



Centers for Disease Control and Prevention

National Center for Injury Prevention and Control

Enhanced State Surveillance of Opioid-Involved Morbidity and Mortality

CDC-RFA-CE16-1608

Application Due Date: 06/27/2016

Enhanced State Surveillance of Opioid-Involved Morbidity and Mortality

CDC-RFA-CE16-1608

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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-CE16-1608. 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. Funding Opportunity Title:

Enhanced State Surveillance of Opioid-Involved Morbidity and Mortality

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 Research for this purpose is defined at <http://www.cdc.gov/od/science/integrity/docs/cdc-policy-distinguishing-public-health-research-nonresearch.pdf>.

New - Type 1

D. Agency Funding Opportunity Number:

CDC-RFA-CE16-1608

E. Catalog of Federal Domestic Assistance (CFDA) Number:

93.136

F. Dates:

1. Due Date for Letter of Intent (LOI): 05/13/2016

2. Due Date for Applications: 06/27/2016, 11:59 p.m. U.S. Eastern Standard Time, at www.grants.gov.

3. Date for Informational Conference Call:

The informational conference call will be held on May 11, 2016 at 2:00 p.m. to understand the conceptual context of this Funding Opportunity Announcement (FOA). The conference call can be accessed at (770) 488-3600 or (855) 644-0229; conference ID: 5740377.

G. Executive Summary:

1. Summary Paragraph:

This 3-year FOA supports states with a high burden of drug overdoses to quickly improve the timeliness of fatal and nonfatal opioid overdose surveillance, including overdoses related to opioid pain relievers and heroin. Also, improvements in risk factor reporting for fatal opioid overdoses are funded. Improvements should inform state and local interventions in areas of greatest need. Applicants must undertake 3 strategies:

1. *Increase the timeliness of aggregate nonfatal opioid overdose reporting.* Produce state and county quarterly reports on emergency department (ED) visits and/or emergency medical services (EMS) responses to suspected overdoses involving any-drug, any-opioid, and/or heroin within 3 months of the overdose.
2. *Increase the timeliness of fatal opioid overdose and associated risk factor reporting.* Abstract standardized case-level data from medical examiner/coroner (ME/C) and death certificate (DC) reports on fatal opioid overdoses within 8 months of death using a CDC web-based data entry platform. Data should be extracted on either: a) all opioid deaths in the state OR b) all opioid deaths in a subset of

counties whose residents account for a minimum of 75% of unintentional or undetermined drug overdose deaths in the state or 1,500 deaths in 2014.

3. *Disseminate surveillance findings to key stakeholders working to prevent or respond to opioid overdoses.*

Data will be shared with CDC and combined into multi-state database to support broader surveillance.

a. Eligible Applicants:	Limited
b. FOA Type:	Cooperative Agreement
c. Approximate Number of Awards:	11
d. Total Project Period Funding:	\$11,550,000
e. Average One Year Award Amount:	\$335,000
f. Total Project Period Length:	3
g. Estimated Award Date:	09/01/2016
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 FOA exists, leveraging other resources and related ongoing efforts to promote sustainability is strongly encouraged.

Part II. Full Text

A. Funding Opportunity Description

1. Background

a. Overview

In the US, opioid overdose deaths have quadrupled since 1999, with 28,647 fatalities in 2014. Research indicates two distinct but interrelated trends: a fifteen-year increase in overdose deaths involving opioid pain relievers (OPRs) and a recent surge in heroin overdose deaths. The surge in heroin deaths is linked to OPR misuse: four-out-of-five people initiating heroin report prior misuse of OPRs. Sharp increases of 26% and 9% in heroin and natural/semi-synthetic opioid overdose, respectively, from 2013 to 2014 highlight the need for timely data to monitor rapid changes in the types of opioids involved in overdose deaths. For example, the supply of illicitly-made fentanyl (IMF) surged swiftly across multiple states from 2013 to 2014, contributing to rapid increases in deaths involving fentanyl. Time lags from current surveillance systems often exceed a year, limiting public health's ability to respond. Also, local data on overdose rates and risk factors are needed to respond to opioid overdoses for the following reasons: 1) opioid overdose rates vary across states and counties and 2) risk factors for opioid deaths vary across communities.

The goal of the FOA is to assist states with high or rapidly increasing drug overdose death rates to improve the timeliness of fatal and nonfatal opioid overdose surveillance. Improvements in reporting of risk factors for fatal opioid overdose are also funded. Awardees are expected to share surveillance data with CDC to support multi-state surveillance.

Specifically, applicants are asked to:

1. *Increase the timeliness of aggregate nonfatal opioid overdose reporting.* Produce aggregate state and county quarterly reports on at least two of the following three indicators: suspected any-drug, any-opioid (e.g., OPR or heroin) and/or heroin overdose occurring from October 2016 to May 2019 within three months of the overdose. States should leverage existing ED and/or EMS data systems to

track nonfatal opioid overdoses. Because states may be unable to rapidly collect data on all ED or EMS visits, applicants are required to track nonfatal opioid overdoses on a minimum of 50% of ED visits and/or EMS transports by September 2016.

2. *Increase the timeliness of fatal opioid overdose and associated risk factor reporting.* Abstract standardized case-level data from DC and ME/C reports on fatal opioid overdoses within 8 months of death using the National Violent Death Reporting (NVDRS) web-based data entry system. States need not currently be funded by CDC funding to collect violent deaths using the NVDRS web-based data entry system (*See CDC-RFA-CE14-1402*) to complete this requirement. Access to the system will be provided to all awardees during the first year of funding. Data should be extracted on either: a) all opioid deaths in the state OR b) all opioid deaths in a subset of counties (i.e., collect data on overdose deaths in 15 of 20 counties) in the applicant's state whose residents accounted for a minimum of 75% of the unintentional or undetermined drug overdose deaths in 2014 or 1,500 deaths in 2014.
3. *Disseminate surveillance findings to key stakeholders working to prevent or respond to opioid overdoses.* Awardees will create and implement a dissemination plan that outlines multiple strategies for sharing surveillance findings with key stakeholders.

Enhanced surveillance will assist key stakeholders in improving prevention and response efforts by providing more timely data on fatal and nonfatal opioid overdoses and more in-depth information on risk factors that can be targeted for intervention.

b. Statutory Authorities

392(a)(1) and 392(b)(3) of the Public Health Service Act [42 USC 280b-1(a)(1) and 280b-1(b)(3)], as amended.

c. Healthy People 2020

This FOA supports [Healthy People 2020 objective SA-12](#): reduce drug-induced deaths.

d. Other National Public Health Priorities and Strategies

This FOA supports the following national public health priorities and strategies:

- HHS Secretary's Opioid Initiative. <https://aspe.hhs.gov/opioid-abuse-us-and-hhs-actions-address-opioid-drug-related-overdoses-and-deaths>
- The National Prevention Strategy (NPS), especially the NPS priority of Preventing Drug Abuse and Excessive Alcohol Use, which includes a recommendation to reduce inappropriate access to and use of prescription drugs. <http://www.surgeongeneral.gov/priorities/prevention/strategy/preventing-drug-abuse-excessive-alcohol-use.html>
- National Heroin Task Force: Final Report and Recommendations (Release pending)
- CDC Injury Center Research Priorities, especially the recommendation to identify risk and protective factors related to the co-use of opioid pain relievers and heroin. <http://www.cdc.gov/injury/pdfs/researchpriorities/cdc-injury-research-priorities.pdf>

e. Relevant Work

This FOA is a new surveillance initiative to support states confronted with a high drug overdose burden to improve surveillance of opioid-involved morbidity and mortality. This FOA builds on ongoing surveillance of violent deaths by NVDRS (*CDC-RFA-CE14-1402*) and syndromic surveillance of emergency department visits supported by *The National Syndromic Surveillance Program: Enhancing Syndromic Surveillance Capacity and Practice* (*CDC-RFA-OE15-1502*). Surveillance data will support ongoing prevention of prescription drug misuse, abuse, and overdose funded by *Prescription Drug Overdose Prevention for States* (*CDC-RFA-CE15-1501*).

2. CDC Project Description

a. Approach

Bold indicates project period outcome.

CDC-RFA-CE16-1608 Logic Model: Enhanced State Surveillance of Opioid-involved Morbidity and Mortality		
Strategies and Activities	Short-Mid Term Outcomes (1-3 years)	Long-Term Outcomes
<p>Strategy 1: Increase the timeliness of aggregate nonfatal opioid overdose reporting</p> <ul style="list-style-type: none"> • Select indicators and data sources (EMS and/or ED) <ul style="list-style-type: none"> - Track 2 of the following 3 indicators: suspected any-drug, any-opioid, and/or heroin overdoses - Selected data source must cover at least 50% of ED visits and/or EMS transports occurring in the state/jurisdiction by September 2016 • Create, validate, and monitor quality of indicator case definitions • Produce state and county aggregate quarterly reports for selected indicators 	<p>Awardee must:</p> <ul style="list-style-type: none"> • Generate reports on more rapid, reliable and geographically-specific changes in the rate of nonfatal opioid-involved overdoses • Share state and county aggregate quarterly reports with CDC on an ongoing basis for aggregation and analysis • Share case definitions and methodology that can be used by CDC to develop surveillance tools <p>Awardee's key stakeholders receiving timely information about trends in nonfatal opioid overdoses that is geographically-specific to assist in prevention planning</p> <p>Awardee data enables CDC to:</p> <ul style="list-style-type: none"> • Create and analyze an aggregate multi-state database tracking quarterly changes in nonfatal opioid overdose to inform national stakeholders • Improve guidance to states on nonfatal opioid overdose surveillance based on awardees' experiences 	<p>Awardee stakeholders:</p> <ul style="list-style-type: none"> • Respond more quickly to changes in nonfatal and fatal opioid overdoses • Implement more effective interventions by using enhanced surveillance data to design, target, and monitor interventions <p>National stakeholders:</p> <ul style="list-style-type: none"> • Respond more quickly to changes in fatal and nonfatal opioid overdoses • Implement more effective

<p>occurring from October 2016 to May 2019 within 3 months of the overdose date. States are encouraged to share and collaboratively analyze case level EMS/ED data with CDC, but this is not required.</p>			<p>interventions by using enhanced surveillance data to design, target, implement and monitor interventions</p>
<p>Strategy 2: Increase the timeliness of fatal opioid overdose and associated risk factor reporting</p> <ul style="list-style-type: none"> • Select target area where data on opioid overdose deaths will be collected • Collect and abstract data on opioid overdose deaths within 8 months of the date of death from July 2016 to December 2018 from DC and ME/C reports using a CDC web-based data entry program and coding standards • Analyze data • Build strong relationships with ME/C and vital statistics offices 	<p>Awardee must:</p> <ul style="list-style-type: none"> • Generate timely reports on deaths involving opioids • Generate timely reports that identify and track key risk factors contributing to opioid overdose deaths at the state and local level • Share timely standardized de-identified case level data with CDC through a web-based data entry program 	<p>Awardee’s key stakeholders receiving timely data on fatal opioid overdoses and risk factors to assist in targeted prevention planning</p> <p>Awardee data enables CDC to:</p> <ul style="list-style-type: none"> • Create and analyze a case level multi-state database describing opioid overdose deaths every 8 months to inform national stakeholders • Improve the web-based data entry program based on awardees’ experiences 	<p>Unfunded states increase timeliness of surveillance of nonfatal and fatal opioid overdoses</p> <p>Reduced morbidity and mortality associated with overdoses involving opioids</p>

<p>Strategy 3: Disseminate surveillance findings to key stakeholders working to prevent or respond to opioid overdoses</p> <ul style="list-style-type: none"> • Create a dissemination plan by the end of Year 1 • Build or strengthen relationships with key stakeholders • Implement dissemination strategies most suited to the needs of the state and its key stakeholders 	<p>Awardee must:</p> <ul style="list-style-type: none"> • Develop and implement an effective dissemination plan that identifies multiple approaches for sharing surveillance findings • Share success stories with CDC on a yearly basis 	<p>CDC broadly disseminates success stories</p>	
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Bold are outcomes to be achieved during funding period

i. Purpose

This FOA seeks to enhance local surveillance of opioid overdoses in states experiencing high or rapidly increasing rates of drug overdose deaths. The FOA will fund states to: 1) increase the timeliness of aggregate nonfatal opioid overdose reporting, 2) increase the timeliness of fatal opioid overdose and associated risk factor reporting, and 3) disseminate surveillance findings to key stakeholders working to prevent opioid overdoses. Awardee data will be aggregated into a multi-state database by CDC to contribute to multi-state or regional surveillance efforts.

ii. Outcomes

As displayed in the logic model, the two key outcomes of the FOA are:

1. Awardee’s key stakeholders receiving timely information about trends in nonfatal opioid overdoses that is geographically-specific to assist in prevention planning.
2. Awardee’s key stakeholders receiving timely data on fatal opioid overdoses and risk factors to assist in targeted prevention planning.

Key stakeholders include two key groups: 1) individuals, partners, or organizations working to prevent or respond to opioid-involved overdoses in the awardee’s state and 2) the public. To effectively design, target, and monitor interventions, key stakeholders need timely access to data on substantial changes in fatal and nonfatal opioid-involved overdose trends and insight into key risk factors driving opioid-involved overdoses in their communities (e.g., illicitly made fentanyl introduced in their community, a sharp increase in overdoses among people recently released from incarceration, or a sharp increase of heroin use in a certain demographic group). Ultimately, more rapid response to changes in opioid-involved overdoses coupled with more effective prevention programs are expected over time to reduce nonfatal and fatal opioid overdoses over time.

By sharing data with CDC, awardee's activities will also support substantial improvements in national surveillance of fatal and nonfatal opioid overdoses. Specifically, CDC will combine awardee data into multi-state databases of nonfatal and fatal opioid overdoses. CDC's analysis of these data will assist national stakeholders to respond more quickly to changes in nonfatal and fatal opioid overdoses as well as identify and respond to key risk factors for fatal opioid overdose. Finally, awardee's surveillance activities will support improvements in CDC guidance on surveillance of nonfatal and fatal opioid overdoses. This in turn should help support improved surveillance in unfunded states.

iii. Strategies and Activities

This FOA asks applicants to implement three key strategies that are designed to improve the timeliness of nonfatal and fatal opioid overdose reporting and reporting of key risk factors related to fatal opioid overdose.

1. Increase the timeliness of aggregate nonfatal opioid overdose reporting
2. Increase the timeliness of fatal opioid overdose and associated risk factor reporting
3. Disseminate surveillance findings to key stakeholders working to prevent or respond to opioid overdoses

Strategy 1: Increase the timeliness of aggregate nonfatal opioid overdose reporting

Applicants are funded to leverage data already being collected on ED visits and/or EMS transports on an ongoing basis to (a) rapidly identify changes in nonfatal overdoses involving any-drug, any-opioid and/or heroin, and (b) to identify areas within a particular state that are experiencing these changes. Rapid surveillance of nonfatal opioid-involved overdoses can act as an early warning system to quickly identify increases or decreases in overdoses. Because these systems often rely on preliminary data that is not specifically coded for drug or opioid-involved overdoses (e.g., opioid-involved overdoses are identified by searching ED chief complaint text data), the surveillance systems are expected to have moderate sensitivity (i.e., percent of real opioid-involved overdose cases identified by the surveillance system) and specificity (i.e., cases incorrectly identified by the surveillance system as a opioid-involved overdose).

Applicants are asked to:

- Select indicators and data sources (EMS and/or ED) that will be used to conduct rapid surveillance.
- Create, validate, and monitor quality of indicator case definitions.
- Produce two aggregate reports on a quarterly basis. Both aggregate reports are described in detail in *Activity 1.3*.
 1. A county-level report that lists the number/rate of suspected any-drug, any-opioid and/or heroin overdoses occurring from October 2016 to May 2019 within three months of the overdose date.
 2. A state report that lists the number/rate of suspected any-drug, any-opioid, and/or heroin overdoses occurring from October 2016 to May 2019 within three months of the overdose date by sex, age, and race/ethnicity (if available).
- Share methodology for calculating indicators and aggregate quarterly reports with CDC.

In addition to developing and analyzing the required indicators, FOA funding can be used to implement general improvements in the applicant's existing ED and EMS surveillance systems (e.g., increase hospital participation or submission of ICD-10-CM codes) as long as these enhancements support improving the timeliness or quality of surveillance of nonfatal opioid-involved overdoses. If an applicant is already conducting rapid surveillance of nonfatal opioid-involved overdoses using ED and/or EMS data, funding may be used to improve the coding, tracking, and/or dissemination of results.

Activity 1.1: *Select indicators and data sources (ED and/or EMS) that will be used to conduct rapid surveillance*

Select indicators: Applicants will track *at least* two of the three opioid-involved overdose indicators (listed

below) using ED visits and/or EMS transport data.

1. *Suspected drug overdoses*: Because a substantial percent of drug overdoses involve opioids, and since preliminary data may have limited ability to detect overdoses related to a specific type of drug, this measure is used as a proxy for opioid-involved overdoses.
2. *Suspected overdoses involving any opioid, including OPRs, heroin, or illicitly made fentanyl*: In early ED and EMS reports, it may be difficult to determine whether an opioid overdose was related to OPRs or heroin (e.g., naloxone was administered, and patient responded, but the type of opioid was not known).
3. *Suspected overdoses involving heroin*: Some data sources may be able to track heroin overdoses to the extent needed to detect substantial changes.

Applicants should clearly indicate in their application the two indicators they plan to track in response to this FOA. If feasible, applicants are encouraged to track all three indicators and additional opioid-involved indicators (e.g. OPRs, heroin withdrawal, or injection drug use with opioids).

Applicants are not required to use standard CDC case definitions to track the above indicators because rapidly available data (i.e. data available for analysis within weeks or months) do not often contain detailed information on drug overdoses, collect text information on health conditions instead of coded variables such as ICD-10-CM codes, and infrequently includes toxicology results. Consequently, ED case identification often relies on text searches of ED chief complaint, clinical impressions, and/or triage notes. Similarly, EMS cases identification may rely on text searches of EMS chief and secondary complaints, medication administered (e.g., naloxone), and transport narratives. These approaches will need to be customized to account for local variation in text entry conventions and quality.

Where ED and EMS diagnoses are coded using the International Classification of Diseases (ICD-10-CM currently), applicant case definitions should be guided by published coding schemes for overdoses involving any-drug, any-opioid, and heroin overdoses outlined in the *Consensus Recommendations for National and State Poisoning Surveillance* (See pp.22-23 and Appendix C1: Poisoning Matrix for ICD9CM Coded Morbidity Data in the Consensus Recommendations for National and State Poisoning Surveillance <http://cymcdn.com/sites/www.cste.org/resource/resmgr/injury/isw7.pdf>). Because ICD-10-CM was broadly implemented in US emergency departments in Fall 2015 and replaced the ICD-9-CM coding scheme, draft drug overdose ICD-10-CM coding definitions based on previous ICD-9-CM coding will be provided to awardees in Fall 2016 and revised in collaboration with them. Also, CDC tools with example cases definitions will be released in Fall 2016 to assist awardees revise and validate proposed case definitions (See *Create, validate, and monitor quality of indicator case definitions* under Activity 1.2). These cases definitions will be revised in consultation with awardees during the first six months of this FOA and on an as needed basis to capture changes in the availability, production, categorization, or use of opioids.

Select data sources: Because the quality and availability of ED and EMS data currently collected by applicants vary, applicants are provided flexibility to track indicators using either ED and/or EMS data. All examples below will be considered responsive to the FOA:

- *Choose a single data source (ED or EMS) to measure both indicators*: The applicant proposes to track both suspected any-drug and opioid-involved overdoses using syndromic ED data OR the applicant proposes to track both suspected opioid and heroin-involved overdoses using EMS data.
- *Choose ED data to measure one indicator and EMS data to measure another indicator*: The applicant proposes to measure suspected any-drug overdose using ED data and suspected opioid-involved overdoses using EMS data.
- *Use linked ED and EMS data to measure indicators*: The applicant has linked ED and EMS data (i.e., an EMS transport is linked to the related ED visit) and is using this linked dataset to track both suspected opioid and heroin-involved overdoses.

Applicants are expected to leverage existing ED or EMS data systems (e.g., the applicant is already

collecting ED and EMS data on an ongoing basis) to conduct surveillance of nonfatal opioid-involved overdoses. FOA funding is insufficient to establish completely new ED or EMS data collection efforts and meet the FOA reporting requirements. Consequently, once applicants choose whether to use ED and/or EMS data to track indicators, applicants must demonstrate their ability to:

- Quickly gain access to the selected data source(s) at the beginning of the funding period. If the applicant is currently using the data source to track opioid-involved overdoses, the scope of the current activities should be described.
- If an applicant's selected indicators use ED data, the applicant must collect data on a minimum of 50% of ED visits occurring in their state by September 2016. Applicants should list in the application the percentage of all ED visits in the state collected by their surveillance system (e.g., current ED syndromic surveillance captures 75% of all ED visits in the state). When calculating this percentage, applicants have the option to include or exclude ED visits to veteran's hospitals because this information may be collected outside of state ED surveillance systems.
- If an applicant's selected indicators use EMS data, the applicant must collect data on a minimum of 50% of EMS transports in their state by September 2016. Applicants should list in the application the percentage of all EMS transports in the state collected by their surveillance system (e.g., EMS surveillance captures 75% of all EMS transports in the state).

Activity 1.2 *Create, validate, and monitor quality of indicator case definitions*

Once the applicant has identified the data sources and indicators to track, the applicant needs to outline the approach used to create and validate the case definitions for each indicator. Because the data being analyzed are preliminary and rapidly acquired, moderate specificity and sensitivity are expected. Analyses should focus on the extent to which the data are a useful tool to inform public health responses. Specifically, validation efforts should focus on the extent to which the case definition predicts sharp changes in overdoses involving any-drug, any-opioid, and heroin at the state, county, and municipal level. Also, validation efforts should identify strategies for reducing false positives and negatives.

Specifically, the applicant is required to outline:

- The variables to be included in each case definition (e.g., ED chief complaint will be used to identify suspected overdoses involving any drug) and a general description of how the variables will be coded (e.g., ED chief complaint text will be searched for phrases indicating opioid-involved overdose).
 - If the applicant has already implemented case definitions related to any-drug, any-opioid, or heroin overdoses, the current case definition and any proposed improvements should be briefly described.
- Strategies to validate and revise the case definition. Validation is expected to be ongoing during the first two years of the project and should not delay the production of quarterly reports outlined below. Validation could include: analyzing the ICD-10-CM codes from identified cases in a subset of hospitals that submit text information and ICD-10-CM codes; comparing historical trends generated using case definitions with trends recorded in other data sources, such as ED discharge files; assessing the ability of case definitions to identify past drug overdose outbreaks; and comparing results of different types of word searches.
 - To facilitate validation efforts, applicants are strongly encouraged to calculate indicator trends from 2014 to present.
 - Extensive validation studies such as record review are not required by this FOA.
- Lessons learned from the selected data source(s), ED or EMS, to rapidly track public health issues, including infectious disease outbreaks, if available.
 - If the applicant has already implemented overdose case definitions involving any-drug,

any-opioid, and heroin, lessons learned about the strengths and limitations of each indicator should be addressed.

- How rates will be calculated including a description of the denominator, such as percent of all ED or EMS visits or rate per 100,000 residents.
 - Describe methods to monitor and account for changes in the number of hospitals and EMS agencies participating in the surveillance system over time (e.g., only include data from hospitals that consistently provide data over time or report percentages of ED or EMS visits).
- A brief plan for how data will be analyzed to detect rapid changes in indicators over time.

Activity 1.3: *Produce state and county aggregate quarterly reports on at least two of the following three indicators: suspected any-drug, any-opioid and/or heroin overdose occurring from October 2016 to May 2019 within 3 months of the overdose date.*

A key expectation of this FOA is that awardees will implement more rapid, reliable, and geographically-specific identification of changes in the number and rate of nonfatal opioid-involved overdoses in their state. A key step in establishing this type of surveillance system is instituting ongoing data collection and reporting.

The applicant will be required to produce quarterly state and county indicator reports on an ongoing basis from April 15, 2017 until August 31, 2019. CDC will provide a template report and a brief overview of each report is provided below.

- In the state report, awardees will be asked to provide the number and rate of any-drug, any-opioid, and/or heroin overdoses for the most recent three-month period available by the following demographic information: sex, age, and race/ethnicity (if available). The data used in the reports should have a time lag of < 3 months. For example, April 2017’s report should include data no older than October 2016 to December 2016. Statistically significant quarterly changes should be highlighted. All available ED and/or EMS data should be used when calculating the demographic rates for each indicator.
- In the county report, awardees will report the number and rate of any-drug, any-opioid, and/or heroin overdoses occurring for each county with data for the most recent three-month period available. The data used in the reports should have a time lag of < 3 months. For example, April 2017’s report should include data no older than October 2016 to December 2016. Statistically significant quarterly changes should be highlighted.

The dates that quarterly reports should be completed are provided below.

Date Quarterly Report Completed	Dates of Overdoses Included in the Report to Meet Minimum Reporting Requirements
April 15, 2017	October 2016 to December 2016
July 15, 2017	January 2017 to March 2017
October 15, 2017	April 2017 to June 2017
January 15, 2018	July 2017 to September 2017
April 15, 2018	October 2017 to December 2017
July 15, 2018	January 2018 to March 2018
October 15, 2018	April 2018 to June 2018

January 15, 2019	July 2018 to September 2018
April 15, 2019	October 2018 to December 2018
August 31, 2019	April to May, 2019*

*Report only includes two months due to funding ending in September 2019

After the quarterly reports are validated by the awardee, the quarterly report provided to CDC may be shared with other awardees, other health agencies, or partners and may be published on the DUIP web site, or in scientific or health professional journals. Data suppression rules will be used to prevent possible identification through publication of tables combining characteristics that could be used to identify an individual (e.g., age, sex, race, ethnicity, and geographic location).

Preferred applicants will:

- Collaboratively work with CDC to improve the timeliness of aggregate reports (e.g., biweekly or monthly instead of quarterly), enhance text searching algorithms (e.g., work with CDC to test different overdose search algorithms), and methodology for tracking selecting indicators. The collaboration will involve secure sharing of case-level ED and/or EMS data negotiated between CDC and the awardee for the sole purpose of working on enhancing the timely tracking of non-fatal drug and opioid overdoses. Reports resulting from this work will always be presented at the aggregate, will never contain any individually identifiable information, and will be done in consultation with the awardee. In order to compensate awardees for costs associated with case-level data sharing and analysis with CDC, applicants who commit to sharing case-level ED and/or EMS data in their application should budget an additional \$10,000 (See ***Funding Strategy for details***).
1. Awardees who use syndromic ED data to track indicator(s) and participate in CDC’s National Syndromic Surveillance Program BioSense Platform (see <http://www.cdc.gov/nssp/biosense/>) may provide CDC limited access to their data through the BioSense platform only for the purposes and duration described in this FOA.
 2. Awardees using ED data not available through the BioSense Platform may negotiate with CDC other secure strategies for sharing case-level ED data.
 3. Awardees using EMS data can share downloads on relevant variables and cases.
- Track more than two indicators.
 - Use both ED and/or EMS data when tracking the indicators.

Activity 1.4: *Share methodology for calculating indicators and report quarterly aggregated data to CDC*

All awardees will be asked to:

- Share case definitions with CDC. CDC will synthesize cases definitions and broadly disseminate to state and local health departments to support improvements in awardee’s case definitions and facilitate implementation of rapid reporting on nonfatal opioid-involved overdoses among unfunded health departments.
- Share de-identified aggregated data in quarterly reports. CDC will combine quarterly reports into a multi-state database that will be used to rapidly track broad or localized changes in opioid-involved overdoses. This will facilitate CDC and stakeholders working across states to respond more quickly to changes in opioid-involved overdoses.

Strategy 2: Increase timeliness of fatal opioid overdose and associated risk factor reporting

This strategy asks applicants to integrate data from death certificates (DC) and medical examiner and coroner (ME/C) reports on all opioid-involved overdoses, including OPR and heroin, in a specified target area using the NVDRS web data-entry system (see http://www.cdc.gov/violenceprevention/pdf/nvdrs_web_codingmanual.pdf) and guidelines specified by CDC. Suicide and homicide deaths related to opioids are

excluded from the data collection because these deaths are collected by NVDRS (see *Collaborations with Other CDC Programs*). States need not currently be participating in the NVDRS funding program to complete this strategy. All awardees will be provided access to the NVDRS web-based data entry system in the first year of funding.

Approximately 175 data elements will be collected on each fatal drug overdose. While numerous data elements can be imported electronically including most of the required death certificate information, a large number of the data elements will need to be manually entered into the NVDRS web data-entry system and will require awardee's to manually review the ME/C and DC report for each death. Examples of data elements that require manual review and entry are: recent contact with public agencies (e.g., recent release from incarceration, recent arrest, or ongoing substance abuse treatment), results from toxicology tests, occurrence of a nonfatal overdose within a month of the fatal overdose, death scene evidence (e.g., presence of drug paraphernalia) and evidence of injection drug use (e.g., fresh track marks) (See Appendix 1 for full list of DC and ME/C variables at <http://www.cdc.gov/drugoverdose/foa/state-opioid-mm.html>).

This strategy involves four activities:

1. Select target area where data on all opioid-involved overdose deaths will be collected
2. Collect and abstract data on opioid-involved overdose deaths within 8 months of the date of death from July 2016 to December 2018 from DC and ME/C reports using the NVDRS web-based data entry program and coding standards
3. Analyze data
4. Build strong relationships with ME/C and vital statistics office

Case definition for opioid-involved deaths: For this strategy, opioid-involved deaths are drug poisoning deaths where the ME/C report indicates that an opioid contributed to the death. Opioids are any drug contributing to death that would be captured by the following International *Classification of Disease, Tenth Revision* (ICD-10) classification coding scheme:

- ICD-10 underlying cause-of-death codes on the death certificate are X40–44 (unintentional) or Y10–Y14 (undetermined intent) AND any of the ICD-10 codes T40.0, T40.1, T40.2, T40.3, T40.4, or T40.6 are indicated in the multiple cause-of-death codes.

Because awardees are collecting data from DC and ME/C reports, examples of drug overdoses considered opioid-involved and not opioid-involved are provided below.

- Meets fatal opioid-involved overdose case definition
 - The ME/C report indicates that a pharmaceutical opioid (e.g., oxycodone) or heroin contributed to the death, but the DC multiple cause-of-death code does not list any of the following ICD-10 codes, T40.0, T40.1, T40.2, T40.3, T40.4, or T40.6, in the multiple cause-of-death codes.
 - The ME/C report does not indicate that a pharmaceutical opioid (e.g., oxycodone) or heroin contributed to the death, but the ICD-10 underlying cause of death code on the DC is one of the following, X40–44 (unintentional) or Y10–Y14 (undetermined intent) AND any of the following ICD-10 codes, T40.0, T40.1, T40.2, T40.3, T40.4, or T40.6, are indicated in the DC multiple cause-of-death codes.
 - The ME/C report indicates that a pharmaceutical opioid (e.g., oxycodone) or heroin contributed to the death AND the ICD-10 underlying cause of death code on the DC is one of the following, X40–44 (unintentional) or Y10–Y14 (undetermined intent) AND any of the following ICD-10 codes, T40.0, T40.1, T40.2, T40.3, T40.4, or T40.6, are indicated in the DC multiple cause-of-death codes.
- Does not meet the fatal opioid-involved overdose case definition

- The ME/C report indicates that a pharmaceutical opioid (e.g., oxycodone) or heroin was detected by toxicology but did not contribute to the death AND the DC multiple cause-of-death code does not list any of the following ICD-10 codes, T40.0, T40.1, T40.2, T40.3, T40.4, or T40.6, in the multiple cause-of-death codes.

Activity 2.1: *Select target area where data on opioid-involved overdose deaths will be collected*

Applicants have two options for targeting data collection efforts. Both options are considered to be responsive to the FOA.

- **Option 1:** Applicants can choose to collect data on all opioid-involved overdose deaths occurring from July 1, 2016 to December 31, 2018 in their state.
- **Option 2:** Applicants can choose to collect data on all opioid-involved overdose deaths occurring from July 1, 2016 to December 31, 2018 in either: (a) a subset of counties in their state if these counties' residents accounted for a minimum of 75% of the unintentional and undetermined drug overdose (UUDO) deaths that occurred in 2014, **OR** (b) a subset of counties if these counties' residents accounted for $\geq 1,500$ UUDO deaths in 2014. For instance, one applicant may decide to collect information on opioid-involved deaths in 15 of its 20 counties. This choice would meet the requirements of this FOA if residents in those 15 counties accounted for more than 75% of UUDO deaths in the state in 2014 or summed to $\geq 1,500$ deaths in 2014. For the purposes of this option:
 1. UUDO overdose deaths are used as a proxy for fatal overdoses involving opioids. Rates of opioid-involved overdose deaths cannot be compared across states because the specific drug(s) causing a fatal drug overdose were not specified in about 1 in 5 drug overdoses in 2014, and this rate varied substantially across states. Also, opioid-involved overdoses accounted for $>60\%$ of drug overdoses in 2014, and this was an underestimate due to lack of specific drug overdose information on 1 in 5 drug overdoses.
 2. Applicants selecting this option should reduce the budget to reflect the choice to collect data on a subset of unintentional and undetermined overdose deaths using the formula listed in Appendix 2 at <http://www.cdc.gov/drugoverdose/foa/state-opioid-mm.html>.
 3. Death data from CDC's *Wonder: Multiple Cause of Death* file (<http://wonder.cdc.gov/mcd-icd10.html>) should be used to calculate the number and percentage of UUDO deaths that occurred in 2014 in the applicant's target area. UUDO deaths are defined as deaths with any of the following ICD-10 codes listed for the underlying cause-of-death on the death certificate: X40–44 (unintentional) or Y10–Y14 (undetermined intent). UUDO deaths by state in 2014 are listed in Appendix 3 at <http://www.cdc.gov/drugoverdose/foa/state-opioid-mm.html>.

Activity 2.2: *Collect and abstract data on opioid-involved overdose deaths within 8 months of the date of death from July 2016 to December 2018 from DC and ME/C reports using a CDC web-based data entry program and coding standards.*

All applicants are asked to:

- Design a process to request and abstract data on opioid-involved overdose deaths in the target area from two required data sources: DC and ME/C reports, including toxicology.
 1. If an applicant is already funded to collect undetermined deaths through the *National Violent Death Reporting System* (NVDRS) [CDC-RFA-CE14-1402], funds from this FOA should be used to abstract information on overdose-specific variables for undetermined deaths.
 2. If an applicant is not funded to collect undetermined deaths through the *National Violent Death Reporting System* (NVDRS) [CDC-RFA-CE14-1402], funds from this FOA should be used to abstract information on all variables for undetermined deaths.
- Abstract and/or import requested data on standardized variables into the NVDRS web-based data entry system and follow CDC standard abstraction guidelines (NVDRS coding manual is available at:

http://www.cdc.gov/violenceprevention/nvdrs/coding_manual.html and a list of drug specific variables is available in Appendix 1 at <http://www.cdc.gov/drugoverdose/foa/state-opioid-mm.html>). States currently do not need to be participating in the NVDRS funded program to complete this activity. All awardees will be provided access to the NVDRS web-based data entry system during the first year of funding.

1. Example of key information abstracted from ME/C reports include:

- Full toxicology findings that can be used to track polysubstance abuse or mixing of other drugs (e.g., fentanyl) with heroin.
- Identify opportunities for intervention by tracking decedent’s contacts with public institutions within a month before the overdose (e.g., left residential substance abuse treatment, released from incarceration, or prescribed an opioid pain reliever).
- Track the percent of decedents experiencing and receiving treatment for mental health and substance abuse disorders.

2. If funding becomes available to revise variables, applicants will be expected to provide suggestions and comments on revisions.

• Meet the following deadlines when abstracting data on opioid-involved overdose deaths

1. Enter **any information** (i.e., initiate the case) from DC or ME/C reports on all opioid-involved overdose deaths in the proposed targeted area within six months of the decedent’s death. A critical step in completing data abstraction is identifying opioid-involved overdose deaths with either ME/C or DC records. This provides time to request, collect, and abstract full information on deaths from both the ME/C and DC reports in a timely manner. Also, this information can be used to track preliminary trends in opioid-involved fatalities. Applicants are encouraged to initiate all cases within 4 months instead of 6 months, if possible.
2. Abstract and/or import **all available data** from the DC and ME/C reports on all opioid-involved overdose deaths occurring from **July 1, 2016 to December 31, 2018** in the proposed target area. This needs to be done within 8 months of the following calendar year, if the death occurred between July and December (e.g., August 31, 2017 for deaths occurring from July to December 2016), and by February 28th of the following calendar year if the death occurred between January to June (e.g., February 28, 2018 for deaths occurring from January to June 2017). Applicants are encouraged to complete data entry within 6 months instead of 8 months, if possible.
3. The table below lists the key dates that data entry should be initiated and completed for 6-month periods of fatal opioid-involved overdoses.

Date of Opioid-Involved Overdose Death	Data Entry on All Opioid-Involved Overdose Deaths Initiated	Data Entry on All Opioid-Involved Overdose Deaths Completed
July 1, 2016 to December 31, 2016	June 30, 2017	August 31, 2017
January 1, 2017 to June 30, 2017	December 31, 2017	February 28, 2018
July 1, 2017 to December 31, 2017	June 30, 2018	August 31, 2018

January 1, 2018 to June 30, 2018	December 31, 2018	February 28, 2019
July 1, 2018 to December 31, 2018	June 30, 2019	August 31, 2019

- Monitor and assess the data collection process and implement improvements based on findings. Efforts should be guided by CDC surveillance evaluation criteria (See <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5013a1.htm>).

Activity 2.3: Analyze data

The applicant is expected to analyze the collected data to support and inform prevention efforts by key stakeholders when responding to opioid-involved overdoses. Applicants should provide a brief yet concise plan for describing and analyzing the key demographics and risk factors associated with fatal overdoses involving opioids across counties during the funding period.

Activity 2.4: Build strong relationships with ME/C and vital statistics

Applicants are expected to build strong relationships with entities (ME/C and vital statistics) supplying data. To obtain information outlined above, applicants will need to establish data sharing agreements with vital statistics and local, regional and/or state ME/C agencies. Also, it is strongly encouraged that ME/C agencies or vital statistics receive funding from this FOA to support timely collection and quality improvement of ME/C reports, but this is not required.

Applicants must provide evidence of their ability and capacity to provide the required data within the requested time frame. Applicants in NVDRS-funded states may demonstrate capacity by reporting how quickly they request and complete abstraction of DC and ME/C information on violent deaths.

As part of this application, applicants are encouraged—but not required—to submit Letters of Support or Memorandums of Understanding/Agreement from a subset of data providers.

- In jurisdictions with a centralized ME/C systems, LOS OR MOU/MOA from the state ME/C office is encouraged.
- In jurisdictions with decentralized ME/C systems, LOS OR MOU/MOA from the ME/C office in cities and counties with a high drug overdose burden is encouraged.
- The process for acquiring death certificate data from the vital statistics office should be described in the application.

The current FOA uses the same web data-entry system as NVDRS. In states funded by NVDRS, applicants must submit a letter of support from their state’s Principal Investigator for the NVDRS project to ensure coordination that: (a) specifies support for the applicant improving the timeliness of fatal overdose and associated risk factor reporting at the county and state level (see *Strategies and Activities, Strategy 2*), and (b) indicates NVDRS staff agrees to manage the authorization process for new users to access the NVDRS web data-entry system.

Awardees not funded by NVDRS will be provided access to the NVDRS web-based data entry system at the beginning of the funding period.

Strategy 3: Disseminate surveillance findings to key stakeholders working to prevent or respond to opioid-involved overdoses

A key component of effective public health surveillance is the ability to move quickly from collecting data to meaningful action. After the applicant has enhanced surveillance reporting via Strategies 1 and 2, it is critical that actionable results be disseminated in a user-friendly format to key stakeholders, such as state and local governments (e.g., local health departments, first responders, law enforcement, city councils, or legislative committees) as well as non-governmental organizations and groups (e.g., people in recovery and their friends

and family, people who use illicit drugs, syringe service programs, lay naloxone providers, overdose prevention programs, drug treatment providers, organizations for safer opioid prescribing, or community based organizations). Dissemination activities include:

- Creating a short dissemination plan by the end of Year 1 funding. The dissemination plan should prioritize a few ways the surveillance data can be used to support public health action (e.g., enhance response to rapid increases in opioid-involved overdoses, improvements in targeted intervention programs, or identify and target interventions on prevalent risk factors) and discuss dissemination strategies to support these usages (e.g., distributing short reports, conducting presentations, developing data dashboards made available to local health departments and other key partners, providing quarterly reports to the state health department group supporting community naloxone programs). The dissemination plan should include at least two key evaluation indicators that will be used to track the success of the plan. These indicators need to be approved by CDC.
- Customizing the dissemination plan to meet the needs of key partners and maximize the public health use of the data.
 - Applicants should briefly describe key goals and strategies for data dissemination. Also, current and ongoing dissemination activities that the applicant plans to leverage should be described. These goals are expected to form the outline for the dissemination plan required from awardees.
- Using the dissemination plan, the awardee should work to build relationships with key partners who can use the data to respond and prevent opioid-involved overdoses. Dissemination plans and strategies are expected to be revised as the data needs of partners are better understood over time. Applicants should describe any key relationships that will be leveraged to disseminate data or are already being used to disseminate drug overdose surveillance data.
- Implementing dissemination strategies most suited to the needs of the state and its stakeholders.
 - The applicant should describe any other factors that will support data dissemination.

1. Collaborations

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

CDC funds a variety of drug overdose prevention activities and these efforts can inform, support, or coordinate with activities developed as part of this FOA.

Applicants are required to collaborate with the following activities, if they are occurring within their jurisdiction.

- **National Violent Death Reporting System (NVDRS) (CDC-RFA-CE14-1402):** Awardees collect and disseminate surveillance data from 2015 to 2019 on homicides, suicides, undetermined deaths, and unintentional firearm deaths to improve the planning, implementation, and evaluation of violence prevention programs. Awardees collect information from three sources: death certificates, ME/C reports, and law enforcement reports.
 1. The current FOA uses the same web data-entry system as NVDRS. In order to ensure effective coordination, **applicants in NVDRS-funded states** must submit a letter of support from their state's Principal Investigator for the NVDRS project that: (a) specifies support for the applicant improving timeliness of fatal overdose and associated risk factor reporting at the county and state level (*see Strategies and Activities, Strategy 2*), and (b) indicates NVDRS staff agrees to manage the authorization process for new users to access the NVDRS web data-entry system.
 2. NVDRS requests and abstracts information from the same data sources required in this FOA (i.e. death certificates and ME/C reports). Leveraging this expertise to efficiently establish rapid surveillance of opioid-involved deaths is strongly suggested.

3. Funds from this FOA should not be used to abstract or analyze data on suicides or homicides as these efforts are funded by NVDRS and fall outside the scope of this FOA. In NVDRS-funded states, funding from this FOA can be used to support unified requests for DC and ME/C records in order to increase efficiency and reduce burden on vital statistics and ME/C office staff.
4. Awardees not funded by NVDRS will be provided access to the NVDRS web data-entry system at the beginning of the funding period. These awardees will be expected to collaborate with NVDRS if NVDRS is funded in their state in the future.

- **Prescription Drug Overdose Prevention for States (CDC-RFA-CE15-1501):** The purpose of this funding is to advance and evaluate comprehensive state-level interventions for preventing prescription drug overuse, misuse, abuse, and overdose. Priority interventions address drivers of the prescription drug overdose epidemic, particularly the misuse and inappropriate prescribing of opioid pain relievers. Awardees are implementing prevention strategies to improve safe prescribing practices and prevent prescription drug overuse, misuse, abuse, and overdose. Improved and timely surveillance may be useful to inform prevention responses. Also, ongoing surveillance activities being conducted as part of this FOA should be coordinated with ongoing surveillance activities conducted as part of *Prescription Drug Overdose Prevention for States (PFS)*. In order to ensure coordination and encourage use of improved and timely surveillance data, applicants in PFS-funded states must submit a letter of support from their state's Principal Investigator for the PFS project that: (a) specifies support the applicant's effort to enhance surveillance for opioid-involved overdose morbidity and mortality and (b) highlights areas for collaboration, if applicable.

Applicants are strongly encouraged—but not required—to collaborate with the following activities if they are occurring within their jurisdiction.

- **The National Syndromic Surveillance Program: Enhancing Syndromic Surveillance Capacity and Practice (CDC-RFA-OE15-1502):** The National Syndromic Surveillance Program's (NSSP) mission is to promote the use of high quality syndromic surveillance data to improve all-hazard situational awareness for public health decision-making and to enhance responses to hazardous events and outbreaks nationwide. NSSP's purpose is to enhance situational awareness and detect and characterize disease outbreaks or other hazardous events or conditions of public health concern in order to respond quickly to local threats. Applicants of the current FOA who propose to use syndromic emergency department data in **jurisdictions funded by the NSSP** are strongly encouraged to outline their collaboration with ongoing syndromic surveillance and describe the plan for leveraging existing expertise and efforts.
- **High Intensity Drug Trafficking Areas (HIDTA) Program:** The High Intensity Drug Trafficking Areas (HIDTA) program, created by Congress with the Anti-Drug Abuse Act of 1988, provides assistance to Federal, state, local, and tribal law enforcement agencies operating in areas determined to be critical drug-trafficking regions of the United States. The purpose of the program is to reduce drug trafficking and production in the United States by: a) facilitating cooperation among Federal, state, local, and tribal law enforcement agencies to share information and implement coordinated enforcement activities; b) enhancing law enforcement intelligence sharing among Federal, state, local, and tribal law enforcement agencies; c) providing reliable law enforcement intelligence to law enforcement agencies needed to design effective enforcement strategies and operations; and d) supporting coordinated law enforcement strategies which maximize use of available resources to reduce the supply of illegal drugs in designated areas and in the United States as a whole (See <https://www.whitehouse.gov/ondcp/high-intensity-drug-trafficking-areas-program>). There are currently 28 HIDTA's, which include approximately 17.2 percent of all counties in the United States and a little over 60 percent of the U.S. population. HIDTA-designated counties are located in 48 states, as well as in Puerto Rico, the U.S. Virgin Islands, and the District of Columbia. Applicants are encouraged to collaborate with HIDTA's if HITDA's are funded in their state.

Applicants may consider—but are not required—to collaborate with the following activities:

- **States with Core VIPP Funding:** The Injury Center provides funding and technical assistance to states through its Core Violence and Injury Prevention Program (Core VIPP). The program supports 20 state health departments to strengthen their capacity to collect and use data for a better understanding of local injury issues and to protect residents by putting science into action to save lives and prevent injuries.
- **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 as well as information centers for the public. ICRCs are good sources of research knowledge and other useful resources for state programs.

b. With organizations not funded by CDC:

Key collaborations are listed for each of the three FOA strategies.

- **Increase timeliness of aggregate nonfatal opioid overdose reporting (Strategy 1):** In order to rapidly collect and analyze nonfatal opioid-involved overdose data, successful applicants will need to build strong relationships between staff who collect EMS and/or ED data and subject matter experts in drug overdose. Applicants should discuss their plan to foster these collaborations over the 3-year funding period. In some states, local health departments have used syndromic surveillance or EMS data to track drug overdoses for more than a year. If this is the case, states are encouraged to leverage this local experience, if feasible.

- No specific Letters of Support (LOS) are required for this strategy.

- **Increase timeliness of fatal opioid overdose and associated risk factor reporting (Strategy 2):** Successful applicants are required to obtain detailed information, or variables, on fatal opioid-involved overdoses from two sources: 1) DC and 2) ME/C reports, including toxicology results, within 8 months of the date of death. In order to achieve these goals, applicants will need to establish data sharing agreements for the 3-year period of the FOA with vital statistics and local, regional, and/or state ME/C agencies. All applicants must provide evidence of their ability and capacity to provide the data within 8 months of the date of death for the 3-year period of the FOA.

1. Applicants are encouraged, but not required, to submit LOS OR MOU/MOA from a subset of data providers in their target area as part of this application.

- In jurisdictions with a centralized ME/C systems, LOS OR MOU/MOA from the state ME/C office is encouraged.

- In jurisdictions with decentralized ME/C systems, LOS OR MOU/MOA from the ME/C office in cities and counties with a high drug overdose burden is encouraged.

- The process for acquiring death certificate data from the vital statistics office should be described in the application.

2. Applicants in NVDRS-funded states may demonstrate capacity by reporting how quickly they request and complete abstraction of DC and ME/C information on violent deaths.

- **Disseminate surveillance findings to key stakeholders working to prevent or respond to opioid-involved overdoses (Strategy 3)**

1. Applicants will target different key stakeholders based on their dissemination plan and unique context. Applicants should provide evidence of their recent ability, within the past 3 years, to disseminate data to targeted key partners or similar groups.

- No specific LOS are required.

2. Target Populations

By collecting and disseminating timely information on nonfatal and fatal opioid-involved overdoses, this FOA is working to reduce nonfatal and fatal opioid-involved overdoses among persons who now or in the future will be at-risk for overdoses involving opioids. Awardees will collect information on all opioid-involved drug overdose deaths in their target area and all nonfatal opioid-involved overdoses captured by EMS and/or ED data. By collecting information on all fatal and nonfatal opioid-involved overdoses, awardees will be able to identify and track health disparities (e.g., based on gender, age, geography, race/ethnicity, and other relevant sociodemographic characteristics) to the extent that this information is available in data sources analyzed as part of the FOA (e.g., ED records, EMS records, ME/C reports, and death certificates). CDC also will track health disparities using aggregated data.

If the applicants propose to collect opioid-involved overdose death information on a subset of counties in their state, states should work to include diverse populations including urban and rural populations, tribal territories, populations that speak English as a second language, and ethnically and racially diverse populations.

a. Inclusion

The applicant is collecting information on all opioid-involved overdose deaths in their target area and all nonfatal opioid-involved overdoses captured by EMS and/or ED data. By collecting information on all deaths and nonfatal opioid overdoses, awardees will be able to identify and track health disparities.

If the applicants propose to collect opioid-involved overdose death information on a subset of counties in their state, states should work to include diverse populations including urban and rural populations, tribal territories, populations that speak English as a second language, and ethnically and racially diverse populations.

iv. Funding Strategy

The total budget was created by estimating three major costs, or budget lines:

1. The cost for funding *Strategy 1: Increase the timeliness of aggregate nonfatal opioid overdose reporting.*
2. The cost for funding *Strategy 2: Increase the timeliness of fatal opioid overdoses and associated risk factor reporting.*
3. Because this is a new FOA and demands rapid data collection across multiple data sources, a small amount of funding was budgeted to address unanticipated costs or challenges.

Funding to support *Strategy 3: Disseminate surveillance findings to key stakeholders working to prevent or respond to opioid-involved overdoses* is built into the budget line supporting Strategy 1 and Strategy 2.

The average annual budget is approximately \$335,000 (See Appendix 2 at <http://www.cdc.gov/drugoverdose/foa/state-opioid-mm.html> for the funding formula). Funding for each strategy is outlined below.

1. **Strategy 1:** States with a greater number of UUDO deaths will be funded at a higher level because: 1) more potential outbreaks are expected to be detected and require follow-up and 2) validation and dissemination work are expected to be more costly. UUDO overdose deaths are used as a proxy for fatal overdoses involving opioids. Rates of opioid-involved overdose deaths cannot be compared across states because the specific drug(s) causing a fatal drug overdose were not specified in about 1 in 5 drug overdoses in 2014 and this rate varied across states. Also, opioid-involved overdoses accounted for >60% of drug overdoses in 2014 and this was an underestimate due to lack of specific drug overdose information on 1 in 5 drug overdoses. Applicants are encouraged to share and collaboratively analyze case-level data with CDC to support near real time surveillance of

opioid-related overdoses, but this is not required. If applicants commit to sharing and collaboratively analyzing case-level ED and/or EMS data in their application, the applicant should budget an additional \$10,000 to account for the cost of sharing data with CDC (See Appendix 2 at <http://www.cdc.gov/drugoverdose/foa/state-opioid-mm.html> for the funding formula).

2. **Strategy 2:** The cost of Strategy 2 will increase as the number of UUDO deaths increases because an abstractor must review and abstract required variables from each ME/C report. Also, funding includes some resources to share with data providers, especially ME/C offices. This amount also increases on a per case basis because the burden on ME/C offices may increase as information on more opioid-involved deaths are requested. Consequently, funding for applicants that choose to collect information on opioid-involved overdose deaths in a subset of counties will have their funding reduced. Specifically, funding will be based on the number of residents who died of an UUDO in selected counties in 2014 instead of all UUDO deaths in the state in 2014 (See Appendix 2 for funding formula by number of UUDO deaths in 2014 at <http://www.cdc.gov/drugoverdose/foa/state-opioid-mm.html>).
3. **Funding to address unanticipated issues:** This funding is designed to support faster data collection and to address unanticipated challenges with either Strategy 1 or Strategy 2. Funding is based on number of UUDO deaths (See Appendix 2 for funding formula by number of UUDO deaths in 2014 at <http://www.cdc.gov/drugoverdose/foa/state-opioid-mm.html>).

b. Evaluation and Performance Measurement

i. CDC Evaluation and Performance Measurement Strategy

CDC will use a set of core process and outcome measures to monitor the implementation of the three key strategies and the two key outcomes outlined in the *Strategies and Activities and Outcomes* Section of the FOA. Example evaluation measures are provided for each strategy and outcome. Evaluation measures will be updated over the course of the first year of funding based on feedback from awardees and a CDC review.

Strategy 1: Increase the timeliness of aggregate nonfatal opioid overdose reporting

- In order to successfully implement Strategy 1, awardees will need to rapidly gain access to ED and/or EMS data and acquire the human resources (e.g., hire new staff or fund contractual resources) identified in their application project plan. Example evaluation measures include:
 1. Awardee has hired all staff and/or secured contractual resources identified in their application that are needed to support Strategy 1 by March 1, 2017
 2. ED/EMS data being accessed and used to support FOA goals by January 15, 2017
- Awardees are required to validate and submit aggregate quarterly reports to CDC on indicators of nonfatal opioid-involved overdoses. The timeliness and quality of the validation work and the quarterly reports will serve as important benchmark for assessing awardee's progress in meeting FOA goals. Example evaluation measures include:
 1. Awardee's validation study provides evidence that case definitions are useful in tracking changes in any-drug, any-opioid, and heroin-involved overdoses.
 2. Percentage of quarterly reports provided to CDC on or before deadlines.
 3. Indications that trends in quarterly overdose indicators are similar to trends found in other data sources (e.g., ED hospital discharge files).
 4. Percentage of counties with information on selected indicators.
 5. Number of times the awardee detect confirmed increases (e.g., detection of an outbreak in a county) or decreases (e.g., successful implementation of a prevention program or change in drug supply) in any overdose indicator.

Strategy 2: Increase the timeliness of fatal opioid overdose and associated risk factor reporting

- In order to successfully implement Strategy 2, awardees will need to gain access to vital statistics and ME/C data as well as acquire the human resources (e.g., hire new staff or fund contractual resources) identified in their application project plan. Example evaluation measures include:
 1. Awardee has hired all staff and/or secured contractual resources identified in their application that are needed to support Strategy 2 by March 1, 2017
 2. Awardee has begun accessing and using death certificate data by February 1, 2017
 3. Awardee has begun requesting and abstracting ME/C reports by February 1, 2017
- Awardees will use the NVDRS web data-entry system to enter abstracted information derived from DC and ME/C reports. This de-identified information is available to CDC staff in near real time and will be used to monitor completeness of reports, timely reporting, and data quality. With feedback from awardees, specific evaluation measures will be developed in the first 6 months of the program and continually updated throughout the program.
 1. *Timeliness*: Two example timeliness measures are: 1) over 90% of fatal opioid-involved overdose deaths have any data entered into the system within six months of the overdose death (i.e., initiated the case) and 2) over 80% of fatal opioid-involved overdose deaths have complete DC and ME/C data within 8 months of the overdose death.
 2. *Completeness*: Two example completeness indicators are: 1) the percent of deaths that have information on key variables (e.g., location of overdose or toxicology findings completed) and 2) number of opioid-involved cases identified using ME/C reports and the DC reports.
 3. *Quality*: Two example quality indicators are: 1) number of issues detected during random reviews of cases by CDC staff and 2) awardee addresses quality issues identified by CDC in timely fashion.

Strategy 3: Disseminate surveillance findings to key stakeholders working to prevent or respond to opioid overdoses. Example measures include:

- Submission of dissemination plan to CDC by June 1, 2017.
- Awardee identifies two evaluation measures that will be used to track the implementation of their dissemination plan by June 1, 2017.
- A minimum of two dissemination strategies implemented by the end of Year 3 of funding. Examples of dissemination strategies include, but are not limited to, ongoing structured data sharing with local health department (e.g., dashboards or alert system), publications on special topics, or creating a public website or dataset.

Outcome 1: Awardee’s key stakeholders receiving timely information about trends in nonfatal opioid overdoses that is geographically-specific to assist in prevention planning. Example measures include:

- Number of times analyses of ED/EMS data is used to support prevention or response activities by key stakeholders or state or local health departments. Examples of activities include, but are not limited to, an investigation of a drug overdose outbreak, informing a funding proposal, identifying a promising prevention or response practice by tracking sharp decreases in drug overdoses or using data to inform overdose response or prevention planning.
- Number of ongoing data sharing relationships (i.e., data are shared on at least 2 or more occasions) with key stakeholders working to prevent opioid-involved overdoses. For instance, harm reduction coalition has an ongoing data request that is completed every 6 months.
- A minimum of one publication or data dissemination effort completed in both Year 2 and Year 3. These can include a web report, report to a key stakeholder, a publication, or implementation of a data sharing system (e.g., dashboard or website).
- Applicant submits at least one short “success story” to CDC each funding year.

Outcome 2: Awardee’s key stakeholders receiving timely data on fatal opioid overdoses and risk factors to

assist in targeted prevention planning. Example measures include:

- Number of times analyses of ME/C and vital statistics data is used to support prevention or response activities by key stakeholders or state or local health department. Examples of activities include, but are not limited to, identification or investigation of a drug overdose outbreak, informing a funding proposal, identifying a promising prevention or response practice by identifying risk factors in the community, or using data to inform overdose response or prevention planning.
- Number of ongoing data sharing relationships (i.e., data are shared on at least 2 or more occasions) with key stakeholders working to prevent opioid-involved overdoses. For instance, harm reduction coalition has an ongoing data request that is completed every 6 months.
- A minimum of one publication or data dissemination effort completed in both Year 2 and Year 3. These can include a web report, report to a key stakeholder, a publication, or implementation of a data sharing system (e.g., dashboard or website).
- Applicant submits at least one short “success story” to CDC each funding year.

ii. Applicant Evaluation and Performance Measurement Plan

Applicants must provide an evaluation and performance measurement plan that demonstrates how the awardee will fulfill the requirements described in the CDC Evaluation and Performance Measurement and Project Description sections of this FOA. 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).

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).

Awardees will be required to submit a more detailed Evaluation and Performance Measurement plan within the first 6 months of award, as described in the Reporting Section of this FOA.

Applicants are encouraged, but not required, to use the CDC surveillance evaluation criteria (See <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5013a1.htm>) to assist in developing their plan. Awardees will refine their evaluation and performance measurement plan within 6 months of award. This more detailed plan should be developed by the awardee 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 submitted in the application must be no longer than 10 pages.

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

Providing evidence of data sharing capacity is strongly encouraged.

c. Organizational Capacity of Awardees to Implement the Approach

Applicants must demonstrate the following skills and resources within the application:

- More than one year of experience managing and conducting quality assurance activities on large databases.
- In order to *increase timeliness of aggregate nonfatal opioid overdose reporting (Strategy 1)*, the applicant must have:
 1. ED or EMS data systems that collect and report information on at least 50% of ED visits or EMS transports within at least three months of the visit or transport.
 2. Authorization and capacity to share aggregate quarterly data on ED visits and/EMS transport related to opioid-involved overdose indicators at the county level with CDC.
- In order to *increase timeliness of fatal overdose and associated risk factor reporting (Strategy 2)*, applicants must have:
 1. More than one year of experience accessing, collecting, linking, editing, managing, and analyzing surveillance data from more than one source.
 2. Meet minimum requirements to make use of the NVDRS web-based data entry system.
 - Own or acquire computer workstations capable of running a modern internet browser such as Microsoft Internet Explorer version 8.0 or higher, Google Chrome version 48 or higher, or Mozilla Firefox version 44 or higher.
 - A computing environment that supports required technologies for the CDC web-based application, including Java Script for all work stations and Java for at least one administrative workstation in order to support data export.
 - Reliable high speed internet connection capable of supporting download speeds of at least 10 megabits per second and upload speeds of at least 10 megabits per second. Network latency, as measured by a ping test to a local server, should be at most 30 milliseconds. This information should be obtained using a speed diagnostic service and testing should be done during standard work hours. Examples of speed diagnostic services are www.speedtest.net, www.att.com/speedtest, speedtest.comcast.net, or www.speakeasy.net/speedtest.
- In order to *disseminate surveillance findings to key stakeholders working to prevent or respond to opioid-involved overdoses (Strategy 3)*, applicants must have:
 1. More than one year of experience using and generating data reports using statistical software such as SAS, SPSS, or STATA.
 2. More than one year of experience disseminating data to support the reduction and prevention of public health problems.

The following skills or experience are desired, but not required, for applicants:

- More than one year of experience performing ongoing fatal and nonfatal drug overdose mortality surveillance.
- In order to *increase timeliness of aggregate nonfatal opioid overdose reporting (Strategy 1)*, the following skills are desired:
 1. More than one year of experience analyzing morbidity or mortality data collected on a monthly or more rapid basis to reliably identify sharp increases (i.e., outbreaks) in public health conditions. This includes experience using algorithms or rules for detecting possible outbreaks.
 2. More than one year of experience working on identifying sharp changes in any type of drug overdose using any type of data.

- *Increase timeliness of fatal overdose and associated risk factor reporting (Strategy 2)*, the following experience is desired:
 1. More than one year of experience conducting statewide surveillance of any type of injury by linking death certificate data with ME/C reports.
 2. More than one year of experience building and sustaining collaborative relationships with their local and state ME/C offices.
- In order to *disseminate surveillance findings to key stakeholders working to prevent or respond to opioid-involved overdoses (Strategy 3)*, the following experience is desired:
 1. More than one year of experience in disseminating drug overdose surveillance data to key stakeholders working to respond and/or prevent drug overdoses.

CDC recommends that applicants have separate individuals assume the role of primary investigator and program manager. If the same individual is in both roles, the applicant must include the supervisor of this person in the application.

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 should organize the work plan according to the 2 key outcomes outlined in the logic model and the 3 key strategies that are driving the outcomes. The 2 key outcomes and the strategies to which they are linked are described below.

1. Awardee’s key stakeholders use of timely information about trends in nonfatal opioid overdoses that is geographically-specific to assist in prevention planning (Outcome 1), is linked to successfully *increasing the timeliness of aggregate nonfatal opioid overdose reporting (Strategy 1)* and *disseminating surveillance findings to key stakeholders working to prevent or respond to opioid-involved overdoses (Strategy 3)*.
2. Awardee’s key stakeholders use of timely data on fatal opioid overdoses and risk factors to assist in targeted prevention planning (Outcome 2), is linked to successfully *increasing the timeliness of fatal opioid overdose and associated risk factor reporting (Strategy 2)*, and *disseminating surveillance findings to key stakeholders working to prevent or respond opioid-involved overdoses (Strategy 3)*.

The work plan should:

- Describe the activities that are planned to implement the required 3 strategies and ultimately achieve the 2 key outcomes.
 - i. Provide specific process measure(s) for key activities supporting each of the 3 strategies described in the FOA.
 - ii. Provide a timeline that identifies key activities and assigns approximate dates for inception and completion, including key dates required by the FOA.
- Describe possible barriers to or facilitators of implementing the three key strategies.
- Describe the planned roles and functions of staff and contracted resources to support the implementation of the specific strategies.
- For the two key outcomes, convert the outcome into Specific, Measurable, Achievable, Relevant, and Time-phased (SMART) objectives for then end of the FOA, or Year 3.

Applicants must name the work plan “Surveillance work plan” and upload it as a PDF file on www.grants

e. CDC Monitoring and Accountability Approach

Monitoring activities include routine and ongoing communication between CDC and awardees, site visits, and awardee 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 awardee progress in achieving the desired outcomes.
- Ensuring the adequacy of awardee 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:

- Ensuring that work plans are feasible based on the budget and consistent with the intent of the award.
- Ensuring that awardees are performing at a sufficient level to achieve outcomes within stated timeframes.
- Working with awardees 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.

Other activities deemed necessary to monitor the award, if applicable.

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 grantees.

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

CDC will provide substantial involvement beyond regular performance and financial monitoring during the project period. Substantial involvement means that applicants can expect federal programmatic partnership in carrying out the effort under the award. CDC will work in partnership with awardees to ensure the success of the cooperative agreement by providing technical assistance to successfully implement each of the three strategies as well as general technical assistance.

The following technical assistance will be provided to awardees by CDC to support Strategy 1:

- Share example drug overdose, opioid-involved overdose, and heroin related overdose ED case definitions that include text and ICD-10-CM text searches developed through work with states by Fall 2016.
- Provide feedback on proposed case definitions, data reports, and validation study design.
- Facilitate sharing of cases definitions and analytical approaches among awardees by providing states a summary of the case definitions by Fall 2017.
- When provided permission by an awardee, CDC will support the implementation, analysis, and sharing of information through the BioSense platform and infrastructure.

The following technical assistance will be provided to awardees by CDC to support Strategy 2:

- Produce and share a coding manual with awardees that will provide cases definitions and coding guidance. This will build on the NVDRS coding manual is available at: http://www.cdc.gov/violenceprevention/nvdrs/coding_manual.html.
- Provide access to the NVDRS web-based data entry program to enter data, to export data to the

applicant, and to share data with CDC. The NVDRS web-based data entry system will also support data quality by providing data summaries and implementing data entry rules, including restricting data entry to valid values.

1. Provide training on how to use the web-based data entry system.

- Provide technical assistance in solving problems in all aspects of the system through monthly or bi-monthly conference calls, discussions with CDC staff, maintaining a help desk for abstraction questions and questions about the web-based data entry system, and periodic applicant site or reverse site visits as resources are available.
- If resources are available, CDC may provide tools to support efficient analysis of the data, such as standard strategies for coding toxicology panel finding.

Other more general technical assistance includes:

- Providing technical assistance to revise annual work plans.
- Facilitating the sharing of information among grantees.

B. Award Information

1. Funding Instrument Type: Cooperative Agreement

CDC's substantial involvement in this program appears in the CDC Program Support to Awardees Section.

2. Award Mechanism: U17

Applied Methods in Violence-involved or Accidental Injury Surveillance Cooperative Agreements

3. Fiscal Year: 2016

4. Approximate Total Fiscal Year Funding: \$3,850,000

5. Approximate Project Period Funding: \$11,550,000

This amount is subject to the availability of funds.

Estimated Total Funding: \$11,550,000

6. Total Project Period Length: 3 year(s)

7. Expected Number of Awards: 11

8. Approximate Average Award: \$335,000 Per Budget Period

9. Award Ceiling: \$775,000 Per Budget Period

This amount is subject to the availability of funds.

10. Award Floor: \$210,000 Per Budget Period

11. Estimated Award Date: 09/01/2016

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 awardee (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 project period comprises the initial competitive segment and any subsequent non-competitive continuation award(s).

13. Direct Assistance

Direct Assistance (DA) is not available through this FOA.

C. Eligibility Information

1. Eligible Applicants

Eligibility Category: State governments

Additional Eligibility Category:

Government Organizations:

State governments or their bona fide agents (includes the District of Columbia)

2. Additional Information on Eligibility

N/A

3. Justification for Less than Maximum Competition

This FOA is limited to state health departments or their bona fide agents based on the following legislative authority:

392(a) The Secretary, through the Director of the Centers for Disease Control and Prevention, shall— (1) assist States and political subdivisions of States in activities for the prevention and control of injuries (b) The Secretary, through the Director of the Centers for Disease Control and Prevention, may— (3) make grants to States and, after consultation with State health agencies, to other public or nonprofit private entities for the purpose of carrying out demonstration projects for the prevention and control of injuries at sites that are not subject to the Occupational Safety and Health Act of 1970, including homes, elementary and secondary schools, and public buildings.

4. Cost Sharing or Matching

Cost Sharing / Matching No Requirement:

Cost sharing or matching funds are not required for this program. Although no statutory matching requirement for this FOA exists, leveraging other resources and related ongoing efforts to promote sustainability is strongly encouraged.

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](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-awardees, those sub-awardees 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 an awardee. 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](http://www.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 “Get Registered” option at www.grants.gov.

All applicant organizations must register at 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.

Step	System	Requirements	Duration	Follow Up
1	Data Universal Number System (DUNS)	1. Click on http://fedgov.dnb.com/webform 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 & update information under DUNS number	1-2 Business Days	To confirm that you have been issued a new DUNS number check online at (http://fedgov.dnb.com/webform) or call 1-866-705-5711

2	System for Award Management (SAM) formerly Central Contractor Registration (CRR)	1. Retrieve organizations DUNS number 2. Go to www.sam.gov 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)	3-5 Business Days but up to 2 weeks and must be renewed once a year	For SAM Customer Service Contact https://fsd.gov/fsd-gov/home.do Calls: 866-606-8220
3	Grants.gov	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 the organization	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 applying on grants.gov)	Register early! Log into grants.gov and check AOR status until it shows you have been approved

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 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 FOA, 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: **05/13/2016**

b. Application Deadline

Due Date for Applications: **06/27/2016**, 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

The informational conference call will be held on May 11, 2016 at 2:00 p.m. to understand the conceptual context of this Funding Opportunity Announcement (FOA). The conference call can be accessed at (770) 488-3600 or (855) 644-0229; conference ID: 5740377.

5. CDC Assurances and Certifications

All applicants are required to sign and submit “Assurances and Certifications” documents indicated at [http://wwwn.cdc.gov/grantassurances/\(S\(mj444mxct51nrv1hljjmaa\)\)/Homepage.aspx](http://wwwn.cdc.gov/grantassurances/(S(mj444mxct51nrv1hljjmaa))/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://wwwn.cdc.gov/grantassurances/\(S\(mj444mxct51nrv1hljjmaa\)\)/Homepage.aspx](http://wwwn.cdc.gov/grantassurances/(S(mj444mxct51nrv1hljjmaa))/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.

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.

An LOI is requested but optional. The content of the LOI can be very simple — all CDC is looking for is a letter from the applicant stating the intention to apply. The purpose of an LOI is to allow CDC program staff to estimate the number of applicants that will need to be reviewed and plan accordingly. LOI must be sent via U.S. express mail, delivery service, fax, or email to:

Renee Wright
CDC, National Center for Injury Prevention and Control
Address: 4770 Buford Hwy. NE
Mailstop F-62
Atlanta, GA 30341
rwright@cdc.gov
Phone: 770.488.1146
Fax: 770.488.1360

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

(Maximum of 20 pages, single spaced, 12 point font, 1-inch margins, number all pages. Content beyond 20 pages will not be reviewed. The 20 page limit includes the work plan.)

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 bolded headings shown in this section. 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 project period as identified in the CDC Project Description section. 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 project period 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 file letters of support, as appropriate, name the file “Letters of Support”, and upload it as a PDF file at www.grants.gov.

The required letters of support are described in the “Collaborations” section of the FOA. If applicants are submitting additional optional materials (e.g., MOUs, MOAs) that demonstrate collaborations in support of the proposed activities, the file should be named “Other Documentation of Collaborations”, and upload it as a PDF file at www.grants.gov.

2. Target Populations

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. Refer back to the Target Population section in the CDC Project Description.

The applicant is collecting information on all opioid-involved drug overdose deaths in their target area. By collecting information on all deaths, awardees will be able to identify and track health disparities. States with tribal organizations should plan and work to include deaths occurring in tribal territories in their surveillance efforts.

c. Applicant Evaluation and Performance Measurement Plan

Applicants must provide an evaluation and performance measurement plan that demonstrates how the awardee will fulfill the requirements described in the CDC Evaluation and Performance Measurement and Project Description sections of this FOA. 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. See Section E (pages 4 and 5) at <http://www.hhs.gov/sites/default/files/grants/grants/policies-regulations/hhsgps107.pdf>. 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, 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).

Awardees will be required to submit a more detailed Evaluation and Performance Measurement plan within the first 6 months of award, as described in the Reporting Section of this FOA.

Applicants are encouraged—but not required—to use the CDC surveillance evaluation criteria (see <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5013a1.htm>) to assist in developing their plan. The evaluation plan should describe plans to monitor and verify data quality, including the completeness, accuracy and timeliness of opioid-involved morbidity and mortality surveillance reports.

Awardees will refine their evaluation and performance measurement plan within 6 months of award. The awardee will develop an enriched and detailed plan with support from CDC as part of first year project activities. This refined plan will build upon elements from the initial evaluation plan described in this

proposal. The plan submitted in the application must be no longer than 10 pages.

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

Providing evidence of data sharing capacity is strongly encouraged.

d. Organizational Capacity of Applicants to Implement the Approach

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

Please attached the CV of the primary investigator. Applicants must name this file "CVs/Resumes" or "Organizational Charts" and upload it at www.grants.gov.

11. Work Plan

(Included in the Project Narrative’s 20 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 awardee plans to carry out achieving the project period outcomes, strategies and activities, evaluation and performance measurement.

Work plans should be double spaced, Calibri 12 point, 1-inch margins, number all pages. Content beyond 20 pages will not be considered and violations of formatting will be penalized.

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

12. Budget Narrative

Applicants must submit an itemized budget narrative, which may be scored as part of the Organizational Capacity of Awardees to Implement the Approach. 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
- Other categories
- Contractual costs
- Total Direct costs
- Total Indirect costs

Indirect costs will not be reimbursed under grants to foreign organizations, international organizations, and foreign components of grants to domestic organizations (does not affect indirect cost reimbursement to the domestic entity for domestic activities).

For guidance on completing a detailed budget, see Budget Preparation Guidelines at: [http:// www.cdc.gov /grants /interested in applying /application resources.html](http://www.cdc.gov/grants/interested_in_applying/application_resources.html) .

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 FOA 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 FOA. Proposed activities must be included in the budget narrative and must indicate which standards will be addressed.

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 Grantees under such a plan. Applicants must name this file “Indirect Cost Rate” and upload it at www.grants.gov.

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

13. Tobacco and Nutrition Policies

Awardees are encouraged to implement tobacco and nutrition policies.

Unless otherwise explicitly permitted under the terms of a specific CDC award, no funds associated with this FOA may be used to implement the optional policies, and no applicants will be evaluated or scored on whether they choose to implement these optional policies.

CDC supports implementing evidence-based programs and policies to reduce tobacco use and secondhand smoke exposure, and to promote healthy nutrition. CDC encourages all awardees to implement the following optional recommended evidence-based tobacco and nutrition policies within their own organizations. The tobacco policies build upon the current federal commitment to reduce exposure to secondhand smoke, specifically Pro-Children Act of 2001, 20 U.S.C. Sections 7181-7184, that prohibits smoking in certain facilities that receive federal funds in which education, library, day care, health care, or early childhood development services are provided to children.

Tobacco Policies:

1. Tobacco-free indoors: Use of any tobacco products (including smokeless tobacco) or electronic cigarettes is not allowed in any indoor facilities under the control of the awardee.
2. Tobacco-free indoors and in adjacent outdoor areas: Use of any tobacco products or electronic cigarettes is not allowed in any indoor facilities, within 50 feet of doorways and air intake ducts, and in courtyards under the control of the awardee.
3. Tobacco-free campus: Use of any tobacco products or electronic cigarettes is not allowed in any indoor facilities or anywhere on grounds or in outdoor space under the control of the awardee.

Nutrition Policies:

1. Healthy food-service guidelines must, at a minimum, align with HHS and General Services Administration Health and Sustainability Guidelines for Federal Concessions and Vending Operations. These guidelines apply to cafeterias, snack bars, and vending machines in any facility under the control of the awardee and in accordance with contractual obligations for these services (see: <http://www.gsa.gov>)

www.gsa.gov/graphics/pbs/Guidelines_for_Federal_Concessions_and_Vending_Operations.pdf).

2. Resources that provide guidance for healthy eating and tobacco-free workplaces are:

<http://www.cdc.gov/nccdphp/dnpao/hwi/toolkits/tobacco/index.htm>

<http://www.thecommunityguide.org/tobacco/index.html>

<http://www.cdc.gov/obesity/strategies/food-serv-guide.html>

14. 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). Grantees will be required to draw down funds from award-specific accounts in the PMS. Ultimately, the subaccounts will provide grantees 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.

15. Health Insurance Marketplaces

A healthier country is one in which Americans are able to access the care they need to prevent the onset of disease and manage disease when it is present. The Affordable Care Act, the health care law of 2010, creates new Health Insurance Marketplaces, also known as Exchanges, to offer millions of Americans affordable health insurance coverage. In addition, the law helps make prevention affordable and accessible for Americans by requiring health plans to cover certain recommended preventive services without cost sharing. Outreach efforts will help families and communities understand these new options and provide eligible individuals the assistance they need to secure and retain coverage as smoothly as possible. For more information on the Marketplaces and the health care law, visit: www.HealthCare.gov.

16. 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: http://www.whitehouse.gov/omb/grants_s poc/.

17. 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 grantees 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.

18. Copyright Interests Provisions

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.

19. Funding Restrictions

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

- Awardees may not use funds for research.
- Awardees may not use funds for clinical care except as allowed by law.
- Awardees may use funds only for reasonable program purposes, including personnel, travel, supplies, and services.
- Generally, awardees 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 awardee.
- 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 awardees](#).
- 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.

20. Data Release Plan

Applications involving release and sharing of data must include a copy of the applicants Data Release Plan. The Data Release Plan is the Grantee's assurance that the dissemination of any and all data collected under the CDC data sharing agreement will be released in a timely manner, completely, and as accurately as possible, to facilitate the broader community, and developed in accordance with CDC policy on Releasing and Sharing Data.

21. Other Submission Requirements

a. Electronic Submission: Applications must be submitted electronically at www.grants.gov. The application package can be downloaded at www.grants.gov. Applicants can complete the application package off-line and submit the application by uploading it at www.grants.gov. All application attachments must be submitted using a PDF file format. Directions for creating PDF files can be found at www.grants.gov. File formats other than PDF may not be readable by OGS Technical Information Management Section (TIMS) staff.

Applications must be submitted electronically by using the forms and instructions posted for this funding opportunity at www.grants.gov.

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 pgotim@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 FOA. 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.

[http:// www.grants.gov/help/html/help/index.htm? callingApp=custom#t= Get_Started%2FGet_Started. htm](http://www.grants.gov/help/html/help/index.htm?callingApp=custom#t=Get_Started%2FGet_Started.htm)

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@www.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@www.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 I Review

All applications will be initially reviewed for completeness by CDC OGS staff. Complete applications will be reviewed for responsiveness by the CDC. 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.

i. Approach

Maximum Points:40

CDC will evaluate the extent to which the applicant:

- Describes an effective and feasible approach for *increasing timeliness of aggregate nonfatal opioid overdose reporting (Strategy 1)* that aligns with CDC criteria outlined in the FOA. **(13 points)**
 1. The applicant provides a feasible and effective plan for providing required *state and county-level quarterly reports* on the selected indicators, including how overdose rates will be calculated and change detected over time
 2. The applicant identifies the two out of three required indicators (i.e. any-drug, any-opioid, and heroin-involved overdose) they will track and whether each indicator will be tracked with ED or EMS data
 3. Applicant confirms required access to datasets
 - If the applicant is using ED data, the applicant: (a) provides evidence they can calculate the selected opioid-involved overdose indicators on $\geq 50\%$ of ED visits in their jurisdiction on a *quarterly basis* and (b) describes how they will assess the data and leverage the experience of people conducting ED surveillance.

- If the applicant is using EMS data, the applicant: 1) provides evidence they can calculate the selected opioid-involved overdose indicators on $\geq 50\%$ of EMS visits in their jurisdiction on a *quarterly basis* and 2) describes how they will assess the data and leverage the experience of EMS staff collecting the data
 - 4. The applicant provides a feasible and effective plan for creating and validating case definitions for selected indicators
- Applicants will receive these points if they commit in their application to complete the following optional activities.
 1. The applicant proposes to collect and share with CDC more than the required 2 indicators OR is using both ED and EMS data when tracking indicators **(1 point)**
 2. The applicant will share case level ED and/or EMS data with CDC in a secure manner for the sole purpose of enhancing the timely tracking of non-fatal opioid overdoses **(3 points)**
 - Describes an effective and feasible approach for *improving timeliness of fatal overdose and associated risk factor reporting at the county and state level* that aligns with CDC criteria outlined in the FOA (Strategy 2) **(13 points)**
 1. The applicant clearly states whether data will be collected on (a) all fatal opioid-involved drug overdoses occurring in their jurisdiction or (b) all opioid-involved deaths occurring in a subset of targeted counties.
 - If the applicant choose to collect information on a subset of targeted counties, the applicant provides evidence that the targeted counties' residents accounted for a minimum of 75% of unintentional or undetermined drug overdose (UUDO) deaths in their state in 2014 or a minimum of 1,500 UUDO deaths in 2014 using the CDC Wonder Multiple Cause of Death data file (<http://wonder.cdc.gov/mcd-icd10.html>) and CDC case definitions (See Appendix 3 at <http://www.cdc.gov/drugoverdose/foa/state-opioid-mm.html>)
 2. The applicant provides an effective and feasible plan for **initiating data entry on opioid-involved deaths** (i.e., entering any information from either the DC or ME/C report) within 6 months of death
 3. The applicant's provides an effective and feasible plan to request and **complete data entry**—using CDC guidance—into the NVDRS web data-entry system within 8 months of the date of death
 4. The applicant provides a brief yet concise plan for describing and analyzing the key demographics and risk factors associated with fatal overdoses involving opioids across counties during the funding period
 - Applicants will receive these points if they commit in their application to complete the following optional activities.
 1. Applicant commits to initiating data entry on all cases within 4 months of death instead of the required 6 months of death **(1 point)**
 2. Applicant will complete data entry on opioid-involved deaths within 6 months of death instead of the required 8 months **(1 point)**
 - Describe an effective and feasible approach for disseminating data to key stakeholders working to prevent or respond to opioid overdoses **(8 points)**
 1. The applicant describes the key goals for the dissemination plan which will be developed during the first year of funding
 2. The applicant briefly describes how they will leverage existing dissemination efforts or initiate new efforts to reach key partners
 3. The applicant dissemination plan is logical and feasible

ii. Evaluation and Performance Measurement

Maximum Points:25

CDC will evaluate the extent to which the applicant:

- Proposes performance measures **(5 points)**:
 1. Align with proposed activities, strategies and outcomes and are useful to assess progress
 2. Will assist in tracking applicant's progress while helping identify potential challenges to implementation
- Outlines an effective and feasible plan for monitoring the timeliness and quality of data collected (as part of *Strategy 1*) to increase timeliness of aggregate nonfatal overdose reporting **(8 points)**.
- Outlines an effective and feasible plan for monitoring the timeliness and quality of data collected (as part of *Strategy 2*) to increase timeliness of fatal overdose and associated risk factor reporting at the state and county level **(8 points)**.
- Has a plan to collect information on the use of their enhanced surveillance data by key partners, including success stories, and will collect the information in manner that facilitates sharing with CDC **(4 points)**.

iii. Applicant's Organizational Capacity to Implement the Approach

Maximum Points:35

Applicants will be scored according to the following elements:

Experience (14 points)

- Experience managing and conducting quality insurance on large databases such as ED, EMS, DC, or ME/C
- Experience that will support *increasing timeliness of nonfatal overdose reporting (Strategy 1)*
 1. ED or EMS data systems that collect and report information on at least 50% of ED visits or EMS transports within at least three months of the visit or transport
 2. Experience analyzing morbidity or mortality data collected on a monthly or more rapid basis to reliably identify sharp increases (i.e., outbreaks) in public health conditions. This includes experience using algorithms or rules for detecting possible outbreaks
 3. Experience working on identifying sharp changes in any type of drug overdoses using any type of data
- Experience that will support *increasing timeliness of fatal overdose and associated risk factor reporting at the state and county level (Strategy 2)*
 1. Experience accessing, collecting, linking, editing, managing and analyzing surveillance information from DC and ME/C in a timely manner on any public health problem
 2. Experience linking DC and ME/C data to conduct surveillance of drug overdose
 3. Provides evidence of strong relationships with ME/C offices in their state or experience conducting statewide surveillance of any type of injury by linking death certificate data with ME/C reports
- Experience disseminating public health information on:
 1. Any type of public health problem
 2. Drug overdose

Staffing and Capacity (6 points)

- Project staff's roles and responsibilities are clearly delineated and staff qualifications offered to

demonstrate qualifications for performing key functions such as requesting, entering, analyzing and disseminating the data.

1. Curriculum vita for the staff person leading the project should be included in the application.
 2. Roles and responsibilities of staff clearly delineated
- Provides evidence of a computing environment that can support entering data into the NVDRS web data-entry program, including information on current or planned speed of their high speed internet connection.

Burden

- **2014 Drug Overdose Burden (10 points):** Applicants will be scored according to age-adjusted drug overdose death rate in their state. CDC will calculate the points assigned to applicants under this section using 2014 National Vital Statistics System drug overdose mortality by state. *Applicants do not need to provide any documentation or materials in support of this criterion.* Applicants among the states with the 10 highest age-adjusted drug overdose death rates will receive 10 points (See Appendix 4 at <http://www.cdc.gov/drugoverdose/foa/state-opioid-mm.html>). Applicants among the states with the 11th—19th highest age-adjusted drug overdose death rates will receive points according to the following table:

Rankings, 2014 age-adjusted drug overdose death rate	Points under this criterion
11th	9
12th	8
13th	7
14th	6
15th	5
16th	4
17th	3
18th	2
19th	1
20th or lower	0

- **Change in Drug Overdose Burden 2012 to 2014 (5 points):** Applicants will be scored by the absolute change in age-adjusted drug overdose death rate in their state from 2012 to 2014. CDC will calculate the points assigned to applicants under this section using 2012 and 2014 National Vital Statistics System drug overdose mortality by state. *Applicants do not need to provide any documentation or materials in support of this criterion.* Applicants among the states with the 10 largest changes in age-adjusted drug overdose death rates will receive 5 points (See Appendix 5 at <http://www.cdc.gov/drugoverdose/foa/state-opioid-mm.html>).

Budget

Presentation of a reasonable budget that is consistent with the stated objectives and planned program activities. Budget will be reviewed but not scored.

c. Phase III Review

Applications will be reviewed and ranked by an objective review panel. Funding will be solely or primarily determined by these rankings. Efforts to ensure geographic diversity across the 10 HHS Regions (See <http://www.hhs.gov/about/agencies/regional-offices/#>) also may affect funding decisions. Specifically, the FOA has the goal of funding states in at least 3 of the 10 HHS Regions.

2. Announcement and Anticipated Award Dates

TBD

F. Award Administration Information

1. Award Notices

Awardees 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 awardee and CDC. The NOA will be signed by an authorized GMO and emailed to the Awardee Business Officer listed in application and the Program Director.

Any applicant awarded funds in response to this FOA 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

Awardees must comply with the administrative and public policy requirements outlined in 45 CFR Part 75 and the HHS Grants Policy Statement, as appropriate.

Brief descriptions of relevant provisions are available at <http://www.cdc.gov/grants/additionalrequirements/index.html#ui-id-17>.

The HHS Grants Policy Statement is available at <http://www.hhs.gov/sites/default/files/grants/grants/policies-regulations/hhsgps107.pdf>.

The Paperwork Reduction Act of 1995 (PRA): Offerors should be advised that any activities involving information collection (i.e., posing similar questions or requirements via surveys, questionnaires, telephonic requests, focus groups, etc.) from 10 or more non-Federal entities/persons, including States, are subject to PRA requirements and may require CDC to coordinate an Office of Management and Budget (OMB) Information Collection Request clearance prior to the start of information collection activities. This would also include information sent to or obtained by CDC via forms, applications, reports, information systems, and any other means for requesting information from 10 or more persons; asking or requiring 10 or more entities/persons to keep or retain records; or asking or requiring 10 or more entities/persons to disclose information to a third-party or the general public. For cooperative agreements PRA applicability will depend on the level of CDC involvement with the development, collection, dissemination, and management of information/data.

(CDC OMB package approval in process)

For more information on the CFR visit <http://www.access.gpo.gov/nara/cfr/cfr-table-search.html>

3. Reporting

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

- Helps target support to awardees;
- Provides CDC with periodic data to monitor awardee progress toward meeting the FOA outcomes and overall performance;
- Allows CDC to track performance measures and evaluation findings for continuous quality and program improvement throughout the project period 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 FOA.

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 FOA copying the CDC Project Officer.

<u>Report</u>	<u>When?</u>	<u>Required?</u>
Awardee Evaluation and Performance Measurement Plan	6 months into award	Yes
Annual Performance Report (APR)	The awardee must submit the APR via www.grants.gov no later than 120 days before the end of the budget period.	Yes
Data on Performance Measures	CDC program determines. Only if program wants more frequent performance measure reporting than annually in APR.	No
Federal Financial Reporting Forms	90 days after end of calendar quarter in which budget period ends	Yes
Final Performance and Financial Report	90 days after end of project period.	Yes
Payment Management System (PMS) Reporting		No

a. Awardee Evaluation and Performance Measurement Plan (required)

With support from CDC, awardees must elaborate their initial applicant evaluation and performance measurement plan. This plan must be no more than 20 pages; awardees 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.

Awardee 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 FOA 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 FOA (e.g., effect on improving public health outcomes, effectiveness of FOA, 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 awardee must submit the APR via www.grants.gov no later than 120 days before the end of the budget period. This report must not exceed 45 pages excluding administrative reporting. Attachments are not allowed, but weblinks are allowed.

This report must include the following:

- **Performance Measures:** Awardees must report on performance measures for each budget period and update measures, if needed.
- **Evaluation Results:** Awardees must report evaluation results for the work completed to date (including findings from process or outcome evaluations).
- **Work Plan:** Awardees must update work plan each budget period to reflect any changes in project period outcomes, activities, timeline, etc.
- **Successes**
 - Awardees must report progress on completing activities and progress towards achieving the project period outcomes described in the logic model and work plan.
 - Awardees must describe any additional successes (e.g. identified through evaluation results or lessons learned) achieved in the past year.
 - Awardees must describe success stories.
- **Challenges**
 - Awardees must describe any challenges that hindered or might hinder their ability to complete the work plan activities and achieve the project period outcomes.
 - Awardees must describe any additional challenges (e.g., identified through evaluation results or lessons learned) encountered in the past year.
- **CDC Program Support to Awardees**
 - Awardees must describe how CDC could help them overcome challenges to complete activities

in the work plan and achieving project period 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.

The awardees must submit the Annual Performance Report via www.grants.gov 120 days before the end of the 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 awardees at the beginning of the award period.

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

Awardees 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 calendar quarter in which the budget period ends. 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, awardees are required to submit a letter of explanation to PGO and include the date by which the Grants Officer will receive information.

e. Final Performance and Financial Report

This report is due 90 days after the end of the project period. CDC programs must indicate that this report should not exceed 40 pages. This report covers the entire project period and can include information previously reported in APRs. At a minimum, this report must include the following:

- Performance Measures – Awardees must report final performance data for all process and outcome performance measures.
- Evaluation Results – Awardees must report final evaluation results for the project period for any evaluations conducted.
- Impact/Results/Success Stories – Awardees 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.
- 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:

- <https://www.gpo.gov/fdsys/pkg/PLAW-109publ282/pdf/PLAW-109publ282.pdf>,
- https://www.fsr.gov/documents/ffata_legislation_110_252.pdf
- <http://www.hhs.gov/grants/grants/grants-policies-regulations/index.html#FFATA>.

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 grantee 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 grantee did not pay any taxes during the reporting period.]

2) Quarterly Report: The grantee 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. grantee 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 grantee must include this reporting requirement in all applicable subgrants and other subagreements.

G. Agency Contacts

CDC encourages inquiries concerning this FOA.

Program Office Contact

For programmatic technical assistance, contact:

Renee Wright, Project Officer
Department of Health and Human Services
Centers for Disease Control and Prevention
4770 Buford Hwy. NE
Mailstop F-62
Atlanta, GA 30341

Telephone: (770) 488-1146

Email: rwright@cdc.gov

Grants Staff Contact

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

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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

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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
- Table of Contents for Entire Submission

For international FOAs:

- SF424
- SF424A
- Letters of Support
- Funding Preference Deliverables

Optional attachments, as determined by CDC programs:

- Resumes / CVs
- Position descriptions
- Letters of Support
- Organization Charts
- Non-profit organization IRS status forms, if applicable
- Indirect Cost Rate, if applicable
- Memorandum of Agreement (MOA)
- Memorandum of Understanding (MOU)
- Bona Fide Agent status documentation, if applicable

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 FOA; awardees must comply with the ARs listed in the FOA. To view brief descriptions of relevant provisions, see [http:// www.cdc.gov/ grants/ additional requirements/ index.html](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).

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.

Catalog of Federal Domestic Assistance (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.

CFDA Number: A unique number assigned to each program and FOA throughout its lifecycle that enables data and funding tracking and transparency.

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 project period (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 awardees. It may include the value of allowable third-party, in-kind contributions, as well as expenditures by the awardee.

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 FOA evaluation plan is used to describe how the awardee 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.gov: A "storefront" web portal for electronic data collection (forms and reports) for federal grant-making agencies at www.grants.gov.

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.

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: http://www.whitehouse.gov/omb/grants_s poc/.

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.

Plain Writing Act of 2010: Plain Writing Act of 2010, Public Law 111-274 requires federal agencies to communicate with the public in plain language to make information more accessible and understandable by intended users, especially people with limited health literacy skills or limited English proficiency. The Plain Writing Act is available at www.plainlanguage.gov.

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 FOA; can be either a project officer, program manager, branch chief, division leader, policy official, center leader, or similar staff member.

Project Period Outcome: An outcome that will occur by the end of the FOA’s funding period.

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>.

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 project period 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.

1. *DC: Death certificate*
2. *ED: Emergency department*
3. *EMS: Emergency medical services*
4. *ICD: International Classification of Diseases*
5. *ME/C: Medical examiner and coroners*
6. *NVDRS: National Violent Death Reporting System*
7. *OPR: Opioid pain reliever*
8. *UUDO: Unintentional or undetermined overdose*