MEMORANDUM

Date: Monday, March 23, 2020

To: Prospective Subrecipient Agencies within Franklin County, Ohio

From: Theresa Seagraves, Assistant Health Commissioner & Director of Health Systems and Planning
Division of Health Systems and Planning
Franklin County Public Health

Subject: Competitive Solicitation: Franklin County Overdose Data to Action Project 9/1/2020 - 8/31/2021

Franklin County Public Health (FCPH), Division of Health Systems and Planning, announces the availability of grant funds.

All electronic applications and attachments are due by 5:00 p.m., April 10, 2020. Applications received after the due date will not be considered for funding. Also, any applications faxed or mailed will not be accepted for review.

Any award made through this project is contingent upon the availability of funds for this purpose. If you have questions, please contact Lindsey Rodenhauser at 614-400-0079 or email at lindseyrodenhauser@franklincountyohio.gov.
Part 1. Background and Overview

A. Background 3
B. Definition of Terms 3
C. Eligibility 3

Part 2. Project Budget, Timeline and Project Life

a. Project Budget 4
b. Award Period 4
c. Due Date 4

Part 3. Purpose, Outcomes and Strategies

a. Purpose 4
b. Outcomes 4
c. Strategies and Activities 5

Part 4. How to Apply

A. Requirements Documentation/Application Checklist 7
B. Unallowable Costs 8
C. Page Formatting Instructions 9
D. Submission Instructions 9

Part 5. Schedule of Activities 10

Part 6. CDC RFA Language 10

Part 7. Attachments 10
Part 1. Background and Overview

A. Background
Franklin County Public Health announces the availability of funds to address the opioid crisis in Franklin County. Funding is made possible through the Centers of Disease Control and Prevention, Division of Overdose Prevention. The complex and changing nature of the opioid overdose epidemic highlights the need for an interdisciplinary, comprehensive, and cohesive public health approach. States, territories, and local partners need access to complete and timely data on prescribing, and on nonfatal and fatal drug overdoses to understand the scope, direction, and contours of the epidemic.

Between 2017 – 2018, Franklin County has seen a 146% increase in the number of residents who died from unintentional drug overdoses. While the opioid overdose epidemic worsens in scope and magnitude, it is also becoming more complex. Research and data have shown three distinct trends: overdose deaths involving prescription opioid pain relievers, a surge in heroin deaths, and a significant increase in deaths involving illicitly manufactured fentanyl and fentanyl analogs. Additionally, data has shown deaths involving cocaine and psychostimulants with abuse potential, with synthetic opioids increasingly being involved in these deaths.

This funding opportunity will continue work focused on: increasing comprehensiveness and timeliness of surveillance data; building state and local capacity for public health programs determined to be promising based on research evidence; making Prescription Drug Monitoring Programs (PDMPs) easier to use and access; and working with health systems, insurers, and communities to improve opioid prescribing. It adds new work focused on linkages to care and other areas of innovation supported by evidence-based practice.

B. Definition of Terms
FCPH – Franklin County Public Health
OD2A – Overdose Data to Action
CDC – Centers for Disease Control and Prevention
PDMP – Prescription Drug Monitoring Program

C. Eligibility
The following criteria must be met for grant applications to be eligible for review:

- Applicants must be a local public or non-profit agency within Franklin County, Ohio.
- Applicant does not owe funds to FCPH or CDC.
- Applicant has submitted application and all required attachment by 5:00 p.m. on April 10, 2020.
Part 2. Project Budget, Timeline and Project Life

A. Project Budget
This project is funded through the Centers of Disease Control and Prevention Overdose Data to Action funding, CDC-RFA-CE19-1904. No grant award will be issued for less than $10,000.00. FCPH anticipates funding a total of $2.1 million to local public and non-profit agencies in Franklin County, Ohio.

*Projects funded in 2019-2020 by FCPH may not receive same level of funding that was previously awarded in 2019-2020.

B. Award Period
The anticipated project start date is September 1, 2020 and end on August 31, 2021 but may vary due to the time required to finalize the sub-recipient work plan, obtain signatures and process contract. The sub-recipient is not authorized to begin work until contract has been signed and dated by the appropriate designee(s). Work conducted outside the effective start date and end date of the contract will not be eligible for reimbursement under this grant.

C. Due Date:
Application, including any required attachments must be completed and received by FCPH electronically to lindseyrodenhauser@franklincountyoiohio.gov by 5:00 p.m. on April 10, 2020. Applications and required attachments received after this deadline will not be considered for review.

Part 3. Purpose, Outcomes and Strategies

A. Purpose:
The purpose of the project is to assist local communities with the planning, design, and implementation of drug overdose prevention programs at the local level within Franklin County.

B. Outcomes:
Sub-recipients are expected to implement activities that will impact relevant short and intermediate outcomes. All sub-recipients should be positioned to contribute in the impact of the long-term outcomes listed below.

- Increased local and state capacity for sustainable surveillance and prevention efforts;
- Decreased rate of opioid misuse and opioid use disorder;
- Increased provision of evidence-based treatment for opioid use disorder;
- Decreased rates of ED visits due to misuse or opioid use disorder;
- Decreased drug overdose death rate, including prescription and illicit opioid overdose death rates.
C. **Strategies and Activities:**

There are two overall components of this award – a surveillance strategy and prevention strategies. Sub-recipients have flexibility to propose activities related to each major strategy of their choosing. Funding is intended to support a balanced approach between evidence based and innovative activities.

The following table outlines the expected short-term outcomes and their respective strategy.

<table>
<thead>
<tr>
<th>Strategy #</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>(3)</td>
<td><strong>Innovative Surveillance: Linking Overdose Data with Risk/Protective Factor Data</strong></td>
</tr>
<tr>
<td></td>
<td>Proposed Activities:</td>
</tr>
<tr>
<td></td>
<td>• Data sharing for syndromic surveillance (ex. client aggregate data on social determinants of health)</td>
</tr>
<tr>
<td></td>
<td>• Capacity building to collect and share surveillance data</td>
</tr>
<tr>
<td></td>
<td>• Timely and actionable surveillance data disseminated by recipients to enhance the implementation of interventions</td>
</tr>
<tr>
<td>(4)</td>
<td><strong>Prescription Drug Monitoring Programs (PDMP)</strong></td>
</tr>
<tr>
<td></td>
<td>Proposed Activities:</td>
</tr>
<tr>
<td></td>
<td>• Actively managing the PDMP in part by sending proactive (or unsolicited) reports to providers to inform prescribing</td>
</tr>
<tr>
<td></td>
<td>• Ensuring that PDMPs are easy to use and access by providers</td>
</tr>
<tr>
<td></td>
<td>• Integrate the PDMP with other health systems data</td>
</tr>
<tr>
<td></td>
<td>• Identification of high-risk prescribing</td>
</tr>
<tr>
<td></td>
<td>• Better tracking of opioid prescriptions</td>
</tr>
<tr>
<td></td>
<td>• Decrease in high risk prescribing behaviors</td>
</tr>
<tr>
<td>(5)</td>
<td><strong>State – Local Integration</strong></td>
</tr>
<tr>
<td>Proposed Activities:</td>
<td>Linkages to Care</td>
</tr>
<tr>
<td>----------------------</td>
<td>-----------------</td>
</tr>
<tr>
<td>• Capacity building for more effective and sustainable surveillance and prevention efforts</td>
<td>• Greater awareness of opioid overdose epidemic, with respect to burden and resources</td>
</tr>
<tr>
<td>• Prevention and response strategies at the state and local level</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(6) Linkages to Care

Proposed Activities:
• Enhance programs and policies
• Increase and improve coordination
• Integrate technology (ex. using technology to facilitate connections to care)

(7) Providers and Health Systems Support

Proposed Activities:
• Implementation, Clinical Education and Training
• Insurers and health system support

(8) Public Safety Partnerships

Proposed Activities:
• Data Sharing (ex. ODMAP, arrest and/or seizure data, etc.)
• Programmatic Partnerships (ex. diversion programs, drug courts, quick response teams, etc.)

(9) Communications/Marketing
Proposed Activities:
- Address stigma surrounding opioid use, overdose, treatment, and naloxone use
- Development of risk reduction messaging for vulnerable populations
- Developing messaging around illicit drugs and harm reduction strategies

• Effectively communicate prevention and outreach messaging to vulnerable populations

Prevention Innovation Project
- Local innovative activities
*Note: Innovation projects and activities should have the aim of reducing opioid-related morbidity, mortality, and associated harms.

• Expanded opioid prevention activities

Part 4. How to Apply

A. Requirements Documentation/Application Checklist:
Use the checklist as a tool to ensure all required information is included. NOTE: Applications that fail to follow all requirements may not be considered for review.

✓ Project Narrative
  o Problem/need: Applicant must provide a description of the context of the problem and need within their agency. Local data is recommended to be addressed in this section. Clearly identify target populations. Describe potential gaps in services within the community.
  o Description of Agency/Personnel: Summarize the agency’s structure as it relates to the project and how it will manage the strategies/activities; outline capacity of personnel and/or contractors.
  o Strategies and Activities: Applicants must detail the strategies they will use to achieve the performance outcomes. Also, applicants must outline how and what efforts will be made to complete the activities. Defines the implementation of the project.
  o Maximum of 8 pages in length. Work plan and project budget are not included in the project narrative page limit.

✓ Work Plan Template
  o This includes all strategies, activities, and timelines necessary to complete the project identified in the project narrative. Instructions
are provided and work plan template can be found as Attachment I and Attachment II.

**Project Budget and Narrative**

- Applicants must submit an itemized budget narrative. When developing the budget narrative, applicants must consider the proposed budget is reasonable and consistent with the purpose, outcomes and program strategy.
- If applicable, the budget narrative should clearly distinguish between funds allocated to support surveillance strategy (3) and prevention strategies (4-10).
- The budget should include the following:
  - Salaries and wages
  - Fringe benefits
  - Equipment
  - Supplies
  - Travel
  - Other categories
  - Contractual costs
  - Total Direct costs
  - Total Indirect costs
- Must include a completed W-9 form
- A budget preparation guidelines template has been provided as Attachment IV.

**B. Unallowable Costs:**

**Funds may not** be used for the following:

- **Prohibited purchases:** Naloxone/Narcan, syringes, fentanyl test strips, harm reduction kits, furniture or equipment (generally, but note that vehicles may be allowable expenses for linkage to care activities). Harm reduction and linkage to care activities are acceptable as long as they are not prohibited purchases.
- HIV/HCV/other STD/STI testing.
- Drug disposal. This includes implementing or expanding drug disposal programs or drug take back programs, drug drop box, drug disposal bags.
- The provision of medical/clinical care.
- Wastewater analysis, including testing vendors, sewage testing and wastewater testing.
- Research.
- Direct funding or expanding the provision of substance abuse treatment.
- Development of educational materials on safe injection.
- The prevention of Adverse Childhood Experiences (ACEs) as a stand-alone activity. However, activities related to ACEs are allowable if they...
pertain to establishing linkage to care, or to providing training to public safety and first responders on trauma-informed care.

- Public safety activities that do not include clear overlap/collaboration with public health partner and objectives.

**Medication Assisted Treatment (MAT) Waivers:** Funds can be used to support training and education around MAT waivers; however, OD2A funds cannot be used to pay for fees associated with providers obtaining waived status. This applies to both direct reimbursements and contracts. If training and waiver fee activities occur together, it must be clear that OD2A funds are not being used to cover the waiver fee itself. Other funding sources can be used to cover waiver fees.

**Neonatal Abstinence Syndrome (NAS):** Please note that certain activities that cover neonatal abstinence syndrome (NAS) are allowable, while others are not. In particular, certain NAS-related surveillance and prevention activities may be allowable; however, funding collection of NAS surveillance data is not allowable. Some examples of what would be allowable (noted in the FAQs) include:

- Surveillance of linkage to care during or after pregnancy for mothers who use opioids during pregnancy.
- Tracking drug use patterns, overdose history, and linkage to treatment and risk reduction services for pregnant women.
- Linking data sources on pregnant women available at the state and local level.
- Prevention strategies and activities for pregnant women, infants born with NAS, and for healthcare provider/clinician support and education.

C. Page Formatting Instructions
   Project Narrative and Budget Narrative must be submitted using the following page formatting requirements:
   - Application Font: Times New Roman
   - Application Font Size: 12 point
   - Margins: 1 inch

D. Submission Instructions
   Application, including any required attachments must be completed and received by FCPH electronically by **5:00 p.m. on April 10, 2020**. Applications and required attachments received after this deadline will not be considered for review.

   - **Electronic Submission:** Applications received via email will receive an email confirming the delivery. When submitting application, please email to lindseyrodenhauser@franklincountyohio.gov and use subject line: “REQUEST FOR APPLICATION: FRANKLIN COUNTY OD2A PROJECT”
**Part 5. Schedule of Activities**

<table>
<thead>
<tr>
<th>Solicitation of Activity Timeline</th>
<th>Time</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. RFA published to public</td>
<td>N/A</td>
<td>March 23, 2020</td>
</tr>
<tr>
<td>2. Deadline for applicant to submit written questions. Submit all question by email to <a href="mailto:lindseyrodenhauser@franklincountyoiohio.gov">lindseyrodenhauser@franklincountyoiohio.gov</a> by 2:00 p.m.</td>
<td>2:00 p.m.</td>
<td>March 30, 2020</td>
</tr>
<tr>
<td><em>Question will not be accepted after this date and time.</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Answers to written inquires published on FCPH website – <a href="http://www.myfcph.org">www.myfcph.org</a></td>
<td>5:00 p.m.</td>
<td>April 1, 2020</td>
</tr>
<tr>
<td>4. Application submission deadline</td>
<td>5:00 p.m.</td>
<td>April 10, 2020</td>
</tr>
<tr>
<td>6. Estimated Notification of Award</td>
<td>N/A</td>
<td>July 1, 2020</td>
</tr>
<tr>
<td>7. Contract Effective Date</td>
<td>N/A</td>
<td>Sept. 1, 2020</td>
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**Part 6. CDC RFA Language**

As previously stated, this project was funded through the CDC’s Overdose Data to Action Funding, CDC-RFA-CE-19-1904. FCPH has provided a copy of the original RFA for applicants to review. The document can be found as Attachment V of this RFA.

**Part 7. Attachments**

A. Attachments:
   - Attachment I: Work Plan Template
   - Attachment II: Work Plan Instructions and Example
   - Attachment III: Scoring Criteria
   - Attachment IV: Budget Preparation Guidelines
   - Attachment V: CDC-RFA-C E-19-1904 PDF
2020 - 2021 Franklin County Overdose Data to Action Project
Annual Work Plan 2020 - 2021

<table>
<thead>
<tr>
<th>Strategy X:</th>
<th>Target Population:</th>
</tr>
</thead>
</table>

**Long-Term Outcome(s):**

**Short-Term Outcome(s):**

<table>
<thead>
<tr>
<th>Activity</th>
<th>Steps Proposed</th>
<th>Submitted Documents</th>
<th>Person Responsible</th>
<th>Start Date</th>
<th>End Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(Describe details on how applicant will complete the activity)</td>
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</table>

<table>
<thead>
<tr>
<th>Strategy X:</th>
<th>Target Population:</th>
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**Long-Term Outcome(s):**

**Short-Term Outcome(s):**

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<th>Person Responsible</th>
<th>Start Date</th>
<th>End Date</th>
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</thead>
<tbody>
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<td>(Describe details on how applicant will complete the activity)</td>
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</tr>
</tbody>
</table>

**NOTE:** Applicants may copy and paste rows to add additional settings (strategies, activities, etc.).
## Project Name: Franklin County Overdose Data to Action Project

Name of Agency: ABC Health       Point of Contact: John Smith

### 2020 - 2021 Franklin County Overdose Data to Action Project
Annual Work Plan 2020 - 2021

<table>
<thead>
<tr>
<th>Strategy 6: Linkages to Care</th>
<th>Target Population: 43201, 43123, 43224</th>
</tr>
</thead>
</table>

**Long-Term Outcome(s):** Decreased drug overdose death rate, including prescription and illicit opioid overdose death rates.

**Short-Term Outcome(s):** Increased referrals to and engagement in evidence-based treatment.

<table>
<thead>
<tr>
<th>Activity</th>
<th>Steps Proposed (Describe details on how applicant will complete the activity)</th>
<th>Submitted Documents</th>
<th>Person Responsible</th>
<th>Start Date</th>
<th>End Date</th>
</tr>
</thead>
</table>
| A. Increase and improve coordination to XYZ Program | 1. Staffing  
   a. Create job description  
   b. Post job  
   2. Identify location site  
   a. Develop potential partner list  
   b. Conduct meetings with potential partners | **A1 Documentation:**  
   - Copy of job description  
   - Offer Letter  
   **A2 Documentation:**  
   - List of partners  
   - Sign-in sheets  
   - Summary of meetings  
   - Signed MOU | John Smith, Program Coordinator | 9/1/2020 | 11/30/2020 |
| | 3. Onboard staff  
   a. Develop onboarding plan for new staff  
   4. Aggregate data collected for location site  
   b. # of referrals to treatment  
   c. # of clients educated  
   5. Participation and Evaluation  
   a. Attend project meetings | **A3 Documentation:**  
   - Onboarding plan  
   **A4 Documentation:**  
   - Quarterly data report  
   **A5 Documentation**  
   - Sign-in sheets  
   - Meeting minutes | Jane Doe, Referral Specialist | 12/1/2020 | 2/28/2021 |
Attachment II: Work Plan Example

<table>
<thead>
<tr>
<th>Activity</th>
<th>Steps Proposed (Describe details on how applicant will complete the activity)</th>
<th>Submitted Documents</th>
<th>Person Responsible</th>
<th>Start Date</th>
<th>End Date</th>
</tr>
</thead>
<tbody>
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</table>

NOTE: Applicants may copy and paste rows to add additional settings (strategies, activities, etc.).
## Project Narrative

**Problem/need:**
- Describes the opioid problems and includes description of local rates and related factors
- Describes segment of the target population or areas of high rates of opioid use
- Describes the potential gaps in services within the community

**Description of Agency/Personnel:**
- Summarizes the structure of the agency as it relates to the project
- Describes how agency will manage the strategies and activities
- Outlines the capacity of personnel and/or contractors

**Strategies and Activities:**
- States the strategies and activities applicants will complete
- Describes how and what efforts will be made to complete activities
- Defines the implementation of the project

**Work Plan**
- List the strategies and activities
- Describes the efforts to complete activities
- Includes long-term and short-term outcomes
- Identifies assigned personnel for each activity
- Includes a specific timeline for proposed step, not just start and end date of the activity or strategy

### Scoring Criteria

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problem/need:</td>
<td></td>
<td></td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>Description of Agency/Personnel:</td>
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<tr>
<td>Strategies and Activities:</td>
<td></td>
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<tr>
<td>Work Plan:</td>
<td></td>
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</tr>
</tbody>
</table>
Attachment III: Scoring Criteria

<table>
<thead>
<tr>
<th>Item</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Includes list of documentation applicant will provide to support the work of the activity</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td><strong>Project Budget and Narrative</strong></td>
<td></td>
</tr>
<tr>
<td>Budget narrative is itemized and reasonably tied to the purpose, outcome(s), strategy(ies), and activity(ies)</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>Itemized budget distinguishes between prevention and surveillance strategies</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>Provides completed W-9 form</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>Notes:</td>
<td></td>
</tr>
</tbody>
</table>

**Did applicant receive Franklin County OD2A funding in 2019-2020?**

<table>
<thead>
<tr>
<th>Score</th>
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<tbody>
<tr>
<td>0 1</td>
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</table>

**Total Score:**

<table>
<thead>
<tr>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>/91</td>
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</tbody>
</table>
Preparing a budget can be one of the most confusing aspects of applying for a CDC grant or cooperative agreement. This document provides guidance for the preparation of a budget request and examples to help with the process. Adherence to this guidance will facilitate timely review and approval of a budget request.

### Salaries and Wages

For each requested position, provide the following information: 1) name of staff member occupying the position, if available; 2) annual salary; 3) percentage of time budgeted for this program; 4) total months of salary budgeted; and 5) total salary requested. Also, provide a justification and describe the scope of responsibility for each position, relating it to the accomplishment of program objectives.

#### Sample Budget

<table>
<thead>
<tr>
<th>Position Title and Name</th>
<th>Annual Salary</th>
<th>Time</th>
<th>Months</th>
<th>Amount Requested</th>
</tr>
</thead>
<tbody>
<tr>
<td>Project Coordinator</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Susan Taylor</td>
<td>$45,000</td>
<td>100%</td>
<td>12 months</td>
<td>$45,000</td>
</tr>
<tr>
<td>Finance Administrator</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>John Johnson</td>
<td>$28,500</td>
<td>50%</td>
<td>12 months</td>
<td>$14,250</td>
</tr>
<tr>
<td>Outreach Supervisor</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Vacant*)</td>
<td>$27,000</td>
<td>100%</td>
<td>12 months</td>
<td>$27,000</td>
</tr>
<tr>
<td><strong>Total Personnel</strong></td>
<td></td>
<td></td>
<td></td>
<td><strong>$86,250</strong></td>
</tr>
</tbody>
</table>

#### Sample Justification

The format may vary, but the description of responsibilities should be directly related to specific program objectives.

**Job Description**: Project Coordinator – (Susan Taylor)

This position directs the overall operation of the project including overseeing the implementation of project activities, coordination with other agencies, development of materials, provisions of service and training, collects, tabulates and interprets required data, program evaluation and staff performance evaluation. This individual is the responsible authority for ensuring reports and documentation are submitted to CDC. This position relates to all program objectives.

### Fringe Benefits

Fringe benefits are usually applicable to direct salaries and wages. Provide information on the rate of fringe benefits used and the basis for their calculation. If a fringe benefit rate is not used, itemize how the fringe benefit amount is computed.
Sample Budget

Fringe benefits computed by an established rate.

\[
\text{Fringe Benefits Total } \$_______ \quad 25\% \text{ of Total salaries} = \text{Fringe Benefits}
\]

If fringe benefits are not calculated using a percentage of salaries, itemize how the amount is determined for each salary and wage being requested.

Project Coordinator Salary - $45,000

<table>
<thead>
<tr>
<th>Fringe Benefit</th>
<th>Percentage of Salary</th>
<th>Amount Requested</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retirement</td>
<td>5%</td>
<td>$2,250</td>
</tr>
<tr>
<td><strong>FICA</strong></td>
<td>7.65%</td>
<td>$3,443</td>
</tr>
<tr>
<td>Insurance</td>
<td>N/A</td>
<td>$2,000</td>
</tr>
<tr>
<td><strong>Workers Compensation</strong></td>
<td>N/A</td>
<td>$</td>
</tr>
<tr>
<td><strong>Total Fringe</strong></td>
<td></td>
<td><strong>$7,693</strong></td>
</tr>
</tbody>
</table>

Consultant Costs

This category should be used when hiring an individual to give professional advice or services (e.g., training, expert consultant, etc.) for a fee, but not as an employee of the grantee organization. Written approval must be obtained from CDC prior to establishing a written agreement for consultant services, and must be obtained annually in order to re-establish the written agreement. Approval to initiate or continue program activities through the services of a consultant requires submission of the following information to CDC for each consultant:

1. **Name of Consultant:** Identify the name of the consultant and describe his or her qualifications.
2. **Organizational Affiliation** (if applicable): Identify the organization affiliation of the consultant.
3. **Nature of Services to Be Rendered:** Describe the consultation that will be provided, including the specific tasks to be completed and specific deliverables. A copy of the actual consultant agreement should not be sent to CDC.
4. **Relevance of Service to the Project:** Describe how the consultant services relate to the accomplishment of specific program objectives.
5. **Number of Days of Consultation** (basis for fee): Specify the total number of days of consultation.
6. **Expected Rate of Compensation:** Specify the rate of compensation for the consultant (e.g., rate per hour, rate per day). Include a budget showing other costs (e.g., travel, per diem, supplies, and other related expenses) and list a subtotal.
7. **Method of Accountability:** Describe how the progress and performance of the consultant will be monitored. Identify who is responsible for supervising the consultant agreement.

If the required information described above is not known at the time the application is submitted, the information may be submitted later as a revision to the budget. In the body of the budget request, a summary should be provided of the proposed consultants and amounts for each.
Equipment

Equipment is defined as tangible, non-expendable personal property (including exempt property) that has a useful life of more than one year AND an acquisition cost of $5,000 or more per unit. However, in circumstances where your organization has a lower threshold, you may work with your CDC Grants Management Officer to establish a threshold that is consistent with your organization’s policy.

All budget requests should individually list each item requested, and provide the following information: 1) number needed; 2) unit cost of each item; and 3) total amount requested. Also, provide a justification for the use of each item and relate it to specific program objectives. Maintenance or rental fees for equipment should be shown in the Other category.

### Sample Budget

<table>
<thead>
<tr>
<th>Item Requested</th>
<th>Number Needed</th>
<th>Unit Cost</th>
<th>Amount Requested</th>
</tr>
</thead>
<tbody>
<tr>
<td>Computer Workstation</td>
<td>2 ea.</td>
<td>$5,500</td>
<td>$11,000</td>
</tr>
<tr>
<td>Computer</td>
<td>1 ea.</td>
<td>$6,000</td>
<td>$6,000</td>
</tr>
<tr>
<td><strong>Total Equipment</strong></td>
<td></td>
<td></td>
<td><strong>$17,000</strong></td>
</tr>
</tbody>
</table>

### Sample Justification

The computer workstations will be used by the principal investigator and statistician to collect required data, perform data analysis, and generate reports. These computers will also support the daily operation of the project, routine correspondence, research, and electronic communication.

Supplies

Individually list each item requested, and provide the following information: 1) specify the type of item, as appropriate; 2) number needed; 3) unit cost of each item; and 4) total amount requested. If appropriate, General office supplies may be shown by an estimated amount per month times the number of months in the budget category. Also, provide a justification for the use of each item and relate it to specific program objectives.

### Sample Budget

<table>
<thead>
<tr>
<th>Item Requested</th>
<th>Type</th>
<th>Number Needed</th>
<th>Unit Cost</th>
<th>Amount Requested</th>
</tr>
</thead>
<tbody>
<tr>
<td>Computer Workstation</td>
<td>(Specify type)</td>
<td>3 ea.</td>
<td>$2,500</td>
<td>$7,500</td>
</tr>
<tr>
<td>Word Processing Supplies</td>
<td>(Specify type)</td>
<td>1 ea.</td>
<td>$400</td>
<td>$400</td>
</tr>
<tr>
<td>Educational Pamphlets</td>
<td>N/A</td>
<td>3,000 copies</td>
<td>$1</td>
<td>$3,000</td>
</tr>
<tr>
<td>General Office Supplies</td>
<td>Pens, pencils, paper</td>
<td>12 months</td>
<td>$20/month per person for 10 people</td>
<td>$2,400</td>
</tr>
<tr>
<td><strong>Total Supplies</strong></td>
<td></td>
<td></td>
<td></td>
<td><strong>$19,900</strong></td>
</tr>
</tbody>
</table>
Sample Justification

Office supplies will be used by staff members to carry out daily activities of the program. The education pamphlets and videos will be purchased from Vendor X and used to illustrate and promote safe and healthy activities. Word Processing Software will be used to document program activities, process progress reports, etc.

Travel

Dollars requested in the Travel category should be for **recipient staff travel only**. Travel for consultants should be shown in the Consultant category. Travel for other participants (e.g., advisory committees, review panel, etc.) should be itemized as specified below and placed on the *Other* category.

For In-State Travel, provide a narrative justification describing the travel staff members will perform. List where travel will be undertaken, number of trips planned, who will be making the trips, and approximate dates. If mileage is to be paid, provide the number of miles and the cost per mile. If travel is by air, provide the estimated cost of airfare. If per diem/lodging is to be paid, indicate the number of days and amount of daily per diem, as well as the number of nights and estimated cost of lodging. Include the cost of ground transportation, when applicable.

For Out-of-State Travel, provide a narrative justification including the same information requested above. Include CDC meetings, conferences, and workshops, if required by CDC. Itemize Out-of-State Travel in the format described above for In-State Travel.

Sample Travel Budget

<table>
<thead>
<tr>
<th></th>
<th>Total $_______</th>
</tr>
</thead>
<tbody>
<tr>
<td>Travel (In-State and Out-of-State)</td>
<td></td>
</tr>
</tbody>
</table>

Sample In-State Travel Budget

<table>
<thead>
<tr>
<th></th>
<th>Total $_______</th>
</tr>
</thead>
<tbody>
<tr>
<td>Travel (In-State):</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Number of Trips</th>
<th>Number of People</th>
<th>Cost of Airfare</th>
<th>Number of Total Miles</th>
<th>Cost per Mile</th>
<th>Amount Requested</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>N/A</td>
<td>500 mi.</td>
<td>$0.27</td>
<td>$270</td>
</tr>
<tr>
<td>25</td>
<td>1</td>
<td>N/A</td>
<td>300 mi.</td>
<td>$0.27</td>
<td>$2,025</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td><strong>$2,295</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Per Diem or Lodging</th>
<th>Number of People</th>
<th>Number of Units</th>
<th>Unit Cost</th>
<th>Amount Requested</th>
</tr>
</thead>
<tbody>
<tr>
<td>Per Diem</td>
<td>2</td>
<td>2 days</td>
<td>$37/day</td>
<td>$148</td>
</tr>
<tr>
<td>Lodging</td>
<td>2</td>
<td>1 night</td>
<td>$67/night</td>
<td>$134</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td></td>
<td><strong>$282</strong></td>
</tr>
</tbody>
</table>

Sample In-State Travel Justification

The Project Coordinator and the Outreach Supervisor will travel to (location) to attend AIDS conference. The Project Coordinator will make an estimated 25 trips to local outreach sites to monitor program implementation.
Sample Out-of-State Travel Budget

Travel (Out of-State): Total $_______

<table>
<thead>
<tr>
<th>Number of Trips</th>
<th>Number of People</th>
<th>Cost of Airfare</th>
<th>Number of Total Miles</th>
<th>Cost per Mile</th>
<th>Amount Requested</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1</td>
<td>$500</td>
<td>N/A</td>
<td>N/A</td>
<td>$500</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Per Diem or Lodging</th>
<th>Number of People</th>
<th>Number of Units</th>
<th>Unit Cost</th>
<th>Amount Requested</th>
</tr>
</thead>
<tbody>
<tr>
<td>Per Diem</td>
<td>1</td>
<td>3 days</td>
<td>$45/day</td>
<td>$135</td>
</tr>
<tr>
<td>Lodging</td>
<td>1</td>
<td>1 night</td>
<td>$88/night</td>
<td>$88</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Ground Transportation?</th>
<th>Number of People</th>
<th>Amount Requested</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>1</td>
<td>$50</td>
</tr>
</tbody>
</table>

Sample Out-of-State Travel Justification

The Project Coordinator will travel to CDC, in Atlanta, GA to attend the CDC conference.

Other

This category contains items not included in the previous budget categories. Individually list each item requested and provide appropriate justification related to the program objectives.

Sample Budget

<table>
<thead>
<tr>
<th>Item Requested</th>
<th>Number of Months</th>
<th>Estimated Cost per Month</th>
<th>Number of Staff</th>
<th>Amount Requested</th>
</tr>
</thead>
<tbody>
<tr>
<td>Telephone</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>Postage</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>Equipment Rental</td>
<td>$</td>
<td>N/A</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>Internet Provider Service</td>
<td>$</td>
<td>N/A</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>Total Other</td>
<td></td>
<td></td>
<td>$</td>
<td>$</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Item Requested</th>
<th>Number Needed</th>
<th>Unit Cost</th>
<th>Amount Requested</th>
</tr>
</thead>
<tbody>
<tr>
<td>Printing</td>
<td>___ documents</td>
<td>$</td>
<td>$</td>
</tr>
</tbody>
</table>

Sample Justification

For printing costs, identify the types and number of copies of documents to be printed (e.g., procedure manuals, annual reports, materials for media campaign).
Contractual Costs

Cooperative Agreement recipients must obtain written approval from CDC prior to establishing a third-party contract to perform program activities. Approval by CDC to utilize funds and initiate program activities through the services of a contractor requires the submission of the following information for each contract to CDC:

1. **Name of Contractor:** Identify the name of the proposed contractor and indicate whether the contract is with an institution or organization.
2. **Method of Selection:** State whether the contract is sole source or competitive bid. If an organization is the sole source for the contract, include an explanation as to why this institution is the only one able to perform contract services.
3. **Period of Performance:** Specify the beginning and ending dates of the contract.
4. **Scope of Work:** Describe the specific services/tasks to be performed by the contractor and relate them to the accomplishment of program objectives. Deliverables should be clearly defined.
5. **Method of Accountability:** Describe how the progress and performance of the contractor will be monitored during and on close of the contract period. Identify who will be responsible for supervising the contract.
6. **Itemized Budget and Justification:** Provide and itemized budget with appropriate justification. If applicable, include any indirect cost paid under the contract and the indirect cost rate used.

If the information described above is not known at the time the application is submitted, the information may be submitted later as a revision to the budget. Copies of the actual contracts should not be sent to CDC, unless specifically requested. In the body of the budget request, a summary should be provided of the proposed contacts and amounts for each.

**Direct Costs**

Show the direct costs by listing the totals of each category, including salaries and wages, fringe benefits, consultant costs, equipment, supplies, travel, other, and contractual costs. Provide the total direct costs within the budget.

**Indirect Costs**

To claim indirect costs, the applicant organization must have a current approved indirect cost rate agreement established with the cognizant federal agency. A copy of the most recent indirect cost rate agreement must be provided with the application.

If the applicant organization does not have an approved indirect cost rate agreement, costs normally identified as indirect costs (overhead costs) can be budgeted and identified as direct costs.
Centers for Disease Control

National Center for Injury Prevention and Control

Overdose Data to Action
CDC-RFA-CE19-1904
Application Due Date: 05/02/2019
Part I. Overview Information
A. Federal Agency Name
B. Funding Opportunity Title
C. Announcement Type
D. Agency Funding Opportunity Number
E. Assistance Listings (CFDA) Number
F. Dates
G. Executive Summary

Part II. Full Text
A. Funding Opportunity Description
B. Award Information
C. Eligibility Information
D. Application and Submission Information
E. Review and Selection Process
F. Award Administration Information
G. Agency Contacts
H. Other Information
I. Glossary
Part I. Overview Information
Applicants must go to the synopsis page of this announcement at www.grants.gov and click on the "Send Me Change Notifications Emails" link to ensure they receive notifications of any changes to CDC-RFA-CE19-1904. Applicants also must provide an e-mail address to www.grants.gov to receive notifications of changes.

A. Federal Agency Name:
Centers for Disease Control and Prevention (CDC) / Agency for Toxic Substances and Disease Registry (ATSDR)

B. Notice of Funding Opportunity (NOFO) Title:
Overdose Data to Action

C. Announcement Type: New - Type 1
This announcement is only for non-research activities supported by CDC. If research is proposed, the application will not be considered. For this purpose, research is defined at https://www.gpo.gov/fdsys/pkg/CFR-2007-title42-vol1/pdf/CFR-2007-title42-vol1-sec52-2.pdf. Guidance on how CDC interprets the definition of research in the context of public health can be found at https://www.hhs.gov/ohrp/regulations-and-policy/regulations/45-cfr-46/index.html (See section 45 CFR 46.102(d)).

D. Agency Notice of Funding Opportunity Number:
CDC-RFA-CE19-1904

E. Assistance Listings (CFDA) Number:
93.136

F. Dates:
1. Due Date for Letter of Intent (LOI):
   03/01/2019
2. Due Date for Applications:

3. Date for Informational Conference Call:
   Conference phone number is 1-888-455-1397
   Conference I.D.  7624894#
   Link: https://adobeconnect.cdc.gov/rtdp86dayqnm/

<table>
<thead>
<tr>
<th>Potential Agenda Items</th>
<th>Potential Dates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kickoff Call</td>
<td>2/12/19</td>
</tr>
<tr>
<td>· Provide NOFO overview</td>
<td>3:30-4:45 Eastern time</td>
</tr>
<tr>
<td>· Review Eligibility</td>
<td></td>
</tr>
<tr>
<td>· Projected average award amount</td>
<td></td>
</tr>
<tr>
<td>Component 1: Surveillance</td>
<td>2/21/19</td>
</tr>
<tr>
<td>· Provide overview of required and optional</td>
<td></td>
</tr>
</tbody>
</table>
Two additional calls will be scheduled in the evening for territories (not including Puerto Rico)
Conference Number: 1-888-455-1397
Conference I.D.: 7264894#
URL:  [https://adobeconnect.cdc.gov/rtdp86dayqnw/](https://adobeconnect.cdc.gov/rtdp86dayqnw/)

<table>
<thead>
<tr>
<th>Component 1: Surveillance (part 2 of 2)</th>
<th>Potential Agenda Items</th>
<th>Potential Dates</th>
</tr>
</thead>
<tbody>
<tr>
<td>· Provide overview of required and optional surveillance strategies</td>
<td>3/5/19 3:30-4:45 Eastern time</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Component 2: Prevention</th>
<th>Potential Agenda Items</th>
<th>Potential Dates</th>
</tr>
</thead>
<tbody>
<tr>
<td>· Provide overview of required and optional strategies</td>
<td>3/7/19 5-7PM Eastern</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Surveillance: Mortality and Morbidity</th>
<th>Potential Agenda Items</th>
<th>Potential Dates</th>
</tr>
</thead>
<tbody>
<tr>
<td>· General overview</td>
<td>2/21/19 5-7PM Eastern</td>
<td></td>
</tr>
<tr>
<td>· Provide overview of required and optional surveillance strategies</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**G. Executive Summary:**

1. **Summary Paragraph:**
Funding is to support recipients in getting high quality, comprehensive, and timelier data on
opioid prescribing, morbidity, and mortality, and to use those data to inform prevention. There are two required components - 3 surveillance strategies (1 – 2 are required for state recipients, D.C. and Puerto Rico, 3 is required for all recipients) and seven prevention strategies (4 – 7 are required, 8 – 10 are optional). The intent is to ensure that recipients are well equipped to do rigorous work under both components, and to ensure that these components are linked and implemented as part of a dynamic system. The purpose of getting more comprehensive and faster surveillance data is to generate insight for action, and to drive prevention and response activities. Required and optional strategies under these components are shown in the table below.

<table>
<thead>
<tr>
<th>Surveillance (italicized strategies are required for state health departments (SHD), DC, and Puerto Rico and bolded strategies are required for all recipients)</th>
<th>STRATEGY:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1: Collect and disseminate timely emergency department (ED) data</td>
<td></td>
</tr>
<tr>
<td>2: Collect and disseminate descriptions of drug overdose death circumstances</td>
<td></td>
</tr>
<tr>
<td>3: Implement innovative surveillance</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Prevention (bolded strategies are required for all recipients)</th>
<th>4: Prescription Drug Monitoring Programs</th>
</tr>
</thead>
<tbody>
<tr>
<td>5: State-local Integration</td>
<td></td>
</tr>
<tr>
<td>6: Linkage to Care</td>
<td></td>
</tr>
<tr>
<td>7: Providers and Health Systems Support</td>
<td></td>
</tr>
<tr>
<td>8: Public Safety Partnerships</td>
<td></td>
</tr>
<tr>
<td>9: Empowering Individuals</td>
<td></td>
</tr>
<tr>
<td>10: Innovation Projects</td>
<td></td>
</tr>
</tbody>
</table>

| a. Eligible Applicants: | Limited |
| b. NOFO Type: | Cooperative Agreement |
| c. Approximate Number of Awards: | 78 |
| d. Total Period of Performance Funding: | $840,000,000 |
| e. Average One Year Award Amount: | $3,000,000 |
| f. Total Period of Performance Length: | 3 |
| g. Estimated Award Date: | 09/01/2019 |
| h. Cost Sharing and / or Matching Requirements: | N |

Cost sharing or matching funds are not required for this program. Although no statutory matching requirement for this NOFO exists, leveraging other resources and related ongoing
efforts to promote sustainability is strongly encouraged. Consistent with the cited authority for this announcement and applicable grants regulations, sources for cost sharing or matching may include complementary foundation funding, other U.S. government funding sources including programs supported by HHS or other agencies (e.g., Department of Justice, Department of Agriculture, Department of Education, Department of Housing and Urban Development, Department of Transportation, Environmental Protection Agency, U.S. Park Service) and other funding sources. Applicants should coordinate with multiple sectors such as public health, transportation, education, health care delivery, and agriculture.

Part II. Full Text

A. Funding Opportunity Description

1. Background

a. Overview

Drug overdose deaths in the United States increased by 18% per year from 2014 to 2016. Of the 70,237 drug overdose deaths in 2017, 2 out of 3 involved an opioid. Opioid overdose deaths have increased fivefold from 1999 to 2016. Nonfatal opioid overdoses are on the rise as well; emergency department (ED) data on opioid overdoses show a 30% increase in visits involving opioid overdoses from July 1, 2016 to September 30, 2017 that impacted all U.S. regions, age groups, and sexes.

While the opioid overdose epidemic worsens in scope and magnitude, it is also becoming more complex. The increase in opioid overdose deaths involves three distinct, but interrelated trends: a 15-year increase in overdose deaths involving prescription opioid pain relievers, a surge in heroin deaths starting in 2010, and a significant increase in deaths involving illicitly-manufactured fentanyl and fentanyl analogs since 2013. Additionally, from 2015 to 2016, rate increases were observed in deaths involving cocaine and psychostimulants with abuse potential, with synthetic opioids (e.g., fentanyl) increasingly being involved in these deaths and used with other opioids, other illicit drugs, benzodiazepines, and alcohol.

The complex and changing nature of the opioid overdose epidemic highlights the need for an interdisciplinary, comprehensive, and cohesive public health approach. States, territories, and local partners need access to complete and timely data on prescribing, and on nonfatal and fatal drug overdoses to understand the scope, direction, and contours of the epidemic. They also need the tools and resources to then use these data to inform and target their prevention and response efforts. This NOFO integrates work funded through three previous CDC funding opportunities: Prescription Drug Overdose Prevention for States (CDC-RFA-CE15-1501), Data Driven Prevention Initiative (CDC-RFA-CE16-1606) and Enhanced State Surveillance of Opioid-Involved Morbidity and Mortality (CDC-RFA-CE16-1608). This funding opportunity will continue work focused on: increasing comprehensiveness and timeliness of surveillance data; building state and local capacity for public health programs determined to be promising based on research evidence; making Prescription Drug Monitoring Programs (PDMPs) easier to use and access; and working with health systems, insurers, and communities to improve opioid prescribing. It adds new work focused on linkages to care and other areas of innovation.
supported by evidence-based practice.

b. Statutory Authorities
Section 311(c)(1) of the PHS Act (42 USC § 243(c)(1)), which provides as follows:
The Secretary is authorized to develop (and may take such action as may be necessary to implement) a plan under which personnel, equipment, medical supplies, and other resources of the Service and other agencies under the jurisdiction of the Secretary may be effectively used to control epidemics of any disease or condition and to meet other health emergencies or problems. The Secretary may enter into agreements providing for the cooperative planning between the Service and public and private community health programs and agencies to cope with health problems (including epidemics and health emergencies).

c. Healthy People 2020
This funding opportunity supports Healthy People 2020 topic areas of injury and violence prevention and substance abuse. For specific objectives within these topic areas, please consult https://www.healthypeople.gov/2020/topics-objectives/topic/injury-and-violence-prevention/objectives.

d. Other National Public Health Priorities and Strategies
This NOFO supports the following national public health priorities and strategies:

- President’s Commission on Combating Drug Addiction and the Opioid Crisis Recommendations ([https://www.whitehouse.gov/ondcp/presidents-commission](https://www.whitehouse.gov/ondcp/presidents-commission))

e. Relevant Work
This funding opportunity builds upon past CDC programs focused on opioid overdose and injury prevention:

- Data-Driven Prevention Initiative (CDC-RFA-CE16-1606)
- Prescription Drug Overdose Prevention for States (CDC-RFA-CE15-1501)
- Enhanced State Surveillance of Opioid-Involved Morbidity and Mortality (CDC-RFA-CE16-1608)
- Core State Violence and Injury Prevention Program (CDC-RFA-CE16-1602)

See also: [https://www.cdc.gov/drugoverdose/states/index.html](https://www.cdc.gov/drugoverdose/states/index.html).

The surveillance component also leverages the Collecting Violent Death Information Using the National Violent Death Reporting System (NVDRS) (CDC-RFA-CE18-1804) and The National

2. CDC Project Description

a. Approach

Bold indicates period of performance outcome.

*CDC-RFA-CE19-1904* Logic Model: Overdose Data To Action

Bold indicates period of performance outcome
<table>
<thead>
<tr>
<th>Strategies and Activities</th>
<th>Short-term Outputs/Outcomes</th>
<th>Intermediate Outcomes</th>
<th>Long-Term Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>COMPONENT 1: SURVEILLANCE</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Strategy 1: Collect and disseminate timely emergency department (ED) data on suspected all drug, all opioid, heroin, and stimulant overdoses (required for SHDs, Puerto Rico, and DC)</td>
<td>Strategy 1.3: Timely and actionable surveillance data disseminated by recipients:</td>
<td>Strategy 1.3: DOJ surveillance data contributed to improvements in drug overdose interventions:</td>
<td>• Decreased rate of opioid misuse and opioid use disorder</td>
</tr>
<tr>
<td></td>
<td>• To enhance the implementation of their NOVO interventions</td>
<td>• ToLink stakeholders working to reduce drug overdoses in their jurisdiction</td>
<td>• Increased provision of evidence-based treatment for opioid use disorder</td>
</tr>
<tr>
<td></td>
<td>• To recipients’ stakeholders working to reduce drug overdoses in their jurisdiction</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• To CDC to readily inform the public and key regional and national stakeholders</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Strategy 2: Collect and disseminate descriptions of drug overdose death circumstances using death certificates and medical examiner/coroner data (required for SHDs, Puerto Rico and DC)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Strategy 3: Implement innovative surveillance to support NOVO interventions (required)</td>
<td></td>
<td></td>
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<tr>
<td><strong>COMPONENT 2: PREVENTION</strong></td>
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<tr>
<td>Strategy 4: Prescription Drug Monitoring Programs (required)</td>
<td>Strategy 4: Increased measurable collaboration and communication</td>
<td>Strategy 4: Increased use of PDMPs by providers and pharmacists</td>
<td>• Decreased rate of ED visits due to misuse or opioid use disorder</td>
</tr>
<tr>
<td>• Universal use among providers within a state</td>
<td>• Increased application of data to drive prevention and response activities between state and local efforts</td>
<td>• Identification of high risk prescribing and patient behaviors</td>
<td></td>
</tr>
<tr>
<td>• Inclusion of more timely or real-time data contained within a PDMP</td>
<td>• Increased access for state health departments to multiple data sources (data dashboards, etc.)</td>
<td>• Better tracking of opioid prescriptions</td>
<td>• Decreased opioid overdose death rates, including prescription and illicit opioid overdose death rates.</td>
</tr>
<tr>
<td>• Actively managing the PDMP in part by sending proactive (or unsolicited) reports to providers to inform prescribing</td>
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<tr>
<td>• Ensuring that PDMPs are easy to use and access by providers</td>
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<tr>
<td>• Intrastate and interstate interoperability</td>
<td></td>
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<tr>
<td>Strategy 5: Integration of State and Local Prevention and Response Efforts (required)</td>
<td>Strategy 5: Increased local and state capacity for sustainable surveillance and prevention efforts</td>
<td>Strategy 5: Increased awareness of drug and opioid overdose epidemic by state health departments, with respect to burden and resources, including at the city/county level.</td>
<td>• Increased state involvement in local-level prevention efforts</td>
</tr>
<tr>
<td>• Explicit efforts to better integrate state and local prevention efforts</td>
<td>• Increased understanding of context, resources, and needs in city/county/state</td>
<td>• Increased state involvement in local-level prevention efforts</td>
<td>• Increased preparedness and response at the local level</td>
</tr>
<tr>
<td>• Capacity building for more effective and sustainable integrated surveillance, prevention, and response efforts</td>
<td>• Increased understanding of evidence-based, scalable response approaches</td>
<td></td>
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<tr>
<td>• Prevention and response strategies at the state and local level</td>
<td>• Increased focus on highest risk groups</td>
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<tr>
<td>Strategy 6: Establishing Linkages to Care (required)</td>
<td>Strategy 6: Increased awareness and coordination of linkages to care</td>
<td>Strategy 6: Increased referrals to and engagement in evidence-based treatment</td>
<td>• Increased referrals to and engagement in evidence-based treatment</td>
</tr>
<tr>
<td>• Identify systems-level strategies in healthcare (e.g., emergency departments, outpatient settings, community programs (e.g., comprehensive syringe services programs) and public safety and courts (e.g., police, emergency response, diversion programs) to support care linkages with improved awareness, coordination, and technology</td>
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<tr>
<td>Strategy 7: Provider and Health Support Systems Support (required)</td>
<td>Strategy 7: Provider, health system, and payer awareness of and support for guideline-concordant opioid prescribing, non-opioid medications, and non-pharmacological treatments</td>
<td>Strategy 7: Increased use of non-opioid medications and non-pharmacological treatments for pain by patients</td>
<td>• Increased awareness and coordination of linkages to care</td>
</tr>
<tr>
<td>• Clinical Education and Training based on evidence-based guidelines (e.g., CDC guideline)</td>
<td></td>
<td></td>
<td>• Decrease in high risk opioid prescribing</td>
</tr>
<tr>
<td>• Insurer and health systems supports</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Data sharing across public health and public safety partners</td>
<td>• Use of shared data to inform collaborative public health/public safety prevention and response activities</td>
<td></td>
<td>• Greater jurisdictional awareness of opioid overdose epidemic and evidence-based approaches by public safety and first responder partners</td>
</tr>
<tr>
<td>• Programmatic collaborations to share and leverage prevention and response resources</td>
<td>• Increased opportunities/processes to link individuals to care</td>
<td></td>
<td>• Increased use of pre-arrest and pre-trial diversion type programs to address opioid-related behaviors</td>
</tr>
<tr>
<td>• Awareness and education informed by media campaigns, translational research for public consumption, and appropriate messaging and resources</td>
<td>• Awareness of non-opioid medications and non-pharmacological treatments among prescribers and other clinical care partners</td>
<td>• Increased fidelity to opioid prescription/medication protocol</td>
<td>• Increased use of non-opioid medications and non-pharmacological treatments among patients</td>
</tr>
<tr>
<td>• Projects that allow states to respond to changing conditions within the jurisdiction.</td>
<td>• Promotes the development of novel prevention strategies</td>
<td>• Expanded opioid prevention activities</td>
<td>• Improved jurisdictional responsiveness</td>
</tr>
<tr>
<td></td>
<td>• Promotes the development of novel prevention strategies</td>
<td></td>
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</tbody>
</table>
i. Purpose
To support recipients in getting high quality, complete, and timelier data on opioid prescribing and overdoses, and to use those data to inform prevention and response. (Response efforts are shorter-term interventions to address an immediate need and are encompassed within the prevention component.) There are two required components of this award – a surveillance component and a prevention component. The intent is to ensure that recipients are well equipped to do rigorous work under both components, and also to ensure that these components are linked and implemented as part of a system.

ii. Outcomes
Recipients are expected to implement activities that will impact relevant short- and intermediate-term outcomes listed in the logic model. The specific short-, intermediate-, and long-term outcomes should be tailored to the work plan of strategies selected. All recipients should be positioned and are expected to impact long-term outcomes within four to six years or earlier after receiving funding, regardless of the strategies chosen. These long-term outcomes include:

- Decreased drug overdose death rate, including prescription opioid and illicit opioid overdose death rates
- Decreased rate of opioid misuse and opioid use disorder
- Increased provision of evidence-based treatment for opioid use disorder
- Decreased rate of emergency department (ED) visits due to misuse or opioid use disorder.

The following table outlines outcomes for each strategy. Refer to the logic model for additional information related to these outcomes.

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Collect and disseminate timely emergency department (ED) data on suspected all drug, all opioid, heroin, and all stimulant overdoses.</td>
<td>• NOFO surveillance data contributed to improvements in drug overdose interventions</td>
</tr>
<tr>
<td></td>
<td>• Timely and actionable surveillance data disseminated by recipients:</td>
</tr>
<tr>
<td></td>
<td>o To enhance the implementation of their NOFO interventions</td>
</tr>
<tr>
<td></td>
<td>o To recipients’ stakeholders working to reduce drug overdoses in their jurisdiction</td>
</tr>
<tr>
<td></td>
<td>o To CDC for CDC to rapidly inform the public and key regional and national stakeholders</td>
</tr>
<tr>
<td>2. Collect and disseminate descriptions of drug overdose death circumstances using death certificates and medical examiner / coroner data</td>
<td></td>
</tr>
<tr>
<td>3. Implement innovative surveillance to support NOFO interventions</td>
<td></td>
</tr>
</tbody>
</table>
| 4. Prescription Drug Monitoring Programs (PDMP) | • Identification of high risk prescribing behaviors  
• Better tracking of opioid prescriptions  
• Decrease in high risk prescribing behaviors |
|---|---|
| 5. Integration of State and Local Prevention and Response Efforts | • Decrease in high risk prescribing behaviors  
• Greater awareness of opioid overdose epidemic by state health departments, with respect to burden and resources  
• Increased state involvement in local-level prevention efforts for both prescription and illicit opioids  
• Increased preparedness and improved response for both prescription and illicit opioids, among both state and local partners |
| 6. Establishing Linkages to Care | • Increased referrals to and engagement in evidence-based treatment |
| 7. Providers and Health Systems Support | • Increased use of non-opioid and non-pharmacologic treatments for pain care when appropriate  
• Decrease in high risk opioid prescribing  
• Increase in referrals to evidence-based treatment for opioid use disorder |
| 8. Public Safety Partnerships | • Improved utilization of evidence-based approaches to prevention, intervention and referral to treatment |
| 9. Empowering Individuals to make safer choices | • Decreased initiation of opioid use and misuse  
• Increased fidelity to opioid prescription/medication protocol  
• Increased use of non-opioid and non-pharmacologic treatments for pain care |
10. Prevention Innovation Projects

- Expanded opioid prevention activities
- Improved jurisdictional responsiveness

iii. Strategies and Activities

There are two overall required components of this award – a surveillance component and a prevention component. Within these two components, there are required and optional strategies to enhance the quality and timeliness of data on opioid prescribing, morbidity, and mortality, and then to use these data to inform and target prevention and response efforts at the state and local level. **Strategies and activities funded by the prevention component should be informed by the insights gleaned from the surveillance component of this award.**

**SURVEILLANCE COMPONENT: STRATEGIES 1-3**

The requirements for the surveillance component of this award vary depending on whether the applicant is a state, local, or territory health department and the size of its resident population. Specifically, if the District of Columbia, Puerto Rico, or any state public health department chooses to apply for this NOFO, they must apply for and implement all three surveillance strategies in the surveillance component of the NOFO:

- **Strategy 1:** Collect and disseminate timely emergency department (ED) data on suspected all drug, all opioid, heroin, and all stimulant overdoses.
- **Strategy 2:** Collect and disseminate descriptions of drug overdose death circumstances using death certificates and medical examiner / coroner data.
- **Strategy 3:** Implement innovative surveillance to support NOFO interventions.

In contrast, county and city health departments, as well as territories other than Puerto Rico, who choose to apply to this NOFO may only implement surveillance activity 3, implement innovative surveillance to support NOFO interventions. In order to ensure coordination of ED and drug overdose death surveillance, city and county health departments are expected to participate in their state health department NOFO funded surveillance of emergency department visits involving all drug, all opioid, heroin, and all stimulant overdoses (Strategy 1) and drug overdose deaths (Strategy 2).

To assist applicants in completing the surveillance component of the application including calculating the jurisdiction’s surveillance maximum budget, CDC has created a checklist of surveillance requirements and funding (See Appendix 1).

**STRATEGY 1: Collect and disseminate timely emergency department (ED) data on suspected all drug, all opioid, heroin, and all stimulant overdoses (Required for the District of Columbia (DC), Puerto Rico (PR), and all state health departments)**

1.1 **Select ED reporting tier:** In their application, applicants must demonstrate their capacity to leverage ED data currently collected by the jurisdiction such as syndromic ED data, ED billing/discharge data, or other similar ED data sources to track and rapidly disseminate changes in ED visits related to suspected overdoses involving all drugs, all opioids, heroin, or all stimulants to CDC, key local stakeholders, and NOFO funded prevention programs. Recognizing differences in current ED data collections across jurisdictions as well as previous
CDC funding for ED surveillance of drug overdoses, applicants may select to report their ED data to CDC using one of four ED reporting schedules, or ED tiers (See Table 1.1). In their application, applicants **must clearly indicate which ED tier they selected** (i.e., ED tier 1, ED tier 2, ED tier 3 or ED tier 4) and **describe their capacity to meet all requirements associated with the selected ED tier**, especially their ability to rapidly share data with CDC for public release (See Appendix 2). Please carefully review ED tier qualifications because some applicants may select any tier, while other applicants are limited to two tiers due to previous CDC funding and type of ED data collected. Funding levels vary across tier based on administrative burden associated with tier requirements as well as the ability of recipient data to rapidly inform public health responses to drug overdoses with high quality data (i.e., applicants sharing data more quickly, frequently, and at the case-level will be funded at higher levels).
<table>
<thead>
<tr>
<th>Table 1.1: ED tier descriptions and requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ED Tier 1: Report ED data every two weeks</strong></td>
</tr>
<tr>
<td><strong>ED Tier 2: Monthly ED reporting</strong></td>
</tr>
<tr>
<td><strong>ED Tier 3: Quarterly ED reporting</strong></td>
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<tr>
<td><strong>ED Tier 4: Planning year then quarterly ED reporting</strong></td>
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<tr>
<td><strong>ED Tier qualifications</strong></td>
</tr>
<tr>
<td>Applicants meeting the following two criteria may select ED tier 1:</td>
</tr>
<tr>
<td>1) The applicant is Puerto Rico, the District of Columbia, or a state health department.</td>
</tr>
<tr>
<td>2) The applicant must commit to sharing real-time, case-level data with CDC using NSSP ESSENCE per the following data sharing agreement (Appendix 2).</td>
</tr>
<tr>
<td>Applicants sharing case-level data with CDC through NSSP ESSENCE must select ED tier 1 or ED tier 2.</td>
</tr>
<tr>
<td><strong>ED sample requirement</strong></td>
</tr>
<tr>
<td>Must include ≥75% of ED visits occurring in their jurisdiction when the recipient begins reporting ED data to CDC.</td>
</tr>
<tr>
<td><strong>Frequency that overdoses are reported to CDC</strong></td>
</tr>
<tr>
<td>Every two weeks: applicants must report preliminary data on suspected overdoses that occurred 2 to 3 weeks previously (e.g., on 11/4/2019 share data from 10/6/2019 – 10/19/2019).</td>
</tr>
<tr>
<td>Every month: applicants must report preliminary data on overdoses that occurred the previous month (See Appendix 3 for reporting schedule).</td>
</tr>
<tr>
<td>Every month: applicants must report preliminary data on overdoses that occurred the previous month (e.g., on 11/4/2019 share data from 9/1 – 9/30) (See Appendix 3 for reporting schedules).</td>
</tr>
<tr>
<td>Every quarter: applicants selecting ED tier 3 or 4 must report data on overdoses that occurred within 4 months of the end of the quarter (e.g., share data on overdoses occurring during April to June, 2019 by 10/14/2019). Quarterly reports will aggregate drug overdose indicators by month (See Appendix 3 for reporting schedules).</td>
</tr>
<tr>
<td>Table 1.1: ED tier descriptions and requirements (Continued)</td>
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<tr>
<td>------------------------------------------------------------------</td>
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<tr>
<td><strong>Date required CDC reporting begins</strong></td>
</tr>
<tr>
<td>• 11/4/2019 if jurisdiction received ESOOS funding (CDC-RFA-CE16-1608) or plans to share data with CDC through NSSP ESSENCE</td>
</tr>
<tr>
<td>• 2/3/2020 all other jurisdictions</td>
</tr>
<tr>
<td><strong>Reporting of historical ED data from 2018 to 2019</strong></td>
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<tr>
<td>All recipients must share aggregate historic ED data from 2018 to 2019. Aggregate data includes the total number of ED visits and the number of ED visits suspected to involve all drug, all opioid, heroin, and all stimulant overdoses stratified by month and county as well as by sex and age group at the jurisdiction level. These data provide a baseline and should be submitted as part of the first required report to CDC (See Date required CDC reporting begins).</td>
</tr>
<tr>
<td>• For recipients sharing data with CDC through NSSP ESSENCE, CDC will run required historic reports and send historic reports to recipients for verification.</td>
</tr>
<tr>
<td>• If not feasible (e.g., ED data not available for historical dates), a written explanation needs to be provided to CDC as part of the first required report to CDC.</td>
</tr>
<tr>
<td><strong>How data will be reported to CDC</strong></td>
</tr>
<tr>
<td>• CDC will run required reports for applicants using NSSP ESSENCE and share reports with recipients for verification.</td>
</tr>
<tr>
<td>Case definitions</td>
</tr>
<tr>
<td></td>
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<tr>
<td>Required data elements reported to CDC</td>
</tr>
<tr>
<td>----------------------------------------</td>
</tr>
<tr>
<td>• Aggregate data on all drug, all opioid, heroin, and all stimulant overdoses by: (a) county and (b) a cross-tab of sex and the following age groups (0-14, 15-24, 25-34, 35-44, 45-54, 55-64, 65-74, 75-84, and 85 and older) at the jurisdiction level such as state.</td>
</tr>
<tr>
<td>• Count of all ED visits in the sample, percent of ED visits with any chief complaint text, and percent of ED visits with any ICD-10-CM codes by county and a cross-tab of sex and age group at the jurisdiction level. These data help track changes in the volume and data quality over time.</td>
</tr>
<tr>
<td>• Provide metadata (e.g., number of EDs submitting data, percent of ED visits covered by recipient’s ED surveillance, and occurrence of a major disruption in ED submissions) using standard CDC forms that will be supplied to recipients at the start of the funding period.</td>
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<table>
<thead>
<tr>
<th>Support ongoing efforts to improve data quality</th>
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<tbody>
<tr>
<td>• Provide the staffing unit responsible for collecting rapid ED data at least $75,000 to support quality improvements such as expanding data collection into new hospitals or improving hospital data quality that directly benefit the collection of drug overdose ED data and are approved by CDC. Funding may be used to increase staffing, execute contracts, or purchase software or hardware used to receive, store, validate or analyze ED data.</td>
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<td>• Commit to having at least one staff person participate in a virtual ED data quality and reporting workgroup coordinated by CDC.</td>
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<td>• Re-run required CDC reports within two weeks, if feasible, when requested by CDC to check data quality or address data quality problems.</td>
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| Collaborate to respond to overdose outbreaks | Collaborate with CDC to rapidly track severe multi-jurisdiction drug overdose outbreaks as rapidly as feasible. |           |           |           |

<table>
<thead>
<tr>
<th>Other tier specific requirements</th>
<th>ED tier 1 &amp; 2 recipients sharing data with CDC through NSSP ESSENCE:</th>
<th>By 11/16/2020, ED tier 3 recipients must submit to CDC estimates of the resources and timeline needed to accelerate CDC data reporting to monthly.</th>
<th>By 11/16/2020, ED tier 4 recipients must submit to CDC:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Must collaborate with CDC to improve data quality issues affecting required NOFO reports by permitting CDC continuous real-time data access to develop, track, and share with recipients key indicators of data quality.</td>
<td>Must collaborate with CDC to improve data quality issues affecting required NOFO reports by permitting CDC continuous real-time data access to develop, track, and share with recipients key indicators of data quality.</td>
<td>• A plan to report quarterly ED data to CDC by 4/12/2021</td>
<td>• Pilot ED data</td>
</tr>
<tr>
<td>• May choose to share data on suspected all drug, all opioid, heroin, and all stimulant overdoses with CDC in near real-time to improve identification or tracking of outbreaks or share data more frequently than 2 weeks.</td>
<td>May choose to share data on suspected all drug, all opioid, heroin, and all stimulant overdoses with CDC in near real-time to improve identification or tracking of outbreaks or share data more frequently than 2 weeks.</td>
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</tbody>
</table>
1.2 Optional quarterly reporting of hospital billing/discharge data on ED visits and hospitalizations involving all drug, all opioid, heroin, and all stimulant overdoses: Because the ED data captured through rapid data collections described in Section 1.1 are preliminary data and may not fully capture the burden of ED visits involving drug overdoses, applicants may choose to share with CDC hospital billing/discharge data on both emergency department visits and hospitalizations involving all drug, all opioid, heroin, and all stimulant overdoses on a quarterly basis. Quarterly reports will be stratified by month. Within month, data on suspected all drug, all opioid, heroin, and all stimulant overdoses will be aggregated by county and sex by age group using the ED tier 3 reporting schedule described in Section 1.1 (See Appendix 3). This reporting option is in addition to the requirements in Section 1.1. Recipients providing hospital billing/discharge data on ED visits quarterly as part of the ED requirements in Section 1.1 only need to provide hospitalization data quarterly to meet this requirement.

- Recipients choosing to implement this optional initiative will receive up to $50,000 per year to support implementation.
- If pursuing this optional activity, clearly indicate this choice in the application by including the following text, “Optional ED project: Choose to share ED and
hospitalization billing/discharge data quarterly”

**STRATEGY 2: Collect and disseminate descriptions of drug overdose death circumstances using death certificates and medical examiner / coroner data (ME/C) (Required for the District of Columbia (DC), Puerto Rico (PR), and all state health departments)**

2.1 Select State Unintentional Drug Overdose Reporting System (SUDORS) reporting tiers: In their application, applicants must demonstrate their capacity to obtain, abstract, analyze, and disseminate de-identified data from medical examiner and coroner (ME/C) reports and death certificates on unintentional and undetermined intent drug overdose (UUDO) deaths using CDC guidelines and SUDORS. SUDORS uses the web-based National Violent Death Reporting System (NVDRS) for data entry. UUDO data must be shared with CDC, key local stakeholders, and NOFO funded prevention programs. UUDO data shared with CDC will be publicly disseminated (See Appendix 4). Recognizing the differences in the structure of ME/C agencies across jurisdictions (e.g., ME/C county agencies versus a state ME/C agency) as well as previous CDC funding for opioid overdose death surveillance, applicants may select to report drug overdose death data to CDC using one of three SUDORS reporting schedules, or SUDORS tiers (See Table 2.1). In their application, applicants must clearly indicate which SUDORS tier they selected (i.e., SUDORS tier 1, SUDORS tier 2, or SUDORS tier 3) and describe their capacity to meet all requirements associated with the selected SUDORS tier, especially their ability to rapidly share data with CDC for public release. Please carefully review SUDORS tier qualifications because some applicants may select any tier, while other applicants are limited to choosing between two tiers due to past CDC drug overdose funding. Funding levels vary across tier based on administrative burden associated with tier requirements as well as the ability of recipient data to rapidly inform public health responses to drug overdose deaths (i.e., applicants sharing data more quickly and frequently will be funded at higher levels) and recipient’s drug overdose burden (i.e., applicants abstracting data on larger numbers of drug overdose deaths have higher administrative burden than applicants with fewer deaths and thus require additional funding).
<p>| TABLE 2.1: SUDORS tier descriptions and requirements |
|---------------------------------|---------------------------------|---------------------------------|---------------------------------|
| <strong>SUDORS tier qualifications</strong> | <strong>SUDORS tier 1: Report with 6-11 month time lag.</strong> | <strong>SUDORS tier 2: Report with 8-13 month time lag.</strong> | <strong>SUDORS tier 3: Planning year then report with 8-13 month time lag.</strong> |
| • The District of Columbia or any state health department that was funded under ESOOS (CDC-RFA-CE16-1608) may only apply to SUDORS tier 1 or SUDORS tier 2. | | Puerto Rico or a state health department not funded under ESOOS (CDC-RFA-CE16-1608) may apply to SUDORS tier 1 and 2, but may also apply for SUDORS tier 3. |
| • Puerto Rico or a state health department not funded under ESOOS (CDC-RFA-CE16-1608) may apply to SUDORS tier 1 and 2, but may also apply for SUDORS tier 3. |
| <strong>SUDORS sample requirement</strong> | • All unintentional or undetermined intent drug overdose (UUDO) deaths in the jurisdiction (i.e., a census of UUDO deaths) OR | • UUDO deaths in a subset of counties whose residents accounted for &gt;75% of UUDO deaths in the jurisdiction or &gt;1,500 UUDO deaths in 2017 (See Appendix 5 to calculate). Applicants selecting this option will receive reduced funding. |
| <strong>Frequency that UUDO deaths are reported to CDC</strong> | Applicants selecting SUDORS tier 1 must report UUDO deaths occurring during January - June and July - December by December of the same year and June of the following year, respectively (See Appendix 3 for reporting schedule). | Applicants selecting SUDORS tiers 2 or 3 must report UUDO deaths occurring during January - June and July- December by February and August of the following year, respectively (See Appendix 3 for reporting schedule). |
| <strong>Date that required CDC reporting begins</strong> | • 1/10/2020 if jurisdiction received ESOOS funding (CDC-RFA-CE16-1608). An extra month is provided for the first report to assist the transition from reporting opioid overdose deaths in ESOOS to reporting UUDO deaths. | • 3/10/2020 if jurisdiction received ESOOS funding (CDC-RFA-CE16-1608). An extra month is provided for the first report to assist the transition from reporting opioid overdose deaths in ESOOS to reporting UUDO deaths. | 8/12/2021 |
| • 6/10/2020 for jurisdictions not receiving ESOOS funding. |
| <strong>How data will be reported to CDC</strong> | SUDORS uses the NVDRS web data entry system accessed through CDC Secure Access Management Services (SAMS) for data entry. <strong>Data entry into other local data systems will not meet the NOFO reporting requirements even if data are provided to CDC in a data file.</strong> Authorized staff of recipients will be provided access to the NVDRS web system. | | |</p>
<table>
<thead>
<tr>
<th>Case definition</th>
<th>SUDORS tier 1</th>
<th>SUDORS tier 2</th>
<th>SUDORS tier 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>• A death assigned any of the following ICD-10 underlying cause-of-death codes on the death certificate: X40–44 (unintentional) / Y10–Y14 (undetermined intent) OR • A death classified as a drug overdose death by the ME/C that is consistent with the ICD-10 definition.</td>
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<tr>
<td>Required data sources and elements reported to CDC</td>
<td>Abstract from death certificates and ME/C reports for each UUDO death data on forensic toxicology results, death scene investigation findings (e.g., evidence of injection drug use), demographics, circumstances surrounding the overdose, and location of overdose. Appendix 6 lists all required data elements.</td>
<td></td>
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</tr>
<tr>
<td>Support ongoing improvement in data quality</td>
<td>• Designate at least one person to attend virtual monthly SUDORS workgroup meetings to discuss key data quality issues and updates to SUDORS guidance. • Ensure SUDORS abstractors engage in required CDC training activities, including budgeting for up to two abstractors to travel to Atlanta, GA once a year to attend the annual meeting or abstractor training. • Recipient must respond and rectify issues identified by CDC in routinely scheduled data checks. The schedule for when CDC will conduct data checks will be supplied to recipients at the start of the funding period. • Recipient in consultation with CDC must establish internal data quality procedures to ensure high quality data are entered consistently across abstractors and comply with CDC guidance (e.g., review of a small subset of deaths by a senior abstractor, automated data quality checks, and/or monthly discussion of abstraction challenges).</td>
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<tr>
<td>Enhance forensic toxicological testing of drug overdose deaths to better detect opioids</td>
<td>• Due to a surge of drug overdose deaths involving fentanyl, fentanyl analogs, and other illicitly manufactured synthetic opioids (e.g., U-47700), applicants must propose to enhance forensic toxicological testing of opioid overdose deaths. • Proposed funding must go to the ME/C community and/or to forensic toxicology labs supporting the ME/C community at a minimum level specified in Appendix 7. Applicants in their application must describe their plan for distributing this funding to ME/C and/or labs and how it will directly impact the quality, cost, speed or burden their ME/C agencies experience while investigating suspected drug overdose deaths. Minimum funding levels vary by jurisdiction and are derived using the number of UUDO deaths from 2017. • Minimum toxicological testing for suspected opioid overdose deaths should include screening and confirmatory/quantitative testing for commonly prescribed medications including benzodiazepines and opioids, as well as commonly distributed illicit drugs including fentanyl, fentanyl analogs, heroin, cocaine, and methamphetamine (See Appendix 8 for guidance). • Applicants providing evidence of sufficient forensic toxicology testing with CDC permission may also use funding to: (a) increase the timeliness of forensic testing of drug overdose deaths, (b) improve forensic investigation of drug overdose deaths, (c) enhance testing for other drugs involved in opioid overdose deaths, (d) reimburse ME/Cs for work related to SUDORS, and (e) initiate other projects approved by CDC.</td>
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</tbody>
</table>
### TABLE 2.1: SUDORS tier descriptions and requirements (Continued)

<table>
<thead>
<tr>
<th>Other tier specific requirements</th>
<th>SUDORS tier 1</th>
<th>SUDORS tier 2</th>
<th>SUDORS tier 3</th>
</tr>
</thead>
</table>
| If a recipient in SUDORS tier 1 or SUDORS tier 2 reported data on opioid overdose deaths occurring between July and December 2018 to SUDORS in August, 2019, the recipient must respond and resolve data quality issues identified by CDC involving these deaths. | SUDORS tier 3 must:  
• Submit a plan to CDC by 11/16/2020 to describe how they will meet SUDORS tier 2 requirements by 8/12/2021.  
• Submit death certificate and forensic toxicology data only, if feasible, on SUDORS tier 2 reporting schedule for UDDO deaths from 7/2019 – 6/2020. |

| Rapid needs assessment of forensic toxicology testing protocols | Conduct a rapid needs assessment of forensic toxicology testing protocols used by ME/Cs to investigate suspected drug overdoses in their jurisdiction by the end of Year 1. CDC will provide guidance to recipients when NOFO funding starts. Data will inform CDC planning. |

| Dissemination requirements | • A critical requirement of this NOFO is the rapid public dissemination by CDC (i.e., within weeks of CDC validation) of recipient data to inform national surveillance. (See Appendix 4). If challenges to rapid public dissemination are anticipated, plans to resolve challenges by the second reporting deadline must be described in the application.  
• Resolve CDC inquiries about data quality within 2 weeks of receipt, including identifying complex issues that will take longer to resolve  
• Support CDC publicly sharing aggregate SUDORS data on key variables through a web-based query system similar to the CDC WISQARS system (https://wisqars.cdc.gov:8443/nvdrsvldsquery.jsp) that may be developed.  
• Ideally, applicants will propose to share data with other public health departments in their geographic proximity to better identify emerging trends.  
• Participate in a SUDORS data dissemination group coordinated by CDC. |

| SUDORS tier 1 and 2 must disseminate at least two products per year to key local stakeholders starting in funding Year 2. Examples include brief reports targeting emerging issues, public-facing dashboards, or data reports that support NOFO interventions or other local interventions. | SUDORS tier 3 must disseminate at least two products starting in funding Year 3. Examples include brief reports targeting emerging issues, public-facing dashboards, or data reports that support NOFO interventions or other local interventions. |

| Indicate in application SUDORS tier selected | Write “Select SUDORS tier 1” in the application | Write “Select SUDORS tier 2” in the application | Write “Select SUDORS tier 3” in the application |

| Funding for each SUDORS tier, or performance level | Core funding based on number of UUDO deaths in 2017 (See Appendix 1) plus $75,000 a year | Core funding based on number of UUDO deaths in 2017 (See Appendix 1) plus $25,000 a year | Core funding based on number of UUDO deaths in 2017 (See Appendix 1) |

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### 2.2 Optional SUDORS enhancement:

To more rapidly detect opioid overdose outbreaks or sharp increases in opioid overdose deaths that have driven increases in drug overdose deaths, Puerto Rico, the District of Columbia, and all state public health departments may choose in their application to collaborate with ME/Cs to collect preliminary count data on suspected opioid overdose deaths (i.e., deaths suspected to involve opioid(s) before receipt of forensic toxicology data). Completion of the drug overdose death certificates often requires months due to the need to complete and interpret forensic toxicology analyses. Some jurisdictions have
found that suspected counts of opioid overdose deaths may be obtained earlier due to the distinctive clinical and scene characteristics of opioid overdoses. This optional initiative has the goal of expanding efforts to report preliminary opioid overdose death count data and targets earlier detection of opioid overdose deaths because these deaths have driven increases in drug overdose deaths. Key requirements of this optional project are listed below.

- Applicants must propose to obtain counts of suspected opioid overdose deaths within a month of date of death, and ideally faster
- Applicants may propose to collect data on their full jurisdiction or target a few high burden areas.
- Data must be reported to the SUDORS system by the end of Year 1 of funding. The exact reporting mechanism will be developed in consultation with
- CDC will work closely with recipients to create, evaluate, and approve case definitions developed by recipients.
- Applicants may propose to collect rapid reports on all suspected drug overdose deaths, but have to be able to also count suspected opioid overdose deaths.
- **Recipients choosing to implement this optional initiative will receive up to $200,000 per year to support implementation.**

**STRATEGY 3: Implement innovative surveillance to support NOFO interventions (Required for all applicants)**

3.1 Core requirements of innovative surveillance project: In their application, applicants **must propose and demonstrate their capacity to enhance or implement at least one innovative surveillance system** that meets the following core requirements:

- Directly inform applicant’s proposed NOFO interventions.
- Address one of seven CDC data collection priorities, described in Section 3.2.
- Recipients will develop their own protocols in consultation with CDC and will not be required by CDC to include standard CDC questions or protocols.
- Comply with local and CDC IRB and OMB regulations, when applicable.
- **Share with CDC aggregate data from the innovative surveillance system annually by the end of funding Year 2.** CDC will work with recipients to identify data elements to share.
- Describe the key technical lessons learned from their efforts no later than their Year 3 annual progress report.
- NOFO funding cannot be used to support research. Guidance on how CDC interprets the definition of research in the context of public health can be found at [https://www.hhs.gov/ohrp/regulations-and-policy/regulations/45-cfr-46/index.html](https://www.hhs.gov/ohrp/regulations-and-policy/regulations/45-cfr-46/index.html).
- Applicants have the option to propose two or more innovative surveillance projects, but are required to propose at least one innovative surveillance project.
- State health departments, Puerto Rico, the District of Columbia, and all eligible city and county health departments will receive up to $400,000 per year to support implementation. Territories with a population of <200,000 people will receive up to $150,000 per year.
3.2 Seven CDC data collection priorities for innovative surveillance project

1. **Linkage to care (Write in application “Innovative Surveillance of Linkage to Care”):** The proposed surveillance system should collect data at least annually and may track the extent persons misusing drugs are linked to opioid use disorder treatment services or substance use risk reduction services, how they become linked to these services including the impact of NOFO interventions on this process, and the impact of linkage to care initiatives on health outcomes. When feasible, data should consider collecting a person’s overdose history, substance use patterns, alcohol use, and medical history such as treatment for acute or chronic pain. Finally, each recipient will work with CDC to identify key data from their unique surveillance system to share with CDC by Year 2. Key elements will be distinct from linkage to care evaluation indicators required in the NOFO Annual Progress Report.

2. **Local health surveillance of persons using and misusing opioids (Write in application “Innovative Surveillance of Opioid Use/Misuse”):** Applicants may propose one of two types of surveillance systems. First, applicants may propose to conduct rapid needs assessments of areas experiencing rapid increases in or high burden of opioid overdose deaths to inform intervention planning and implementation. Needs assessment should be completed in under 6 months and more rapidly if linked to outbreaks. Alternatively, applicants may track current drug use patterns, overdose history, and linkage to substance use disorder treatment or risk reduction services of persons misusing opioids on at least an annual basis. Ideally, applicants will also collect health data such as drug test results.

3. **Track public health risk of illicit opioid drug supply (Write in application “Innovative Surveillance of the Illicit Opioid Drug Supply”):** Track changes in the illicit opioid supply, including a plan to test for fentanyl and fentanyl analogs, at least bi-annually by testing drug products, drug paraphernalia such as syringes, or through other innovative testing approaches such as implementing comprehensive screening of nonfatal overdoses in the ED, as allowed by state and local law.

4. **Link overdose data from different sources within the same jurisdiction (Write in application “Innovative Surveillance: Linking Overdose Data with Risk/Protective Factor Data”):** Link drug overdose databases (e.g., SUDORS, emergency medical services (EMS), and ED) with data on overdose risk or protective factors (e.g., exposure to interventions or recent institutionalization) or other social service or child welfare data using personal identifiers or probabilistic matching, as allowed by state and local law.

5. **Link PDMP data to other data systems within the same jurisdiction (Write in application “Innovative Surveillance: PDMP Data Linkages”):** Link PDMP with other datasets such as: 1) SUDORS; 2) EMS or ED data; 3) Medicaid / worker’s compensation data; 4) Indian Health Services data; 5) Veteran’s Health Administration data; 6) other social service or child welfare data; and/or 7) incarceration history, as allowed by state and local law.

6. **Innovative drug overdose morbidity/mortality data (Write in application “Innovative Morbidity/Mortality Surveillance”):** Enhance the timeliness or quality of morbidity and mortality data using strategies that complement NOFO ED and SUDORS data collections. Priorities include: (a) detecting drug overdose outbreaks in less than 24
hours by rapidly analyzing law enforcement reports, EMS data or other existing data sources, (b) conducting drug overdose surveillance with EMS data including integrating EMS data with ESSENCE at the local or national level and (c) rapidly collecting supplemental data on a subset of suspected drug overdose deaths within a month of death, such as interviews with friends or families of the decedent. If proposing to detect drug overdose outbreaks, recipients will be expected to collaborate with CDC to identify major drug overdose outbreaks.

7. **Other critical surveillance (Write in application “Local Innovative Surveillance of Other Health Outcomes”):** Applicants may propose to implement other innovative surveillance projects that provide critical health data to reduce opioid use/misuse or overdose AND inform applicant’s NOFO interventions; however, the six activities listed above are preferred. If this option is selected, the recipient must submit a short 3-5 page proposal no later than October 31, 2019 that describes the critical data gap addressed by the proposed surveillance system and how data will be shared with local stakeholders and CDC. Proposals will be reviewed and approved, approved with revision or rejected by CDC within a month of receipt. If rejected, jurisdictions will be provided the opportunity to propose a new innovative project.

**PREVENTION COMPONENT: STRATEGIES 4 - 10**

Within the prevention component, the required and optional strategies are:

Required: (4) Prescription Drug Monitoring Programs, (5) State-local Integration, (6) Linkage to Care, and (7) Providers and Health Systems Support


Applicants have flexibility to propose activities within each major strategy. However, each application must include the following:

- Activities that improve PDMP functionality.
- State health departments are required to allocate at least 20% of their prevention component award to fund targeted mini-grants and sub-awards to counties/cities/communities to address opioid overdose in high burden areas, particularly those identified by the surveillance component of this award.
- If optional strategies are selected, specific activities must be proposed.

Note that within the prevention component of this NOFO, the activities identified within each major strategy are intended to be illustrative rather than prescriptive, and therefore are not comprehensive. Applicants have discretion to propose specific activities within each strategy. Proposed activities are subject to CDC approval, but any that align with the spirit and scope of the major strategy and fit within the logic model are likely to be approved.

**Please note:** Program funds cannot be used for purchasing naloxone, implementing or expanding drug “take back” programs or other drug disposal programs (e.g. drop boxes or disposal bags), purchasing fentanyl test strips, or directly funding or expanding direct provision of substance abuse treatment programs. Such activities are outside the scope of this NOFO.

The prevention efforts funded by this award should be informed by and derived from the
existing evidence base, but should also contribute to the evolving evidence base. This funding is intended to support a balanced approach between evidence and innovation. Thus, proposed activities should include a mix of existing best practices and evidence-based strategies, and innovative ideas and strategies, which, upon being subjected to rigorous evaluation, may provide further depth, and breadth of evidence for effective opioid overdose prevention.

Peer-to-Peer Learning Coordinators (Optional)

Enhanced funds ($250,000) are offered for those recipients who want to serve as Peer-to-Peer Learning Coordinators for a specific area of expertise within the prevention component (e.g. academic detailing, overdose fatality reviews, PDMP integration, or other domains as identified by the applicant). The application should specify and demonstrate the content area of expertise, and should propose a curriculum and process by which they would build capacity and expertise among their peers.

STRATEGY 4: Prescription Drug Monitoring Programs (Required)

Overview: PDMPs are databases that collect patient-specific prescription information at the point of dispensing. PDMPs continue to be validated as an effective strategy affecting prescribing behavior and improving opioid-related outcomes. PDMPs can inform clinical practice and protect patients at heightened risk of opioid misuse, abuse, and overdose. Robust PDMP implementation is associated with decreased opioid-related overdose deaths. In addition, PDMPs can be utilized as a public health surveillance tool and provide public health authorities with timely information that rapidly identifies “hot spots” or geographic areas with disproportionately higher rates of opioid prescribing and allow for targeted interventions such as academic detailing, or clinical training and outreach.

A primary purpose of this funding is to support recipients as they implement strategies to advance the development and expansion of existing PDMPs and increase their utilization as a public health surveillance tool and clinical decision-making tool. This funding seeks to leverage Federal funding to ensure that recipients scale up the use of PDMP data through interoperability. This funding also aims to incentivize and improve nationwide overdose tracking systems that will help resources to be rapidly deployed to hard-hit areas.

CDC recognizes that PDMPs operate differently from state to state, as each is operated under different purview and management. Applicants who can demonstrate the ability to improve PDMP functionality as outlined below AND attain intra- and interstate interoperability will receive an additional $215,000 per year in funding.

**TABLE 4.1: Prescription Drug Monitoring Programs funding activities (BASE)**

<table>
<thead>
<tr>
<th>Activities: applicants must select activities that demonstrate improved PDMP functionality to receive base funding.</th>
<th>Recommended Sub-activities: below CDC has listed some recommended sub-activities applicants can select to meet the PDMP functionality requirement. These sub-activities are not required; applicants can choose from the recommended activities or applicants can propose sub-activities that are not listed below if they improve PDMP functionality – please</th>
</tr>
</thead>
<tbody>
<tr>
<td>Action Description</td>
<td>Supporting Activities</td>
</tr>
<tr>
<td>----------------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Universal use among providers within a state</td>
<td>Universal PDMP registration and use that includes a streamlined and simplified PDMP registration process.</td>
</tr>
<tr>
<td></td>
<td>Other sub-activities as needed to advance universal use among providers.</td>
</tr>
<tr>
<td>Inclusion of more timely or real-time data contained within a PDMP</td>
<td>Improving PDMP infrastructure or information systems to support reduced data collection intervals.</td>
</tr>
<tr>
<td></td>
<td>Developing and disseminating information or guidance to aid in reducing the PDMP data collection interval.</td>
</tr>
<tr>
<td></td>
<td>Other sub-activities as needed to increase timely or real-time data.</td>
</tr>
<tr>
<td>Actively managing the PDMP in part by sending proactive (or unsolicited) reports to providers to inform prescribing</td>
<td>Designing, validating, or refining algorithms for identifying high-risk prescribing activity to use as a trigger for proactive reports.</td>
</tr>
<tr>
<td></td>
<td>Improving PDMP infrastructure or information systems to support proactive reporting and data analysis, including enhancing reporting system to increase frequency and quality of reporting.</td>
</tr>
<tr>
<td></td>
<td>Developing and disseminating information or guidance to aid in proactive reporting. (example guidance for opioid naïve patients, patients with overlapping opioids and benzodiazepines).</td>
</tr>
<tr>
<td></td>
<td>Integrating CDC or state guideline-concordant tools such as cumulative morphine milligram equivalent (MME) calculations into patient PDMP reports.</td>
</tr>
<tr>
<td></td>
<td>Incorporating prescriber notification of patient overdose deaths</td>
</tr>
<tr>
<td></td>
<td>Other sub-activities as needed to reduce PDMP data collection interval.</td>
</tr>
<tr>
<td>Ensuring that PDMPs are easy to use and access by providers</td>
<td>Facilitate improved delegate access and training.</td>
</tr>
<tr>
<td></td>
<td>Expand access to PDMPs via a health information exchange.</td>
</tr>
<tr>
<td></td>
<td>Support PDMP training efforts in high-burden regions.</td>
</tr>
<tr>
<td></td>
<td>Other actions as needed to make PDMPs easier to use and access.</td>
</tr>
</tbody>
</table>

In addition to the activities required in the base option, applicants may seek additional funds to make PDMP data more actionable both within and across states borders. **applicants should**
propose strategies that improve both intrastate interoperability and interstate interoperability. Applicants are required to propose activities that:

- Integrate the PDMP with other health systems data
- Integrate across state lines/interstate interoperability

**TABLE 4.2: Prescription Drug Monitoring Programs funding activities (ENHANCED)**

<table>
<thead>
<tr>
<th>Activities: applicants must select activities that demonstrate improved both intra- and interstate interoperability. Applicants must select at least 1 activity within each grouping in order to qualify for additional funding.</th>
<th>Recommended Sub-activities: below CDC has listed some recommended sub-activities applicants can select to meet the expanded funding requirements. These sub-activities are not required; applicants can choose from the recommended activities or applicants can propose sub-activities that are not listed below if they improve intra- and interstate interoperability – please provide detail on how these actions support the strategy.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Integrate the PDMP with other health systems data</td>
<td>Integrate PDMP data with electronic health records (EHRs). Health Information Technology infrastructure data integration/Health Information Exchange (HIEs) integration. Other actions as needed to integrate PDMPs with other health systems data within the state.</td>
</tr>
<tr>
<td>Integrate across state lines/interstate interoperability</td>
<td>Facilitate electronic information sharing among states in compliance with the National Prescription Monitoring Information Exchange (PMIX) Architecture. Other actions as needed to integrate PDMPs across state lines/interstate interoperability.</td>
</tr>
</tbody>
</table>

**STRATEGY 5: Integration of State and Local Prevention and Response Efforts (Required)**

**Overview:** States and local communities play an important role in preventing opioid overdoses and related harms. Building off the work and successes of the previous CDC opioid-related NOFOs, a primary focus of this funding opportunity will be to provide state and local communities with the support and resources needed to implement comprehensive strategies that prevent morbidity and mortality associated with opioid overdoses. These include strategies that prevent opioid overdose, misuse, use disorder, overdose, and opioid-related harms. Interventions of priority will address drivers of both prescription and illicit opioids, and may address other prescription or illicit drugs to the extent that they are associated with the opioid overdose epidemic.

Integrating and empowering state, local and community-level prevention is a key component to effective prevention of opioid-related overdose and opioid related harms such as Neonatal Abstinence Syndrome, HIV, viral hepatitis, and other infectious disease complications. Given the complexity and reach of the opioid overdose epidemic, it is important that interventions are
primed for success through effective collaborations between state and local agencies and other relevant stakeholders. This strategy allows applicants to propose activities in three general categories:

- explicit efforts to better integrate state and local prevention efforts
- capacity building for more effective and sustainable surveillance and prevention efforts
- prevention and response strategies at the state and local level

**Priority will be given to opioid-overdose prevention approaches that are underpinned by state and local level integration.** Applicants will be scored, in part, on the basis of their ability to provide Letters of Support (LOS) from state/local counterparts at the time of application and deliverables demonstrating meaningful integration and collaboration will be required for the duration of the period of performance. Additional details related to LOS can be found in the “Collaborations” section of this funding opportunity.

Simultaneously, CDC recognizes that the needs of states vary considerably. Some states have relatively limited capacity in addressing opioid overdose and need support to strengthen their ability to collect, analyze, and apply data, as well as translate data into action in the form of a comprehensive strategy to combat the epidemic. In contrast, other states are at a higher state of readiness and need resources and support to scale up a comprehensive program and/or advance a multi-pronged, multi-year prevention program. To this end, strengthening and enhancing the capacity of state and local communities will also continue to be a goal of this funding opportunity. Emphasis will be placed on promoting strategies and activities that build state and local capacity to prevent morbidity and mortality associated with opioid overdoses.

**All applicants must direct at least 20% of their prevention component award to fund targeted mini-grants and sub-awards to counties/cities/communities** (including NGOs and coalitions) to address opioid overdose in high burden areas, particularly those identified by the Surveillance Component of this award. Funded activities in localities should combine the best of what we know to be effective with the unique ability of communities to innovate and test new approaches that help grow the evidence base. Any strategy proposed should be theoretically informed and driven by experiential and contextual evidence, and should have reasonable expectations of achieving demonstrable impact on NOFO intermediate and long-term outcomes. Funded activities are subject to CDC review and approval and must involve an evaluation component. The same restrictions will apply to sub-awards and mini-grants as for the overall award. Program funds cannot be used for purchasing naloxone, implementing or expanding drug “take back” programs or other drug disposal programs (e.g. drop boxes or disposal bags), purchasing fentanyl test strips, or directly funding or expanding direct provision of substance abuse treatment programs.

**TABLE 5.1: Integration of State and Local Prevention and Response Efforts (Required)**

<table>
<thead>
<tr>
<th>Activities: applicants must select activities that demonstrate integration of state and local prevention</th>
<th>Recommended Sub-activities: below CDC has listed some recommended sub-activities applicants can select to meet this category requirement. These sub-activities are not required; applicants can choose from the recommended activities or applicants can propose sub-activities that are not listed below – please provide detail on how these actions support the strategy.</th>
</tr>
</thead>
</table>

26 of 88
and response efforts.

<table>
<thead>
<tr>
<th>Explicit efforts to better integrate state and local prevention efforts</th>
<th>Establishment of MOUs with state or local health departments that demonstrate collaboration and yield actionable products for prevention efforts (e.g. toolkits, action guides, technical assistance resources, coalitions, etc). Establishment and ongoing support of an overdose fatality review committee. Establishment and ongoing support of an “Rx Stat” model (<a href="http://www.pdmpassist.org/pdf/RxStat.pdf">http://www.pdmpassist.org/pdf/RxStat.pdf</a>). Establishment of MOUs with other relevant stakeholders that demonstrate collaboration and yield actionable products for prevention efforts (e.g. toolkits, action guides, technical assistance resources, coalitions, etc). Implementation of a comprehensive strategic plan to prevent opioid overdose or establish a coordinated rapid response to spikes in overdoses or overdose-related deaths.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Capacity building for more effective and sustainable surveillance and prevention efforts</td>
<td>Direct assistance/embedded CDC staff to support epidemiologic, evaluation, and program administration activities, or other mechanisms of staffing and technical support (e.g. contract support, facilitated support from other agencies or entities). Create a multi-disciplinary data-focused group convening stakeholders from local public health and public safety and first responders to prevent opioid misuse and overdose, especially by focusing on prescribing and/or the development of post-overdose protocols. Provision of technical assistance and other supports for practitioners implementing evidence-based interventions in high-burden communities and counties.</td>
</tr>
<tr>
<td>Prevention and response strategies at the state and local level</td>
<td>Implementation of community-level interventions in state &quot;hot spots&quot; or high burden/spike areas, as identified by the Surveillance Component of this award, or by data from NOFO collaborators. Applicants and their sub-recipients are encouraged to consider strategies identified as evidence-based in peer-reviewed literature. Examples include:</td>
</tr>
<tr>
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</tr>
</tbody>
</table>
STRATEGY 6: Establishing Linkages to Care (Required)

Overview: Surveillance and programmatic expressions of public health are perfectly positioned to identify persons in need of care, because public health areas of practice span every setting and venue in which such an individual may find themselves (see Appendix B). It is therefore incumbent on public health to ensure that once an indication of need is observed, systems, processes, and collaborations are in place to ensure that needed care is provided. Linkages to care are the bridges that connect the work of public health with that of other agencies and partners. Connections or linkages to care may be viewed as the vehicle by which one system meaningfully coordinates with another. While CDC does not provide direct services or treatment, it is our intent for recipients to leverage their systems and upstream prevention efforts to ensure that people are connected with the care they need. Currently, the predominant examples of these linkages to care with respect to the opioid crisis come largely in the form of peer navigators and warm hand-offs in emergency settings upon the event of an overdose. These are valuable examples worthy of continued support, but applicants are also encouraged to broaden their thinking and to innovate around what linkages to care may look like. While overdose events are a clear and necessary instigating event, so too are visits to syringe service programs, interactions with public safety and first responders, engagement with crisis services related to substance use, primary care visits, emergent care for injection-related infections (e.g., skin and soft tissue infections, endocarditis, osteomyelitis), diagnosis of HIV, viral hepatitis,
and pre-natal care. Partners from a broad range of practices and disciplines can become a part of linkage to care efforts. Applicants are encouraged to seek funds to support linkage to care efforts, particularly those for which a clear system or protocol can be outlined, and those for which replication in other sites is feasible. Note that linkage to care efforts may also be reasonably classified in other strategies identified in this funding opportunity. Mutual exclusivity is not required, and some proposed activities may be classified under more than one strategy.

This strategy allows applicants to propose activities in three general categories:

- Improve awareness
- Increase and improve coordination
- Integrate technology

### TABLE 6.1: Establishing Linkages to Care (Required)

<table>
<thead>
<tr>
<th>Activities: applicants must select activities that establish linkages to care.</th>
<th>Recommended Sub-activities: below CDC has listed some recommended sub-activities applicants can select to meet this category requirement. These sub-activities are not required; applicants can choose from the recommended activities or applicants can propose sub-activities that are not listed below – please provide detail on how these actions support the strategy.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enhance programs and policies</td>
<td>Establishing protocols and policies in emergency departments to guide referrals and linkages to care for persons who have experienced overdose.</td>
</tr>
<tr>
<td></td>
<td>Efforts to increase awareness of area service providers and current evidence-based treatment space/capacity.</td>
</tr>
<tr>
<td></td>
<td>Development of coordinated treatment access plans.</td>
</tr>
<tr>
<td></td>
<td>Outreach and corollary services that are attached with syringe services programs. Please note the purchase of syringes is not authorized by this funding.</td>
</tr>
<tr>
<td></td>
<td>Outreach and corollary services in school settings, for students and for their families and loved ones. Linkages to care sub-activities may also engage youth through non-school settings.</td>
</tr>
<tr>
<td>Increase and improve coordination</td>
<td>Staffing emergency departments with peer navigators to connect directly with individuals who have experienced an overdose (or their family/friends/community as appropriate) to ensure awareness of and connection to treatment and other services.</td>
</tr>
<tr>
<td></td>
<td>Case management systems to help individuals navigate the processes by which care may be procured.</td>
</tr>
<tr>
<td></td>
<td>Public safety diversion programs that include an explicit system to</td>
</tr>
</tbody>
</table>
deliver individuals into systems of care.

Venue-based programs (e.g. fire stations) that provide linkages to care on-site at the request of individuals at risk of overdose.

Outreach teams to follow up with individuals at risk of overdose, particularly those who have just experienced a non-fatal overdose. Such teams may include first responders, medical staff, community health workers, and clergy. The appropriate composition of these teams will vary highly by community.

Insurer mechanisms that make entry into care services accessible and feasible for individuals seeking treatment.

<table>
<thead>
<tr>
<th>Integrate technology</th>
<th>Using technology to facilitate connections to care (for example, a “reservations” system that allows referring clinicians to see what treatment options are available and to reserve a spot for a patient in need of fast connection to care.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Development, distribution, and training on mobile applications that are utilized by emergency medical services, public safety, community health workers to link individuals with treatment facilities.</td>
</tr>
</tbody>
</table>

**STRATEGY 7: Providers and Health Systems Support (Required)**

**Overview:** While the balance of opioid-related morbidity and mortality has undergone a general – but not uniform – shift from prescription to illicit opioids, the importance of ensuring that providers and health systems are equipped to contribute to prevention and response solutions remains a priority. There may be a natural overlap between Providers and Health Support Systems and activities proposed under other strategies. Mutual exclusivity is not required, and some proposed activities may be classified under more than one strategy. Applicants may propose strategies in this domain that equip providers and health systems to make evidence-based prescribing decisions, have timely and complete information regarding non-opioid medications and non-pharmacologic treatments, and identify patients at risk for overdose or opioid use disorder and can then either offer or connect their patients with appropriate care. Such activities include but are not limited to:

**TABLE 7.1: Providers and Health Support Systems Support (Required)**

<table>
<thead>
<tr>
<th>Activities: applicants must select activities that establish linkages to care.</th>
<th>Recommended Sub-activities: below CDC has listed some recommended sub-activities applicants can select to meet this category requirement. These sub-activities are not required; applicants can choose from the recommended activities or applicants can propose sub-activities that are not listed below – please provide detail on how these actions support the strategy.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Guideline</td>
<td>Implementation of the CDC Guideline for Opioid Prescribing for</td>
</tr>
<tr>
<td>Implementation, Clinical Education, and Training</td>
<td>Chronic Pain, other Federal opioid guidelines, state-specific guidelines, or specialty-specific guidelines to advance guideline-concordant care within health systems. This can include implementation of the specific recommendation statements included in guidelines as practice-level policies, integrating guidelines into clinical workflow through EHR-based clinical decision support tools, implementing and tracking quality improvement (QI) measures that map onto guidelines, or creating data dashboards to show progress to providers. Applicants are encouraged to consult CDC’s Quality Improvement and Coordinated Care Implementation Guide: <a href="https://www.cdc.gov/drugoverdose/pdf/prescribing/CDC-DUIP-QualityImprovementAndCareCoordination-508.pdf">https://www.cdc.gov/drugoverdose/pdf/prescribing/CDC-DUIP-QualityImprovementAndCareCoordination-508.pdf</a></td>
</tr>
<tr>
<td>Academic detailing, as defined by the National Resource Center for Academic Detailing (NaRCAD) and in accordance with their scientifically derived implementation guidance. Applicants are encouraged to use PDMP data to inform allocation of academic detailing resources and efforts.</td>
<td></td>
</tr>
<tr>
<td>Collaborate with clinical specialty collaboratives (e.g., surgical collaboratives) in developing dashboards, reports, and other methods for providing feedback to providers on opioid prescribing or administration, offering clinical decision support tools to improve prescribing behavior, and evaluating efforts.</td>
<td></td>
</tr>
<tr>
<td>Clinician and provider training and systems support for implementation of the full suite of safe prescribing practices, resources for clinical support of patients with chronic pain (e.g. tapering, de-prescribing training for patients at risk of overdose), and ensuring linkages to care when patients are in need of evidence-based treatment options.</td>
<td></td>
</tr>
<tr>
<td>Promising Emergency Department interventions to create post-overdose protocols, policies, and procedures to ensure that vulnerable patients are receiving naloxone, being referred to MAT, provided “warm hand-offs” to community-based recovery organizations and supports, and are linked to patient navigators or other peer-led strategies at this critical time of care. This activity may be an extension of the applicants Linkage to Care Activities.</td>
<td></td>
</tr>
<tr>
<td>Insurers and health system support</td>
<td>Drug claim screening for outlier controlled substance prescribers and targeted efforts to increase use by insurers/health systems of these reports.</td>
</tr>
<tr>
<td>Set up, implement, or enhance a Coordinated Care Program for patients on long-term opioid therapy. Develop a quality improvement model utilizing a provider review or system level approach to improve the effectiveness of opioid therapy in meeting patients’ goals for pain relief and improved function.</td>
<td></td>
</tr>
</tbody>
</table>
Insurer mechanisms that improve access to non-opioid pain treatment modalities (e.g. coverage of non-opioid medication for pain treatment, cognitive behavioral therapy, physical therapy).

Other sub-activities to implement or improve opioid prescribing interventions for prescribers and targeted efforts to increase use by insurers/health systems to improve or reduce opioid prescribing and improve the use of non-opioid pain treatment modalities.

**STRATEGY 8: Partnerships with Public Safety and First Responders (Optional)**

**Overview:** Public safety partners play a critical role in responding to opioid overdoses and should be engaged in prevention efforts aimed at reducing opioid-related morbidity, mortality, and associated harms. This domain is an opportunity for funded partners to either develop new partnerships, or build upon existing partnerships, with state and local public safety entities. For the purposes of this funding opportunity, public safety entities include police and public safety and first responder agencies, courts and corrections, as well as fire and paramedic/emergency services. Within regions where they exist, funded states can also choose to develop partnerships with regional entities, such as High-Intensity Drug Trafficking Area (HIDTA) units and the Drug Enforcement Administration (DEA). There are two broad types of partnerships, and funded states can choose to engage in one or both types: 1) data sharing and 2) programmatic partnerships to advance evidence-based strategies. Public safety partnerships that incorporate both data and programming are strongly encouraged. Program funds cannot be used for purchasing naloxone, implementing or expanding drug “take back” programs or other drug disposal programs (e.g. drop boxes or disposal bags), purchasing fentanyl test strips, or directly funding or expanding direct provision of substance abuse treatment programs.

**TABLE 8.1: Partnerships with Public Safety and First Responders (Optional)**

<table>
<thead>
<tr>
<th>Activities: applicants may select activities that establish partnerships with Public Safety</th>
<th>Recommended Sub-activities: below CDC has listed some recommended sub-activities applicants can select to meet this category goal. These sub-activities are not required; applicants can choose from the recommended activities or applicants can propose sub-activities that are not listed below – please provide detail on how these actions support the strategy.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Data Sharing</td>
<td>Syndromic or sentinel data systems that utilize data from different government agencies to locate emerging hot-spots or drug threats. (For example, RxStat model).</td>
</tr>
<tr>
<td></td>
<td>Implement High Intensity Drug Trafficking Area’s (HIDTA) Overdose Detection Mapping Application (ODMAP).</td>
</tr>
<tr>
<td></td>
<td>Implement other systems that utilize arrest and/or seizure data to identify the possibility of a spike in overdose and to inform response and communication protocols within specific communities.</td>
</tr>
<tr>
<td>Programmatic</td>
<td>Pre-arrest or pre-trial diversion, which use interactions with public</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Partnerships</td>
<td>safety and first responders as an opportunity to refer individuals with substance use disorder to treatment and other forms of needed care.</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td></td>
<td>Naloxone training and awareness, resource mapping and tracking. Again, note that these funds may not be used for purchase of naloxone.</td>
</tr>
<tr>
<td></td>
<td>Developing partnerships among public safety and first responders and school and/or community partners to identify risk from Adverse Childhood Experiences and leverage partnerships to connect individuals and families at risk with necessary prevention resources.</td>
</tr>
<tr>
<td></td>
<td>Other sub-activities to partner with public safety and first responders to engage in prevention efforts aimed at reducing opioid-related morbidity, mortality, and associated harms.</td>
</tr>
</tbody>
</table>

PLEASE NOTE: For programmatic activities, public safety partnerships should focus on linkages to care and/or risk reduction. Applicants should explore potential partnerships with public safety and first responders, courts, and corrections partners. All proposed work in this domain must include a strong public health component and cannot simply address public safety and first responders or criminal justice responses (e.g., those that focus solely on upholding social control, mitigating crime, or sanctioning those who violate laws, with a primary focus on areas such as policing, arrest, trial, or sentencing).

**STRATEGY 9: Empowering Individuals to Make Safer Choices (Optional)**

**Overview:** One of CDC’s priorities is raising awareness about the risks of prescription opioid misuse. Ideally, this will result in true primary prevention, such that individuals never approach the possibility of risky opioid use, misuse, or opioid use disorder. For individuals who may already be experiencing some degree of risk, awareness of risk and the power to manage those risks comes in the form of harm reduction strategies. To provide individuals with the resources and insight they need to make informed choices, CDC launched the Rx Awareness communication campaign, which features testimonials from people recovering from opioid use disorder and people who have lost loved ones to opioid overdose. The goal of the campaign is to educate the public about the risks of prescription opioids and the importance of discussing safer and more effective pain management with their healthcare providers. CDC is also promoting awareness of risks associated with non-medical use of opioids, factors that increase risks (such as fentanyl in the local drug supply), and approaches to reduce risks.

Under this component, recipients can elect to implement CDC’s Rx Awareness campaign. Additional health communications efforts approved by HHS or the White House may be used to
supplement the CDC campaign.

Communications campaigns are an essential step in the work of empowering individuals to make safer choices, but they should be part of a suite of activities. For those individuals already experiencing some risk, secondary and tertiary prevention strategies offer an essential venue by which to minimize that risk. Tertiary strategies are vital; without these strategies, the opportunity to provide intervention and support services is lost and the epidemic of opioid overdose fatalities continues. In addition, even among those who receive services such as medication-assisted treatment, multiple attempts at treatment may be needed before sustained recovery is achieved. Offering accessible, life-saving strategies is critical to prevent death in the opioid-using population. Public health focused harm reduction strategies that are supported by multi-sector partners and coordinated with communication campaign activities increases our ability to decrease overdose-related harms and fatalities and increases opportunities for interventions and linkages to care.

Some notable harm reduction strategies include: naloxone distribution (inclusive of Good Samaritan Policies in some cases), medication-assisted treatment, and public education. Activities that may be funded within this strategy include but are not limited to:

- Address stigma surrounding opioid use disorder, overdose, disclosure, help seeking/treatment, and naloxone among the public, healthcare providers, public safety professionals, emergency medical service professionals, and others
- Developing messaging for those who use illicit drugs about fentanyl in the drug supply and harm reduction strategies.
- Partnering with harm reduction organizations to develop, implement, and evaluate strategies based on the best available research evidence.
- Risk reduction messaging for vulnerable populations such as pregnant women and justice-involved persons.
- Partnering with syringe service programs to offer comprehensive services that facilitate both reduction of opioid-related harms and linkages to care for opioid use disorder.
- Evaluating the impact of harm reduction strategies to better understand the core components, prevention potential, and implementation factors necessary to scale up these efforts and the collective and individual impact of these efforts in combination with other prevention strategies.
- Evaluation efforts should include the collection of quantitative and qualitative data, including data on reach and impact of efforts, as well as contextual evidence and experiential evidence from people using substances, families, and practice professionals.

**STRATEGY 10: Prevention Innovation Projects (Optional)**

To allow flexibility for recipients to respond to emerging threats and opportunities and to promote innovation in prevention strategies, this opportunity includes an option that 10% of the prevention budget may be used for innovation projects beyond the strategies already outlined in this NOFO. States may propose activities that focus on a jurisdictional-specific issue or long-term prevention strategies. All innovation activities must be approved by CDC prior to implementation. Program funds cannot be used for purchasing naloxone, implementing or expanding drug “take back” programs or disposal programs, or directly funding/expanding
substance abuse treatment programs. As with other prevention strategies supported by this funding, innovation projects should have the aim of reducing opioid-related morbidity, mortality, and associated harms.

1. Collaborations

a. With other CDC programs and CDC-funded organizations:

The complex and changing nature of the opioid overdose epidemic highlights the need for an interdisciplinary, comprehensive, and cohesive public health approach, of which collaborations are a cornerstone. No single player can address all the levers that impact opioid overdose prevention. To accomplish the work under this funding opportunity, recipients will need to engage in, coordinate with, and leverage partnerships and collaborations with a broad swath of multi-level, multi-sector partners who can aid in successful implementation and evaluation. As such, applicants should capitalize on this funding opportunity to develop new, and/or build upon existing partnerships with state and local public health and safety entities to prevent opioid misuse, use disorder, overdose, and opioid-related harms. It is expected that collaborators selected to partner with recipient(s) will have extensive knowledge of the identified target populations and demonstrated experience addressing opioid misuse, use disorder, overdose and opioid-related harms within these populations. Below are both required and optional collaborations.

For the requested Letters of Support below, applicants must file the LOS, as appropriate, name the file "LOS_[Partner]", (e.g., LOS_PublicSafety) and upload it as a PDF file at www.grants.gov.

Required collaborations are as follows:

- **States with Core SVIPP Funding:** Recipients currently receiving funding under CDC’s Core State Violence and Injury Prevention Program (Core SVIPP) must meet quarterly with the Core SVIPP point of contact in the state health department to coordinate program activities where possible.

- **National Syndromic Surveillance Program (NSSP): Enhancing Syndromic Surveillance Capacity and Practice (CDC-RFA-OE15-1502):** In order to meet the requirements of Strategy 1 of this NOFO, applicants may propose to share ED data on drug overdoses with CDC through NSSP ESSENCE. Applicants who choose to share ED data on drug overdoses with CDC through NSSP ESSENCE and are funded by NSSP must submit a letter of support (LOS) from their NSSP Principal Investigator. In the LOS, the NSSP PI should: (a) support sharing NOFO-related NSSP data with CDC and (b) indicate that state NSSP staff will manage the authorization process for CDC users.

- **Collecting Violent Death Information Using the National Violent Death Reporting System (NVDRS) (CDC-RFA-CE18-1804):** Strategy 2 of this NOFO uses the same web data-entry system as NVDRS and also makes similar data requests to ME/C agencies and vital statistics as NVDRS. As a result, applicants must provide a LOS from the NVDRS Principal Investigator. In the LOS, the NVDRS Principal Investigator should agree to manage access to the NVDRS web system for authorized NOFO staff and to coordinate ME/C and vital statistics data collections with this NOFO.
Encouraged collaborations are as follows:

- **The High Intensity Drug Trafficking Areas (HIDTA) Program** is a federally funded program within the Office of National Drug Control Policy (ONDCP) that provides assistance to federal, state, local, and tribal law enforcement agencies operating in critical drug-trafficking regions of the United States. Recipients are strongly encouraged but not required to collaborate with the Opioid Response Strategy (ORS). The ORS is a collaboration between HIDTA and CDC with a mission to reduce fatal and nonfatal opioid overdose by developing and sharing information about heroin and other opioids across agencies, and by offering evidence-based intervention strategies (See [https://www.nationalhiddta.org/content/opioid-response-strategy](https://www.nationalhiddta.org/content/opioid-response-strategy)).

- **Injury Control Research Centers**: Injury Control Research Centers (ICRCs) conduct research in all three core phases of injury control (prevention, acute care, and rehabilitation) and serve as training centers and information centers for the public. ICRCs are great sources of research knowledge and other resources for state programs. Recipients are encouraged but not required to collaborate with any of the ICRCs across the nation.

- **Research Grants to Identify Effective Strategies for Opioid Overdose Prevention (CDC RFA-CE-19-002)**: Recipients are encouraged but not required to collaborate with investigators applying for this funding. Recipients of this CDC funding will rigorously evaluate the implementation and impact of new or existing strategies in states and local communities funded through this NOFO (e.g., enhance PDMP use; support providers and health systems in improving prescribing, pain management, and overdose response; enhance public health systems that support linkage to care for opioid use disorder and overdose; infuse public health approaches into public safety and law enforcement response; or empower individuals to make safer choices about opioid use). This offers the opportunity for partnership to conduct rigorous research on the strategies implemented by states, territories, and local communities.

- **City and County Jurisdictions Awarded Under this Announcement**: City and county recipients must collaborate with their state health department, if it is a recipient of funding under this announcement, on their state health department’s NOFO-funded effort to collect drug overdose ED and death data required as part of Strategy 1 and Strategy 2 of this NOFO.

- **Other Jurisdictions Awarded Under this Announcement**: With the exception of the required collaboration of city and county recipients with their state health department’s efforts to meet Strategy 1 and Strategy 2 NOFO requirements, described above, recipients are encouraged but not required to collaborate and share information and findings with other states awarded under this announcement.

**b. With organizations not funded by CDC:**

It is expected that recipients will collaborate closely with a diverse group of multi-sector and multi-level prevention and surveillance partners addressing opioid misuse, use disorder, overdose and opioid-related harms. The objectives of such partnerships are to leverage knowledge and resources to increase capacity for, support, and reach of implementation and
evaluation of the prevention and surveillance component activities.

For the requested Letters of Support below, applicants must file the LOS, as appropriate, name the file "LOS_[Partner]", (e.g., LOS_PublicSafety) and upload it as a PDF file at www.grants.gov

**Applicants Must Show Engagement with Public Safety and First Responders**

The opioid overdose epidemic has major implications for public health, public safety, and first responders. Success in reducing mortality and morbidity associated with opioid overdoses from both prescription and illicit opioids, as well as other prescription or illicit drugs to the extent that they are associated with the opioid overdose epidemic (e.g., cocaine mixed with fentanyl), requires coordination and engagement with these sectors. Applicants must demonstrate engagement with public safety and first responders. Applicants should provide a Letter of Support (LOS) from a state-level public safety and/or first responders authority in their state. The LOS should demonstrate that the public safety and/or first responders authority supports the application and agrees to regular meetings to support and coordinate activities. Applicants should specify how proposed strategies and activities align with and complement existing efforts supported by the U.S. Department of Justice (DOJ).

**Applicants Must Show Engagement with the State Substance Abuse Services Authority**

State substance abuse services authorities are important partners in this effort. Applicants must demonstrate coordination and engagement with the state substance abuse services authority.

Applicants should provide a Letter of Support (LOS) from the state substance abuse services authority in their state. The LOS should show that the state substance abuse services authority supports the application and agrees to regular meetings to support and coordinate activities. Applicants should specify how proposed strategies and activities align with and complement existing efforts supported by the Substance Abuse and Mental Health Services Administration (SAMHSA) without duplication.

**Applicants Must Show Engagement with their Prescription Drug Monitoring Program (PDMP) Authority**

PDMPs are vital public health surveillance tools and clinical decision-making tools in preventing opioid misuse, use disorder, and overdose. All applicants should provide a Letter of Support (LOS) from the PDMP authority responsible for their jurisdiction. (For territories with pending PDMP legislation, the draft legislation may be provided in addition to a LOS from the agency in which the PDMP will be housed.) The LOS should show that the PDMP authority supports the application, agrees to regular meetings to support and coordinate activities, and how the PDMP authority will facilitate proposed activities for enhancing and maximizing the PDMP. Applicants may provide any other materials (e.g., MOUs, LOS from other entities) that demonstrate collaborations that will make the work in this area stronger.

Please note, applicants who receive funding under the Harold Rogers Prescription Drug Monitoring Program from the Bureau of Justice Assistance will be expected to coordinate activities under the two programs and communicate with CDC what activities they are engaging in with the BJA funding. However, no LOS or other documentation is required for the PDMP collaboration.

**Applicants Must Show Collaboration with Other Key Partners**
Applicants must demonstrate support from other key authorities involved in their work. Who these authorities are depends on which strategies are being pursued. Applicants should provide a LOS for each key partner depending on the other strategies they are advancing. These can include other federal, state, or local government agencies, hospitals and health systems, state boards of medicine, boards of pharmacy, and medical organizations, among others. For example, if the applicant proposes to create an opioid management program for the state Medicaid program it should provide a LOS from the Medicaid authority. If the applicant is working in partnership with a particular health system or insurance program (e.g., integrating and/or disseminating evidence-based opioid prescribing guidelines), the applicant should include a LOS from that system or program. The LOS must demonstrate the authority’s support, agreement to regular meetings, and explanation of how the state authority will facilitate the proposed activities.

**Applicants Must Show Collaboration with Key Surveillance Partners in Meeting Surveillance Strategy Requirements (Strategy 1 – 3)**

Applicants must demonstrate in their application their ability to collaborate with the following five key data partners to meet the NOFO surveillance requirements: (1) staffing unit collecting ED data submitted rapidly to CDC as part of Strategy 1, (2) the American Hospital Association (AHA) program to collect hospital billing/discharge data on emergency department visits and hospitalizations in their jurisdiction related to drug overdoses, when applicable (Strategy 1), (3) medical examiner/coroner (ME/C) agencies in collecting data on drug overdose deaths (Strategy 2), (4) the vital statistics death registry program in the jurisdiction in collecting data on drug overdose deaths (Strategy 2), and (5) key external partner(s) needed to implement applicant’s proposed innovative surveillance project (Strategy 3). **Applicants must provide the following information as part of their application:**

- **Evidence of direct support of and collaboration with the staffing unit collecting their rapid ED data by:** (a) budgeting at least $75,000 to the staffing unit collecting rapid ED data to support efforts to maintain and enhance collection of rapid ED data and (b) submitting a LOS from the staffing unit or unit supervisor describing support for the current NOFO and plans for spending the budgeted amount.
- **Evidence of their ability to provide ME/C data on drug overdose deaths by the NOFO deadlines.** Applicants are encouraged, but not required, to submit a LOS or MOU/MOA from their state or territorial ME/C offices or counties with a high drug overdose burden when ME/C agencies operate at the local level.

**Applicants Are Encouraged to Show Other Relevant Collaborations**

Regardless of the strategies selected, applicants are strongly encouraged to describe other strategic partnerships and collaborations with organizations that will make this work stronger and more impactful or may have a role in achieving the outcomes and proposed activities in this funding opportunity (e.g. traditional and social media; non-government organizations; nonprofit agencies; public health and public safety communities; and the business community).

Applicants may provide any materials (e.g., MOUs, LOS from non-government organizations) that demonstrate these collaborations, but are not required to do so.
2. Target Populations
For each jurisdiction, applicants must describe relevant target population(s), and these target population(s) may vary across implemented activities. Applicants should demonstrate specific consideration of population(s) of highest risk (e.g., people involved in the justice system, those who have experienced Adverse Childhood Experiences), as well as populations that have been historically underserved (e.g., people who are experiencing homelessness). Applicants must justify the rationale for selection of target population(s) and describe how their inclusion will help to achieve the program purpose of decreasing opioid overdose morbidity, mortality, and associated harms. Data-driven identification of target population(s) is encouraged and upon award, funded entities will be asked to specify how the appropriateness of target population(s) will be assessed throughout the program period.

a. Health Disparities
As described in previous sections of this funding opportunity, applicants should pay particular attention to underserved population(s) and the selection of target population(s) should be made with an emphasis on promoting health equity.

iv. Funding Strategy
Surveillance Component Funding
Surveillance funding levels vary across applicants and are described separately for three groups: (a) state health departments, the District of Columbia, and Puerto Rico who are required to apply for Strategies 1 - 3, (b) local city and county health departments who are required to apply for Strategy 3 and (c) territories with fewer than 200,000 residents who are required to apply for Strategy 3. For state health departments, the District of Columbia, and Puerto Rico, the maximum surveillance budget ranges from around $600,000 to $2.5 million and is impacted by the number of drug overdose deaths occurring in the jurisdiction as well as the type of surveillance proposed by applicants including participation in optional surveillance projects.

A jurisdiction’s maximum surveillance budget is calculated by adding together the estimated maximum budgets for Strategy 1 – 3 listed in Appendix 1. The estimated maximum budget for Strategy 1 (i.e., collect and disseminate timely ED data on suspected all drug, all opioid, heroin, and all stimulant overdoses) varies across four ED tiers based on administrative burden associated with tier requirements as well as the ability of recipient data to rapidly inform public health responses to drug overdose with quality data (i.e., applicants sharing data more quickly, frequently, and at the case-level will be funded at higher levels). The estimated maximum budget for Strategy 2 (i.e., collect and disseminate descriptions of drug overdose death circumstances using death certificates and ME/C data) varies across three SUDORS tiers based on three factors: 1) administrative burden associated with tier requirements, 2) the ability of recipient data to rapidly inform public health responses to drug overdose deaths (i.e., applicants sharing data more quickly and frequently will be funded at higher levels) and 3) the recipient’s drug overdose burden (i.e., applicants abstracting data on larger numbers of drug overdose deaths have higher administrative burden than applicants with fewer deaths and thus require additional funding). The estimated maximum budget for Strategy 3 (i.e., implement innovative surveillance to support NOFO interventions) is $400,000 per applicant and is meant to implement one or more innovative surveillance approaches that align with both CDC and
applicant priorities. Finally, applicants may receive additional funding if they propose to implement optional projects described in Strategies 1 and 2. In depth descriptions of the budgets for Strategy 1 and Strategy 2 by tier and jurisdiction is in Appendix 1.

Eligible city and county health departments are required to implement at least one innovative surveillance project, Strategy 3, and can propose a maximum budget of up to $400,000 per year. The applicant may propose two or more innovative surveillance efforts. This funding amount is the same as provided to state health departments because eligible city and county health departments are selected in part due to the high number of drug overdose deaths occurring in their jurisdiction. Eligible city and county health departments may not apply to implement Strategy 1 or 2.

Eligible territories with a population of <200,000 people (i.e., all eligible territories except Puerto Rico) are required to implement at least one innovative surveillance project, Strategy 3. These territories will receive up to $150,000 per year due to the lower number of nonfatal and fatal drug overdoses in their jurisdiction.

**Prevention Component Funding**

Prevention funding levels also vary across applicants. Applicants proposing to do the PDMP enhancement work may add an additional $215,000 to their prevention budget. Applicants proposing to serve as Peer-to-Peer Learning Coordinators may add an additional $250,000 to their budget. The total prevention budget ranges from approximately $400,000 to $4,669,478 and is impacted by the specific strategies and activities proposed, and state and territorial applicants’ decisions regarding the optional PDMP enhancement and the peer learning coordinator role.

**b. Evaluation and Performance Measurement**

**i. CDC Evaluation and Performance Measurement Strategy**

Evaluation and Performance Measurement are tools used to: 1) help demonstrate achievement of program outcomes; 2) build a stronger evidence base for specific program interventions; 3) clarify applicability of the evidence base to different populations, settings, and contexts; and 4) drive continuous program improvement. Evaluation and performance measurement can also determine whether program strategies are scalable and effective at reaching the target or intended populations.

Applicants will develop an evaluation plan for the primary purpose of jurisdiction-specific evaluation and program improvement. Additionally, recipients are expected to participate in a CDC-sponsored cross-site evaluation by sharing data already collected (e.g. required indicator data) and/or participating in new data collection activities (e.g. qualitative interviews). CDC will not direct jurisdictional evaluation, but will provide suggestions and support for implementation of their evaluation plans.

Applicants should consider their selected or proposed short-term outcomes (from the Outcomes Section), and for each, develop short-term (process) measures that will show whether the anticipated change took place. CDC will work with recipients to finalize short-term (1 year) performance measures in the first year of the program.
Applicants should consider their selected strategies, activities and short-term outcomes, and intermediate behavioral measures. Applicants should include with their application a list of their short-term measures, and intermediate measures, plus the long term (required) measures. For illustrative purposes, examples of short-term performance measures and intermediate behavioral performance measures are listed below:

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Example measures</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Strategy 1-3:</strong> Collect and disseminate timely ED data on suspected all drug, all opioid, heroin, and all stimulant overdoses (Strategy 1), Collect and disseminate descriptions of drug overdose death circumstances using death certificates and medical examiner / coroner data (ME/C) (Strategy 2), and implement innovative surveillance to support NOFO interventions (Strategy 3)</td>
<td></td>
</tr>
<tr>
<td>Short term</td>
<td>Timely and actionable surveillance data disseminated by recipients:</td>
</tr>
<tr>
<td>- To enhance the implementation of their NOFO interventions</td>
<td></td>
</tr>
<tr>
<td>- To recipient’s stakeholders working to reduce drug overdoses in their jurisdiction</td>
<td></td>
</tr>
<tr>
<td>- To CDC for CDC to rapidly inform the public and key regional and national stakeholders</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Surveillance data supports NOFO interventions.</td>
</tr>
<tr>
<td></td>
<td>o Evidence of ongoing use of ED, fatal drug overdose, and innovative project data to inform interventions funded by this NOFO by the end of Year 2 of funding.</td>
</tr>
<tr>
<td></td>
<td>• Timely and actionable surveillance data disseminated to recipient’s stakeholders working to reduce drug overdoses.</td>
</tr>
<tr>
<td></td>
<td>o Number of major surveillance products disseminated by recipients with targets of at least two ED overdose, two drug overdose death, and two innovative project products such as dashboards, outbreak alerts, or special topic reports disseminated each year starting in Year 2.</td>
</tr>
<tr>
<td></td>
<td>• Surveillance data shared with CDC in compliance with CDC surveillance guidance and reporting deadlines.</td>
</tr>
<tr>
<td></td>
<td>o Percent of times recipients meet CDC reporting deadlines. Targets are 80%, 100%, and 100% for ED overdoses, drug overdose deaths, and innovative projects, respectively.</td>
</tr>
<tr>
<td></td>
<td>o Percent of CDC rapid surveillance</td>
</tr>
</tbody>
</table>
reports that include recipient data with targets of 75%, 90%, and 67% for ED overdoses, drug overdose deaths, and innovative projects, respectively.

- Finalized counts of ED visits and hospitalizations involving all drug, all opioid, heroin, and all stimulant overdoses from billing/discharge files shared yearly with CDC.
  - In order to help CDC track the impact of NOFO interventions, applicants must demonstrate their capacity to share with CDC hospital billing/discharge data on ED visits and hospitalizations that occurred two years previously. For instance, 2017 data must be submitted to CDC by 5/29/2020
  - Recipients must use a CDC template and ICD-10-CM case definitions provided by CDC at the beginning of the funding period. These definitions will be derived from definitions used by *Prescription Drug Overdose Prevention for States* (CDC-RFA-CE15-1501) and *Data Driven Prevention Initiative* (CDC-RFA-CE16-1606).

**Strategy 4: Prescription Drug Monitoring Program**

<table>
<thead>
<tr>
<th>Short Term</th>
<th>Increased measurable collaboration and communication</th>
<th>PDMP use by prescribers and pharmacists</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Increased application of data to drive prevention and response activities between state and local efforts</td>
<td>Disseminated information/reports related to registration and use of PDMP</td>
</tr>
<tr>
<td></td>
<td></td>
<td>State-Local data accessibility/sharing (metrics)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Identification of high burden areas</td>
</tr>
<tr>
<td></td>
<td></td>
<td>PDMP reports (for example to track increased integrating CDC or state guideline-concordant tools such as cumulative morphine milligram equivalent</td>
</tr>
<tr>
<td>Intermediate</td>
<td>Increased access of state health departments to multiple data sources (data dashboards, etc.)</td>
<td>(MME) calculations into patient PDMP reports)</td>
</tr>
<tr>
<td>-------------</td>
<td>------------------------------------------------------------------------------------------------</td>
<td>--------------------------------------------------</td>
</tr>
</tbody>
</table>
|             | • Reduced data collection intervals  
• Number and proportion of healthcare professionals permitted to access PDMP data, including delegates  
• PDMP accessible via a health information exchange |                                                   |

<table>
<thead>
<tr>
<th>Intermediate</th>
<th>Increased state involvement in local-level prevention efforts</th>
<th>• Frequency and quality of reporting.</th>
</tr>
</thead>
</table>
|             | Increased preparedness and response                             | • Real-time data  
• Training efforts in high burden areas/regions |
|             | Identification of high-risk prescribing behaviors               | • Decrease in high-risk prescribing behavior  
• Proactive reports |
|             | Better tracking of opioid prescriptions                         | • Registered prescribers/pharmacist (increase)  
• Proactive reporting (increase) |

**Strategy 5: Integration of State and Local Prevention and Response Efforts**

<table>
<thead>
<tr>
<th>Short Term</th>
<th>Increased local and state capacity for sustainable surveillance and</th>
<th>• Number of trainings and technical assistance requests provided</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prevention Efforts</td>
<td>Number of MOUs with relevant local health departments and/or stakeholders (for TA, tools and resources, etc.)</td>
<td></td>
</tr>
<tr>
<td>--------------------</td>
<td>-----------------------------------------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Number of overdose review committee/RxStat meetings and/or reports</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Number of tools and resources generated for prescribers, public, patients, partners, etc.</td>
<td></td>
</tr>
</tbody>
</table>

### Intermediate

<table>
<thead>
<tr>
<th>Change in high risk prescribing behaviors</th>
<th>Number of prescribers trained or provided TA</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number and proportion of prescribers implementing evidence-based practices</td>
</tr>
</tbody>
</table>

#### Strategy 6: Establishing Linkages to Care

<table>
<thead>
<tr>
<th>Short Term</th>
<th>Increased awareness and coordination of linkages to care</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of emergency departments with protocols and policies to increase referrals to care for persons experiencing opioid overdose</td>
</tr>
<tr>
<td></td>
<td>Number of outreach services that coordinate with syringe service programs</td>
</tr>
</tbody>
</table>

#### Intermediate

<table>
<thead>
<tr>
<th>Increased access to treatment</th>
<th>Number of ED referrals to care</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of peer navigator contacts</td>
</tr>
<tr>
<td></td>
<td>Number and proportion of outreach team follow-ups</td>
</tr>
</tbody>
</table>

#### Strategy 7: Providers and Health Systems Support

<table>
<thead>
<tr>
<th>Short Term</th>
<th>Increased understanding of context, resources, and needs in local/city/county</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Reach of academic detailing</td>
</tr>
<tr>
<td></td>
<td>Number of improved/developed prescribing guidelines (integration into workflow, practice-level policies)</td>
</tr>
<tr>
<td></td>
<td>Number and proportion of trained providers for prescribing practices and linkages to care</td>
</tr>
<tr>
<td>Intermediate</td>
<td>Better allocation of resources to higher-burden areas</td>
</tr>
<tr>
<td>--------------</td>
<td>------------------------------------------------------</td>
</tr>
</tbody>
</table>
| Improved response to opioid overdose epidemic | • Number of EDs, clinics, and hospitals with short-duration defaults for opioids in prescription-writing software  
• Number of clinicians receiving academic detailing on patient-centered de-prescribing |
| Greater awareness of opioid overdose epidemic by state health departments | • Number of QI measures reported to state |

**Strategy 8: Partnerships with Public Safety and First Responders**

| Short Term | Improved coordination of Public Health and Public Safety efforts | • Number of systems/data sharing being utilized by different government agencies  
• Number and proportion of linkages to care offered in correction facilities or post-release  
• Number of pre-arrest or pre-trial diversions  
• Increased awareness within public safety and first responders about risks from ACEs |
|-----------|---------------------------------------------------------------|---------------------------------------------------------------------------------|
| Intermediate | Improved response to opioid overdose epidemic | • Number of naloxone training and awareness activities with first responders  
• Increased linkages to support for families with identified ACEs risk factors |
| Greater awareness of opioid overdose epidemic by state health departments | • Increase in Syndromic data availability |
### Strategy 9: Empowering Individuals to make safer choices

**Short Term**
- Awareness of non-opioid and non-pharmacologic treatment approaches among prescribers
  - Referrals for non-opioid and non-pharmacologic treatments

**Intermediate**
- Increased use of non-opioid and non-pharmacological alternatives among patients
  - Proportion of patients receiving non-opioid treatment modalities
  - Decreased initiation of opioid use
  - Increased harm reduction behaviors among people at risk of overdose

### Strategy 10: Prevention Innovation Projects

**Short Term**
- Improved flexibility to respond to changing conditions within the jurisdiction
  - Intermediate and long-term outcomes to be addressed by these projects are expected to be largely consistent with those indicated in the logic model

### Long-term Evaluation Measures:

All long-term outcome evaluation measures will be provided by CDC. They will include measures of morbidity, mortality, and prescribing behavior.

### Data Management Plan:

**Applicants will need to supply a preliminary draft or outline of a Data Management Plan (DMP).** The DMP must describe the data to be collected or generated in the proposed project; standards to be used for collected or generated data; mechanisms for providing access to and sharing of the data (including provisions for the protection of privacy, confidentiality, security, intellectual property, or other rights); plans to share data with CDC that meet CDC reporting and surveillance requirements; use of data standards that ensure all released data have appropriate documentation that describes the method of collection, what the data represent, and potential limitations for use; and plans for archival and long-term preservation of the data, or explaining why long-term preservation and access are not justified. Recipients will be required to submit a more detailed DMP, within the first 6 months of award, as described in the Reporting Section of this NOFO (See CDC DMP policy [https://www.cdc.gov/grants/additional_requirements/ar-25.html](https://www.cdc.gov/grants/additional_requirements/ar-25.html)).

**ii. Applicant Evaluation and Performance Measurement Plan**

Applicants must provide an evaluation and performance measurement plan that demonstrates how the recipient will fulfill the requirements described in the CDC Evaluation and
Performance Measurement and Project Description sections of this NOFO. At a minimum, the plan must describe:

- How applicant will collect the performance measures, respond to the evaluation questions, and use evaluation findings for continuous program quality improvement.
- How key program partners will participate in the evaluation and performance measurement planning processes.
- Available data sources, feasibility of collecting appropriate evaluation and performance data, and other relevant data information (e.g., performance measures proposed by the applicant)
- Plans for updating the Data Management Plan (DMP), if applicable, for accuracy throughout the lifecycle of the project. The DMP should provide a description of the data that will be produced using these NOFO funds; access to data; data standards ensuring released data have documentation describing methods of collection, what the data represent, and data limitations; and archival and long-term data preservation plans. For more information about CDC’s policy on the DMP, see https://www.cdc.gov/grants/additionalrequirements/ar-25.html.

Where the applicant chooses to, or is expected to, take on specific evaluation studies, they should be directed to:

- Describe the type of evaluations (i.e., process, outcome, or both).
- Describe key evaluation questions to be addressed by these evaluations.
- Describe other information (e.g., measures, data sources).

Recipients will be required to submit a more detailed Evaluation and Performance Measurement plan, including a DMP, if applicable, within the first 6 months of award, as described in the Reporting Section of this NOFO.

All recipients must develop a draft evaluation and performance measurement plan for the Data to Action NOFO as part of this application. Applicants are encouraged, but not required, to use the Data to Action Evaluation Framework located on the FTP site: http://ftp.cdc.gov/pub/TBI/PDO/CDC-RFA-CE16-1606_NOFO_Prescription_Drug_Overdose/ to assist in developing their plan.

Recipients will refine their evaluation and performance measurement plan within 6 months of award and more detailed plan should be developed by the recipient with support from CDC as part of first year project activities and should build on the elements stated in the initial evaluation plan described in this proposal. The plan must be refined and adjusted as needed each year as part of the annual performance report (APR).

Plans must be no longer than 10 pages and must:

- Identify implementation measures for each strategy they proposed. Some strategies may be crosscutting strategies (those selected for more than one priority focus area).
- Define short, mid-term, and long-term outcome measures for the outcomes presented in
their logic model/approach presented earlier. Applicants may also add long-term outcomes that are relevant to state and local stakeholders. Measures for these long-term outcomes are outcomes that are relevant to state and local stakeholders. Final process and outcome measures will be developed in consultation with CDC during the first six months of award

- Describe where (data source), how (rate, percent, count), by whom (which organization), and how often the measures for the short, mid-term and long-term outcomes will be collected and indicate if the state health department has access to this information or intended plans to gain access
- Describe dissemination channels and audiences (including stakeholder and public dissemination) for performance measurement and evaluation findings. Applicants must name this file “(<Statename>Evaluation Plan)” and upload it as a PDF file on www.grants.gov.

c. Organizational Capacity of Recipients to Implement the Approach

Applicants need to demonstrate the capacity to complete all activities proposed. “Organizational capacity” demonstrates the applicant’s ability to successfully execute the funding opportunity strategies and meet project outcomes. Applicants should have adequate infrastructure (physical space and equipment), workforce capacity and competence, relevant skill sets, information and data systems, and electronic information and communication systems to implement the award.

Applicants must describe their organizational capacity to carry out the strategies and activities proposed. Please describe:

- Prior knowledge and experience working with the strategies selected.
- Proven ability to collect data at a population level and use data to demonstrate impact.
- Experience with planning and implementing programs state-level, statewide, or at a systems-level.
- Subject matter expertise to plan and implement strategies addressing opioid misuse, misuse, use disorder, overdose and opioid-related harms.
- Established or newly built partnerships with health systems and other relevant partner organizations with demonstrated experience addressing opioid misuse, use disorder, overdose and opioid-related harms or working with identified high-risk populations.
- Extensive knowledge of the identified target or high-risk populations.
- Experience with evaluating programs state-level and/or statewide.
- Ability to access at least 75% of ED visits within their jurisdiction by the time they first report to CDC and share ED overdose indicator data with CDC on at least a quarterly basis using CDC guidance.
- Capacity to collect ME/C reports, including toxicology, and death certificate data on all UUDO deaths in compliance with CDC guidelines and timelines.
- Capacity to use the NVDRS web-based data entry system (See Appendix 9 for minimum requirements) to enter SUDORS data.
- Experience in establishing proposed surveillance innovation projects or in implementing similar innovative surveillance efforts.
- Experience in disseminating mortality and/or morbidity data to support public health
action.
- Capacity to use drug overdose death and morbidity data to support NOFO interventions.
- The applying organization should have sufficient existing staff (or relationships with external contractors/collaborators) with expertise in program implementation, surveillance, program and performance management, evaluation, policy and management of travel and program requirements, and the full capability to manage the required award. Applicants should identify key staff. Please document these capabilities with résumés of key staff.

d. Work Plan
Applicants must prepare a detailed work plan for the first year of the award and a high-level plan for subsequent years. If funded, CDC will provide feedback and technical assistance to help finalize the work plan post-award.

Applicants must name this file “Work Plan” and upload it as a PDF file on www.grants.gov.

Applicants should organize the work plan according to the Priority Strategies being advanced and the Major Activities selected. The work plan at a minimum should:

1. Describe major strategies and activities to be conducted to meet the program outcomes for each of the chosen priority strategies.
2. List objectives that are Specific, Measurable, Achievable, Relevant, and Time-phased (SMART) during the first 12-month budget period. The applicant should also develop a long-term work plan of overarching goals that will be accomplished over the entire cooperative agreement project cycle.
3. Describe possible barriers to or facilitators for reaching each objective.
4. Provide a timeline that identifies key activities and assigns approximate dates for inception and completion.
5. Describe the multi-sector collaboration that will be utilized to assist in carrying out the proposed activities.
6. Describe staff and administrative roles and functions to support implementation of the award, including evaluation functions.
7. Explain administration and assessment processes to ensure successful implementation and quality assurance.
8. Explain how lessons learned will be translated and disseminated (e.g., through publications, presentations).

e. CDC Monitoring and Accountability Approach
Monitoring activities include routine and ongoing communication between CDC and recipients, site visits, and recipient reporting (including work plans, performance, and financial reporting). Consistent with applicable grants regulations and policies, CDC expects the following to be included in post-award monitoring for grants and cooperative agreements:

- Tracking recipient progress in achieving the desired outcomes.
- Ensuring the adequacy of recipient systems that underlie and generate data reports.
• Creating an environment that fosters integrity in program performance and results.

Monitoring may also include the following activities deemed necessary to monitor the award:

• Ensuring that work plans are feasible based on the budget and consistent with the intent of the award.
• Ensuring that recipients are performing at a sufficient level to achieve outcomes within stated timeframes.
• Working with recipients on adjusting the work plan based on achievement of outcomes, evaluation results and changing budgets.
• Monitoring performance measures (both programmatic and financial) to assure satisfactory performance levels.

Monitoring and reporting activities that assist grants management staff (e.g., grants management officers and specialists, and project officers) in the identification, notification, and management of high-risk recipients.

These activities may include monitoring and reporting activities that assist grants management staff (e.g., grants management officers and specialists, and project officers) in the identification, notification, and management of high-risk recipients.

Applicant’s budget must include travel for two to four staff to a two-day kickoff meeting at CDC’s National Center for Injury Prevention and Control in Atlanta, GA at the beginning of the first-year of the project. All recipients will attend this meeting. For the second and third years of the period of performance, the budget should include annual reverse site visits for a minimum of two program staff to visit Atlanta and meet with CDC staff.

f. CDC Program Support to Recipients (THIS SECTION APPLIES ONLY TO COOPERATIVE AGREEMENTS)

CDC will provide substantial involvement beyond regular performance and financial monitoring during the period of performance. Substantial involvement means that recipients can expect federal programmatic partnership in carrying out the effort under the award. CDC will work in partnership with recipients to ensure the success of the cooperative agreement by:

• Providing cross-site and recipient-specific surveillance technical assistance, such as providing tools to identify nonfatal and fatal drug poisonings using ICD-9-CM, ICD-10-CM, text searches of ED chief complaint and ICD-10 cause of death codes;
• Providing technical assistance to revise annual work plans;
• Assisting in advancing program activities to achieve project outcomes;
• Providing scientific subject matter expertise and resources;
• Collaborating with recipients to develop evaluation plans that align with CDC evaluation activities;
• Providing technical assistance on recipient’s evaluation and performance measurement plan;
• Providing technical assistance to define and operationalize performance measures;
• Facilitating the sharing of information among recipients;
• Participating in relevant meetings, committees, conference calls, and working groups related to the cooperative agreement requirements to achieve outcomes;
• Coordinating communication and program linkages with other CDC programs and Federal agencies, such as Centers for Medicare and Medicaid Services (CMS), Food and Drug Administration (FDA), the National Institutes of Health (NIH), the Substance Abuse and Mental Health Services Administration (SAMHSA), Department of Justice (DOJ), and the HHS Office of the National Coordinator for Health Information Technology (ONC);
• Translating and disseminating lessons learned through publications, meetings, surveillance measures and other means on promising and best practices to expand the evidence base;
• Providing guidance on SUDORS data abstraction, use of necessary data sharing platforms (e.g. NVDRS, NSSP ESSENCE) and CDC templates to collect ED data;
• Supporting use of CDC ED case definitions by providing recipients computer programming code such as SAS, R, and ESSENCE to implement the cases definitions if resources are available;
• Providing ongoing data quality reviews and feedback on required ED and drug overdose death data submissions; and
• Providing technical assistance on data management plans.

B. Award Information

1. Funding Instrument Type: Cooperative Agreement
   CDC’s substantial involvement in this program appears in the CDC Program Support to Recipients Section.

2. Award Mechanism: U17

3. Fiscal Year: 2019
4. Approximate Total Fiscal Year Funding: $280,000,000
5. Approximate Period of Performance Funding: $840,000,000
   This amount is subject to the availability of funds.

   Estimated Total Funding: $840,000,000
6. Approximate Period of Performance Length: 3 year(s)
7. Expected Number of Awards: 78

8. Approximate Average Award: $3,000,000 Per Budget Period
9. Award Ceiling: $7,100,000 Per Budget Period
   This amount is subject to the availability of funds.
10. Award Floor: $400,000 Per Budget Period

11. Estimated Award Date: 09/01/2019

12. Budget Period Length: 12 month(s)

Throughout the project period, CDC will continue the award based on the availability of funds, the evidence of satisfactory progress by the recipient (as documented in required reports), and the determination that continued funding is in the best interest of the federal government. The total number of years for which federal support has been approved (project period) will be shown in the “Notice of Award.” This information does not constitute a commitment by the federal government to fund the entire period. The total period of performance comprises the initial competitive segment and any subsequent non-competitive continuation award(s).

13. Direct Assistance

Direct Assistance (DA) is available through this NOFO. Direct Assistance (DA) may be available for years 2 and 3 of this NOFO under the following authority: Section 311(c)(1) of the PHS Act (42 USC § 243(c)(1)), which provides as follows:

The Secretary is authorized to develop (and may take such action as may be necessary to implement) a plan under which personnel, equipment, medical supplies, and other resources of the Service and other agencies under the jurisdiction of the Secretary may be effectively used to control epidemics of any disease or condition and to meet other health emergencies or problems. The Secretary may enter into agreements providing for the cooperative planning between the Service and public and private community health programs and agencies to cope with health problems (including epidemics and health emergencies).

Additional details regarding the process for requesting direct assistance will be issued during year 1 of the award.

C. Eligibility Information

1. Eligible Applicants

Eligibility Category: State governments
County governments
City or township governments

Additional Eligibility Category:

Government Organizations:
State governments or their bona fide agents (includes the District of Columbia)
Local governments or their bona fide
agents
Territorial governments or their bona fide agents in the Commonwealth of Puerto Rico, the Virgin Islands, the Commonwealth of the Northern Marianna Islands, American Samoa, Guam, the Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau.

2. Additional Information on Eligibility

Eligible entities include:

- State health departments, U.S. territories, or their bona fide agents (includes the District of Columbia). A state health department or territory may only submit a single application to this funding announcement.
  - For the surveillance component,
    - State health departments, the District of Columbia, and Puerto Rico must apply for all of the surveillance strategies (i.e., Strategy 1, 2, and 3).
    - All eligible territories except Puerto Rico may only apply for the innovative projects strategy of the surveillance component (i.e., Strategy 3). See additional information in Appendix 1.
- Local health departments or their bona fide agents may submit a single application if they meet the following requirements:
  - A city or county health department
  - Serve a population greater than 700,000 people by 2017 census estimates.
  - Reported > 395 drug overdose deaths to the National Center for Health Statistics (NCHS) in 2017.
  - If the state health department in which the local health department is situated is funded by this NOFO, the local health department must support state health department efforts to collect required NOFO data: 1) ED data on suspected all drug, all opioid, heroin and all stimulants overdoses and 2) death certificates and ME/C reports on drug overdose deaths.
  - All local health departments that meet the criteria outlined above may apply for the prevention component in its entirety.
  - For the surveillance component, local health departments that meet the criteria outlined above may only apply to implement an innovative surveillance project (Strategy 3) and may NOT apply to collect and disseminate timely emergency department data (Strategy 1) or describe drug overdose deaths (Strategy 2). See additional information in Appendix 1.

The award ceiling for this NOFO is $7,100,000. CDC will consider any application requesting an award higher than this amount as nonresponsive and it will receive no further review.
3. Justification for Less than Maximum Competition

Competition is limited to state health departments (SHD), the District of Columbia, U.S. territories, or their bona fide agents and local health departments (LHD) or their bona fide agents, if they meet the following criteria. Local health departments or their bona fide agents must meet the following to apply: 1) be a city or county health department; 2) serve a population greater than 700,000 people by 2017 census estimate and; 3) report 395 or more drug overdose deaths to the National Center for Health Statistics (NCHS) in 2017. This focus on high-burden cities and counties is critical to rapidly and efficiently address the overdose crisis, as this crisis needs response at the state and local level. Direct funding to these high burden cities/counties allows state resources to remain focused on state-level surveillance systems and health systems prevention efforts, while also ensuring that local solutions to local manifestation of the overdose crisis may be identified and addressed appropriately.

These entities are uniquely qualified to implement the identified surveillance and prevention strategies identified above. The complex and changing nature of the opioid overdose epidemic highlights the need for an interdisciplinary, comprehensive, and cohesive public health approach, which SHDs and LHDs have established through previous CDC funding. Specifically, this funding allows SHDs and LHDs to build upon work from past CDC programs focused on opioid overdose prevention such as the Data-Driven Prevention Initiative (CDC-RFA-CE16-1606), the Prevention for States (CDC-RFA-CE15-1501) program and the Enhanced State Surveillance of Opioid-Involved Morbidity and Mortality (CDC-RFA-CE16-1608). Many of the strategies will continue to build state and local capacity to address opioid overdose, increase timeliness of surveillance data, increase use and access of PDMPs and collaborations with health systems. SHDs and LHDs have unique sole authority to administer state PDMPs and access data that is critical to increasing the timeliness of surveillance data available to inform prevention interventions. These entities have epidemiologic and surveillance capacities to identify trends and patterns driving the epidemic and develop timely responses.

Additionally, as specified in FY 2019 appropriations, CDC shall continue to use the provided funds to advance the understanding of the opioid overdose epidemic and scale up prevention activities across all 50 States, the District of Columbia, territories, as well as extend eligibility to local health departments. Limiting eligibility to SHDs and LHDs, which meet the requirements identified above, ensures that this funding is utilized by communities with the greatest need to address the opioid overdose epidemic.

Failure to limit eligibility to health departments or their bona fide agents would undermine the ability of this award to achieve its intended outcomes. Agencies/entities other than these lack the surveillance and evaluation capacity needed to fulfill the funding’s objective. Such applicants, including other government agencies, state controlled institutions, and housing authorities, lack the connections and collaborations with state-level organizations like PDMPs and emergency departments necessary to advance the strategies. The lack of capacity, expertise, and collaborations would make it extremely unlikely for recipients other than health departments or their bona fide agents to fulfill the requirements of the funding and ultimate goal of decreasing morbidity and mortality associated with the overdose epidemic.

4. Cost Sharing or Matching
Cost Sharing / Matching Requirement: No
Cost sharing or matching funds are not required for this program. Although no statutory matching requirement for this NOFO exists, leveraging other resources and related ongoing efforts to promote sustainability is strongly encouraged. Consistent with the cited authority for this announcement and applicable grants regulations, sources for cost sharing or matching may include complementary foundation funding, other U.S. government funding sources including programs supported by HHS or other agencies (e.g., Department of Justice, Department of Agriculture, Department of Education, Department of Housing and Urban Development, Department of Transportation, Environmental Protection Agency, U.S. Park Service) and other funding sources. Applicants should coordinate with multiple sectors such as public health, transportation, education, health care delivery, and agriculture.

5. Maintenance of Effort
Maintenance of effort is not required for this program.

D. Application and Submission Information

1. Required Registrations
An organization must be registered at the three following locations before it can submit an application for funding at www.grants.gov.

a. Data Universal Numbering System:
All applicant organizations must obtain a Data Universal Numbering System (DUNS) number. A DUNS number is a unique nine-digit identification number provided by Dun & Bradstreet (D&B). It will be used as the Universal Identifier when applying for federal awards or cooperative agreements.
The applicant organization may request a DUNS number by telephone at 1-866-705-5711 (toll free) or internet at http://fedgov.dnb.com/webform/displayHomePage.do. The DUNS number will be provided at no charge.
If funds are awarded to an applicant organization that includes sub-recipients, those sub-recipients must provide their DUNS numbers before accepting any funds.

b. System for Award Management (SAM):
The SAM is the primary registrant database for the federal government and the repository into which an entity must submit information required to conduct business as a recipient. All applicant organizations must register with SAM, and will be assigned a SAM number. All information relevant to the SAM number must be current at all times during which the applicant has an application under consideration for funding by CDC. If an award is made, the SAM information must be maintained until a final financial report is submitted or the final payment is received, whichever is later. The SAM registration process can require 10 or more business days, and registration must be renewed annually. Additional information about registration procedures may be found at www.SAM.gov.

c. Grants.gov:
The first step in submitting an application online is registering your organization at www.grants.gov, the official HHS E-grant Web site. Registration information is located at the...
"Applicant Registration" option at [www.grants.gov](http://www.grants.gov).
All applicant organizations must register at [www.grants.gov](http://www.grants.gov). The one-time registration process usually takes not more than five days to complete. Applicants should start the registration process as early as possible.

<table>
<thead>
<tr>
<th>Step</th>
<th>System</th>
<th>Requirements</th>
<th>Duration</th>
<th>Follow Up</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Data Universal Number System (DUNS)</td>
<td>1. Click on <a href="http://fedgov.dnb.com/webform">http://fedgov.dnb.com/webform</a> 2. Select Begin DUNS search/request process 3. Select your country or territory and follow the instructions to obtain your DUNS 9-digit # 4. Request appropriate staff member(s) to obtain DUNS number, verify &amp; update information under DUNS number</td>
<td>1-2 Business Days</td>
<td>To confirm that you have been issued a new DUNS number check online at <a href="http://fedgov.dnb.com/webform">http://fedgov.dnb.com/webform</a> or call 1-866-705-5711</td>
</tr>
<tr>
<td>2</td>
<td>System for Award Management (SAM) formerly Central Contractor Registration (CCR)</td>
<td>1. Retrieve organizations DUNS number 2. Go to <a href="http://www.sam.gov">www.sam.gov</a> and designate an E-Biz POC (note CCR username will not work in SAM and you will need to have an active SAM account before you can register on grants.gov)</td>
<td>3-5 Business Days but up to 2 weeks and must be renewed once a year</td>
<td>For SAM Customer Service Contact <a href="https://fsd.gov/fsd-gov/home.do">https://fsd.gov/fsd-gov/home.do</a> Calls: 866-606-8220</td>
</tr>
<tr>
<td>3</td>
<td>Grants.gov</td>
<td>1. Set up an individual account in Grants.gov using organization new DUNS number to become an authorized organization representative (AOR) 2. Once the account is set up the E-BIZ POC will be notified via email 3. Log into grants.gov using the password the E-BIZ POC received and create new password 4. This authorizes the AOR to submit applications on behalf of</td>
<td>Same day but can take 8 weeks to be fully registered and approved in the system (note, applicants MUST obtain a DUNS number and SAM account before</td>
<td>Register early! Log into grants.gov and check AOR status until it shows you have been approved</td>
</tr>
</tbody>
</table>
2. Request Application Package
Applicants may access the application package at www.grants.gov.

3. Application Package
Applicants must download the SF-424, Application for Federal Assistance, package associated with this notice of funding opportunity at www.grants.gov. If Internet access is not available, or if the online forms cannot be accessed, applicants may call the CDC OGS staff at 770-488-2700 or e-mail OGS ogstims@cdc.gov for assistance. Persons with hearing loss may access CDC telecommunications at TTY 1-888-232-6348.

4. Submission Dates and Times
If the application is not submitted by the deadline published in the NOFO, it will not be processed. Office of Grants Services (OGS) personnel will notify the applicant that their application did not meet the deadline. The applicant must receive pre-approval to submit a paper application (see Other Submission Requirements section for additional details). If the applicant is authorized to submit a paper application, it must be received by the deadline provided by OGS.

a. Letter of Intent Deadline (must be emailed or postmarked by)
Due Date for Letter of Intent: 03/01/2019

b. Application Deadline
Due Date for Applications: 05/02/2019, 11:59 p.m. U.S. Eastern Standard Time, at www.grants.gov. If Grants.gov is inoperable and cannot receive applications, and circumstances preclude advance notification of an extension, then applications must be submitted by the first business day on which grants.gov operations resume.

Date for Information Conference Call
Conference phone number is 1-888-455-1397
Conference I.D. 7624894#
Link: https://adobeconnect.cdc.gov/rtdp86dayqnw/

<table>
<thead>
<tr>
<th>Potential Agenda Items</th>
<th>Potential Dates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kickoff Call</td>
<td>2/12/19</td>
</tr>
<tr>
<td>· Provide NOFO overview</td>
<td>3:30-4:45 Eastern time</td>
</tr>
<tr>
<td>· Review Eligibility</td>
<td></td>
</tr>
<tr>
<td>· Projected average award amount</td>
<td></td>
</tr>
</tbody>
</table>
Component 1: Surveillance (part 1 of 2)  ·  Provide overview of required and optional surveillance strategies  2/21/19  3:30-4:45 Eastern time

Component 2: Prevention  ·  Provide overview of required and optional strategies  2/26/19  3:30-4:45 Eastern time

Component 1: Surveillance (part 2 of 2)  ·  Provide overview of required and optional surveillance strategies  3/5/19  3:30-4:45 Eastern time

Final Wrap Up  ·  Provide an informal question and answer opportunity for potential applicants to have final questions answered  ·  Grant conditions  3/12/19  3:30-4:45 Eastern time

Two additional calls will be scheduled in the evening for territories (not including Puerto Rico)
Conference Number: 1-888-455-1397
Conference I.D.: 7264894#
URL:  [https://adobeconnect.cdc.gov/rtdp86dayqnw/](https://adobeconnect.cdc.gov/rtdp86dayqnw/)

<table>
<thead>
<tr>
<th>Potential Agenda Items</th>
<th>Potential Dates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surveillance: Mortality and Morbidity</td>
<td></td>
</tr>
<tr>
<td>·  General overview</td>
<td>2/21/19</td>
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<td>·  Provide overview of required and optional</td>
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<td>strategies</td>
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5. CDC Assurances and Certifications
All applicants are required to sign and submit “Assurances and Certifications” documents indicated at [http://wwwn.cdc.gov/grantassurances/](http://wwwn.cdc.gov/grantassurances/) (S(mj444mxct51lnrv1hljjjmaa)/Homepage.aspx).
Applicants may follow either of the following processes:

- Complete the applicable assurances and certifications with each application submission, name the file “Assurances and Certifications” and upload it as a PDF file with at www.grants.gov
- Complete the applicable assurances and certifications and submit them directly to CDC on an annual basis at http://www.cdc.gov/grantassurances/(S(mj444mxct51lnrv1hljjjmaa))/ Homepage.aspx

Assurances and certifications submitted directly to CDC will be kept on file for one year and will apply to all applications submitted to CDC by the applicant within one year of the submission date.

**Risk Assessment Questionnaire Requirement**

CDC is required to conduct pre-award risk assessments to determine the risk an applicant poses to meeting federal programmatic and administrative requirements by taking into account issues such as financial instability, insufficient management systems, non-compliance with award conditions, the charging of unallowable costs, and inexperience. The risk assessment will include an evaluation of the applicant’s CDC Risk Questionnaire, located at https://www.cdc.gov/grants/documents/PPMR-G-CDC-Risk-Questionnaire.pdf, as well as a review of the applicant’s history in all available systems; including OMB-designated repositories of government-wide eligibility and financial integrity systems (see 45 CFR 75.205(a)), and other sources of historical information. These systems include, but are not limited to: FAPIIS (https://www.fapiis.gov/), including past performance on federal contracts as per Duncan Hunter National Defense Authorization Act of 2009; Do Not Pay list; and System for Award Management (SAM) exclusions.

CDC requires all applicants to complete the Risk Questionnaire, OMB Control Number 0920-1132 annually. This questionnaire, which is located at https://www.cdc.gov/grants/documents/PPMR-G-CDC-Risk-Questionnaire.pdf, along with supporting documentation must be submitted with your application by the closing date of the Notice of Funding Opportunity Announcement. If your organization has completed CDC’s Risk Questionnaire within the past 12 months of the closing date of this NOFO, then you must submit a copy of that questionnaire, or submit a letter signed by the authorized organization representative to include the original submission date, organization’s EIN and DUNS. When uploading supporting documentation for the Risk Questionnaire into this application package, clearly label the documents for easy identification of the type of documentation. For example, a copy of Procurement policy submitted in response to the questionnaire may be labeled using the following format: Risk Questionnaire Supporting Documents _ Procurement Policy.

**Duplication of Efforts**

Applicants are responsible for reporting if this application will result in programmatic, budgetary, or commitment overlap with another application or award (i.e. grant, cooperative agreement, or contract) submitted to another funding source in the same fiscal year. Programmatic overlap occurs when (1) substantially the same project is proposed in more than
one application or is submitted to two or more funding sources for review and funding consideration or (2) a specific objective and the project design for accomplishing the objective are the same or closely related in two or more applications or awards, regardless of the funding source. Budgetary overlap occurs when duplicate or equivalent budgetary items (e.g., equipment, salaries) are requested in an application but already are provided by another source. Commitment overlap occurs when an individual’s time commitment exceeds 100 percent, whether or not salary support is requested in the application. Overlap, whether programmatic, budgetary, or commitment of an individual’s effort greater than 100 percent, is not permitted. Any overlap will be resolved by the CDC with the applicant and the PD/PI prior to award.

Report Submission: The applicant must upload the report in Grants.gov under “Other Attachment Forms.” The document should be labeled: "Report on Programmatic, Budgetary, and Commitment Overlap."

6. Content and Form of Application Submission
Applicants are required to include all of the following documents with their application package at www.grants.gov.

7. Letter of Intent
The purpose of an LOI is to allow CDC program staff to estimate the number of and plan for the review of submitted applications. For applicants who choose to submit the optional requested LOI, it must be sent via U.S. express mail, delivery service, fax, or email to:

Overdose Data To Action LOI, c/o Sarah Bacon
CDC, National Center for Injury Prevention and Control 4770 Buford Highway, MS F62
Telephone number: (770) 488-0520
Fax: (770) 488-4349
Email address: overdosedata2action@cdc.gov

Please include the following information in your Letter of Intent:

- Descriptive title of proposed project:

- Name, address, telephone number, and email address of the Principal Investigator or Project Director, or both

- Name, address, telephone number, and e-mail address of the primary contact for writing and submitting this application

- Number and title of this NOFO

- Please identify which tiers and strategies applicant will propose, for both the surveillance and prevention components, and whether they intend to apply for a Peer-to-
8. Table of Contents
(There is no page limit. The table of contents is not included in the project narrative page limit.): The applicant must provide, as a separate attachment, the “Table of Contents” for the entire submission package. Provide a detailed table of contents for the entire submission package that includes all of the documents in the application and headings in the "Project Narrative" section. Name the file "Table of Contents" and upload it as a PDF file under "Other Attachment Forms" at www.grants.gov.

9. Project Abstract Summary
(Maximum 1 page)
A project abstract is included on the mandatory documents list and must be submitted at www.grants.gov. The project abstract must be a self-contained, brief summary of the proposed project including the purpose and outcomes. This summary must not include any proprietary or confidential information. Applicants must enter the summary in the "Project Abstract Summary" text box at www.grants.gov.

10. Project Narrative
(Unless specified in the "H. Other Information" section, maximum of 20 pages, single spaced, 12 point font, 1-inch margins, number all pages. This includes the work plan. Content beyond the specified page number will not be reviewed.) Applicants must submit a Project Narrative with the application forms. Applicants must name this file “Project Narrative” and upload it at www.grants.gov. The Project Narrative must include all of the following headings (including subheadings): Background, Approach, Applicant Evaluation and Performance Measurement Plan, Organizational Capacity of Applicants to Implement the Approach, and Work Plan. The Project Narrative must be succinct, self-explanatory, and in the order outlined in this section. It must address outcomes and activities to be conducted over the entire period of performance as identified in the CDC Project Description section. Applicants should use the federal plain language guidelines and Clear Communication Index to respond to this Notice of Funding Opportunity. Note that recipients should also use these tools when creating public communication materials supported by this NOFO. Failure to follow the guidance and format may negatively impact scoring of the application.

a. Background
Applicants must provide a description of relevant background information that includes the context of the problem (See CDC Background).

b. Approach
i. Purpose
Applicants must describe in 2-3 sentences specifically how their application will address the public health problem as described in the CDC Background section.

ii. Outcomes
Applicants must clearly identify the outcomes they expect to achieve by the end of the project period, as identified in the logic model in the Approach section of the CDC Project Description. Outcomes are the results that the program intends to achieve and usually indicate the intended direction of change (e.g., increase, decrease).

iii. Strategies and Activities
Applicants must provide a clear and concise description of the strategies and activities they will use to achieve the period of performance outcomes. Applicants must select existing evidence-based strategies that meet their needs, or describe in the Applicant Evaluation and Performance Measurement Plan how these strategies will be evaluated over the course of the project period. See the Strategies and Activities section of the CDC Project Description.

1. Collaborations
Applicants must describe how they will collaborate with programs and organizations either internal or external to CDC. Applicants must address the Collaboration requirements as described in the CDC Project Description.

2. Target Populations and Health Disparities
Applicants must describe the specific target population(s) in their jurisdiction and explain how such a target will achieve the goals of the award and/or alleviate health disparities. The applicants must also address how they will include specific populations that can benefit from the program that is described in the Approach section. Applicants must address the Target Populations and Health Disparities requirements as described in the CDC Project Description.

c. Applicant Evaluation and Performance Measurement Plan
Applicants must provide an evaluation and performance measurement plan that demonstrates how the recipient will fulfill the requirements described in the CDC Evaluation and Performance Measurement and Project Description sections of this NOFO. At a minimum, the plan must describe:

- How applicant will collect the performance measures, respond to the evaluation questions, and use evaluation findings for continuous program quality improvement. The Paperwork Reduction Act of 1995 (PRA): Applicants are advised that any activities involving information collections (e.g., surveys, questionnaires, applications, audits, data requests, reporting, recordkeeping and disclosure requirements) from 10 or more individuals or non-Federal entities, including State and local governmental agencies, and funded or sponsored by the Federal Government are subject to review and approval by the Office of Management and Budget. For further information about CDC’s
requirements under PRA see http://www.hhs.gov/ocio/policy/collection/.

- How key program partners will participate in the evaluation and performance measurement planning processes.
- Available data sources, feasibility of collecting appropriate evaluation and performance data, data management plan (DMP), and other relevant data information (e.g., performance measures proposed by the applicant).

Where the applicant chooses to, or is expected to, take on specific evaluation studies, they should be directed to:

- Describe the type of evaluations (i.e., process, outcome, or both).
- Describe key evaluation questions to be addressed by these evaluations.
- Describe other information (e.g., measures, data sources).

Recipients will be required to submit a more detailed Evaluation and Performance Measurement plan (including the DMP elements) within the first 6 months of award, as described in the Reporting Section of this NOFO.

d. Organizational Capacity of Applicants to Implement the Approach

Applicants must address the organizational capacity requirements as described in the CDC Project Description.

11. Work Plan

(Included in the Project Narrative’s page limit)
Applicants must prepare a work plan consistent with the CDC Project Description Work Plan section. The work plan integrates and delineates more specifically how the recipient plans to carry out achieving the period of performance outcomes, strategies and activities, evaluation and performance measurement.

12. Budget Narrative

Applicants must submit an itemized budget narrative. When developing the budget narrative, applicants must consider whether the proposed budget is reasonable and consistent with the purpose, outcomes, and program strategy outlined in the project narrative. The budget must include:

- Salaries and wages
- Fringe benefits
- Consultant costs
- Equipment
- Supplies
- Travel
Indirect costs could include the cost of collecting, managing, sharing and preserving data. Indirect costs on grants awarded to foreign organizations and foreign public entities and performed fully outside of the territorial limits of the U.S. may be paid to support the costs of complying with federal requirements at a fixed rate of eight percent of MTDC exclusive of tuition and related fees, direct expenditures for equipment, and subawards in excess of $25,000. Negotiated indirect costs may be paid to the American University, Beirut, and the World Health Organization.

If applicable and consistent with the cited statutory authority for this announcement, applicant entities may use funds for activities as they relate to the intent of this NOFO to meet national standards or seek health department accreditation through the Public Health Accreditation Board (see: http://www.phaboard.org). Applicant entities to whom this provision applies include state, local, territorial governments (including the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, the Commonwealth of the Northern Mariana Islands, American Samoa, Guam, the Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau), or their bona fide agents, political subdivisions of states (in consultation with states), federally recognized or state-recognized American Indian or Alaska Native tribal governments, and American Indian or Alaska Native tribally designated organizations. Activities include those that enable a public health organization to deliver public health services such as activities that ensure a capable and qualified workforce, up-to-date information systems, and the capability to assess and respond to public health needs. Use of these funds must focus on achieving a minimum of one national standard that supports the intent of the NOFO. Proposed activities must be included in the budget narrative and must indicate which standards will be addressed.

Vital records data, including births and deaths, are used to inform public health program and policy decisions. If applicable and consistent with the cited statutory authority for this NOFO, applicant entities are encouraged to collaborate with and support their jurisdiction’s vital records office (VRO) to improve vital records data timeliness, quality and access, and to advance public health goals. Recipients may, for example, use funds to support efforts to build VRO capacity through partnerships; provide technical and/or financial assistance to improve vital records timeliness, quality or access; or support vital records improvement efforts, as approved by CDC.

Applicants must name this file “Budget Narrative” and upload it as a PDF file at www.grants.gov. If requesting indirect costs in the budget, a copy of the indirect cost-rate agreement is required. If the indirect costs are requested, include a copy of the current negotiated federal indirect cost rate agreement or a cost allocation plan approval letter for those Recipients under such a plan. Applicants must name this file “Indirect Cost Rate” and upload it at www.grants.gov.

All applicants must calculate the maximum budget for the surveillance component of this NOFO using Appendix 1. The overall surveillance budget submitted to CDC by applicants should not exceed this amount. Also, surveillance funding should only be spent to support
surveillance activities, or Strategies 1 – 3, and the budget narrative should clearly distinguish between funds allocated to support surveillance activities (Strategies 1 – 3) from prevention activities (Strategies 4 – 10).

In order to provide state health departments, the District of Columbia, and Puerto Rico flexibility in optimizing the use of CDC funds to conduct surveillance, these applicants may propose budgets that exceed the CDC suggested funding levels for each Strategy listed in Appendix 1 and used to calculate applicant’s maximum budget. For instance, a state may choose to spend more on their collection of drug overdose deaths using SUDORS, or Strategy 2, and less on rapid ED data collection, Strategy 1, than suggested by CDC in Appendix 1 because the state has a strong existing ED data collection system and has to build the infrastructure for collecting drug overdose death data. An applicant, however, must justify the decision in the budget narrative, must never exceed the overall surveillance budget maximum and must clearly demonstrate that their funding level for each strategy 1 – 3 is sufficient to meet CDC requirements.

The budget narrative for state health departments, the District of Columbia, and Puerto Rico must also meet the following two requirements:

1. Clearly indicate in the budget that at least the minimum funding level listed in Appendix 7 is allocated to support and enhance comprehensive post-mortem toxicological testing of suspected drug overdose deaths to detect opioids. This funding should go directly to ME/C and/or forensic laboratories to directly support forensic toxicology work. If allocated to forensic laboratories, the budget narrative should explain how the funding will directly impact ME/C work. Applicants providing evidence of sufficient forensic toxicology testing and CDC permission may also use funding to: (a) increase the timeliness of forensic testing of drug overdose deaths, (b) improve forensic investigation of drug overdose deaths, (c) enhance testing for other drugs involved in opioid overdose deaths, (d) reimburse ME/Cs for work related to SUDORS, and (e) initiate other projects approved by CDC. The minimum required funding level is higher for applicants with more drug overdose deaths because forensic toxicology test costs increase per forensic test conducted.

2. Ensure at least $75,000 per year is budgeted to support the staffing unit responsible for collecting rapid ED data to enhance ED quality improvements.

Eligible city and county health departments are required to implement at least one innovative surveillance project, Strategy 3, and can propose a maximum surveillance budget of up to $400,000 per year. The applicant may propose two or more innovative surveillance efforts. This funding amount is similar to that of state health departments because eligible city and county health departments are selected in part due to the high number of drug overdose deaths in their jurisdiction. Finally, eligible territories with a population of <200,000 people (i.e., all territories except Puerto Rico) will receive up to $150,000 per year to implement at least one innovative surveillance project. Proposed surveillance budgets should never exceed these maximums.

All applicants’ surveillance budgets (i.e., state, DC, all territories, and city and county health departments) must include travel for a minimum of two staff to a two-day kickoff meeting at CDC’s National Center for Injury Prevention and Control in Atlanta, GA at the beginning of the first-year of the project. All recipients will attend this meeting. For the second and third years of
the period of performance, the budget should include annual reverse site visits for at least two program staff to visit Atlanta and meet with CDC staff.

13. Funds Tracking
Proper fiscal oversight is critical to maintaining public trust in the stewardship of federal funds. Effective October 1, 2013, a new HHS policy on subaccounts requires the CDC to set up payment subaccounts within the Payment Management System (PMS) for all new grant awards. Funds awarded in support of approved activities and drawdown instructions will be identified on the Notice of Award in a newly established PMS subaccount (P subaccount). Recipients will be required to draw down funds from award-specific accounts in the PMS. Ultimately, the subaccounts will provide recipients and CDC a more detailed and precise understanding of financial transactions. The successful applicant will be required to track funds by P-accounts/sub accounts for each project/cooperative agreement awarded. Applicants are encouraged to demonstrate a record of fiscal responsibility and the ability to provide sufficient and effective oversight. Financial management systems must meet the requirements as described 2 CFR 200 which include, but are not limited to, the following:

- Records that identify adequately the source and application of funds for federally-funded activities.
- Effective control over, and accountability for, all funds, property, and other assets.
- Comparison of expenditures with budget amounts for each Federal award.
- Written procedures to implement payment requirements.
- Written procedures for determining cost allowability.
- Written procedures for financial reporting and monitoring.

14. Intergovernmental Review
The application is subject to Intergovernmental Review of Federal Programs, as governed by Executive Order 12372, which established a system for state and local intergovernmental review of proposed federal assistance applications. Applicants should inform their state single point of contact (SPOC) as early as possible that they are applying prospectively for federal assistance and request instructions on the state's process. The current SPOC list is available at: https://www.whitehouse.gov/wp-content/uploads/2017/11/Intergovernmental_Review_SPOC_01_2018_OFFM.pdf.

15. Pilot Program for Enhancement of Employee Whistleblower Protections
Pilot Program for Enhancement of Employee Whistleblower Protections: All applicants will be subject to a term and condition that applies the terms of 48 Code of Federal Regulations (CFR) section 3.908 to the award and requires that recipients inform their employees in writing (in the predominant native language of the workforce) of employee whistleblower rights and protections under 41 U.S.C. 4712.

This provision is intended to ensure that the public has access to the results and accomplishments of public health activities funded by CDC. Pursuant to applicable grant regulations and CDC’s Public Access Policy, Recipient agrees to submit into the National Institutes of Health (NIH) Manuscript Submission (NIHMS) system an electronic version of the final, peer-reviewed manuscript of any such work developed under this award upon acceptance for publication, to be made publicly available no later than 12 months after the official date of publication. Also at the time of submission, Recipient and/or the Recipient’s submitting author must specify the date the final manuscript will be publicly accessible through PubMed Central (PMC). Recipient and/or Recipient’s submitting author must also post the manuscript through PMC within twelve (12) months of the publisher's official date of final publication; however the author is strongly encouraged to make the subject manuscript available as soon as possible. The recipient must obtain prior approval from the CDC for any exception to this provision.

The author’s final, peer-reviewed manuscript is defined as the final version accepted for journal publication, and includes all modifications from the publishing peer review process, and all graphics and supplemental material associated with the article. Recipient and its submitting authors working under this award are responsible for ensuring that any publishing or copyright agreements concerning submitted articles reserve adequate right to fully comply with this provision and the license reserved by CDC. The manuscript will be hosted in both PMC and the CDC Stacks institutional repository system. In progress reports for this award, recipient must identify publications subject to the CDC Public Access Policy by using the applicable NIHMS identification number for up to three (3) months after the publication date and the PubMed Central identification number (PMCID) thereafter.

17. Funding Restrictions

Restrictions that must be considered while planning the programs and writing the budget are:

- Recipients may not use funds for research.
- Recipients may not use funds for clinical care except as allowed by law.
- Recipients may use funds only for reasonable program purposes, including personnel, travel, supplies, and services.
- Generally, recipients may not use funds to purchase furniture or equipment. Any such proposed spending must be clearly identified in the budget.
- Reimbursement of pre-award costs generally is not allowed, unless the CDC provides written approval to the recipient.
- Other than for normal and recognized executive-legislative relationships, no funds may be used for:
  - publicity or propaganda purposes, for the preparation, distribution, or use of any material designed to support or defeat the enactment of legislation before any legislative body
  - the salary or expenses of any grant or contract recipient, or agent acting for such recipient, related to any activity designed to influence the enactment of legislation, appropriations, regulation, administrative action, or Executive order
proposed or pending before any legislative body

• See Additional Requirement (AR) 12 for detailed guidance on this prohibition and additional guidance on lobbying for CDC recipients.

• The direct and primary recipient in a cooperative agreement program must perform a substantial role in carrying out project outcomes and not merely serve as a conduit for an award to another party or provider who is ineligible.

• In accordance with the United States Protecting Life in Global Health Assistance policy, all non-governmental organization (NGO) applicants acknowledge that foreign NGOs that receive funds provided through this award, either as a prime recipient or subrecipient, are strictly prohibited, regardless of the source of funds, from performing abortions as a method of family planning or engaging in any activity that promotes abortion as a method of family planning, or to provide financial support to any other foreign non-governmental organization that conducts such activities. See Additional Requirement (AR) 35 for applicability (https://www.cdc.gov/grants/additionalrequirements/ar-35.html).

Program funds cannot be used for purchasing naloxone, implementing or expanding drug “take back” programs or other drug disposal programs (e.g. drop boxes or disposal bags), purchasing fentanyl test strips, or directly funding or expanding direct provision of substance abuse treatment programs. Such activities are outside the scope of this NOFO.

18. Data Management Plan

As identified in the Evaluation and Performance Measurement section, applications involving data collection must include a Data Management Plan (DMP) as part of their evaluation and performance measurement plan. The DMP is the applicant’s assurance of the quality of the public health data through the data’s lifecycle and plans to deposit data in a repository to preserve and to make the data accessible in a timely manner. See web link for additional information: https://www.cdc.gov/grants/additionalrequirements/ar-25.html

19. Other Submission Requirements

a. Electronic Submission:

Applications must be submitted electronically by using the forms and instructions posted for this notice of funding opportunity at www.grants.gov. Applicants can complete the application package using Workspace, which allows forms to be filled out online or offline. All application attachments must be submitted using a PDF file format. Instructions and training for using Workspace can be found at www.grants.gov under the "Workspace Overview" option. If Internet access is not available or if the forms cannot be accessed online, applicants may contact the OGS TIMS staff at 770- 488-2700 or by e-mail at ogstims@cdc.gov, Monday through Friday, 7:30 a.m.–4:30 p.m., except federal holidays. Electronic applications will be considered successful if they are available to OGS TIMS staff for processing from www.grants.gov on the deadline date.
b. Tracking Number: Applications submitted through www.grants.gov are time/date stamped electronically and assigned a tracking number. The applicant’s Authorized Organization Representative (AOR) will be sent an e-mail notice of receipt when www.grants.gov receives the application. The tracking number documents that the application has been submitted and initiates the required electronic validation process before the application is made available to CDC.

c. Validation Process: Application submission is not concluded until the validation process is completed successfully. After the application package is submitted, the applicant will receive a “submission receipt” e-mail generated by www.grants.gov. A second e-mail message to applicants will then be generated by www.grants.gov that will either validate or reject the submitted application package. This validation process may take as long as two business days. Applicants are strongly encouraged to check the status of their application to ensure that submission of their package has been completed and no submission errors have occurred. Applicants also are strongly encouraged to allocate ample time for filing to guarantee that their application can be submitted and validated by the deadline published in the NOFO. Non-validated applications will not be accepted after the published application deadline date.

If you do not receive a “validation” e-mail within two business days of application submission, please contact www.grants.gov. For instructions on how to track your application, refer to the e-mail message generated at the time of application submission or the Grants.gov Online User Guide.

d. Technical Difficulties: If technical difficulties are encountered at www.grants.gov, applicants should contact Customer Service at www.grants.gov. The www.grants.gov Contact Center is available 24 hours a day, 7 days a week, except federal holidays. The Contact Center is available by phone at 1-800-518-4726 or by e-mail at support@grants.gov. Application submissions sent by e-mail or fax, or on CDs or thumb drives will not be accepted. Please note that www.grants.gov is managed by HHS.

e. Paper Submission: If technical difficulties are encountered at www.grants.gov, applicants should call the www.grants.gov Contact Center at 1-800-518-4726 or e-mail them at support@grants.gov for assistance. After consulting with the Contact Center, if the technical difficulties remain unresolved and electronic submission is not possible, applicants may e-mail CDC GMO/GMS, before the deadline, and request permission to submit a paper application. Such requests are handled on a case-by-case basis.
An applicant’s request for permission to submit a paper application must:

1. Include the www.grants.gov case number assigned to the inquiry
2. Describe the difficulties that prevent electronic submission and the efforts taken with the www.grants.gov Contact Center to submit electronically; and
3. Be received via e-mail to the GMS/GMO listed below at least three calendar days before the application deadline. Paper applications submitted without prior approval will not be
considered.

If a paper application is authorized, OGS will advise the applicant of specific instructions for submitting the application (e.g., original and two hard copies of the application by U.S. mail or express delivery service).

E. Review and Selection Process

1. Review and Selection Process: Applications will be reviewed in three phases

a. Phase 1 Review
All applications will be initially reviewed for eligibility and completeness by CDC Office of Grants Services. Complete applications will be reviewed for responsiveness by the Grants Management Officials and Program Officials. Non-responsive applications will not advance to Phase II review. Applicants will be notified that their applications did not meet eligibility and/or published submission requirements.

b. Phase II Review
A review panel will evaluate complete, eligible applications in accordance with the criteria below.

i. Approach
ii. Evaluation and Performance Measurement
iii. Applicant’s Organizational Capacity to Implement the Approach

Not more than thirty days after the Phase II review is completed, applicants will be notified electronically if their application does not meet eligibility or published submission requirements.

1. Purpose, Outcomes, Strategies and Activities, and Target Populations (25 points):
   - **Background:** Applicants must provide a description of relevant background information that includes the context of the problem, particularly in the applicant’s jurisdiction. (2 points)
   - **Purpose:** Applicants must describe in 2-3 sentences specifically how their application will address the problem as described in the Background section of this NOFO. (3 points)
   - **Outcomes:** Applicants must clearly identify the outcomes they expect to achieve by the end of the period of performance. Outcomes are the results that the program intends to achieve. All outcomes must indicate the intended direction of change (e.g., increase, decrease, maintain). (3 points)
   - **Strategies and Activities (15 points total, see below for breakdown):**
     - State health departments, Puerto Rico, and DC:
       - Applicants must provide a clear and concise description of surveillance strategies and activities they will use to achieve the period of performance outcomes for the surveillance component
(10 points).
- Must specify the ED tier and SUDORS tier that the applicant is proposing to implement. Regardless of ED and SUDORS tier selected or optional projects, applicants providing a clear concise description that aligns with the NOFO requirements should receive 3 points, while unclear descriptions that do not align should receive 1 point.
- Applicants proposing to implement ED tier 1 or ED tier 2 should receive 1 additional point and applicants proposing to implement SUDORS tier 1 should receive 1 additional point.
  - City and county health departments as well as eligible territories except Puerto Rico:
    - Applicants must provide a clear and concise description of surveillance strategies and activities they will use to achieve the period of performance outcomes for the surveillance component (10 points).
    - Must propose at least one innovative surveillance project to support NOFO interventions. Regardless of innovative project(s) proposed, applicants providing a clear concise description that aligns with the NOFO requirements should receive 4 to 5 points. Applicants providing a description with some weaknesses should receive 2 to 3 points, while unclear descriptions that do not align with NOFO priorities should receive 1 point.
    - The prevention strategies and activities they will use to achieve the period of performance outcomes for the prevention component (5 points).

- **Target Populations:** Applicants must describe how the interventions to be improved or evaluated target high-risk groups of clinicians and patients to achieve the greatest health impact, as described in the "Target Populations" section of this NOFO. (2 points)

2. **Work Plan (15 points):** Applicants will be scored on their preparation of a work plan consistent with this NOFO's "Work Plan" section. It must include a detailed first-year work plan and a high-level plan for subsequent years. This is the applicant's opportunity to clearly show what it will do with the funding. After reading the work plan, reviewers should be able to understand how the applicant plans to carry out achieving the period of performance outcomes, strategies, and activities.

- **Surveillance component work plan (5 points):** Applicant will be scored on the extent to which their work plan is well-organized and has a high probability of producing surveillance data that will inform its NOFO prevention programs and meet CDC reporting deadlines. Specifically, applicants with a high probability of meeting these goals should receive 5 points, applicants with a moderate probability should receive 3 to 4 points, and applicants with a weak probability should receive 1 to 2 points.
- **Prevention component work plan (10 points):** Applicants will be scored on the extent to which their work plan is well organized, describes feasible work, is consistent with the strategies as outlined in this Notice of Funding Opportunity (NOFO), and may be
expected to lead to the long-term outcomes required by this award.

3. Collaborations (10 points): Applicants will be scored on the extent to which they demonstrate strong, multi-sector collaborations to support their work, including:

- Applicants that include all letters of Support (LOS) required under the "Collaboration" section of this NOFO will receive 5 points.
- Applicants demonstrating strong LOS and evidence of collaboration with key partners should receive an additional 5 points. When evaluating the strength of collaborations, reviewers should assess: (1) the inclusion of any other recommended MOAs/MOUs/LOSs that demonstrate strategic partnerships and collaborations with organizations that have a role in achieving the NOFO outcomes and proposed activities, (2) strong evidence of previous or ongoing collaborations that support required surveillance data collections, and (3) demonstration of collaborations with other CDC programs, including Core VIPP states, R01 awards, Core VIPP regional networks, and Injury Control Research Centers, as applicable.
- **Prevention component collaborations:** Applicants that do not include LOS from appropriate partners will still be deemed responsive, but the applicant should explain why they LOS was not submitted and how these challenges will be addressed if they receive funding.
- **Surveillance component collaborations:** Failure by state health departments, Puerto Rico and DC to include required surveillance LOS from the staffing unit or supervisor supplying rapid ED data, the NSSP PI when applicable, and NVDRS PI will still be deemed responsive, but the applicant should explain why the LOS was not submitted and how these challenges will be addressed if they receive funding.

### ii. Evaluation and Performance Measurement

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- Applicants will be scored on the extent to which their evaluation plan for Strategies 1 – 3 of the surveillance component of the NOFO is well organized, feasible, and likely to inform surveillance improvements. Applicants with an extremely strong evaluation plan should receive 7 points, applicants with a strong evaluation plan with a few weaknesses should receive 5 to 6 points, applicants with an evaluation plan with equal number of strengths and weaknesses should receive 3 to 4 points, and applicants with a uniformly weak evaluation plan should receive 1 to 2 points. When scoring evaluation plans in applications, consider the following:
  - Presents a feasible plan to constantly monitor and improve the quality of data reported to CDC.
  - Presents a feasible plan to assess the use and utility of surveillance data to NOFO programs.
  - Presents a feasible plan to track the dissemination and impact of surveillance data.
- Applicants will be scored on a sliding scale, earning up to 18 points. Applicants presenting a comprehensive and rigorous evaluation plan for their prevention component could receive 18 points, while applicants with a weak or incomplete evaluation plan could receive 1 point. Any score between one and 18 may be applied
based on the quality of the proposed evaluation plan. When scoring applications consider the following organizational capacities.

- Presents a feasible plan including appropriate indicators and measures of program implementation, including dosage, fidelity, and duration.
- Includes appropriate evaluation expertise on staff (whether internal or through formal contracting).
- Includes information on data sources and the data use agreements or memoranda of understanding that may need to be in place to procure necessary data.
- Includes appropriate short-, medium-, and long-term outcome data and/or outlines how CDC-provided data will be leveraged and incorporated into the evaluation and performance measurement plan.

### iii. Applicant's Organizational Capacity to Implement the Approach

<table>
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<th>Maximum Points: 25</th>
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- One to 10 points will be assigned based on the applicant’s organizational capacity to implement Strategies 1 – 3 of the surveillance component of the NOFO. Specifically, applicants with uniformly strong capacity should receive 10 points, applicants with strong capacity with a few weaknesses should receive 7 to 9 points, applicants with equal numbers of strengths and weaknesses should receive 5 to 6 points, applicants with weak capacity with a few strengths should receive 2 to 4 points, and applicants with uniformly weak capacity should receive 1 point. When scoring applications consider the following organizational capacities.
  - For state health departments, Puerto Rico and DC:
    - Ability to access at least 75% of ED visits within their jurisdiction by first submission to CDC and share ED overdose indicator data with CDC on at least a quarterly basis using CDC guidance.
    - Capacity to collect ME/C reports, including toxicology, and death certificate data on all UUDO deaths in compliance with CDC guidelines and timelines.
  - For all applicants:
    - Demonstrate the feasibility of establishing proposed surveillance innovation projects.
    - Experience in disseminating mortality and/or morbidity data to support public health action.
    - Capacity to use drug overdose death and morbidity data to support NOFO interventions.

- Applicants with an extremely strong capacity to implement the prevention component of the NOFO should receive 15 points while applicants with weak capacity should receive 1 point. When scoring applications consider the following organizational capacities.
  - Demonstrated success in implementing similar strategies and activities as those proposed in the application.
  - Demonstrated effective relationships with the necessary partners to accomplish the work proposed in the application.
  - Appropriate staffing with respect to award strategy and planning, program
implementation and project management, epidemiology, evaluation, policy, and communications. These capacities may reside within the applicant’s staff or be formally arranged through contracts and other mechanisms of procuring external expertise.

**Budget**

Budgets are not scored.

**c. Phase III Review**

Eligible applicants will be reviewed through a two-stage process. In the first stage, all eligible applications will be evaluated by an objective review panel on the basis of each item referenced in Section E. Application and Submission Information. In the second stage, some applicants may then be considered for a pre-decisional site visit (PDSV).

**Review of risk posed by applicants.**

Prior to making a Federal award, CDC is required by 31 U.S.C. 3321 and 41 U.S.C. 2313 to review information available through any OMB-designated repositories of government-wide eligibility qualification or financial integrity information as appropriate. See also suspension and debarment requirements at 2 CFR parts 180 and 376.

In accordance 41 U.S.C. 2313, CDC is required to review the non-public segment of the OMB-designated integrity and performance system accessible through SAM (currently the Federal Recipient Performance and Integrity Information System (FAPIIS)) prior to making a Federal award where the Federal share is expected to exceed the simplified acquisition threshold, defined in 41 U.S.C. 134, over the period of performance. At a minimum, the information in the system for a prior Federal award recipient must demonstrate a satisfactory record of executing programs or activities under Federal grants, cooperative agreements, or procurement awards; and integrity and business ethics. CDC may make a Federal award to a recipient who does not fully meet these standards, if it is determined that the information is not relevant to the current Federal award under consideration or there are specific conditions that can appropriately mitigate the effects of the non-Federal entity's risk in accordance with 45 CFR §75.207.

CDC’s framework for evaluating the risks posed by an applicant may incorporate results of the evaluation of the applicant's eligibility or the quality of its application. If it is determined that a Federal award will be made, special conditions that correspond to the degree of risk assessed may be applied to the Federal award. The evaluation criteria is described in this Notice of Funding Opportunity.

In evaluating risks posed by applicants, CDC will use a risk-based approach and may consider any items such as the following:

1. Financial stability;
2. Quality of management systems and ability to meet the management standards prescribed in this part;
3. History of performance. The applicant's record in managing Federal awards, if it is a prior recipient of Federal awards, including timeliness of compliance with applicable reporting
requirements, conformance to the terms and conditions of previous Federal awards, and if applicable, the extent to which any previously awarded amounts will be expended prior to future awards;
(4) Reports and findings from audits performed under subpart F 45 CFR 75 or the reports and findings of any other available audits; and
(5) The applicant's ability to effectively implement statutory, regulatory, or other requirements imposed on non-Federal entities.

CDC must comply with the guidelines on government-wide suspension and debarment in 2 CFR part 180, and require non-Federal entities to comply with these provisions. These provisions restrict Federal awards, subawards and contracts with certain parties that are debarred, suspended or otherwise excluded from or ineligible for participation in Federal programs or activities.

2. Announcement and Anticipated Award Dates
Applicants can anticipate notice of funding by August 15, 2019.

F. Award Administration Information

1. Award Notices

Recipients will receive an electronic copy of the Notice of Award (NOA) from CDC OGS. The NOA shall be the only binding, authorizing document between the recipient and CDC. The NOA will be signed by an authorized GMO and emailed to the Recipient Business Officer listed in application and the Program Director.

Any applicant awarded funds in response to this Notice of Funding Opportunity will be subject to the DUNS, SAM Registration, and Federal Funding Accountability And Transparency Act Of 2006 (FFATA) requirements.

Unsuccessful applicants will receive notification of these results by e-mail with delivery receipt or by U.S. mail.

2. Administrative and National Policy Requirements


The full text of the Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards, 45 CFR 75, can be found at: https://www.ecfr.gov/cgi-bin/text-idx?node=pt45.1.75
3. Reporting

Reporting provides continuous program monitoring and identifies successes and challenges that recipients encounter throughout the project period. Also, reporting is a requirement for recipients who want to apply for yearly continuation of funding. Reporting helps CDC and recipients because it:

- Helps target support to recipients;
- Provides CDC with periodic data to monitor recipient progress toward meeting the Notice of Funding Opportunity outcomes and overall performance;
- Allows CDC to track performance measures and evaluation findings for continuous quality and program improvement throughout the period of performance and to determine applicability of evidence-based approaches to different populations, settings, and contexts; and
- Enables CDC to assess the overall effectiveness and influence of the NOFO.

The table below summarizes required and optional reports. All required reports must be sent electronically to GMS listed in the “Agency Contacts” section of the NOFO copying the CDC Project Officer.

<table>
<thead>
<tr>
<th>Report</th>
<th>When?</th>
<th>Required?</th>
</tr>
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<tbody>
<tr>
<td>Recipient Evaluation and Performance Measurement Plan, including Data Management Plan (DMP)</td>
<td>6 months into award</td>
<td>Yes</td>
</tr>
<tr>
<td>Annual Performance Report (APR)</td>
<td>No later than 120 days before end of budget period. Serves as yearly continuation application</td>
<td>Yes</td>
</tr>
<tr>
<td>Federal Financial Reporting Forms</td>
<td>90 days after end of calendar quarter in which budget period ends</td>
<td>Yes</td>
</tr>
<tr>
<td>Final Performance and Financial Report</td>
<td>90 days after end of period of performance</td>
<td>Yes</td>
</tr>
<tr>
<td>Payment Management System (PMS) Reporting</td>
<td>Quarterly</td>
<td>Yes</td>
</tr>
</tbody>
</table>

CDC will require recipients to update and report their performance and evaluation measures 60 days after the end of each funding year. Recipients are expected to use CDC provided annual performance report templates for reporting progress and evaluation results.

a. Recipient Evaluation and Performance Measurement Plan (required)

With support from CDC, recipients must elaborate on their initial applicant evaluation and performance measurement plan. This plan must be no more than 20 pages; recipients must
submit the plan 6 months into the award. HHS/CDC will review and approve the recipient’s monitoring and evaluation plan to ensure that it is appropriate for the activities to be undertaken as part of the agreement, for compliance with the monitoring and evaluation guidance established by HHS/CDC, or other guidance otherwise applicable to this Agreement.

Recipient Evaluation and Performance Measurement Plan (required): This plan should provide additional detail on the following:

Performance Measurement

• Performance measures and targets
• The frequency that performance data are to be collected.
• How performance data will be reported.
• How quality of performance data will be assured.
• How performance measurement will yield findings to demonstrate progress towards achieving NOFO goals (e.g., reaching target populations or achieving expected outcomes).
• Dissemination channels and audiences.
• Other information requested as determined by the CDC program.

Evaluation

• The types of evaluations to be conducted (e.g. process or outcome evaluations).
• The frequency that evaluations will be conducted.
• How evaluation reports will be published on a publically available website.
• How evaluation findings will be used to ensure continuous quality and program improvement.
• How evaluation will yield findings to demonstrate the value of the NOFO (e.g., effect on improving public health outcomes, effectiveness of NOFO, cost-effectiveness or cost-benefit).
• Dissemination channels and audiences.

HHS/CDC or its designee will also undertake monitoring and evaluation of the defined activities within the agreement. The recipient must ensure reasonable access by HHS/CDC or its designee to all necessary sites, documentation, individuals and information to monitor, evaluate and verify the appropriate implementation the activities and use of HHS/CDC funding under this Agreement.

b. Annual Performance Report (APR) (required)

The recipient must submit the APR via www.Grantsolutions.gov no later than 120 days prior to the end of the budget period. This report must not exceed 45 pages excluding administrative reporting. Attachments are not allowed, but web links are allowed. This report must include the following:

• Performance Measures: Recipients must report on performance measures for each budget period and update measures, if needed.
• Evaluation Results: Recipients must report evaluation results for the work completed to date (including findings from process or outcome evaluations).
• **Work Plan:** Recipients must update work plan each budget period to reflect any changes in period of performance outcomes, activities, timeline, etc.

• **Successes**
  - Recipients must report progress on completing activities and progress towards achieving the period of performance outcomes described in the logic model and work plan.
  - Recipients must describe any additional successes (e.g. identified through evaluation results or lessons learned) achieved in the past year.
  - Recipients must describe success stories.

• **Challenges**
  - Recipients must describe any challenges that hindered or might hinder their ability to complete the work plan activities and achieve the period of performance outcomes.
  - Recipients must describe any additional challenges (e.g., identified through evaluation results or lessons learned) encountered in the past year.

• **CDC Program Support to Recipients**
  - Recipients must describe how CDC could help them overcome challenges to complete activities in the work plan and achieving period of performance outcomes.

• **Administrative Reporting** (No page limit)
  - SF-424A Budget Information-Non-Construction Programs.
  - Budget Narrative – Must use the format outlined in "Content and Form of Application Submission, Budget Narrative" section.
  - Indirect Cost Rate Agreement.

For year 2 and beyond of the award, recipients may request that as much as 75% of their estimated unobligated funds be carried over into the next budget period.


c. **Performance Measure Reporting (optional)**
CDC programs may require more frequent reporting of performance measures than annually in the APR. If this is the case, CDC programs must specify reporting frequency, data fields, and format for recipients at the beginning of the award period.

CDC will require recipients to update and report their performance and evaluation measures 60 days after the end of each funding year.

Recipients are expected to use CDC provided annual performance report templates for reporting progress and evaluation results.

d. **Federal Financial Reporting (FFR) (required)**
The annual FFR form (SF-425) is required and must be submitted 90 days after the end of the budget period. The report must include only those funds authorized and disbursed during the timeframe covered by the report. The final FFR must indicate the exact balance of unobligated funds, and may not reflect any unliquidated obligations. There must be no discrepancies.
between the final FFR expenditure data and the Payment Management System’s (PMS) cash transaction data. Failure to submit the required information by the due date may adversely affect the future funding of the project. If the information cannot be provided by the due date, recipients are required to submit a letter of explanation to OGS and include the date by which the Grants Officer will receive information.

e. Final Performance and Financial Report (required)
This report is due 90 days after the end of the period of performance. CDC programs must indicate that this report should not exceed 40 pages. This report covers the entire period of performance and can include information previously reported in APRs. At a minimum, this report must include the following:

- Performance Measures – Recipients must report final performance data for all process and outcome performance measures.
- Evaluation Results – Recipients must report final evaluation results for the period of performance for any evaluations conducted.
- Impact/Results/Success Stories – Recipients must use their performance measure results and their evaluation findings to describe the effects or results of the work completed over the project period, and can include some success stories.
- A final Data Management Plan that includes the location of the data collected during the funded period, for example, repository name and link data set(s)
- Additional forms as described in the Notice of Award (e.g., Equipment Inventory Report, Final Invention Statement).

4. Federal Funding Accountability and Transparency Act of 2006 (FFATA)
Federal Funding Accountability and Transparency Act of 2006 (FFATA), P.L. 109–282, as amended by section 6202 of P.L. 110–252 requires full disclosure of all entities and organizations receiving Federal funds including awards, contracts, loans, other assistance, and payments through a single publicly accessible Web site, http://www.USASpending.gov. Compliance with this law is primarily the responsibility of the Federal agency. However, two elements of the law require information to be collected and reported by applicants: 1) information on executive compensation when not already reported through the SAM, and 2) similar information on all sub-awards/subcontracts/consortiums over $25,000.
For the full text of the requirements under the FFATA and HHS guidelines, go to:


5. Reporting of Foreign Taxes (International/Foreign projects only)
A. Valued Added Tax (VAT) and Customs Duties – Customs and import duties, consular fees,
customs surtax, valued added taxes, and other related charges are hereby authorized as an allowable cost for costs incurred for non-host governmental entities operating where no applicable tax exemption exists. This waiver does not apply to countries where a bilateral agreement (or similar legal document) is already in place providing applicable tax exemptions and it is not applicable to Ministries of Health. Successful applicants will receive information on VAT requirements via their Notice of Award.

B. The U.S. Department of State requires that agencies collect and report information on the amount of taxes assessed, reimbursed and not reimbursed by a foreign government against commodities financed with funds appropriated by the U.S. Department of State, Foreign Operations and Related Programs Appropriations Act (SFOAA) (“United States foreign assistance funds”). Outlined below are the specifics of this requirement:

1) Annual Report: The recipient must submit a report on or before November 16 for each foreign country on the amount of foreign taxes charged, as of September 30 of the same year, by a foreign government on commodity purchase transactions valued at 500 USD or more financed with United States foreign assistance funds under this grant during the prior United States fiscal year (October 1 – September 30), and the amount reimbursed and unreimbursed by the foreign government. [Reports are required even if the recipient did not pay any taxes during the reporting period.]

2) Quarterly Report: The recipient must quarterly submit a report on the amount of foreign taxes charged by a foreign government on commodity purchase transactions valued at 500 USD or more financed with United States foreign assistance funds under this grant. This report shall be submitted no later than two weeks following the end of each quarter: April 15, July 15, October 15 and January 15.

3) Terms: For purposes of this clause:
“Commodity” means any material, article, supplies, goods, or equipment;
“Foreign government” includes any foreign government entity;
“Foreign taxes” means value-added taxes and custom duties assessed by a foreign government on a commodity. It does not include foreign sales taxes.

4) Where: Submit the reports to the Director and Deputy Director of the CDC office in the country(ies) in which you are carrying out the activities associated with this cooperative agreement. In countries where there is no CDC office, send reports to VATreporting@cdc.gov.

5) Contents of Reports: The reports must contain:
a. recipient name;
b. contact name with phone, fax, and e-mail;
c. agreement number(s) if reporting by agreement(s);
d. reporting period;
e. amount of foreign taxes assessed by each foreign government;
f. amount of any foreign taxes reimbursed by each foreign government;
g. amount of foreign taxes unreimbursed by each foreign government.
6) Subagreements. The recipient must include this reporting requirement in all applicable subgrants and other subagreements.

G. Agency Contacts

CDC encourages inquiries concerning this notice of funding opportunity.

Program Office Contact

For programmatic technical assistance, contact:

Reshma Mahendra, Project Officer  
Department of Health and Human Services  
Centers for Disease Control and Prevention  
4770 Buford Hwy, NE MS F62  
Atlanta GA 30341  
Email: overdosedata2action@cdc.gov

Grants Staff Contact

For financial, awards management, or budget assistance, contact:

Barbara (Rene) Benyard, Grants Management Specialist  
Department of Health and Human Services  
Office of Grants Services  
Centers for Disease Control and Prevention  
2920 Brandywine Road  
Atlanta, GA 30341  
Email: bnb8@cdc.gov

For assistance with submission difficulties related to www.grants.gov, contact the Contact Center by phone at 1-800-518-4726.  
Hours of Operation: 24 hours a day, 7 days a week, except on federal holidays.

For all other submission questions, contact:  
Technical Information Management Section  
Department of Health and Human Services  
CDC Office of Financial Resources  
Office of Grants Services  
2920 Brandywine Road, MS E-14  
Atlanta, GA 30341  
Telephone: 770-488-2700  
Email: ogstims@cdc.gov
CDC Telecommunications for persons with hearing loss is available at: TTY 1-888-232-6348

H. Other Information

Following is a list of acceptable attachments applicants can upload as PDF files as part of their application at www.grants.gov. Applicants may not attach documents other than those listed; if other documents are attached, applications will not be reviewed.

- Project Abstract
- Project Narrative
- Budget Narrative
- CDC Assurances and Certifications
- Report on Programmatic, Budgetary and Commitment Overlap
- Table of Contents for Entire Submission

For international NOFOs:

- SF424
- SF424A
- Funding Preference Deliverables

In responding to this NOFO, applicants’ Project Narrative sections will have an expanded limit of 30 pages.

I. Glossary

Activities: The actual events or actions that take place as a part of the program.

Administrative and National Policy Requirements, Additional Requirements (ARs): Administrative requirements found in 45 CFR Part 75 and other requirements mandated by statute or CDC policy. All ARs are listed in the Template for CDC programs. CDC programs must indicate which ARs are relevant to the NOFO; recipients must comply with the ARs listed in the NOFO. To view brief descriptions of relevant provisions, see http://www.cdc.gov/grants/additional_requirements/index.html. Note that 2 CFR 200 supersedes the administrative requirements (A-110 & A-102), cost principles (A-21, A-87 & A-122) and audit requirements (A-50, A-89 & A-133).

Approved but Unfunded: Approved but unfunded refers to applications recommended for approval during the objective review process; however, they were not recommended for funding by the program office and/or the grants management office.

Assistance Listings (CFDA): A government-wide compendium published by the General Services Administration (available on-line in searchable format as well as in printable format as a .pdf file) that describes domestic assistance programs administered by the Federal Government.
Assistance Listings (CFDA) Number: A unique number assigned to each program and NOFO throughout its lifecycle that enables data and funding tracking and transparency.

Award: Financial assistance that provides support or stimulation to accomplish a public purpose. Awards include grants and other agreements (e.g., cooperative agreements) in the form of money, or property in lieu of money, by the federal government to an eligible applicant.

Budget Period or Budget Year: The duration of each individual funding period within the project period. Traditionally, budget periods are 12 months or 1 year.

Carryover: Unobligated federal funds remaining at the end of any budget period that, with the approval of the GMO or under an automatic authority, may be carried over to another budget period to cover allowable costs of that budget period either as an offset or additional authorization. Obligated but liquidated funds are not considered carryover.

CDC Assurances and Certifications: Standard government-wide grant application forms.

Competing Continuation Award: A financial assistance mechanism that adds funds to a grant and adds one or more budget periods to the previously established period of performance (i.e., extends the “life” of the award).

Continuous Quality Improvement: A system that seeks to improve the provision of services with an emphasis on future results.

Contracts: An award instrument used to acquire (by purchase, lease, or barter) property or services for the direct benefit or use of the Federal Government.

Cooperative Agreement: A financial assistance award with the same kind of interagency relationship as a grant except that it provides for substantial involvement by the federal agency funding the award. Substantial involvement means that the recipient can expect federal programmatic collaboration or participation in carrying out the effort under the award.

Cost Sharing or Matching: Refers to program costs not borne by the Federal Government but by the recipients. It may include the value of allowable third-party, in-kind contributions, as well as expenditures by the recipient.

Direct Assistance: A financial assistance mechanism, which must be specifically authorized by statute, whereby goods or services are provided to recipients in lieu of cash. DA generally involves the assignment of federal personnel or the provision of equipment or supplies, such as vaccines. DA is primarily used to support payroll and travel expenses of CDC employees assigned to state, tribal, local, and territorial (STLT) health agencies that are recipients of grants and cooperative agreements. Most legislative authorities that provide financial assistance to STLT health agencies allow for the use of DA. [http://www.cdc.gov/grants/additionalrequirements/index.html](http://www.cdc.gov/grants/additionalrequirements/index.html).

DUNS: The Dun and Bradstreet (D&B) Data Universal Numbering System (DUNS) number is a nine-digit number assigned by Dun and Bradstreet Information Services. When applying for Federal awards or cooperative agreements, all applicant organizations must obtain a DUNS number as the Universal Identifier. DUNS number assignment is free. If requested by telephone, a DUNS number will be provided immediately at no charge. If requested via the Internet, obtaining a DUNS number may take one to two days at no charge. If an organization does not know its DUNS number or needs to register for one, visit Dun & Bradstreet at [http://fedgov.dnb.com/webform/displayHomePage.do](http://fedgov.dnb.com/webform/displayHomePage.do).

Evaluation (program evaluation): The systematic collection of information about the activities, characteristics, and outcomes of programs (which may include interventions, policies, and specific projects) to make judgments about that program, improve program effectiveness, and/or inform decisions about future program development.
Evaluation Plan: A written document describing the overall approach that will be used to guide an evaluation, including why the evaluation is being conducted, how the findings will likely be used, and the design and data collection sources and methods. The plan specifies what will be done, how it will be done, who will do it, and when it will be done. The NOFO evaluation plan is used to describe how the recipient and/or CDC will determine whether activities are implemented appropriately and outcomes are achieved.

Federal Funding Accountability and Transparency Act of 2006 (FFATA): Requires that information about federal awards, including awards, contracts, loans, and other assistance and payments, be available to the public on a single website at www.USAspending.gov.

Fiscal Year: The year for which budget dollars are allocated annually. The federal fiscal year starts October 1 and ends September 30.

Grant: A legal instrument used by the federal government to transfer anything of value to a recipient for public support or stimulation authorized by statute. Financial assistance may be money or property. The definition does not include a federal procurement subject to the Federal Acquisition Regulation; technical assistance (which provides services instead of money); or assistance in the form of revenue sharing, loans, loan guarantees, interest subsidies, insurance, or direct payments of any kind to a person or persons. The main difference between a grant and a cooperative agreement is that in a grant there is no anticipated substantial programmatic involvement by the federal government under the award.


Grants Management Officer (GMO): The individual designated to serve as the HHS official responsible for the business management aspects of a particular grant(s) or cooperative agreement(s). The GMO serves as the counterpart to the business officer of the recipient organization. In this capacity, the GMO is responsible for all business management matters associated with the review, negotiation, award, and administration of grants and interprets grants administration policies and provisions. The GMO works closely with the program or project officer who is responsible for the scientific, technical, and programmatic aspects of the grant.

Grants Management Specialist (GMS): A federal staff member who oversees the business and other non-programmatic aspects of one or more grants and/or cooperative agreements. These activities include, but are not limited to, evaluating grant applications for administrative content and compliance with regulations and guidelines, negotiating grants, providing consultation and technical assistance to recipients, post-award administration and closing out grants.

Health Disparities: Differences in health outcomes and their determinants among segments of the population as defined by social, demographic, environmental, or geographic category.

Health Equity: Striving for the highest possible standard of health for all people and giving special attention to the needs of those at greatest risk of poor health, based on social conditions.

Health Inequities: Systematic, unfair, and unavoidable differences in health outcomes and their determinants between segments of the population, such as by socioeconomic status (SES), demographics, or geography.

Healthy People 2020: National health objectives aimed at improving the health of all Americans by encouraging collaboration across sectors, guiding people toward making informed health decisions, and measuring the effects of prevention activities.

Inclusion: Both the meaningful involvement of a community’s members in all stages of the
program process and the maximum involvement of the target population that the intervention will benefit. Inclusion ensures that the views, perspectives, and needs of affected communities, care providers, and key partners are considered.

**Indirect Costs:** Costs that are incurred for common or joint objectives and not readily and specifically identifiable with a particular sponsored project, program, or activity; nevertheless, these costs are necessary to the operations of the organization. For example, the costs of operating and maintaining facilities, depreciation, and administrative salaries generally are considered indirect costs.

**Intergovernmental Review:** Executive Order 12372 governs applications subject to Intergovernmental Review of Federal Programs. This order sets up a system for state and local governmental review of proposed federal assistance applications. Contact the state single point of contact (SPOC) to alert the SPOC to prospective applications and to receive instructions on the State’s process. Visit the following web address to get the current SPOC list: https://www.whitehouse.gov/wp-content/uploads/2017/11/Intergovernmental_Review_-_SPOC_01_2018_OFFM.pdf.

**Letter of Intent (LOI):** A preliminary, non-binding indication of an organization’s intent to submit an application.

**Lobbying:** Direct lobbying includes any attempt to influence legislation, appropriations, regulations, administrative actions, executive orders (legislation or other orders), or other similar deliberations at any level of government through communication that directly expresses a view on proposed or pending legislation or other orders, and which is directed to staff members or other employees of a legislative body, government officials, or employees who participate in formulating legislation or other orders. Grass roots lobbying includes efforts directed at inducing or encouraging members of the public to contact their elected representatives at the federal, state, or local levels to urge support of, or opposition to, proposed or pending legislative proposals.

**Logic Model:** A visual representation showing the sequence of related events connecting the activities of a program with the programs’ desired outcomes and results.

**Maintenance of Effort:** A requirement contained in authorizing legislation, or applicable regulations that a recipient must agree to contribute and maintain a specified level of financial effort from its own resources or other non-government sources to be eligible to receive federal grant funds. This requirement is typically given in terms of meeting a previous base-year dollar amount.

**Memorandum of Understanding (MOU) or Memorandum of Agreement (MOA):** Document that describes a bilateral or multilateral agreement between parties expressing a convergence of will between the parties, indicating an intended common line of action. It is often used in cases where the parties either do not imply a legal commitment or cannot create a legally enforceable agreement.

**Nonprofit Organization:** Any corporation, trust, association, cooperative, or other organization that is operated primarily for scientific, educational, service, charitable, or similar purposes in the public interest; is not organized for profit; and uses net proceeds to maintain, improve, or expand the operations of the organization. Nonprofit organizations include institutions of higher educations, hospitals, and tribal organizations (that is, Indian entities other than federally recognized Indian tribal governments).

**Notice of Award (NoA):** The official document, signed (or the electronic equivalent of signature) by a Grants Management Officer that: (1) notifies the recipient of the award of a
grant; (2) contains or references all the terms and conditions of the grant and Federal funding limits and obligations; and (3) provides the documentary basis for recording the obligation of Federal funds in the HHS accounting system.

**Objective Review:** A process that involves the thorough and consistent examination of applications based on an unbiased evaluation of scientific or technical merit or other relevant aspects of the proposal. The review is intended to provide advice to the persons responsible for making award decisions.

**Outcome:** The results of program operations or activities; the effects triggered by the program. For example, increased knowledge, changed attitudes or beliefs, reduced tobacco use, reduced morbidity and mortality.

**Performance Measurement:** The ongoing monitoring and reporting of program accomplishments, particularly progress toward pre-established goals, typically conducted by program or agency management. Performance measurement may address the type or level of program activities conducted (process), the direct products and services delivered by a program (outputs), or the results of those products and services (outcomes). A “program” may be any activity, project, function, or policy that has an identifiable purpose or set of objectives.

**Period of performance –formerly known as the project period - :** The time during which the recipient may incur obligations to carry out the work authorized under the Federal award. The start and end dates of the period of performance must be included in the Federal award.

**Period of Performance Outcome:** An outcome that will occur by the end of the NOFO’s funding period

**Plain Writing Act of 2010:** The Plain Writing Act of 2010 requires that federal agencies use clear communication that the public can understand and use. NOFOs must be written in clear, consistent language so that any reader can understand expectations and intended outcomes of the funded program. CDC programs should use NOFO plain writing tips when writing NOFOs.

**Program Strategies:** Strategies are groupings of related activities, usually expressed as general headers (e.g., Partnerships, Assessment, Policy) or as brief statements (e.g., Form partnerships, Conduct assessments, Formulate policies).

**Program Official:** Person responsible for developing the NOFO; can be either a project officer, program manager, branch chief, division leader, policy official, center leader, or similar staff member.

**Public Health Accreditation Board (PHAB):** A nonprofit organization that works to promote and protect the health of the public by advancing the quality and performance of public health departments in the U.S. through national public health department accreditation [http://www.phaboard.org](http://www.phaboard.org).

**Social Determinants of Health:** Conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

**Statute:** An act of the legislature; a particular law enacted and established by the will of the legislative department of government, expressed with the requisite formalities. In foreign or civil law any particular municipal law or usage, though resting for its authority on judicial decisions, or the practice of nations.

**Statutory Authority:** Authority provided by legal statute that establishes a federal financial assistance program or award.

**System for Award Management (SAM):** The primary vendor database for the U.S. federal government. SAM validates applicant information and electronically shares secure and
encrypted data with federal agencies' finance offices to facilitate paperless payments through Electronic Funds Transfer (EFT). SAM stores organizational information, allowing www.grants.gov to verify identity and pre-fill organizational information on grant applications.

**Technical Assistance:** Advice, assistance, or training pertaining to program development, implementation, maintenance, or evaluation that is provided by the funding agency.

**Work Plan:** The summary of period of performance outcomes, strategies and activities, personnel and/or partners who will complete the activities, and the timeline for completion. The work plan will outline the details of all necessary activities that will be supported through the approved budget.

### NOFO-specific Glossary and Acronyms

- **CDC SAMS:** CDC’s Secure Access Management System to exchange and share data with partners.
- **DC:** Death certificate
- **DDPI:** Data Driven Prevention Initiative is a CDC-funded initiative (CDC-RFA-CE16-1606) to improve data collection and analysis around opioid misuse, abuse, and overdose. Activities include increasing states’ abilities to: improve data collection and analysis around opioid misuse, abuse, and overdose; develop strategies that impact behaviors driving prescription opioid dependence and abuse; and work with communities to develop more comprehensive opioid overdose prevention programs.
- **ED:** Emergency department
- **EMS:** Emergency medical services
- **ESOOS:** Enhanced State Surveillance of Opioid - Involved Morbidity and Mortality (CDC-RFA-CE16-1608) is a CDC-funded initiative to provide more timely and comprehensive data on fatal and nonfatal opioid overdoses and risk factors associated with fatal overdoses.
- **ESSENCE:** The Electronic Surveillance System for the Early Notification of Community-Based Epidemics captures and analyzes public health indicators for early detection of disease outbreaks. This system is currently used to analyze data in CDC’s National Syndromic Surveillance Program, [https://www.cdc.gov/nssp/overview.html](https://www.cdc.gov/nssp/overview.html).
- **ICD-10:** International Statistical Classification of Diseases and Related Health Problems 10th Revision
- **ICD-10-CM:** International Classification of Diseases, Tenth Revision, Clinical Modification
- **MAT:** Medication-assisted treatment
- **ME/C:** Medical examiner or coroner
- **NSSP:** The National Syndromic Surveillance Program is collaboration among public health agencies for timely exchange of syndromic data to improve the nation’s situational awareness, and responsiveness to hazardous events and disease outbreaks, [https://www.cdc.gov/nssp/](https://www.cdc.gov/nssp/).
- **NVDRS:** National Violent Death Reporting System (CDC-RFA-CE18-1804) collects and disseminates surveillance data collected from death certificates, ME/C reports, and law enforcement reports on homicides, suicides, undetermined intent deaths, and
unintentional firearm deaths to improve the planning, implementation, and evaluation of violence prevention programs.

- PDMP: Prescription Drug Monitoring Program
- PfS: Prevention for States is a CDC-funded program (CDC-RFA-CE15-1501) that helps states combat the ongoing prescription drug overdose epidemic. The purpose of Prevention for States is to provide state health departments with resources and support needed to advance interventions for preventing prescription drug overdoses.
- SSP: Syringe services program
- SUDORS: The State Unintentional Drug Overdose Reporting System (CDC-RFA-CE16-1608) is a CDC-funded initiative to increase the timeliness and comprehensiveness of fatal opioid overdose reporting by abstracting critical information from DC and ME/C reports including toxicology findings, route of administration, prior overdose and other risk factors that may be associated with a fatal overdose. This NOFO supports data collected in SUDORS.
- UUDO: Unintentional or undetermined intent drug overdose.