May 2022

# Centers for Disease Control and Prevention
# Notice of Funding Opportunity (NOFO) CDC-RFA-CE22-2204
# Expansion of Comprehensive Suicide Prevention Across the U.S.
# Frequently Asked Questions

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1. **Question:** What is a comprehensive approach to suicide prevention?
   **Answer:** The comprehensive approach to suicide prevention is characterized by:
   1. *Strong leadership* that convenes multi-sectoral **partnerships**
   2. *Prioritization of **data*** to identify vulnerable populations and to better characterize risk and protective factors impacting suicide
   3. *Leveraging **existing** suicide prevention **programs***
   4. *Selection of **multiple and complementary strategies*** with the best available evidence to fill gaps
   5. *Effective **communication***
   6. *Rigorous **evaluation*** of the overall approach and individual activities that feeds data back into the system for quality improvement and sustainability

2. **Question:** How does syndromic surveillance fit into the comprehensive approach?
   **Answer:** Syndromic surveillance fits into components 1, 2, 5, and 6 above, as follows:

   <u>Partnerships (component 1 above)</u>
   - i. Includes strengthening partnerships by providing training to understand and use National Syndromic Surveillance Program (NSSP) data and participating in the NSSP Community of Practice

   <u>Prioritization of data (component 2 above) includes:</u>
   - i. increasing the timeliness of data from emergency department visits related to suicide,
   - ii. using syndrome definitions developed by CDC,
   - iii. monitoring and using near real-time syndromic surveillance data to inform selection of vulnerable/disproportionately affected populations,
   - iv. selecting and monitoring impact of programs, polices, and practices to address emergent trends

   <u>Communication (component 5 above) includes:</u>
   - i. encouraging funded programs and local emergency departments to submit data to NSSP
   - ii. updating partners and stakeholders at the state and local level to act on emerging trends identified from syndromic surveillance
   - iii. providing CDC copies of syndromic surveillance reports and other products shared with partners (e.g., dashboards, factsheets, data briefs, etc.). Information on how partners act on these data for suicide prevention will be important to track.

   <u>Evaluation (component 6 above) includes:</u>
   - iv. Using syndromic surveillance for evaluation purposes (e.g., assess timeliness and quality of data submitted to NSSP from participating facilities, effectiveness of responses or prevention efforts by locality or by population group)

3. **Question:** What is considered a disproportionately affected population?
   **Answer:** For the purposes of this NOFO, a disproportionately affected population is a population that has suicide rates greater than the general population and/or accounts for a significant proportion of the suicide burden (i.e., large numbers) in a jurisdiction (e.g., county, state).

4. **Question:** What are examples of disproportionately affected populations?
   **Answer:** Disproportionately affected populations may include veterans; tribal populations; rural populations; lesbian, gay, bisexual, transgender, queer or questioning (LGBTQ) populations; homeless populations; or other groups (e.g., middle-aged adults).

5. **Question:** What is a jurisdiction?
   **Answer:** A jurisdiction is a geographically bounded area such as a state/territory, city/county, or tribal land

6. **Question:** Can a jurisdiction be some other location such as a college, university, or workplace?
   **Answer:** Yes, however, a suicide rate in that jurisdiction must be definable (i.e., it is possible to count the number of suicides, suicide attempts, and population size to create a rate). The disproportionately affected population selected must then have either a rate greater than the general population in that jurisdiction and/or account for a significant proportion of the suicide burden in that jurisdiction.

7. **Question:** Can disproportionately affected populations cross state boundaries? For example, if working in a tribal area, a population might live in multiple states.
   **Answer:** Yes, however, there must be a suicide/attempt rate that can be calculated (e.g., number of suicides and population size among both the disproportionately affected population and the general population) in the multiple states. These figures must be able to be calculated for the duration of the funding period. Finally, in the instance of cross-state work, permission will likely be needed from the other state.

8. **Question:** How many disproportionately affected populations must be selected?
   **Answer:** Applicants must select at least one disproportionately affected population in at least one jurisdiction. One disproportionately affected population may span multiple jurisdictions (e.g., multiple counties).

9. **Question:** The NOFO says that the disproportionately affected population must represent a *significant proportion of the suicide burden?* What is meant by significant proportion?
   **Answer:** There is no target proportion specified in the NOFO. The applicant must determine what population to target based on their jurisdiction's unique needs. However, we encourage applicants to consider a population that has a rate of suicide greater than that of the general population and a large enough burden that it's possible to see a 10% reduction over time.

10. **Question:** May I select youth or another disproportionately affected population apart from those listed in the NOFO?
    **Answer:** Yes, other disproportionately affected populations are allowable. Applicants must show evidence that the population selected has suicide rates greater than the general population in the jurisdiction and/or that it comprises a significant proportion of the burden (i.e., large numbers of suicide/attempts) in the jurisdiction.

11. **Question:** Is the long-term goal of a 10% reduction in suicide and suicide attempts in the entire jurisdiction or a 10% reduction in suicide and suicide attempts in the disproportionately affected population in the selected jurisdiction?
    **Answer:** A key outcome of this funding opportunity is a 10% reduction in suicide and suicide attempts in the disproportionately affected population within the jurisdiction.

12. **Question:** What is the timeline for reducing suicide rates by 10%?
    **Answer:** A 10% reduction in suicide rates should be achieved by the end of the 5-year period of performance.

13. **Question:** Can I propose activities that would reach "non- disproportionately affected," population as well as disproportionately affected population(s)?
    **Answer:** The funding is meant to reduce suicide rates in one or more disproportionately affected populations in a jurisdiction(s). Some funded activities (e.g., safe messaging) may reach the general population. This is fine and expected. However, outcomes should be measured in the disproportionately affected population. Additionally, syndromic surveillance monitoring activities are intended to include the full state or regions of a state, but it's possible that syndromic surveillance activities will alert programs to hotspots/upticks/emergent trends that might identify other populations of focus that do not align with the initially identified disproportionately affected population. This NOFO supports the identification of these emergent trends in jurisdictions and action by programs and partners/stakeholders engaged to implement prevention strategies that address these trends.

14. **Question:** If more than one disproportionately affected population is selected, do recipients need to demonstrate a 10% reduction in suicide rates in both groups individually or in the two groups combined?
    **Answer:** If more than one vulnerable population is selected, prevention strategies will need to target each group independently, and so we would expect to see reductions in both groups.

15. **Question:** What should be included in the partnership plan?
    **Answer:** The partnership plan should include a list of partners and their roles related to funded activities (e.g., the tier, strategy, approach), their expertise related to the disproportionately affected populations , the frequency of interaction (e.g., monthly check-ins), the sector and jurisdiction the partners work within, engagement activities to onboard facilities to submit data to NSSP, training activities to promote understanding/using/responding to syndromic surveillance findings, and evaluation metrics (e.g., frequency, type of activity, time spent collaborating, goals for partner collaboration). The plan should also address any identified gaps as well as opportunities to close these gaps.

16. **Question:** Will the recipients receive the same amount of funding every year?
    **Answer** Awards are based on the availability of congressionally appropriated funds, the evidence of satisfactory progress by the recipient (as documented in required reports), and the determination that continued funding is in the best interest of the federal government. Recipients typically receive the same amount of funding every year if all of the above is aligned.

17. **Question:** Will a budget template be provided?

**Answer:** A budget template is not provided. See page 37 of the NOFO for what to include in your budget.

18. **Question:** Can recipients use funding to expand a program NOT included in the technical package?
**Answer:** If an alternate program not included in the technical package is selected, recipients will need to provide documentation of evidence of impact on suicide, suicide attempts, or risk and protective factors for suicide. A selection outside of the technical package is only permissible if the program or practice is backed by evidence on par with the level of evidence in the technical package (please describe the evidence and include a reference).

19. **Question:** Can recipients fund policy-level interventions?
**Answer:** Public health entities can play an important role by gathering and synthesizing information to inform policy, raise awareness, and evaluate the effectiveness of various policies. Activities described in this NOFO may include consultation on the implementation of prevention programs and assessment of policies as part of a comprehensive suicide prevention strategy (pg. 18 of NOFO). Applicants should refer to the Anti-Lobbying Restrictions for CDC Grantees to make sure their work is within the legal bounds of policy work: https://www.cdc.gov/grants/documents/Anti-Lobbying-Restrictions.pdf.

20. **Question:** Are there any activities/approaches that recipients cannot use CDC funding to do?
**Answer:** Yes. CDC will not fund crisis hotlines or mental health services/treatment. Funds also may not be used to support activities currently funded under other funding mechanisms. In addition, applicants proposing policy initiatives should refer to the Anti-Lobbying Restrictions for CDC Grantees to make sure their work is within the legal bounds of policy work: https://www.cdc.gov/grants/documents/Anti-Lobbying-Restrictions.pdf

21. **Question:** If my state receives SAMHSA funding for suicide prevention, can I still apply for CDC funding, and can I use the CDC funds for my SAMHSA-funded activities or vice versa?
**Answer:** You may still apply for CDC funding even if you receive funding from another federal agency, such as SAMHSA. However, activities funded as part of this NOFO may not be funded by another agency, and this funding cannot be used to fund work supported by another agency. Please see page 34 of the NOFO for information on *duplication of efforts*.

22. **Question:** Is this funding opportunity open to applicants from other countries?
**Answer:** No, this funding opportunity is only open to US entities, as well as the territorial governments or their bona fide agents in the Commonwealth of Puerto Rico, the Virgin Islands, the Commonwealth of the Northern Marianna Islands, American Samoa, Guam, the Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau.

23. **Question:** Is there a specific indirect cost percentage for this grant?
**Answer:** If requesting indirect costs in the budget, a copy of the indirect cost-rate agreement is required. According to 45 CFR §75.414, if an organization **has never** had a negotiated indirect cost rate agreement, then it can request a de minimis rate of 10% of MDTC indefinitely. If an organization **has** ever negotiated an indirect cost rate agreement with the federal government, then it will need to use that agreement for all indirect cost requests, assuming the agreement has not expired. If the agreement has expired, the organization needs to renegotiate one for future requests of indirect costs. If an organization has an indirect rate agreement, it can

request a lower percentage in indirect costs than the agreement rate in an application, but not higher than the agreed upon rate.

24. **Question:** What are the requirements for applying for this NOFO?
**Answer:** The NOFO highlights numerous programmatic and organizational requirements throughout the document. Applicants are encouraged to read the NOFO thoroughly to evaluate their capacity to implement and evaluate a comprehensive public health approach to suicide prevention with attention to one or more disproportionately affected populations representing a significant proportion of the suicide burden in a jurisdiction(s) and to monitor, use, and respond to emergent trends identified in syndromic surveillance. Applicants should also review the "Organizational Capacity of Recipients to Implement the Approach" section of the NOFO to ensure they meet organizational requirements.

25. **Question:** We are a small 501(c)(3) located in a rural area. We have an extremely high suicide rate and would like to conduct psychological autopsies to assist our medical examiners in assessing "why suicide, why now, why by this particular method, and what could have been done to prevent this." These autopsies would support bereaved families, assist our medical examiner, and inform prevention. Could a recipient use funding for this type of activity?
**Answer:** Psychological autopsies cannot be funded as a standalone activity or the sole activity of the NOFO, but they can be funded as part of the development of the comprehensive approach.

26. **Question:** There are approximately 20,000 new people every month who require the assistance of a service dog, but there are only about 10,000 service dogs available each year. Can I use this grant to buy a piece of property for my dogs?
**Answer:** No. Funds may not be used for purchase of property. See funding restrictions beginning on page 40 of the NOFO.

27. **Question:** Are IHS (Indian Health Service) facilities eligible to apply for this grant?
**Answer:** This NOFO is being competed openly, with eligible applicants including but not limited to Native American tribal governments (federally recognized), Indian Housing Authorities, Native American tribal organizations (other than federally recognized tribal governments), nonprofits with or without a 501(c)(3) status, for profit organization, small businesses, and American Indian/Alaska Native tribal governments (federally or state-recognized). See page 20 of NOFO.

28. **Question:** I work at the National Highway Traffic Safety Administration Office of Emergency Medical Services (EMS). EMS clinicians die by suicide at higher rates than the general population. One of our priority areas is reducing suicide rates among EMS clinicians. Can EMS clinicians be considered a disproportionately affected population?
**Answer:** For EMS clinicians to be considered a vulnerable population for this funding opportunity, applicants must be able to document that the rate of suicide among EMS clinicians is greater than the rate of suicide for the general population in the jurisdiction. There must be a way to count suicides and suicide attempts among EMS clinicians in the jurisdiction and a way to count the total population of EMS clinicians. These counts must be able to be calculated throughout the funding period.

29. **Question:** Can this funding be used to address any increases in suicide or suicide attempts related to COVID-19?

**Answer:** If specific populations experienced increases in suicides during the COVID-19 pandemic such that they now have a suicide rate that is higher than the general population in the jurisdiction and/or they represent a significant proportion of the of suicide burden in the jurisdiction, then they could be considered a disproportionately affected population.

30. **Question:** Will you accept late applications?
**Answer:** Generally, the answer is no. However, there may be an exception related to COVID-19. You will find guidance about this on our CDC grants website: https://www.cdc.gov/grants/public-health-emergencies/covid-19/faqs/index.html. When a delay occurs because the applicant or recipient is directly impacted by COVID-19, CDC will consider extending the application due date beyond the date specified in the NOFO on a case-by-case basis, in accordance with the Department of Health and Human Services (HHS) Grants Policy Statement "Submitting an Application," Part I-25-26. Please submit your request to extend the NOFO deadline to the assigned grants management specialist/program official noted in the NOFONOFO under Agency Contacts before the NOFO closing date. Your request should include enough detail about the delay so that CDC can determine whether circumstances justify extending the NOFO application submission deadline.

31. **Question:** Can we use an existing group of suicide prevention partners as long as we build in new partners?
**Answer:** Definitely. The NOFO states on page 8 that there should be existing partners and new partners brought on, as needed, related to the disproportionately affected population.

32. **Question:** Is the draft partnership plan part of the narrative (and counts toward page total) or is it a separate appendix?
**Answer:** The application should include descriptions of all components of the comprehensive approach as part of the narrative, including the partnership plan. While these components are not expected to be fully fleshed out until 6-months post-award, providing a description of plan elements will be expected (see question 15 for more information).

33. **Question:** If the disproportionately affected population is geographically defined (e.g., 4 counties), would the inventory of programs be the entire state or within the geographically bounded are?
**Answer:** The inventory would be for the geographically defined area.

34. **Question:** Can you say more about how you are defining "sufficient" evidence?
**Answer:** All programs outside of the technical package must have the same level of evidence as those in the technical package, including a meta-analysis or systematic review showing impact on suicide, suicide attempts, or risk and protective factors for suicide andevidence from at least one rigorous evaluation study (e.g., RCT, quasi-experimental design) showing effects on suicide, suicide attempts, or risk and protective factors for suicide and no harmful effects from the intervention.

35. **Question:** Can you define what a "Behavioral Scientist" is in reference to the FTE requirement? Are there certain academic credentials that are required?
**Answer:** A behavioral scientist is familiar with behavior change, implementation of programs, and prevention. Such people may have a public health, psychology, or social science

background. Behavioral scientists generally may serve as project manager or someone overseeing the comprehensive approach.

36. **Question:** Can you speak at all about whether applicants can (or should) incorporate multiple strategies into their proposal? Or would it be better to focus on a single strategy?
    **Answer:** Applicants must select at least one program, practice, or policy from each of three tiers (community-based, healthcare-based, and upstream tiers). See the NOFO Appendix, starting on page 56 for help with selections.

37. **Question:** Does the grant solutions abstract serve as the application abstract or are they separate documents?
    **Answer:** They are separate documents.

38. **Question:** My agency provides support to homeless populations. We conduct an intake assessment and then refer people to services. Does the intake assessment count as data for the comprehensive approach?
    **Answer:** What we are looking for is surveillance data that are collected routinely that identifies a disproportionately affected population with a large suicide burden (numbers) and/or a rate of suicide greater than the general population in a jurisdiction. This means being able to count suicide or suicide attempts in the population as well as knowing the denominator or number of people in the population. The goal is to reduce suicide and/or suicide attempts by 10% in the selected disproportionately affected population by creating a comprehensive approach with selected activities from the CDC technical package. To learn more, see pages 9-11 of the NOFO.

39. **Question:** Will this PPT also be posted on the CDC grants web page?
    **Answer:** Yes, the PDF is now posted at https://www.cdc.gov/suicide/programs/ecsp/index.html

40. **Question:** Can you please clarify re: the prohibition of grant funds for treatment? The NOFO does indicate ED brief interventions and follow-up can be an approach under healthcare strategies. Same with treatment that reduces reattempts. But psychotherapy is prohibited. Can funds support AI screening tools? Teleheath services?
    **Answer:** Funds cannot be used for mental health treatment or crisis intervention services per our CDC authority. Funds can pay for training related to telehealth or brief interventions in the emergency department, but funding cannot pay for direct clinical services.

41. **Question:** Can you give more specific info about 10% reduction in morbidity/mortality in the disproportionately affected populations? Is it from a baseline year? Is it from a 3-year average? Is it up to the applicant?
    **Answer:** It is up to the applicant how they wish to calculate their rates. Once decided, this same approach should be used every year.

42. **Question:** Please clarify the number of pages allowed for Project Narrative. Page 35 of NOFO indicates 15.
    **Answer:** An amendment is being made to the NOFO. The correct page limit is 20 pages.

43. **Question:** For the required 1.0 FTE epi, 0.5 FTE comms specialist, and 1.0 FTE behavioral health scientist roles, do these roles have to be 100% on this grant or can they be covered from multiple positions adding to a total of 1.0, 0.5, and 1.0, respectively?

**Answer:** They can be covered from multiple people.

44. **Question:** Is a draft communication plan required for the proposal, and if so, is it also part of the 20-page limit?
    **Answer:** The application should include descriptions of all components of the comprehensive approach as part of the narrative. While these components are not expected to be fully fleshed out until 6-months post-award, providing a description of the communication plan elements with some examples will be expected.

45. **Question:** If we choose different disproportionately affected populations for mortality vs morbidity, do we need to select strategies from Tier 1-3 for both disproportionately affected populations (so 6 strategies total)?
    **Answer:** Yes, for each disproportionately affected population selected, there should be corresponding approaches.

46. **Question:** What types of partnerships would be recommended for projects with a nationwide focus?
    **Answer:** Partnerships would likely be with partners at the national level who have familiarity with the public health approach to suicide prevention and with the disproportionately affected population(s) of interest. They may include people in mental health, education, health care, suicide prevention interest groups, national non-profit groups, among others.

47. **Question:** Is there a page limit for Letters of Support?
    **Answer:** No

48. **Question:** Are precursors to suicidal ideation also applicable to this?
    **Answer:** Suicidal ideation could be considered a risk-factor or intermediate outcome. It is not the primary outcome of interest. The primary outcomes of interest are a 10% reduction in suicide mortality and morbidity.

49. **Question:** Will CDC provide SAS licenses for analyzing data?
    **Answer:** CDC will not provide SAS licenses for analyzing data. Applicants can request funds to cover this in their budget request.

50. **Question:** Can recipients use the funds designated for the ED data collection staffing unit towards IT services?
    **Answer:** Yes, they can be allocated for this purpose if the funds are used to support efforts to maintain and enhance the collection of rapid ED data.

51. **Question:** Can the funds designated for the emergency department data collection be given to the department of public health if they are the ones running ESSENCE?
    **Answer:** Yes.

52. **Question:** What are the required deliverables?
    **Answer:** In the first six months of the project period, recipients will submit the five components of the comprehensive approach: partnership plan, selection of disproportionately affected populations using surveillance data, inventory of suicide prevention programs in the jurisdiction,

selection of strategies and approaches with the best available evidence from the CDC technical package, and a communication plan. An evaluation plan is also required. The annual progress report will also require updates to these documents and a success story.

53. **Question:** What are the expectations regarding syndromic surveillance?
**Answer:**
The recipient is expected to keep the program team and community partners apprised of nonfatal suicide-related syndromic data trends (e.g., suicidal ideation, suicide attempts, self-harm), including upticks or changes in patterns or impacted groups. This activity is expected to be linked to activities 1a and 1e and will also contribute to selection of strategies in 1d and evaluation in activity 2. Syndromic surveillance data for these activities will be updated annually in the annual progress report. Recipients must commit to sharing real-time, case-level data with CDC using NSSP ESSENCE through a data sharing agreement. See Appendix 2 for syndrome definitions and https://www.cdc.gov/nssp/index.html for more information.
The following items will be collected in the annual progress report:
    - Materials and products related to observed trends from syndromic surveillance data of nonfatal suicide-related outcomes/syndromes and syndromic surveillance summary activities (e.g., number and percent of emergency department facilities submitting data to NSSP, counts of cases, percent of total emergency department visits that were suicide-related, changes in rates, upticks or changes in patterns or groups impacted, and barriers to data collection)
    - Samples or URL links to syndromic surveillance dissemination products shared with partners/stakeholders (e.g., dashboards, reports, factsheets, data briefs, publications, newsletters, etc.) and any information about the **use** of this data by partners/stakeholders for suicide prevention such as data utilization activities and responses.
    - Products and materials used to engage partners including trainings implemented and materials related to syndromic surveillance and its uses that were shared with partners/stakeholders.
    - Information or materials from coordination and participation in the National Syndromic Surveillance Program (NSSP) Community of Practice, CDC's Suicide Syndrome Definition Validation Workgroup, and CDC's Suicide Data to Action Workgroup.

54. **Question:** Do you have a suggested data sharing agreement template?
**Answer:** Please submit a data sharing agreement with your application. Specific language to share state-level syndromic surveillance data with CDC will be provided post award, as needed.

55. **Question:** Our state is already submitting data via the National Syndromic Surveillance Program (NSSP). Would data sharing for this opportunity fall under those current agreements or arrangements with NSSP?
**Answer:** Data sharing for this opportunity is slightly different than existing NSSP agreements which don't include line-level data from states. Specific language for a Data Sharing Agreement to share state-level syndromic surveillance data with CDC will be provided post award, as needed.