Continuation Sheet, or reproduced copies of such forms marked ORIGINAL should be used to submit claims for reimbursement. In lieu of SF-1034 and SF-1035, claims may be submitted on Form HHS-646 , Financial Report of Individual Project/Contract, or on the payee's letterhead or self-designed form provided that it contains the information shown on the sample invoice/financing request.

Number of Copies: As indicated in the Invoice Submission/Contract Financing Request clause in the contract.

Frequency: Invoices/financing requests submitted in accordance with the payment clause shall be submitted monthly unless otherwise authorized by the Contracting Officer.

Cost Incurrence Period: Costs incurred must be within the contract performance period or covered by precontract cost provisions.

Billing of Costs Incurred: If billed costs include: (1) Costs of a prior billing period, but not previously billed, or (2) costs incurred during the contract period and claimed after the contract period has expired, the amount and month(s) in which such costs were incurred shall be cited.

Contractor's Fiscal Year: Invoices/financing requests shall be prepared in such a manner that costs claimed can be identified with the Contractor's fiscal year.

Currency: All NIH contracts are expressed in United States dollars. Where expenditures are made in a currency other than United States dollars, billings on the contract shall be expressed, and reimbursement by the United States Government shall be made, in that other currency at amounts coincident with actual costs incurred. Currency fluctuations may not be a basis of gain or loss to the Contractor. Notwithstanding the above, the total of all invoices paid under this contract may not exceed the United States dollars authorized.

Costs Requiring Prior Approval: Costs requiring the Contracting Officer's approval which are not set forth in an advance understanding in the contract shall be so identified and reference the Contracting Officer's Authorization (COA) number.

Invoice/Financing Request Identification: Each invoice/financing request shall be identified as either:

(a) Cost Reimbursable - Financing Request: These are interim payment requests submitted during the contract performance period.

(b) Completion/Final Invoice: The completion invoice is a final invoice which is submitted promptly upon completion of the work, but no later than one year from the contract completion date. The completion invoice should be submitted when all costs (except for finalization of indirect cost rates) have been assigned to the contract and all performance provisions have been completed. A revised final invoice may be required after the amounts owed have been settled between the Government and the Contractor (e.g., final indirect cost rates and resolution of all suspensions and audit exceptions).

Preparation and Itemization of the Invoice/Financing Request: The Contractor shall furnish the information set forth in the explanatory notes below. These notes are keyed to the entries of the sample invoice/financing request.

(a) Paying Office and Address: The paying office and address, identified in the Invoice Submission/Contract Financing Request clause of the contract, shall be entered on all copies of the invoice/financing request.

(b) Invoice/Financing Request Number: Insert the appropriate serial number of the invoice/financing request.

(c) Date of Invoice/Financing Request: Insert the date of the invoice/financing request is prepared.

(d) Contract Number and Date: Insert the contract number and the date of the contract.

(e) Payee's Name and Address: Show the Contractor's name (as it appears in the contract), correct address, and the title and phone number of the responsible official to whom payment is to be sent. When an approved assignment has been made by the Contractor, or a different payee has been designated, then insert the name and address of the payee instead of the Contractor.

(f) Contract Amount: Insert the total estimated cost of the contract, exclusive of fixed-fee. For incrementally funded contracts, enter the amount currently obligated and available for payment.

(g) Fixed-Fee: Insert the total fixed-fee (where applicable).

(h) Billing Period: Insert the beginning and ending dates (day, month, and year of the period in which costs were incurred and for which reimbursement is claimed.

(i) Amount Billed for Current Period: Insert the amount billed for the major cost elements, adjustment and adjusted amounts for the period.

(j) Cumulative Amount from Inception to Date of this Billing: Insert the cumulative amounts billed for the major cost elements and adjusted amounts claimed during this contract.

(k) Direct Costs: Insert the major cost elements. For each element, consider the application of the paragraph entitled Costs Requiring Prior Approval on page 1 of these instructions.

(1) Direct Labor: This consists of salaries and wages paid (or accrued for direct performance of the contract.

(2) Fringe Benefits: This represents fringe benefits applicable to direct labor and billed as a direct cost. Fringe benefits included in indirect costs should not be identified here.

(3) Nonexpendable Equipment: This category of cost includes permanent research equipment and general purpose equipment having a unit acquisition cost of $500 or more and having an expected service life of more than two years. Show permanent research equipment separate from general purpose equipment. Prepare and attach Form HHS-565 in accordance with the following instructions:

List each item for which reimbursement is requested. A reference shall be made to the following (as applicable):

(A) The item number for the specific piece of equipment listed in the Property Schedule;

(B) The Contracting Officer's Authorization letter and number, if the equipment is not covered by the Property Schedule, or;

(C) Be preceded by an asterisk (*) if the equipment is below the approval level.

Further itemization of invoices/financing requests shall only be required for items having specific limitations set forth in the contract.

(4) Materials and Supplies: This category includes equipment with unit costs of less than $500 or an expected service life of two years or less, and consumable material and supplies regardless of amount.

(5) Premium Pay: This is remuneration in excess of the basic hourly rate.

(6) Consultant Fee: Fees paid to consultants. Identify consultant by name or category as set forth in the contract's advance understanding or in the COA letter, as well as the effort (i.e., number of hours, days, etc.) and rate being billed.

(7) Travel: Domestic travel is travel within the United States, its territories, possessions and Canada for Contractors located there; otherwise it is the Contractor's own country. It should be billed separately from foreign travel.

(8) Subcontract Costs: List subcontractor(s) by name and amount billed.

(9) Other: List all other direct costs in total unless exceeding $1,000 in amount. If over $1,000, list cost elements and dollar amount separately. If the contract contains restrictions on any cost element, that cost element should be listed separately.

(l) Cost of Money (COM): Cite the COM factor and base in effect during the time the cost was incurred and for which reimbursement is claimed.

(m) Indirect Costs--Overhead: Cite the formula (rate and base) in effect during the time the cost was incurred and for which reimbursement is claimed. If special rate is being used; e.g., off-site, then so specify.

(n) Fixed-Fee: If the contract provides for a fixed-fee, it must be claimed as provided for by the contract. Cite the formula or method of computation.

(o) Total Amounts Claimed: Insert the total amounts claimed for the current and cumulative periods.

(p) Adjustments: This includes amounts conceded by the Contractor, outstanding suspensions and disapprovals subject to appeal.

(q) Grand Totals

SAMPLE INVOICE/FINANCING REQUEST

(a) Payor's Name and Address NATIONAL INSTITUTES OF HEALTH Division of Financial Management Contracts Section, FAAB Building 31, Room B1B05A Bethesda, Maryland 20892	(b) Invoice/Financing Request No._____ (c) Date Voucher Prepared (d) Contract No. and Date
(e) Payee's Name and Address ABC CORPORATION 100 Main Street Attention: Name, Title and Phone Number of Official to Whom Payment is Sent	(f) Total Est. Cost of Contract (g) Total Fixed-Fee

(h) This invoice/financing request represents reimbursable costs from August 1, 1982 through August 31, 1982

	(i) Amount Billed for Current Period	(j) Cumulative Amount From Inception to Date of this Billing
(k) Direct Costs	$ 3,400	$ 6,800
(1) Direct Labor	600	1,200
(2) Fringe Benefits		
(3) Nonexpendable Equipment (Attach Form HHS-565)		
Permanent Research	3,000	8,000
General Purpose	2,000	
(4) Materials and Supplies	2,000	4,000
(5) Premium Pay	100	150
(6) Consultant Fee	100	100
Dr. Jones/1 day @ 100 (COA #3)		
(7) Travel -- (Domestic)	200	200
(Foreign)	200	200
(8) Subcontract Cost	0	0
(9) Other	0	0
Total Direct Costs	$11,600	$20,650
(l) Cost of Money (Factor) of (Approp. Base)	2,400	3,600
(m) Indirect Costs - Overhead ____% of Direct Labor or Other Base (Formula)	4,000	6,000
(n) Fixed-Fee Earned (Formula)	700	1,400
(o) Total Amount Claimed	$18,700	$31,650
(p) Adjustments Outstanding Suspensions		
(q) Grand Totals	$18,700	$29,950

"I certify that all payments requested are for appropriate purposes and in accordance with the contract."

(Name of Official) (Title)

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PROCUREMENT OF CERTAIN EQUIPMENT

Notwithstanding any other clause in this contract, the contractor will not be reimbursed for the purchase, lease, or rental of any item of equipment listed in the following Federal Supply Groups, regardless of the dollar value, without the prior written approval of the contracting Officer.

67 - Photographic Equipment
69 - Training Aids and Devices
70 - General Purpose ADP Equipment, Software, Supplies and Support (Excluding 7045-ADP Supplies and Support Equipment.)
71 - Furniture
72 - Household and Commercial Furnishings and Appliances
74 - Office Machines and Visible Record Equipment
77 - Musical Instruments, Phonographs, and Home-type Radios
78 - Recreational and Athletic Equipment

When equipment in these Federal Supply Groups is requested by the contractor and determined essential by the contracting officer, the Government will endeavor to fulfill the requirement with equipment available from its excess personal property sources, provided the request is made under a cost-reimbursement contract. Extensions or renewals of approved existing leases or rentals for equipment in these Federal Supply Groups are excluded from the provisions of this article.

NIH(RC)-7
OMB Bulletin 81-16
4/1/84

Department of Health and Human Services

Financial Report of Individual Project/ Contract

Note: Complete this Form in Accordance with Accompanying Instructions.

Project Task:

Reporting Period

Contract No.:

Contractor Name and Address:

Date of Report:

Expenditure Category	Percentage of Effort/Hours		Cumulative Incurred Cost at End of Prior Period	Incurred Cost - Current Period	Cumulative Cost to Date (D + E)	Estimated Cost to Complete	Estimated Cost at Completion (F + G)	Funded Contract Amount	Variance (Over or Under) (I - H)
	Funded	Actual							
A	B	C	D	E	F	G	H	I	J

ATTACHMENT 16

HHS-645 Rev-1/81

INSTRUCTIONS FOR COMPLETING FORM HHS-646
FINANCIAL REPORT OF INDIVIDUAL PROJECT/CONTRACT

GENERAL INFORMATION

Purpose. Form HHS-646 is designed to: (1) provide a management tool for use by HHS in monitoring the application of financial and manpower resources to HHS contracts, (2) provide contractors with financial and manpower management data which is usable in their management processes, (3) indicate promptly, potential areas of contract underruns or overruns by making possible comparisons of actual performance and projections with prior estimates on individual elements of cost and manpower; and (4) obtain contractor's analyses of cause and effect of significant variations between actual and prior estimates of financial and manpower performance.

REPORTING REQUIREMENTS

(a) Scope. Necessary reporting requirements will be established by agreement between the contracting officer and contractor prior to contract award. The Government will limit the details of the reporting requirements to those which are necessary to accomplish the goal of contract management without being unduly burdensome on the contractor.

(b) Number of copies and mailing address. An original and three copies of the report(s) shall be sent to the contracting officer at the address shown on the face page of the contract, no later than thirty working days after the end of the period reported.

REPORTING STATISTICS

A modification which extends the period of performance of an existing contract will not require reporting on a separate Form HHS-646, except where it is determined by the contracting officer that separate reporting is necessary. Furthermore, when incrementally funded contracts are involved, each separate allotment is not considered a separate contract entity (only a funding action). Therefore, the statistics under incrementally funded contracts should be reported cumulatively from the inception of the contract through completion.

Definitions and Instructions for Completing Form HHS-646. For the purpose of establishing expenditure categories in column A, the following definitions and instructions will be utilized. Each contract will specify the categories to be reported.

(1) Personnel - Professional. Included are the senior level and all other personnel whose total annual salary rates are $20,000 or more. It should include key personnel regardless of annual salary rates. All such individuals should be listed by name and

job title on a separate line including those whose salary is not directly charged to the contract but whose effort is directly associated with the contract. The listing must be kept up to date.

(2) **Personnel - Other.** This will be listed as one amount unless otherwise required by the contract.

(3) **Fringe Benefits.** Include allowances and services provided by the contractor to employees as compensation in addition to regular salaries and wages. If a fringe benefit rate has been established, the rate will be applied to the agreed upon base. If a rate has not been established, the various fringe benefit costs may be required to be shown separately. Fringe benefits which are included in the direct cost rate should not be shown here.

(4) **Capitalized nonexpendable equipment.** This represents personal property of a capital nature, i.e. property acquired at a cost of $500.00 or more and has a service life of more than two years.

Form HEW-565, Report of Capitalized Nonexpendable Equipment, as outlined in the Departmental Manual "Control of Property in Possession of Contractors," will accompany the contractor's public voucher (SF 1034/SF 1035) as required, or this report if not previously submitted.

(5) **Supplies.** Includes the cost of supplies and material and equipment charged directly to the contract, but excludes the cost of capitalized nonexpendable equipment as defined in (4) above.

(6) **Inpatient Care.** Costs associated with a patient while occupying a bed in a patient care setting. It normally includes both routine and ancillary costs.

(7) **Outpatient Care.** Costs associated with a patient while not occupying a bed. It normally includes ancillary costs only.

(8) **Travel.** Includes all direct costs of travel, including transportation, subsistence and miscellaneous expenses. Travel for staff and consultants shall be shown separately. Identify foreign and domestic travel separately. If required by the contract, the following information shall be submitted: (i) Name of traveler and purpose of trip; (ii) Place of departure, destination and return, including time and dates; and (iii) Total cost of trip.

(9) **Consultant Fee.** Fees paid to consultant.

(10) **Premium pay.** Includes the amount of salaries and wages over and above the basic rate of pay.

(11) **Other costs.** Includes a number of separate expenditure categories for which the Government does not require individual line item reporting. It may include some of the above categories.

(12) **Overhead/Indirect Costs.** Cite the rate and the base.

(13) **General and Administrative expense.** Cite the rate and the base. In the case of nonprofit organizations, this item will usually be included in the indirect cost.

(14) **Fee.** If any, cite the fee earned.

(15) **Total Costs to the Government.**

PREPARATION INSTRUCTIONS

These instructions are keyed to the columns on Form HHS-646.

Column A - **Expenditure Category.** Enter in column A the expenditure categories required by the contract.

Column B - **Percentage of Effort/Hours Funded.** Enter in column B the percentage of effort or number of hours agreed to during contract negotiations of each labor category listed in column A.

Column C - **Percentage of Effort/Hours-Actual.** The Contractor will enter the cumulative percentage of effort or number of hours worked by each employee or group of employees listed in Column A.

Column D - **Cumulative Incurred Cost at End of Prior Period.** This column should show the cumulative incurred costs up to the end of the prior reporting period. This column will be blank at the time of the submission of the initial report.

Column E - **Incurred Cost-Current Period.** The contractor should enter the costs which were incurred during the current period.

Column F - **Cumulative Incurred Cost to Date.** The Contractor should enter the combined total of columns D and E.

> NOTE: The following instructions apply to the preparation of the second and subsequent reports. No entries are to be made in columns (G), (h), and (J) for the first report.

Column G - **Estimated Cost to Complete.** Entries need only be made when the contractor estimates that a particular expenditure category will vary from the amount funded. Realistic estimates are essential.

Column H - **Estimated Costs at Completion.** No entry is required in this column unless an entry is made in Column G.

Column I - **Funded Contract Amount.** Enter in this column the costs agreed to during contract negotiations for all expenditure categories listed in Column A.

Column J - **Variance (Over or Under).** This column need not be filled in when Column H is blank. When entries have been made in Column H, this column should show the difference between the estimated costs at completion (Column H) and funded costs (Column I). When a line item varies by plus or minus 10%, i.e., the percentage arrived at by dividing Column J by Column I, an explanation of the variance should be submitted. In the case of an overrun (net negative variance), this submission shall not be deemed as notice under the Limitation of Cost (Funds) clause of the contract.

Modifications. Any modification in the amount funded for an item since the preceding report should be listed in the appropriate cost category with the word "modification" immediately following the listed element in Column A and with all columns filled in including the new funded amount. A line should be drawn through the old cost element. Subtotals among cost categories should be changed where necessary.

Expenditures Not Funded. An expenditure for an item for which no amount was funded (e.g., at the discretion of the contractor in performance of its contract) should be listed in the appropriate cost category and all columns filled in except for I. Column J will of course show a 100% variance and will be explained along with those identified under J above.

PART IV

REPRESENTATIONS AND INSTRUCTIONS

PART IV - REPRESENTATIONS AND INSTRUCTIONS

SECTION K - REPRESENTATIONS, CERTIFICATIONS AND OTHER STATEMENTS OF OFFERORS

SECTION L - INSTRUCTIONS, CONDITIONS AND NOTICES TO OFFERORS

SECTION M - EVALUATION FACTORS FOR AWARD

PART IV - SECTION K

Representations, Certifications and Other Statements or Offers or Quoters (Negotiated)

1. REPRESENTATIONS AND CERTIFICATIONS

1.	FAR 52.203-2	Certification of Independent Price Determination.
2.	FAR 52.203-4	Contingent Fee Representation and Agreement.
3.	FAR 52.203-8	Requirement for Certificate of Procurement Integrity
4.	FAR 52.203-9	Requirement for Certificate of Procurement Integrity - Modification
5.	FAR 52.204-3	Taxpayer Identification.
6.	FAR 52.209-5	Certification Regarding Debarment, Suspension, Proposed Debarment, and other Responsibility Matters.
7.	FAR 52.215-6	Type of Business Organization.
8.	FAR 52.215-11	Authorized Negotiators.
9.	FAR 52.215-19	Period for Acceptance of Offer.
10.	FAR 52.215-20	Place of Performance.
11.	FAR 52.219-1	Small Business Concern Representation.
12.	FAR 52.219-2	Small Disadvantaged Business Concern Representation.
13.	FAR 52.219-3	Women-Owned Small Business Representation.
14.	FAR 52.219-15	Notice of Participation by Organizations for the Handicapped
15.	FAR 52.220-1	Preference for Labor Surplus Area Concerns.
16.	FAR 52.222-19	Walsh-Healy Public Contracts Act Representation.
17	FAR 52.222-21	Certification of Nonsegregated Facilities.
18.	FAR 52.222-22	Previous Contracts and Compliance Reports.
19.	FAR 52.222-25	Affirmative Action Compliance.
20.	FAR 52.223-1	Clean Air and Water Certification.
21.	FAR 52.223-5	Certification Regarding a Drug-Free Workplace.
22.	FAR 52.225-1	Buy American Certification.
23.	FAR 52.225-12	Notice of Restrictions on Contracting with Sanctioned Persons.
24.	FAR 52.230-2	Cost Accounting Standards Notices and Certification (Non Defense).
25.	FAR 15.804-4	Certificate of Current Cost or Pricing Data.

To Be Completed by the Offeror: (The Representations and Certifications must be executed by an individual authorized to bind the offeror.)

The offeror makes the following Representations and Certifications as part of its proposal (check or complete all appropriate boxes or blanks on the following pages).

_____	NCI-CN-95165-38
(Name of Offeror)	(RFP Number)
_____	_____
(Signature of Authorized Individual)	(Date)

_____
(Typed Name of Authorized Individual)

Note: The penalty for making false statements in offers is prescribed in 18 U.S.C. 1001.

1. 52.203-2 CERTIFICATE OF INDEPENDENT PRICE DETERMINATION (APRIL 1985)

(a) The offeror certifies that -

(1) The prices in this offer have been arrived at independently, without, for the purpose of restricting competition, any consultation, communication, or agreement with any other offeror or competitor relating to (i) those prices, (ii) the intention to submit an offer, or (iii) the methods or factors used to calculate the prices offered;

(2) The prices in this offer have not been and will not be knowingly disclosed by the offeror, directly or indirectly, to any other offeror or competitor before bid opening (in the case of a sealed bid solicitation) or contract award (in the case of a negotiated solicitation) unless otherwise required by law; and

(3) No attempt has been made or will be made by the offeror to induce any other concern to submit or not to submit an offer for the purpose of restricting competition.

(b) Each signature on the offer is considered to be a certification by the signatory that the signatory -

(1) Is the person in the offeror's organization responsible for determining the prices being offered in this bid or proposal, and that the signatory has not participated and will not participate in any action contrary to subparagraphs (a)(1) through (a)(3) above; or

(2) (i) Has been authorized in writing, to act as agent for the following principals in certifying that those principals have not participated, and will not participate in any action contrary to subparagraphs (a)(1) through (a)(3) above

.....
.....
[insert full name of person(s) in the offeror's organization responsible for determining the prices offered in this bid or proposal, and the title of his or her position in the offeror's organization];

(ii) As an authorized agent, does certify that the principals named in subdivision (b)(2)(i) above have not participated, and will not participate, in any action contrary to subparagraphs (a)(1) through (a)(3) above; and

(iii) As an agent, has not personally participated, and will not participate, in any action contrary to subparagraphs (a)(1) through (a)(3) above.

(c) If the offeror deletes or modifies subparagraph (a)(2) above, the offeror must furnish with its offer a signed statement setting forth in detail the circumstances of the disclosure.

2. 52.203-4 CONTINGENT FEE REPRESENTATION AND AGREEMENT - (APRIL 1984)

(a) Representation. The offeror represents that, except for full-time bona fide employees working solely for the offeror, the offeror -

(Note: **The offeror must check the appropriate boxes. For interpretation of the representation, including the term "bona fide employee," see Subpart 3.4 of the Federal Acquisition Regulation.)**

(1) [ ] has, [ ] has not employed or retained any person or company to solicit or obtain this contract; and

(2) [ ] has, [ ] has not paid or agreed to pay to any person or company employed or retained to solicit or obtain this contract any commission, percentage, brokerage, or other fee contingent upon or resulting from the award of this contract.

(b) Agreement. The offeror agrees to provide information relating to the above Representation as requested by the Contracting Officer and, when subparagraph (a)(1) or (a)(2) is answered affirmatively, to promptly submit to the Contracting Officer -

(1) A completed Standard Form 119, Statement of Contingent or Other Fee, (SF-119); or

(2) A signed statement indicating that the SF 119 was previously submitted to the same contracting office, including the date and applicable solicitation or contract number, and representing that the prior SF 119 applies to this offer or quotation.

~~3~~ 52.203-8 REQUIREMENT FOR CERTIFICATE OF PROCUREMENT INTEGRITY - (MAY 1989)

(a) Definitions. ~~The~~ definitions at FAR ~~3.104-4~~ are hereby incorporated in this ~~provision.~~

(b) Certifications. ~~As~~ required in paragraph ~~(c) of this~~ provision, the ~~officer~~ or employee responsible for this offer ~~shall execute the~~ following certification:

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CERTIFICATE OF PROCUREMENT INTEGRITY

(1) I, _____, (Name of Offeror) am the officer or employee responsible for the preparation of this offer or bid and hereby certify that, to the best of my knowledge and belief, with the exception of any information described in this certificate, I have no information concerning a violation or possible violation of subsection 27 (a), (b), (c), or (e) of the Office of Federal Procurement Policy Act* (41 U.S.C. 423)(hereinafter referred to as "the Act"), as implemented in the FAR, occurring during the conduct of this procurement _____, (solicitation number).

(2) As required by subsection 27 (d)(1)(B) of the Act, I further certify that each officer, employee, agent, representative, and consultant of _____, (Name of Offeror) who has participated personally and substantially in the preparation or submission of this offer has certified that he or she is familiar with, and will comply with, the requirements of subsection 27(a) of the Act, as implemented in the FAR, and will report immediately to me any information concerning a violation or possible violation of the Act, as implemented in the FAR, pertaining to this procurement.

(3) Violations of possible violations: (Continue on plain bond paper if necessary and label Certificate of Procurement Integrity (Continuation Sheet), ENTER "NONE" IF NONE EXISTS)

_____

_____

_____

(Signature of the Officer or Employee Responsible for the Offer and Date)

(Typed Name of the Officer or Employee Responsible for the Offer)

*Section 27 became effective on July 16, 1989.

THIS CERTIFICATION CONCERNS A MATTER WITHIN THE JURISDICTION OF AN AGENCY OF THE UNITED STATES AND THE MAKING OF A FALSE, FICITITIOUS, OR FRAUDULENT CERTIFICATION MAY RENDER THE MAKER SUBJECT TO PROSECUTION UNDER TITLE 18, UNITED STATES CODE, SECTION 1001.

(End of Certification)

(c) The signed certification in paragraph (b) of this provision shall be executed and submitted as follows:

(1) If this is an invitation for bids (IFB), with bid submission exceeding $100,000.

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(2) If this is a procurement using the two-step sealed bidding procedure (see FAR Subpart 14.5), with bids exceeding $100,000, with submission to the Government of step-two sealed bids.

(3) If this is a request for proposal (RFP) or quotation (RFQ), by the successful offeror as close as practicable to, but in no event later than, the date of award of a contract exceeding $100,000.

(4) If this is an invitation for bids for an indefinite delivery-type contract, and if the estimated value of orders to be placed under the contract is expected to exceed $100,000, with the bid submissions.

(5) If this is an RFQ or RFP for an indefinite delivery-type contract, and if the estimated balue of orders expected to be placed under the contract is expected to exceed $100,000, by the successful offeror as close as practicable to, but in no event later than the date of contract award.

(6) For letter contracts, prior to award of the letter contract and prior to definitization of the letter contracts.

(7) For other procurement actions in excess of $100,000, prior to award or execution as specified by the Cotnracting Officer.

(8) The certificate required by subparagraphs (c)(3) and (c)(5) through (c)(7) of this provision shall be submitted to the Contracting Officer within the time period specified by the Contracting Officer when requesting the certificate.

(d) Pursuant to FAR 3.104-9(d), the offeror may be requested to execute additional certifications at the request of the Government.

(e) Failure of an offeror to submit the certification required by FAR 3.104-9(b) or any additional certifications pursuant to FAR 3.104-9(d) will render the offeror ineligible for contract award (see FAR 9.104-1(g)).

(f) A certification containing a disclosure of a violation or possible violation will not necessarily result in the withholding of award under this solicitation. However, the Government, after evaluation of the disclosure, may cancel this procurement or take any other appropriate actions in the interest of the Government, such as disqualification of the offeror.

(g) In making the certification in subparagraph (b)(2) of this provision, the offeror may rely upon the certification by an officer, employee, agent, representative, or consultant that such person is in compliance with the requirements of subsections 27(a), (b), (c), or (e) of the Office of Federal Procurement Policy Act (41 U.S.C. 423), as implemented in the FAR, unless the offeror knows, or should have known, of reasons to the contrary. The offeror may rely upon periodic certifications that must be obtained at least annually, supplemented with periodic training

programs. These certifications shall be maintained by the contractor for 6 years from the date of execution.

(h) The certifications in paragraph (b) and (d) of this provision are a material representation of fact upon which reliance will be placed in awarding a contract.

4. FAR 52.203-9 REQUIREMENT FOR CERTIFICATION OF PROCUREMENT INTEGRITY - MODIFICATION - (MAY 1989)

(a) Definitions. The definitions set forth in FAR 3.104-4 are hereby incorporated in this clause.

(b) The Contactor agrees that it will execute the certification set forth in paragraph (c) of this clause, when requested by the contracting officer in connection with the execution of any modification of this contract. A contract modification may not be executed with the certification.

(c) Certification. As required in paragraph (b) of this clause, the officer or employee responsible for the modification proposal shall execute the following certification:

CERTIFICATION OF PROCUREMENT INTEGRITY - MODIFICATION
(MAY 1989)

(1) I, _____ (Name of Certifier) am the officer or employee responsible for the preparation of this modification proposal and hereby certify that, to the best of my knowledge and belief, with the exception of any information described in this certification, I have no information concerning a violation or possible violation of subsection 27(a), (b), (c), or (e) of the Office of Federal Procurement Policy Act* (41 U.S.C. 423), (hereinafter referred to as the Act), as implemented in the FAR, occurring during the conduct of this procurement _____, (Contract and Modification Number).

(2) As required by subsection 27(d)(1)(B) of the Act, I further certify that each officer, employee, agent, representative, and consultant of _____, (Name of Offeror) who has participated personally and substantially in the preparation or submission of this proposal has certified that he or she is familiar with, and will comply with, the requirements of subsection 27(a) of the Act, as implemented in the FAR, pertaining to this procurement.

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(3) Violations or possible violations: (Continue on plain bond paper if necessary and label Certificate of Procurement Integrity - Modification (Continuation Sheet), ENTER "NONE" IF NONE EXISTS)

(Signature of the Officer of Employee Responsible for the Modification Proposal and Date)

(Typed Name of the Officer or Employee Responsible for the Modification Proposal)

*Section 27 became effective on July 16, 1989.

THIS CERTIFICATION CONCERNS A MATTER WITHIN THE JURISDICTION OF AN AGENCY OF THE UNITED STATES AND THE MAKING OF A FALSE, FICITIOUS, OR FRAUDULENT CERTIFICATION MAY RENDER THE MAKER SUBJECT TO PROSECUTION UNDER TITLE 18, UNITED STATES CODE, SECTION 1001.

(End of Certification)

(d) In making the certification in paragraph (2) of the certificate, the Contractor may rely upon the certification by an officer, employee, agent, representative, or consultant that such person is in compliance with the requirements of subsections 27(a), (b), (c), or (e) of the Office of Federal Procurement Policy Act (41 U.S.C. 423), as implemented in the FAR, unless the Contractor knows, or should have known, of reasons to the contrary. The Contractor may rely upon periodic certifications that must be obtained at least annually, supplemented with periodic training programs. These certifications shall be maintained by the Contractor for a period of 6 years from the date of execution.

(e) The certification required by paragraph (c) of this clause is a material representation of fact upon which reliance will be placed in executing this modification.

5. 52.204-3 TAXPAYER'S IDENTIFICATION - (SEPTEMBER 1989)

(a) Definitions.

"Common parent," as used in this solicitation provision, means that corporate entity that owns or controls an affiliated group of corporations that files its federal income tax returns on a consolidated basis, and of which the offeror is a member.

"Corporate status," as used in this solicitation provision, means a designation as to whether the offeror is a corporate entity, an unincorporated entity (e.g., sole proprietorship or partnership), or a corporation providing medical and health care services.

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"Taxpayer Identification Number (TIN)," as used in this solicitation provision, means the number required by the IRS to be used by the offeror in reporting income tax and other returns

(b) The offeror is required to submit the information required in paragraphs (c) through (e) of this solicitation provision in order to comply with reporting requirements of 26 U.S.C. 6041, 6041A, and 6050M and implementing regulations issued by the Internal Revenue Service (IRS). If the resulting contract is subject to the reporting requirements described in 4.902(a), the failure or refusal by the offeror to furnish the information may result in a 20 percent reduction of payments otherwise due under the contract.

(c) Taxpayer Identification Number (TIN).

( ) TIN:_____
( ) TIN has been applied for.
( ) TIN is not required because:

( ) Offeror is a nonresident alien, foreign corporation, or foreign partnership that does not have income effectively connected with the conduct of a trade or business in the U.S. and does not have an office or place of business or a fiscal paying agent in the U.S.;

( ) Offeror is an agency or instrumentality of a foreign government;

( ) Offeror is an agency or instrumentality of a Federal, state or local government;

( ) Other. State basis. _____
_____

(d) Corporate Status.

( ) Corporation providing medical and health care services, or engaged in the billing and collecting of payments for such services;
( ) Other corporate entity;
( ) Not a corporate entity;
( ) Sole proprietorship
( ) Partnership
( ) Hospital or extended care facility described in 26 CFR 501(c)(3) that is exempt from taxation under 26 CFR 501 (a).

(e) Common Parent.

( ) Offeror is not owned or controlled by a common parent as defined in paragraph (a) of this clause.

( ) Name and TIN of common parent:

Name_____
TIN_____

(End of Provision)

6. 52.209-6 PROTECTING THE GOVERNMENT'S INTEREST WHEN SUBCONTRACTING WITH CONTRACTORS DEBARRED, SUSPENDED, OR PROPOSED FOR DEBARMENT - (MAY 1989)

(a) The Government suspends or debars Contractors to protect the Government's interests. Contractors shall not enter into any subcontract equal to or in excess of $25,000 with a Contractor that has been debarred, suspended, or proposed for debarment unless there is a compelling reason to do so. If a Contractor intends to subcontract with a party that is debarred, suspended, or proposed for debarment (see FAR 9.404 for information on the list of Parties Excluded from Procurement Programs), a corporate officer or designee of the Contractor shall notify the Contracting Officer, in writing, before entering into such subcontract. The notice must include the following:

(1) The name of the subcontractor;

(2) The Contractor's knowledge of the reasons for the subcontractor being on the list of Parties Excluded from Procurement Programs;

(3) The compelling reason(s) for doing business with the subcontractor notwithstanding its inclusion on the list of Parties Excluded from Procurement Programs; and

(4) The systems and procedures the Contractor has established to ensure that it is fully protecting the Government's interests when dealing with such subcontractor in view of the specific basis for the party's debarment, suspension, or proposed debarment.

(b) The Contractor's compliance with the requirements of 52.209-6 will be reviewed during Contractor Purchasing System Reviews (see FAR Subpart 44.3).

(End of Clause)

7. 52.215-6 TYPE OF BUSINESS ORGANIZATION - (JULY 1987)

The offeror or quoter, by checking the applicable box, represents that -

(a) It operates as [ ] a corporation incorporated under the laws of the State of _____, [ ] an individual, [ ] a partnership, [ ] a nonprofit organization, or [ ] a joint venture; or

(b) If the offeror or quoter is a foreign entity, it operates as [ ] an individual, [ ] a joint venture, or [ ] a corporation, registered for business in _____.
country

8. 52.215-11 AUTHORIZED NEGOTIATORS - (APRIL 1984)

The offeror or quoter represents that the following persons are authorized to negotiate on its behalf with the Government in connection with this request for proposals or quotations: (list names, titles, and telephone numbers of the authorized negotiators)

NAME	TITLE	TELEPHONE NUMBER
_____	_____	_____
_____	_____	_____
_____	_____	_____

9. 52.215-19 PERIOD FOR ACCEPTANCE OF OFFER - (APRIL 1984)**

**NOTE: This provision is applicable only: (1) if the RFP is not issued on SF 33 (except those for construction work) or, (2) in solicitations where the Government does not specify a minimum acceptance period elsewhere in the RFP.

In compliance with the solicitation, the offeror agrees, if this offer is accepted within _____ calendar days (60 calendar days unless a different period is inserted by the offeror) from the date specified in the solicitation for receipt of offers, to furnish any or all items on which prices are offered at the price set opposite each item, delivered at the designated point(s) within the time specified in the Schedule.

10. 52.215-20 PLACE OF PERFORMANCE - (APRIL 1984)

(a) The offeror or quoter, in the performance of any contract resulting from this solicitation, [ ] intends, [ ] does not intend (check applicable block) to use one or more plants or facilities located at a different address from the address of the offeror or quoter as indicated in this proposal or quotation.

(b) If the offeror or quoter checks "intends" in paragraph (a) above, it shall insert in the spaces provided below the required information:

Place of Performance (Street Address, City, County, State, Zip Code)	Name and Address of Owner and Operator of the Plant or Facility if Other than Offeror or Quoter

11. 52.219-1 SMALL BUSINESS CONCERN REPRESENTATION - (MAY 1986)

The offeror represents and certifies as part of its offer that it [ ] is, [ ] is not a small business concern and that [ ] all, [ ] not all end items to be furnished will be manufactured or produced by a small business concern in the United States, its territories or possessions, Puerto Rico or the Trust Territory of the Pacific Islands. "Small business concern," as used in this provision, means a concern, including its affiliates that is independently owned and operated, not dominant in the field of operation in which it is bidding on Government contracts, and qualified as a small business under the size standards in this solicitation.

12. 52.219-2 SMALL DISADVANTAGED BUSINESS CONCERN REPRESENTATION - (APRIL 1984)

(a) Representation. The offeror represents that it [ ] is, [ ] is not a small disadvantaged business concern.

(b) Definitions

"Asian-Indian American," as used in this provision, means a United States citizen whose origins are in India, Pakistan, or Bangladesh.

"Asian-Pacific American," as used in this provision, means a United States citizen whose origins are in Japan, China, the Philippines, Vietnam, Korea, Samoa, Guam, the U.S. Trust Territory of the Pacific Islands, the Northern Mariana Islands, Laos, Cambodia, or Taiwan.

"Native Americans," as used in this provision, means American Indians, Eskimos, Aleuts, and native Hawaiians.

"Small Business concern," as used in this provision, means a concern, including its affiliates, that is independently owned and operated, not dominant in the field of operation in which it is bidding on Government contracts, and qualified as a small business under the criteria and size standards in 13 CFR 121.

"Small disadvantaged business concern," as used in this provision, means a small business concern that (1) is at least 51 percent owned by one or more individuals who are both socially and economically disadvantaged, or a publicly owned business having at least 51 percent of its stock owned by one or more socially and economically disadvantaged individuals and (2) has its management and daily business controlled by one ore more such individuals.

(c) Qualified groups. The offeror shall presume that socially and economically disadvantaged individuals include Black Americans, Hispanic Americans, Native Americans, Asian-Pacific Americans, Asian-Indian Americans, and other individuals found to be qualified by the SBA under 13 CFR 124.1.

13. 52.219-3 WOMEN-OWNED SMALL BUSINESS REPRESENTATION - (APRIL 1984)

(a) Representation. The offeror represents that it [ ] is, [ ] is not a women-owned small business concern.

(b) Definitions.

"Small Business concern," as used in this provision, means a concern, including its affiliates, that is independently owned and operated, not dominant in the field of operation in which it is bidding on Government contracts, and qualified as a small business under the criteria and size standards in 13 CFR 121.

"Women-owned," as used in this provision, means a small business that is at least 51 percent owned by a woman or women who are U.S. citizens and who also control and operate the business.

14. 52.219-15 NOTICE OF PARTICIPATION BY ORGANIZATIONS FOR THE HANDICAPPED - (JUNE 1989)

(NOTE: This provision applies only to acquisitions involving total or partial small business set-asides.)

(a) Definitions.

"Handicapped individual" means a person who has a physical, mental, or emotional impairment, defect, ailment disease, or disablility of a permanent nature which in any way limits the selection of any type of employment for which the person would otherwise be qualified or qualifiable.

(b) The Offeror certifies that it is ( ) is not ( ) a public or private organization for the handicapped. An offeror certifying in the affirmative is eligible to participate in any resultant contract as if it were a small business concern.

(c) An Offeror certifying as a public or private organization for the handicapped agrees that at least 75 percent of the direct labor required in the performance of the contract will be performed by handicapped individuals.

"Public or private organization for the handicapped" means one which (1) is organized under the laws of the United States or of any State, operated in the interest of handicapped individuals, the net income of which does not inure in whole or in part to the benefit of any shareholder or other individual; (2) complies with any applicable occupational health and safety standard prescribed by the Secretary of Labor, and (3) employs in the production of commodities and in the provision of services, handicapped individuals for not less than 75 percent of the direct labor required for the production or provision of the commodities or services.

(End of Clause)

15. 52.220-1 PREFERENCE FOR LABOR SURPLUS AREA CONCERNS - (APRIL 1984)

(a) This acquisition is not a set aside for labor surplus area (LSA) concerns. However, the offeror's status as such a concern may affect (1) entitlement to award in case of tie offers or (2) offer evaluation in accordance with the Buy American Act clause of this solicitation. In order to determine whether the offeror is entitled to a preference under (1) or (2) above, the offeror must identify below, the LSA in which the costs to be incurred on account of manufacturing or production (by the offeror or the first-tier subcontractors) amount to more than 50 percent of the contract price.

_____

_____

(b) Failure to identify the locations as specified above will preclude consideration of the offeror as an LSA concern and would not have otherwise qualified for award, the offeror shall perform the contract or cause the contract to be performed in accordance the obligations of an LSA concern.

16. 52.222-19 WALSH-HEALY PUBLIC CONTRACTS ACT REPRESENTATION - (APRIL 1984)

The offeror represents as a part of this offer that the offeror is [ ] or is not [ ] a regular dealer in, or is [ ] or is not [ ] a manufacturer of, the supplies offered.

17. 52.222-21 CERTIFICATION OF NONSEGREGATED FACILITIES - (APRIL 1984)

(a) "Segregated facilities," as used in this provision, means any waiting rooms, work areas, rest rooms and wash rooms, restaurants and other eating areas, time clocks, locker rooms and other storage or dressing areas, parking lots, drinking fountains, recreation or entertainment areas, transportation, and housing facilities provided for employees, that are segregated by explicit directive or are in fact segregated on the basis of race, color, religion, or national origin because of habit, local custom or otherwise.

(b) By the submission of this offer, the offeror certifies that it does not and will not maintain or provide for its employees any segregated facilities at any of its establishments, and that it does not and will not permit its employees to perform their services at any location under its control where segregated facilities are maintained. The offeror agrees that a breach of this certification is a violation of the Equal Opportunity clause in the contract.

(c) The offeror further agrees that (except where it has obtained identical certifications from proposed subcontractors for specific time periods) it will -

(1) Obtain identical certifications from proposed subcontractors before the award of subcontracts under which the subcontractor will be subject to the Equal Opportunity clause;

(2) Retain the certification in the files; and

(3) Forward the following notice to the proposed subcontractors (except if the proposed subcontractors have submitted identical certifications for specific time periods):

NOTICE TO PROSPECTIVE SUBCONTRACTORS OF REQUIREMENT FOR CERTIFICATIONS OF NONSEGREGATED FACILITIES

A Certification of Nonsegregated Facilities must be submitted before the award of a subcontract under which the subcontractor will be subject to the Equal Opportunity Clause. The certification may be submitted for all subcontracts during a period (i.e. quarterly, semiannually, or annually).

NOTE: The penalty for making false statements in offers is prescribed in 18 U.S.C. 1001.

18. 52.222-22 PREVIOUS CONTRACTS AND COMPLIANCE REPORTS - (APRIL 1984)

The offeror represents that -

(a) It [ ] has, [ ] has not participated in a previous contract or subcontract subject either to the Equal Opportunity clause of the solicitation, the clause originally contained in Section 310 of Executive Order No. 10925, or the clause contained in Section 201 of Executive Order No. 11114;

(b) It [ ] has, [ ] has not, filed all required compliance reports; and

(c) Representations indicating submission of required compliance reports, signed by proposed subcontractors, will be obtained before subcontract awards.

19. 52.222-25 AFFIRMATIVE ACTION COMPLIANCE - (APRIL 1984)

The offeror represents that (a) it [ ] has developed and has on file, [ ] has not developed and does not have on file, at each establishment, affirmative action programs required by the rules and regulations of the Secretary of Labor (41 CFR 60-1 and 60-2), or (b) it [ ] has not previously had contracts subject to the written affirmative action programs requirement of the rules and regulations of the Secretary of Labor.

20. 52.223-1 CLEAN AIR AND WATER CERTIFICATION - (APRIL 1984)

The offeror certifies that -

(a) Any facility to be used in the performance of this proposed contract is [ ], is not [ ] listed on the Environmental Protection Agency List of Violating Facilities;

(b) The offeror will immediately notify the Contracting Officer, before award, of the receipt of any communication from the Administrator, or a designee, of the Environmental Protection Agency, indicating that any facility that the offeror proposes to use for the performance of the contract is under consideration to be listed on the EPA List of Violating Facilities; and

(c) The offeror will include a certification substantially the same as this certification, including this paragraph (c), in every nonexempt subcontract.

21. 52.223-5 CERTIFICATION REGARDING A DRUG-FREE WORKPLACE - (MARCH 1989)

(a) Definitions. As used in this provision,

"Controlled substance" means a controlled substance in schedules I through V of section 202 of the Controlled Substances Act (21 U.S.C. 812) and as further defined in regulation at 21 CFR 1308.11-1308.15.

"Conviction" means a finding of guilt (including a plea of nolo contendere or imposition of sentence, or both, by any judicial body charged with the responsibility to determine violations of the Federal or State criminal drug statutes.

"Criminal drug statute" means a Federal or non-Federal criminal statute involving the manufacture, distribution, dispensing, possession or use of any controlled substance.

"Drug-free workplace" means a site for the performance of work done in connection with a specific contract at which employees of the Contractor are prohibited from engaging in the unlawful manufacture, distribution, dispensing, possession, or use of a controlled substance.

"Employee" means an employee of a Contractor directly engaged in the performance of work under a Government contract.

"Individual" means an offeror/contractor that has no more than one employee including the offeror/contractor.

(b) By submission of its offer, the offeror, if other than an individual, who is making an offer that equals or exceeds $25,000, certifies and agrees, that with respect to all employees of the offeror to be employed under a contract resulting from this solicitation, it will-

(1) Publish a statement notifying such employees that the unlawful manufacture, distribution, dispensing, possession c use of a controlled substance is prohibited in the Contractor's workplace and specifying the actions that will be taken against employees for violations of such prohibition;

(2) Establish a drug-free awareness program to inform such employees about-

(i) The dangers of drug abuse in the workplace;
(ii) The Contractor's policy of maintaining a drug-free workplace;
(iii) Any available drug counseling, rehabilitation, and employee assistance programs; and
(iv) The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;

(3) Provide all employees engaged in performance of the contract with a copy of the statement required by subparagraph (b)(1) of this provision;

(4) Notify such employees in the statement required by subparagraph (b)(1) of this provision, that as condition of continued employment on the contract resulting from this solicitation, the employee will-

(i) Abide by the terms of the statement; and
(ii) Notify the employer of any criminal drug statute conviction for a violation occurring in the workplace nc later than five (5) days after such conviction;

(5) Notify the contracting officer within ten (10) days after receiving notice under subdivision (b)(4)(ii) of this provision, from an employee or otherwise receiving actual notice of such conviction; and

(6) Within 30 days after receiving notice under subdivision (b)(4)(ii) of this provision of a conviction, impose the following sanctions or remedial measures on any employee who is convicted of drug abuse violations occurring in the workplace:

(i) Take appropriate personnel action against such employee, up to and including termination; or
(ii) Require such employee to satisfactorily participate in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency.

(7) Make a good faith effort to maintain a drug-free workplace through implementation of subparagraphs (b)(1)through (b)(6) of this provision.

(c) By submission of its offer, the offeror, if an individual who is making an offer of any dollar value certifies and agrees that the offeror will not engage in the unlawful manufacture, distribution, dispensing, possession, or use of a controlled substance in the performance of the contract resulting from this solicitation.

(d) Failure of the offeror to provide the certification required by paragraph (b) or (c) of this provision, renders the offeror unqualified and ineligible for award. (See FAR 9.104-1(g) and 19.602-1(a)(2)(i).)

(e) In addition to other remedies available to the Government, the certification in paragraphs (b) and (c) of this provision concerns a matter within the jurisdiction of an agency of the United States and the making of a false, fictitious, or fraudulent certification may render the maker subject to prosecution under Title 18, United States Code, Section 1001.

(End of Provision)

22. 52.225-1 BUY AMERICAN CERTIFICATE - (APRIL 1984)

The offeror certifies that each end product, except those listed below, is a domestic end product, (as defined in the clause entitled "Buy American Act - Supplies"), and that components of unknown origin are considered to have been mined, produced, or manufactured outside the United States.

Excluded End Products	Country of Origin
_____	_____
_____	_____
_____	_____

(List as necessary)

Offerors may obtain from the contracting officer lists of articles, materials, and supplies excepted from the Buy American Act (listed at 25.108 of the Federal Acquisition Regulation).

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23. 52.225-12 NOTICE OF RESTRICTIONS ON CONTRACTING WITH SANCTIONED PERSONS - (MAY 1989)

(a) Statutory prohibitions have been imposed on contracting with sanctioned persons, as specified in Federal Acquisition Regulation (FAR) 52.225-13, Restrictions on Contracting with Sanctioned Persons.

(b) By submission of this offer, the Offeror represents that no products or services, except those listed in this paragraph (b), delivered to the Government under any contract resulting from this solicitation will be products or services of a sanctioned person, as defined in the clause referenced in paragraph (a) of this provision, unless one of the exceptions in paragraph (d) of the clause at FAR 52.225-13 applies.

Product or Service	Sanctioned Person
.....	.....
.....	.....
.....	.....

(List as Necessary)
(End of Provision)

24. 52.230-2 COST ACCOUNTING STANDARDS NOTICES AND CERTIFICATION - (NONDEFENSE) - (SEPTEMBER 1987)

Note: This notice does not apply to small businesses or foreign governments.

(a) Any contract over $100,000 resulting from this solicitation shall be subject to Cost Accounting Standards (CAS) if it is awarded to a business unit that is currently performing a national defense CAS-covered contract or subcontract, except when -

(1) The award is based on adequate price competition;

(2) The price is set by law or regulation;

(3) The price is based on established catalog or market prices of commercial items sold in substantial quantities to the general public; or

(4) One of the exemptions in Federal Acquisition Regulation (FAR) 30.201-1(b) applies.

(b) Contracts not exempted from CAS shall be subject to full or modified coverage as follows:

(1) If the business unit receiving the award is currently performing a national defense contract or subcontract subject to full CAS coverage FAR 30.201-1(a), this contract will have full CAS coverage and will contain the clauses from the FAR entitled Cost Accounting Standards, 52.230-3 and Administration of Cost Accounting Standards, 52.230-4.

(2) If the business unit receiving the award is currently performing a national defense contract or subcontract subject to modified CAS coverage FAR 30.210-2(b), this contract will have modified coverage and will contain the clauses entitled Disclosure and Consistency of Cost Accounting Practices, 52.230-5 and Administration of Cost Accounting Standards, 52.230-4.

A. **Certificate of CAS Applicability**

The offeror hereby certifies that -

[ ] The offeror is not performing any CAS-covered national defense contract or subcontract. The offeror further certifies that it will immediately notify the Contracting Officer in writing if it is awarded any national defense CAS-covered contract or subcontract subsequent to the date of this certificate but before the date of the award of a contract resulting from this solicitation. **(If this statement applies, no further certification is required.)**

[ ] The offeror is currently performing a negotiated national defense contract or subcontract that contains the Cost Accounting Standards clause at FAR 52.230-3.

[ ] The offeror is currently performing a negotiated national defense contract or subcontract that contains the Disclosure and Consistency of Cost Accounting Practices clause at FAR 52.230-5.

B. **Additional Certification-CAS Applicable Offerors**

[ ] The offeror subject to Cost Accounting Standards further certifies that practices used in estimating costs in pricing this proposal are consistent with the practices disclosed in the Disclosure Statement where it has been submitted as required by FAR 30.202-5.

C. **Data Required-CAS covered Offerors**

The offeror certifying that it is currently performing a national defense contract containing either CAS clause (see A above) is required to furnish the name, address (including agency or department component), and telephone number of the cognizant Contracting Officer administering the offeror's CAS-covered contracts.

Name of Contracting Officer:.....
Address:.....
.....
Telephone Number:.....

25. 15.804-4 CERTIFICATE OF CURRENT COST OR PRICING DATA

(When a certificate of cost or pricing date is required to be submitted in accordance with Federal Acquisition Regulation (FAR) 15.804-4, the Contracting Officer will request that the offeror complete, execute, and submit to the Contracting Officer a certification in the format shown in the following Certificate of Current Cost or Pricing Data. The certification shall be submitted only at the time negotiations are concluded. Offerors should complete the certificate set forth below and return it when requested by the Contracting Officer.)

This is to certify that, to the best of my knowledge and belief, the cost or pricing date (as defined in section 15.801 of the Federal Acquisition Regulation (FAR) and required under FAR subsection 15.804-2) submitted, either actually or by specific identification in writing, to the Contracting Officer or the Contracting Officer's representative in support of _____* are accurate, complete, and current as of _____**.

This certification includes the cost or pricing date supporting any advance agreements and forward pricing rate agreements between the offeror and the Government that are part of the proposal.

Firm_____
Name_____
Title_____
Date of execution***_____

* Identify the proposal, quotation, request for price adjustment, or other submission involved, giving the appropriate identifying number (e.g., RFP No.)

** Insert the day, month, and year when price negotiations were concluded and price agreement was reached.

*** Insert the day, month, and year of signing, which should be as close as practicable to the date when the price negotiations are concluded and the contract price was agreed to.

PART IV

SECTION L - INSTRUCTIONS, CONDITIONS AND NOTICES TO OFFERORS

1. GENERAL INFORMATION

AWARD

It is anticipated that Multiple Awards will be made from this solicitation and that the award(s) will be made on/about June 15, 1991.

It is anticipated that the awards from this solicitation will be multiple-year cost reimbursement type contract with a term of seven years, and that incremental funding will be used [see paragraph 5)d) of Business Proposal Instructions].

PRE-PROPOSAL CONFERENCES

Two pre-proposal conferences will be held with prospective offerors. The first conference will be at the Westin Peachtree Plaza Hotel, Peachtree at International Boulevard, 6 Flags Suite, Atlanta, GA 30343-9986, on January 30, 1990, from 8:30 A.M. to 12:30 P.M. The second conference will be at Executive Plaza North, Conference Room C, 6130 Executive Boulevard, Rockville, MD 20852, on February 14, 1990, from 9:30 A.M. to 1:30 P.M. The pre-proposal conferences will be held for the purpose of providing information concerning the Government's requirements which may be helpful in the preparation of proposals and for answering any questions which you have regarding this solicitation.

The success of this type of conference depends largely on the lead-time available to the Government for research in connection with questions submitted by offerors. Therefore, you are requested to mail written questions concerning any areas of uncertainty which, in your opinion, require clarification or correction, in sufficient time to be received by the contract specialist five days before either conference at the address cited in Attachment 5.

Your questions should be submitted to the contract specialist, Barbara Mercer, and the envelope should be marked, "Pre-proposal conference, RFP No. NCI-CN-95165-38." A set of all questions and answers will be furnished simultaneously to all prospective offerors whether or not they are in attendance.

Because of space limitations, each prospective offeror shall be limited to a total of two representatives.

Attendance at the pre-proposal conference is recommended; however, attendance is not a prerequisite for proposal submission and will not be considered a factor in proposal evaluation.

RESTRICTION OF COMPETITION

Competition for this acquisition is restricted to eligible health departments that apply in cooperation with a voluntary health agency (See Mandatory Qualification Criteria, page 263). The acquisition has been announced in the Commerce Business Daily and no other possible offerors responded within the 45 day time period specified in FAR 5.203. This RFP is issued pending final approval of the Justification for Other than Full and Open Competition.

ESTIMATE OF EFFORT

To assist you in the preparation of your proposal, the Government is providing the following Staffing Guidelines and Uniform Budget Assumptions, which contain direct labor estimates. This is furnished for the offeror's information only and is not to be considered restrictive for proposal purposes.

STAFFING GUIDELINES

Proposals should describe the staffing required to complete all tasks during the two phases of this project.

The following guidelines describe the functions and estimated number of staff and resources required to conduct ASSIST. They should be closely reviewed in costing the two phases of ASSIST. Full-time equivalent (FTE) guidelines are provided for each position. Individuals' proposed time commitments should be stated in the proposal.

I. Phase I Staffing Estimates

A. Professional Staff

The following areas should be represented or available to staff:

- o experience in public health applications in community health or social service programs;
- o knowledge of community organizations and their functions;
- o experience in organizing and managing community health programs;
- o knowledge of large scale community project management;
- o knowledge of chronic disease prevention and health promotion activities;
- o experience in group decision making;
- o experience in coalition building;
- o experience in working with volunteers;
- o ability to communicate with different community groups and community leaders.

Contract Project Director. The ASSIST Contract Project Director shall be a senior level employee of the state or local health department. This person shall be in a sufficiently high policy and decision-making position within the department to use the authority of the department to legitimize the project as a major health priority, ensure the availability of needed resources, resolve project problems, and provide direction. This person shall be responsible for (a) co-chairing the

Executive Committee along with the ACS or qualified voluntary health agency (QVHA) representative; (b) ensuring the availability of and access to the policy makers, and program and fiscal staff and other departmental resources required for project implementation; (c) managing the fiscal resources and affairs of the project, and (d) resolving any contract-related problems which cannot be solved by the Contract Project Manager.

This individual must have a minimum of five years of demonstrated public health management experience in directing large scale projects of this size and complexity. It is desirable that this individual have knowledge of or experience with chronic disease prevention or health promotion issues. A graduate degree in a health or related field is desired.

Contract Project Manager. The ASSIST Project Manager shall be an employee of the state or local health department. This individual is responsible for the day-to-day operations of the project. This includes working with the ACS or QVHA project manager on coordination and support of all state or large metropolitan coalition activities, producing the Phase I Plan, and directing the field staff.

Five years of experience related to public health applications and service delivery, and three years managing projects of similar size and complexity are requested. A graduate degree in public health or a related field is also desired. Previous experience in community programs, chronic diseases and health promotion is also desirable. Experience in organizing community programs, and knowledge of community organization are essential.

Field Director. The Field Director during Phase I shall introduce the project to the community, conduct and complete the baseline site analysis, and ensure that the Smoking Control Plan addresses local and community concerns. The Director shall organize local coalitions, if appropriate, write relevant parts of the Plan, work with ACS or QVHA, and hire and supervise Field Coordinators.

The Field Director should have five years of experience in public health applications in community health or social service programs, be knowledgeable about community organization, and have experience in this area. The ability to communicate with different

community groups, and with community leaders is essential.

2. Support Staff

One Administrative Assistant

One Secretary

Sufficient time should be allotted to these positions so that all fiscal, coalition, planning, and programmatic support services can be provided. Such services include but are not limited to timely communications as requested by the NCI, and support of the coalition and its planning efforts.

B. Phase II Staffing Estimates

1. Professional Staff

Contract Project Director. As in Phase I, the ASSIST Contract Project Director must be a person of authority within the state or local health department who is employed by the department. This individual shall work with ACS or QVHA through the Executive Committee. This person will be directly responsible to NCI for the fiscal management of the ASSIST project.

Contract Project Manager. The Contract Project Manager is an employee of the State or local heath department who is responsible for all day-to-day operations during the implementation stage of Phase II. This individual shall work with the ACS or QVHA project manager to ensure the continued organization of the coalition, coordinate operations with the Field Director, participate and organize project-related training, ensure proper record keeping and reporting as required by the NCI, and supervise administrative staff.

Field Director. In Phase II, the Field Director is responsible for the implementation of all ASSIST field activities, the continued operation of local coalitions, if applicable, local training, and the proper collection and maintenance of program records. The Field Coordinators, if present, are under the supervision of the Field Director.

Field Coordinators. These individuals will assist the Field Director in establishing interventions, supporting local coalitions, and maintaining project records. They need not be employees of the health department. The Field Coordinator should have two years

of experience in community organization or community projects, or a graduate degree in public health or a related discipline.

2. Support Staff:

Administrative Assistant
Secretary
Clerk

Support staff will continue to provide the same services as described in Phase I. To these services will be added support for all implementation activities and data acquisition and entry.

Each offeror shall include details concerning any subcontractual arrangements that impact on the offeror's technical approach. This shall be construed to mean that any use of labor, experts, or expert consultants that are necessary for the contractor to successfully perform the Statement of Work must be addressed in detail in the proposal, including organizations to be used, their backgrounds, specific dates, places, and contributions.

C. Current and Projected Time Commitments

In addition, the offeror must, for the Project Director, Project Manager and Field Director, and for proposed consultants, describe projected activities and time commitments, in addition to those submitted for this study.

UNIFORM BUDGET ASSUMPTIONS INSTRUCTIONS

Because the protocol for ASSIST sites will be developed during Phase I, this project does not lend itself to accurate predictions of many staffing and budget items. In order to evaluate proposals in a common and fair manner, the staffing patterns and budget projections listed below should be used by all offerors in preparing technical and business proposals.

General Guidelines

1. The number of smokers in a site will be the primary determinant of funding levels. A site in which there are ≤250,000 smokers is considered to be a minimum site. Such sites should estimate costs at the base level described below. As the number of smokers increases, estimated costs will increase for specific line items as described below.

> NOTE: The number of smokers in a site can be determined by the following formula:
>
> Site Population X site smoking Prevalence = Total Smokers
>
> To determine site population, see 1988 U.S. Census estimates.
> To determine smoking prevalence, see March 16, 1989 Journal of the National Cancer Institute (JNCI) article titled "Prevalence of Cigarette Smoking in the United States: Estimates from the 1985 Current Population Survey." Metropolitan areas should use State smoking prevalence estimates.

2. A model budget format is included on page 214. This budget should be completed using the instructions in this document. Pages 215-217 refer to the budget for Direct Labor. Pages 218-223 refer to the budget for Other Direct Costs. Indirect costs are addressed on page 224.

3. If a standard inflation rate is applied to any items in budget (salary rates, etc.), please provide appropriate documentation on methods used to derive rates.

4. If a standard formula is used to compute the cost of other items (e.g., materials, supplies) which differs from the formulas listed below, please provide appropriate documentation.

BUDGET TEMPLATE

Contract Year

COST ITEM	1	2	3	4	5	6	7
A. DIRECT LABOR							
1. Professional Staff							
2. Support Staff							
SUBTOTAL							
B. FRINGE BENEFITS							
C. OTHER DIRECT COSTS							
1. Materials/Supplies							
2. Equipment							
3. Travel							
4. Computer Costs							
5. Facilities							
6. Consultants							
7. Other Costs							
SUBTOTAL							
D. INDIRECT COSTS							
TOTAL ESTIMATED COSTS							

NOTE: A summary by cost by year and by total for the full period of performance must be provided.

DIRECT LABOR

Notes:

1. **FULL TIME EQUIVALENT (FTE).** Uniform assumptions for labor hours are expressed in hours based upon 100% effort (1.0 FTE) equal to 1860 maximum billable hours per year. This total assumes that holiday, vacation, and sick leave hours are billed to the fringe rate. If the offeror's personnel office FTE is not based on 1860 hours, please provide documentation and information of costs billed to fringe rate.

2. **FRINGE BENEFITS.** Please provide documentation on fringe benefit rate for the offeror's health department.

3. **USE OF CONSULTANTS AND/OR SUBCONTRACTORS.** Any professional or support staff hours proposed on the consultant or subcontractor line items (C.6. and C.7.a., respectively) will require reduction in hours billed under Direct Labor on the appropriate lines. Consultants or subcontractor labor should exceed fifty percent of direct labor.

STAFFING:

Staffing estimates are based on a "minimum" site (≤250,000 smokers). See Site Augmentation Formula for Labor (page 217) for additional information.

PROFESSIONAL STAFF
Professional staff includes project positions with specialized expertise, such as Project Director, Project Manager, and Field Coordinators (see "Staffing Guidelines" for position descriptions). These positions listed are examples which would be the maximum staff for an minimum site. The Project Director and Project Manager positions must each be filled by one individual. The salary rates or ranges must recognize the distinct differences in professional skills and the complexity of varied disciplines as well as job difficulty.

SUPPORT STAFF
This project requires various support personnel, including but not necessarily limited to an Administrative Assistant, Secretary and a Clerk/data processor. Sufficient time should be allotted to these positions so that all fiscal, coalition, planning, and programmatic support services can be provided. Additional staff will be required to support implementation activities and data acquisition and entry for Phase II.

Below are listed the hours per year and (FTE's) estimated for a minimum site. Please see page 217 for augmentation instruction if site has more than 125,000 smokers.

Direct Labor Estimates for a Minimum Site

(See Site Augmentation for Labor, page 217)

		Contract Year						
		1	2	3	4	5	6	7
A. DIRECT LABOR								
1. Professional Staff								
a. Project Director	(hrs)	372	372	372	372	372	372	372
	(FTE)	.20	.20	.20	.20	.20	.20	.20
b. Project Manager	(hrs)	1860	1860	1860	1860	1860	1860	1860
	(FTE)	1.0	1.0	1.0	1.0	1.0	1.0	1.0
c. Field Director	(hrs)+	1860	1860	1860	1860	1860	1860	1860
	(FTE)	1.0	1.0	1.0	1.0	1.0	1.0	1.0
d. Field Coord.	(hrs)+			3720	3720	3720	3720	3720
	(FTE)			2.0	2.0	2.0	2.0	2.0
2. Support Staff								
a. Admin. Asst.	(hrs)+	1860	1860	1860	1860	1860	1860	1860
	(FTE)	1.0	1.0	1.0	1.0	1.0	1.0	1.0
b. Secretary	(hrs)+	1860	1860	1860	1860	1860	1860	1860
	(FTE)	1.0	1.0	1.0	1.0	1.0	1.0	1.0
c. Clerk	(hrs)			1860	1860	1860	1860	1860
	(FTE)			1.0	1.0	1.0	1.0	1.0

+ Augmented Positions: see page 217.

SITE AUGMENTATION FORMULA FOR DIRECT LABOR

Based upon population, area, geography, and distribution in the proposed site the following augmentation percentages have been computed. These numbers should be used to determine selected Professional and Support Staff lines. The positions eligible for augmentation are:

Field Director - line A.1.c.
Field Coordinator - line A.1.d.
Administrative Assistant - line A.2.a.
Secretary - line A.2.b.

The following FTE's for the above listed positions is allowed according to the number of smokers:

- If there are 125,000 or fewer smokers in the site, then .50 FTE position(s) should be used.
- For sites where the number of smokers is between 125,001 and 250,000, an additional .25 FTE position(s) may be added to the appropriate staff lines.
- For each 250,000 smokers up to 1,000,000 smokers, an additional .25 FTE position(s) may be added to the appropriate line item(s).
- For sites in which the number of smokers exceeds 1,000,000, an additional .25 FTE position(s) may be added to the appropriate line item(s) for every 500,000 additional smokers.

For example if a site has 750,000 smokers the applicant may request the following additional staff:

.50 FTE for the first 125,000 smokers
.25 FTE for 125,001 to 250,000 smokers
.25 FTE for 250,001 to 500,000 smokers
.25 FTE for 500,001 to 750,000 smokers

1.25 FTE for the following lines:

A.1.c. (Field Director), A.1.d. (Field Coordinator)
A.2.a. (Administrative Assistant)
A.2.b (Secretary)

OTHER DIRECT COSTS

Other Direct Costs are all costs except direct labor, fringe benefits, and indirect costs. Each line is defined below.

MATERIALS AND SUPPLIES (Line C.1.)
Materials and supplies are general costs related to maintaining the office. These include telephone, utilities, office supplies, and mailing and shipping. A standard formula is to be used to compute materials and supply estimates: ten percent of the total of Direct Labor salary plus Fringe Benefits.

If the offeror uses a standard formula different than this, documentation and justification is required.

EQUIPMENT (Line C.2.)
No funds will be negotiated for the purchase of large equipment (purchase of VHS equipment, overhead projectors, typewriters, etc.). Proposals should document existing access to FAX machine, slide projector, and a VHS equipment and the availability of a dedicated computer telephone line is required.

TRAVEL (Line C.3.)

Local (Line C.3.a.)
It is recognized that distances, the number of staff members traveling and the frequency of travel will vary by site. Annual proposed local travel budgets must include information on local assumptions and approach to estimating cost (e.g., average cost per trip, estimated number of trips, and rationale for each trip). A copy of the offeror's travel reimbursement policy should be submitted with the business proposal.

National (Line C.3.b.)
National travel should use budget estimates for economy fare travel to the meeting sites designated on the "National Travel Schedule" see page 219.

UNIFORM BUDGET ASSUMPTIONS
ASSIST
National Travel Schedule

Contract Year 1 (12 Months Phase I)
- o Two 2-day Coordinating Committee Meetings in Bethesda, MD.
- o Three 2-day training sessions; two held in Bethesda, MD and one in some central U.S. city easily accessible by air.*

Contract Year 2 (12 months Phase I)
- o Two 2-day Coordinating Committee Meetings in Bethesda, MD.
- o Two 2-day training sessions in Bethesda, MD.

Contract Year 3 (12 Months Phase II)
- o Three 2-day Coordinating Committee Meetings in Bethesda, MD.
- o Eight 2-day training sessions; four held in Bethesda, MD and four in some central U.S. city easily accessible by air.*
- o Four 2-day Information Exchange Conferences in Bethesda, MD.

Contract Year 4 (12 Months Phase II)
- o Three 2-day Coordinating Committee Meetings in Bethesda, MD.
- o Eight 2-day training sessions; four held in Bethesda, MD and four in some central U.S. city easily accessible by air.*
- o Two 2-day information Exchange Conferences in Bethesda, MD.

Contract Year 5 (12 Months Phase II)
- o Two 2-day Coordinating Committee Meetings in Bethesda, MD.
- o Two 2-day Information Exchange Conferences in Bethesda, MD.

Contract Year 6 (12 Months Phase II)
- o Two 2-day Coordinating Committee Meetings in Bethesda, MD.
- o Two 2-day Information Exchange Conferences in Bethesda, MD.

Contract Year 7 (6 Months Phase II)
- o Two 2-day Coordinating Committee Meetings in Bethesda, MD.
- o Two 2-day Information Exchange Conferences in Bethesda, MD.

Travel Notes:
Travel should be budgeted for two people for Training and Information Exchange Conferences and one person (Project Director or proxy) for the Coordinating Committee.

* For proposal estimation, use Dallas Texas or Chicago Illinois as site of meeting place outside of Washington D.C.. Please note which site was used for estimates.

COMPUTER EQUIPMENT (Line C.4.)
Each site should use existing IBM compatible computers when available. Sufficient IBM-compatible micro computer equipment and software must be available to support the current version of word processing used by the government. The STCP currently uses WordPerfect 5.0 and it is likely that similar software will be in place at the time of the contract award. Computers in each site must have enough memory to store records, send and retrieve electronic mail, and maintain records of project expenditures; specifics include: a computer with 2Mb RAM, 1.2 Mb disk drive, 40 Mb hard disk, CGA graphics; monitor; Laser printer; cables and connections; dedicated phone line; and 2400 Baud Hayes compatible modem.

FACILITIES (Line C.5.)
Any facilities and office expenses (e.g., satellite office) which are not covered by the indirect rate require appropriate documentation. If an offsite rate requires rent and other facility costs to be billed to the contract, appropriate documentation will be required regarding local office space rental rates and related proposed expenses. Moderately priced office space should be estimated as opposed to Class A or New, Full Service space. Lower-option, older office space should be estimated if deemed available.

If off-site facilities are needed, note that in addition to staff space, meeting space is essential (hold up to 40 people).

CONSULTANTS (Line C.6.)
ASSIST-wide consultants will be provided to sites and paid through the ASSIST Coordinating Center's Budget. Consultants hours to perform <u>site specific</u> tasks include media advocacy training, worksite policy workshops, working with minority or special population groups, etc. shall be paid by the ASSIST site. Site specific consultant fee(s) must be stated by rate per day, number of days and total cost including travel.

OTHER DIRECT COSTS (Line C.7.)
Other costs include subcontractors and intervention monies. Please use the Site Augmentation Formula for Other Costs (page 223) as the basis for this estimate.

Subcontractors (Line C.7.a.)
Subcontractors must include: detailed list of activities, a list of staff names, justification for usage, and an estimated timeline and cost.

Intervention Monies (Line C.7.b.)
Intervention monies are population based and include but are not limited to: mailings, printing of local public relations announcements, media, public relation events, and training. For proposal purposes. offerors should assume:

- A maximum of 10% of the total annual contract funds may be used for the purchase of media (TV). Additionally, media must follow guidelines set by ASSIST-wide protocol (to be developed).

- No funds will be provided to develop new smoking prevention, cessation, and education materials.

- No funds will be provided for labor to support the delivery of smoking prevention, cessation, or education programs.

While budgeting for intervention funds please consider the following costs and submit a rough estimate for each:

- Site organization and mobilization
- Media
- Policy
- Program Services
- Health Care Systems
- Worksites
- Community Networks
- Schools

Please refer to The NCI Standards for Comprehensive Smoking Prevention and Control (Appendix A) for activities anticipated in each area.

Other Direct Costs for "Average" Size Site
(See Site Augmentation Formula, page 223)

	Contract Year						
	1	2	3	4	5	6	7
1. Materials and Supplies							
2. Equipment							
3. Travel							
a. Local							
b. National (see "National Travel Schedule")							
1. Staff							
2. Training							
4. Computer Costs							
5. Facilities							
6. Consultants							
7. Other Costs							
a. Subcontractors							
b. Intervention monies							

SITE AUGMENTATION FORMULA FOR OTHER COSTS

Based upon the geographic size, population density, and similar factors the following augmentation percentages have been established. These percentages should be applied to Intervention Monies line C.7.b. of the Other Costs budget template on page 214.

The following augmentation is allowed according to the number of smokers:

- In sites where the number of smokers = ≤125,000 smokers $150,000 should be used as the estimate.
- In sites where the number of smokers = 125,001 - 250,000, an additional $.60 is allowed for each smoker over 125,000.
- In sites where the number of smokers = 250,001 - 500,000, an additional $.45 is allowed for each smoker over 250,000.
- In sites where the number of smokers = 500,001 - 750,000, an additional $.25 is allowed for each smoker over 500,000.
- In sites where the number of smokers = 750,001 - 1,000,000, an additional $.15 is allowed for each smoker over 500,000.
- In sites where the number of smokers exceeds 1,000,000, an additional $.05 is allowed for each smoker over 1,000,000.

For example if a site has 750,000 smokers, the offeror may request $375,000 for intervention monies. This estimate was obtained by using the above formula:

$125,000	for the first 125,000 smokers
75,000	($.60 x 125,000 smokers) for 125,001 to 250,000 smokers
112,500	($.45 x 250,000 smokers) for 250,001 to 500,000 smokers
62,500	($.25 x 250,000 smokers) for 500,001 to 750,000 smokers
$375,000	for line item C.7.b. (Intervention Monies)

INDIRECT COSTS (Line D)

Organizations that have a current negotiated rate agreement with the DHHS or any other Government Audit agency should include a copy of the agreement in the business proposal. Organizations without such an agreement must submit documentation sufficient to justify the rates proposed.

NOTE: Ceilings will be imposed for all indirect costs (e.g., overhead and G & A) applicable to any contract resulting from this solicitation. Current negotiated indirect cost rate agreements will be used as a basis for negotiating contract ceiling rates. Offerors may propose ceiling rates to be incorporated into the contract should they be accepted for award.

Define rules for indirect rates and services/costs covered by each. Specifically address offsite rates that require rent and other facilities costs to be billed to the contract (not billed directly to Facilities, line item C.5). Appropriate documentation will be required regarding local office space rental rates and related proposed expenditures. Indicate how indirect costs have been computed and provide appropriate explanation. Where a rate agreement exists, provide a copy.

COMMITMENT OF PUBLIC FUNDS

The Contracting Officer is the only individual who can legally commit the Government to the expenditure of public funds in connection with the proposed procurement. Any other commitment, either explicit or implied, is invalid.

COMMUNICATIONS PRIOR TO CONTRACT AWARD

Offerors shall direct all communications to the attention of the Contract Specialist cited on the face page of this RFP. Communications with other officials may compromise the competitiveness of this acquisition and result in cancellation of the requirement.

RELEASE OF INFORMATION

Contract selection and award information will be disclosed to offerors in accordance with regulations applicable to negotiated acquisition. Prompt written notice will be given to unsuccessful offerors as they are eliminated from the competition, and to all offerors following award.

COMPARATIVE IMPORTANCE OF PROPOSALS

You are advised that paramount consideration shall be given to the evaluation of technical proposals with geographic location and relative levels of smoking prevalence considered as described in Section M - Evaluation Factors for Award. In the event that the technical evaluation reveals two or more offerors are approximately equal in technical ability as well as these factors, the estimated cost of performance will become paramount. In any event the Government reserves the right to make an award to the best advantage of the Government, cost and other factors considered.

PREPARATION COSTS

This RFP does not commit the Government to pay for the preparation and submission of a proposal.

SERVICE OF PROTEST (NOVEMBER 1988) -
FEDERAL ACQUISITION REGULATION, FAR 52.233-2

(a) Protests, as defined in section 33.101 of the Federal Acquisition Regulation, that are filed directly with an agency, and copies of any protests that are filed with the General Accounting Office (GAO) or the General Services Administration Board of Contract Appeals (GSBCA), shall be served on the Contracting Officer (addressed as follows) by obtaining written and dated acknowledgement of receipt from:

Barbara Mercer
Contracting Officer
Research Contracts Branch, OD
National Cancer Institute
Executive Plaza South, Room 635
Bethesda, Maryland 20892

(b) The copy of any protest shall be received in the office designated above on the same day a protest is filed with the GSBCA or within one day of filing a protest with the GAO.

(End of Provision)

LATE PROPOSALS, MODIFICATIONS OF PROPOSALS AND WITHDRAWALS OF PROPOSALS (NOVEMBER 1983), PHS 352.215-10

Notwithstanding the procedures contained in the provision of this solicitation entitled Late Submissions, Modifications, and Withdrawals of Proposals, (FAR 52.215-10) a proposal received after the date specified for receipt may be considered if it offers significant cost or technical advantages to the Government, and it was received before proposals were distributed for evaluations, or within five working days after the exact time specified for receipt, whichever is earlier. (End of provision)

FISCAL YEAR 1990 SALARY LIMITATION FOR INDIVIDUALS FUNDED UNDER EXTRAMURAL MECHANISMS

Although award of contracts resulting from this solicitation are not scheduled until fiscal year 1991, this information is provided for its possible applicability in future years.

Offerors are advised that, pursuant to Public Law (P.S.) 101-166, no NIH Fiscal Year 1990 (October 1, 1989 - September 30, 1990) funds may be used to pay direct salary (plus fringe benefits and associated indirect costs) of an individual through a contract a a rate in excess of $120,000 per year. Offerors may propose staff whose salaries do no exceed $120,000 a year or absorb that portion

of an employee's salary that exceeds a rate of $120,000 a year. The salary limitation set by P.L. 101-166 applies only to Fiscal Year 1990 funds, however, salary ceilings for subsequent years may be included in future DHHS appropriation bills. Multi-year contracts awarded pursuant to this solicitation may be subject to unilateral modifications by the Government if an individual's salary exceeds any salary ceiling established in future appropriation bills. The $120,000 per year salary limit also applies to individuals proposed under subcontracts. P.L. 101-166 states in pertinent part:

> "None of the funds appropriated in this title for the National Institutes of Health and the Alcohol, Drug Abuse and Mental Health Administration shall be used to pay the salary of individuals through a grant or other extramural mechanism at a rate in excess of $120,000 per year."

2. INSTRUCTIONS TO OFFERORS

a. GENERAL INSTRUCTIONS

INTRODUCTION

The following instructions will establish the acceptable minimum requirements for the format and contents of proposals. Special attention is directed to the requirements for technical and business proposals to be submitted in accordance with these instructions.

1) Contract Type and General Clauses

It is contemplated that a cost-reimbursement type contract will be awarded. (See General Information) Any resultant contract shall include the clauses applicable to the selected offeror's organization and type of contract awarded as required by Public Law, Executive Order, or acquisition regulations in effect at the time of execution of the proposed contract.

2) Authorized Official and Submission of Proposal

The proposal must be signed by an official authorized to bind your organization and must stipulate that it is predicated upon all the terms and conditions of this RFP. Your proposal shall be submitted in the number of copies, to the address, and marked as indicated in Attachment 1, Part III, Section J hereof. Proposals will be typewritten, reproduced on letter size paper and will be legible in all required copies. To expedite the proposal evaluation, all documents required for responding to the RFP should be placed in the following order:

I. COVER PAGE

Include RFP title, number, name of organization, identification of the proposal part, and indicate whether the proposal is an original or a copy.

II. TECHNICAL PROPOSAL

It is recommended that the technical proposal consist of a cover page, a table of contents, and the information requested in the Technical Proposal Instructions.

III. BUSINESS PROPOSAL

It is recommended that the business proposal consist of a cover page, a table of contents, and the information requested in the Business Proposal Instructions.

3) Proposal Summary and Data Record (NIH-2043)

The Offeror must complete the Form NIH-2043, attached, with particular attention to the length of time the proposal is firm and the designation of those personnel authorized to conduct negotiations. (See Section J, Attachment 9.)

4) Separation of Technical and Business Proposals

The proposal must be prepared in two parts: a "Technical Proposal" and a "Business Proposal." Each of the parts shall be separate and complete in itself so that evaluation of one may be accomplished independently of, and concurrently with, evaluation of the other. The technical proposal must include direct cost and resources information, such as labor-hours and categories and applicable rates, materials, subcontracts, travel, etc., and associated costs so that the offeror's understanding of the project may be evaluated (See Attachment 2.) However, the technical proposal should not include pricing data relating to indirect cost rates or amounts, fee amounts (if any), and total costs. The technical proposal should disclose your technical approach in as much detail as possible, including, but not limited to, the requirements of the technical proposal instructions.

5) Alternate Proposals

You may, at your discretion, submit alternate proposals, or proposals which deviate from the requirements; provided, that you also submit a proposal for performance of the work as specified in the statement of work. Such proposals may be considered if overall performance would be improved or not compromised and if they are in the best interests of the Government. Alternative proposals, or deviations from any requirements of this RFP, shall be clearly identified.

6) Confidentiality of Proposals

The proposal submitted in response to this request for proposals may contain data (trade secrets; business data, e.g., commercial information, financial information, and cost and pricing data; and technical data) which the offeror, including its prospective subcontractor(s), does not want used or disclosed for any purpose other than for evaluation of the proposal. The use and disclosure of any data may be so restricted; provided, that the Government determines that the data is not required to be disclosed under the Freedom of Information Act, 5 U.S.C. 552, as amended, and the offeror marks the cover sheet of the proposal with the following legend, specifying the particular portions of the proposal which are to be restricted in accordance with the conditions of the legend. The Government's determination to withhold or disclose a record will be based upon the particular circumstances involving the record in question and whether the record may be exempted from disclosure under the Freedom of Information Act:

> Unless disclosure is required by the Freedom of Information Act, 5 U.S.C. 552, as amended, (the Act) as determined by Freedom of Information (FOI) Officials of the Department of Health and Human Services, data contained in the portions of this proposal which have been specifically identified by page number, paragraph, etc. by the offeror as containing restricted information shall not be used or disclosed except for evaluation purposes.
>
> The offeror acknowledges that the Department may not be able to withhold a record (data, document, etc.) nor deny access to a record requested pursuant to the Act, and that the Department's FOI officials must make that determination. The offeror hereby agrees that the Government is not liable for disclosure if the Department has determined that disclosure is required by the Act.
>
> If a contract is awarded to the offeror as a result of, or in connection with, the submission of this proposal; the Government shall have the right to use or disclose the data to the extent provided in the contract. Proposals not resulting in a contract remain subject to the Act.

The offeror also agrees that the Government is not liable for disclosure or use of unmarked data and may use or disclose the data for any purpose, including the release of the information pursuant to requests under the Act.

The data subject to this restriction are contained in pages (insert page numbers, paragraph designations, etc. or other identification)

In addition, the offeror should mark each page of data it wishes to restrict with the following legend:

> "Use of disclosure of data contained in this page is subject to the restriction on the cover sheet of this proposal."

NOTE: Offerors are cautioned that proposals submitted with the restrictive legends or statements differing in substance from the above legend may not be considered for award. The Government reserves the right to reject any proposal submitted with a nonconforming legend.

7) Evaluation of Proposals

The Government will evaluate technical proposals in accordance with the criteria set forth in Part IV, Section M of this RFP.

8) Selection of Offerors

a) The acceptability of the scientific and technical portion of each research contract proposal will be evaluated by the technical review committee. The committee will evaluate each proposal in strict conformity with the evaluation criteria of the RFP, utilizing point scores and written critiques. The committee may suggest that the Contracting Officer request clarifying information from an offeror.

b) The business portion of each contract proposal will be subjected to a cost and price analysis, management analysis, etc.

c) The Contracting Officer will, in concert with program staff, decide which proposals are in the competitive range. Oral or written discussions will be conducted with all offerors in the competitive range. All aspects of the proposals are subject to discussions,

including cost, technical approach and contractual terms and conditions. Best and Final Offers (BAFOs) will be requested with the reservation of the right to conduct limited negotiations after BAFOs.

d) Best-Buy Analysis. A final best-buy analysis will be performed taking into consideration the results of the technical evaluation, cost analysis, and ability to complete the work within the Government's required schedule. The Government reserves the right to make an award to the best advantage of the Government, technical merit, cost, and other factors considered.

e) The NCI reserves the right to make a single award, multiple awards, or no award at all to the RFP. In addition, the RFP may be amended or cancelled as necessary to meet NCI requirements. Synopses of awards exceeding $25,000 will be published in the Commerce Business Daily.

9) Small Business and Small Disadvantaged Business Subcontracting Plan

If the proposed contract exceeds a total estimated cost of $500,000 for the entire period of performance, the apparent successful offeror shall be required to submit a subcontracting plan in accordance with the terms of the clause entitled "Small Business and Small Disadvantaged Business Subcontracting Plan" FAR Clause No. 52.219-9, incorporated herein by reference in the Solicitation." Attachment to this RFP is an example of such a plan.

a) THIS PROVISION DOES NOT APPLY TO SMALL BUSINESS CONCERNS.

b) The term "subcontract" means any agreement (other than one involving an employer-employee relationship) entered into by a Federal Government prime contractor or subcontractor calling for supplies or services required for the performance of the original contract or subcontract.

c) The offeror understands that:

(1) No contract will be awarded unless and until an acceptable plan is negotiated with the Contracting Officer which plan will be incorporated into the contract, as a material part thereof.

(2) An acceptable plan must, in the determination of the Contracting Officer, provide the maximum practicable opportunity for small business concerns and small business concerns owned and controlled by socially and economically disadvantaged persons to participate in the performance of the contract.

(3) If a subcontracting plan acceptable to the Contracting Officer is not negotiated within the time limits prescribed by the contracting activity and such failure arises out of causes within the control and with the fault or negligence of the offeror, the offeror shall be ineligible for an award. The Contracting Officer shall notify the Contractor in writing of the reasons for determining a subcontracting plan unacceptable early enough in the negotiation process to allow the Contractor to modify the plan within the time limits prescribed.

(4) Prior compliance of the offeror with other such subcontracting plans under previous contracts will be considered by the Contracting Officer in determining the responsibility of the offeror for award of the contract.

(5) It is the offeror's responsibility to develop a satisfactory subcontracting plan with respect to both small business concerns and small business concerns owned and controlled by socially and economically disadvantaged individuals and that each such aspect of the offeror's plan will be judged independent of the other.

(6) The offeror will submit, as required by the Contracting Officer, subcontracting reports in accordance with the instructions thereon, and as further directed by the Contracting Officer. Subcontractors will also submit these reports to the Government's Contracting Officer or as otherwise directed, with a copy to the prime Contractor's designated small and disadvantaged business liaison.

10) Clauses Incorporated by Reference

This Solicitation incorporates the following clauses by reference with the same force and effect as if they were given in full text. Upon request, the Contracting Officer will make their full text available.

FEDERAL ACQUISITION REGULATION (48 CFR CHAPTER 1):

a) Anti-Kickback Procedures, 52.203-7 (October 1988)

b) Solicitation Definitions, 52.215-5 (July 1987)

c) Unnecessarily Elaborate Proposals or Quotations, 52.215-7 (April 1984)

d) Acknowledgement of Amendments to Solicitations, 52.215-8 (November 1988)

e) Submission of Offers, 52.215-9 (April 1984)

f) Late Submissions, Modifications, and Withdrawals of Proposals, 52.215-10 (April 1984)

g) Preparation of Offers, 52.215-13 (April 1984)

h) Explanation to Prospective Offerors, 52.215-14 (April 1984)

i) Failure to Submit Offer, 52.215-15 (April 1984)

j) Contract Award, 52.215-16 (April 1985)

k) Order of Precedence, 52.215-33 (January 1986)

l) Payment of Overtime Premiums, 52.222-2 (April 1984)

m) Employment Reports on Special Disabled Veterans and Veterans of the Vietnam Era, 52.222-37 (January 1988)

n) Prompt Payment, 52.232-25 (April 1989)

o) Electronic Funds Transfer Payment Methods (April 1989)

p) Protest After Award, 52.233-3 (June 1985)
Alternate I (June 1985)

b. TECHNICAL PROPOSAL INSTRUCTIONS

A detailed work plan must be submitted indicating how each aspect of the Statement of Work is to be accomplished. An outline for the technical proposal is provided below. The technical proposal should adhere to suggested page limits. The technical proposal shall not exceed 200 single-spaced one-sided pages. Appendices and attachments to the technical proposal shall not exceed 150 single-spaced one-sided pages. Photocopy reductions are not permitted.

The technical proposal should reflect a clear understanding of the nature of the work to be undertaken. Information should be provided which demonstrates the offeror's understanding and management of important events and tasks.

NOTES:

Exhibit A: Technical Proposal Data Sources (page 245) lists suggested and required data sources and should be used in the preparation of all tables suggested in these instructions.

The NCI Standards for Comprehensive Smoking Prevention and Control (Appendix A) describe the kinds of activities to be accomplished during Phase II of ASSIST. This draft document is included for the offeror's information in order to illustrate the level and diversity of effort to be delivered during the intervention phase. ASSIST proposals should not include a detailed account of how these activities will be delivered, but rather should follow the Technical Proposal Instructions below.

1) Technical Discussion

The technical discussion included in the technical proposal should respond to the items set forth below:

I. INTRODUCTION (15 pages)

A. Provide a general description of the site.

B. Discuss population distribution and demographics.

C. Discuss site organization, structure, political, and geopolitical factors.

D. Justify and discuss proposed organization of the site for intervention, including any identified intervention regions.

E. Provide tables of demographics for the site overall and proposed intervention regions

Table 1: Population Distribution by Age and Gender (see Exhibit A, page 245)

Table 2: Population Estimates by Race and Hispanic Origin

II. STRUCTURE OF CHANNELS FOR SMOKING PREVENTION AND CONTROL (30 pages)

Note: For each item, discuss the entire site as well as any proposed intervention regions.

A. Health Care System

1. Discuss the organization of the health care delivery system (fee-for-service, HMOs, PPOs, public services, etc.) and how it is geographically distributed.

2. Discuss the organization of health care providers (medical, dental, and nursing societies, other professional organizations).

3. Discuss the roles of health care-related unions.

4. Tables

   a. Number of Health Care Providers by Specialty and Location

   b. Providers of Continuing Professional Education by Specialty and Location

B. Worksites

1. Discuss the recent and current economic climate.

2. Discuss the geographic distribution of the working population throughout the site by occupational status.

3. Discuss the networks linking businesses to one another (Chambers of Commerce, Rotary, trade and professional organizations).

4. Discuss the influence and structure of unions.

5. Tables

a. Number of Worksites by Type, Location, and Size

b. Number of People in the Work Force by Employment Status

C. Schools

1. Discuss the organization of private and public education (public and private elementary and secondary, schools, trade schools, junior colleges, colleges, universities, etc.).

2. Describe the organizations and unions associated with schools (PTAs, teacher and staff unions).

3. Table

Type of Schools by Grade Level and Location

D. Community Networks

Identify the major community networks in which smokers are significantly represented as members and/or constituencies.

E. Community Environment

1. Discuss the presence and relative influence of cues and messages supporting smoking and those supporting nonsmoking.

2. Discuss the potential for decreasing messages supporting smoking and increasing cues and messages supporting non-smoking.

III. THE SMOKING PROBLEM (10 pages)

A. Use available smoking prevalence data to describe the smoking problem on the site. (Note: Representative samples may not be available for some areas.)

B. Discuss the smoking and health problem as justification for proposed intervention regions.