CDC-RFA-CE19-1904: Overdose Data to Action (OD2A)
Notice of Funding Opportunity Frequently Asked Questions (FAQs) Part II

Date Last Updated: March 8, 2019

The FAQs below contain questions received and answered from February 20 – March 1, 2019.
We will continue to update the FAQs throughout the application process.
Questions not yet addressed should be sent to overdosedata2action@cdc.gov.
To find FAQs and additional information visit the CDC NOFO webpage.

General Questions

Q: Has the website for OD2A been released yet?

A: Yes, the OD2A webpage is available: www.cdc.gov/drugoverdose/od2a/index.html. You may also subscribe to this NOFO on grants.gov to receive email notifications when updates are released.

Q: Can I receive a copy of the slides from the informational calls?

A: Please email overdosedata2action@cdc.gov for a PDF copy of slides from the informational calls.

Q: Will you please send me the contact/mailing address for the letters of support or direct me to the page it can be found in the NOFO?

A: Letters of Support can be addressed to the NOFO's Program Office Contact:

Reshma Mahendra, Project Officer
Department of Health and Human Services
Centers for Disease Control and Prevention
4770 Buford Hwy, NE MS F62
Atlanta GA 30341

As a reminder, for the requested Letters of Support, applicants must file the LOS, as appropriate, name the file "LOS_[Partner]", (e.g., LOS_PublicSafety) and upload it as a separate PDF file with your application package at grants.gov (page 37 of the NOFO).

Q: Are multiple PIs allowed, either within an organization or across organizations?

A: The typical structure calls for one PI with other Co-Is as needed, but if multiple PI designations are preferred, there are no rules against that.

Q: Could you please advise if there is a work plan template that has been approved for this application? If so, can I please get a copy? If not, would you be able to tell me what components does this work plan need to have to satisfy the requirements of the application?

A: There is no required work plan template for this application. A full description of the content requirements for the work plan can be found on page 49 of the NOFO. Please note that your work plan counts toward your project narrative page limit. Also note, the FAQ document shows which sections count towards the Project Narrative page limit.

Q: Is research still prohibited?

A: Yes. This announcement is only for non-research activities. If research is proposed, the application will not be considered. However, note that collaborations with Injury Control Research Centers and investigators applying for funding through *Research Grants to Identify Effective Strategies for Opioid Overdose Prevention* (CDC RFA-CE-19-002) are encouraged.

Q: Does this funding opportunity come as a result of Section 7152 of the Support Act? Language in the Support Act says that the funding can be used for establishment and implementation of a PDMP, maintenance of a PDMP, improvements to a PDMP. So can these funds be used to enhance or upgrade an existing system to be more efficient?

A: Yes. The Support Act did have some authorizing language in alignment with some of these programs. This funding opportunity and its associated activities are intended to be in alignment with that legislation. Please refer to the language within the NOFO for a listing of allowable PDMP activities.

Eligibility Questions

Q: In a given state, can more than one eligible entity apply separately for this NOFO (e.g., SHD & LHD separately, or SHD & another state agency separately) or is the expectation that each state/jurisdiction submit just one application?

A: State and eligible local health departments may both apply separately and may be separately funded. Among eligible local health departments (e.g., city of Chicago and Cook County), more than one eligible entity may apply, but note that only one will be funded. That is, we will not fund two local entities who serve overlapping populations. You may choose to compete with an overlapping entity or you may coordinate prior to submitting an application. One entity would still have to be the primary/named applicant, but could certainly use the budget to support staff in the coordinating/complementary health department.

Please also note that eligible cities and the states in which they are housed are NOT competing with one another. Both may be funded.

Budget Questions

Q: Can local health departments use OD2A funds to test for HIV, hepatitis C, and vaccinate against hepatitis A?

A: This is not an allowable expense. However, to the extent that sites providing these services may provide a venue for linkage to care for opioid use disorder, they may still play a role in other allowable expenses.

Q: Can local health departments use OD2A funds to purchase a mobile harm reduction syringe exchange van?

A: This is not an allowable expense.

Q: For our application for Overdose Data to Action, do we need to have separate budgets for the surveillance component and the prevention component (two total budgets) or should our budgets combine the required strategy budget and the enhanced implementation budget? Assuming we are applying for all available funding, how many budget documents do we need to submit?

A: There should be one budget that includes projected costs for all of your project activities, including prevention activities, surveillance activities, and innovation activities. The budget narrative should indicate which costs are associated with which strategy/activity.

Q: There are two budgets listed, a "Required Strategy Implementation Budget" and an "Enhanced Implementation Budget", are these two budgets additive, or should a jurisdiction would pick one or the other (i.e., either apply for the Required Strategy Budget or the Enhanced Implementation Budget)?

A: These budget numbers are NOT additive; they are the range within which you may apply. Your final proposed budget would likely fall somewhere between those amounts.

Q: Are the budget amounts listed in Appendix 10 just for Year 1?

A: Yes, the budget range in Appendix 10 is the estimated dollar amount per year (i.e. annual approximation). However, applicants must indicate in the Travel budget category that they will commit to funding travel to the annual reverse-site visits in Years 2 and 3.

Q: Let's say a state Department of Public Health & a local health department can and do apply separately, are the budget caps listed in Appendix 10 shared across both entities? For instance, the state's cap for the Innovation Project is $400,000 – would that mean the state health department could apply for up to $400,000 and the local health department could also apply for up to $400,000, or does it mean we need to ensure collectively, we stay under the cap?

A: With respect to state and local applicants, all budget numbers are entirely separate and independent from one another. Each applicant/recipient would have autonomy over their entire budget as described in Appendix 10.

Q: When applying for enhanced funding for the PDMP, does the budget need to reflect how the additional $215,000 will support PDMP activities or can it just be added to the total amount available to the state?

A: If an eligible jurisdiction is interested in applying for the enhanced PDMP funding, their budget would need to include specifics related to which enhanced elements they would be implementing.

Q: Can we fund non-governmental agencies or should the focus be on building local government agency capacity?

A: Yes. You can fund non-governmental organizations or other private partners as long as you can demonstrate that they are the appropriate ones to accomplish the work.

Prevention Component Questions

Q: The NOFO states "State health departments are required to allocate at least 20% of their prevention component award to fund targeted mini-grants and sub-awards to counties/cities/communities to address opioid overdose in high burden areas", is this saying the state health department must award mini-grants for the communities to identify their needs and use the funding to meet those needs? Or can state health departments work with communities to identify needs and sub-award funding to specific agencies within targeted communities to address identified needs?

A: To further the goal of state and local integration, these "mini-grants" would need to be made to a locality, rather for a specific activity that can be implemented by interested localities. As CDC works with funded recipients to collaborate and ensure successful program implementation, it is expected that states/territories would similarly collaborate with localities awarded "mini-grants" to ensure successful program implementation as part of Strategy 5.

Q: On the NOFO it lists that at least 20% of prevention funding needs to go to the local level and it mentions high-burden areas. Does this money need to only go to the identified high-burden areas or can other areas of the state be funded?

A: State health departments will have significant discretion as to how they allocate the 20% funding to the local level. Activities should align with site-specific data. As an example, some state health departments may determine that prevention investments are appropriate in lower-burden areas while high-burden areas would benefit from more response activities. It will be up to states in collaboration with their local partners to determine how these funds are allocated.

Q: In our state, our county or local health departments are part of the state department of health. Currently, our county health departments are not receiving any funding for opioid response activities so this would be an opportunity to build capacity at the local level. Is it permissible to allocate 20% of the prevention budget to these county health departments?

A: The allocation of the 20% local prevention funds as described here is allowable. The 20% allocation is a minimum; states may elect to direct more than 20% of their prevention budget to local partners to accomplish the work and outcomes of this NOFO.

Q: For Strategy 5 integration, it refers to 20% of the total prevention award going to the local level. Is there also a cap on how much can go to a sub-award mini-grant to the community?

A: There is no official cap. Please be mindful that a review of the budget is part of the application process and you will want to maintain adequate funding within the state level budget to implement the four required strategies.

Q: Please provide more information about the enhanced funding for peer-to-peer learning coordinators. What can these funds can be spent on and what the scope of this project entails?

A: Per the NOFO, recipients interested in serving as Peer-to-Peer Learning Coordinators should specify a content area within the prevention component and demonstrate their expertise within this content area. You would be expected to be a resource to all other funded jurisdictions that are also engaged in that type of work. Additionally, interested recipients should propose a curriculum and process by which they would build capacity among their funded counterparts in other states and/or funded local health departments. You may choose to propose a series of webinars, or in-person meetings/trainings for capacity building, or direct technical assistant to other funded jurisdictions implementing similar work. These are just examples and are not comprehensive. The onus is on the applicant to demonstrate how you will facilitate peer-to-peer learning in the field in the specific content area. Peer-to-Peer Learning Coordinators are for the prevention component only.

Q: Is the intention of the NOFO to be on accidental opioid overdoses, or can intentional/suicidal overdoses be considered as well in prevention activities?

A: The purpose of the prevention activities under this NOFO is to avert opioid overdose related morbidity and mortality. Prevention activities can consider both unintentional and intentional overdoses. However, activities whose focus is primarily on intentional opioid overdose or on suicide prevention more broadly would be considered out of the scope of this funding.

Q: For the peer-to-peer component, can a state apply for surveillance activities or does it have to be part of the prevention component?

A: All of the peer-to-peer learning coordinators have to promote content that resides within the prevention component.

Q: If we do not apply for the peer learning coordinator in year one, would there be an opportunity to apply in future years?

A: Currently no. However, depending on availability of future funds this may be a possibility in later years. If additional funds become available and they are designated for this purpose, CDC will issue a competitive supplement.

Q: What is the name of the PDMP hub referenced in Appendix 11? Is it the RxCheck hub?

A: Yes. The grant conditions (Appendix 11) refers to the Bureau of Justice Assistance's designated PDMP data-sharing system, which is the RxCheck hub.

Q: What do you mean by collateral and unintended consequences of actively managing their PDMP?

A: We have heard concerns from currently funded recipients that when providers are alerted to aberrant prescribing rates and/or patients who may be at risk of overdose, there are concerns about punitive action or sanctions taken against the prescribers. As a result, we have heard that some providers are reluctant to continue providing care for certain individuals.

Q: There are four main types of activities under the base PDMP activities. Do all of these need to be completed? What if you are already doing some of them?

A: You do not have to do all four activities. Please identify activities that work best with your population and policy or legislative context.

Q: How is the city supposed to engage with a PDMP seemed geared toward states?

A: While PDMPs are administered at the state level, there are numerous opportunities for cities to engage with their local healthcare systems to improve the usage of PDMPs as a clinical decision tool and public health surveillance system. We recognize that states have different relationships with cities and the PDMP- part of the goal of this funding is to strengthen those relationships and collaborations within a state. There are a number of quality improvement programs that are being piloted throughout the country that may be of interest to you. Many healthcare systems are engaged in implementing CDC Guideline for Prescribing Opioids for Chronic Pain. A few examples for you to consider are: pursuing a range of system-level changes to facilitate implementation of the CDC Prescribing Guideline recommendations in their practices including:

- Engage behavioral health specialists
- Leverage electronic health records
- Use clinical decision support tools
- Document Prescription Drug Monitoring Program (PDMP) checks
- Develop a patient registry
- Use a dashboard for audit and feedback
- Use shared medical appointments
- Standardize approach across providers

At the city level this will depend highly on how the health systems are structured within your jurisdiction. However, we have found healthcare systems to be highly engaged in this process and finding partners for this work we believe will be fairly straightforward process.

Q: Is analyzing PDMP using CDC performance measures and disseminating results to improve practice funded under this strategy?

A: Yes

Q: Is it possible to receive clarification regarding the necessity of exchanging data with other PDMP systems via the PDMP hub as opposed to using a different data exchange system such as PMP InterConnect?

A: Please attend the informational call on March 12, 2019 at 3:30 pm EST for additional information. You can find the call information in the NOFO.

Q: Our state's PDMP is housed and managed in a different department that the public health department that is applying for the Overdose Data to Action grant. The public health department does not have control over the PDMP or access to it. Per a public health statute, the PDMP's governing agency, the regulatory agency in our state, cannot share data with the public health department as stipulated in Appendix 11 and 12 (from the viewpoint of the regulatory agency). Does Appendix 11 apply to the entire Strategy 4, including 4.1 (Required) and 4.2 (Enhanced) or either 4.1 OR 4.2?

A: Appendix 11 applies to both 4.1 and 4.2. The Grant Conditions do not require the PDMP to share data with the Department of Health, nor do they grant access to the PDMP. These conditions require PDMP-to-PDMP connections to facilitate interstate interoperability and data exchange.

Q: Do the special conditions in Appendix 11 apply to all applicants regardless of whether the state uses the CDC funding for PDMP enhancement?

A: Yes.

Q: Is analyzing PDMP using CDC performance measures funded under base or enhanced activities?

A: If you are able to demonstrate that that process is enhancing inter or intra-state interoperability, it could be enhanced. Otherwise, it is a base activity.

Q: Can states use funds to support HIV, STD, and HCV testing in at-risk populations?

A: There's significant overlap in vulnerable populations. While funds from this NOFO cannot be used to provide clinical care or testing, activities leveraging access to this vulnerable population for the purposes of linkage to care are allowable. Consider aligning proposed work with strategy 6 and demonstrate how this achieves the long-term outcomes associated with opioid use disorder, misuse and overdose, which are outlined in the NOFO.

Q: For the peer-to-peer network and PDMP award, does $250,000 and $215,000, respectively, have to go directly to this work? If so, do we need to submit a separate budget narrative? Would indirect costs be allowable, for example, communications and/or evaluation supports?

A: The $250,000 and $215,000, respectively, do have to go directly to that work. Yes, you will need a separate budget narrative for that. Indirect costs are allowable.

Q: Can you elaborate on direct assistance? Some guidance on how to balance or navigate that potential request would be helpful. Is it similar to surge staff support?

A: Direct assistance will not be available during the first year of the award. The goal is for you to develop a better understanding of your staffing and technical assistance needs during the first year of the award. We will offer more specific guidance soon.

Q: Can education to OB/GYNs regarding OUD and treatment count as prevention?

A: Yes. Evidence-based provider education regarding prescribing of opioids or resources for linkage to care counts as prevention.

Q: Do the required prevention strategies also apply to the local community applicants?

A: City or county health departments who meet the eligibility criteria to receive direct funding for this NOFO must complete the required prevention activities. State health departments must allocate at minimum 20% of their prevention budget to the local level, and those recipients are not required to do all the required prevention strategies.

Q: What harm reduction activities are allowed?

A: OD2A funds may NOT be used for: purchasing naloxone, purchasing fentanyl test strips, purchasing syringes, drug take-back or other safe disposal programs and direct provision of treatment services. If you have additional questions, please email overdosedata2action@cdc.gov.

Q: Does supporting work around enabling physicians to acquire buprenorphine prescribing waivers count as direct provision of treatment services or is this allowed?

A: That would be allowable as a linkage to care process and equipping health systems to deliver people into treatment.

Q: For Strategy 7, provider and health system support, is there a possibility for a patient-focused program in addition to a prescriber focused program? For example, a prior authorization process, prescriber evaluation, program use in addition to a patient-focused NTM program or is the intent for prescriber focus only?

A: There is the possibility to focus on patient-focused programs. You may propose this under provider and health system support if you can adequately capture how this work would be accomplished by a health system. You may also consider framing this work as something under empowering individuals (strategy 9). Patient-focused education programs are allowable.

Q: Can you please elaborate on the statement, "All innovation activities must be approved by the CDC prior to implementation"? Is this referring to further approval after the grant or just the approval of the activities when states submit their applications?

A: It is both. You can submit an innovation project idea with your original application. But you may also submit an innovation proposal at almost any point over the course of the award itself.

Q: Can Strategy 10 funds be utilized in collaboration activities that may overlap treatment and/or recovery and require collaboration with other state agencies?

A: As long as the innovation funds are not directly supporting provision of treatment services or direct care, then yes.

Q: Are we able to utilize funds for this NOFO to build onto the work resulting from the vulnerability assessment finding?

A: You can build and expand upon the vulnerability assessment funded by the National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention (NCHHSTP). If results from that work inform prevention efforts aligning with the long-term outcomes of this NOFO and prevention strategies then the proposed activities would be allowable.

Q: For Strategy 6, linkages to care, are funds allowed to cover the cost of transportation, such as grant money funds, organizations that work specifically to transport people into treatment centers?

A: This is potentially an allowable expense, but would be subject to review and approval. Applicants proposing to use funds for transportation should demonstrate how the funds are achieving linkage to care.

Q: We received funding through the opioid crisis CoAg which ends on 9/20/19 and took advantage of the partner request to secure several key project staff. These are for ongoing projects that we will be applying for through this NOFO. Given the need to maintain staffing, infrastructure, continuity, when will we find out whether there will be an extension to the partner mechanism or should we plan to budget for these positions in our application?

A: Please contact the Division of State and Local Readiness (DSLR) for questions pertaining to 2018 Opioid Overdose Crisis Response Funding.

Q: This NOFO states that harm reduction strategies include medication assisted treatment. However, this NOFO also directly states that funds cannot be used - to directly use to fund substance abuse treatment programs. How can we ensure that we are not crossing this line when dealing with buprenorphine and other treatment and recovery programs?

A: This NOFO restricts using funds directly paying for the provision of care or the purchase of substances associated with that care. This funding is allowed to provide linkage to care, such as medication assisted treatment.

Q: Is analyzing EMS data for Naloxone administration in a timely manner to support hotspot identification funded under Strategy 8, public safety partnerships?

A: Yes

Q: Regarding Strategy 8, could you elaborate on other sub-activities to partner with public safety and first responders to engage prevention efforts aimed at reducing opioid-related morbidity, mortality and associated harm?

A: We are excited to review the innovations that emerge from applicants. Examples of these partnerships can involve pre-arrest diversion programs and connections with opioid or other substance use or utilizing peer navigators or community health workers in the justice system to connect individuals with treatment or other harm reduction services. These are just two examples and is not an exhaustive list. Please propose innovative ideas that work within the context of your population and community.

Surveillance Component Questions

Q: Can you provide additional information about the Biosense data and reporting element mentioned in surveillance strategy 1/ tier 1?

A: The reporting elements are included in the NOFO and are described in the surveillance informational slides. To request a copy of the slides, please email overdosedata2action@cdc.gov.

Q: For the surveillance criteria (e.g., syndromic queries, ICD-10-CM codes), is there a timeframe of when this information will be distributed?

A: Final case definitions for all indicators for billing/discharge data will be available on or before award date. Syndromic surveillance definitions will also be available at that time; however, the CCDD categories based on the syndrome definitions for all drug, opioid, heroin, and stimulant overdose are now available in NSSP/ESSENCE.

Q: The NOFO states "In order to ensure coordination of ED and drug overdose death surveillance, city and county health departments are expected to participate in their state health department NOFO funded surveillance of emergency department visits involving all drug, all opioid, heroin and all stimulant overdoses (Strategy 1) and drug overdose deaths (Strategy 2)." Is their indication to do this in a letter of support sufficient to ensure this occurs? Do the city and county health departments need to state this in their application?

A: There is no specific requirement in the NOFO to submit a letter of support from the state health department or explicitly include language that the city or county health department will meet the requirement of participating with the state health department on surveillance Strategy 1 and surveillance Strategy 2. Letters of support, however, are strongly encouraged and obtaining a letter of support from the state health department and/or explicitly including language in the NOFO confirming participation would provide evidence of the applicant's ability to meet an important surveillance requirement and thus may result in a higher evaluation score (See *Section, E. Review and Selection Process, b. Phase II Review* for details on how applications will be scored). Also, a letter of support from the state health department is encouraged by the following text located in the *Section 1b: Collaborations with organizations not funded by CDC*:

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

Applicants may provide any materials (e.g., MOUs, LOS from non-government organizations) that demonstrate these collaborations, but are not required to do so.

Q: I'm unclear why fentanyl test strips are not an allowed expense – For one of the activities under Surveillance Strategy 3, "Track public health risk of illicit of opioid drug supply," it was described on the webinar that it includes directly testing the drug – which is where fentanyl test strips would have a significant impact.

A: Funds from this NOFO cannot be used to purchase fentanyl strips (i.e., it is a prohibited activity). Rapid field testing of drugs, however, with other technologies such as field toxicology testing machines (e.g., TruNarc Raman spectroscopy machine and the Bruker Alpha machine), toxicological assays that rapidly test for drug that are commonly misused or used as adulterants (e.g., heroin or fentanyl), or other types of rapid fentanyl tests that use solutions instead of strips are allowable and support the prioritized goal of Surveillance Strategy 3. "Track public health risk of illicit of opioid drug supply". Also, health departments may propose to use NOFO funds to rapidly collect and share the results from fentanyl test strips or other toxicology testing technologies conducted by people who misuse drugs as long as funding is not used to purchase fentanyl strips.

Q: Our jurisdiction collects SUDORS (NVDRS) information in a different system, and last time funding was available for this, they elected not to participate in it because they wanted to use their current data collection system. As we understand the current NOFO, if our jurisdiction wants to apply for their own funding, then they will need to specifically agree to use SUDORS and also share this data with the local department of health. Is this correct?

A: Yes, a requirement of the current OD2A NOFO funding is that the 50 states, DC, and Puerto Rico must use the SUDORS system to abstract all fatal drug overdoses of unintentional or undetermined intent. Cities and localities are not eligible to receive funding for Strategy 2. If your jurisdiction is eligible to receive funding for Strategy 2, you will be required to document your ability to partner with localities to receive the data necessary and enter it into SUDORS to comply with the requirements in Strategy 2 (e.g., provide electronic access to local health department Medical Examiner/Coroner (ME/C) records or have your jurisdiction enter data directly into SUDORS; however, this would not prohibit you from also using a local system as long as the all the data are entered into SUDORS).

However, your jurisdiction may use OD2A NOFO funding to implement innovative projects (See Strategy 3) that utilize locally collected data, including ME/C data or data elements outside the scope of Strategy 1 and Strategy 2. The proposed innovative projects would need to move beyond the scope of Strategy 1 and Strategy 2 and align with one of the 7 data collection priorities outlined in *Section 3.2 Seven CDC data collection priorities for innovative surveillance project.* For instance, a city or county health department could propose to use NOFO funding to link ED or ME/C data with prescription drug monitoring data, conduct interviews with family members, and/or data on recent decedent institutionalization or involvement in a city or county intervention such as being linked to treatment by a patient navigator, or participation in medically-assisted treatment programs. CDC encourages the sharing of this innovative city and county data with the state health department, but sharing is not required as outlined in *1a Collaborations: With other CDC programs and CDC-funded organizations section* (Relevant text reprinted below).

Excerpt of relevant text from the OD2A NOFO on encouraged, but not required data sharing and collaboration on data collections outside Strategy 1 and Strategy 2.

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

Q: Is enhanced toxicology strategy required?

A: Yes.

Q: Our state is discussing whether we want to submit a SUDORS commitment of all unintentional or undetermined intent drug overdose deaths in the jurisdiction or commit to the second option of UUDO deaths in a subset of counties. The NOFO suggests that if we chose the latter we would receive reduced funding. Is it possible to share how much the funding would be reduced if we chose option 2?

A: If your state chooses to collect data on a subset of unintentional or undetermined intent drug overdose deaths (i.e., UUDO deaths) instead of all UUDO deaths, the reduction in funding would be based on the total number of UUDO deaths that occurred in the subset of counties in 2017. Thus, if you collect 95% of the UUDO deaths in your jurisdiction, you will receive a smaller deduction than if you collect 75% of UUDO deaths in your jurisdiction. If you send CDC a list of the targeted subset of counties through OverdoseData2Action (CDC) <overdosedata2action@cdc.gov>, we can send your revised suggested maximum budget for SUDORS. Because the SUDORS formula takes into account a variety of factors such as staffing, travel, and supplies, the percentage reduction in budget will likely not be exactly the same as the reduction in deaths (e.g., if Indiana chooses to collect 80% of UUDO deaths the revised maximum budget is unlikely to be exactly 80% of the current SUDORS suggested maximum). Finally, if your state chooses to collect UUDO deaths in a subset of counties, please use Appendix 5 to inform this process.

Q: Surveillance strategy 1 provides an additional $50,000 for quarterly reporting of hospital discharge data (Section 1.2 in the NOFO). The reporting schedule (Appendix 3) indicates that these data must be reported with a one quarter lag. Currently in our state, hospital discharge data are not made available for analysis in the department until approximately 10 months after the end of the reporting period (e.g., we received provisional Q1 2018 discharge data in February of 2019). We would like to continue to provide these data to CDC as we've spent a significant amount of effort building infrastructure around the hospital discharge data in order to meet our requirements for the PFS grant, but we will not currently be able to adhere to the reporting schedule. Does this make us ineligible to request the $50,000 enhancement for strategy 1 or can we apply for it and work with CDC to develop a revised reporting timeline that fits our data release schedule?

A: In order to receive the additional $50,000 of optional funding, applicants must agree to adhere to the reporting timeline outlined in the data release schedule. A revised reporting timeline is not allowable.

Q: Does surveillance strategy one refer to county of death or county of residence?

A: Surveillance strategy one is on nonfatal overdoses as seen in emergency departments and county refers to the county of the patient residence NOT the county of the emergency department/facility.

Q: As I read the NOFO and Appendix 3, it appears that data needs to be submitted to CDC practically from the start of the NOFO (ESOOS and SUDOR data). However, we do not currently have the filters for stimulants in ESOOS and that may take more than one month to implement. Also, our current filters are more stringent than CDC's (we will share these – they are better at eliminating the false positives) and will need to be revised based upon the finally accepted filters. Should we be starting to implement these new filters prior to receiving funding?

More of concern is the timeline for the SUDORS data. Since our state is not a SUDORS state, even though we can access the death certificates and get them into the NVDRS system, obtaining and abstracting the ME/C reports will take time, especially since staff need to be hired and trained which cannot occur until after the grant starts. Am I reading Table 2.1 correctly that all 2019 deaths for currently non-SUDORS states need to be submitted by 6/10/2020 rather than the 1/10/2020 deadline?

A: If Tier 1 or Tier 2 is selected the first due date for data submission is November 4, 2019. If Tier 3 is selected, since you are not a currently funded ESOOS state the first due date for data submission is April 13, 2020. As mentioned on the call, additional guidance will be provided by the time of award. NSSP/ESSENCE pre-set queries are currently available for suspected all drug, opioid, heroin, and stimulant overdose in the CCDD category field and are appended to this email.

As for SUDORS, if you select Tier 1, the first reporting requirement is June 10, 2020 for deaths from July 1, 2019 through December 31, 2019 (i.e., the last half of 2019). If you select Tier 2, the first reporting requirement is August 12, 2020 for deaths from July 1, 2019 through December 31, 2019 (i.e., the last half of 2019). If you select SUDORS tier 3, which includes a planning year, then the first reporting deadline is 8/12/2021. The first due dates will vary based on the tier you select.

Q: In the document Appendix 1 Data Surveillance Checklist under Checklist for Surveillance Strategy 1: Collect and disseminate timely ED data on suspected all drug, all opioid, heroin, and all stimulant overdoses, one of the checkboxes states, "Applicant budget includes at least $75,000 per year to support the staffing unit responsible for collecting rapid ED data to enhance ED quality improvements". Does the $75,000 have to go to the program area in the state health department that coordinates syndromic surveillance or can it be used by the injury program when they have dedicated staff responsible for all drug overdose work conducted using syndromic surveillance, or also be used to contract with the syndromic surveillance system vendor (HMS EpiCenter) to enhance quality improvements.

A: The intention of the $75,000 is to support staff who are responsible for management, analysis, and OD2A reporting requirements pertaining to syndromic surveillance that may or may not sit in the unit responsible for management of the overall OD2A program. We understand staffing situations may vary across state health departments and want to provide flexibility in determining the appropriate unit. If you can provide justification for providing it to staff in the injury program, please do so.

Q: Will the drug overdose module in SUDORS be expanded to include contextual information about overdoses for drugs other than opioids?

A: We will use the platform as it currently exists; however, the system will likely be updated in the future. Funded jurisdictions will enter information on all drug overdoses. We will collect information on other drugs, although our primary focus is still going to be on opioids.

Q: Would data that is uploaded to the ESSENCE Cloud daily meet this data requirement or is there separate reporting that is needed on top of the cloud data shared?

A: This would meet the requirement for Tiers 1 and 2.

Q: For the optional SUDORS activity, can the $200,000 per year be used to hire staff for coroner officers to help implement the activity?

A: Yes.

Q: Are states required to use the exact syndrome definition provided by CDC or can there be modifications based on what is seen in the data in their state?

A: Yes, we are requiring the recipients to use the exact syndrome definition provided by CDC. If there are things that you are seeing in your state that are not consistent with the definitions that ESOOS has been working on, please email us.

Q: For early enhancement, what is the lag allowed for data reporting?

A: The lag is one quarter. For example, the quarterly data submission for April 2020 would consist of data from quarter 4 of 2019.

Q: Is there a place for local communities with the surveillance components of OD2A?

A: Yes. Local communities are eligible to apply for surveillance strategy three, which focuses on innovative projects.

Q: What constitutes sufficient toxicology testing to qualify for the other five strategies?

A: Please refer to Appendix 8 where we specifically say which substances would be included. If you have additional questions, please email overdosedata2action@cdc.gov

Note: These FAQs address questions received and answered from February 20 – March 1, 2019.

Q: For strategy 1, what is the best method for determining if you have 75% of emergency department visits for syndromic?

A: There are multiple methods that you can use to determine if you have 75% of ED visits. The CDC does not endorse one method. If you share data in the National Syndromic Surveillance Program Essence Platform, they calculate the emergency department coverage in a very specific way. A good starting place might be to look at the facilities in the American Hospital Association within your state, and then determine the number of ED visits that occur in those facilities and that will give you, at least, a general number of how many ED visits are occurring in your state.

Q: Will we supply a budget for the enhanced pieces up to $200,000 or will you determine how much we receive?

A: Applicants are required to describe the activities that will be included for the SUDORS enhancement and the amount of funding that will be needed to complete the activities in the budget. This information will be reviewed as part of the overall budget review.

Q: The NOFO states that innovative surveillance projects must comply with CDC OMB regulation, does that include the paperwork reduction act?

A: Yes.

Q: Please clarify a local health department applying under Strategy 3 must address one of the priorities, but may address more than one, correct?

A: Yes, correct. One is required, but it can be more than one.

Q: Was Strategy 3 changed from local health surveillance of persons using and misusing opioids to local health surveillance of persons using or misusing drugs?

A: There was an error on the initial slide set from the call on 2/21/2019, which was corrected in for the call on 3/5/19. The wording in the NOFO is correct. For strategy 3 (innovative projects), local surveillance should focus on persons using and misusing opioids.

Q: I think given that incidents of HCV is an excellent indicator of potential IDU in the community, would enhancing HCV surveillance count as an innovative project?

A**:** No.

Q: Can a partnership application consisting of two or three local health departments be submitted under Strategy 3?

A: No.

Q: Can you provide the ICD10-CM codes for the ED billing data?

A: Final case definitions for all indicators for billing/discharge data will be available on or before award date.

Q: Is the EMS Surveillance strategy from ESOOS no longer included?

A: EMS data submission is not part of strategy one; however, EMS data activities are included in the innovative surveillance project (strategy 3).

Q: Does CDC intend to integrate EMS data with Essence at the national level as reference to the innovative surveillance of drug overdose mortality and morbidity?

A: The intent of this innovative project is to allow states the opportunity to integrate EMS data into their local instance of ESSENCE. At this time, there is not national-level effort to integrate this data in NSSP ESSENCE.

Q: What happens when you're not at 75% ED syndromic or ED billing data?

A: If you are not at the 75% for the ED Syndromic or ED billing data threshold, then you do not meet the requirements for this NOFO.

Q: Would billing discharge data for inpatients only be sufficient for optional 1.2?

A: Yes, but it would only be sufficient for the optional enhancement. If a state is sharing billing/discharge data for Tiers 1-4 it must include at least ED visits.

Q: For Strategy One, if Tier 2 is chosen using syndromic data rather than granting ESSENCE access, is it required to submit case level data or will just aggregate template be required?

A: For this NOFO, no case level data will be reported to CDC. The only situation when case level data are going to be accepted by CDC is when states provide access to the NSSP ESSENCE Platform. States sharing data outside of NSSP ESSENCE will be required to use an aggregate template to be shared following award.

Note: These FAQs address questions received and answered from February 20 – March 1, 2019.

Q: Please confirm if applying under Strategy Three you must demonstrate collaboration with all five key data partners listed on Page 38 of 88? Is that correct?

A: Yes, all five are required. The exception is for hospital associations if you are not sharing billing/discharge data

Q: Are deaths based on where the injury occurred or where the death took place?

A: Where the death took place.

Q: Will hospitalization cases be identified using principle diagnosis codes only or all diagnosis codes?

A: All diagnosis codes.

Q: Is billing discharge data for overdose required only or for patients admitted with OUD as a comorbidity as well?

A: The billing discharge data submitted would be for overdose for all four indicators. The surveillance component on this NOFO includes all drug overdoses, all opioid overdoses, all heroin overdoses, and stimulant overdoses.

Q: Does CDC anticipate that NSSP sharing will require a new DUA with hospital contributors?

A: This will depend on your current DUA with the facilities and your state policies.

Q: Can a state apply for the ED billing quarterly enhancement if data are only available for analysis on a lag longer than one quarter?

A: No. According to the NOFO, the enhanced ED billing data is required on a quarterly basis and can only have a quarter lag.

Q: Why doesn't the OD2A NOFO use the word "biosurveillance" to describe the activities in the surveillance component?

A: The OD2A NOFO uses the general term "surveillance" throughout. Though the word "biosurveillance" is not explicitly used within the OD2A NOFO, the intention of "surveillance" is to be inclusive of "biosurveillance."

Note: These FAQs address questions received and answered from February 20 – March 1, 2019.

Q: If ESSENCE access is granted, states would then be required to conduct review either every two weeks or monthly depending on if Tier 1 or Tier 2 are selected. What does that review look like?

A: We will provide an update of what the review look like following award.

Q: Does screening need to be done by immunoassay?

A: Screening tests do not necessarily need to be performed by immunoassay. Screening often is done via immunoassay, but screens using GC, GC-MS, or LC-time of flight MS are also acceptable.