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

Date Last Updated: April 5, 2019

The FAQs below contain questions received and answered from March 1 – 14, 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: What are appropriate ways to identify people misusing opioids?

A: We encourage health departments to work with local community-based or treatment organizations to identify persons who misuse opioids. For example, a jurisdiction could partner with local harm reduction organizations or other organizations that offer risk reduction services, including syringe service programs, to potentially recruit persons. This is only an example and not exhaustive.

Q: Does the work plan need to be in a table format or can it be in a narrative format?

A: There is no required format for the work plan. An example work plan template you may use to inform the development of your work plan can be found here: https://ftp.cdc.gov/pub/TBI/PDO/CDC-RFA-CE16-1606_FOA_Prescription_Drug_Overdose/

Q: The work plan requires us to discuss SMART objectives for the first 12 months only. Should we also write SMART objectives for Years 2 and 3 activities?

A: Objective reviewers will only score your application based on the SMART objectives in your work plan for Year 1. You include SMART objectives for Years 2 and 3 if it is helpful for your application approval process, but they will not be scored. Additionally, be mindful that they will count toward your work plan page limit.

Q: Should evaluation positions cover all components or just prevention?

A: The evaluation position must cover prevention content; you have the option to also propose evaluation work related to surveillance content.

Q: Is the evaluation plan supposed to be written in the prevention category, the surveillance category, or as a standalone piece?

A: The evaluation plan is a standalone piece. Your evaluation plan may refer to both surveillance and prevention content. It may be more pertinent to prevention content but you can propose evaluation work associated with your surveillance component as well. For an example of the evaluation template, please visit: https://ftp.cdc.gov/pub/TBI/PDO/CDC-RFA-CE16-1606_FOA_Prescription_Drug_Overdose/

Q: Where an activity fits in more than one strategy, should we just pick one or pick the same activity in multiple strategies?

A: Please select one**.**

Q: Do the letters of support requirements for state level, public safety, first responder, and mental health agencies also apply to local applicants?

A: Yes. If you are proposing work that depends on those partners to accomplish the outcomes identified in this NOFO, then you should include a letter of support from them.

Q: If there are activities that require collaboration with different departments/administrative units within my jurisdiction's health department, do I need to include a letter of support?

A: Yes. For example, regarding surveillance, letters of support are required for the National Violent Death Reporting System. Even if the department/administrative unit is within your jurisdiction's health department, the letter of support is necessary for objective reviewers to have all of the required elements of your application.

Q: Can you direct me to where information regarding the dissemination plan is described and where it fits in the grant application?

A: Please see Appendix 1 for information on dissemination requirements for Strategies 1 and 2. Additional guidance will be provided following award.

Q: Do we need a brief dissemination plan outside of what we are writing as our strategies in our grant narrative?

A: The data dissemination plan is not part of the application, but it will be part of post-award processes. The OD2A team is working on a template for funded states to guide their data dissemination plans, which will be available following award.

Q: Is there a template for the Data Management Plan (DMP)?

A: No, there is no template for the DMP.

Q: Page 46 of the NOFO has language around the inclusion of a Data Management Plan (DMP) in our application. Can you provide more guidance on how to develop the plan and what this means?

A: A preliminary draft or outline of a DMP is required in the application for all public health data collected or generated as part of OD2A. Recipients are required to submit a detailed DMP, within the first 6 months of award, with assistance from CDC. We are not requiring a specific format or structure, but the final DMP should include the following information:

- A description of the data to be collected or generated in the proposed project;
- Standards to be used for the collected or generated data;
- Mechanisms for or limitations to providing access to and sharing of the data (include a description of provisions for the protection of privacy, confidentiality, security, intellectual property, or other rights);
- Plans to address access to identifiable and de-identified data (see below for additional information about access);
- Statement of the use of data standards that ensure all released data have appropriate documentation that describes the method of collection, what the data represent, and potential limitations for use; and
- Plans for archiving and long-term preservation of the data, or explaining why long-term preservation and access are not justified. This section should address archiving and preservation of identifiable and de-identified data (see below for additional information regarding archiving).

Given page limit requirements, the preliminary draft or outline DMP in the application is expected to be brief, but it should reflect intent to address the bullets above. Applicants should also describe how the plan will be more fully developed and updated during the course of the award. Further information about DMPs may be found at: https://www.cdc.gov/grants/additional-requirements/ar-25.html.

Eligibility Questions

Q: Why are tribes not eligible to apply since cities are now allowed to apply? What consideration was given to tribes to address the similar issues, concerns, and data usage?

A: CDC did not include tribal entities as eligible applicants for OD2A, as we started a program in 2018 devoted specifically to opioid overdose in tribal communities.

CDC committed approximately $13 million/year to support tribal organizations and communities to focus efforts on strategies and interventions that are best suited to meet their unique needs. CDC has the following three NOFOs to fund tribal opioid overdose prevention efforts:

- Tribal Public Health Capacity-Building and Quality Improvement Umbrella Cooperative Agreement (CDC-RFA-OT18-1803), whose recipients are tribal entities.
- Building Public Health Infrastructure in Tribal Communities to Accelerate Disease Prevention and Health Promotion in Indian Country program (CDC-RFA-DP17-1704), whose recipients are tribal epidemiology centers.
- Preventive Health and Health Services – Strengthening Public Health Systems and Services through National Partnerships to Improve and Protect the Nation's Health (CDC-RFA-OT18-1802), whose recipients are technical assistance providers to tribal communities, tribal epidemiology centers, and other tribal entities.

These recipients are midway through their first budget period and are undertaking projects in surveillance and prevention to address opioid overdoses.

Q: Do the conditions of this award require that we submit copies of our contracts to CDC prior to approval? Or do you simply require information about any contracts that will potentially be involved in the grant?

A: No. As part of your application, you are required to list all contracts (including a scope of work) you wish to fund with this cooperative agreement. You are not required to submit the actual contract with your application. Please see page 63 of the NOFO for additional details.

Budget Questions

Q: Should we be creating a separate budget for surveillance and prevention and then a third version with everything?

A: There should be one budget that includes projected costs for all of your project activities, including prevention, surveillance, and innovation activities. The budget narrative should indicate which costs are associated with which strategy/activity and should clearly distinguish between funds allocated to support surveillance activities (Strategies 1 – 3) from prevention activities (Strategies 4 – 10) (See Section 12. Budget Narrative p. 64 – 65). For example, we would consider the principal investigator salary and fringe costs to be designated as an overall budget line item, a data abstractor as a surveillance budget item, and a provider education/support coordinator as a prevention budget item.

As a reminder, at least $75,000 per year should be budgeted to support the staffing unit responsible for collecting rapid ED data to enhance ED quality improvements (regardless of the tier selected). Your jurisdiction will have discretion on how to distribute the budget across the surveillance strategies (Strategies 1 – 3) and across the prevention strategies (Strategies 4 – 10).

Q: Regarding the surveillance budget, our understanding is that staff doing surveillance work are allowed to be included in the budget for Strategies 1 – 3. What about coordinators and other support staff?

A: Please include coordinators and other support staff in your overall budget. Review previous question clarifying the budget.

Q: Can a jurisdiction apply for more than the state budget for overall budget needs?

A: No. Please review Appendix 10 or email overdosedata2action@cdc.gov for your budget 1-pager**.**

Q: Will fiscal reporting be on just the total category of funding (combined component and strategy budget) or will we need to track categories of funding separately?

A: The categories you will need to track separately are those that come with already specified limits associated with them.

Q: Appendix 10 worksheets are listed by state. Are the figures listed a limit of all possible awards made to the state, or are these per applicant? For example, if more than one county in Ohio applies, can each have a budget of $400,000 for Surveillance Strategy 3, or is that the limit of funds available to each state, regardless of how many counties apply?

A: Budget numbers are entirely separate and independent for each applicant. Funding for counties within a state do not apply towards the funding limit available for that state. Each applicant/recipient would have autonomy over their entire budget as described in Appendix 10. Please email overdosedata2action@cdc.gov for your jurisdiction-specific budget, which provides more detail than just the upper and lower parameters found in Appendix 10.

Q: Must sub-grants (20% of prevention award) meet the 700,000 population / +395 OUD requirements?

A: The 20% of the prevention award can go to local partners in any jurisdiction and does not have to meet the burden requirement. Partners receiving sub-grants do not need to

be resident in jurisdictions meeting the burden requirements associated with eligibility criteria for the overall award funding.

Q: "Ensure at least $75,000 per year is budgeted to support the staffing unit responsible for collecting rapid ED data to enhance ED quality improvements." Is the $75,000 from each recipient or just from the states?

A: This requirement only applies to state applicants, the District of Columbia, and Puerto Rico because it is part of Strategy 1. City/county applicants are not responsible to meeting this requirement or addressing the requirement in the OD2A NOFO application.

Q: In Appendix 1, on page 14, the NOFO lists four tasks for the Surveillance Budget. The final two are a bit confusing. Does the following statement apply to eligible city/county recipients, "Ensure minimum funding listed in Table 4.1 is allocated to enhance comprehensive forensic toxicological testing of suspected drug overdose deaths to better detect opioids"?

A: This requirement only applies to state applicants, the District of Columbia, and Puerto Rico because it is part of Strategy 2. City/county applicants are not responsible for this requirement and are only eligible to apply for Strategy 3 under Surveillance. Once funding is allocated, you should be aware that your state department may be conducting outreach or ask your assistance to conduct outreach to your medical examiner/coroners or forensic labs if your state has a decentralized medical death investigation system.

Q: Does the toxicology budget in Appendix 10 represent the maximum amount of funds that can be spent on enhancing toxicology testing capabilities? Or can additional money be used from one of the other budget lines that pertain to mortality reporting?

A: The toxicology budget in Appendix 10 represents the minimum amount of funds that can be spent on enhancing toxicology testing capabilities. There is no explicit cap on funds provided for forensic toxicology testing, but you need to ensure that sufficient funding is budgeted to meet all of the requirements associated with surveillance Strategies 1, 2, and 3.

Requirements for shifting funding among surveillance budget lines is in Section 12: Budget Narrative:

> "In order to provide state health departments, the District of Columbia, and Puerto Rico flexibility in optimizing the use of CDC funds to conduct surveillance, these applicants may propose budgets that exceed the CDC suggested funding levels for each Strategy listed in Appendix 1 and used to calculate applicant's maximum budget. For instance, a state may choose to spend more on their collection of drug overdose deaths using SUDORS, or Strategy 2, and less on rapid ED data collection, Strategy 1, than suggested by CDC in Appendix 1 because the state has a strong existing ED data collection system and has to

build the infrastructure for collecting drug overdose death data. An applicant, however, must justify the decision in the budget narrative, must never exceed the overall surveillance budget maximum and must clearly demonstrate that their funding level for each Strategy 1 - 3 is sufficient to meet CDC requirements."

Prevention Questions

Q: Can we use prevention funds to purchase vehicles or otherwise pay for transportation costs associated with Linkage to Care?

A: If vehicle or transportation costs are consistent with the linkage to care strategy, they may be allowable expenses. Please note that there are specific justifications that must accompany proposed costs and they will be subject to additional review and approval by our Office of Grants Services. Recipients must provide an itemized budget that identifies cost determination and a narrative that links the vehicle (or other transportation costs) to the associated strategies in this funding opportunity (CE19-1904). As with all strategies supported by this NOFO, funds may not be used to provide treatment services or direct provision of care.

Q: What are the expectations for evaluation as far as maximum or minimum percent of dollar amount to spend on evaluation?

A: There is no pre-set limit or cap associated with evaluation. Please ensure you clearly identify that the evaluation activities align with the objectives of the NOFO.

Q: Can linkage to care activities include referrals and linkages to services other than medication-assisted treatment that are considered primary prevention (e.g. mental health, alternative treatment for pain management, support services for children and families who are traumatized by witnessing an overdose event, etc.)?

A: Funds from this NOFO can be used to support linkages to care for mental health services and evidence-based alternative treatments. Funds cannot be used to provide linkages to support services for children and families who witness an overdose event, but these activities may be allowable under a different strategy. For example, in the Public Health and Public Safety strategy, "developing partnerships among public safety and first responders and school and/or community partners to identify risk from Adverse Childhood Experiences and leverage partnerships to connect individuals and families at risk with necessary prevention resources" is an allowable activity.

Q: Is this $250,000 Peer-to-Peer Learning Coordinator amount included in the total potential jurisdictional budget?

A: Yes, this potential funding enhancement is reflected in your max ceiling.

Q: CORE is listed under the required letters of support, but the NOFO just says that a quarterly meeting is required to coordinate activities with CORE. Do we need to submit an actual letter?

A: Yes, please include a letter of support from CORE partners.

Q. If we are applying for the Peer-to-Peer Learning Coordinator role, does that proposed work have to fit within the project narrative?

A. You can submit your responses and a proposed work plan for your Peer-to-Peer activities as separate documents and upload them under the category of "Other Documents," clearly labeling them as your Peer-to-Peer Learning Coordinator Narrative and Peer-to-Peer Learning Coordinator Work Plan. The narrative should clearly demonstrate that you have area(s) of expertise within the prevention component and that you have a list of proposed curriculum activities to build capacity and expertise among your peers. Your Program Support Team will discuss your proposed activities with you if you are selected to serve as a Peer-to-Peer Coordinator. Additionally, the resumes of the experts that will be a part of the Peer-to-Peer Learning are not required, but it is preferred that you share them. They can also be uploaded under "Other" attachments as Peer-to-Peer Learning Expert Resumes.

Q: Can you provide clarification regarding whether or not we can fund hospitals, clinics, and pharmacies directly to support a one-time software upgrade of existing electronic health records and/or pharmacy management systems to support integration to the Gateway?

A: Based on the information provided, this would be an allowable activity.

Q: Can Neonatal Abstinence Syndrome (NAS) be included under Component 2?

A: Yes, NAS activities can fall under Strategies 6, 7, and 10. Specifically for Strategy 10, the applicant should demonstrate how the work of the proposed prevention innovation project aligns with the short-, intermediate-, and long-term objectives identified in the logic model. NAS incidence can be a sensitive marker of the impact of surveillance efforts to reduce opioid use during pregnancy and consequently, maternal misuse and opioid use disorder.

Q: What are some examples of Neonatal Abstinence Syndrome (NAS) prevention activities?

A: Examples include:

- linkage to care for mothers and infants of mothers who use opioids during pregnancy;

- ensuring clinicians and health systems have the data, tools, resources, and implementation strategies available to provide evidence-based care to infants with NAS and mothers with opioid use disorder; and
- identifying changes in long-term outcomes flagged in the logic model in 4-6 years.

Surveillance Questions

Q: Can we use our surveillance funding (particularly for Strategy 1) to give money to another entity (e.g., a non-profit organization, contractor, etc.) to pool resources to provide all states technical assistance?

A: CDC is working on a strategic plan to ensure states receive the best technical assistance possible to be successful in implementing all strategies within OD2A. Thus, including funding for any other organization to provide OD2A-specific technical assistance will be duplicative with contracting activities secured by CDC and would constitute a supplanting of federal funds. Federal law prohibits recipients of federal funds from attempting to replace state funds with federal funds.

Q: How will the surveillance tiers be determined for the applicants? If we apply for Tier 1, will we get it?

A: OD2A applicants must demonstrate capacity to meet all of the requirements within the selected tier in each Surveillance Strategy. Applicants are expected to meet reporting deadlines for that tier for each budget year, beginning in Year 1. States will be held accountable for the requirements in the tier for which they apply.

For example:

1. If applying for ED Tier 1, the applicant must demonstrate capacity to share ED data with CDC every 2 weeks through the National Syndromic Surveillance Program or NSSP. Applicants must also have the ability to access at least 75% of ED visits within their jurisdiction by the time they first report to CDC.
2. If applying for SUDORS Tier 1, the applicant must demonstrate capacity to meet all requirements associated with the selected SUDORS tier. Applicants must use NVDRS for data entry and report within a 6-11 month time lag.

Q: For ESOOS, we were asked to submit previous quarters with each submission. Will we be asked to re-submit previous quarters' data in OD2A?

A: No, there are no requirements to share previous quarters in each new submission. However, on page 13 of the NOFO we ask that historical data be included in your first submission for 2018 and 2019 (up until the required month/quarter). For those states with ESOOS funding, decisions will be made in concert with your state support team on how much data will need to be re-submitted.

Q: Our state would like to either apply for Tier 2 using our hospital discharge data, but we don't receive the data until right before the data submission date. Is there any wiggle room is our ability to share data a bit delayed from the required submission dates?

A: OD2A applicants must demonstrate capacity to meet all of the reporting requirements within the selected tier. Applicants are expected to meet reporting deadlines for that tier for each budget year, beginning in Year 1. If you select Tier 2, the requirement will be to share data monthly, with no delay.

Q: We can only meet the requirement of submitting emergency department discharge data within the CDC timeframe if we submit initial data which will be subsequently be revised. Is this okay?

A: In previous experience with ESOOS, we have allowed states to share updated data in situations where they have changed their case definition or experience a significant change in data quality, which impacts the data they previously submitted. Though we allowed this in ESOOS, we will not allow this in OD2A, due to the significantly enhanced requirements for data dissemination and sharing on an even quicker deadline. Because this task is optional, we are requiring that final files shared be dissemination-ready, following our internal cleaning processes and vetting with your state team.

Q: Can Prenatal Opioid Exposure surveillance activities be included under Component 1? If so, what are some examples of Prenatal Opioid Exposure surveillance activities?

A: Yes, prenatal opioid exposure projects can fall under Strategy 3 as long it addresses one of the seven CDC data collection priorities for an innovative surveillance project. Examples include:

- surveillance of linkage to care during or after pregnancy for mothers who use opioids during pregnancy;
- tracking drug use patterns, overdose history, and linkage to treatment and risk reduction services for pregnant women; and
- linking data sources on pregnant women available at the state and local level.

Q: How much detail should we provide in describing Strategy 3 (the innovative projects component) or strategies within the surveillance component?

A: Please provide as much detail as possible within your application so that it is clear what innovative activities are being proposed by your jurisdiction. For jurisdictions that will not be choosing the six preferred CDC innovative surveillance projects, a more detailed 3-5 page proposal is due to CDC for review and approval no later than October 31, 2019. This proposal should describe the critical data gap addressed by the proposed surveillance system and how data will be shared with local stakeholders and CDC.

Q: With regard to the funds targeting improving toxicology testing, do all of the funds have to be dispersed directly to medical examiner offices, or can some of these funds go toward staff?

A: The priority is for the funds to go to medical examiner/coroner offices for comprehensive toxicology testing. These funds can be used for staff, but it will need to be for staff within the medical examiner or coroner's offices.

Q: If we already have a contract with a post-mortem toxicology testing lab that can meet the requirements of subjectivity, can we use the funds to pay for those tests directly to the company by passing it in the coroner's office?

A: Yes.

Q: Can you elucidate a bit more regarding the intention behind the emergency department (ED) staffing unit requirement? For states that have a syndromic surveillance team, does a letter of support suffice?

A: It is required that $75,000 of your ED budget directly supports the staffing unit conducting the work. A letter of support is required, but alone is not sufficient.

Q: NVDRS and syndromic surveillance and others are in our same division in our health department. Are letters of support needed then?

A: Yes, they are still required.

Q: When we have looked at these data there are many cases that are really not related to the intent of SUDORS. We have found many that are accidental overdoses of medications that are not drugs of abuses (digoxin, blood thinners, etc.) and will still increase the case load. Is it possible to be a little more specific in the case definition to weed these out?

A: While SUDORS was started in response to the opioid overdose epidemic, the scope of SUDORS has been expanded to include all drug overdose deaths as defined by the published ICD-10 definition (i.e., ICD-10 underlying cause-of-death codes on the death certificate: X40–44 (unintentional) / Y10–Y14 (undetermined intent)) or a death classified as a drug overdose death by the ME/C that is consistent with the ICD-10 definition. As you highlight, an important task of the SUDORS system moving forward will be to distinguish drug overdose deaths caused by drugs with a high likelihood of abuse versus accidental overdose deaths related to medicines that are unlikely to be abused.

Q: The ESOOS coding did not have stimulant overdose in it. Will coding be provided for that?

A: Yes, coding will be provided for suspected stimulant overdoses.

Q: For the $50,000 (optional activity under Strategy 1), must you provide inpatient data?

A: No. If you only have access to inpatient data or emergency department data for your hospital billing, that is sufficient. If you have both, you can share both; but only one is required as part of the optional activity for billing and discharge data.

Q: For the states choosing to do optional quarterly reporting of billing and discharge data, will county level data be stratified by month? Who will this be shared with? How will the suppression criteria required by the data owner and state law be handled by CDC?

A: The county level data will be stratified by month and reported to CDC. The data will be collected and shared with the OD2A surveillance support team internally. Please review Appendix 2 on data sharing for more details. CDC will suppress data when counts are 1 to 9 in order to prevent possible identification of individuals.

Q: Is the emergency department data dissemination and data sharing requirements a formal signed data use agreement?

A: No, it is not. Please review Appendix 2 for more information about data sharing.

Q: Must we use the $400,000 specifically on the innovative surveillance projects?

A: Yes. Note that you are able to pick more than one innovative project.

Q: Who is the data collector who receives the $75,000?

A: The $75,000 for data collection is to support the staff who are responsible for the OD2A management, analysis, and reporting requirements pertaining to syndromic surveillance or billing data.

Q: What is the emergency department (ED) data sharing time frame again?

A: Please review Appendix 3 associated with the NOFO.

Q: What is CDC's view on comprehensive screening of biologic samples, blood, and urine as a useful and innovative strategy to provide substance use patterns, which could be tied into either innovative surveillance of linkage to care, innovative surveillance of opioid use/misuse, or innovative surveillance of the illicit opioid drug supply? Would such surveillance strategies be in line with the outcomes of the NOFO?

A: These strategies would be in line with the outcomes of the NOFO.