



Centers for Disease Control and Prevention

National Center for Injury Prevention and Control

Prescription Drug Overdose Prevention for States

CDC-RFA-CE15-1501

Application Due Date: 05/08/2015

Prescription Drug Overdose Prevention for States

CDC-RFA-CE15-1501

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Part I. Overview Information

Applicants must go to the synopsis page of this announcement at www.grants.gov and click on the "Send Me Change Notifications Emails" link to ensure they receive notifications of any changes to CDC-RFA-CE15-1501. Applicants also must provide an e-mail address to www.grants.gov to receive notifications of changes.

A. Federal Agency Name:

Centers for Disease Control and Prevention (CDC)

B. Funding Opportunity Title:

Prescription Drug Overdose Prevention for States

C. Announcement Type: New - Type 1

This announcement is only for non-research domestic activities supported by CDC. If research is proposed, the application will not be considered Research for this purpose is defined at <http://www.cdc.gov/od/science/integrity/docs/cdc-policy-distinguishing-public-health-research-nonresearch.h.pdf>.

D. Agency Funding Opportunity Number:

CDC-RFA-CE15-1501

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

93.136

F. Dates:

1. Due Date for Letter of Intent (LOI):

03/16/2015

2. Due Date for Applications:

05/08/2015, 11:59 p.m. U.S. Eastern Standard Time, at www.grants.gov.

3. Date for Informational Conference Call:

03/11/2015

Informational conference call for potential applicants: Wednesday March 11, 2015 at 1:00PM ET

Conference call number: (855) 644-0229 Conference ID: 9654605

The purpose of **Amendment 1** to this FOA is to provide additional clarifying information based on questions received from potential applicants during the Pre-Application Informational Conference Call held on March 11, 2015. A summary of the questions and answers can be found in Section H. Other Information beginning on page 39 of the amended FOA.

G. Executive Summary:

1. Summary Paragraph:

The purpose of this funding is to advance and evaluate comprehensive state-level interventions for preventing prescription drug overuse, misuse, abuse, and overdose. Interventions of priority address drivers of the prescription drug overdose epidemic, particularly the misuse and inappropriate prescribing of opioid pain relievers. Awardees will implement prevention strategies to improve safe prescribing practices and prevent prescription drug overuse, misuse, abuse, and overdose. This funding lays out four priority strategies that states may advance; two of these strategies are required, two are optional. The two required strategies are:

- 1) Enhance and maximize a state PDMP and
- 2) Implement community or insurer/health system interventions aimed at preventing prescription drug overdose and abuse.

The two optional strategies are:

- 3) Conduct policy evaluations and/or
- 4) Develop and implement Rapid Response Projects.

The targeted outcomes of each strategy will vary and may include programmatic outcomes, as well as changes in behaviors thought to be linked to drug overdose morbidity or mortality. Awardees will be expected to implement robust evaluations of their program activities using timely data from a variety of sources. A key to the success of this FOA is multi-sector collaboration with partners that have shared authority over this issue. Applicants are therefore required to submit letters of support from state-level governmental entities and other partners depending on the strategies they pursue. Finally, while the primary purpose of this funding is the prevention of prescription drug overdoses, it also presents opportunities to advance surveillance and evaluation efforts to understand and respond to the increase in heroin overdose deaths, especially at the intersection of prescription opioid abuse and heroin use. Funded states will track heroin morbidity and mortality as an outcome of their work and have opportunities to evaluate policies with implications for preventing both prescription drug and heroin overdoses (e.g., naloxone access policies).

a. Eligible Applicants:	Limited
b. FOA Type:	Cooperative Agreement
c. Approximate Number of Awards:	16
d. Total Project Period Funding:	\$55,600,000
e. Average One Year Award Amount:	\$875,000
f. Number of Years of Award:	4
g. Estimated Award Date:	09/15/2015

h. Cost Sharing and / or Matching Requirements:

N

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

Consistent with the cited authority for this announcement and applicable grants regulations, sources for cost sharing or matching may include complementary foundation funding, other U.S. government funding sources including programs supported by HHS or other agencies (e.g., Department of Agriculture, Department of Education, Department of Housing and Urban Development, Department of Transportation, Environmental Protection Agency, U.S. Park Service) and other funding sources. Applicants should coordinate with multiple sectors such as public health, transportation, education, health care delivery, and agriculture.

Part II. Full Text

A. Funding Opportunity Description

1. Background

a. Overview

Overdose deaths from prescription opioid pain relievers have quadrupled since 1999, killing more than 16,000 people in the U.S. in 2013.

Changes in how providers prescribe these powerful drugs created, and continue to fuel, the epidemic. The amount of opioids prescribed and sold in the U.S. quadrupled in ten years, yet there has not been an overall change in the amount of pain that Americans report. Heroin overdose death rates have been climbing sharply since 2010. Evidence to date suggests that widespread prescription opioid exposure and increasing rates of opioid addiction have played a role in the growth of heroin use.

States, including state health departments, are crucial players in reversing the epidemic. This funding builds on a previous CDC FOA, Prescription Drug Overdose: Boost for State Prevention FOA CE14-1404, to provide states the support and resources needed to build robust prevention programs. States may advance four priority strategies under this funding; two of these strategies are required, two are optional. The two required strategies are:

- 1) Enhance and maximize a state PDMP and
- 2) Implement community or insurer/health system interventions aimed at preventing prescription drug overdose and abuse.

The two optional strategies are:

- 3) Conduct policy evaluations and/or
- 4) Develop and implement Rapid Response Projects.

This FOA provides funding to implement these four major strategies.

Below is a brief description of each strategy:

- (1) **Enhancing and maximizing PDMPs:** Existing evidence, though sparse, indicates the potential of PDMPs to identify patients at high risk of overdose and to impact key prescribing behaviors. All applicants will be required to propose two or more activities to enhance use of PDMPs.
- (2) **Implementing community or insurer/health system interventions:** This strategy targets two promising avenues for prevention: 1) enhancing and empowering community-level prevention and 2) implementing insurer and health system improvements to reduce overdose risk. For community interventions, activities include deploying and coordinating intensive prevention efforts in high-burden communities and working with local health departments to disseminate analyses of prescribing and overdose trends. Insurer/health system interventions include drug utilization review, prior authorization, quantity limits, and coordinated care. All applicants will be required to propose at least one activity under this strategy (i.e., community and/or insurer/health system interventions).
- (3) **Evaluating existing policies designed to reduce prescription drug overdose morbidity and mortality:** Understanding the effectiveness of prescription drug overdose policies is crucial. Awardees can conduct evaluations of laws/policies/regulations designed to prevent prescription drug overuse, misuse, abuse, and overdose.
- (4) **Developing and implementing Rapid Response Projects (RRPs):** The prescription drug epidemic is fast moving. States can propose small, innovative projects that do not fit into the above three strategies to break new ground on addressing the epidemic. For example, states could use RRP to build a new syndromic surveillance system or test a communication campaign. This strategy allows states to be nimble and work collaboratively with other states and CDC in identifying priority actions and responding to emerging public health threats.

While the primary purpose of this funding is the prevention of prescription drug overdoses, CDC recognizes that the increase in heroin use and overdose deaths in recent years is not unrelated to the unprecedented levels of prescription opioid exposure and abuse seen over the last decade. The strategies outlined above present opportunities to advance surveillance and evaluation efforts to understand and respond to the increase in heroin overdose deaths, especially at the intersection of prescription opioid abuse and heroin use. Funded states will track heroin morbidity and mortality as an outcome of their work and have opportunities to evaluate policies with implications for preventing both prescription drug and heroin overdoses.

b. Statutory Authorities

Section 301 (a) [42 U.S.C. 241a] of the Public Health Service Act, and Section 391 (a) [42 U.S.C. 280 b (a)] of the Public Health Service Act

c. Healthy People 2020

This FOA supports two [Healthy People 2020 objectives](#): SA-12, to reduce drug-induced deaths and SA-19, to reduce the past-year nonmedical use of prescription drugs.

d. Other National Public Health Priorities and Strategies

This FOA aligns with and supports the National Prevention Strategy (NPS) in several ways: 1) addresses one of the seven priorities designated in the NPS, i.e., Injury and Violence Free Living; 2) emphasizes engaging partners across disciplines, sectors, and institutions as an important factor in significantly improving well-being; 3) supports state governments to facilitate collaboration among diverse sectors when making decisions to have a significant effect on health; and 4) supports the NPS priority of Preventing Drug Abuse and Excessive Alcohol Use, which includes a recommendation to reduce inappropriate access to and use of prescription drugs.

<http://www.surgeongeneral.gov/initiatives/prevention/strategy/>

e. Relevant Work

CDC’s Injury Center is committed to directly strengthening state efforts to reduce and prevent prescription drug overuse, misuse, abuse, and overdose through implementation and evaluation of strategies supported by promising research. This FOA builds on the 2014 FOA, Prescription Drug Overdose: Boost for State Prevention, CDC-RFA-CE14-1404, or Prevention Boost. Also, through the Core Violence and Injury Prevention Program (Core VIPP) the Injury Center supports health departments to strengthen their general capacity to collect and use data to better understand local injury issues and to put science into action to prevent injury; many of these states have identified PDO as a priority area for action.

2. CDC Project Description

a. Approach

Inputs	Priority Strategies & Major Activities	State-Level Outcomes		
		Short-Term Policy/Program Development	Intermediate-Term Behavior Change	Long-Term Health Outcomes
Funding Surveillance expertise TA on policy & program development Evaluation guidance Dissemination of best practices	<u>Enhance and Maximize PDMPs</u> <ul style="list-style-type: none"> • Move toward universal registration and use • Make PDMPs easier to use and access • Move toward a real-time PDMP (i.e., reduce data collection interval) • Expand and improve proactive (i.e., unsolicited) reporting • Conduct public health surveillance with PDMP data and publicly disseminate 	<u>PDMPs</u> <ul style="list-style-type: none"> • Reduced barriers to PDMP registration and use • Shorter data collection interval • Increased rate of unsolicited reports • Increased use of standard PDMP reports for surveillance 	<u>Providers</u> <ul style="list-style-type: none"> • Increased registration and use of PDMPs • Decreased rate of high dose (>100 MME/day) opioid prescribing • Increased treatment referrals for opioid use disorder • Increased use of non-opioid therapies for pain • Reduced problematic drug co-prescribing (e.g., opioid/benzodiazepines) 	Decreased rates of opioid abuse Increased opioid use disorder treatment (ultimately want decrease) Decreased rate of ED visits related to opioids Decreased drug overdose death rate, including both opioid and heroin death rates Improved health outcomes in state "hot spots"
		<u>High-burden Communities</u> <ul style="list-style-type: none"> • Implementation of community level interventions in state "hot spots" 		
		<u>Insurers & Health Systems</u> <ul style="list-style-type: none"> • Expanded opioid management programs • Implementation of opioid prescribing interventions • Expanded uptake and use of evidence-based opioid prescribing guidelines 	<u>Patients</u> <ul style="list-style-type: none"> • Decreased use of multiple prescribers for opioids 	
		<u>Implement Community or Insurer/Health System Interventions</u> <ul style="list-style-type: none"> • Provide technical assistance to high-burden communities and counties, especially efforts to address problematic prescribing • Implement opioid prescribing interventions for insurers and/or health systems • Enhance uptake of evidence-based opioid prescribing guidelines 		

<p><u>Policy Evaluation</u></p> <ul style="list-style-type: none"> • Conduct a rigorous evaluation on a law, policy, or regulation designed to prevent opioid overuse, misuse, abuse, and overdose 	<p><u>Indicators of system or practice change</u></p> <ul style="list-style-type: none"> • Evidence of implementation of law, policy or regulation 	<p><u>Insurers & Health Systems</u></p> <ul style="list-style-type: none"> • Decreased rate of high dose (>100 MME/day) opioid Rx • Increased use of claims reviews to identify high-risk prescribing • Increased # of patients in opioid mgmt. programs 	<p><i>*Note: all outcomes are project period outcomes</i></p>
<p><u>Rapid Response Project</u></p> <ul style="list-style-type: none"> • Implement an RRP to advance an innovative prevention approach 	<p><u>Oversight/Enforcement</u></p> <ul style="list-style-type: none"> • Increased enforcement actions against outlier providers • Decreased number of outlier pain clinics (“pill mills”) 		

i. Purpose

To provide states guidance and resources to prevent prescription drug overdoses by addressing problematic opioid prescribing. This funding lays out four priority strategies that states may advance: 1) enhance and maximize a state PDMP (required); 2) implement community or insurer/health system interventions aimed at preventing prescription drug overdose and abuse (required); 3) conduct policy evaluations (optional); and 4) develop and implement Rapid Response Projects (optional).

While the primary purpose of this funding is prescription drug overdose prevention, it also presents opportunities to advance surveillance and evaluation efforts to respond to the increase in heroin overdose deaths.

ii. Outcomes

Awardees are expected to implement activities that will impact relevant short and intermediate outcomes listed in the logic model. The specific short, intermediate, and long-term outcomes should be tailored to the work plan of strategies selected.

All awardees should be positioned and are expected to impact long-term outcomes within four to six years or earlier after receiving funding, regardless of the strategies chosen. These outcomes include:

- decreased rate of opioid abuse
- increased opioid use disorder treatment
- decreased rate of emergency department (ED) visits due to misuse or abuse of controlled prescription drugs, and
- decreased drug overdose death rate, including prescription opioid and heroin overdose death rates.

OUTCOMES FOR PRIORITY STRATEGY #1

For work under Priority Strategy #1, **enhance and maximize PDMPs**, (see logic model) awardees are expected to demonstrate change in short-term outcomes associated with the PDMP enhancements being implemented. Examples include:

- Reduced barriers to registration and use
- Shorter data collection interval
- Increased rate of unsolicited reports
- Increased timeliness and use of standard population-based PDMP reports for surveillance
- Regular distribution of reports on surveillance metrics established by CDC.

Awardees are also to demonstrate change in intermediate behavior changes to some of the following provider and patient behaviors; for example:

- Increased registration for and use of PDMPs

- Decreased rate of high dose (>100 MME/day) opioid prescriptions
- Increased use of non-opioid therapies for pain
- Reduced problematic drug co-prescribing (e.g., opioids with benzodiazepines)
- Decreased use of multiple prescribers for opioids

OUTCOMES FOR PRIORITY STRATEGY #2

For work under Priority Strategy #2, **implement community or insurer/health system interventions**, (see logic model) awardees are expected to demonstrate change in outcomes that show implementation of promising interventions.

Outcomes for community intervention include:

- Identification of counties and communities with a high burden of drug overdose deaths
- Expanded use of opioid prescribing guidelines in the EDs of high-burden areas
- Improved local health department capacity for acquiring, analyzing, and disseminating drug overdose data
- Decreases in opioid abuse, ED visits, overdoses, and other indicators in high-burden counties and localities.

For work on insurer/health system interventions, examples of outcomes include:

- Implementation of opioid management programs (e.g., prior authorization for opioids used at dosages or durations that are not recommended, drug utilization review, coordinated care programs, and patient review and restriction (PRR) programs, aka "Lock In")
- Enhancements in a drug utilization review program in a state health insurance program that screens prescription drug claims for problematic prescribing and potential misuse (see, e.g., Proactive notification to providers of outlier prescribing as discussed in Betses M, Brennan T. Abusive prescribing of controlled substances—a pharmacy view. *N Engl J Med* 2013; 369:989-991.)
- Implementation of improved drug formularies (e.g., removal of methadone as a preferred drug for the treatment of pain)
- Interventions and practices that expand access to medication assisted treatment
- Expanded uptake of evidence-based opioid prescribing guideline
- Alignment of insurance incentives with evidence-based opioid prescribing guidelines (e.g. non-opioid therapies accessible and preferred for conditions for which guidelines do not support opioids as first-line treatment; prior authorization for dosages that are not recommended)
- Implementation of programs that can enhance prescribing guideline adherence beyond incentives (e.g., implementation of health system quality improvement programs to enhance guideline adherence)

In the intermediate term, awardees are also expected to demonstrate change in provider and patient behaviors; for example:

- Decreased rate of high-dose opioid prescribing by providers;
- Decreased rate of problematic drug combinations prescribing by providers;
- Decreased rate of multiple providers for opioid prescriptions;
- Increased use of medication assisted treatment;
- Increased use of drug utilization reviews to identify prescriptions that may put patients at increased risk for overdose
- Increased use of insurance claims reviews to identify outlier providers
- Increase in academic detailing or other provider outreach related to potentially risky prescribing based on drug utilization reviews; and
- Decreased prescribing of methadone for pain.

OUTCOMES FOR PRIORITY STRATEGY #3

If chosen, the work under Priority Strategy #3, **policy evaluation**, (see logic model) awardees should conduct an evaluation of laws/policies/regulations designed to prevent prescription drug overuse, misuse, abuse, or overdose (e.g., pain clinic laws, naloxone access policies) to:

- Assess and enhance the implementation of these initiatives (i.e., referred to quality improvement or process evaluation); and/or
- Analyze the impact of the law on behaviors related to prescription drug overuse, misuse, abuse, or overdose and/or to prescription drug overdose morbidity and mortality.

These evaluations should improve the effectiveness of a state's prevention efforts by enhancing the implementation of current prevention efforts; concentrating resources on prevention initiatives that are promising for reducing high-risk behaviors, morbidity, or mortality associated with prescription drug overdoses; understanding the impact of interventions on heroin use and overdose; examining unintended consequences of interventions; and reducing resources allocated to prevention initiatives found to have no or limited impact on targeted behavioral, morbidity, and mortality outcomes. Short-term outcomes will include increased evidence of system or practice change—either positive or negative—as a result of the studied policy's implementation. Findings from evaluations across awardees may be used to identify best practices and highlight the most effective interventions.

OUTCOMES FOR PRIORITY STRATEGY #4

If chosen, the work under Priority Strategy #4, **develop and implement Rapid Response Projects**, (see logic model) awardees are expected to implement initiatives not covered by Priority Strategy #1 (PDMP enhancement) or Priority Strategy #2 (implement community or insurer/health system interventions). The description of the Rapid Response Project should specify clear implementation goals logically related to the Rapid Response Project and developed in accordance with CDC. While short-term implementation outcomes may vary, the intermediate and long-term outcomes to be addressed by these projects are expected to be largely consistent with those indicated in the logic model.

iii. Strategies and Activities

This program requires work in certain areas, called "priority strategies," but allows some flexibility and discretion in the specific activities chosen to advance these strategies. This design is intentional: CDC wants awardees to advance work in prioritized, high-impact areas, but also wants to make sure the program can be tailored to fit the state's specific needs and capacities and be responsive to emerging concerns.

This funding lays out four priority strategies that states may advance; two of these strategies are required, two are optional. The two required strategies are:

- 1) Enhance and maximize a state PDMP and
- 2) Implement community or insurer/health system interventions aimed at preventing prescription drug overdose and abuse.

The two optional strategies are:

- 3) Conduct policy evaluations and/or
- 4) Develop and implement Rapid Response Projects.

These priority strategies are listed on the left hand side of the logic model. Under each of these priority strategies are bulleted “major activities” that applicants can choose. Not all of these major activities need to be chosen, but CDC requires that a certain number of major activities be implemented by the awardee, specifically:

- Awardees must do at least two major activities under the PDMP priority strategy.
- Awardees must do at least one major activity under the community or insurer/health system priority strategy.
- Awardees may, but are not required to, choose one or more policies to evaluate under the policy evaluation strategy.
- Awardees may, but are not required to, choose a Rapid Response Project to develop and implement under the Rapid Response Project strategy.

Once priority strategies and major activities have been chosen, the applicant has significant discretion in how to advance these strategies and activities. The sub-activities provided for each major activity are suggestions on the type of work that can be done. Specific sub-activities are not required — applicants can design their own plan for advancing the chosen priority strategies and major activities.

Please note: Program funds cannot be used for purchasing naloxone, implementing or expanding drug “take back” programs, or directly funding or expanding substance abuse treatment programs. Such activities are outside the scope of this FOA.

PRIORITY STRATEGY 1: ENHANCING AND MAXIMIZING PDMPs

Overview: PDMPs are foundational programs for reversing the epidemic. Their potential impact on clinical practice and public health surveillance is critical to understanding and addressing the behaviors driving over-prescribing. The PDMP priority strategy is designed to advance three key PDMP practices that can help reduce the overuse and misuse of prescription of opioids:

1. **Real-time:** The PDMP captures up-to-the-minute dispensing and provides near real-time data to clinicians and public health officials working to prevent inappropriate prescribing.
2. **Universal use:** PDMPs should be reviewed by clinicians before writing prescriptions for opioids and other key controlled substances,
3. **Actively managed:** PDMP data should be used as a public health surveillance system to inform and evaluate interventions.

CDC recognizes that not all states are ready, or have the legal authority, to achieve these aims. This program would enable states to make incremental improvements toward these goals (e.g., streamlining registration, expanding the pool of providers with PDMP access, reducing data collection interval to 24-hours, improving data management and reporting of key surveillance metrics).

Awardees must advance at least two of the major PDMP activities listed in the left-hand column below (also found in the logic model).

Priority Strategy 1: ENHANCING AND MAXIMIZING PDMPs, Major Activities and Sub-Activities

Major Activities <i>Applicants must pick at least 2 of these major activities.</i>	Recommended Sub-Activities: <i>Below CDC has listed some recommended sub-activities applicants can engage in to advance chosen PDMP strategies. These sub-activities are <u>not required</u>; applicants can choose from the recommended sub-activities or applicants can propose actions that are not listed below if they still advance the selected strategy—please provide detail on how these actions support the strategy.</i>
Move toward universal PDMP registration and use	Streamline and simplify PDMP registration process.
	Build PDMP information systems to support universal registration and use.
	Develop and disseminate information to aid in universal registration and use.
	Other sub-activities as needed to advance universal registration and use.
Make PDMPs easier to use and access	Review and rectify barriers to data sharing between PDMPs and EHRs.
	Expand pool of healthcare professionals permitted to access PDMP data, including delegates who can obtain PDMP data on behalf of a PDMP provider.
	Expand access to PDMPs via a health information exchange.
	Expand access to PDMPs via an interstate exchange.
	Support PDMP training efforts in high-burden regions.
	Other actions as needed to make PDMPs easier to use and access.
Move toward a real-time PDMP (i.e., reduce the data collection interval)	Improving PDMP infrastructure or information systems to support reduced data collection intervals
	Developing and disseminating information or guidance to aid in reducing the PDMP data collection interval
	Other sub-activities as needed to reduce PDMP data collection interval.
Expand and improve proactive (i.e., unsolicited) reporting	Designing, validating, or refining algorithms for identifying high-risk prescribing activity to use as a trigger for proactive reports.
	Improving PDMP infrastructure or information systems to support proactive reporting and data analysis.
	Developing and disseminating information or guidance to aid in proactive reporting.
	Enhancing reporting system to increase frequency and quality of reporting.

	Other sub-activities as needed to expand or improve proactive and unsolicited reporting about both patients and providers.
Conduct public health surveillance with PDMP data and publicly disseminate reports quarterly or semi-annually on CDC-directed metrics [1]	Developing and disseminating guidance on the use of PDMP data for public health surveillance.
	Improving PDMP infrastructure or information systems to support PDMP use as a public health surveillance system.
	Implementing strategies that improve linkage of prescription records for each consumer (e.g., software enhancements).
	Linking PDMP data to health outcomes data, e.g., overdose emergency department visits, vital records or medical claims data on patient diagnoses.
	Collect, disseminate, and analyze county and community level PDMP data and facilitate the use of PDMP data by county and local health departments.
	Establishing working relationships (e.g., by developing memorandums of understanding or data use agreements) between PDMPs and other state agencies or community organizations.
	Other sub-activities as needed to expand or maximize PDMPs as a surveillance system.

[1] Awardees using PDMPs for public health surveillance will be required, to the extent permissible under their state's law: to publically report the following five indicators: (1) Decrease in the percent of patients receiving more than an average daily dose of >100 morphine milligram equivalents (across all opioid prescriptions); (2) Decrease in the rate of multiple provider episodes for prescription opioids (5 or more prescribers and 5 or more pharmacies in a 6-month period) per 100,000 residents; (3) decrease in the percent of patients prescribed long-acting/extended-release opioids who were opioid-naïve (i.e., have not taken prescription opioids in 60 days); (4) decrease in percent of prescribed days overlap between opioid prescriptions; and (5) decrease in percent of prescribed opioid days that overlap with benzodiazepine prescriptions. These metrics can be generated with SAS programs developed by CDC and its partner the Brandeis University PDMP Center of Excellence; CDC can provide the SAS programs to awardees pursuing this activity.

**PRIORITY STRATEGY 2:
IMPLEMENTING COMMUNITY OR INSURER/HEALTH SYSTEM INTERVENTIONS**

Overview: This strategy targets two promising avenues for prevention: enhancing and empowering local and community-level prevention and implementing insurer/health system improvements designed to reduce overdose risk.

The severity of the prescription drug overdose epidemic can vary widely throughout a state, and there are many opportunities for enhancing prevention at the county and local level. This program presents states the opportunity to engage community partners and implement community-level interventions in state “hot spots”. By equipping high-burden communities with promising, evidence-informed, data-driven prevention, states can focus resources and efforts within the communities most impacted by the epidemic. As noted above, program funds cannot be used for purchasing naloxone, implementing drug “take back” programs, or directly funding or expanding substance abuse treatment programs. Such activities are outside the scope of this FOA.

In addition to the community partnerships and interventions captured by this strategy, insurance programs and health systems present critical opportunities for prevention. States run some of the largest insurance programs (e.g., Medicaid, workers compensation) and have access to important levers that can improve controlled substance prescribing in these programs. States can also exercise influence over local and community health system practices. This priority strategy will support state strategies to improve prescribing in their roles as major public insurers and health care leaders to implement effective strategies. Promising insurer and health system interventions include pain management programs for long-term opioid patients, drug claim screening for outlier prescribing, and quality improvement programs to enhance guideline adherence (e.g., academic detailing).

Awardees must advance at least one of the major activities in the left hand column below, also found in the logic model. States do not have to advance both a community intervention and an insurer/health system intervention—they may choose just one major activity to advance.

Priority Strategy 2: IMPLEMENTING COMMUNITY OR INSURER/HEALTH SYSTEM INTERVENTIONS, Major Activities and Sub-Activities

Major activities:	Recommended Sub-Activities:
<i>Awardees must select <u>at least 1</u> of these major activities.</i>	<i>Listed below are some recommended sub-activities to engage in to advance the chosen Insurer or Health System major activities. These sub-activities are <u>not required</u>; awardees can choose from the recommended sub-activities or propose sub-activities that are not listed below if they still advance the selected strategy—please detail how they do so.</i>
Identify and provide technical assistance to high-burden communities and counties, especially efforts to address problematic prescribing	Create a multidisciplinary data-focused group convening players from local public health and law enforcement to prevent prescription opioid abuse and overdose, especially by focusing on prescribing. For an example, see, New York City’s RxStat initiative, as described in Heller D, Bradley O’Brien D, Harocopos A, Hreno J, Lerner J, McCoy EB, Nolan M, Phillips Lum P, Tuazon E, Parker C, Kunins H, Paone D. RxStat: Technical Assistance Manual. 2014, New York City, available at http://www.pdmpassist.org/pdf/RxStat.pdf .
	Build local health department capacity to develop and disseminate accessible analyses of local prescribing and mortality trends (e.g., by press release) to facilitate pickup by local media.
	Coordinate intensive prevention efforts aimed at high-burden counties or sub-state regions with an emphasis on addressing problematic prescribing.

Implement or improve opioid prescribing interventions for insurers, health systems, or pharmacy benefit managers	Implement or enhance a program that moves toward alignment of opioid prescribing with guidelines, using effective insurance levers such as prior authorization for prescriptions that are outside of recommended dosages or durations.
	Create or expand academic detailing for outlier opioid prescribers; implement program for sending proactive notification to prescribers when their prescribing deviates significantly from other prescribers in the program.
	Set up, implement, or enhance a Coordinated Care Program for patients on chronic opioid therapy (e.g., Group Health’s Chronic Opioid Therapy Safety Guideline). These programs would re-evaluate effectiveness of opioid therapy in meeting patients’ goals for pain relief and improved function, offer non-opioid pain therapy (e.g., non-opioid medication, cognitive-behavioral therapy, physical therapy), offer tapering for patients on high-dose opioids, and offer opioid use disorder treatment or referral when appropriate.
	Set up, implement, or enhance Patient Review and Restriction Program (or PRR, also called a “Lock In” Program). While these programs are most frequently found in Medicaid programs, awardees can also use this funding to create a program in another type of insurance program (e.g., Workers Compensation).
	Design, validate, refine, and then apply algorithms or metrics for inappropriate prescribing or high-risk patient behaviors using a health system or insurer’s own data. These metrics or algorithms would then be used by the insurer or health system to trigger mechanisms to prevent inappropriate prescribing or otherwise protect patients.
	Drug claim screening for outlier controlled substance prescribers and targeted efforts to increase use by insurers/health systems of these reports.
	Other sub-activities to implement or improve opioid prescribing interventions for insurers, health systems, or pharmacy benefit managers
Enhance uptake of evidence-based opioid prescribing guidelines	Awardees can use this funding to enhance uptake of evidence-based opioid prescribing guidelines. For example, awardees could engage in efforts to enhance guideline-concordant care (e.g., quality improvement programs, such as use of academic detailing); and effective dissemination of information about the guidelines to providers, health systems, insurers, or pharmacy benefit managers, particularly in high burden areas of the state

**PRIORITY STRATEGY 3:
POLICY EVALUATION**

Overview: Awardees may choose to evaluate laws, policies, or regulations designed to address prescription drug overuse, misuse, abuse, and overdose. Awardees are expected to clearly articulate the policy or policies to be evaluated, use qualitative and quantitative approaches to analyze the results, and engage in active dissemination of the findings. The evaluation of laws, policies, or regulations should include both process evaluation (to examine the implementation of the law/policy/regulation) and outcome evaluation (to examine the law/policy/regulation’s impact on a health metric outcome, such as prescribing rates or emergency department visits). Evaluations that consider the economic costs and benefits of laws, policies, and regulations are also of interest. CDC will work closely with awardees to develop protocols for policy evaluation. Dissemination efforts should focus on improving implementation of current initiatives based on process evaluation findings and expanding knowledge of effective and ineffective approaches to improve prioritization of high-impact interventions.

Priority Strategy 3: POLICY EVALUATION, Major Activities and Sub-Activities

Major Activities for Policy Evaluation	Recommended laws, policies, or regulations applicants can evaluate (sub-activities)
	<i>Applicants may pick one or more policies, regulations, laws, or practices to evaluate.</i>
Conduct a rigorous evaluation on a law, policy, or regulation designed to prevent opioid overuse, misuse, abuse, and overdose	Evaluate existing PDMP practices: For example, awardees can evaluate the implementation and impact of universal use requirements, real-time reporting, proactive use, etc.
	Existing health insurer or health system policies or practices: Awardees can evaluate the implementation and impact of health insurer or health system policies
	Examining the impact of laws, policies, and regulations on heroin use and overdose
	Other laws, policies, or regulations, including, but not limited to: <ul style="list-style-type: none"> • Pain clinic laws and regulations • Public or private payer policies that may serve as barriers to medication assisted treatment access (MAT) (e.g. duration limits on buprenorphine for substance use disorder) or facilitators of MAT Healthcare licensure board policies and actions • Naloxone access laws • Impact of state efforts to increase the number of providers who are waived to prescribe buprenorphine, such as release of specific state guidance regarding office-based buprenorphine use for opioid use disorder • Laws that provide for immunity for those seeking medical assistance following an overdose

**PRIORITY STRATEGY 4:
RAPID RESPONSE PROJECT**

Overview: The prescription drug epidemic is fast moving—new interventions can arise; the effectiveness of existing programs can be reevaluated; and new problems, like heroin, can emerge. Under this optional strategy, states can propose to implement Rapid Response Project (RRP) throughout the course of the award that do not fit into the above three strategies to break new ground on addressing the epidemic. For example, states could use RRP to build a new syndromic surveillance system; test a communication campaign; or facilitate intradepartmental data sharing, review and analysis to address opioid overdoses.

Applicants interested in this strategy do not need to submit an initial RRP proposal in the application, though they may propose potential RRP ideas that would be examined further during the funding period. Applicants selecting the RRP strategy would take the first year of the funding period to develop a plan for identifying RRP throughout the course of the award. This would include working with internal (e.g., state, community) and external (e.g., other states, CDC) stakeholders and partners to develop a process to assess needs, detect emerging concerns, propose RRP, and plan for RRP implementation. In year 1, up to 10% of the year’s funding can be used for the RRP planning process. CDC intends to work closely with the awardee to develop RRP; all RRP are subject to CDC approval. In each year of years 2-4, the applicant would submit the RRP plan to CDC in the Annual Performance Report/continuation application for approval. The applicant could use up to 10% of project funding each year to implement RRP in years 2-4 of the project period. RRP could be conducted for single years or multiple years depending on emerging concerns, aims, and scope.

To recap, this is how the program is structured:

Priority Strategies	Major Activities	Sub-Activities
These are the four major categories of work supported by this funding: (1) PDMPs; (2) community or insurer/health system interventions; (3) policy evaluation; and (4) Rapid Response Projects. Awardees must do work supporting (1) and (2); awardees may also choose (3) and/or (4), but are not required to.	These are the specific activities that awardees can choose from to advance the priority strategies. Awardees must choose two or more major activities for PDMPs and one or more for community or insurer/health systems interventions. Awardees may choose none, one, or more major activities for the other two priority strategies.	These are recommended activities awardees can do to advance chosen major activities. These are not required—just suggestions on things that can be done.

1. Collaborations

Collaborations are a vital part of this work; no single player can address all the levers that impact prescribing and drug overdoses. Success in this work is not possible without effective collaboration with key stakeholders. Below are both required and optional collaborations.

a. With CDC-funded programs:

Awardees are required to collaborate with CDC to improve technical and program guidance and conduct evaluations. Awardees will also be expected to work with CDC staff to identify and develop success stories arising from their program.

Here are some collaborations to address in the application, as applicable:

- **States with Core VIPP Funding:** Awardees currently receiving funding under CDC’s Core Violence and Injury Prevention Program (Core VIPP) must meet quarterly with the Core VIPP point of contact in the state health department to coordinate program activities where possible.
- **Core VIPP Regional Networks:** The Core VIPP Regional Networks provide a structure for cross-state collaboration and assistance to all states within their designated regions on a variety of injury and violence prevention topics. Awardees are encouraged but not required to be active participants of their Regional Network and provide information and technical assistance about their PDO program.
- **Other States Awarded Under this Announcement and Prevention Boost States:** Awardees are encouraged but not required to collaborate and share information and findings with other states awarded under this announcement and/or with states currently funded under the Prescription Drug Overdose: Prevention Boost FOA (CDC-RFA-CE14-1404).
- **Injury Control Research Centers:** Injury Control Research Centers (ICRCs) conduct research in all three core phases of injury control (prevention, acute care, and rehabilitation) and serve as training centers as well as information centers for the public. ICRCs are great sources of research knowledge and other resources for state programs and awardees are encouraged but not required to collaborate with any of the ICRCs across the nation.

b. With organizations external to CDC:

Applicants Must Show Engagement with Law Enforcement

The prescription drug overdose epidemic has major implications for both public health and law enforcement. Success in reducing prescription drug overdoses requires coordination and engagement between these two sectors. Applicants must demonstrate this engagement with law enforcement.

- Applicants must provide a Letter of Support (LOS) from a state-level law enforcement authority in their state.
- The LOS must show that the law enforcement authority supports the application and agrees to regular meetings to support and coordinate activities.

Applicants Must Show Engagement with the State Substance Abuse Services Authority

State substance abuse services authorities are important partners in this effort. Applicants must demonstrate coordination and engagement with the state substance abuse services authority.

- Applicants must provide a Letter of Support (LOS) from the state substance abuse services authority in their state.
- The LOS must show that the state substance abuse services authority supports the application and agrees to regular meetings to support and coordinate activities.

Applicants Must Show Collaboration with Certain Key Partners

Applicants must demonstrate support from other key authorities involved in their work. Who these authorities are depends on which Priority Strategies are being pursued. Because all applicants must do work on Priority Strategy #1 (PDMPs), applicants must demonstrate support from the state PDMP authorities. Applicants must provide additional LOSs depending on the other priority strategies they are advancing.

Priority Strategy #1: Enhancing and Maximizing PDMPs:

- All applicants must provide a Letter of Support (LOS) from the PDMP authority in their state.
- The LOS must show that the PDMP authority supports the application, agrees to quarterly meetings to support and coordinate activities, and how the PDMP authority will facilitate proposed activities for enhancing and maximizing the state's PDMP.
- Applicants may provide any other materials (e.g., MOUs, LOS from other entities) that demonstrate collaborations that will make the work in this area stronger.
- Please note, applicants who receive funding under the Harold Rogers Prescription Drug Monitoring Program from the Bureau of Justice Assistance will be expected to coordinate activities under the two programs and communicate with CDC what activities they are engaging in with the BJA funding. However, no LOS or other documentation is required for the application.

Priority Strategy #2: Implementing Community or Insurer/Health System Interventions:

- Applicants advancing insurer/health system work under Priority Strategy #2 must provide a LOS from the entity where the work is focused. For example, if the applicant proposes to create an opioid management program for the state Medicaid program it should provide an LOS from the Medicaid authority. If improving an element of the Workers' Compensation program, it should provide an LOS from the Workers' Compensation authority. If the applicant is working in partnership with a particular health system or insurance program (e.g., integrating and/or disseminating evidence-based opioid prescribing guidelines), the applicant should include an LOS from that system or program.
- The LOS must demonstrate the authority's support, agreement to quarterly meetings, and explanation of how the state authority will facilitate the proposed activities.
- Applicants implementing community interventions under Priority Strategy #2 may provide any materials (e.g., MOUs, LOS from local health departments) that demonstrate collaborations that will make this work stronger and more impactful, but are not required to do so.
- Applicants may provide any other materials (e.g., MOUs, LOS from other entities) that demonstrate collaborations that will make the work in this area stronger.

Priority Strategy #3: Policy Evaluation

- Applicants proposing work under this Priority Strategy must provide a LOS from agencies that maintain access to relevant data the state will be using for evaluation. For example, provide an LOS from the state medical board or Medicaid agency if their data is to be used in an evaluation. The LOS must indicate the agency's support and intention to share data with the awardee for evaluation purposes.
- Applicants may provide any other materials (e.g., MOUs, LOS from other entities) that demonstrate collaborations that will make the work in this area stronger.

Priority Strategy #4: Develop and Implement a Rapid Response Project

- No materials are required; however, applicants may provide any materials (e.g., MOUs, LOS from other entities) that demonstrate collaborations that will make the work in this area stronger.

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 have a role in achieving the FOA outcomes and proposed activities (e.g., state boards of medicine, boards of pharmacy, substance abuse and mental health agencies, local businesses, medical organizations).

2. Target Populations

Applicants must describe how the interventions initiated, improved or evaluated target high-risk groups of clinicians and patients to achieve the greatest health impact. Awardees should use data to identify groups within their jurisdiction or community that are disproportionately contributing to or affected by the public health problem, and plan activities to reduce or eliminate disparities. Disparities by race, ethnicity, gender, age, geography, socioeconomic status, and other relevant dimensions should be considered.

a. Inclusion

Applicants should address how the program will be inclusive of specific populations who can benefit from proposed strategies. These populations include groups such as providers and patients in rural areas, populations with low socio-economic status, or patients covered under state insurance mechanisms (e.g., Medicaid), or other populations that might be otherwise missed by promising strategies.

iv. Funding Strategy (for multi-component FOAs only)

N/A

b. Evaluation and Performance Measurement

i. CDC Evaluation and Performance Measurement Strategy

Evaluation and performance measurement help demonstrate achievement of program outcomes, build a stronger evidence base for specific program interventions, clarify applicability of the evidence to different populations and settings, drive continuous program quality improvement, and identify and articulate successes achieved to inform other states' efforts. Evaluation and performance measurement can also determine if program strategies are scalable and effective at reaching target populations.

Awardees will develop an evaluation plan for the primary purpose of local evaluation and program improvement. Awardees are expected to participate in a CDC-sponsored cross-site evaluation by sharing local data already collected for state program enhancement purposes. CDC will not direct local data collection efforts, but will provide suggestions and support for implementation of their evaluation plans. Please see the CDC Evaluation and Performance Measurement Strategy section below for more detail.

CDC Evaluation and Performance Measurement Strategy:

This section presents example measures that CDC will use to track the implementation of awardee strategies and activities (process evaluation) and examples of how CDC will determine progress on achieving the project period outcomes (outcome evaluation).

In many cases, data used for performance measurement are administrative data that already exist within states. In some cases, states may propose to collect new data to allow for outcome measurement depending on the strategies selected.

This FOA’s Logic Model shows the expected outcomes of this program. States are expected to see short-term policy and program developments around PDMPs, high-burden communities, insurers/health systems, and indicators of system or practice change. Which short-term changes states should expect to see depends on the specific priority strategies they select and the activities they advance.

In the intermediate term, states are expected to see impacts on key behaviors that drive the epidemic among providers, patients, high-burden communities, and insurers/health systems. In the long-term, states should expect changes in health outcomes—including rates of opioid abuse and treatment, opioid-related ED visits, and overdose deaths.

Process and Outcome Performance Measures

To understand why an outcome did or did not occur, it is critical to capture process or implementation outcomes as well. An analysis that includes both process and outcome measures is necessary to determine what is working well and what may need to change in order to get to impact.

To show how to measure performance over the course of the funding, below CDC has provided example measures for process and outcome evaluation. These are offered to give applicants an understanding of the scope and breadth of implementation and outcome evaluation related to this FOA.

These example measures are neither comprehensive nor final. CDC will work with awardees in the first year of the project to discuss and finalize performance measures. Awardees will be expected to report their performance measures at least annually and preferably on a semi-annual basis. For specific reporting requirements, refer to section F.3.b “Annual Performance Report” and F.3.c “Performance Measure Reporting” later in this FOA.

Awardees will track and report on appropriate process measures for the strategies and activities they have undertaken. These measures are to help track the implementation of strategies and their component activities. CDC will work with awardees in the six months following award to finalize these measures

Example Process (Implementation) Performance Measures

Strategy	Example Process Performance Measures
Enhance and Maximize PDMPs	<ul style="list-style-type: none"> • Was there improved efficiency of the PDMP registration process? • Were there increases in access to PDMP, for example, increases in the number or types of healthcare professionals with access PDMP data? • Were there reductions in PDMP data collection intervals? • Did improvements to the PDMP infrastructure or information systems improve proactive reporting? • Did the enhancements to the reporting system increase frequency and quality of reporting? • Were there linkages made between PDMP data and health outcome data?
Implementing Community or Insurer/Health System Interventions	<ul style="list-style-type: none"> • Was there an increase in local health department capacity to develop and disseminate analyses of local prescribing and mortality trends? • Was there an increase in the number or scope of academic detailing for outlier opioid prescribers? • Was there an increase in the number of proactive notifications sent to outlier prescribers? • Was there an increase in the number of patients enrolled in Patient Review and Restriction programs?
Policy Evaluation	<ul style="list-style-type: none"> • Was the implementation of the selected policy evaluated (e.g., observation checklists or logs, record reviews, list of barriers and facilitators to implementation, documentation of completion of steps in CDC Framework for Program Evaluation)? • Was there an outcome evaluation conducted related to the impact of the selected policy? • Was a comprehensive evaluation report generated, integrating information from the implementation and outcome evaluation?
Rapid ResponseProject	<ul style="list-style-type: none"> • Were internal and external stakeholders and partners convened to develop a process to identify RRP? • Was an RRP identified and developed?

Grantees will track and report on outcome measures for the outcomes they are being held accountable for. These measures are to help measure progress on achievement of the accountable outcomes.

The table below lists example outcome measures for selected outcomes in some of the categories of short-term, intermediate-term, and long-term outcomes. CDC will work with awardees in the six months following award to finalize these measures for all relevant outcomes.

Example Short and Intermediate Term Outcomes and Measures

<i>EXAMPLE SHORT –TERM OUTCOMES</i> Policy/Program Development	
Example Outcome	Example Outcome Measure/Indicator
Reduced barriers to PDMP registration and use	<ul style="list-style-type: none"> • Expanded list of providers able to use PDMP • Reduction in amount of time and number of steps required to register for PDMP
Implementation of community level interventions in state “hot spots”	<ul style="list-style-type: none"> • Execution of data sharing and use agreements between local partners and agencies

Expanded opioid management programs	<ul style="list-style-type: none"> • Increase in the number of claims reviews conducted to identify high-risk prescribing (e.g., high-dose opioids, opioids from multiple prescribers for same patient, opioids co-prescribed with benzodiazepines) • Increased projected patient capacity for opioid management programs
EXAMPLE INTERMEDIATE-TERM OUTCOMES	
Behavior Change	
Example Outcome	Example Outcome Measure/Indicator
Increased registration and use of PDMP	<ul style="list-style-type: none"> • Increase in the number/percent of providers and dispensers registered in PDMP
Decreased rate of high dose (>100 MME/day) opioid Rx	<ul style="list-style-type: none"> • Increase in the percentage of providers who check the PDMP the first time an opioid pain reliever prescription is written for a patient
Decreased use of multiple prescribers for opioids	<ul style="list-style-type: none"> • Percent of patients receiving more than an average daily dose of >100 morphine milligram equivalents (across all opioid prescriptions)*
Decreased prescribing of long acting/extended release opioids for patients who are opioid-naïve (i.e., have not taken prescription opioids in 60 days)	<ul style="list-style-type: none"> • Rate of multiple provider episodes for prescription opioids (5 or more prescribers and 5 or more pharmacies in a 6-month period) per 100,000 residents*
Reduced instance of opioid prescription overlap	<ul style="list-style-type: none"> • Decrease in the percent of patients prescribed long-acting/extended-release (LA/ER) opioids who were opioid-naïve (i.e., have not taken prescription opioids in 60 days)*
Reduced overlap of opioid prescriptions with benzodiazepine prescriptions.	<ul style="list-style-type: none"> • Percent of prescribed days overlap between opioid prescriptions*
Improvements in key provider and patient behaviors in high-burden areas of state	<ul style="list-style-type: none"> • E.g., decreased rate of high dose opioid prescribing, decreased number of outlier providers, decreased patient use of multiple providers for opioids
Increased use of claims reviews to identify high-risk prescribing	<ul style="list-style-type: none"> • Number of claim reviews to identify outlier prescribing
Increased number of patients in opioid management programs	<ul style="list-style-type: none"> • Number of patients actively enrolled in program
<i>* Can be generated with SAS programs that CDC will provide to awardees. Awardees will be expected to provide this information.</i>	

Long-term Health Outcomes

To assess the long-term impact of awardees' activities on the health of their residents, awardees will be required to calculate and report to CDC seven health outcomes each year:

1. Rate/number of emergency department (ED) visits related to acute poisonings associated with the effects of opioid analgesics.
2. Rate/number of emergency department (ED) visits related to heroin poisoning.
3. Rate/number of ED visits related to acute poisonings due to the effects of drugs.
4. Age-adjusted mortality rate of fatalities related to acute poisonings associated with the effects of opioid analgesics.
5. Age-adjusted mortality rate of fatalities related to heroin.
6. Age-adjusted mortality rate of fatalities related to acute poisonings associated with the effects of prescription drugs.
7. Age-adjusted mortality rate of fatalities related to acute poisonings due to the effects of drugs.

Awardees are strongly encouraged to collect more timely information by tracking quarterly the rate/number of ED visits related to drug overdoses (e.g., syndromic surveillance) or death certificates.

Information on how to calculate the indicators will be provided to awardees and finalized during the first year of funding, in consultation with awardees.

Cross-Site National Evaluation

For the cross-site evaluation (as resources permit), CDC and any contracted agents will lead the design, work and collaborate with awardees to identify research questions, coordinate data collection/submission, oversee analysis, and disseminate findings to awardees and other key stakeholders. Awardees are expected to participate in and provide administrative data for a cross-site national evaluation of the program. It is anticipated that awardees will share data sources (e.g., de-identified aggregate PDMP data, claims data) with CDC to assist in evaluation efforts. Evaluators within state programs are expected to collaborate with CDC and contracted evaluators to identify evaluation questions based on selected strategies, share data sources, and implement cross-site evaluation activities. The CDC evaluation team will use the CDC Framework for Program Evaluation in Public Health (<http://www.cdc.gov/eval/framework/index.htm>) to assist in designing the evaluation strategy.

The cross-site evaluation will consider both process and outcome measures for all four priority strategies. The evaluation will assess the progress of

each awardee and determine the feasibility and utility of a cross-awardee comparisons (i.e., what common activities can be compared across awardees). Results from the cross-site evaluation will support continuous quality improvement for the program, contribute to the evidence about effective practices to reduce prescription drug overdose morbidity and mortality, document and share lessons learned to support replication of successful interventions, and inform future funding opportunities at CDC.

ii. Applicant Evaluation and Performance Measurement Plan

Applicants must provide an Evaluation and Performance Measurement Plan that is consistent with the CDC Evaluation and Performance Measurement Strategy section of the CDC Project Description of this FOA. Data collected must be used for ongoing monitoring of the award to evaluate its effectiveness, and for continuous program improvement.

The Evaluation and Performance Measurement plan must:

- Be no more than 25 pages (excluding tables and diagrams)
- Be organized around the selected priority strategies 1-4.
- Describe the type of evaluations (i.e., process, outcome, or both).
- Describe key evaluation questions to be addressed by these evaluations.
- Describe indicators, data sources (specifying if administrative data already exists or if new/primary data collection is necessary), and frequency of data collection. Collection and sharing of timely (i.e., within one year) aggregate morbidity and mortality data is of particular interest and importance.
- Describe how key program partners will participate in the evaluation and performance measurement planning processes.
- Describe how evaluation findings will be used for continuous program quality improvement.
- Describe the dissemination channels (including public ones) and audiences for performance measures and evaluation findings.
- Affirm ability to collect the performance measures and respond to the evaluation questions specified in the CDC strategy. (For guidance regarding the Paperwork Reduction Act, please visit (<http://www.hhs.gov/ocio/policy/collection/infocollectfaq.html>))

When preparing an evaluation and performance measurement plan it is important to keep in mind resource considerations, how results will be disseminated, and how results will be used.

Resources. Resource considerations affect scope and level of effort. For example:

- What resources are available to conduct the evaluation?
- How will you prioritize your evaluation questions/activities given the resources you have available?
- What data are available to you/are you already collecting?
- How often will data be collected?
- Who is responsible for collecting the data?

Dissemination. It is important to know how you will share your evaluation findings with your stakeholders, and how these findings will be used. Referring back to your evaluation goals can help you focus your dissemination activities. Was your goal to evaluate your program for the purpose of improving it, or was the purpose of your evaluation to show the impact of your activities on selected outcomes? The answers to these questions, and the ones below, can help you organize your plan for disseminating and using your evaluation findings.

- Who are your audiences—both internal and external? (e.g., project team, coalition members, state public health department, state decision makers, community members, potential funders, etc.)
- How will you disseminate the evaluation findings to your audiences (e.g., presentation at a meeting, brief fact sheet/summary of findings, comprehensive report, weekly program improvement meetings, overview of findings on a website, etc.)?
- Who will develop these dissemination materials and/or present your evaluation findings to key stakeholders?
- Please refer to http://www.cdc.gov/dhdsp/docs/Evaluation_Reporting_Guide.pdf for more information on how to ensure use of evaluation findings.

Use. A goal of any evaluation is to ensure that the findings are used by the stakeholders. Writing the report is not the end point or the final step in the evaluation process. To ensure use of evaluation findings, work must continue beyond completing a final report.

- What are your plans for using evaluation findings? (e.g., program improvement, generating stakeholder buy-in, demonstrating impact, etc.)
- How, where, and when will the findings be used?
- Who will use these findings?
- How will you monitor the use of these findings?

Awardees will be required to submit a more detailed Evaluation and Performance Measurement Plan within the first six months of the project, as outlined in the reporting section of this FOA.

c. Organizational Capacity of Awardees to Execute the Approach

Applicants need to demonstrate the capacity to complete all activities proposed. “Organizational capacity” demonstrates the applicant’s ability to successfully execute the FOA strategies and meet project outcomes. Applicants should have adequate infrastructure (physical space and equipment), workforce capacity and competence, relevant skill sets, information and data systems, and electronic information and communication systems to implement the award.

Applicants must describe their organizational capacity to carry out the strategies and activities proposed. Please describe:

- Prior knowledge and experience working with the strategies selected.
- Proven ability to collect data at a population level and use data to demonstrate impact.
- Experience with planning and implementing programs state-level and/or statewide.
- Experience with evaluating programs state-level and/or statewide.

Specifically, the applying organization should have existing staff with expertise in program implementation, surveillance, program and performance management, evaluation, policy and management of travel and program requirements, and the full capability to manage the required award. Applicants should identify a qualified **evaluator who will conduct evaluation activities** within the state and collaborate with the CDC evaluation team. Please document these capabilities with résumés of key staff.

d. Work Plan

Applicants must prepare a detailed work plan for the first year of the award and a high-level plan for subsequent years. If funded, CDC will provide feedback and technical assistance to help finalize the work plan post-award.

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

Applicants should organize the work plan according to the Priority Strategies being advanced and the Major Activities selected. The work plan at a minimum should:

1. Describe major activities and sub-activities to be conducted to meet the program outcomes for each of the chosen priority strategies.
2. Include a single, state-specific Logic Model describing the comprehensive approach being proposed to work toward the outcomes specified on the overall CDC program logic model.
3. List objectives that are Specific, Measurable, Achievable, Relevant, and Time-phased (SMART) during the first 12-month budget period. The applicant should also develop a long-term work plan of overarching goals that will be accomplished over the entire cooperative agreement project cycle.
4. Describe possible barriers to or facilitators for reaching each objective.
5. Provide a timeline that identifies key activities and assigns approximate dates for inception and completion.
6. Describe the multi-sector collaboration that will be formed to assist in carrying out the proposed activities.
7. Describe staff and administrative roles and functions to support implementation of the award, including evaluation functions.
8. Explain administration and assessment processes to ensure successful implementation and quality assurance.
9. Explain how lessons learned will be translated and disseminated (e.g., through publications, presentations).

e. CDC Monitoring and Accountability Approach

Monitoring activities include routine and ongoing communication between CDC and awardees, site visits, and awardee reporting (including work plans, performance, and financial reporting). Consistent with applicable grants regulations and policies, CDC expects the following to be included in post-award monitoring for grants and cooperative agreements:

- Tracking awardee progress in achieving the desired outcomes.
- Ensuring the adequacy of awardee systems that underlie and generate data reports.
- Creating an environment that fosters integrity in program performance and results.

Monitoring may also include the following activities:

- Ensuring that work plans are feasible based on the budget and consistent with the intent of the award.
- Ensuring that awardees are performing at a sufficient level to achieve outcomes within stated timeframes.
- Working with awardees on adjusting the work plan based on achievement of outcomes, evaluation results and changing budgets.
- Monitoring performance measures (both programmatic and financial) to assure satisfactory performance levels.

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

These activities may include monitoring and reporting activities that assist grants management staff (e.g., grants management officers and specialists, and project officers) in the identification, notification, and management of high-risk grantees.

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

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

CDC will provide substantial involvement beyond regular performance and financial monitoring during the project period. Substantial involvement means that applicants can expect federal programmatic partnership in carrying out the effort under the award. CDC will work in partnership with awardees to ensure the success of the cooperative agreement by:

- Providing cross-site and awardee-specific surveillance technical assistance such as providing tools to identify drug poisonings using ICD-9-CM, ICD-10, text searches and ICD-10-CM, if implemented during the award period;
- Providing technical assistance to revise annual work plans;
- Assisting in advancing program activities to achieve project outcomes;
- Providing scientific subject matter expertise and resources;
- Collaborating with awardees to develop evaluation plans that align with CDC evaluation activities;
- Providing technical assistance on awardee’s evaluation and performance measurement plan;
- Providing technical assistance to define and operationalize performance measures;
- Facilitating the sharing of information among grantees;
- Participating in relevant meetings, committees, conference calls, and working groups related to the cooperative agreement requirements to achieve outcomes;
- Coordinating communication and program linkages with other CDC programs and Federal agencies, such as Centers for Medicare and Medicaid Services (CMS), Food and Drug Administration (FDA), the National Institutes of Health (NIH), the Substance Abuse and Mental Health Services Administration (SAMHSA), and the HHS Office of the National Coordinator for Health Information Technology (ONC).
- Translating and disseminating lessons learned through publications, meetings, surveillance measures and other means on promising and best practices to expand the evidence base.

B. Award Information

1. Funding Instrument Type:

Cooperative Agreement

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

2. Award Mechanism:	U17
3. Fiscal Year:	2015
Estimated Total Funding:	\$55,600,000
4. Approximate Total Fiscal Year Funding:	\$13,900,000
5. Approximate Project Period Funding:	\$55,600,000
6. Total Project Period Length:	4 year(s)
7. Expected Number of Awards:	16
8. Approximate Average Award:	\$875,000 Per Budget Period
9. Award Ceiling:	\$1,000,000 Per Budget Period
10. Award Floor:	\$750,000 Per Budget Period
11. Estimated Award Date:	09/15/2015

Throughout the project period, CDC will continue the award based on the availability of funds, the evidence of satisfactory progress by the awardee (as documented in required reports), and the determination that continued funding is in the best interest of the federal government. The total number of years for which federal support has been approved (project period) will be shown in the “Notice of Award.” This information does not constitute a commitment by the federal government to fund the entire period. The total project period comprises the initial competitive segment and any subsequent non-competitive continuation award(s).

12. Budget Period Length: 12 month(s)

13. Direct Assistance

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

C. Eligibility Information

1. Eligible Applicants

Eligibility Category: State governments

2. Additional Information on Eligibility

Current Boost States: States funded under the Boost FOA (CDC-RFA-CE14-1404) are eligible to apply for this program. If a state currently receiving support under Prevention Boost receives funding under this FOA, it will no longer receive funding under Boost and will instead receive funding exclusively under this program. Prevention Boost states that do not apply or are not awarded funds under this program will continue their work under Boost.

Because this funding requires activity to enhance state PDMPs, states where a PDMP is not authorized are not eligible to apply for this funding.

Applicants must provide a Letter of Support (LOS) from:

- A state-level law enforcement authority in their state. The LOS must show that the law enforcement authority supports the application and agrees to regular meetings to support and coordinate activities.
- The state substance abuse services authority in their state. The LOS must show that the substance abuse authority supports the application and agrees to regular meetings to support and coordinate activities.
- The PDMP authority in their state showing the PDMP authority supports the application, agrees to quarterly meetings to support and coordinate activities, and how the PDMP authority will facilitate proposed activities for enhancing and maximizing the state’s PDMP.

Applicants implementing insurer/health system interventions under Priority Strategy #2 must provide a LOS from the state authority managing the entity where the work is focused. For example, if a proposal is for creating an opioid management program for the state Medicaid program, show an LOS from the Medicaid authority. If improving an element of the Workers’ Compensation program, provide a LOS from the Workers’ Compensation authority. If the applicant is integrating and/or disseminating evidence-based opioid prescribing guidelines in partnership with a particular health system or insurance program, the applicant should include a LOS from that system or program. The LOS must demonstrate the authority’s support, agreement to quarterly meetings, and explanation of how the state authority will facilitate the proposed activities.

If the priority strategy of policy evaluation is chosen, applicants must provide a LOS from agencies that maintain access to relevant data the state will be using for evaluation. The LOS must indicate the agency’s support and agreement to share data for evaluation purposes.

The award ceiling for this FOA is \$1,000,000. CDC will consider any application requesting an award higher than this amount as non-responsive and it will receive no further review. If a pre-application is required, then specify here and include it in the special eligibility requirements section. ([http:// www.hhs.gov/ asfr/ ogapa/ aboutog/ hhsgps107.pdf](http://www.hhs.gov/asfr/ogapa/aboutog/hhsgps107.pdf))

3. Justification for Less than Maximum Competition

Competition is limited to state health departments (SHDs) or their bona fide agents. SHDs are critical to the success of this FOA for several reasons: (1) the surveillance and evaluation capacity unique to SHDs; (2) the authority and connections of SHDs to other stakeholders at the state level; (3) the necessity of state-level perspective for applicable lessons learned to inform other SHDs; and (4) the connection and likely collaboration with other injury awardees.

SHDs have the unique epidemiologic and surveillance capacity to identify crucial trends and patterns driving the epidemic. Identifying such patterns is critical for all the interventions funded under this program. Further, evaluation is a required and integral piece of this FOA and SHDs are unique in their evaluation capacity and expertise at the state level, especially with regard to the impact of the kind of health-related interventions at the core of this FOA.

SHDs also have deep collaborative relationships with, or direct authority over, all of the critical state-level stakeholders needed to advance the FOA's focus areas—including PDMPs, state boards of medical licensure, state boards of pharmacy, and state health insurance programs like Medicaid or Workers Compensation. No other entity or body within the state government has the necessary connections and collaborative relationships necessary to fulfill the requirements of this FOA.

Another purpose of this FOA is to create a reproducible model for state action on prescription drug overdose. Because this FOA will only fund a small number of states, it is critical that the lessons learned from this project are applicable to other state efforts. Every state has a SHD that can serve as the hub of prevention efforts, further supporting the necessity of awarding grants solely to SHDs as under this FOA.

Failure to limit eligibility to SHDs would undercut the purposes of this funding. Non-SHD awardees would lack the surveillance and evaluation expertise needed to fulfill the funding's objective. Such awardees would also lack the connections and collaborations with the state-level organizations like PDMPs and state Medicaid programs necessary to advance the Priority Strategies. This lack of capacity, expertise, and connection would make it extremely unlikely awardees could fulfill the requirements of the funding or achieve the expected outcomes of the project. The utility of lessons learned from the funding—one of the key purposes of the program—would be seriously undermined, as it would be unlikely to be applicable to state health departments, who are in critical need of demonstrated effective approaches to prescription drug overdose prevention.

4. Cost Sharing or Matching

Cost Sharing / Matching No
Requirement:

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

Consistent with the cited authority for this announcement and applicable grants regulations, sources for cost sharing or matching may include complementary foundation funding, other U.S. government funding sources including programs supported by HHS or other agencies (e.g., Department of Agriculture, Department of Education, Department of Housing and Urban Development, Department of Transportation, Environmental Protection Agency, U.S. Park Service) and other funding sources. Applicants should coordinate with multiple sectors such as public health, transportation, education, health care delivery, and agriculture.

5. Maintenance of Effort

Maintenance of effort is not required for this program.

D. Required Registrations

Additional materials that may be helpful to applicants: <http://www.cdc.gov/od/pgo/funding/docs/FinancialReferenceGuide.pdf>.

1. Required Registrations

An organization must be registered at the three following locations before it can submit an application for funding at www.grants.gov.

a. Data Universal Numbering System: All applicant organizations must obtain a Data Universal Numbering System (DUNS) number. A DUNS number is a unique nine-digit identification number provided by Dun & Bradstreet (D&B). It will be used as the Universal Identifier when applying for federal awards or cooperative agreements.

The applicant organization may request a DUNS number by telephone at 1-866-705-5711 (toll free) or Internet at <http://fedgov.dnb.com/webform/displayHomePage.do>. The DUNS number will be provided at no charge. If funds are awarded to an applicant organization that includes sub-awardees, those sub-awardees must provide their DUNS numbers before accepting any funds.

b. System for Award Management (SAM): The SAM is the primary registrant database for the federal government and the repository into which an entity must submit information required to conduct business as an awardee. All applicant organizations must register with SAM, and will be assigned a SAM number. All information relevant to the SAM number must be current at all times during which the applicant has an application under consideration for funding by CDC. If an award is made, the SAM information must be maintained until a final financial report is submitted or the final payment is received, whichever is later. The SAM registration process usually requires not more than five business days, and registration must be renewed annually. Additional information about registration procedures may be found at www.SAM.gov.

c. Grants.gov: The first step in submitting an application online is registering your organization through www.grants.gov, the official HHS E-grant website. Registration information is located at the "Get Registered" option at www.grants.gov.

All applicant organizations must register with www.grants.gov. The one-time registration process usually takes not more than five days to complete. Applicants must start the registration process as early as possible.

2. Request Application Package

Applicants may access the application package at www.grants.gov.

3. Application Package

Applicants must download the SF-424, Application for Federal Assistance, package associated with this funding opportunity at www.grants.gov. If Internet access is not available, or if the online forms cannot be accessed, applicants may call the CDC PGO staff at 770-488-2700 or e-mail PGO PGOTIM@cdc.gov for assistance. Persons with hearing loss may access CDC telecommunications at TTY 1-888-232-6348.

4. Submission Dates and Times

If the application is not submitted by the deadline published in the FOA, it will not be processed. PGO personnel will notify the applicant that their application did not meet the deadline. The applicant must receive pre-approval to submit a paper application (see Other Submission Requirements section for additional details). If the applicant is authorized to submit a paper application, it must be received by the deadline provided by PGO.

a. Letter of Intent Deadline (must be emailed or postmarked by)

Due Date for Letter of Intent: **03/16/2015**

b. Application Deadline

Due Date for Applications: **05/08/2015**, 11:59 p.m. U.S. Eastern Standard Time, at www.grants.gov. If Grants.gov is inoperable and cannot receive applications, and circumstances preclude advance notification of an extension, then applications must be submitted by the first business day on which grants.gov operations resume.

Date for Informational Conference Call: 03/11/2015

Informational conference call for potential applicants: Wednesday March 11, 2015 at 1:00PM ET

Conference call number: (855) 644-0229 Conference ID: 9654605

The purpose of **Amendment 1** to this FOA is to provide additional clarifying information based on questions received from potential applicants during the Pre-Application Informational Conference Call held on March 11, 2015. A summary of the questions and answers can be found in Section H. Other Information beginning on page 39 of the amended FOA.

5. CDC Assurances and Certifications

All applicants are required to sign and submit "Assurances and Certifications" documents indicated at <http://www.cdc.gov/grants/interestedinapplying/applicationprocess.html>.

- Complete the applicable assurances and certifications on an annual basis, name the file "Assurances and Certifications" and upload it as a PDF file at www.grants.gov
- Complete the applicable assurances and certifications and submit them directly to CDC on an annual basis at [http://wwwn.cdc.gov/grantassurances/\(S\(mj444mxct51Inrv1hljjjmaa\)\)/Homepage.aspx](http://wwwn.cdc.gov/grantassurances/(S(mj444mxct51Inrv1hljjjmaa))/Homepage.aspx)

Assurances and certifications submitted directly to CDC will be kept on file for one year and will apply to all applications submitted to CDC by the applicant within one year of the submission date.

6. Content and Form of Application Submission

Applicants are required to include all of the following documents with their application package at www.grants.gov.

7. Letter of Intent

An LOI is requested but optional. The content of the LOI can be very simple — all CDC is looking for is a letter from the applicant stating the intention to apply.

LOI must be sent via U.S. express mail, delivery service, fax, or email to:

Eric S. Gross

CDC, National Center for Injury Prevention and Control

Address: 4770 Buford Hwy. NE

Mailstop F-62

Atlanta, GA 30341

euw9@cdc.gov

Phone: 770.488.4398

Fax: 770.488.3551

8. Table of Contents

(No page limit and not included in Project Narrative limit): The applicant must provide, as a separate attachment, the "Table of Contents" for the entire submission package.

Provide a detailed table of contents for the entire submission package that includes all of the documents in the application and headings in the "Project Narrative" section. Name the file "Table of Contents" and upload it as a PDF file under "Other Attachment Forms" at www.grants.gov.

9. Project Abstract Summary

(Maximum 1 page)

A project abstract is included on the mandatory documents list and must be submitted at www.grants.gov. The project abstract must be a self-contained, brief summary of the proposed project including the purpose and outcomes. This summary must not include any proprietary or confidential information. Applicants must enter the summary in the "Project Abstract Summary" text box at www.grants.gov.

10. Project Narrative

(Maximum of 20 pages, single spaced, Calibri 12 point, 1-inch margins, number all pages. Content beyond 20 pages will not be considered. The 20 page limit includes the work plan. For a multi-component FOA, maximum page limit is 25.)

The Project Narrative must include all of the bolded headings shown in this section. The Project Narrative must be succinct, self-explanatory, and in the order outlined in this section. It must address outcomes and activities to be conducted over the entire project period as identified in the CDC Project Description section. Applicants must submit a Project Narrative with the application forms. Applicants must name this file "Project Narrative" and upload it at www.grants.gov.

a. Background

Applicants must provide a description of relevant background information that includes the context of the problem (See CDC Background).

b. Approach

i. Purpose

Applicants must describe in 2-3 sentences specifically how their application will address the problem as described in the CDC Background section.

ii. Outcomes

Applicants must clearly identify the outcomes they expect to achieve by the end of the project period. Outcomes are the results that the program intends to achieve. All outcomes must indicate the intended direction of change (e.g., increase, decrease, maintain). (See the logic model in the Approach section of the CDC Project Description.)

iii. Strategies and Activities

Applicants must provide a clear and concise description of the strategies and activities they will use to achieve the project period outcomes. Applicants must select existing evidence-based strategies that meet their needs, or describe in the Applicant Evaluation and Performance Measurement Plan, how these strategies will be evaluated over the course of the project period. (See CDC Project Description: Strategies and Activities section.)

1. Collaborations

Applicants must describe how they will collaborate with programs and organizations either internal or external to CDC.

Applicants must file letters of support, as appropriate, name the file “Letters of Support”, and upload it as a PDF file at www.grants.gov.

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

2. Target Populations

Applicants must describe the specific target population(s) in their jurisdiction and explain how such a target will achieve the goals of the award and/or alleviate health disparities. Refer back to the CDC Project Description section – Approach: Target Population.

c. Applicant Evaluation and Performance Measurement Plan

Applicants must provide an overall evaluation and performance measurement plan that is consistent with the CDC Evaluation and Performance Measurement Strategy section of the CDC Project Description of this FOA. Data collected must be used for ongoing monitoring of the award to evaluate its effectiveness, and for continuous program improvement.

The plan must:

- Affirm the ability to collect the performance measures and respond to the evaluation questions specified in the CDC strategy. (For guidance regarding the Paperwork Reduction Act, please visit <http://www.hhs.gov/ocio/policy/collection/infocollectfaq.html>)
- Describe how key program partners will participate in the evaluation and performance measurement planning processes.
- Describe how evaluation findings will be used for continuous program quality improvement.

Where the applicant chooses to, or is expected to, take on specific evaluation studies:

- Describe the type of evaluation(s) (i.e., process, outcome, or both) to be conducted.
- Describe key evaluation questions to be addressed by these evaluations.
- Describe other information relevant to the evaluation (e.g., measures, data sources)

Timely collection and sharing of aggregate morbidity and mortality data with CDC is important to quality evaluation. Applicants should expect to share with CDC yearly counts of drug overdose morbidity and/or mortality data aggregated at the state level within a year of injury or death. Provision of evidence of such a data sharing capacity is strongly encouraged.

Awardees will be required to submit a more detailed evaluation and performance measurement plan within the first 6 months of the project, as outlined in the reporting section of the FOA.

d. Organizational Capacity of Applicants to Implement the Approach

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

Please include appropriate CVs, resumes, and organizational charts that will demonstrate organizational capacity. Name this file “CVs/Resumes” or “Organizational Charts” and upload it at www.grants.gov.

11. Work Plan

(Included in the Project Narrative’s 20 page limit)

Applicants must prepare a work plan consistent with the CDC Project Description Work Plan section. The work plan integrates and delineates more specifically how the awardee plans to carry out achieving the project period outcomes, strategies and activities, evaluation and performance measurement.

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

12. Budget Narrative

Applicants must submit an itemized budget narrative, which may be scored as part of the Organizational Capacity of Awardees to Execute the Approach. When developing the budget narrative, applicants must consider whether the proposed budget is reasonable and consistent with the purpose, outcomes, and program strategy outlined in the project narrative. The budget must include:

- Salaries and wages
- Fringe benefits
- Consultant costs
- Equipment
- Supplies
- Travel

- Other categories
- Contractual costs
- Total Direct costs
- Total Indirect costs

Indirect costs will not be reimbursed under grants to foreign organizations, international organizations, and foreign components of grants to domestic organizations (does not affect indirect cost reimbursement to the domestic entity for domestic activities). The CDC will not reimburse indirect costs unless the recipient has an indirect cost rate covering the applicable activities and period.

For guidance on completing a detailed budget, see Budget Preparation Guidelines at <http://www.cdc.gov/grants/interestedinapplying/applicationresources.html>.

If applicable and consistent with the cited statutory authority for this announcement, applicant entities may use funds for activities as they relate to the intent of this FOA to meet national standards or seek health department accreditation through the Public Health Accreditation Board (see: <http://www.phaboard.org>). Applicant entities to whom this provision applies include state, local, territorial governments (including the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, the Commonwealth of the Northern Mariana Islands, American Samoa, Guam, the Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau), or their bona fide agents, political subdivisions of states (in consultation with states), federally recognized or state-recognized American Indian or Alaska Native tribal governments, and American Indian or Alaska Native tribally designated organizations. Activities include those that enable a public health organization to deliver public health services such as activities that ensure a capable and qualified workforce, up-to-date information systems, and the capability to assess and respond to public health needs. Use of these funds must focus on achieving a minimum of one national standard that supports the intent of the FOA. Proposed activities must be included in the budget narrative and must indicate which standards will be addressed.

Applicants must name this file “Budget Narrative” and upload it as a PDF file at www.grants.gov. If requesting indirect costs in the budget, a copy of the indirect cost-rate agreement is required. If the indirect costs are requested, include a copy of the current negotiated federal indirect cost rate agreement or a cost allocation plan approval letter for those Grantees under such a plan. Applicants must name this file “Indirect Cost Rate” and upload it at www.grants.gov.

Applicants submitting activities under Priority Strategy #4 (developing and implementing a Rapid Response Project) cannot use more than 10% of their award to advance that project. Year 1 of activities under Priority Strategy #4 will be dedicated to developing a plan for identifying, selecting, and implementing the Rapid Response Project(s). Years 2-4 of the project period will be dedicated to the implementation of the Rapid Response Project.

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

13. Tobacco and Nutrition Policies

Awardees are encouraged to implement tobacco and nutrition policies.

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

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

Tobacco Policies:

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

Nutrition Policies:

1. Healthy food-service guidelines must, at a minimum, align with HHS and General Services Administration Health and Sustainability Guidelines for Federal Concessions and Vending Operations. These guidelines apply to cafeterias, snack bars, and vending machines in any facility under the control of the awardee and in accordance with contractual obligations for these services (see: http://www.gsa.gov/graphics/pbs/Guidelines_for_Federal_Concessions_and_Vending_Operations.pdf).
2. Resources that provide guidance for healthy eating and tobacco-free workplaces are:

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

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

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

14. Health Insurance Marketplaces

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

15. Intergovernmental Review

The application is subject to Intergovernmental Review of Federal Programs, as governed by Executive Order 12372, which established a system for state and local intergovernmental review of proposed federal assistance applications. Applicants should inform their state single point of contact (SPOC) as early as possible that they are applying prospectively for federal assistance and request instructions on the state's process. The current SPOC list is available at: http://www.whitehouse.gov/omb/grants_spoc/.

16. Pilot Program for Enhancement of Employee Whistleblower Protections

Pilot Program for Enhancement of Employee Whistleblower Protections: All applicants will be subject to a term and condition that applies the terms of 48 CFR section 3.908 to the award and requires that grantees inform their employees in writing (in the predominant native language of the workforce) of employee whistleblower rights and protections under 41 U.S.C. 4712.

17. Funding Restrictions

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

- Awardees may not use funds for research.
- Awardees may not use funds for clinical care.
- Awardees may use funds only for reasonable program purposes, including personnel, travel, supplies, and services.
- Generally, awardees may not use funds to purchase furniture or equipment. Any such proposed spending must be clearly identified in the budget.
- Reimbursement of pre-award costs is not allowed.
- Other than for normal and recognized executive-legislative relationships, no funds may be used for:
 - publicity or propaganda purposes, for the preparation, distribution, or use of any material designed to support or defeat the enactment of legislation before any legislative body
 - the salary or expenses of any grant or contract recipient, or agent acting for such recipient, related to any activity designed to influence the enactment of legislation, appropriations, regulation, administrative action, or Executive order proposed or pending before any legislative body
- See http://www.cdc.gov/grants/additional_requirements/index.htm#ar12 for detailed guidance on this prohibition and <http://intranet.cdc.gov/od/adp/docs/ImplementationofAnti-LobbyingProvisions-June2012.pdf>.
- The direct and primary recipient in a cooperative agreement program must perform a substantial role in carrying out project outcomes and not merely serve as a conduit for an award to another party or provider who is ineligible.

18. Other Submission Requirements

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

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

If Internet access is not available or if the forms cannot be accessed online, applicants may contact the PGO TIMS staff at 770-488-2700 or by e-mail at pgotim@cdc.gov, Monday through Friday, 7:30 a.m.–4:30 p.m., except federal holidays. Electronic applications will be considered successful if they are available to PGO TIMS staff for processing from www.grants.gov on the deadline date.

b. Tracking Number: Applications submitted through www.grants.gov are time/date stamped electronically and assigned a tracking number. The applicant's Authorized Organization Representative (AOR) will be sent an e-mail notice of receipt when www.grants.gov receives the application. The tracking number documents that the application has been submitted and initiates the required electronic validation process before the application is made available to CDC.

c. Validation Process: Application submission is not concluded until the validation process is completed successfully. After the application package is submitted, the applicant will receive a "submission receipt" e-mail generated by www.grants.gov. A second e-mail message to applicants will then be generated by www.grants.gov that will either validate or reject the submitted application package. This validation process may take as long as two business days. Applicants are strongly encouraged to check the status of their application to ensure that submission of their package has been completed and no submission errors have occurred. Applicants also are strongly encouraged to allocate ample time for filing to guarantee that their application can be submitted and validated by the deadline published in the FOA. Non-validated applications will not be accepted after the published application deadline date.

If you do not receive a "validation" e-mail within two business days of application submission, please contact www.grants.gov. For instructions on how to track your application, refer to the e-mail message generated at the time of application submission or the [Applicant User Guide](#), Version 1.1, page 102.

<http://www.grants.gov/documents/19/18243/GrantsgovApplicantUserGuide.pdf/ce754626-c2aa-44bc-b701-30a75bf428c8>

d. Technical Difficulties: If technical difficulties are encountered at www.grants.gov, applicants should contact Customer Service at www.grants.gov. The www.grants.gov Contact Center is available 24 hours a day, 7 days a week, except federal holidays. The Contact Center

is available by phone at 1-800-518-4726 or by e-mail at support@www.grants.gov. Application submissions sent by e-mail or fax, or on CDs or thumb drives will not be accepted. Please note that www.grants.gov is managed by HHS.

e. Paper Submission: If technical difficulties are encountered at www.grants.gov, applicants should call the www.grants.gov Contact Center at 1-800-518-4726 or e-mail them at support@www.grants.gov for assistance. After consulting with the Contact Center, if the technical difficulties remain unresolved and electronic submission is not possible, applicants may e-mail or call CDC GMO/GMS, before the deadline, and request permission to submit a paper application. Such requests are handled on a case-by-case basis.

An applicant's request for permission to submit a paper application must:

1. Include the www.grants.gov case number assigned to the inquiry
2. Describe the difficulties that prevent electronic submission and the efforts taken with the www.grants.gov Contact Center to submit electronically; and
3. Be postmarked at least three calendar days before the application deadline. Paper applications submitted without prior approval will not be considered. If a paper application is authorized, PGO will advise the applicant of specific instructions for submitting the application (e.g., original and two hard copies of the application by U.S. mail or express delivery service).

E. Review and Selection Process

1. Review and Selection Process: Applications will be reviewed in three phases.

a. Phase I Review

All applications will be reviewed initially for completeness by CDC PGO staff and will be reviewed jointly for eligibility by the CDC NCIPC and PGO. Incomplete applications and applications that do not meet the eligibility criteria will not advance to Phase II review. Applicants will be notified that their applications did not meet eligibility or published submission requirements.

b. Phase II Review

A review panel will evaluate complete, eligible applications in accordance with the criteria below.

- i. Approach
- ii. Evaluation and Performance Measurement
- iii. Applicant's Organizational Capacity to Implement the Approach

Approach

Maximum Points: 35

1. Purpose, Outcomes, Strategies and Activities, and Target Populations (10 points):
 - Background: Applicants must provide a description of relevant background information that includes the context of the problem, particularly in the applicant's state.
 - Purpose: Applicants must describe in 2-3 sentences specifically how their application will address the problem as described in the Background section of this FOA.
 - Outcomes: Applicants must clearly identify the outcomes they expect to achieve by the end of the project period. Outcomes are the results that the program intends to achieve. All outcomes must indicate the intended direction of change (e.g., increase, decrease, maintain).
 - Strategies and Activities: Applicants must provide a clear and concise description of the strategies and activities they will use to achieve the project period outcomes.
 - Target Populations: Applicants must describe how the interventions to be improved or evaluated target high-risk groups of clinicians and patients to achieve the greatest health impact, as described in the "Target Populations" section of this FOA
2. Work Plan (15 points): Applicants will be scored on their preparation of a work plan consistent with this FOA's "Work Plan" section. It must include a detailed first-year work plan and a high-level plan for subsequent years. This is the applicant's opportunity to clearly show what it will do with the funding. After reading the work plan, reviewers should be able to understand how the applicant plans to carry out achieving the project period outcomes, strategies, and activities.
3. Collaborations (10 points): Applicants will be scored on the extent to which they demonstrate strong, multi-sector collaborations to support their work, including:
 - Inclusion of the Letters of Support (LOS) required under the "Collaboration" section of this FOA. Applicants should carefully read that section to ensure they have all required LOS. Failure to include a required letter of support will be deemed non-responsive.
 - Inclusion of any other recommended MOAs/MOUs/LOSs that demonstrate strategic partnerships and collaborations with organizations that have a role in achieving the FOA outcomes and proposed activities.
 - Demonstration of collaborations with other CDC programs, including Core VIPP states, Core VIPP regional networks, and Injury Control Research Centers, as applicable. Applicants should also demonstrate a commitment to collaborate with the CDC evaluation team on evaluation questions, methods, data sharing, and data analysis.

Evaluation and Performance Management

Maximum Points: 25

Applicants will be scored on the extent to which their evaluation and performance measurement plan addresses:

1. Inclusion of clearly proposed measures of effectiveness (10 points): Measures should be consistent with the components and objectives in the work plan and are designed to measure the intended performance outcomes and relate to the FOA’s performance goals.
2. Timely collection and sharing of aggregate morbidity and mortality data with CDC (5 points). Specifically, the 5 points under this criterion will be scored based on the applicant’s inclusion of the following elements:
 - Applicant can share with CDC required yearly rates and counts of drug overdose morbidity (e.g., emergency department visits related to drug overdoses) or mortality indicator data (e.g., drug overdose deaths) listed in the CDC Evaluation and Performance Measurement Strategy aggregated at the state level within a year of the calendar year in which the injury occurred (e.g., report the number and rate of drug overdose emergency department visits in 2015 by 12/31/2016) or death occurred (e.g., report the number and rate of drug overdose deaths in 2015 by 12/31/2016) (3 points).
 - Applicant can share with CDC either morbidity (e.g., emergency department visits related to drug overdoses) or mortality data (e.g., drug overdose deaths) aggregated at the state level at least every six months (e.g., share information on the rate and count of drug overdose deaths occurring between 1/1/2016 to 6/30/2016 by 12/31/2016 and share information on drug overdose deaths occurring between 7/1/2016 and 12/31/2016 by 6/30/2017) (2 points)
3. Development of a state- or jurisdiction-specific evaluation plan (8 points). Applicants will be scored on their inclusion of a clearly proposed evaluation plan that is consistent with the work plan and the CDC evaluation performance strategy, and that is feasible and likely to demonstrate grantee performance outcomes, including successes and needed improvements.
4. Participation as requested by CDC in a cross-site national evaluation (2 points). Applicants will be scored on their documented ability and willingness to participate in a cross-site national evaluation.

Applicants Organizational Capacity to Implement the Approach

Maximum Points: 40

Applicants will be scored according to the following elements:

1. Prior knowledge and experience working with the strategies selected (10 points).
2. Proven ability to collect data at a population level and use data to demonstrate impact (10 points).
3. Experience with planning, implementing, and evaluating programs state-level and/or statewide (10 points). Applicants should have existing staff with expertise in evaluation, policy and program implementation, surveillance, program and performance management, management of travel and program requirements, and the full capability to manage the required award. Applicants should identify a qualified evaluator who will conduct evaluation activities within the state and collaborate with the CDC evaluation team or provide plans to fill that position within six months of the award.
4. Burden (10 points): Applicants will be scored according to age-adjusted drug overdose death rate in their state. CDC will calculate the points assigned to applicants under this section using 2013 National Vital Statistics System drug overdose mortality by state - applicants do not need to provide any documentation or materials in support of this criterion. Applicants among the states with the 10 highest age-adjusted drug overdose death rates will receive 10 points. Applicants among the states with the 11th—19th highest age-adjusted drug overdose death rates will receive points according to the following table:

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

5. Budget and Budget Narrative (reviewed, but not scored): Presentation of a reasonable budget that is consistent with the stated objectives and planned program activities.

Not more than thirty days after the Phase II review is completed, applicants will be notified electronically if their application does not meet eligibility or published submission requirements.

Not more than thirty days after the Phase II review is completed, applicants will be notified electronically if their application does not meet eligibility or published submission requirements.

c. Phase III Review

Applications will be funded in order by score and rank determined by the review panel.

2. Announcement and Anticipated Award Dates

Successful applicants will anticipate notice of funding by August 15, 2015 with a start date of September 15, 2015.

F. Award Administration Information

1. Award Notices

Awardees will receive an electronic copy of the Notice of Award (NOA) from CDC PGO. The NOA shall be the only binding, authorizing document between the awardee and CDC. The NOA will be signed by an authorized GMO and emailed to the Awardee Business Officer listed in application and the Program Director.

Any applicant awarded funds in response to this FOA will be subject to the DUNS, SAM Registration, and Federal Funding Accountability And Transparency Act Of 2006 (FFATA) requirements.

Unsuccessful applicants will receive notification of these results by e-mail with delivery receipt or by U.S. mail.

2. Administrative and National Policy Requirements

Awardees must comply with the administrative and public policy requirements outlined in 45 C.F.R. Part 74 or Part 92 and the HHS Grants Policy Statement, as appropriate.

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

The HHS Grants Policy Statement is available at <http://www.hhs.gov/asfr/ogapa/aboutog/hhsgps107.pdf>.

*Note that 2 CFR 200 will supersede the administrative requirements (A-110 & A-102), cost principles (A-21, A-87 & A-122) and audit requirements (A-50, A-89 & A-133).

This FOA is for a cooperative agreement. Under the cooperative agreement mechanism, the Centers for Disease Control and Prevention's (CDC) purpose is to support the awardee's activities. Applicants are advised that any activities involving information collection (i.e., surveys, questionnaires, etc.) from 10 or more individuals funded by a cooperative agreement will be subject to PRA determination and may or may not be subject to approval by the Office of Management and Budget (OMB) under the Paperwork Reduction Act (PRA). PRA applicability will depend on level of CDC involvement with the development, collection and management of information/data.

For more information on the C.F.R. visit <http://www.ecfr.gov/cgi-bin/ECFR?page=browse>.

3. Reporting

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

- Helps target support to awardees;
- Provides CDC with periodic data to monitor awardee progress toward meeting the FOA outcomes and overall performance;
- Allows CDC to track performance measures and evaluation findings for continuous quality and program improvement throughout the project period and to determine applicability of evidence-based approaches to different populations, settings, and contexts; and
- Enables CDC to assess the overall effectiveness and influence of the FOA.

The table below summarizes required and optional reports. All required reports must be sent electronically to GMS listed in the "Agency Contacts" section of the FOA copying the CDC Project Officer.

Report	When?	Required?
Awardee Evaluation and Performance Measurement Plan	6 months into award	Yes
Annual Performance Report (APR)	120 days before end of budget period. Serves as yearly continuation application.	Yes
Data on Performance Measures	CDC program determines. Only if program wants more frequent performance measure reporting than annually in APR.	No
Federal Financial Reporting Forms	90 days after end of calendar quarter in which budget period ends	Yes
Final Performance and Financial Report	90 days after end of project period.	Yes

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

Awardees are expected to use CDC provided annual performance report templates for reporting progress and evaluation results.

a. Awardee Evaluation and Performance Measurement Plan (required)

With support from CDC, awardees must elaborate on their initial applicant evaluation and performance measurement plan. This plan must be no more than 20 pages; awardees must submit the plan 6 months into the award.

This plan should provide additional detail on the following:

- The frequency that evaluation and performance data are to be collected.
- How data will be reported.
- How evaluation findings will be used for continuous quality and program improvement.
- How evaluation and performance measurement will yield findings to demonstrate the value of the FOA (e.g., improved public health outcomes, effectiveness of FOA, cost-effectiveness or cost benefit).
- Dissemination channels and audiences.
- Other information requested as determined by the CDC program.

b. Annual Performance Report (APR) (required)

The awardee must submit the APR via www.grants.gov 120 days before the end of the budget period. This report must not exceed 45 pages excluding administrative reporting. Attachments are not allowed, but weblinks are allowed.

This report must include the following:

- **Performance Measures:** Awardees must report on performance measures for each budget period and update measures, if needed.
- **Evaluation Results:** Awardees must report evaluation results for the work completed to date (including findings from process or outcome evaluations).
- **Work Plan:** Awardees must update work plan each budget period to reflect any changes in project period outcomes, activities, timeline, etc.
- **Successes**
 - Awardees must report progress on completing activities and progress towards achieving the project period outcomes described in the logic model and work plan.
 - Awardees must describe any additional successes (e.g. identified through evaluation results or lessons learned) achieved in the past year.
 - Awardees must describe success stories.
- **Challenges**
 - Awardees must describe any challenges that hindered or might hinder their ability to complete the work plan activities and achieve the project period outcomes.
 - Awardees must describe any additional challenges (e.g., identified through evaluation results or lessons learned) encountered in the past year.
- **CDC Program Support to Awardees**
 - Awardees must describe how CDC could help them overcome challenges to complete activities in the work plan and achieving project period outcomes.
- **Administrative Reporting** (No page limit)
 - SF-424A Budget Information-Non-Construction Programs.
 - Budget Narrative – Must use the format outlined in "Content and Form of Application Submission, Budget Narrative" section.
 - Indirect Cost Rate Agreement.

For year 2 and beyond of the award awardees may request that as much as 75% of their estimated unobligated funds be carried over into the next budget period.

The awardee must submit the Annual Performance Report via www.grants.gov 120 days before the end of the budget period.

c. Performance Measure Reporting (optional)

CDC programs may require more frequent reporting of performance measures than annually in the APR. If this is the case, CDC programs must specify reporting frequency, data fields, and format for awardees at the beginning of the award period.

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

Awardees are expected to use CDC provided annual performance report templates for reporting progress and evaluation results.

d. Federal Financial Reporting (FFR) (required)

The annual FFR form (SF-425) is required and must be submitted through eRA Commons 90 days after the end of the calendar quarter in which the budget period ends. The report must include only those funds authorized and disbursed during the timeframe covered by the report. The final FFR must indicate the exact balance of unobligated funds, and may not reflect any unliquidated obligations. There must be no discrepancies between the final FFR expenditure data and the Payment Management System's (PMS) cash transaction data. Failure to submit the required information by the due date may adversely affect the future funding of the project. If the information cannot be provided by the due date, awardees are required to submit a letter of explanation to PGO and include the date by which the Grants Officer will receive information.

e. Final Performance and Financial Report (required)

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

- Performance Measures – Awardees must report final performance data for all process and outcome performance measures.
- Evaluation Results – Awardees must report final evaluation results for the project period for any evaluations conducted.
- Impact/Results/Success Stories – Awardees must use their performance measure results and their evaluation findings to describe the effects or results of the work completed over the project period, and can include some success stories.
- Additional forms as described in the Notice of Award (e.g., Equipment Inventory Report, Final Invention Statement).

4. Federal Funding Accountability and Transparency Act of 2006 (FFATA)

The FFATA and Public Law 109-282, which amends the FFATA, require full disclosure of all entities and organizations that receive federal funds including awards, contracts, loans, other assistance, and payments. This information must be submitted through the single, publicly accessible website, www.USASpending.gov.

Compliance with these mandates is primarily the responsibility of the federal agency. However, two elements of these mandates require information to be collected and reported by applicants: 1) information on executive compensation when not already reported through SAM; and 2) similar information on all sub-awards, subcontracts, or consortiums for greater than \$25,000. For the full text of these requirements, see: <http://www.gpo.gov/fdsys/browse/collection.action?collectionCode=BILLS>.

G. Agency Contacts

CDC encourages inquiries concerning this FOA.

Program Office Contact

For programmatic technical assistance, contact:

Eric Gross, Project Officer
Department of Health and Human Services
Centers for Disease Control and Prevention
4770 Buford Hwy NE
MS F-62
Atlanta, GA 30341
Telephone: 770.488.4398
Email: euw9@cdc.gov

Grants Staff Contact

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

Shicann Phillips, Grants Management Specialist
Department of Health and Human Services
CDC Procurement and Grants Office
2920 Brandywine Road
MS E-01
Atlanta, GA 30341
Telephone: 770.488.2809
Email: ibq7@cdc.gov

For assistance with **submission difficulties related to** www.grants.gov, contact the Contact Center by phone at 1-800-518-4726.

Hours of Operation: 24 hours a day, 7 days a week, except on federal holidays.

For all other **submission** questions, contact:

Technical Information Management Section
Department of Health and Human Services
CDC Procurement and Grants Office
2920 Brandywine Road, MS E-14
Atlanta, GA 30341
Telephone: 770-488-2700
E-mail: pgotim@cdc.gov

CDC Telecommunications for persons with hearing loss is available at: TTY 1-888-232-6348.

H. Other Information

Following is a list of acceptable attachments **applicants** can upload as PDF files as part of their application at www.grants.gov. Applicants may not attach documents other than those listed; if other documents are attached, applications will not be reviewed.

- Project Abstract
- Project Narrative
- Budget Narrative
- CDC Assurances and Certifications
- Table of Contents for Entire Submission

Optional attachments, as determined by CDC programs

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

CDC Injury Center: <http://www.cdc.gov/Injury/>

CDC Injury Center/PDO: <http://www.cdc.gov/homeandrecreationalafety/overdose/index.html>

Amendment 1:

Questions and answers from potential applicants during the Pre-Application Informational Conference Call held on March 11, 2015.

Q: Regarding the required letter of support from the state substance abuse authority, if the responsibilities for state substance abuse services are shared by two different agencies, should the state obtain a letter of support from both agencies?

A: If one agency is not designated as the “authority”, then the applicant should obtain letters of support from both agencies.

Q: If the PDMP authority is housed under the state law enforcement authority will just one letter of support be needed?

A: Yes, the one letter of support will count as both the required PDMP and law enforcement letters of support.

FOA Reference: Page 28

Q: The Project Narrative section gives conflicting information regarding the page limit. It states a maximum page limit of 20 including the work plan. It also states a maximum page limit of 25 for a multi-component FOA. What is the page limit for this FOA?

A: This is not a multi-component FOA and the maximum page limit, including the work plan, is 20. The FOA includes standard language that cannot be revised or removed.

FOA Reference: Page 30

Q: The Evaluation and Performance Measurement Plan is listed in c. under items to be included in the Project Narrative on page 31, however, in the Applicant Evaluation and Performance Management Plan on page 25 it states that the plan should be no more than 25 pages. Is this separate from the Project Narrative page limit?

A: Yes, the Evaluation and Performance Measurement Plan is a separate document and not included in the Project Narrative page limit. It should be uploaded to grants.gov as an attachment.

Q: In the Reporting section under Awardee Evaluation and Performance Measurement Plan it states that the plan must be no more than 20 pages in conflict with the 25 page limit stated on page 25.

A: That is an error. The plan should be no more than 25 pages.

Q: The Evaluation and Performance Measurement plan is not listed as one of the acceptable attachments on page 39 but is required to be submitted with the application.

A: That is an error. The plan should be uploaded to grants.gov as an attachment.

Q: The Dissemination section of the Applicant Evaluation and Performance Measurement Plan on page 25 states that awardees will be required to submit a more detailed Evaluation and Performance Measurement Plan within the first six months. Will this be the same plan that is submitted with the application?

A: Yes, CDC will work with awardees to revise their plans.

Q: Can a community intervention strategy incorporate naloxone distribution (not for purchase)?

A: Yes, distribution can be a part of a community intervention activity. Note that the purchase of naloxone is outside the scope of this FOA and is not allowed.

Q: Regarding the calculation of burden on page 35 does the age-adjusted drug overdose death rate include all intents?

A: Yes

Q: Are there limitations on contracting personnel? Some states have limitations on hiring FTE’s and plan to contract through a university for some positions.

A: Although the FOA does not specify a limited percent of the budget that may be used for contracting personnel, the FOA includes the following funding restriction on page 33 stating that “The direct and primary recipient in a cooperative agreement program must perform a substantial role in carrying out project outcomes and not merely serve as a conduit for an award to another party or provider who is ineligible.”

Q: When downloading the application from grants.gov it indicates that the application due date is April 28, 2015. The FOA states May 8, 2015. What is the correct date?

A: The application deadline is May 8, 2015.

Q: Is a “take back” program an allowable strategy for this funding?

A: No. As stated on page 11 of the FOA “Program funds cannot be used for purchasing naloxone, implementing or expanding drug “take back” programs, or directly funding or expanding substance abuse treatment programs. Such activities are outside the scope of this FOA.”

Q: Regarding the third strategy “evaluating existing policies designed to reduce prescription drug overdose morbidity and mortality” is it

acceptable to evaluate a “take back” policy.

A: Yes

Q: Will the budget be scored as part of the objective review process?

A: The budget will be reviewed but not be scored as stated on page 35 under Budget and Budget Narrative. Applicants should ignore the part of the first sentence under the Budget Narrative section on page 31 stating “...which may be scored...” as the FOA includes standard language that cannot be revised or removed.

Q: Are states required to have access to emergency department data?

A: No, states without emergency department data can substitute hospitalization or other morbidity data.

I. Glossary

Activities: The actual events or actions that take place as a part of the program.

Administrative and National Policy Requirements, Additional Requirements (ARs): Administrative requirements found in 45 CFR Part 74 and Part 92 and other requirements mandated by statute or CDC policy. All ARs are listed in the Template for CDC programs. CDC programs must indicate which ARs are relevant to the FOA; awardees must comply with the ARs listed in the FOA. To view brief descriptions of relevant provisions, see <http://www.cdc.gov/grants/additionalrequirements/index.html>

. Note that 2 CFR 200 will supersede the administrative requirements (A-110 & A-102), cost principles (A-21, A-87 & A-122) and audit requirements (A-50, A-89 & A-133).

Award: Financial assistance that provides support or stimulation to accomplish a public purpose. Awards include grants and other agreements (e.g., cooperative agreements) in the form of money, or property in lieu of money, by the federal government to an eligible applicant.

Budget Period or Budget Year: The duration of each individual funding period within the project period. Traditionally, budget periods are 12 months or 1 year.

Carryover: Unobligated federal funds remaining at the end of any budget period that, with the approval of the GMO or under an automatic authority, may be carried over to another budget period to cover allowable costs of that budget period either as an offset or additional authorization. Obligated but liquidated funds are not considered carryover.

Catalog of Federal Domestic Assistance (CFDA): A government-wide compendium published by the General Services Administration (available on-line in searchable format as well as in printable format as a .pdf file) that describes domestic assistance programs administered by the Federal Government.

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

CDC Assurances and Certifications: Standard government-wide grant application forms.

Competing Continuation Award: A financial assistance mechanism that adds funds to a grant and adds one or more budget periods to the previously established project period (i.e., extends the “life” of the award).

Continuous Quality Improvement: A system that seeks to improve the provision of services with an emphasis on future results.

Contracts: An award instrument used to acquire (by purchase, lease, or barter) property or services for the direct benefit or use of the Federal Government.

Cooperative Agreement: A financial assistance award with the same kind of interagency relationship as a grant except that it provides for substantial involvement by the federal agency funding the award. Substantial involvement means that the recipient can expect federal programmatic collaboration or participation in carrying out the effort under the award.

Cost Sharing or Matching: Refers to program costs not borne by the Federal Government but by the awardees. It may include the value of allowable third-party, in-kind contributions, as well as expenditures by the awardee.

Direct Assistance: A financial assistance mechanism, which must be specifically authorized by statute, whereby goods or services are provided to recipients in lieu of cash. DA generally involves the assignment of federal personnel or the provision of equipment or supplies, such as vaccines. DA is primarily used to support payroll and travel expenses of CDC employees assigned to state, tribal, local, and territorial (STLT) health agencies that are recipients of grants and cooperative agreements. Most legislative authorities that provide financial assistance to STLT health agencies allow for the use of DA. <http://www.cdc.gov/grants/additionalrequirements/index.html>.

DUNS: The Dun and Bradstreet (D&B) Data Universal Numbering System (DUNS) number is a nine-digit number assigned by Dun and Bradstreet Information Services. When applying for Federal awards or cooperative agreements, all applicant organizations must obtain a DUNS number as the Universal Identifier. DUNS number assignment is free. If requested by telephone, a DUNS number will be provided immediately at no charge. If requested via the Internet, obtaining a DUNS number may take one to two days at no charge. If an organization does not know its DUNS number or needs to register for one, visit Dun & Bradstreet at <http://fedgov.dnb.com/webform/displayHomePage.do>.

Evaluation (program evaluation): The systematic collection of information about the activities, characteristics, and outcomes of programs (which may include interventions, policies, and specific projects) to make judgments about that program, improve program effectiveness, and/or inform decisions about future program development.

Evaluation Plan: A written document describing the overall approach that will be used to guide an evaluation, including why the evaluation is being conducted, how the findings will likely be used, and the design and data collection sources and methods. The plan specifies what will be done, how it will be done, who will do it, and when it will be done. The FOA evaluation plan is used to describe how the awardee and/or CDC will determine whether activities are implemented appropriately and outcomes are achieved.

Federal Funding Accountability and Transparency Act of 2006 (FFATA): Requires that information about federal awards, including awards, contracts, loans, and other assistance and payments, be available to the public on a single website at www.USAspending.gov.

Fiscal Year: The year for which budget dollars are allocated annually. The federal fiscal year starts October 1 and ends September 30.

Grant: A legal instrument used by the federal government to transfer anything of value to a recipient for public support or stimulation authorized by statute. Financial assistance may be money or property. The definition does not include a federal procurement subject to the Federal Acquisition Regulation; technical assistance (which provides services instead of money); or assistance in the form of revenue sharing, loans, loan guarantees, interest subsidies, insurance, or direct payments of any kind to a person or persons. The main difference between a grant and a cooperative agreement is that in a grant there is no anticipated substantial programmatic involvement by the federal government under the award.

Grants.gov: A "storefront" web portal for electronic data collection (forms and reports) for federal grant-making agencies at www.grants.gov.

Grants Management Officer (GMO): The individual designated to serve as the HHS official responsible for the business management aspects of a particular grant(s) or cooperative agreement(s). The GMO serves as the counterpart to the business officer of the recipient organization. In this capacity, the GMO is responsible for all business management matters associated with the review, negotiation, award, and administration of grants and interprets grants administration policies and provisions. The GMO works closely with the program or project officer who is responsible for the scientific, technical, and programmatic aspects of the grant.

Grants Management Specialist (GMS): A federal staff member who oversees the business and other non-programmatic aspects of one or more grants and/or cooperative agreements. These activities include, but are not limited to, evaluating grant applications for administrative content and compliance with regulations and guidelines, negotiating grants, providing consultation and technical assistance to recipients, post-award administration and closing out grants.

Health Disparities: Differences in health outcomes and their determinants among segments of the population as defined by social, demographic, environmental, or geographic category.

Healthy People 2020: National health objectives aimed at improving the health of all Americans by encouraging collaboration across sectors, guiding people toward making informed health decisions, and measuring the effects of prevention activities.

Inclusion: Both the meaningful involvement of a community's members in all stages of the program process and the maximum involvement of the target population that the intervention will benefit. Inclusion ensures that the views, perspectives, and needs of affected communities, care providers, and key partners are considered.

Indirect Costs: Costs that are incurred for common or joint objectives and not readily and specifically identifiable with a particular sponsored project, program, or activity; nevertheless, these costs are necessary to the operations of the organization. For example, the costs of operating and maintaining facilities, depreciation, and administrative salaries generally are considered indirect costs.

Intergovernmental Review: Executive Order 12372 governs applications subject to Intergovernmental Review of Federal Programs. This order sets up a system for state and local governmental review of proposed federal assistance applications. Contact the state single point of contact (SPOC) to alert the SPOC to prospective applications and to receive instructions on the State's process. Visit the following web address to get the current SPOC list: http://www.whitehouse.gov/omb/grants_spoc/.

Letter of Intent (LOI): A preliminary, non-binding indication of an organization's intent to submit an application.

Lobbying: Direct lobbying includes any attempt to influence legislation, appropriations, regulations, administrative actions, executive orders (legislation or other orders), or other similar deliberations at any level of government through communication that directly expresses a view on proposed or pending legislation or other orders, and which is directed to staff members or other employees of a legislative body, government officials, or employees who participate in formulating legislation or other orders. Grass roots lobbying includes efforts directed at inducing or encouraging members of the public to contact their elected representatives at the federal, state, or local levels to urge support of, or opposition to, proposed or pending legislative proposals.

Logic Model: A visual representation showing the sequence of related events connecting the activities of a program with the programs' desired outcomes and results.

Maintenance of Effort: A requirement contained in authorizing legislation, or applicable regulations that a recipient must agree to contribute and maintain a specified level of financial effort from its own resources or other non-government sources to be eligible to receive federal grant funds. This requirement is typically given in terms of meeting a previous base-year dollar amount.

Memorandum of Understanding (MOU) or Memorandum of Agreement (MOA): Document that describes a bilateral or multilateral agreement between parties expressing a convergence of will between the parties, indicating an intended common line of action. It is often used in cases where the parties either do not imply a legal commitment or cannot create a legally enforceable agreement.

Nonprofit Organization: Any corporation, trust, association, cooperative, or other organization that is operated primarily for scientific, educational, service, charitable, or similar purposes in the public interest; is not organized for profit; and uses net proceeds to maintain, improve, or expand the operations of the organization. Nonprofit organizations include institutions of higher education, hospitals, and tribal organizations (that is, Indian entities other than federally recognized Indian tribal governments).

Notice of Award (NoA): The official document, signed (or the electronic equivalent of signature) by a Grants Management Officer that: (1) notifies the recipient of the award of a grant; (2) contains or references all the terms and conditions of the grant and Federal funding limits and obligations; and (3) provides the documentary basis for recording the obligation of Federal funds in the HHS accounting system.

Objective Review: A process that involves the thorough and consistent examination of applications based on an unbiased evaluation of scientific or technical merit or other relevant aspects of the proposal. The review is intended to provide advice to the persons responsible for making award decisions.

Outcome: The results of program operations or activities; the effects triggered by the program. For example, increased knowledge, changed attitudes or beliefs, reduced tobacco use, reduced morbidity and mortality.

Performance Measurement: The ongoing monitoring and reporting of program accomplishments, particularly progress toward pre-established goals, typically conducted by program or agency management. Performance measurement may address the type or level of program activities conducted (process), the direct products and services delivered by a program (outputs), or the results of those products and services (outcomes). A "program" may be any activity, project, function, or policy that has an identifiable purpose or set of objectives.

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

Program Strategies: Strategies are groupings of related activities, usually expressed as general headers (e.g., Partnerships, Assessment, Policy) or as brief statements (e.g., Form partnerships, Conduct assessments, Formulate policies).

Program Official: Person responsible for developing the FOA; can be either a project officer, program manager, branch chief, division leader, policy official, center leader, or similar staff member.

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

Public Health Accreditation Board (PHAB): A nonprofit organization that works to promote and protect the health of the public by advancing the quality and performance of public health departments in the U.S. through national public health department accreditation <http://www.phaboard.org>.

Statute: An act of the legislature; a particular law enacted and established by the will of the legislative department of government, expressed with the requisite formalities. In foreign or civil law any particular municipal law or usage, though resting for its authority on judicial decisions, or the practice of nations.

Statutory Authority: Authority provided by legal statute that establishes a federal financial assistance program or award.

System for Award Management (SAM): The primary vendor database for the U.S. federal government. SAM validates applicant information and electronically shares secure and encrypted data with federal agencies' finance offices to facilitate paperless payments through Electronic Funds Transfer (EFT). SAM stores organizational information, allowing www.grants.gov to verify identity and pre-fill organizational information on grant applications.

Technical Assistance: Advice, assistance, or training pertaining to program development, implementation, maintenance, or evaluation that is provided by the funding agency.

Work Plan: The summary of project period outcomes, strategies and activities, personnel and/or partners who will complete the activities, and the timeline for completion. The work plan will outline the details of all necessary activities that will be supported through the approved budget.