Questions and Answers, Part 3

Cancer Prevention and Control Programs for State, Territorial, and Tribal Organizations

CDC-RFA-DP17-1701

Responded to on January 20, 2017

Q1: Under bullet #1 and #2 (highlighted above) related to Environmental Approaches and Community-Clinical linkages, it does not define how many EBIs should be selected for the priority areas. Looking to determine what the requirements are? I assume it’s looking for two since it reads “interventions….,” but it does not state from what priority area and wanted to confirm.

A: Applicants are required to select three EBIs per priority area (primary prevention, screening and early detection of cancer, and improving quality of life of cancer survivors). Selected EBIs can be environmental approaches for sustainable cancer control, community-clinical linkages, or health systems changes. Each EBI must have activities that align with the five funding opportunity announcement (FOA) strategies (Program Collaboration, External Partnerships, Cancer Data and Surveillance, Implementation of EBIs, and Program Monitoring and Evaluation).

Q2: Under bullet 1 for component 2 of the NPCR portion, as highlighted above it states obtaining screening and diagnostic information on breast and cervical cases. Please confirm that this is a project that will create a screening registry on ONLY cases DIAGNOSED with breast or cervical cancer—that this is NOT a project that will keep records of all screening and diagnostic mammograms and Pap tests for the state applying.

A: Yes. This project is to test the feasibility of collecting screening and diagnostic information on all diagnosed cervical and breast cancer cases in the cancer registry database.

Q3: Are applicants for Program 3: NPCR required to submit a logic model and/or to weave the elements of the logic model related to cancer registry operations into the grant response? In the past 5-year cycle, we did not complete one. Are we required to complete one for the upcoming 5-year grant cycle?

A: Grantees are not required to develop their own logic model for the NPCR application. Grantees are expected to reflect the strategies and activities outlined in the NPCR section of the FOA in their application and work plan.

Q4: Need clarification of the data to be collected. What is the difference in patient-level and clinic-level data? Under Strategy 3: Collect, analyze, and report to CDC required clinic-level data.

A: Patient-level data is individual screening tests and results for each client. Clinic-level data are the clinic screening rates and use of EBIs.

Q5: Is there a place where we can read your responses to all of the questions submitted by potential bidders on DP 17-1701? If so, please provide link or the pdf. Thank you.


Q6: During the technical assistance phone call, it was stated that the 40% included salary and fringe of program administrators—not staffing awarded via subcontract to implement the action plan (this would count toward the 60%). Therefore, if a bidder proposes to allocate a certain amount to its cancer coalition to be used toward its staffing costs to allow it to work toward its DP 17-1701 goals, does this amount count toward the 60%?

A: The 40% limitation on the Comprehensive Cancer Control budget includes both salary and fringe benefits for staff. This limitation does not apply to staffing through subcontracts for services to implement cancer plan strategies.

Q7: Following up on a question we asked earlier, while you have clearly stated that no more than 40% of an award can be used for salaries and fringe benefits, if the Policy Systems and Environmental Change Strategy Expert position that you recommend is housed at a state health department but is providing direct assistance and support to the cancer coalition and other community-based groups to help them achieve their cancer plan objectives and implement their work plans, does that position count toward the 60% or the 40%? If the same position is subcontracted to a cancer coalition and housed there, does it count toward the 60% or the 40%?

A: The expectation is that not more than 40% of NCCCP budget will be allocated for salaries (including fringe benefits), including salaries for shared staff.
Q8: At the bottom of page 37 and the top of page 38 there are two references to page limits. I want to verify that Program 3 applicants have a 35-page limit for component 1 and a 15-page limit for each item applying for under component 2.

A: Correct, at the top of page 38 of 57 you will see the page limits clarification:

If applying for a single program: a maximum of 35 pages, single-spaced, 12-point font, 1-inch margins, and number all pages.

If applying for more than one program: maximum of 35 pages for each program and up to 15 additional pages are allowed for each subcomponent under NPCR Program 3.

Text should be single-spaced, 12-point font, 1-inch margins, and number all pages.

Page limits include work plan; content beyond specified limits will not be reviewed.

Q9: If applying for component 2 and CDC accepts our application but does not fully meet our budget request, can we decide not to accept the award and not participate in component 2?

A: While awardees can choose not to accept funding, it could impact future funding decisions as it can negatively impact the overall goal and intent of the national program and its possible recipients.

Q10: Are we allowed to provide Web links within the narrative?

A: Applicants are cautioned about using links for pertinent information, as reviewers will be evaluating the 35 pages of the Project Narrative.

Responded to on January 19, 2017

Q1: Is Component Two focusing on only breast and cervical cancer patients that have been diagnosed, and collecting additional screening and diagnostic data items for these cases? Or, would it involve creating a new registry for breast and cervical cancer screening events; in other words, all mammograms, all Pap tests?

A: Yes. Component 2 focuses on breast and cervical cancer patients who have been diagnosed, and collecting additional screening and diagnostic data for these cases, not creating a new registry.

Q2: For the NBCCEDP program, one of the staff requirements is listed as 0.5 FTE Evaluator. We are wondering if part of that FTE can be an outside evaluation contractor?

A: CDC requires applicants to include an individual with evaluation expertise at half-time. This should not be spread across multiple people. It is up to the applicant to determine how to best cover staffing requirements either through direct hire or a contact.

Q3: Does the range given in the guideline apply to the sum of both component 1 and component 2?

A: Component 1 only.

Q4: Does the range given in the guideline apply to the sum of direct and indirect costs requested from CDC?

A: The total funding range refers to the total amount of federal funds, which includes direct and indirect costs. The funding range provided is a guide. Applicants should request an amount consistent with your proposed activities and within the funding ceilings stated in the FOA.

Q5: It is unclear to us after reading the FOA whether the Data Management Plan (DMP) is required for the Breast and Cervical Cancer Program as part of our application OR if it is required to be completed within the first 6 months of the award (along with the Evaluation Plan)?

A: Per the FOA, an initial data management plan (DMP) must be submitted for any data collected with federal dollars. As needed or required, DP17-1701 awardees will submit a more detailed Evaluation and Performance Measurement plan, including a DMP, within the first 6 months of award, as described in the Reporting Section of this FOA.

Also see page 43 of 57:

16d. Data Management Plan
As identified in the Evaluation and Performance Measurement section, applications involving data collection must include a Data Management Plan (DMP) as part of their evaluation and performance measurement plan. The DMP is the applicant’s assurance of the quality of the public health data through the data’s lifecycle and plans to deposit data in a repository to preserve and to make the data accessible in a timely manner. See Web link for additional information: https://www.cdc.gov/grants/additionalrequirements/index.html#ui-id-49.

Q6: What is the maximum that we can apply for? The FOA states $3.3 million, but NPCR Funding Bands attachment states $3 million.

A: The funding bands as well as the amount in the FOA are simply to provide guidance. You may ask for what you need. Actual funding will depend on availability of funds.

Q7: The FOA states that in the Budget Narrative staff time must be reflected as a percent of time spent on specific activities and percent time funded by each source (state, federal, etc.), but the budget guidelines provided do not show that in the template. Is there an updated template that can be provided? If not, can applicants follow the traditional budget guidelines and submit the requested information as a budget attachment?

A: Applicants should determine how to best address this within their budget narrative. Please note the approved attachments on page 54. Applicants should not attach documents and/or information than what is listed.

Q8: The FOA states that applicants must disclose all state and federal (in other words, NCI SEER) funding provided to entities within the catchment area directed toward core cancer surveillance operations. What template should be used to submit this information? Should applicants provide overall dollar figures or is more detailed information required? If so, what level of detail is required?

A: Please provide the additional information as part of your budget. You may include it in the section where you list Match and MOE.

Q9: Can we submit individual programs proposals separately?

A: An applicant should submit a single application for all programs for which they are applying. If there is a bona fide agent, it is acceptable for the bona fide agent to submit their portion separately.

Q10: Can we revise order of proposal Approach sections as listed in FOA (include outcomes as part of strategies)?

A: Unless otherwise instructed in the FOA, it is at the applicant’s discretion how to address the requirements of the funding opportunity.

Q11: Is the Data Management Plan part of the Evaluation & Performance Management Plan?

A: Yes. Please see page 43 of 57:

16d. Data Management Plan

As identified in the Evaluation and Performance Measurement section, applications involving data collection must include a Data Management Plan (DMP) as part of their evaluation and performance measurement plan. The DMP is the applicant’s assurance of the quality of the public health data through the data’s lifecycle and plans to deposit data in a repository to preserve and to make the data accessible in a timely manner. See Web link for additional information: https://www.cdc.gov/grants/additionalrequirements/index.html#ui-id-49.

Responded to on January 18, 2017

Q1: For the work plan, can we have more than three objectives per strategy?

A: Applicants can include more than three objectives per strategy in their workplan.

Q2: How should we budget for services in light of the ACA being up in the air?

A: The applicant should budget for services based on the current status in their geographical area, as there is no way to predict the future changes.
Q3: Additionally, do we need to include anticipated challenges and successes for the objectives and activities outlined in the work plan (per the template) or are those to be included with reporting?

A: Challenges and successes do not need to be completed with the application this year. They will be used to update the workplan in future years. Applicant may include anticipated challenges and successes in their narrative.

Q4: Can you provide the locations for the following Program 3 required meetings, as well as the number of days the meetings are expected to be held? How many persons are expected to attend each? NAACCR Annual Meeting, NCRA Annual Meeting, and Education Training Coordinator’s Meeting.

A: Please refer to the Web sites of NAACCR and NCRA for 2018 meeting details. The Education Training Coordinator’s Meeting takes place at the NCRA meeting. The number of staff attending these conferences are at the applicant’s discretion.

Responded to on January 17, 2017

Q1: Page 12: Clarification is requested regarding chart audit process requirement. What is the expectation? What will be elements be?

A: There are no pre-defined elements for chart audits. Applicants should determine this according to the structure of the health systems that they are partnering with. CDC will work with awardees to further refine the elements.

Q2: Page 17, Strategy 6: Please clarify the requirement to collaborate with state programs to achieve increased electronic reporting.

A: If other state programs are also working to improve electronic reporting, such as the Immunization Program, then it makes sense to collaborate as appropriate.

Q3: Page 20: Do the MDE measures only include clients with paid services?

A: Current MDEs contain information on women with paid services. As stated in the FOA, purposed updates to the MDE and Clinical Quality Indicators will be implemented within the first two years.

Q4: Page 48 #3 and Page 50 c: Please explain optional Performance Measure Reporting.

A: We apologize, but we are unclear about your question to page 48 #3. Please clarify and we will respond. For page 50 c., we believe you are actually referring to page 52 of 57, c. Performance Measure Reporting (Optional), which is not a requirement for DP17-1701.

Q5: Page 49: There is a new requirement for Payment Management System Reporting. Please clarify the expectations and content of this reporting.

A: The Payment Management System (PMS) Reporting is outside of Program (Division of Cancer Prevention and Control). Please see section G. Agency Contacts. Pamela Render should be able to additional information related to PMS.

Grants Management Office Information
For financial, awards management, or budget assistance, contact:
Pamela Render, Grants Management Specialist
Department of Health and Human Services
Office of Grants Services
Telephone: (770) 488-2712
E-Mail: plr3@cdc.gov

Q6: On page 2, under the Administration and Operations heading, the first bullet states:

• Hire or retain staff sufficient in number and expertise to manage, implement, and evaluate the central cancer registry, as well as use and disseminate the data. Core staff must fill the roles of program director, project director, principal investigator, quality assurance or quality control manager, and education and training coordinator.
In order to address this standard in our work plan, we wanted clarification on the definition of “core staff,” as well as how to clarify and distinguish the roles of “program director, project director, principal investigator,” within the “core staff.”

Our registry staff structure consists of a Branch Manager overseeing the entire registry, with subsequent sub-managers overseeing Core Business Operations, Statewide Data Acquisition, Statewide Compliance Monitoring, Non-Hospital Reporting and Training, Quality Assurance, and Epidemiology activities of the registry.

A: It is at the applicant’s discretion to determine how to best use staff to ensure that all roles and functions are performed properly and that the programmatic requirements of the FOA are met. Potential applicants are encouraged to review section c. Organizational Capacity of Awardees to Implement the Approach (pages 25–28 of 57) as well as the related section under E. Review and Selection Process (pages 45–49 of 57) for the review criteria related to Organizational Capacity of Applicants. Applicants should address their staffing proposal in their Project Narrative (see page 38 of 57) under d. Organizational Capacity as well as their proposed budget justification should align with their proposed plan to use staff within the Central Cancer Registry. Resumes and CVs can be submitted as approved attachments as needed.

Q7: In reference to the NPCR Funding Bands for DP17-1701, is a program permitted to apply for funds above the designated range?

A: Please note that the funding ranges are intended only to provide guidance. NPCR awards for successful applicants will be guided by the funding ranges. However, applicants are encouraged to note the funding ceilings provided on page 31 of 57 of the FOA. CDC may not consider any application requesting an award higher than the specified ceiling amounts.

Program-specific ceilings per budget period:
- Program 1 NBCCEDP: $9,000,000
- Program 2 NCCCP: $750,000
- Program 3 NPCR (Component 1): $3,300,000
- Program 3 NPCR (Component 2):
  - CIN3 - $75,000
  - Screening - $250,000
  - Biomarkers - $200,000

Q8: Are program staff salaries hired under subcontracts included in that 40% calculation?

A: The 40% limitation on the Comprehensive Cancer Control budget includes both salary and fringe benefits for staff. This limitation does not apply to staffing through subcontracts for services to implement cancer plan strategies.

Q9: Only one work plan template is provided which is structured specifically for use with Strategies 4–6. For strategies and activities related to program management and the other strategies, we are inclined to create a work plan (which was done in prior years). Should we use the provided work plan template? Or should we create our own template that mirrors the current MIS structure for those strategies?

A: The workplan should provide direction and guidance for the implementation of environmental approaches for sustainable cancer control; community-clinical linkages to aid patient support; and health systems changes (strategies 4–6) only. Documentation of other programmatic information can be included in the project narrative as described on pages 37 and 38 of the FOA.

Q10: Will direct assistance be provided for SAS in year 1? Will the program be responsible for obtaining and funding SAS licenses in year 1? If there is DA for SAS in year 1, what is the cost?

A: No. Direct assistance is not available for year 1. Because SAS/SUDAAN license are purchased based on the calendar year, for DP17-1701 awardees, licenses will not be available until January 2018. Current 2017 SAS/SUDAAN licenses are valid for the entire 2017 calendar year. DP17-1701 awardees will receive instructions related to their 2018 request.

Q11: If we are allowed to include this justification for a range change, should it be included in the budget narrative or the project narrative?

A: While a funding range has been provided for this FOA, applicants are encouraged to ask for what they need. A justification for adjusting funding range can be included in the Budget Justification.
Q12: For Program 3, Component 1, when looking at the items that will be used to score the Approach on page 46 of the FOA, many of the items listed in the section are not requirements listed in the Approach section on page 38. The criteria in the Approach section do not match the criteria in the Review and Selection section of the Approach. Will the scoring of the Approach section be based solely on the material written under within that section, or will other sections like organization capacity and the budget narrative be used to score the section?

A: It is suggested that applicants pay particular attention to section 10, Project Narrative as well as section E, Review and Selection Process for the evaluation criteria when developing their application. Reviewers will be instructed to review the applications based on the overall requirements of the FOA and its programs.

Q13: I am requesting clarification of the requirement to submit a Data Management Plan (DMP) as part of the evaluation and performance measurement plan submitted by respondents to CDC-RFA-DP17-1701. Page 23 of the (amended) Funding Opportunity Announcement (FOA) indicates that a DMP may not be applicable for all respondents. Is a DMP required of Breast and Cervical Cancer Early Detection Programs for the clinical and patient navigation data they collect? The clinical data is captured in CaST, the Cancer Screening and Tracking system. De-identified data from CaST are shared with the Centers for Disease Control and Prevention (CDC) through Minimum Data Element (MDE) reports that are submitted twice each year. Also, as required by CDC through the cooperative agreement, CaST data are linked with the state's central cancer registry data annually. Patient Navigation data are captured in a separate database from which aggregate data on required elements are reported to CDC annually. Please advise whether or not the above activities would require the program to submit a Data Management Plan with this application.

A: Per the FOA, an initial data management plan (DMP) must be submitted for any data collected with federal dollars. As needed or required, DP17-1701 awardees will submit a more detailed Evaluation and Performance Measurement plan, including a DMP, within the first 6 months of award, as described in the Reporting Section of this FOA.

Q14: Do we need to submit the name of our medical consultant when we submit the cooperative application? Can we use these funds to pay the medical consultant?

A: The name and expertise should be submitted, if known, at the time of the application. Otherwise, it is acceptable to note “To be determined” for staff positions, consultants, or contractors to be filled after award. Funds may be used to pay consultants as appropriate for their duties.

Q15: On page 25 of the FOA Program 1: NBCCEDP Staffing requires at least one medical advisor. Is the CV a required appendix for the grant application or can we indicate that the individual is to be determined?

A: It is acceptable to note “To be determined” for staff positions to be filled after award.

Responded to on January 14, 2017

Q1: On pages 14 and 15 of the revised FOA above, revised 12/28/2016, the following is stated: “Staffing should not comprise more than 40% of the award as the program's success is related to capacity to support the implementation of the cancer plan strategies.” How is staffing defined? Does this include central office personnel only or does this also include contract personnel or field personnel? In most cases, in my experience, implementation of activities requires a paid health educator or some other field representative, e.g. paid regional coordinator, to spearhead the activities of a volunteer organization, since these individuals provide substantial capacity to support the implementation of cancer plan strategies. For example, the local county health councils all have a designated, paid health educator from the state Department of Health that spearheads and provides consultation to health council volunteers so they can effectively implement community-based activities. These paid field representatives for the county health councils provide much needed capacity to support the implementation of community health plan strategies.

A: The 40% limitation on the Comprehensive Cancer Control budget includes both salary and fringe benefits for staff. This limitation does not apply to staffing through subcontracts for services to implement cancer plan strategies. It does not apply to other indirect administrative or operational costs.
Q2: The NBCCEDP workplan template instructions say that applicants should use the work plan template and that "The applicant’s work plan for Program 1 should include work in all Program 1 strategy areas included in the funding opportunity announcement (FOA)." However, the template only includes pages for Program Management and Strategies 4, 5, and 6. Where should we put work plan information for Strategies 1, 2, 3, and 7?

A: The information for strategies 1, 2, 3, and 7 should be included within each of workplan for strategies for 4, 5, and 6. The activities to meet strategies 1, 2, 3, and 7 are crosscutting activities that should be used with each of strategies 4, 5, and 6. Applicants are encouraged to read section d. workplans carefully on page 28 of 57.

Q3: On page 43 (of the revised FOA), under 17-Funding Restrictions, Program 3: NPCR, does bullet 1 prevent us from using any vendor software, such as Elekta’s Precis Central Software? If so, what if the functionality of the vendor software we use goes above and beyond CDC’s CRS+? Also, we are already locked into a contract with the vendor for three more years of a five-year contract, so would that make a difference? Or can we fall under bullet 3 as long as the cost does not exceed 20% of the total direct budget request per year? (This would fall under 1 Software Maintenance Activities on the provided document titled “NPCR Central Cancer Registry Database System Maintenance and Support Activities,” which states maintenance and license contracts).

- Bullet 1 reads: Purchase, licensing, or development of central cancer registry applications or database systems that perform the same functions as tools provided by CDC/NPCR (see CDC/NPCR Registry Plus module description).

- Bullet 3 reads: Funding for activities associated with the maintenance and support of a central registry database system that exceeds 20 percent of the total direct budget request per year.

A: If you believe your circumstance pertain more to bullet 3, please proceed with your application and budget and be sure to provide sufficient justification.

Q4: Is a Clinical Cost Worksheet required with the application? I have tried finding guidance in the FOA and grant page, but I am missing it.

A: Because this is a new open competitive funding opportunity, the Clinical Cost Worksheet will not be used during the application process. Applicants should refer to the DP-1701 Web site for the NBCCEDP Clinical and Non-Clinical Services Budget Breakdown Worksheet.

Q5: For the workplan template for the Breast and Cervical cancer program, should we use a size 12 font or can we use a size 10 font?

A: There are no prescribed font sizes for the template. However, applicants are cautioned not to use a font size that makes reading the document difficult for reviewers during the objective review process.

Responded to on January 13, 2017

Q1: I cannot seem to find a 2017–2018 Clinical Costs Worksheet on the NBCCEDP portal, and I will need a new template to complete the Service Delivery Projections template. Please let me know when this will be available, or where I could get the latest version.

A: Because this is a new competitive funding opportunity, CCWs are not being used. Applicants should refer to the DP-1701 Web site for the NBCCEDP Clinical and Non-Clinical Services Budget Breakdown Worksheet.

Q2: On page 14 of the FOA under Strategy 6 – Health Systems Change (Domain 3) Item #4 Conduct a comprehensive assessment of each partner health care delivery system: We are trying to understand the scope of assessment. Is the expectation that the IBCCP will conduct a survey of all the provider networks in the state or just the program-contracted provider networks?

A: This is an assessment of the health systems that the applicant will work with on health systems change interventions.

Q3: On page 19 of the FOA under Strategy 6 – Health System Change Item #4 Participate in and encourage electronic reporting from cancer care providers and collaborate with other state programs to achieve increased electronic reporting: Please provide clarification on what CDC is looking for in this requirement, because our cancer registry is fully electronic in the submission and receipt of reportable cancers.

A: Working with cancer registries to ensure and maintain timely electronic reporting of cases to the cancer registry.
Q4: On page 25 of the FOA under NBCCEDP Staffing requires a minimum .50 evaluator. Does this have to be a program hire? Is an Inter-Agency Agreement with the University of Illinois at Chicago School of Public Health sufficient to satisfy this requirement?

A: It is up to the applicant to determine how to best acquire their staff. It just has to be 0.5 FTE.

Q5: I have a very quick question regarding the work plan template. The work plan template makes it pretty clear that the direction of change, unit of measurement, baseline, and target fields refer to the project period objective or annual objective, but a previous response said that these actually refer to the LIDS indicator. I just wanted to double-check. Are the direction of change, unit of measurement, baseline, and target fields for the project period objective/annual objective, OR are they for the LIDS indicator? The table makes it look like those fields are referring to the PPO or AO.

A: All PPOs and AO must be written in the SMART format:

- Specific: Who? (target population and persons doing the activity) and What? (action or activity).
- Measurable: How much change is expected.
- Achievable: Can be realistically accomplished given current resources and constraints.
- Realistic: Addresses the scope of the health program and proposes reasonable programmatic steps.
- Time-phased: Provides a timeline indicating when the objective will be met.

The selected LIDS indicator should be aligned clearly with the objective. If the PPO is written in the SMART format and the selected LIDS indicator is aligned with the PPO, there should be no discrepancy when setting the direction of change, unit of measurement, baseline, and target.

Q6: I have a question regarding the Cancer Prevention and Control Programs FOA Approach Section. Much of the FOA, and the workplan, is organized based on priority areas, but the narrative approach directions organize strategies by domain. Is there an organizational requirement for how the strategies are organized within the approach? We currently have them organized by domain, and state which priority areas the strategies will be focusing on. Any guidance would be greatly appreciated.

A: Unless otherwise explicitly instructed in the FOA, it is up to the applicants how to best address the requirements of the FOA and its programs within their application.

Q7: In the grant documents on the Web site, there is a workplan template we must fill out as part of the application, utilizing the NCCCP Library of Indicators and Data Sources. My question: Should the "health equity" LIDS tool table be used to fill the "health disparities" workplan template?

The workplan instructions say "Per the FOA, applicants must ensure that at least one of the evidence-based strategies in each priority area addresses cancer-related disparities as evidenced by risk, incidence, and mortality. Regarding the workplan, these strategies will be documented in the Health Disparities template with separate PPOs and AOs to monitor and track program effort."

So when the instructions say that we need to choose a health equity strategy for each of the other Priority areas (prevention, screening, etc.) AND also include these strategies in the health disparity template, how would this work? Would the strategy from the other priority area (and thus another PPO) have to be paired with a new PPO from the health disparity section? For example, if in my screening PPO of "Increase the percentage adults aged 50–75 who did FIT or sigmoidoscopy in the past 5 years", and one of my EBIs is small media to increase community demand, and my activity would have the target for small media being a disparate population...how would this then be reflected in the separate health disparities section, when none of the Indicators listed are related to it?

A: Applicants must ensure that at least one of the evidence-based strategies in each priority area addresses cancer-related disparities as evidenced by risk, incidence, and mortality. Regarding the workplan, these strategies will be documented in the Health Disparities template with separate PPOs and AOs to monitor and track program effort.

Q8: Is the 40% limit on funding staff applicable to total DIRECT costs, or total costs?

A: The 40% limitation on the Comprehensive Cancer Control budget includes both salary and fringe benefits for staff. This limitation does not apply to staffing through subcontracts for services to implement cancer plan strategies. It does not apply to other indirect administrative or operational costs.
Q9: Will CDC be providing a mechanism (in CaST or other) for reporting the patient navigation data detailed in the FOA?

A: CDC will determine the best way to collect and report the patient navigation data. Current plans are to enhance the current data collection system.

Q10: In the new competitive cycle, do states still have the ability to define direct screening eligibility criteria as long as they fall within the federal program requirements?

A: Yes.

Q11: Will the narrative be included in the MIS as well as a separate document? When will the MIS be opened to start entering the PPOs and AOs?

A: There is no management information system (MIS) for the DP-1701 application process. Please follow the instructions for submitting application materials found in the FOA.

Q12: Is there an annual report for June 30 through December 31, 2016 due as part of the grant application, or do we submit this separate and apart?

A: Reports related to DP12-1205 should not be submitted with DP17-1701 applications. DP17-1701 is a new, separate funding opportunity. DP12-1205 grantees should refer to their year 5 NOA for closeout reporting requirements.

Q13: Should states budget to purchase SAS through their own state purchasing systems for year 1?

A: Because SAS/SUDAAN license are purchased based on the calendar year, for DP17-1701 applicants/awardees, licenses will not be available until January 2018. However, current 2017 license will be valid for the entire 2017 calendar year. DP17-1701 awardees will provided instructions for requesting 2018 licenses.

Q14: What are the REQUIRED trips for each of the grant programs? It is unclear whether all 3 leadership positions are to participate in the August 2017 Cancer Conference. Also, if the FOA suggests that a trip be budgeted, does that mean the trip is REQUIRED by CDC?

A: Participation in required CDC meetings and trainings to facilitate the accomplishment of proposed objectives is expected for all awardees. Applicants are instructed on page 40 of 57 to include travel in their proposed budget for a reverse site visit as well as for the 2017 CDC National Cancer Conference and DP17-1701 kickoff meeting.

   **TRAVEL**

   All Programs: Budget for CDC-sponsored travel, including one reverse site visit and the 2017 CDC National Cancer Conference and DP17-1701 Program Kickoff Meeting in August 2017.

   At least one representative, and no more than three, from each funded program should attend. Applicants should use travel estimates or costs associated traveling to Atlanta, Georgia for about five business days. Registration is $375 per person in advance, or $425 on-site.

Q15: If a Program 2 funded staff member (Policy, Systems and Environmental Change Expert) is employed by a state health department but is spending 100% of his or her time working with the statewide cancer coalition and other community partners to support their work to implement the state’s cancer plan, does this staff position count toward the 60% or the 40%? If the Program 2 Evaluator is spending part of his or her time evaluating the work and progress of the state’s cancer coalition, does that portion of the Evaluator’s time count toward the 60% or the 40%?

A: The expectation is that not more than 40% of NCCCP budget will be allocated for salaries (including fringe benefits).


A: The strategies listed in the Collaboration Table represent the minimum strategies that the FOA writing team deemed to be cross-cutting in nature or of the highest priority for the Collaboration Plan. Programs are encouraged to review all of the strategies and identify additional strategies that are critical to reducing the cancer burden their state.
Q17: Please clarify bullet 3 under Strategy 3 on page 14: “Collect, analyze, and report to CDC required clinic-level data.” Is the expectation that we develop a new set of performance measures for clinic-level data in addition to MDEs. Does this include only those we are contracted with, or every clinic? Are we to develop performance measures in addition to screening rates?

A: CDC will require grantees to collect and report a new clinic-level data set to monitor changes in breast and cervical cancer screening rates. This data set is separate and different from the MDEs. Grantees will report clinic-level data for all partner health system clinics where they are implementing system-level evidence-based interventions to increase screening across the age-eligible clinic population, including those insured. CDC will work with awardees to develop performance measures for the clinic-level data.

Q18: Please clarify Item 2: Target Populations under Program 1: NBCCEDP (page 21). Age for breast cancer services states 40 to 64 years. Previously targeted women have been aged 50 to 64 years. Please confirm that 25% of funding for services for women between the ages of 40 and 49 is still applicable.

A: The rule is that at least 75% of paid mammograms must be for women ages 50 to 64 years. It is not a funding service.

Q19: Please clarify bullet 3 under Program 3: NPCR – Component 1 (page 21). “Selecting, implementing and evaluating evidence-based interventions.” In the past, the cancer registry has not done this. Are there resource lists for evidence-based interventions we can use to develop this new activity?

A: The context of the phrase is important. This is meant as part of whatever collaborative activities that the three cancer teams identify to work on in the Collaboration Plan. Each program is expected to contribute, lending their strength and expertise to the project. There is no intent for the registries to implement and evaluate evidence-based interventions on their own under this strategy.

Per the FOA: Program 3 : National Program for Cancer Registries (NPCR)– Component 1

Strategy 1: Program Collaboration

- Promote use of central cancer registry data for planning and evaluation of cancer control objectives and public health practice.

- Collaborate with NCCCP and NBCCEDP programs on activities across the four domains with defined and measureable cancer prevention or control outcomes. See Collaboration Section for additional information.

- Coordinate and collaborate with other chronic disease programs, and with key external organizations and programs, such as, but not limited to, Medicaid, to

  a) Identify priority populations

  b) Select, implement and evaluate evidence-based interventions

  c) Increase screening among priority population

  d) Create synergies that facilitate the alignment of implementation and optimize shared priorities.

See Collaboration section for more detailed information

Q20: Please clarify that we’re being asked to develop collaboration activities across all four domains. (page 16) Is the registry required to develop collaborative activities with Comprehensive Cancer and BCCEDP for each domain? Is the registry supposed to collaborate with Domain 2?

A: All three cancer programs are required to participate in the development and implementation of the collaboration plan that includes the strategies listed under the Collaboration section in the table. Similar to how the State Cancer Plan is implemented, one program might be better suited to one strategy than the other, but it is expected that the plan will be comprehensive and the required strategies will be implemented by working collaboratively and collectively.

Q21: Is there a preferred font to be used?

A: The only requirement stated in the FOA is related to the font size (12-point).
Q22: In regards to the NBCCEDP workplan template, can the “Status” section and the “Challenges and Successes” be left off?

A: Yes. The status and challenges may be left blank for this application. Those sections will be used for annual reporting in years 2 through 5 for applicants who are funded.

Q23: Is there a clinical cost worksheet for the B&C Program?

A: “The Clinical and Non-Clinical Services Budget Breakdown Worksheet” is available on the DP-1701 Web site.

Q24: NPCR, Component 2, SCREENING (page 18): Need clarification of the following: Will the Registry have to collect all of the screening and follow-up data or just on diagnosed cases?

A: Applicants are encouraged to think through the project and propose a project that can be implemented successfully with the FOA time frame. The design of activity should take into account how cancer surveillance data can be useful to evaluate and enhance cancer screening program.

Q25: Do we have CDC TA available to develop screening and diagnostic follow-up fields in WebPlus if we are awarded the screening and diagnostic pilot project?

A: CDC is determining TA and resource needs and will provide additional communication after awards have been made.

Q26: Can CDC funds be used to develop a screening focus area in RMCDS and WebPlus software to collect additional screening data?

A: Make a proposal based on your needs and CDC will consider it if your project is selected for funding.

Q27: Will the data elements required for Component 2-Screening be provided by CDC at this time, or will they be included in the CDC NPCR CSS submissions specifications document at a later time? Will the component 2 data elements affect or be included in the evaluation to determine NPCR certification?

A: This is an enhancement project to demonstrate collection of data elements that are not currently captured, and may serve to inform the feasibility of these elements in future submission requirements of CDC NPCR CSS.

Q28: You note that the 40% staffing limit is for salary and fringe benefits only. Would this allow for having the indirect costs associated with staffing outside of the 40% cap? I ask this very specifically because on page 40 of the FOA, it states ‘Applicants must ensure that not more than 40% of the requested budget is allocated for program staffing. In addition, applicant must ensure that at least 60% of the requested budget is allocated to program implementation at state and local levels.’ Would the indirect costs fit into this 60% of budget going to ‘program implementation at state and local levels’ statement?

A: The 40% limitation on the Comprehensive Cancer Control budget includes both salary and fringe benefits for staff. This limitation does not apply to staffing through subcontracts for services to implement cancer plan strategies. It does not apply to other indirect administrative or operational costs.

Q29: Are there any specific qualifications of this position? Can the role be served by an RN/Public Health Nurse who works for the Breast and Cervical Cancer Program State Office or does this role need to be filled by an outside, independent clinical person? Is an MD required? “At least one medical advisor with relevant expertise in breast and cervical cancer screening to serve as clinical consultant throughout the five-year funding period.”

A: Preference would be to have a physician that could provide medical consultation to the grantee.