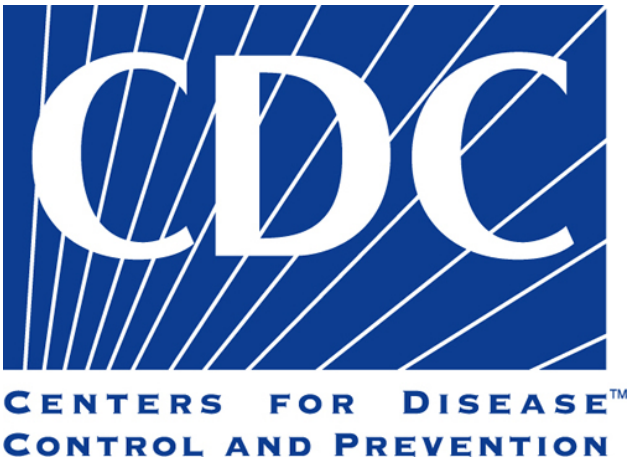

Centers for Disease Control and Prevention

NATIONAL CENTER FOR INJURY PREVENTION AND CONTROL

Overdose Data to Action in States

CDC-RFA-CE-23-0002

05/08/2023

Table of Contents

Part I. Overview

Applicants must go to the synopsis page of this announcement at www.grants.gov and click on the "Subscribe" button link to ensure they receive notifications of any changes to CDC-RFA-CE-23-0002. 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. Notice of Funding Opportunity (NOFO) Title:

Overdose Data to Action in States

C. Announcement Type: New - Type 1:

This announcement is only for non-research activities supported by CDC. If research is proposed, the application will not be considered. For this purpose, research is defined at https://www.gpo.gov/fdsys/pkg/CFR-2007-title42-vol1/pdf/CFR-2007-title42-vol1-sec52-2.pdf. Guidance on how CDC interprets the definition of research in the context of public health can be found at https://www.hhs.gov/ohrp/regulations-and-policy/regulations/45-cfr-46/index.html (See section 45 CFR 46.102(d)).

D. Agency Notice of Funding Opportunity Number:

CDC-RFA-CE-23-0002

E. Assistance Listings Number:

93.136

F. Dates:

1. Due Date for Letter of Intent (LOI):
03/27/2023
Recommended but not Required
The purpose of an LOI is to allow CDC program staff to estimate the number of and plan for the review of submitted applications. An LOI is requested and encouraged as part of the application for this NOFO. In addition, applicants eligible for optional and competitive Surveillance Strategies 4 and 5, who intend to apply for these strategies, should indicate their intention in their LOI (see Strategies and Activities section for additional guidance).
LOI must be sent via email to:

Overdose Data to Action in States Mailbox od2a-states@cdc.gov
Please include the following information in your Letter of Intent:

- Descriptive title of proposed project
- Number and title of this NOFO
- Indicate intent to apply to optional and competitive Surveillance Strategies 4 and 5

2. Due Date for Applications:
05/08/2023
11:59 p.m. U.S. Eastern Standard Time, at www.grants.gov.

3. Due Date for Informational Conference Call
Overdose Data to Action in States Informational Call

March 16, 2023, 3:00 p.m. – 5:00 p.m. EST.

Use the link below to join the webinar:

https://us02web.zoom.us/j/82995126349?pwd=QnNMNS9nN1NxM2JDMWxyU3pJL0RzQT09

Passcode: 064355

Or One tap mobile :

US: +13017158592,,82995126349#,,,,*064355# or +13092053325,,82995126349#,,,,*064355#

Or Telephone:

Dial (for higher quality, dial a number based on your current location):

US: +1 301 715 8592 or +1 309 205 3325 or +1 312 626 6799 or +1 646 931 3860 or +1 929 205 6099 or +1 305 224 1968 or +1 669 900 6833 or +1 689 278 1000 or +1 719 359

4580 or +1 253 205 0468 or +1 253 215 8782 or +1 346 248 7799 or +1 360 209 5623 or +1 386 347 5053 or +1 507 473 4847 or +1 564 217 2000 or +1 669 444 9171

Webinar ID: 829 9512 6349

Passcode: 064355

International numbers available: https://us02web.zoom.us/u/ket1wbuwAz

This two-hour call will provide a comprehensive overview of all the NOFO strategies. Attendees will learn about eligibility requirements, the surveillance and prevention components, and the application and selection process for required and optional competitive strategies. Throughout the session, participants will have the opportunity to ask questions. All potential applicants are encouraged to attend this call. A recording will be posted here following the webinar.

F. Executive Summary:

Summary Paragraph

The Overdose Data to Action in States (OD2A-S) funding opportunity is open to all state health departments (SHDs), including the District of Columbia, or their bona fide agents. The goal of this funding is to enhance the ability of SHDs to track and prevent nonfatal and fatal overdoses while also identifying emerging drug threats. The funding opportunity emphasizes surveillance strategies and the promotion of evidence-based and evidence-informed interventions that have an immediate impact on reducing overdose morbidity and mortality, with a focus on opioids, stimulants, and polysubstance use (if addressed in combination with opioids and stimulants).

OD2A-S is underpinned by a data to action framework that reinforces the use of surveillance and other data to inform and drive prevention efforts and policies, with an emphasis on addressing health equity and health disparities. This funding opportunity builds off work and gains from previous overdose surveillance and prevention investments supporting SHDs.

Surveillance Component
Core Required Strategies: 1. Surveillance Infrastructure 2. Morbidity Surveillance 3. Mortality Surveillance Optional and Competitive Strategies (up to 20 awards for each strategy): 4. Biosurveillance 5. Data Linkage
Prevention Component
Required Strategies: 6. Clinician/Health System Engagement and Health IT/PDMP Enhancement 7. Public Safety Partnerships/Interventions

8. Harm Reduction
9. Community-Based Linkage to Care

a. Eligible Applicants:
Open Competition

b. NOFO Type:
CA (Cooperative Agreement)

c. Approximate Number of Awards
51

d. Total Period of Performance Funding:
$995,000,000

e. Average One Year Award Amount:
$3,753,774

f. Total Period of Performance Length:
5 year(s)

g. Estimated Award Date:
August 01, 2023

h. Cost Sharing and / or Matching Requirements:
No
Cost sharing or matching funds are not required for this program. Although no statutory matching requirement for this NOFO 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 CDC 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, National 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
In 2021, 106,699 drug overdose deaths occurred in the United States, which is a 14% rate increase from 2020 (91,799) [1]. Drug overdose death rates increased for each race and Hispanic-origin group except non-Hispanic Asian people between 2020 and 2021 [1]. Non-Hispanic Native Hawaiian or Other Pacific Islander and non-Hispanic American Indian or Alaska Native (AI/AN) people experienced the largest percentage increases in drug overdose death rates from 2020 through 2021, with rates increasing 47% and 33%, respectively [1]. The overdose epidemic has continued to evolve, with the majority of overdose deaths now involving

illicitly manufactured fentanyl and fentanyl analogs [2]. In addition, opioids are nested in a broadening epidemic, including polysubstance overdose deaths, largely driven by deaths co-involving opioids and stimulants, such as cocaine and methamphetamine [1-3]. Finally, many states' data suggest that more than three out of five overdose deaths involved at least one potential opportunity to link a person to care or to implement a lifesaving action like administering naloxone when an overdose occurred [4].

OD2A-S supports SHDs in reducing overdose morbidity and mortality. It builds on the work, expertise, and lessons learned from CDC's previous cooperative agreement, Overdose Data to Action, while simultaneously aligning with shifts in the epidemic, including changes in the illicit drug supply and a rise in polysubstance overdoses (i.e., involving more than one substance). OD2A-S strategies continue to promote the use of surveillance and other data to inform prevention and policy interventions that are anchored in the best available evidence. Under OD2A-S, funding has also been allocated for surveillance infrastructure, biosurveillance, and data linkage. There is also a greater emphasis on harm reduction (e.g., using fentanyl test strips [FTS] for drug checking and distributing during post-overdose outreach), support for and expansion of navigation programs and outreach by people with lived experience to communities they represent, and an increased focus on achieving health equity to ultimately reduce disparities in overdoses.

CDC offers additional funding mechanisms for overdose surveillance and prevention activities tailored to local, township, and territorial jurisdictions. In addition to the Overdose Data to Action in States NOFO, CDC is providing a NOFO suited to local governments and territories called Overdose Data to Action: Limiting Overdose through Collaborative Actions in Localities (OD2A: LOCAL), CDC-RFA-CE-23-0003.

In addition to this funding opportunity for states, CDC continues to respond to changes in the epidemic by investing in innovative partnerships addressing areas such as public health and public safety, collaboration and training opportunities with medical examiners and coroners, and improved toxicology testing. CDC invests in primary prevention to address risk factors for overdoses, such as adverse childhood experiences and youth substance use, via the Drug-Free Communities support program. CDC is also expanding its partnerships with national partners by supporting and leveraging community-based organizations that can engage and prevent overdose using effective strategies with specific populations (e.g., individuals living in rural areas and those in criminal justice settings) who are experiencing a disproportionate burden of overdose and/or groups that are at greater risk of experiencing adverse outcomes related to substance use due to social determinants of health.

b. Statutory Authorities

Per the statutory language under Section 311 of the PHS Act, PHSA § 311 (c)(1), and the SUPPORT Act, this funding opportunity is open to all state health departments (SHDs), including the District of Columbia, or their bona fide agents. CDC is concurrently offering an opportunity tailored to local jurisdictions and territories called Overdose Data to Action: Limiting Overdose through Collaborative Actions in Localities (OD2A: LOCAL; CDC-RFA-CE-23-0003). CDC also provides funding to tribes or tribal-serving organizations via the cooperative agreement "Strengthening Public Health Systems and Services in Indian Country (CDC-RFA-TO-23-0001)."

c. Healthy People 2030

- Addiction
- Drug and Alcohol Use
- Health Care Access and Quality
- Injury Prevention
- Mental Health and Mental Health Disorders - General

d. Other National Public Health Priorities and Strategies

- Office of National Drug Control Policy National Drug Control Strategy
- HHS Overdose Prevention Strategy
- HHS Equity Action Plan
- Ending the HIV Epidemic

e. Relevant Work

- Prevention BOOST
- Prevention for States
- Data-Driven Prevention Initiative
- Enhanced State Opioid Overdose Surveillance Program
- Opioid Prevention in States – Surge Support via the Cooperative Agreement for Emergency Response
- Overdose Data to Action
- CDC offers additional funding mechanisms for overdose surveillance and prevention activities tailored to local, township, and territorial jurisdictions. As a complementary effort to the Overdose Data to Action in States NOFO, CDC is concurrently offering an opportunity tailored to local jurisdictions and territories called Overdose Data to Action: Limiting Overdose through Collaborative Actions in Localities (OD2A: LOCAL), CDC-RFA-CE-23-0003.
- CDC supports tribes and tribal organizations to address overdose prevention in tribal communities (Strengthening Public Health Systems and Services in Indian Country, CDC-RFA-TO-23-0001). Recipients develop a strategic agenda to guide response, conduct quality improvement and continuous improvement of care, and advance efforts to collaboratively address the health, social, economic, and cultural costs of substance use disorders.

2. CDC Project Description

a. Approach

Bold indicates period of performance outcome.

CDC-RFA-CE-23-0002 | Logic Model: Overdose Data to Action in States

Strategies and Activities	Short-term Outcomes	Intermediate Outcomes	Long-term Outcomes
OVERDOSE DATA TO ACTION IN STATES: GUIDING PRINCIPLES FOR ALL STRATEGIES			

Strategies and Activities	Short-term Outcomes	Intermediate Outcomes	Long-term Outcomes
• Collect data around community characteristics, including race/ethnicity, and conduct analyses that consider Social Determinants of Health and use a health equity lens • Use data to inform and tailor prevention strategies, with emphasis on reaching groups disproportionately affected by the overdose epidemic • Ensure implementation of culturally relevant interventions and equitable delivery of prevention services			
SURVEILLANCE STRATEGIES 1. Surveillance Infrastructure: Improve and enhance overall capacity to conduct surveillance 2. Morbidity: Collect and disseminate timely data from emergency departments and hospital admissions for suspected overdoses 3. Mortality: Collect and disseminate timely data on unintentional and undetermined intent drug overdose deaths 4. Optional and Competitive Surveillance Strategy: Biosurveillance 5. Optional and Competitive Surveillance Strategy: Data Linkage **PREVENTION STRATEGIES**	• **More timely, detailed, comprehensive, and actionable surveillance data, including toxicology testing for both nonfatal and fatal overdose cases (1-5)** • Improved identification of factors contributing to overdose using linked data sets (1-5) • **Increased data dissemination (1-5)** • **Increased data sharing and data availability**	• **Expanded use of data to inform the implementation and improvement of prevention and response efforts, especially for groups disproportionately affected by overdose (1-9)** • **Expanded utilization of evidence-based approaches to prevent and respond to overdoses (6,7,8,9)** • **Improved ability for clinicians to monitor their prescribing practices (6)** • **Decreased high-risk opioid**	**Decreased fatal drug overdoses overall:** • **Primarily involving opioids and/or stimulants** • **Among populations disproportionately affected by overdose and underserved by overdose prevention programs and the healthcare system** **Decreased nonfatal drug overdoses overall:** • **Primarily involving opioids and/or stimulants** • **Among populations disproportionately affected by overdose and underserved by overdose prevention programs and**

Strategies and Activities	Short-term Outcomes	Intermediate Outcomes	Long-term Outcomes
6a. Clinician/Health System Engagement: Provide clinician education on evidence-based practices for pain management and on screening, diagnosis, and linkage to care for opioid use disorder (OUD) and stimulant use disorder (StUD); build clinical capacity to screen, diagnose, and support longitudinal care for OUD and StUD and support recovery 6b. Health IT/PDMP Enhancement: Support and expand integration of prescription drug monitoring program (PDMP) data with health IT systems and intrastate and bi-directional interstate data sharing; promote universal PDMP use among clinicians and their delegates; possess more timely or real-time data within a PDMP; proactively manage the PDMP; ensure easy access and use of PDMPs 7. Public Safety Partnerships/ Interventions: Develop and maintain public health and public safety (PH/PS)	**(2,3,4,5,6,7,8,9)** • **Increased clinician awareness of evidence-based practices for pain management (6)** • **Increased clinician expertise and confidence to provide equitable OUD and StUD care (6,9)** • Increased and improved access to PDMPs (6) • **Increased collaboration, coordination, and communication among partners (6,7,8,9)**	**prescribing and increased use of the full complement of evidence-based pain care modalities (6)** • **Increased and improved health system and clinician capacity to provide care for OUD and StUD (6,9)** • **Increased linkages to care and engagement in care across various settings (6,7,8,9)** • **Increased equitable delivery and improved access to care/services, especially among PWUD as well as those previously underserved by overdose prevention programs and**	**the healthcare system** **Decreased illicit opioid and stimulant use, including co-use with other substances, OUD, and StUD** **Increased uptake of evidence-based treatment and retention with long-term recovery supports, with a primary focus on OUD and StUD** **Improved health equity among groups disproportionately affected by the overdose epidemic and those previously underserved by overdose prevention programs and the healthcare system** **Decreased stigma related to substance use and overdose**

Strategies and Activities	Short-term Outcomes	Intermediate Outcomes	Long-term Outcomes
partnerships; improve data sharing, availability, and use; provide education on preventing and responding to overdose; implement evidence-informed and evidence-based overdose prevention strategies 8. Harm Reduction: Utilize navigators* to connect people to services; ensure persons who use drugs (PWUD) have access to overdose prevention and reversal tools, treatment options, and drug checking equipment; develop and sustain partnerships with syringe services programs and harm reduction organizations; create and disseminate education and communication materials 9. Community-Based Linkage to Care: Initiate linkage to care activities; support retention in care; maintain recovery	• Increased awareness of the drug overdose epidemic, harm reduction efforts, and evidence-based approaches (6,7,8,9) • **Increased use of navigators to link PWUD to care and services (6,7,8,9)** • **Increased access to harm reduction education and services, including increased distribution of naloxone (8)** • Increased availability of and decreased barriers to care/services, especially for those disproportionately affected by overdose and those previously	**the healthcare system (6,7,8,9)** • **Reduced health disparities related to access to and receipt of care, including care for pain, especially among PWUD as well as those previously underserved by overdose prevention programs and the healthcare system (6,7,8,9)**	

Strategies and Activities	Short-term Outcomes	Intermediate Outcomes	Long-term Outcomes
	underserved by overdose prevention programs and the healthcare system (6,7,8,9)		

* Bolded outcomes are the outcomes CDC expects recipients to achieve or make progress on during the period of performance and that CDC expects recipients to measure and report. Bolded outcomes are described below. Recipients also may measure and report on unbolded outcomes included in the logic model and other outcomes.

** Navigators can include peer navigators, certified peer recovery specialists, peer support specialists, case managers, patient navigators, community health workers, persons with lived experience, and other individuals who link PWUD to care and harm reduction resources. These are individuals familiar with the local public health landscape and who work directly with individuals with OUD and/or StUD to ensure they have the tools to address barriers to seeking care and who support people accessing treatment and their retention (and reengagement if necessary) in substance use disorder (SUD) treatment and care, as well as support access to other services, such as harm reduction and social supports. CDC defines linkage using navigators as: 1) linkage to evidence-based treatment for substance use disorders- to include medications for opioid use disorder (MOUD) and other treatment (e.g., cognitive behavioral therapy [CBT], contingency management) and 2) linkage to harm reduction services.

i. Purpose

OD2A-S aims to enhance the ability of SHDs to track and prevent nonfatal and fatal overdoses while also identifying emerging drug threats. It emphasizes surveillance strategies and evidence-based and evidence-informed interventions that have an immediate impact on reducing overdose morbidity and mortality, with a focus on opioids, stimulants, and polysubstance use (if addressed in combination with opioids and stimulants). OD2A-S also focuses on closing gaps related to access to care and services to reduce health inequities for populations at greatest risk for overdose.

ii. Outcomes

Measurable outcomes are essential for determining the extent to which strategies and interventions achieve the expected outcomes, as described in the logic model. Recipients are expected to implement interventions that will impact the logic model's relevant short-, intermediate, and long-term outcomes. Recipients will report on short- and intermediate-term outcomes (see below) as part of annual reporting and through performance measures reporting, emphasizing outcomes associated with required interventions. To identify how activities address health equity, recipients will be expected to document how they are closing gaps and working with groups disproportionately affected by the overdose epidemic and those previously underserved by overdose prevention programs and the healthcare system. Recipients also will be expected to make progress toward long-term outcomes. Recipients may also opt to track

additional short- and intermediate-term outcomes of local relevance and importance.

The following list outlines the short-, intermediate-, and long-term outcomes across surveillance and prevention strategies. Refer to the logic model for additional information related to these outcomes. Recipients should develop SMART process and outcome objectives with nondirectional indicators to guide their evaluation activities and help communicate their progress to CDC and other individuals and entities with a vested interest in the program, those who participate in and could be affected by the program, and supporters and partners for the operation of the program (referred to as "partners" throughout this NOFO).

Recipients should strive to achieve short-term outcomes that will identify progress toward achieving surveillance and prevention objectives. Short-term outcomes presented in the logic model and listed below represent the more immediate outcomes that will lead to and enable progress toward achieving intermediate-term outcomes; however, recipients are only required to report short-term outcomes associated with required interventions. Recipients are encouraged to identify short-term outcomes associated with optional interventions. Recipients will report on progress toward achieving selected short-term outcomes within the annual performance report (APR). Short-term outcomes include:

- More timely, detailed, comprehensive, and actionable surveillance data, including toxicology testing for both nonfatal and fatal overdose cases (strategies 1,2,3,4,5)
- Increased data dissemination (strategies 1,2,3,4,5)
- Increased data sharing and data availability (strategies 2,3,4,5,6,7,8,9)
- Increased clinician awareness of evidence-based practices for pain management (strategy 6)
- Increased clinician expertise and confidence to provide equitable OUD and StUD care (strategies 6,9)
- Increased collaboration, coordination, and communication among partners (strategies 6,7,8,9)
- Increased use of navigators to link PWUD to care and services (strategies 6,7,8,9)
    - Navigators can include peer navigators, certified peer recovery specialists, peer support specialists, case managers, patient navigators, community health workers, persons with lived experience, and other individuals who link PWUD to care and harm reduction resources.
    - Navigators are individuals familiar with the local public health landscape and who work directly with individuals with OUD and/or StUD to ensure they have the tools to address barriers to seeking care and who support people accessing treatment and their retention (and reengagement if necessary) in SUD treatment and care, as well as support access to other services, such as harm reduction and social supports.
    - CDC defines linkage using navigators as: 1) linkage to evidence-based treatment for substance use disorders- to include medications for opioid use disorder (MOUD) and other treatment (e.g., cognitive behavioral therapy [CBT], contingency management) and 2) linkage to harm reduction services.

- Increased access to harm reduction education and services, including increased distribution of naloxone (strategy 8).

Recipients should strive to achieve intermediate outcomes for surveillance and prevention strategies throughout the cooperative agreement, building on programmatic achievements and applicable short-term outcomes. Intermediate outcomes will be reported within the annual performance report (APR) and through performance measures reporting. Intermediate outcomes include:

- Expanded use of surveillance, evaluation, programmatic, and community data to inform the implementation and improvement of prevention and response efforts, especially for groups disproportionately affected by the overdose epidemic (strategies 1,2,3,4,5,6,7,8,9)
- Expanded utilization of evidence-based approaches (e.g., targeted naloxone distribution, access to pharmacological treatments such as MOUD in criminal justice settings and upon release, academic detailing, syringe service programs) to prevent and respond to overdoses (strategies 6,7,8,9)
- Improved ability for clinicians to monitor their prescribing practices (e.g., at the individual clinician level via implementation of tools and policies to facilitate patient panel management, at the PDMP level with quarterly prescribing insight reports) (strategy 6)
- Decreased high-risk opioid prescribing and increased use of the full complement of evidence-based pain care modalities (strategy 6)
- Increased and improved health system and clinician capacity to screen, diagnose, and support (or connect to) longitudinal care for OUD and StUD for adults and adolescents (strategies 6,9)
- Increased linkages to care (e.g., use of navigators to link people to evidence-based treatment and promote access and link PWUD to harm reduction services) and engagement in care (e.g., peer support groups or linkages to community-based self-help groups, increasing access and retention to care through strengthened telehealth infrastructure and resources) across various settings including community, healthcare, and public safety settings (strategies 6,7,8,9)
- Increased equitable delivery and improved access to care/services (e.g., harm reduction services such as SSPs, treatment services, warm hand-off programs, post-overdose outreach, support services such as transportation assistance, and recovery services), especially among PWUD as well as those previously underserved by overdose prevention programs and the healthcare system overall (strategies 6,7,8,9)
- Reduced health disparities related to access to and receipt of care, including care for pain, especially among PWUD as well as those previously underserved by overdose prevention programs and the healthcare system overall (strategies 6,7,8,9)

All recipients should be positioned and are expected to impact long-term outcomes within five years of receiving funding. Long-term outcomes include:

- Decreased fatal drug overdoses overall:
    - Primarily involving opioids and/or stimulants

    - Among those disproportionately affected by the overdose epidemic and those previously underserved by overdose prevention programs and the healthcare system overall

- Decreased nonfatal drug overdoses overall:
    - Primarily involving opioids and/or stimulants
    - Among those disproportionately affected by the overdose epidemic and those previously underserved by overdose prevention programs and the healthcare system overall
- Decreased illicit opioid and stimulant use, including co-use with other substances, OUD, and StUD
- Increased uptake of evidence-based treatment and retention with long-term recovery supports, with a primary focus on OUD and StUD
- Improved health equity among groups disproportionately affected by the overdose epidemic and those previously underserved by overdose prevention programs and the healthcare system overall
- Decreased stigma related to substance use and overdose

iii. Strategies and Activities

Data to Action Framework

Underlying this NOFO is a four-stage data to action framework (analyze, prioritize, implement, and evaluate) (see Figure 1. in Appendix 10). The data to action framework describes how multiple sources of data (e.g., surveillance data, process and outcome evaluation data, community data from partners including those with lived experience with drug use and misuse, and scientific evidence on effective programs) should be integrated and iteratively used to select, improve, and scale-up drug overdose prevention activities funded through this cooperative agreement. This framework builds on and updates previous work describing how to translate data into action to prevent opioid overdose funded by Prescription Drug Overdose Prevention for States (CDC-RFA-CE15-1501).[1] Through the use of this framework, recipients will work together with their communities to use data and evidence to save lives, achieving impactful reductions in overdose and in disparities in overdose in five years.

This framework provides a guide to recipients to ensure that data are used to develop and implement interventions that reduce overdose, expand evidenced-based interventions, and scale up and synchronize efforts throughout their jurisdictions. It can be used to identify priority populations and inform the tailoring of interventions. For example, surveillance, evaluation, program, and other community data, can help identify drug overdose hotspots and populations at disproportionate risk, leading to opportunities to intervene and reduce health disparities. This framework can assist prevention programs in using data and engaging partners to meet the needs of persons impacted by overdose, responding to emerging issues, addressing gaps in overdose prevention with evidence-based programs, and using evaluation data to improve programs.

Recipients are expected to document their progress on data to action in workplans and annual progress reports submitted to CDC each year.

Establish Partnerships

As deaths involving multiple substances increase, partnerships can address risks posed by opioids, stimulants, and other drugs through increased and coordinated information tracking and sharing, post-overdose outreach programs, and community re-entry supports. Partnerships should represent various demographic groups; ensure strategies that recruit and reach those at greatest risk are implemented; provide input on implementing programs (e.g., linkage to care, naloxone distribution, overdose education); and determine the impact of these programs. Strong, multi-sectoral partnerships, such as those between public health, public safety, harm reduction, and health systems, and the involvement of persons who use drugs, are essential for addressing overdose. Additionally, program planning and implementation should include ongoing participation from populations of interest (under-resourced communities, groups that are at higher risk of overdose, and individuals with lived experience) and foster shared decision-making among program participants. Resources such as the PHAST Toolkit and the Overdose Fatality Review Practitioner's Guide include frameworks for addressing overdose through partnerships. Table 1 provides guidance on how recipients will be expected to engage partners and people with lived experiences through the four stages of the data to action model.

Table 1. Engaging Partners through the Data to Action Framework

Four Stages of Data to Action	Description of Use of Data and Evidence	Engage partners and people with lived experience
Synthesize & Analyze	Applicants must select data sources that will be used to inform prevention interventions. In addition, recipients should analyze data to produce easy to understand and actionable indicators that can be shared with key partners.	• Partners help document current harm reduction and treatment capacity, including critical gaps. • Partners provide data from non-traditional sources (e.g., SSPs, SUD treatment programs, services for people experiencing homelessness, experiences of PWUD). • Collaborate and coordinate with partners to interpret the data and make them meaningful and actionable. • Engage in an ongoing analysis and dissemination of timely data on drug overdoses, emerging threats, and associated risk factors to key partners implementing prevention programs.
Prioritize	Allocation of resources to surveillance and prevention strategies should be prioritized in conversation with partners to maximize impacts on drug overdose in the short-term while	• Partners and people with lived experience help identify realistic and actionable goals. • Program priorities align with priorities of partners. • Select most impactful approaches and programs.

	decreasing health disparities and expanding capacity over the five-year funding period. Factors considered in prioritizing capacity to gather high quality data and evidence-based prevention investments, in consultation with partners, include local drug overdose burden, populations at greatest risk, feasibility of implementing strategies to reduce drug overdoses, and partner support and buy-in.	• Describe how populations of focus and/or specific geographic areas were chosen (i.e., informed by data on drug overdose burden and health disparities) and how selected interventions will improve health equity for disproportionately affected populations. • Disparity impact statements, strategic plans, recommendations from overdose fatality reviews, and work group recommendations are examples of program prioritization.
Implement	Recipients must implement prevention interventions aimed to reduce drug overdoses and health disparities and focus on populations at disproportionate risk based on the best data and evidence possible. As the drug overdose crisis and the science on how to address it are evolving, recipients may implement evidence-informed or evidence-based programs.	• Partners can share resources. • Partners help gain buy-in. • Coordinate with other programs. • Increase the reach of programs. • Inform program development and program improvement. • Partners can provide feedback on quality improvement measures and program monitoring efforts in order to ensure interventions have sufficient scope and high fidelity. Partners can provide feedback on quality improvement measures and program monitoring efforts in order to ensure interventions have sufficient scope and high fidelity. • See OD2A-S Prevention Section for additional information.
Evaluate	Recipients must identify program impact on drug overdoses and health disparities, as well as implementation opportunities and barriers, using surveillance, evaluation, and other program data. Findings should also be used to determine if new data need to be acquired to enhance prevention efforts.	• Incorporate feedback from partners and their clients. • Partners and clients help interpret evaluation findings. • Partners and clients identify strategies to address challenges and identify opportunities to improve interventions. • See OD2A-S Evaluation Section for additional information.

Health Equity

Reducing health inequities and disparities is a key focus within each of the prevention strategies and applicants are expected to use data to identify disproportionately affected populations and high burden geographic areas that will be prioritized within each prevention strategy. Applicants are expected to submit a health disparity impact statement using local data to identify populations at highest risk and high burden geographic areas in their jurisdictions. Applicants may use data tools (such as those at https://www.cdc.gov/socialdeterminants/data/index.htm) in developing disparity impact statements.

To identify populations and areas to be prioritized by prevention interventions more precisely, recipients will collect surveillance data on nonfatal overdoses treated in emergency departments and on fatal overdoses, and (for a limited subset of recipients) link datasets related to overdose. Each surveillance strategy has mechanisms to capture key data elements to identify disproportionately affected populations and high burden geographic areas for prevention interventions. Additionally, recipients will examine their program evaluation and community data to also help identify:

- Disproportionately affected populations (e.g., race, ethnicity, age, sex, patient residence information); or
- Elements that can be used to link to other data to better understand social determinants of health (e.g., reduced economic stability; limited healthcare access, including those who have been historically underserved or are uninsured; etc.); and
- Populations experiencing certain social or physical health conditions that may place them at disproportionate risk (e.g., homelessness, a mental health condition, chronic pain, incarceration, or recent release from incarceration).

Additionally, recipients will examine their program evaluation and community data to also help identify and inform prevention interventions for populations who are disproportionately affected.

Surveillance Component

Three surveillance core strategies are required for all recipients (i.e., Surveillance Infrastructure, Morbidity Surveillance, and Mortality Surveillance) and two strategies have an optional and competitive application process (i.e., Biosurveillance and Data Linkage).

Surveillance Infrastructure – Strategy 1

The overall purpose of this strategy is to build and sustain the overdose surveillance infrastructure within a jurisdiction.

This funding is meant to meet the needs of states to build and sustain the necessary infrastructure to complete required OD2A-S surveillance activities. Funding must not duplicate or overlap with resources provided under other federal funding sources or CDC mechanisms including – but not limited to - Epidemiology and Laboratory Capacity for Prevention and Control of Emerging Infectious Diseases (ELC; CDC-RFA-CK19-1904), Data Modernization Initiative (DMI), and efforts to strengthen the overall U.S. public health infrastructure, workforce, and data systems (i.e., CDC-RFA-OE22-2203). This strategy is meant to provide resources for jurisdictions to

better capture, analyze, and disseminate overdose surveillance data. Due to the nature of how this funding can be used, no additional technical assistance will be available from CDC. This infrastructure strategy should be differentiated from the 2019-2023 OD2A Strategy 3 because no projects are allowed except those mentioned in the NOFO text below. Applicants can budget no more than $250,000 for surveillance infrastructure. These funds can only be used in the following ways:

- Enhancing emergency medical services (EMS) data and systems, which can include analysis of EMS data, funding for data sharing with vendors such as biospatial, and other general EMS data improvements. This does not include any activities related to ODMAP, which is discussed more under the "Public Safety Partnerships/Interventions" prevention strategy.
- Hiring surveillance staff (FTEs, contractors, etc.), specifically for overdose surveillance, to perform data management and analysis, and supporting overdose surveillance data dissemination and building staff capacity by attending trainings and conferences for professional development.
- State-led DMI initiatives that are specific to nonfatal and fatal drug overdose surveillance data.
- Enhancing analysis and dissemination of drug overdose surveillance data by:
    - Purchasing scientific computers or analysis software.
    - Creating data warehouses, data lakes, and/or data cubes to link drug overdose morbidity data (e.g., Emergency Department [ED], EMS), drug overdose mortality data, and/or risk or protective factors for drug overdose.
    - Building application programming interfaces (APIs) to facilitate automatic transfer of drug overdose data.
    - Securing cloud storage of drug overdose data and/or risk and protective factor data for drug overdose.
    - Creating internal or external dashboards that disseminate drug overdose data.
    - Purchasing of data not currently owned by health department may be allowed but will be determined in consultation with CDC.

- Enhancing/modernizing public health laboratories, including increased staffing and/or laboratory equipment or supplies for testing related to nonfatal drug overdose.

Morbidity Surveillance – Strategy 2

Recipients will collect data from healthcare facilities, specifically from emergency departments (EDs), as part of CDC's Drug Overdose Surveillance and Epidemiology (DOSE) system. Overdose-involved visits to healthcare facilities will be captured using two data source options: 1) syndromic surveillance data from EDs, which most often includes unstandardized text (e.g., the primary purpose of the visit or chief complaint) and discharge diagnosis codes, for timely situational awareness of ED visits involving drug overdoses and 2) discharge/billing data from healthcare facilities (e.g., both discharges from EDs and/or hospital admissions) that use the standard UB-04 form and International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) discharge diagnosis coding, which will provide an accurate assessment of drug overdose incidence and burden. Race and ethnicity data will be added to the data collection (in addition to the continuing collection of age, sex, and county data) in order to

improve the identification of disproportionately affected subpopulations for targeted delivery of prevention interventions.

Recipients must meet the following six requirements:

1. Recipients must already be collecting data from a minimum of 80% of ED facilities in their jurisdiction, either through syndromic surveillance or receiving discharge/billing data from healthcare facilities, by the date they receive funding.
2. If submitting ED syndromic surveillance data, recipients must share data using a CDC-developed template and syndrome definition (the "national" definition) for eight required drug overdose indicators (all drugs, all opioids, heroin, fentanyl, benzodiazepines, all stimulants, methamphetamine, and cocaine), demographic variables (e.g., sex, age, race/ethnicity), and geographic variables (e.g., state, county of patient residence). The demographic and geographic variables will help measure health disparities around suspected nonfatal overdoses across various drugs. (See Appendix 1 for more details on data sharing requirements and Appendix 2 for more details on surveillance activities requirements.)
3. Recipients must commit to sharing ED syndromic surveillance data or ED hospital discharge/billing data with all required data elements and on the routine reporting timeline specified in Appendix 3. Both options will require that recipients share historic ED data from January 1, 2018, or the earliest available data for the annual reporting option. (See Appendix 2 for details.) Recipients must meet reporting requirements using syndromic surveillance data unless a statewide syndromic system is unavailable, or the coverage listed above in requirement #1 cannot be met through syndromic surveillance data. Recipients not able to share syndromic surveillance data will be required to share discharge/billing data from healthcare facilities (e.g., both discharges from EDs and/or hospital admissions), that use the standard UB-04 form and ICD-10-CM discharge diagnosis coding from their state hospital association or other agency that collects UB-04 billing data. Recipients that elect to share annual line-level ED discharge/billing data and aggregate denominator data will receive a lower funding amount.

Overview of Data Submission Requirement

Reporting Option	**Reporting Timelines and Data Sources**	**Data Elements**	**Metadata**
Syndromic Surveillance Reporting* *For recipients not currently funded by OD2A/DOSE, monthly reporting (if selected) will not be required to start in Year 1 in case	For recipients currently funded by OD2A/DOSE, on a monthly basis, share aggregate data on suspected drug overdoses within one month after the end of the month (e.g., November 6, 2023, for ED visits occurring September 1-30, 2023) from NSSP ESSENCE or local ESSENCE, or	ED syndromic surveillance data will be shared with CDC each reporting period on total counts of ED visits for suspected all drug, all opioid, heroin, fentanyl, benzodiazepine, all stimulant, methamphetamine, and cocaine-involved overdoses, in addition to counts of total emergency department	For both ED syndromic surveillance reporting and discharge/billing data reporting, recipients will be required to submit metadata to CDC using the timelines in Appendix 3.

additional time is needed to collect data. However, they must start in Year 2 with the first data submission (i.e., September 2024).	other syndromic surveillance systems. These data will be considered final and approved for use by CDC once submitted (i.e., states will not be asked to validate data submitted to CDC; the submission itself constitutes their validation and approval).	visits for any reason, by county, sex, age group, race, and ethnicity.** **Though race and ethnicity are required variables, if unavailable at the time of the application or if improvements are ongoing, please describe efforts to add this variable to the data collection or improve data quality to meet NOFO requirements.	
Discharge/Billing Data Reporting	On an annual basis, share data from their state hospital association or other agency that collects UB-04 billing data within 6 months of the end of the calendar year (i.e., CY 2023 data will be due on the second Monday of the month in July 2024). These data will be considered final and approved for use by CDC once submitted (i.e., states will not be asked to validate data submitted to CDC; the submission itself constitutes their validation and approval).	Recipient will need to submit line-level data for any case with a code indicating drug poisoning (ICD-10-CM codes T36-T50) and aggregate counts of total ED visits, by county, sex, age group, race, and ethnicity.** **Though race and ethnicity are required variables, if unavailable at the time of the application, please describe efforts to add this variable to the data collection to meet NOFO requirements	

4. Starting in Year 2, recipients must disseminate two or more DOSE data products per year to key local partners and/or the public (e.g., data dashboards, web pages, reports, presentations, or peer-reviewed manuscripts). States previously unfunded by OD2A will be required to disseminate or produce two DOSE products per year starting in Year 3.

1. On an annual basis, jurisdictions must submit to CDC an annual listing of DOSE data products.

5. NOFO funding must be used to meet the data sharing and dissemination requirements of the NOFO. Funding can be used to enhance collection of ED syndromic and discharge/billing data (e.g., expand data collection into new hospitals, improve the quality of data submitted by hospitals, or build partnerships with associations, such as state hospital associations, for timelier hospital discharge/billing data). All improvements, however, must

directly benefit the collection of drug overdose data funded in this NOFO and be approved by CDC.

6. Applicants must provide letter(s) of support/agreement from the agency responsible for collecting and overseeing/maintaining access to the data sources (i.e., syndromic surveillance or hospital discharge/billing data). If the applicant is the unit responsible for the data source, this must be written in the application. Letters of support must demonstrate the agencies' awareness of the data requested and CDC deliverable dates; they must also include statements agreeing to data access, analysis, and dissemination, and information on previous collaborations using these or similar data.

Within the morbidity component, applicants may also elect to complete the following activities:

- Applicants may elect optional activity annual discharge/billing data reporting. Recipients submitting monthly ED syndromic surveillance data are eligible to elect this activity and report an annual file including line-level ED and/or inpatient hospital discharge/billing data. Recipients who are only able to share ED discharge/billing data must submit an annual file including line-level inpatient hospital discharge/billing data to be eligible for this optional activity. The file submitted must be a final file, submitted no later than 6 months after the end of the calendar year, follow the same requirements as mentioned above in #1-3, and be approved for use in analyses by CDC. See Appendix 2 for anticipated funding.
- Recipients have the option of allowing CDC OD2A-S staff access to their line-level ED syndromic surveillance data in NSSP ESSENCE to assist in case definition refinement and development. Recipients will not receive funding for this activity.
- Support the overall surveillance infrastructure and capacity to collect, analyze, and share ED data in ways that will enhance the data sharing required in this NOFO. For example, recipients not currently engaged in state-wide syndromic surveillance data collection can use morbidity resources to work towards state-wide implementation. Recipients may also seek to improve the timeliness, quality, and completeness of data as long as these activities do not overlap with existing funding mechanisms from other federal agencies and CDC, such as Epidemiology and Laboratory Capacity for Prevention and Control of Emerging Infectious Diseases (ELC; CDC-RFA-CK19-1904).
- Leverage existing ED data systems to more rapidly detect nonfatal drug overdose outbreaks, clusters, and anomalies. Recipients could implement the surveillance methodology strategies listed in several CDC-funded products to identify outbreaks, clusters, and general anomalies (e.g., the Council of State and Territorial Epidemiologists (CSTE) Overdose Anomaly Toolkit, the National Association of County and City Health Officials (NACCHO) Overdose Spike Response Framework for Communities and Local Health Departments, the Association of State and Territorial Health Officials (ASTHO) Responding to an Overdose Spike: A Guide for State Health Departments, and the Public Health and Safety Team (PHAST) Toolkit).

Variables collected by DOSE are limited to those included in the patient electronic health record (EHR); however, DOSE will collect county of patient residence which will allow for triangulating this data with county-level variables to better understand social determinants of health (e.g., reduced economic stability; limited healthcare access, including those who have been historically underserved or are uninsured; etc.) and people experiencing certain social or

physical health conditions that may place them at disproportionate risk of nonfatal drug overdose (e.g., homelessness, a mental health condition, chronic pain, incarceration or recent release from incarceration).

Mortality Surveillance – Strategy 3

This strategy requires recipients to collect and enter data on the characteristics and substances detected and involved in unintentional and undetermined intent drug overdose (UUDO) deaths into the State Unintentional Drug Overdose Reporting System (SUDORS). Obtaining data on the characteristics and circumstances surrounding the overdose allows SUDORS to capture information on risk factors and social determinants of health associated with the overdose death. Data from three required data sources must be collected and entered into SUDORS: 1) death certificates (DC), 2) medical examiner or coroner reports (ME/C), and 3) postmortem toxicology results.
Recipients will abstract and enter DC data for all UUDO deaths that occur in the jurisdiction; in addition, recipients will abstract and enter ME/C and postmortem toxicology results, for either all UUDO deaths that occur in the jurisdiction or for all UUDO deaths that occur in a subset of counties that account for at least 75% of UUDO deaths in the jurisdiction.

Required data submissions will be processed and finalized twice per year using the following time lags: 7-13 months from the date of death in Year 1 and 6-12 months from the date of death in Years 2-5. Jurisdictions will be required to support enhanced forensic toxicology testing according to CDC's Comprehensive Toxicology Testing Guidance (Appendix 4). Jurisdictions will also be required to adhere to routine data quality and data dissemination requirements. Mortality surveillance data should be used to inform prevention interventions during program development and to improve prevention activities throughout implementation. A planning year will be provided for states that have not previously participated in SUDORS.

Recipients must meet the following eight requirements.

1. Recipients must collect data on all UUDO deaths that occur in the jurisdiction or in a subset of counties in a given reporting period. To calculate UUDO deaths for this application, recipients should use the most recent data available in CDC's Wonder: Multiple Cause of Death file and count deaths that have the following ICD-10 codes listed for the underlying cause-of-death on the death certificate: X40–44 (unintentional) or Y10–Y14 (undetermined intent).
    1. Recipients must collect data on all UUDO deaths that occur within the jurisdiction, meeting one of the following criteri
        1. Option 1: Recipients will collect data on all UUDO deaths that occur in their jurisdiction between January 1, 2023, to December 31, 2027, using all three required data sources: death certificates, ME/C reports, and postmortem toxicology results.
        2. Option 2: Recipients will collect data on all UUDO deaths that occur in their jurisdiction between January 1, 2023, to December 31, 2027, using information from death certificates, and will collect information from the remaining two required data sources (ME/C reports and postmortem toxicology results) for all UUDO deaths within a subset of counties whose residents accounted for a minimum of 75% of UUDO deaths in the

jurisdiction; counties included in the initial subset must remain the same for the duration of the funding; however, additional counties can be added over the course of the funding period.
        1. Depending on the option that is selected, applicants' budgets should reflect whether all or a subset of UUDO with all three required data sources will be entered into SUDORS. Recipients choosing Option 2 will receive reduced funding for SUDORS.

    3. A planning year will be provided for states who have not previously participated in SUDORS.

2. Recipients must share case-level de-identified data with CDC for confirmed UUDO deaths using the SUDORS web-based data entry system, including information on social determinants of health (e.g., evidence of prior substance use disorder treatment, housing instability), demographic characteristics that may influence health equity (e.g., race and ethnicity) and contextual information on the circumstances surrounding the death that is not available on the death certificate and that can be used to inform prevention and response efforts (e.g., was naloxone administered, what was the route of administration, was a bystander present, did the decedent have a prior nonfatal overdose).
3. Recipients must commit to the following data reporting schedules (see Appendix 3 for complete schedule):
    1. Year 1
        1. Complete data abstraction from required sources on UUDO deaths occurring during January - June by January of the following calendar year.
        2. Complete data abstraction from required sources on UUDO deaths occurring July - December by July of the following calendar year.
        3. Continue to collect any additional data from required data sources on UUDO overdose deaths before the end of the funding period.

    2. Years 2, 3, 4, and 5
        1. Complete data abstraction from required sources on UUDO deaths occurring during January - June by December of the same calendar year.
        2. Complete data abstraction from required sources on UUDO deaths occurring July - December by June of the following calendar year.
        3. Continue to collect any additional data from required data sources on UUDO overdose deaths before the end of the funding period.

4. Recipients are required to collaborate with CDC to maintain and improve data quality (e.g., review a small subset of deaths by a senior abstractor, automated data quality checks, and/or monthly discussion of abstraction challenges) and must participate in a case reconciliation process and address any data entry errors identified for each reporting period.
    1. Jurisdictions will review and address errors identified by CDC in quality control reports sent on a quarterly basis.
    2. SUDORS data quality assurance activities must be included in the workplan.

5. Starting in Year 2, recipients must disseminate two or more SUDORS data products per year to key local partners and/or the public (e.g., data dashboards, web pages, reports,

presentations, or peer-reviewed manuscripts). States previously unfunded by OD2A will be required to disseminate or produce two SUDORS products per year starting in Year 3.

    1. On an annual basis, jurisdictions must submit to CDC an annual listing of SUDORS data products.

6. Clearly indicate in the budget the amount of funding allocated to support enhanced toxicological testing of opioid and stimulant overdose deaths by their medical examiner and coroner community (see testing guidance listed in Appendix 4 and budget guidance in Appendix 5). The funding can be provided directly to forensic toxicology labs supporting medical examiners and coroners or directly to medical examiners and coroners. If the recipient provides evidence of sufficient forensic toxicology testing of opioid and stimulant overdose deaths according to CDC guidance outlined in Appendix 4, with CDC approval, funding may also be used for the activities listed below. In addition, surveillance infrastructure funding, which is separate from mortality funding, can also be used to support and supplement funding for the below activities.
    1. Improve forensic investigation of drug overdose deaths.
    2. Reimburse medical examiners and coroners for SUDORS-related work (i.e., embedded abstractors, forensic epidemiologists, case management systems, modernizing ME/C case management systems).
    3. Support general ME/C staffing needs (i.e., administrative or laboratory staff, medicolegal death investigators, medical examiners, coroners).
    4. Projects approved by CDC project and science officer.
7. The recipient must dedicate the following staffing resources for SUDORS activities:
    1. A SUDORS project manager/lead is required and must participate on SUDORS workgroup calls, participate in all regular CDC calls with the jurisdiction that deal with SUDORS, and be a point of contact for technical assistance.
    2. A minimum number of SUDORS abstractors will be recommended based on abstraction burden, which is influenced by the number of UUDO in 2021 and the jurisdiction's ME/C system (i.e., centralized or de-centralized) (Appendix 6).
        1. Since changes in the number of deaths impact the number of cases to abstract, money can be moved to and from surveillance infrastructure activities to address increases or decreases in deaths.
8. To ensure successful implementation of SUDORS, the recipient must develop and maintain ongoing collaborations with others working in the medicolegal death investigation community. Letters of support must be obtained from the following entities:
    1. NVDRS principal investigators
    2. Vital Records staff
    3. State Medical Examiner or state coroner association or if an association does not exist, letters must be obtained from ME/Cs that serve at least 75% of the population in the jurisdiction

Please see Collaborations Section for file naming and upload instructions.

Variables collected by SUDORS are largely limited to those included on the death certificate or in the medical examiner or coroner report; however, SUDORS will collect county-level

information which will allow for CDC staff to triangulate this data with county-level variables to better understand social determinants of health (e.g., reduced economic stability; limited healthcare access, including those who have been historically underserved or are uninsured, etc.) and people experiencing certain social or physical health conditions that may place them at disproportionate risk (e.g., homelessness, a mental health condition, chronic pain, incarceration or recent release from incarceration).

Summary of SUDORS Data Submission Requirements

SUDORS eligibility	**The District of Columbia or any state health department.**
SUDORS sample requirement	• Option 1: Recipients will collect data on **all unintentional and undetermined intent drug overdose (UUDO) deaths** that occur in their jurisdiction **using all three required data sources: death certificates, medical examiner and coroner (ME/C) reports, and postmortem toxicology results**. • Option 2: Recipients will collect data on **all UUDO deaths** that occur in their jurisdiction **using information from death certificates** that occur in the jurisdiction and will collect information from **the remaining two required data sources (ME/C reports and postmortem toxicology results) for all UUDO deaths within a subset of counties whose residents accounted for a minimum of 75% of UUDO deaths** in the jurisdiction. ○ ***Applicants that select this option should adjust their budget according to case burden.*** • **Applicants must clearly indicate which option they are applying for.**
Case definition	• A death assigned the following ICD-10 underlying cause of death codes on the death certificate: X40-44 (unintentional)/Y10-14 (undetermined intent) drug poisonings **OR** • A death classified as a drug overdose death by the medical examiner or coroner that is consistent with the ICD-10 definition.
Required data sources and elements reported to CDC	Abstract from death certificates and ME/C reports for each UUDO data on cause and manner of death, forensic toxicology results, death scene investigation findings (e.g., evidence of injection drug use), demographics, circumstances surrounding the overdose, and location of overdose, etc.
How data will be reported to CDC	SUDORS uses the NVDRS web-based data entry system accessed through CDC's Secure Access Management Services (SAMS) for data entry. **Data entry into other local data systems will not meet**

	the NOFO reporting requirements. Authorized staff of recipients will be provided access to the SUDORS/NVDRS system.
Frequency that UUDO are reported to CDC	Year 1 • Complete data abstraction from required sources on UUDO deaths occurring during January - June by January of the following calendar year. • Complete data abstraction from required sources on UUDO deaths occurring July - December by July of the following calendar year. • Continue to collect any additional data from required data sources on UUDO overdose deaths before the end of the funding period. Years 2-5 • Complete data abstraction from required sources on UUDO deaths occurring during January - June by December of the same calendar year. • Complete data abstraction from required sources on UUDO deaths occurring July - December by June of the following calendar year. • Continue to collect any additional data from required data sources on UUDO overdose deaths before the end of the funding period. A planning year will be provided for states that have not previously participated in SUDORS.
Date that required CDC reporting begins (See Appendix 3 for full reporting schedule)	• Friday, January 26, 2024, for recipients who previously received OD2A funding for SUDORS (CDC-RFA-CE16-1608). • Wednesday, December 13, 2024, for recipients who did not previously receive OD2A funding for SUDORS.
Support ongoing improvement in data quality	• Ensure SUDORS abstractors engage in required CDC training activities. • Recipient must respond to and rectify issues identified by CDC in routine data checks and during data closeout. • Recipients, in consultation with CDC, must incorporate internal data quality procedures to ensure high quality data are entered consistently across abstractors and comply with CDC guidance (e.g., review a small subset of deaths by a senior abstractor, automated data quality checks, and/or monthly discussion of abstraction challenges).

Enhance forensic toxicological testing of drug overdose deaths to better detect opioids and stimulants	• Clearly indicate in the budget the amount of funding allocated to support enhanced toxicological testing of opioid and stimulant overdose deaths by their medical examiner and coroner community and provide an itemized list of activities (see testing guidance listed in Appendix 4 and budget guidance in Appendix 5).
	• The funding can be provided directly to forensic toxicology labs supporting medical examiners and coroners or directly to medical examiners and coroners.
	• If the applicant provides evidence of sufficient forensic toxicology testing of opioid and stimulant overdose deaths according to CDC guidance, with CDC approval, funding may also be used for the activities listed below.
	  ○ Improve forensic investigation of drug overdose deaths.
	  ○ Reimburse medical examiners and coroners for SUDORS-related work (i.e., embedded abstractors, forensic epidemiologists, case management systems, modernizing ME/C case management systems).
	  ○ Support general ME/C staffing needs (i.e., administrative or laboratory staff, medicolegal death investigators, medical examiners, coroners).
	  ○ Projects approved by CDC project and science officer.

Data dissemination requirements	• Starting in Year 2, recipients must disseminate two or more SUDORS data products per year to key local partners and/or the public (e.g., data dashboards, web pages, reports, presentations, or peer-reviewed manuscripts). States previously unfunded for SUDORS will be required to disseminate or produce two SUDORS products per year starting in Year 3. • On an annual basis, jurisdictions must submit to CDC an annual listing of SUDORS data products.
Staffing	• Designate a project manager or SUDORS lead to attend virtual monthly SUDORS workgroup meetings to discuss key data quality issues and updates to SUDORS guidance and serve as a point of contact for technical assistance. • A minimum number of SUDORS abstractors will be recommended based on abstraction burden, which is influenced by the number of UUDO and the jurisdiction's ME/C system (i.e., centralized or de-centralized) (Appendix 6).
Letters of support	The recipient must develop and maintain ongoing collaborations with others working in the medicolegal death investigation community.

	Letters of support (Please see Collaborations Section for file naming and upload instructions) must be obtained from the following entities: • NVDRS principal investigators • Vital Records staff • State Medical Examiner or state coroner association or if an association does not exist, letters must be obtained from ME/Cs that serve at least 75% of the population in the jurisdiction

Optional and Competitive Surveillance Strategy (up to 20 awardees): Biosurveillance – Strategy 4

The primary goal of this surveillance strategy is to gather a standard set of laboratory data from biological specimens from suspected overdoses in the emergency department (ED). These data will be used to enhance existing DOSE data by providing more contextual information for ED visits that can be used to identify trends in drugs contributing to overdose.

Definitive toxicological testing, such as with liquid chromatography-tandem mass spectrometry (LC-MS/MS), can be used to identify specific substances and quantitative measures of specific substances. Overlaying these data with existing DOSE data on suspected nonfatal overdoses will allow for a more comprehensive picture of specific drugs implicated in overdoses and can assist communities in responding to the latest drug use trends. The data collected as part of this strategy will include race, ethnicity, age, sex, and geographic location of the patients who provided the samples. This will allow a granular assessment of specific substances affecting groups that may be disproportionately affected by overdose. As with DOSE, variables collected are limited to those included in the hospital EHR system; however, county of patient residence will be collected, which will allow for triangulation of this data with county-level variables to better understand social determinants of health (e.g., reduced economic stability; limited healthcare access, including those who have been historically underserved or are uninsured, etc.) and also people experiencing certain social or physical health conditions that may place them at disproportionate risk of nonfatal drug overdose (e.g., homelessness, a mental health condition, chronic pain, incarceration or recent release from incarceration).

Recipients awarded this funding must meet the following six requirements:

1. By the start of Year 2, recipient will have established systematic sampling of available leftover biological specimens from patients presenting to emergency departments with suspected nonfatal overdose and identified a partner laboratory (with a preference for state or regional public health laboratories) to perform definitive testing for a standardized panel of drugs. Results from definitive testing will be shared with CDC in a routine and standardized fashion that will utilize existing data systems where possible.
    1. Line-level data will be reported quarterly for all new tests performed by the due date. Mechanism for submission will be specified and will build upon existing reporting systems as much as possible (e.g., LRN-C messaging or SAMS upload).

2. Recipient agrees to meet data preparation and submission requirements including but not limited to the following: specimen ID, patient ID, collection date, receipt date, test date, test performed, result, and limited patient data (age, sex, race and ethnicity, patient residence location, clinical presentation information [if available]). The demographic variables will help better measure health disparities, particularly as these data are overlaid with DOSE data. Optional data, such as quantitative results, will also be accepted, although may not be required.
3. Metadata will also be required to facilitate proper interpretation and aggregation of data, including, but not limited to the following: submitter information, sampling scheme used (CDC will provide options for this), panel used for testing (CDC will provide options for this), and information about the lab performing this testing.
4. Coverage = Testing of a minimum of 20 specimens (preferably from unique overdose events) per week (per initial pilot hospital/hospital system partners; this may expand if the number of submitting hospital facilities expand and laboratory capacity allows.
5. Letters of support from definitive testing laboratory partner (e.g., state public health laboratory) that is evidence of agreement to perform the required activities (please see Collaborations Section for file naming and upload instructions).
6. Demonstration of proficiency from the identified laboratory.

2. Recipients must provide a narrative description of experience in conducting overdose biosurveillance with definitive biosurveillance testing; preference will be given to laboratories who demonstrate good working relationships with hospitals and the ability to receive specimens routinely from hospitals.
3. Letters of support/agreement from partner hospitals must be provided to demonstrate that partner hospitals have been identified who will share a subset of patient specimens for definitive testing along with required data (please see Collaborations Section for file naming and upload instructions).
4. By Year 3, recipients must produce or contribute to at least 2 data products per year using biosurveillance data. These can either include sharing results with internal partners, such as epidemiologists, or external data products showing analyzed results (e.g., contributing data to a larger overdose data dashboard, external reports or alerts, etc.). Recipients must describe plans to share and disseminate data, including for use in local overdose prevention activities and to partner hospital sites.
5. Recipients must describe how they will work with local jurisdictions on this project.
6. Recipients must participate in CDC-hosted workgroup for this strategy.

Additionally, recipients may opt to use these strategy funds for additional biosurveillance activities, provided the core requirements listed above are met. Activities such as testing for outbreak response, pooling specimens to analyze for emerging drug threats, or analyzing point of care testing data are some examples of additional activities that can be supported by this funding as appropriate for recipients.

Optional and Competitive Surveillance Strategy (up to 20 awardees): Data Linkage – Strategy 5

This surveillance strategy will support development of recipient capacity to link key data sources, such as linking EMS or ED records of previous nonfatal overdoses with mortality data (i.e., SUDORS, vital records), at the person-level. Linking these data sources together will provide a more richly detailed picture of overdoses and allow state health departments and other partners to better understand and respond to key events that occur before, during or after a drug overdose. Additionally, a better understanding of how trends in nonfatal and fatal overdose vary across groups at disproportionate overdose risk (e.g., persons who recently experienced a nonfatal overdose or were released from incarceration) will inform interventions as the overdose crisis rapidly evolves. This strategy requires data linkages at the person-level; linking aggregate data from two or more sources by geographic areas (e.g., linking rates of fatal and nonfatal overdoses at the county level) will not be funded for linkages #1, #2a, and #2b (below). Linkages for #2c below can include county-level data linkage for merging of variables on social determinants of health that may only be available at the county-level. Data linkages should be developed by leveraging existing data streams and data elements when possible. Additional information regarding types of data sources is detailed below.

Recipients awarded this funding must meet the following seven requirements. (See Appendix 7 for indicators and metadata):

1. Link fatal drug overdose data (i.e., SUDORS, vital records) to at least one data source that captures nonfatal drug overdoses treated by first responders or hospitals (e.g., EMS or ED/inpatient records).
2. Perform at least one of the data linkages listed below.
    1. Link criminal justice data (e.g., incarceration or arrest) to either fatal drug overdose data (i.e., SUDORS, vital records) and/or a data source that captures nonfatal drug overdoses treated by first responders or hospitals (e.g., EMS or ED/inpatient records).
    2. Link PDMP prescription history with fatal drug overdose data (i.e., SUDORS, vital records) and/or a data source that captures nonfatal drug overdoses treated by first responders or hospitals (e.g., EMS or ED/inpatient records).
    3. Link data on social determinants of health (e.g., income, employment, social services data, County Health Ranking, or other county-level metrics) with either fatal drug overdose data (i.e., SUDORS, vital records) and/or a data source that captures nonfatal drug overdoses treated by first responders or hospitals (e.g., EMS or ED/inpatient records). Recipients who are able to conduct patient-level linkages with social determinant of health variables will be preferred and will receive a higher score in the application review process.
3. For all data linkages, deaths that occurred on or after January 1, 2022, must be included. For requirement 1, nonfatal overdoses that occurred during the year prior to the fatal overdose must be included. For requirement 2, if linking with nonfatal data, then nonfatal overdoses that occurred on or after January 1, 2023, must be included.
    1. Recipients who can also link historical baseline data on deaths that occurred in 2021 or nonfatal overdoses that occurred during 2021–2022 will be preferred and will receive a higher score in the application review process.
    2. Data linkages should be completed within 1 year of the date of the fatal or nonfatal drug overdose. This will require updating the data linkage multiple times

during each calendar year. Preference will be given to applicants who can link the data within 6 months of the date of the fatal or nonfatal overdose.

4. Data linkages that involve an entire state or the District of Columbia, versus databases that focus on a smaller geographic area (e.g., a city within the jurisdiction), are preferred and will receive a higher score in the application review process.
    1. To encourage capacity building, data linkages that use data from a large jurisdiction within a state or multiple jurisdictions within a state will be allowed.
5. Data dissemination requirements:
    1. The recipient must produce at least two data products each year, starting in Year 2 and also share with CDC publicly released data products resulting from the data linkages within 1 month of the date of release.
6. Recipients will be required to share additional information on the datasets, linkage procedures, analysis results, and indicators with CDC on an annual basis (See Appendix 7).
7. CDC will require applicants for this strategy to provide the following information in their application:
    1. A description of the geographic scope of the proposed data linkage project(s) (i.e., state or a subset of the state).
    2. Evidence the applicant can access the data sources and perform the data linkage within the first year of funding.
        1. Evidence must include letters of support from the agencies that will be sharing data as part of these data linkages- please see Collaborations Section for file naming and upload instructions.
        2. Evidence of performing proposed data linkages in the past year is preferred and will receive a higher score in the application review process but is not required.
        3. Submission of data sharing agreements established with agencies sharing the data or confirmed access to data warehouse, cubes or similar data infrastructure with the needed databases is preferred and will receive a higher score in the application review process but is not required.
    3. Evidence the applicant can link the databases with the required time lag of approximately 1 year from the date of fatal or nonfatal overdose, with preference given to those who can link within 6 months.

Prevention Component

To make meaningful strides in reducing nonfatal and fatal overdoses, state health departments need a comprehensive portfolio of prevention strategies that span key sectors/settings and work in concert to promote protective factors and minimize risk factors associated with the overdose epidemic. For the purposes of this funding opportunity, the OD2A-S prevention component is composed of a portfolio of four key prevention strategies:

- Clinician/Health System Engagement and Health IT/PDMP Enhancement
- Public Safety Partnerships/Interventions
- Harm Reduction

- Community-Based Linkage to Care

Recipients are required to implement interventions in all four prevention strategies. In addition, key intervention categories have been identified within each required prevention strategy and include some combination of required and recommended interventions. Please refer to each individual strategy section for additional guidance on selecting interventions to implement. **Applicants must include, at a minimum, one linkage to care intervention that utilizes navigators in each of the following strategies: clinician/health system engagement, harm reduction, and community-based linkage to care. Navigators can include peer navigators, certified peer recovery specialists, peer support specialists, case managers, patient navigators, community health workers, persons with lived experience, and other individuals who link PWUD to care and harm reduction resources. These are individuals familiar with the local public health landscape and who work directly with individuals with OUD and/or StUD to ensure they have the tools to address barriers to seeking care and who support people accessing treatment and supporting their retention (and reengagement if necessary) in SUD treatment and care, as well as support access to other services, such as harm reduction and social supports. CDC defines linkage using navigators as: 1) linkage to evidence-based treatment for substance use disorders- to include MOUD and other treatment (e.g., cognitive behavioral therapy [CBT], contingency management) and 2) linkage to harm reduction services.**

Additionally, health equity should be prioritized as a key focus within each of the prevention strategies. Applicants should utilize surveillance and sociodemographic data to focus their activities on underserved populations and populations at disproportionate risk for overdose. Populations who are at increased risk of overdose may include: people with a history of substance use disorders and/or overdose, people experiencing incarceration or recent release from incarceration, and people experiencing homelessness. To further promote health equity and reduce disparities related to drug overdose, recipients should utilize a health equity lens in the targeted implementation and evaluation of efforts.

Aligning with other overdose prevention guidance released by CDC, the OD2A-S prevention strategies take a setting-or sector-based approach. In particular, linkage-to-care interventions are organized according to the following sectors: clinical, public safety, harm reduction, or community-related settings. OD2A-S prevention strategies are not mutually exclusive, meaning an intervention may fit within more than one strategy. For example, an intervention that addresses harm reduction for public safety partners could reasonably be included in either prevention strategy. Recipients should consider the location where the intervention will take place and the sector that will be engaged (e.g., healthcare, law enforcement, harm reduction organization) in order to determine the best placement for that intervention.

CDC has identified facilitators that help accelerate and improve the implementation of interventions. There are two categories of facilitators relevant to this funding announcement: 1) crosscutting facilitators which are relevant to all prevention strategies and 2) intervention-specific facilitators which are specific to a given intervention. Recipients are encouraged to consider these facilitators and their impact during planning for and implementation of selected interventions.

The following list identifies crosscutting facilitators relevant to all prevention strategies presented in this funding announcement:

- Using data to inform action (determining populations of focus and improving health equity)
- Ensuring cultural responsiveness (providing culturally tailored trainings, workshops, technical assistance, and other support; engaging with people with lived experience to inform development; employing human-centered design)
- Creating partnerships (including with local Drug Free Communities (DFC) coalitions and organizations)
- Integrating/coordinating state and local efforts related to overdose prevention
- Co-locating services (prevention programs and treatment services with other community services)
- Addressing implementation barriers (including data sharing agreements, improving contract awarding, staffing support, and health IT enhancements to enable data access and sharing)
- Reducing stigma related to substance use and overdose

Similarly, intervention-specific facilitators are also identified to guide the implementation of specific interventions within each strategy.

A diagram was developed (see Figure 2. in Appendix 10) to guide applicants in describing how crosscutting facilitators will benefit their efforts across all prevention strategies and how intervention-specific facilitators will help improve the interventions they select within each strategy.

The table below provides an overview of required and recommended intervention categories within each of the four prevention strategies. Applicants also have the flexibility to propose additional evidence-based or evidence-informed interventions within each strategy that align with the goals of that strategy. Applicants should follow instructions for each strategy carefully to determine the organization of the prevention component.

Overview of Prevention Strategies

Prevention Strategy	Categories of Interventions
6. Clinician/Health System Engagement and Health IT/PDMP Enhancement (Applicants must propose at least 1 intervention in each of the three required categories under Clinician/Health System Engagement AND in the required category under	**Clinician/Health System Engagement** • *Required* – Educating clinicians on best practices for acute, subacute, and chronic pain including opioid prescribing, as described in the *CDC Clinical Practice Guideline for Prescribing Opioids for Pain – United States, 2022 ("2022 CDC Clinical Practice Guideline").* • *Required* – Training clinicians on screening, diagnosis, and linkage to care and retention in care for opioid use disorder (OUD) and stimulant use disorder (StUD).

Health IT/PDMP Enhancement.)	• *Required* – Building and implementing health system-wide clinical capacity to screen, diagnose, and support (or connect to) longitudinal care for OUD and StUD and support recovery for adults and adolescents. **Health IT/PDMP Enhancement** • *Required* – Expanding PDMP data sharing across state lines/interstate interoperability. • Implementing universal use among clinicians and their delegates within a state. • Possessing more timely or real-time data contained within a PDMP. • Actively managing the PDMP in part by sending proactive (or unsolicited) reports to clinicians to inform prescribing and patient care. • Ensuring that PDMPs are easy to use and access by clinicians.
7. Public Safety Partnerships/Interventions (Applicants must propose an intervention in at least 1 of the categories.)	• Developing and maintaining public health and public safety (PH/PS) partnerships or collaboratives at the state level. • Improving data sharing, availability, and use at the intersection of PH/PS, without duplicating efforts. • Improving knowledge, attitudes, and capacity among PH/PS to prevent and respond to overdose. • Implementing evidence-based overdose prevention strategies at the intersection of PH/PS (including evidence-based linkage to care and harm reduction strategies). • Implementing promising overdose prevention strategies at the intersection of PH/PS.
8. Harm Reduction (Applicants are required to select at least the two required interventions.)	• *Required* – Using navigators to connect people to services. • *Required* – Ensuring PWUD have access to overdose prevention and reversal tools, treatment options, and drug checking equipment. • Developing and sustaining partnerships with syringe services programs (SSPs) and harm reduction organizations to improve access to and delivery of harm reduction services and to reduce overdose. • Creating and disseminating education and communication materials to increase awareness of and access to harm reduction resources (such as

	SSPs) and to combat stigma and change social norms around harm reduction.
9. Community-Based Linkage to Care *****Linkage to care interventions occurring outside of health systems and public safety-involved settings. (Applicants must propose at least one intervention that utilizes navigators.)	• Initiating linkage to care activities. • Supporting retention in care. • Maintaining recovery.

Clinician/Health System Engagement and Health IT/PDMP Enhancement – Strategy 6

As the drug overdose crisis continues to worsen in the United States, ensuring that clinicians and health systems are equipped to contribute to prevention solutions remains a priority. Health systems and clinicians can help prevent overdose-related morbidity and mortality by ensuring safer and more effective pain management through guideline-concordant care as well as improving linkages to and retention/reengagement in evidence-based substance use disorder (SUD) treatment, particularly for opioid and stimulant use disorders, including engagement of recovery support and harm reduction services. This strategy aims to support clinician and health systems activities in states through state health department-led collaboratives, across multiple domains in the state, who are well-positioned to implement and advance health system-level activities and improve health equity.

Using this framework of a state collaborative, funded recipients will implement and advance clinician/health system initiatives and provide overarching public health leadership, allowing for focused dialogue among collaborative participants in sharing of best practices, success stories, resources, and ideas by bringing together leaders most closely connected to the tools needed to implement health system-focused activities and improve health equity. Examples of key partners to engage for this strategy include, but are not limited to, representatives from health systems administrations; accountable care organizations; leaders of relevant state-wide community-based organizations; patient and caregiver organizations; state chapters of clinical professional associations or boards; academic institutions; state insurer/payer organizations; and harm reduction coalitions. Existing state collaboratives may be leveraged for OD2A-S purposes if similar representation is present. In addition, evaluation data should be used to inform both the clinician/health system engagement and the health IT/PDMP enhancement prevention interventions during activity or program development and to improve prevention interventions throughout implementation. Evaluating these interventions is critical to understand which interventions have the most impact and demonstrate progress.

Considerations for Clinician/Health System Engagement:
CDC has outlined three categories of Clinician/Health System Engagement interventions and listed required and recommended interventions within each category (see table below):

- **Category 1** - Clinician education on best practices for acute, subacute, and chronic pain including opioid prescribing, as described in the *CDC Clinical Practice Guideline for Prescribing Opioids for Pain – United States, 2022 ("2022 CDC Clinical Practice Guideline").*
- **Category 2** - Clinician education on screening, diagnosis, and linkage to care and retention in care for opioid use disorder (OUD) and stimulant use disorder (StUD).
- **Category 3** - Building and implementing health system-wide clinical capacity to screen, diagnose, and support (or connect to) longitudinal care for OUD and StUD and support recovery for adults and adolescents. Of particular focus should be maximizing opportunities in all health care encounters to link patients to evidence-based care.

Recipients must implement at least one intervention in each of the three required categories within the clinician/health system engagement strategy. For Category 3, recipients must implement, at a minimum, an intervention that supports the use of navigators to link patients to care in emergency departments. Additionally:

- Focused attention should be paid to implementing health system-wide initiatives that: 1) ensure clinician education efforts actively lead to change in clinical practice; 2) support careful identification and addressing of inequities in access to evidence-based care for pain and SUDs; and 3) reduce stigma and increase positive interactions between clinicians and people living with pain as well as with people who have experienced an overdose or are at high risk of overdose.
- Educational efforts focused on the 2022 CDC Clinical Practice Guideline will require an expanded set of clinical audiences than the 2016 CDC *Guideline for Prescribing Opioids for Chronic Pain* due to the 2022 Clinical Practice Guideline's expansion of scope, including dentists, clinicians managing postoperative pain on an outpatient basis, and clinicians providing pain management upon discharge from emergency departments.
- Participation by state pharmacy associations/boards in the collaborative is highly encouraged to help promote messaging to pharmacists as key partners.
- Offering continuing medical education credits for clinician trainings is highly encouraged to support participation.

Examples of interventions may include but are not limited to:

Required Categories	Recommended/Required Interventions
1. Educating clinicians on best practices for acute, subacute, and chronic pain including opioid prescribing, as described in the CDC Clinical Practice Guideline for Prescribing Opioids for Pain – United States, 2022 **[Required]**	• Developing trainings on the management of pain, focusing on dissemination to all clinicians who may treat acute, subacute, and chronic pain in outpatient settings. • Supporting health system implementation of the 2022 CDC Clinical Practice Guideline via use of electronic clinical decision support tools (CDS) or a health system quality improvement measurement framework. • Developing and/or enhancing existing in-state center of excellence facilities to build state-wide referral network and expertise hubs to facilitate the provision of multi-modal, evidence-based pain care.

2. Training clinicians on screening, diagnosis, and linkage to care for opioid use disorder (OUD) and stimulant use disorder (StUD) **[Required]**	• Developing trainings on screening and diagnosis of SUDs, especially OUD and StUD, intended for clinicians across a range of specialties. • Disseminating information to clinicians on health system-wide SUD care options with a focus on addressing inequities in access to these care options. • Raising awareness of existing large-scale, national mentorship programs for SUD care for technical assistance and peer support, including but not limited to Opioid Response Network, Providers Clinical Support System, among others.
3. Building and implementing health system-wide clinical capacity to screen, diagnose, and support (or connect to) trauma-informed longitudinal care for OUD and StUD and support recovery for adults and adolescents **[Required]**	• **Required Intervention**: Supporting emergency department linkages via multidisciplinary teams including navigators, broadening the scope from only post-overdose scenarios to also include strategies like focused connections during care for conditions that may represent sequelae of substance use (e.g., skin/soft tissue infections) and enhanced universal screening for SUD (e.g., opioids and stimulants) among patients presenting for other reasons to identify new opportunities to engage in and link to care. • Supporting health system-wide expansion of MOUD provision in primary care, such as via removal of system-wide administrative barriers, addressing stigma, and addressing inequities towards MOUD uptake; strengthening collaborations with behavioral health networks to support evidence-based treatment for StUD (e.g., contingency management, cognitive behavioral therapy); and supporting new system-wide policies that aim to reduce inequities in access to evidence-based care. • Supporting new system-wide inpatient workflows and policies to identify hospitalized patients who are ready to engage in SUD care, to build clinician awareness of health system care options, to help improve clinician perception and attitudes towards MOUD, and to help advance linkage to care efforts. • Integrating pharmacists as part of the SUD linkage and care model. • Training, implementation, and adoption of trauma-informed practices into health system and clinical staff policies and standards.

Considerations for Health IT/PDMP Enhancement:
Health information technology (health IT) enhancement is a cornerstone for equipping clinicians and health systems to contribute to prevention solutions. Integrating both evidence-based

guideline recommendations and prescription drug monitoring program (PDMP) data into electronic health records (EHRs) to support electronic clinical decision support (CDS) tools, such as morphine milligram equivalence (MME) calculators, prescribing suggestions when initiating pain care, and prompts to check the PDMP, can be incorporated into clinical workflows and are available at the point of care in the EHR for clinicians. This strategy also aims to support recipients in continuing to advance the development and expansion of existing PDMPs and increase their utilization as a public health surveillance tool and clinical decision-making tool. This funding seeks to leverage federal funding to ensure that recipients scale up the use of PDMP data through interoperability with health IT systems such as EHRs.

CDC recognizes that PDMPs operate differently from state to state, as each is operated under different purviews and management. The establishment and operation of PDMPs vary, given that each PDMP is subject to existing policies and management of its own respective state. While PDMPs may operate differently, there are system components that CDC promotes to improve PDMP functionality as both a clinical decision-making tool and public health surveillance tool. **CDC has outlined five categories, with Category 1 being required, of Health IT/PDMP Enhancement interventions and listed required and recommended interventions within each category** (see table below):

- **Category 1** - Expanding PDMP data sharing across state lines/interstate interoperability **[Required]**.
- **Category 2** - Implementing universal use among clinicians and their delegates within a state.
- **Category 3** - Possessing more timely or real-time data contained within a PDMP.
- **Category 4** - Actively managing the PDMP in part by sending proactive (or unsolicited) reports to clinicians to inform prescribing and patient care.
- **Category 5** - Ensuring that PDMPs are easy to use and access by clinicians.

Additional considerations for implementation of these interventions include:

- Supporting the integration of PDMP data within health IT systems (e.g., EHRs, health information exchanges [HIEs].
- Developing a framework, best practices, and formalized process for actionable data sharing such as data use agreements (DUAs) and/or memoranda of understanding (MOUs).
- Integrating PDMP data with other health information technology systems such as EHRs, pharmacy dispensing software (PDS) systems, medical examiner/coroner case management systems, and other health information technology infrastructure such as HIEs and health information networks (HINs).

Examples of interventions may include but are not limited to:

Category	Recommended/Required Interventions
1. Expanding PDMP data sharing across state lines/interstate interoperability **[Required]**	• **Required Intervention:** Implementing and expanding electronic information sharing among states in compliance with the National Prescription Monitoring Information Exchange (PMIX) Architecture.

	• **Required Intervention:** Connecting and maintaining bidirectional connection for the exchange of PDMP data with other "state" PDMP systems and ensuring that every request received by the recipient's PDMP system sends an appropriate and timely response.
2. Implementing universal use among clinicians and their delegates within a state	• Implementing universal PDMP registration and use that includes a streamlined and simplified PDMP registration process. • Expanding and improving medical examiner and coroner access to prescription history from within an integrated PDMP and medical examiner's/coroner's case management system interface.
3. Possessing more timely or real-time data contained within a PDMP	• Improving PDMP infrastructure or information systems to support proactive reporting and data analysis, including enhancing reporting systems to increase frequency and quality of reporting.
4. Actively managing the PDMP in part by sending proactive (or unsolicited) reports to clinicians to inform prescribing and patient care	• Designing, validating, or refining algorithms for identifying high-risk prescribing activity and other risk factors associated with overdose to use as a trigger for proactive reports (e.g., receiving prescriptions from multiple clinicians, and concurrent substance use or dangerous combinations that put patients at higher risk for opioid use disorder and overdose). • Developing and implementing behavioral health and MOUD support/treatment systems within an integrated PDMP-EHR interface, which can help with addressing inequities in access to evidence-based care.
5. Ensuring that PDMPs are easy to use and access by clinicians	• Expanding access to PDMPs via a health information exchange. • Integrating PDMP data into electronic health records.
Health IT activities must align with standards and implementation specifications adopted in 45 CFR part 170, Subpart B: Standards and Implementation Specifications for Health Information Technology)	

Public Safety Partnerships/Interventions – Strategy 7

Public safety partners play a critical role in responding to drug overdoses in their role as first responders. Public health and public safety (PH/PS) partnerships can ensure that strategies for recruiting and reaching participants, implementing programs (e.g., linkage to care, naloxone distribution, overdose education), and determining impact are developed with input from all interested entities, including PH/PS partners and individuals with lived experience of drug use, and encompass principles of harm reduction. These partnerships can also redress the disproportionate burden of overdose and justice involvement among people in communities of

color. In an increasingly polysubstance use landscape, PH/PS partnerships can address risks posed by opioids, stimulants, and other drugs through increased information tracking and sharing, post-overdose outreach programs, and community re-entry supports, for example. Additionally, public safety agencies increasingly engage in overdose prevention efforts during their frequent engagement with people who use drugs (PWUD), including people with substance use disorders (SUDs).

Public health and public safety (PH/PS) partners share the same goal: to achieve safety and security for populations. Therefore, partnerships between PH/PS can be mutually beneficial and result in an increased impact on drug overdose in states and communities. At the state level, partnerships between PH/PS are critical to engaging cross-sector partners and bringing about state-level changes in policies, procedures, and norms to address the state's overdose crisis. For example, these partnerships can identify and address overdose risks, standardize overdose prevention programs at the intersection of PH/PS, and ensure collaboration between partners at the state level. This strategy is an opportunity for recipients to develop new partnerships or build upon existing partnerships between PH/PS entities at the state level. For the purposes of this funding opportunity, public safety entities include law enforcement, courts, corrections, prosecution, fire, and emergency medical services.

Considerations for PH/PS Strategy:
CDC has outlined five categories of PH/PS interventions and listed recommended interventions within each category (see table below). **Recipients must implement an intervention in at least one of the five identified categories.** For each proposed PH/PS intervention, applicants must indicate the category that most appropriately aligns with it. If an intervention aligns with more than one category, applicants should choose the most relevant category. Additionally:

- This funding opportunity is aimed at state-level entities so interventions and corresponding outcomes should follow suit (i.e., interventions that address state-level systems, state-wide barriers, standardization, dissemination across the state, etc.).
- All linkage to care interventions that have a PH/PS element should be included in this strategy of the funding application, not in the linkage to care strategy. Use of navigators must be employed when conducting linkage to care activities.
- The way in which the activity includes both the public health sector *and* the public safety sector must be clearly articulated.
- Funds should not be used to provide information for or carry out investigations, sentencing, and/or arrests.
- Recipients must align and collaborate with local-level PH/PS overdose prevention efforts to ensure no duplication of efforts.
- Interventions should directly address drug overdose and/or its proximal drivers.
- Interventions should prioritize populations at greatest risk for overdose, including individuals involved in the criminal justice system and individuals who have experienced a non-fatal overdose.
- Interventions should aim to improve health equity (e.g., by diverting individuals at risk of overdose away from the criminal justice system and into evidence-based prevention interventions, identifying and addressing systemic inequities in overdose risk and response efforts, and focusing on communities most affected by overdose).

- Recipients should recognize and commit to improving racial equity and use data to implement culturally tailored activities to reduce disparities in drug overdoses.

Facilitators for PH/PS Interventions:

- Partnerships with local Drug Free Communities Support Program (DFC) coalitions when appropriate and based on available evidence of local risk and protective factors. These partnerships should involve coalitions with strong public safety sector involvement.
- Meaningful partnerships with people who use drugs are encouraged, as their involvement brings expertise and relevance to the design and implementation of programs.
- Collaboration with the Overdose Response Strategy (ORS) state team, consisting of a public health analyst and drug intelligence officer.
- Establishing data use agreements and memos of understanding between PH/PS partners.

Examples of interventions may include but are not limited to:

Category	Recommended Interventions
1. Developing and maintaining PH/PS partnerships or collaboratives at the state level	• Facilitating the initiation or expansion of the PHAST toolkit or another framework across the state, to engage PH/PS in efforts to convene multi-sector partners, share information on the overdose crisis, prioritize strategies and interventions accordingly, and monitor progress collectively. • Supporting the development and implementation of protocols to mitigate risks to patients experiencing disrupted access to prescription opioids or other controlled substances, in line with CDC's Opioid Rapid Response Program (ORRP). Creating partnerships between PH/PS and clinical leaders across the state to improve coordination during a sudden clinic closure or access disruption event. • Standardizing processes and procedures for overdose fatality review (OFR) teams at the state or regional levels.
2. Improving data sharing, availability, and use at the intersection of PH/PS	• Initiating or expanding the use and coverage of novel data systems, such as High Intensity Drug Trafficking Area's (HIDTA) Overdose Detection Mapping Application (ODMAP), to monitor overdoses, facilitate post-overdose outreach efforts, detect overdose spikes, locate hotspots, and/or identify emerging drug threats. • Implementing systems that utilize arrest and/or seizure data to identify the possibility of a spike in overdose and to inform response and communication protocols, excluding the linkage of specific overdose cases across datasets. • Developing and implementing plans to respond to acute events, such as overdose spikes (identified through

	surveillance – see “Morbidity” section above or through ODMAP or similar tools).
3. Improving knowledge, attitudes, and capacity among PH/PS to prevent and respond to overdose	• Developing, disseminating, and evaluating efforts to reduce barriers to overdose prevention and response among PH/PS partners. • Improving understanding of how systemic issues in communities (e.g., structural racism, criminalization of drug use, lack of education or economic opportunity) contribute to overdose risk and identify a strategy for PH/PS partners to reduce trauma and burden of overdose in these communities. • Training PH/PS partners on topics such as stigma reduction, OUD, StUD, harm reduction, naloxone administration, trauma-informed care, recovery-oriented approaches, and other overdose prevention strategies.
4. Implementing evidence-based overdose prevention strategies at the intersection of PH/PS (including LtC and harm reduction)	• Implementing evidence-based overdose prevention strategies, including distribution of naloxone and drug checking supplies (i.e., fentanyl test strips), raising awareness of Good Samaritan Laws, drug checking interventions, providing access to medications for opioid use disorder (MOUD), and facilitating access to syringe services programs. (When implementing linkage to care, navigators must be used to facilitate linkages). • Implementing strategies that may take place in criminal justice settings (e.g., courts, jail, parole), upon reentry, and in the community.
5. Implementing promising overdose prevention strategies at the intersection of PH/PS	• Implementing promising practices that have demonstrated some impact on overdose and associated risk factors and may include diversion and deflection programs, post-overdose outreach programs, and linkage to care and support services. (When implementing linkage to care, navigators must be used to facilitate linkages). • Developing and adapting culturally tailored training and program implementation materials (e.g., training curriculum addressing stigma or trauma-informed care, approach for responding to overdose in communities of color, implementation plan for linkage to care program).

Harm Reduction – Strategy 8

Harm reduction involves a set of practical strategies and interventions aimed at reducing negative consequences associated with drug use. Harm reduction strategies have been shown to reduce overdose, increase treatment entry, reduce drug use frequency, and improve the health of

people who use drugs. These strategies may include overdose education and naloxone distribution, syringe services programs, low-threshold access to medications for opioid use disorder (MOUD) via co-location with harm reduction services or patient navigation, drug checking (e.g., using fentanyl test strips [FTS] or mass spectrometry), and education about safer drug use. Health departments, clinicians, community-based organizations, and people with lived experience all play an important role in reducing the harms associated with drug use and can incorporate harm reduction strategies and approaches into their activities. Harm reduction is one of the four priorities of the HHS overdose prevention strategy.

Considerations for Harm Reduction Strategy:
This funding may be used to implement and support selected evidence-based interventions while partnering with harm reduction organizations, for activities to reduce stigma toward people who use drugs, and to facilitate the implementation and uptake of harm reduction strategies. Similarly, understanding the effect of existing policies on harm reduction efforts is crucial. Hence, recipients may conduct evaluations of laws/policies/regulations and/or current resources that affect harm reduction activities in their communities with the goal of improving the effectiveness and reach of these activities, particularly among populations most in need of these services. The work implemented through this funding opportunity should be complementary and not duplicative of work implemented through other funding streams (including CDC funding).

Interventions should center health equity and include plans to reach groups who are disproportionally affected by overdose and/or underserved by harm reduction services and the healthcare system more broadly. Activities may be carried out by recipients, community harm reduction organizations, or other organizations that have the capacity to reach PWUD and people at risk of overdose.

Applicants should also include interventions that actively target and reduce stigma in their communities. Populations engaged with stigma reduction interventions may include: clinicians, public safety, first responders, community leaders, and other service providers and community partners who may have stigma toward PWUD. Recipients are encouraged to partner with local Drug-Free Communities (DFC) coalitions when appropriate and based on available evidence of local risk and protective factors. These partnerships should involve coalitions working on reducing stigma in addition to primary prevention efforts. Interventions should be tailored to each population of focus and take into consideration that stigma may take different forms among different groups. Recipients should take into consideration designated ethnicity, designated race, designated socioeconomic status (SES), immigrant status, and sexual orientation/gender identity in conjunction with stigma reduction. Harm reduction interventions should acknowledge broader social, political, and environmental systems, and the general social, political, and economic conditions influenced by general beliefs and attitudes in respective communities.

Under the harm reduction strategy, **recipients must, at a minimum, implement the required interventions within categories one and two ("Using navigators to connect people to services" and "Ensuring PWUD have access to overdose prevention and reversal tools, treatment options, and drug checking equipment").** If recipients choose to implement additional interventions within these and other categories under this strategy, they must identify

the category aligned with that intervention. If an intervention aligns with more than one category, applicants should choose the most relevant category.

Proposed harm reduction activities should support the inclusion of people with lived and/or living experience in all stages of program implementation and evaluation. Interventions conducted as part of the harm reduction strategy may have local health departments, community-based organizations (such as syringe services programs and other organizations that support PWUD), clinicians, or people with lived experience as populations of focus.

Facilitators for Harm Reduction Interventions:

- Initiating, expanding, and supporting efforts that center people with lived experience in programs and communities they represent (e.g., programs staffed by people with lived experience who have a demonstrated history of serving disproportionately affected populations, such as racial/ethnic/sexual/gender minority groups, to provide outreach to PWUD from those minority groups).
- Improving visibility and reach of peer services providers to reduce self-stigma.
- Developing and supporting interventions to increase contact among people with lived experience and others in the community (e.g., community programs that reduce stigma by bringing together PWUD and other community members).
- Collaborating with SSPs and harm reduction organizations to improve access to and delivery of harm reduction services to reduce overdose.
- Building capacity at SSPs and harm reduction organizations (per the guidance provided in the harm reduction resource guide). Capacity building can include working with harm reduction organizations to identify methods for improving governance, operations, and service delivery, as well as enhancing sustainability, such as enhancing data collection and management practices, staff training, and other activities that increase robust operations and promote sustainability at SSPs and harm reduction organizations.
- Using overdose data and other data sources to identify areas that may benefit from additional SSP support and populations who may need services from SSPs and harm reduction programs.
- Implementing other interventions that may correct misinformation or contradict negative attitudes or beliefs regarding harm reduction in the community it seeks to assist.
- Using data and the evidence base to inform policy and procedures to reduce stigma associated with places where PWUD may access community resources.

Examples of interventions may include but are not limited to:

Category	**Recommended/Required Interventions**
1. Using navigators to connect people to services **[Required]**	• **Required Intervention**: Initiating, expanding, and supporting programs and outreach by navigators (e.g., people with lived experience, case managers) to promote access to harm reduction services (such as SSPs) and to link people to care from harm reduction services, as appropriate.
2. Ensuring PWUD have access to overdose	• **Required Intervention**: Developing and expanding overdose education and naloxone distribution programs that prioritize

prevention and reversal tools, treatment options, and drug checking equipment **[Required]**	education and distribution among those who are at the greatest risk of experiencing or witnessing an overdose. • Improving access to low-threshold MOUD and treatment for other substance use disorders (e.g., stimulant use disorder) via co-location with harm reduction services or patient navigation • Improving availability and access to field drug checking (e.g., mass spectrometry and/or educating PWUD about and disseminating drug checking supplies such as FTS).
3. Improving access to and delivery of harm reduction services to reduce overdose	• Partnering with and providing support to existing SSPs and harm reduction organizations to increase access to harm reduction services and support programming to reduce overdose, including support of staff time to increase hours and services. • Increasing awareness of SSPs and harm reduction organizations in communities. • Supporting mobile SSPs. • Supporting other interventions that increase SSP and harm reduction services utilization and reduce overdose
4. Creating and disseminating education and communication materials to increase awareness of and access to harm reduction resources (such as SSPs) and to combat stigma and change social norms around harm reduction	• Producing and distributing risk reduction and overdose prevention educational resources and materials for PWUD. • Developing and implementing trainings and education interventions for those who interact with or provide services to PWUD (e.g., clinicians, community-based organizations, and local leadership) to address stigma experienced by PWUD in their community. • Deploying communication campaigns that focus on harm reduction or stigma reduction messaging, including television, print, radio, outdoor, online, and social media outlets. Campaigns may use CDC-developed resources such as the Stop Overdose campaigns, the Rx Awareness campaign, or other evidence-based resources developed locally and tested with the intended audience.

Community-Based Linkage to Care – Strategy 9

CDC views linkage to care as a cascade of care that includes linking to care, retention in care, and supporting recovery. It is critical to increase access to care within all community settings to minimize health disparities associated with drug overdose and overdose co-morbidities, and meet individuals where they are in their substance use and recovery journey. Applicants should identify specific populations experiencing a disproportionate burden of substance use disorder within their jurisdictions and ensure that health equity and stigma reduction are appropriately integrated within their programs.

CDC's previous funding announcement, OD2A, funded a large range of linkage to care

interventions that included patient support services, warm hand-off programs, and post-overdose outreach. Under OD2A-S, recipients are expected to continue implementing and, if appropriate, scaling-up these interventions, as well as other evidence-based and/or evidence-informed interventions that facilitate linkage to and retention in care.

Considerations for Community-Based Linkage to Care Strategy:
Linkage interventions that facilitate care retention and/or prevention of treatment interruption, as well as access to recovery services, will be supported by this funding. CDC recognizes that many federal partners support linkage delivery of services for people with SUD. CDC's funding is focused on building capacity in communities to help people with SUD get connected to services and stay connected to them. Recipients are strongly encouraged to co-locate services in communities and use funding from different funding sources to create robust service hubs that attend to the complex interrelated needs of persons experiencing SUDs. Examples of appropriate interventions include connecting individuals with substance use disorders (SUDs) to an array of support services within communities, including transportation assistance and linking persons to employment training and temporary housing services; OD2A-S funds cannot support treatment services directly (e.g., purchasing medications, clinician salaries).

The table below outlines three community-based linkage to care categories and recommended interventions. For the purposes of this funding opportunity, **applicants must include, at a minimum, one linkage to care intervention that utilizes navigators. CDC defines linkage using navigators as: 1) linkage to evidence-based treatment for substance use disorders- to include MOUD and other treatment (e.g., CBT, contingency management); 2) linkage to harm reduction services.** Additionally:

- Interventions selected by applicants must align with one or more of the three identified categories (e.g., initiating linkage to care activities, supporting retention in care, maintaining recovery). Examples of different community settings include:
    - Harm reduction programs and syringe services programs
    - Community-based organizations
    - Community at large, fire departments, libraries, schools (when appropriate)
- Interventions may be carried out by recipients and/or by appropriate partners. Reminder: OD2A-S does not pay for the operation/management of programs in these settings.

Applicants are encouraged to incorporate the following facilitators as part of their implementation plans for selected interventions aimed at community-based linkage to care, supporting retention in care, and maintaining recovery:

Facilitators for Community-Based Linkage to Care Interventions:

- Facilitating care coordination or a "warm hand-off" (e.g., in-person/video/phone conversation among the individual, the organization making the referral, and the organization receiving the referral).
- Initiating or expanding partnerships with local Drug Free Communities (DFC) coalitions and local organizations that have implemented or can facilitate linkage to care activities, where applicable and appropriate (e.g., connecting individuals to culturally tailored

services, LGBTQ+ community health centers, or organizations that focus on persons with lived experience).

- Addressing barriers to care to facilitate engagement in prevention/treatment/long term recovery. For example, transportation barriers may be addressed by using car services, or leasing vehicles for mobile units. Housing barriers may be addressed by connecting individuals to housing services. Telehealth barriers may be mitigated by providing pre-paid cell phone plans to assist individuals entering treatment.
- Utilization of data to tailor outreach and increase focus on populations who are at disproportionate risk. Recipients are also encouraged to utilize MMWR Rural Health Series | MMWR (cdc.gov).
- Prioritization of a multidisciplinary team approach with special attention on education and training designed to increase empathy, reduce stigmatization, and increase staff understanding of the role of persons with lived experience within the team model.

Please note: Linkage to care interventions occurring in health care settings or within public safety settings should be included within the Clinician/Health System Engagement strategy and the Public Safety Partnerships/Interventions strategy respectively and not repeated here.

Select at least one of the two required interventions listed in this table. Examples of interventions may include but are not limited to:

Category	Recommended/Required Interventions
1. Initiating linkage to care activities	• **Required Intervention**: Using navigators to facilitate linking people to care and other services. • Developing case management systems to help individuals navigate the processes by which care may be procured. Recipients are encouraged to implement these case management systems within existing SSPs and local harm reduction programs. • Creating post-overdose outreach teams or Assertive Community Outreach programs that connect with the individual within 72 hours of a suspected overdose and provide linkages to care. Team composition may include first responders, community health workers, and health care workers. The composition of these teams varies by community.
2. Supporting retention in care	• **Required Intervention:** Using navigators to facilitate implementing monitoring programs following discharge from acute care to prevent treatment interruption. • Creating peer support groups or linkages to community-based self-help groups with an emphasis on peers with lived experience. • Increasing access to and retention in care through the development of telehealth infrastructure and resources.
3. Maintaining recovery	• Developing and implementing Recovery Management Checkups protocols that provide support, ongoing assessment, and monitoring after primary treatment for SUD.

	• Supporting Recovery Community Centers and Mutual-Help Organizations (fostering peer groups that are supportive of recovery and self-acceptance). • Supporting linkage to ancillary services such as job skills trainings, training/employment, cultural community centers, and transportation through partnerships or direct staffing support.

1. Collaborations

The complex and changing nature of the overdose epidemic highlights the need for an interdisciplinary, comprehensive, and cohesive public health approach. To accomplish the work under this funding opportunity, recipients will need to engage in, coordinate with, and leverage various partnerships.

a. With other CDC programs and CDC-funded organizations:

Below are both required and recommended collaborations with other CDC-funded programs. Please submit Letters of Support (LOS) or Memorandums of Understanding/Agreement (MOU/MOA) for any required collaborations. Additional requirements to document collaborations may be indicated below. Applicants must file the MOU or MOA, as appropriate, name the file "MOUs/MOAs," and upload it as a PDF file at www.grants.gov.

Required collaborations with other CDC programs are as follows:

- Epidemiology and Laboratory Capacity for Prevention and Control of Emerging Infectious Diseases Cooperative Agreement (ELC; CK19-1904), if applicable:
    - Under ELC, applicants may also be provided funding by CDC for the National Syndromic Surveillance Program (NSSP).
    - Those applicants who choose to use their state's NSSP data for ED data submission must submit a LOS from their NSSP Principal Investigator. Please label the document "S2 NSSP PI LOS" and upload it as a PDF file at www.grants.gov.
    - In the LOS, the NSSP PI should indicate 1) that state-based staff working on the NOFO will be allowed access to the state's data in NSSP; 2) agreement to allow (or not allow) CDC with access to the state line-level data details; 3) agreement to work with state staff to remedy any data quality issues and meet all CDC deliverable due dates; and 4) the overall ED visit and ED facility coverage of the state's data in NSSP including completeness of data in the following fields: age, sex, race, ethnicity, patient 5-digit zip code, chief complaint, and discharge diagnosis.
- National Violent Death Reporting System (NVDRS, CDC-RFA-CE18-1804):
    - This NOFO uses the same web data-entry system as NVDRS and makes similar data requests to ME/C agencies and vital statistics as NVDRS. As a result, applicants must provide a LOS from the NVDRS Principal Investigator. In the LOS, the NVDRS Principal Investigator should agree to coordinate ME/C and vital statistics data collections with this NOFO.

- Please label the document "S3 NVDRS PI LOS" and upload it as a PDF file at www.grants.gov.

- **If proposing biosurveillance activities performed by a public health laboratory,** collaboration with the Laboratory Response Network for Chemical Threats (LRN-C, funded through the Public Health Emergency Preparedness (PHEP) Cooperative Agreement; CDC-RFA-TP19-1901) is required. A LOS from your LRN-C lead showing that there is support for staff cross-training, equipment sharing, and other resources as needed to support the activities proposed is required, and the ability to report data through LRN-C electronic laboratory reporting (ELR) or other LRN-C reporting will strengthen your application. Please label the document "S4 LRN C Lead LOS" and upload it as a PDF file at www.grants.gov.

Recommended collaborations with other CDC programs are as follows:

- The Overdose Response Strategy (ORS) (CSTLS NU38OT000288-03-08):
  - The ORS is a national public health and public safety collaboration between the Office of National Drug Control Policy's (ONDCP) High Intensity Drug Trafficking Areas (HIDTA) program and the CDC that helps local communities reduce drug overdoses by sharing timely data, pertinent intelligence, and evidence-based and emerging strategies. Through this cooperative agreement with the CDC Foundation, CDC supports the ORS. In a letter of support, (please label the document "PS ORS LOS" and upload as a PDF file) the Public Health Analyst or another ORS team member could outline how activities proposed in this NOFO align with or leverage the work of the ORS (https://ahidta.org/content/overdose-response-strategy).

- The Drug-Free Communities (DFC) Support Program (CDC-RFA-CE22-2205):
  - DFC is the nation's leading effort to mobilize communities to prevent and reduce substance use among youth. Created in 1997 by the Drug-Free Communities Act, administered by the White House Office of National Drug Control Policy (ONDCP), and managed through a partnership between ONDCP and CDC, the DFC program provides grants to community coalitions to strengthen the infrastructure among local partners to create and sustain a reduction in local youth substance use. Applicants are encouraged but not required to collaborate with DFC recipients. In a letter of support (please label document "DFC LOS" and upload as a PDF file), DFC staff could outline how activities proposed in this NOFO align and leverage the work of DFC coalitions at the local level. (https://www.whitehouse.gov/ondcp/dfc/).

- Core State Injury Prevention Program (Core SIPP, CDC-RFA-CE21-2101), if applicable:
  - Applicants currently receiving funding under Core SIPP are encouraged to meet quarterly with the Core SIPP point of contact in the state health department to coordinate program activities.

- Projects using syndromic surveillance to track injury: Advancing Violence Epidemiology in Real-Time (AVERT; CDC-RFA-CE-23-2307), Essentials for Childhood (EfC): Preventing Adverse Childhood Experiences through Data to Action (PACE; CDC-RFA-

CE23-2305), and Expansion of Comprehensive Suicide Prevention Across the US (CDC-RFA-CE22-2204)
    - Applicants receiving funding through these mechanisms should collaborate to coordinate staffing and similar activities across these activities and OD2A-S.

- Additional overdose-related funding announcements from NCIPC:
    - Applicants are encouraged but not required to collaborate with recipients of the following funding opportunities:
        - Injury Control Research Centers (ICRCs, RFA-CE-24-001)
        - Grants to Support New Investigators in Conducting Research Related to Understanding Polydrug Use Risk and Protective Factors (RFA-CE-22-001)
        - Rigorous Evaluation of Community-Level Substance Use and Overdose Prevention Frameworks that Incorporate ACEs-Related Prevention Strategies (RFA-CE-22-009)
        - Understanding Polydrug Use Risk and Protective Factors, Patterns, and Trajectories to Prevent Drug Overdose (RFA-CE-22-011)
        - Research Grants to Develop or Identify Effective Strategies to Prevent Overdose Involving Illicit Stimulants and Polysubstance Use Involving Stimulants (RFA-CE-21-002)

- Other Jurisdictions Awarded Under this Announcement:
    - Recipients are encouraged but not required to collaborate and share information and findings with other jurisdictions awarded under this announcement. Recipients will have the opportunity to share best practices and lessons learned via communities of practice and webinars facilitated by DOP's Technical Assistance Center throughout the lifecycle of this funding announcement.

b. With organizations not funded by CDC:
It is expected that recipients will collaborate closely with diverse multi-sector and multi-level surveillance and prevention partners addressing the following:

1. opioid and stimulant use and misuse,
2. opioid and stimulant use disorder,
3. overdose
4. opioid and stimulant-related harms.
5. social determinants of health and health equity

The objectives of such partnerships are to 1) leverage knowledge and resources to increase capacity, support and increase reach of implementation strategies, 2) broaden the scope and diversity of evaluation activities related to the surveillance and prevention components, and 3) address the disparities in overdose and access to care through a health equity lens.

Below are required and encouraged collaborations with entities, organizations, and/or programs not funded by CDC. Please submit Letters of Support (LOS) or Memorandums of Understanding/Agreement (MOU/MOA) for any required collaborations. Additional requirements to document collaborations may be indicated below. Applicants must file the MOU

or MOA, as appropriate, name the file "MOUs/MOAs," and upload it as a PDF file at www.grants.gov.

Required collaborations are as follows:

- Surveillance partners
    - There are several required collaborations to fulfill surveillance requirements. Applicants must submit an LOS and demonstrate their ability to collaborate with the following key data partners to meet the NOFO surveillance requirements:
        - Evidence of direct support of and collaboration with the staffing unit collecting their rapid ED data by submitting an LOS from the staffing unit or unit supervisor describing support for the current NOFO and plans for spending the budgeted amount. Please label document "S2 Syndromic Staffing LOS" and upload it as a PDF.
        - When applicable, the state's hospital association or the entity responsible for collecting hospital discharge/billing data on ED visits and hospitalizations in their jurisdiction related to drug overdoses. Please label the document "S2 State Hospital Assoc LOS" and upload it as a PDF.
        - The agency responsible for overseeing/maintaining access to the data sources (i.e., syndromic surveillance or hospital discharge/billing). (If the recipient is the unit responsible for the data source, this must be written in the application). LOS must demonstrate the agencies' awareness of the data requested and CDC deliverable dates; they must also include statements agreeing to data access, analysis, dissemination, and information on previous collaborations using these or similar data. Please label the document "S2 ED Data Access LOS" and upload it as a PDF.
        - Medical examiner/coroner (ME/C) agencies collecting data on drug overdose deaths.
            - Applicants must submit an LOS from their state or territorial ME/C offices (if applicable). For applicants with medical examiners please label the document "Medical Examiner LOS" and for applicants with coroners please label the document "Coroner LOS."
            - If a state ME or coroner association does not exist, letters are requested from MEs or coroners who oversee at least 75% of the jurisdiction's population. ME/Cs will be asked to include estimates of their population served in their respective letters of support.
        - Vital statistics death registry program in the jurisdiction collecting data on drug overdose deaths. Please label the document "S3 Vital Statistics LOS" and upload as a PDF.
        - **If proposing activities for the biosurveillance strategy**, LOS must be provided from:
            - Laboratory testing partner (e.g., state public health laboratory) that is evidence of an agreement to perform the required activities. Please label the document "S4 Partner Testing Lab LOS" and upload as a PDF.

        - Partner hospitals: demonstrating that the hospitals identified will share a subset of specimens from patients presenting with overdose for definitive testing along with required data. Please label the document “S4 Partner Hospital LOS” (number if multiple hospitals are participating).

    - **If proposing activities for the data linkage strategy**, LOS from the agencies that will be sharing data as part of these data linkages. Each agency's LOS should include:
        - If not previously linked, evidence of performing proposed data linkage or details of the proposed data linkage.
        - Acknowledgment that necessary data sharing agreements are already in place or being established.
        - Evidence that proposed linkages can be performed within the first year of funding.
        - Evidence that proposed linkages can be completed within a year of the overdose data.
        - Please label each document (S5 Agency Data Linkage LOS) (number if multiple submissions).

- Public safety and first responders
    - Applicants must demonstrate engagement with public safety and/or first responders. Applicants must submit an LOS from a state-level public safety and/or first responder authority in their state. The LOS should demonstrate that the public safety and/or first responder authority supports the application, the roles outlined for all partners, and corresponding activities. Applicants should specify how proposed activities align with and complement existing efforts supported by the U.S. Department of Justice (DOJ) (e.g., COSSAP grants and demonstration projects), as applicable. Please label document “S7 Public Safety LOS” and upload as a PDF.

- State substance abuse services authority
    - Applicants must demonstrate coordination and engagement with the state substance abuse services authority and must submit an LOS. The LOS should show that the authority supports the application and agrees to regular meetings to support and coordinate activities. Applicants should specify how proposed strategies and activities align with or complement existing efforts supported by the Substance Abuse and Mental Health Services Administration (SAMHSA) without duplication. Please label document “S6 Substance Abuse SVC LOS” and upload as a PDF.

- Prescription drug monitoring program (PDMP)
    - Applicants must submit an LOS from the PDMP authority responsible for their jurisdiction. The LOS should show that the PDMP authority supports the application, agrees to regular meetings to support and coordinate activities, and facilitates proposed activities to enhance and maximize the PDMP. Applicants may provide other materials (e.g., MOUs, LOS from other entities) that

demonstrate collaborations that will strengthen the work in this area. Please label document “S6 PDMP LOS” and upload as a PDF.
    - Please note applicants who receive funding under the Harold Rogers Prescription Drug Monitoring Program from the Bureau of Justice Assistance (BJA) 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.

- Health system and clinical organization partners
    - To advance clinician/health system work, applicants must provide an LOS from the entity where the work is focused. For example, if the applicant proposes building and implementing a health system-wide clinical capacity to screen, diagnose, and support (or connect to) trauma-informed longitudinal care for OUD and StUD for adolescents and adults, it should provide an LOS from the health system(s). If the applicant is working in partnership with a collaborative of clinical partners, the applicant should include an LOS from each participating system, as well as other partner examples described elsewhere. Please label document “S6 Health System LOS” (number if multiple submissions).
    - The LOS must demonstrate the authority’s support, agreement to regular meetings, and explanation of how the state authority will facilitate the proposed activities.
    - Applicants may provide other materials (e.g., MOUs, LOS from other entities) that demonstrate collaborations that will strengthen the work in this area.

- Additional key partners and agencies
    - Applicants should provide an LOS for each identified key partner and agency needed to fulfill NOFO requirements. These can include other federal, state, or local government agencies, among other examples. 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 (Please label document “S6 Medicaid LOS”. If the applicant works in partnership with a particular health system or program (e.g., integrating and/or disseminating evidence-based opioid prescribing guidelines) the applicant should include a LOS from that system or program, see Health System above for naming convention. The LOS must demonstrate the authority’s support, agreement to regular meetings, and explanation of how the state authority will facilitate the proposed activities.

Recommended collaborations are as follows:

- The SAMHSA State Opioid Response Grant (TI-22-005)
    - The purpose of this program is to address the opioid overdose crisis by providing resources to states and territories for increasing access to FDA-approved medications for the treatment of opioid use disorder (MOUD), and for supporting the continuum of prevention, harm reduction, treatment, and recovery support services for opioid use disorder (OUD) and other concurrent substance use disorders. The SOR program also supports the continuum of care for stimulant

misuse and use disorders, including for cocaine and methamphetamine. The SOR program aims to help reduce unmet treatment needs and opioid-related overdose deaths across America.

- The HRSA Rural Communities Opioid Response Program (HRSA-22-061)
    - The Rural Communities Opioid Response Program (RCORP) is a multi-year initiative by the Health Resources and Services Administration (HRSA) aimed at reducing the morbidity and mortality of substance use disorders (SUDs), including opioid use disorder (OUD) in high-risk rural communities. RCORP-BHS will advance RCORP's overall goal by improving access to and quality of SUD and other behavioral health care services in rural communities. For the purposes of this NOFO, improving rural behavioral health care service delivery includes increasing access to and utilization of prevention, treatment, and recovery services to improve the care for those affected by behavioral health conditions, which may include substance use and mental health disorders.

- Comprehensive Opioid, Stimulant, and Substance Abuse Program (COSSAP)
    - The Comprehensive Opioid, Stimulant, and Substance Abuse Program (COSSAP), formerly the Comprehensive Opioid Abuse Program (COAP), was developed as part of the Comprehensive Addiction and Recovery Act (CARA) legislation. COSSAP's purpose is to provide financial and technical assistance to states, local government units, and tribal governments to develop, implement, or expand comprehensive efforts to identify, respond to, treat, and support those impacted by illicit opioids, stimulants, and other drugs.

- The BJA Harold Rogers PDMP Funding
    - The Harold Rogers Prescription Drug Monitoring Program (PDMP) enhances the capacity of regulatory and law enforcement agencies and public health officials to collect and analyze controlled substance prescription data and other scheduled chemical products through a centralized database administered by an authorized agency. This program assists state, local, and tribal efforts by helping improve and support PDMP efficiencies, measure performance, and effectiveness, and promote best practices.

- Additional key partners and agencies
    - Organizations that represent individuals with lived OUD and/StUD experience
    - Regardless of the strategies selected, applicants are strongly encouraged to describe other strategic partnerships and collaborations with organizations that will make this work more robust and more impactful or may have a role in achieving the outcomes and proposed activities in this funding opportunity (e.g., traditional and social media; non-government organizations; nonprofit agencies; public health and public safety communities; and the business community). Applicants are encouraged to provide materials (e.g., MOUs, and LOS from non-government organizations) that demonstrate these collaborations but are not required to do so.

For the optional and competitive surveillance strategies, DUAs or MOUs related to hospitals providing specimens for biosurveillance or agencies providing data sets to be linked will strengthen the application.

2. Target Populations

For the purposes of this cooperative agreement, "target populations" will be referred to as populations of focus. Populations of focus include:

1. Persons who have experienced an overdose or have a history of substance use disorder(s).
2. Persons experiencing incarceration or recent release from incarceration.
3. Persons experiencing homelessness.
4. Additionally, groups experiencing a disproportionate burden of substance use disorders and overdose may include but are not limited to people in certain socio-demographic groups (e.g., non-English speaking populations, tribal populations, rural communities, racial/ethnic minority groups, and sexual and gender minority groups), people experiencing certain social determinants of health (e.g., reduced economic stability; limited educational attainment; limited healthcare access, including those who have been historically underserved or are uninsured; limited access to substance use treatment; limited health literacy; or geographically underserved areas), and people experiencing certain social or physical health conditions, or experiences (e.g., a mental health condition, chronic pain, a disability, adverse childhood experiences, a history of suicidal ideation or suicide attempt).

a. Health Disparities

OD2A-S will focus on closing gaps in access to care and services, which represent critical approaches to reducing health inequities. Successful applicants are expected to submit a health disparity impact statement using local data to identify populations at the highest risk in their jurisdictions. Using the Data to Action Framework, recipients will be required to use surveillance and other data to propose interventions aimed at reducing health disparities within their communities.

iv. Funding Strategy

Per the statutory language under Section 311 of the PHS Act, PHSA § 311 (c)(1), and the SUPPORT Act, this funding opportunity is open to all state health departments (SHDs), including the District of Columbia, or their bona fide agents.

All eligible applicants will be awarded funding for both the surveillance and prevention components. Applicants may apply for optional and competitive strategies 4 and 5 within the surveillance component. There will be up to 20 recipients for optional strategy 4 (Biosurveillance) and up to 20 recipients for strategy 5 (Data Linkage).

Surveillance Component Funding Strategy

Recipients' surveillance funding will be based on the following criteria: 1) Surveillance infrastructure needs; 2) Frequency in submitting morbidity surveillance data (e.g., recipients electing monthly syndromic data submission will receive more funding than those electing annual discharge/billing data submissions.); 3) The number of unintentional and undetermined intent drug overdose deaths occurring among residents of the jurisdiction; 4) Participation in

optional projects described in Strategy 2; and 5) Participation in optional and competitive projects described in Strategies 4-5.

Prevention Component Funding Strategy
All recipients' prevention funding will be based upon the following criteria: 1) Their age-adjusted rate of drug overdose deaths in the state and 2) their overdose count in the state (See Appendix 9).

The anticipated funding amounts for the surveillance and prevention components are provided in Appendix 9 and SUDORS funding amounts are presented in Appendix 5. Applicants should prepare their budgets based on these amounts. **Please note** that recipients will be able to move funds between the surveillance and prevention components provided they are meeting their programmatic reporting requirements noted under Section 2a(iii) Strategies and Activities.

b. Evaluation and Performance Measurement

i. CDC Evaluation and Performance Strategy

The following table outlines the evaluation requirements—activities and reporting requirements—that applicants must address as part of their OD2A-S application. These requirements are described in greater detail below; applicants should refer to **Appendix 1 for data sharing information**. OD2A-S recipients are also encouraged to share evaluation findings and data with recipients of CDC's OD2A: LOCAL cooperative agreement to support local health department prevention implementation and evaluation capacity. In addition, recipients will be required to demonstrate how they have considered or factored in social determinants of health (SDOH), the needs of populations of focus and people with lived experience, and health equity in their program/evaluation planning and development. They will be asked to describe how they will develop relevant evaluations tailored to their populations of focus and how the findings will inform their work plan and relevant evaluations.

Evaluation Activity	**Emphasis on the Evaluation Activity**	**Reporting Frequency**	**Reporting Mechanism***
Revised evaluation and performance measurement plan	All evaluation requirements	Once, 6 months post-award	Evaluation and performance measurement plan template
Evaluation of all required prevention activities	Implementation of prevention activities	Annual	APR
Evaluation of recipient-selected optional prevention activities	Implementation of prevention activities	Annual	APR

Assessment of selected short-term outcomes for prevention strategies	Short-term outcomes	Annual	APR
	Short-term outcomes†	Annual/Semi-annual¶	Performance measures reporting
Assessment of intermediate outcomes for prevention strategies	Intermediate-term outcomes	Annual	APR
	Intermediate-term Outcomes†	Annual/Semi-Annual¶	Performance measures reporting
Targeted evaluation project focused on navigation activities	Implementation of the targeted evaluation project	Annual	APR
	Implementation of targeted evaluation project and evaluation of outcomes	Year 4 of the cooperative agreement	Products from the targeted evaluation project
Evaluation community of practice (CoP)	Implementation of prevention activities and evaluation of outcomes	Quarterly	CoP Calls and Webinars
Evaluation translational product	Implementation of prevention activities and/or assessment of outcomes	The final year of the cooperative agreement	Disseminatable product
Cross-site evaluation	Implementation of prevention activities and assessment of outcomes	Annually beginning in Year 3 of the cooperative agreement	Primary data collection through qualitative interviews, focus groups, surveys, and other mechanisms to be determined

*Recipients should expect to share all data and evaluation products with CDC, the translational products, and other products from the targeted evaluation project with other recipients.
†Some performance measures might address short-term outcomes.
¶Specific performance measures for required activities, such as naloxone distribution and linkage to care, will be prioritized for semi-annual reporting to inform CDC about these critical efforts in reducing overdose deaths. CDC will confirm the frequency of all performance measure reporting based on reporting needs and the feasibility of reporting more frequently than annually

1) Applicants must submit an initial Evaluation and Performance Measurement Plan as part of their NOFO application package that describes their approach to conducting and completing all

of the above-described evaluation requirements. Recipients will also be required to use a CDC-provided template to provide an updated Evaluation and Performance Measurement Plan 6 months post-award that provides additional details and refinement of their approach to conducting and completing all of the above-described evaluation requirements.

2) Recipients will be expected to evaluate **all** required interventions within each prevention strategy and use process and outcome evaluation findings to guide ongoing intervention development and refinement. Recipients will report on this requirement in the APR. Recipients' reporting should include progress in their evaluation of required activities, identify the short- and intermediate-term outcomes addressed for each required activity, and specify the indicators measured for each outcome. Additionally, recipients should also report on the progress of their evaluation of selected optional prevention activities, including identification of outcomes and indicators measured for each outcome.

3) Recipients will be required to report on a CDC-provided standard set of approximately 15 logic model-driven performance measures. Recipients will be required to report on these performance measures semi-annually or annually beginning in the second year of the cooperative agreement. Reporting frequency for performance measures will depend on reporting needs and the feasibility of reporting more frequently than annually. These standardized performance measures will be linked to and will address the prevention strategy outcomes and measures related to partnerships and health equity/social determinants of health more broadly. *Required activities*' (i.e., use of navigators, naloxone distribution, clinician/health system engagement, and expanded PDMP data sharing) performance measures will primarily address short-term outcomes associated with required activities and intermediate-term outcomes specified in the logic model. Some potential examples of required performance measures that recipients may be asked to report include: number of naloxone doses distributed, number of people utilizing OD2A-funded harm reduction services, number of available evidence-based OUD treatment programs, number of new health equity-focused overdose prevention interventions that address drivers of health disparities, number of partnerships mobilized to address overdose prevention health disparities and inequities, and number of prescribers who use a PDMP before prescribing opioids. Performance measures may be disaggregated by key characteristics, such as age, gender, race/ethnicity, setting, and county of residence. It is anticipated that some disaggregates will be required and others will be optional, and some optional disaggregates may become required later in the funding period. In addition, performance measure denominators will vary by available data source across settings (e.g., hospital and emergency medical services data, PDMPs, data from harm reduction partners, community surveys, public safety policies). Recipients will also be required to submit metadata (e.g., number and type of agencies contributing data, percent of service providers contributing data) to help assess data quality, data completeness and representativeness, and overall strengths and limitations of data shared with CDC. CDC will work with recipients to operationalize the performance measures and identify available and feasible data sources for the measures. CDC will develop specific reporting processes and templates and provide guidance on their function to facilitate and standardize data collection. CDC will provide more guidance and final measures upon award.

Recipients will use the award's first year to develop their data sharing agreements and identify reporting systems to facilitate data collection and reporting in year 2 of the funding period. In

addition to reporting on a required set of performance measures as described above, CDC may require additional performance measures to be reported or change the frequency of reporting throughout the notice of funding opportunity, given the complex and evolving nature of the drug overdose epidemic. Standardized performance measures will help CDC monitor the progress of all recipients over the five-year funding cycle and inform program guidance to collect outcome measures to monitor overdose prevention work.

4) Recipients will be required to complete an in-depth evaluation of navigation activities implemented during the cooperative agreement. This in-depth evaluation—called a targeted evaluation project (TEP)—is a program evaluation task that will provide a greater understanding of these navigation activities and will guide program improvement. Specifically, it will require an in-depth evaluation of navigation for linkage to care and linkage to harm reduction services. The TEP will provide recipients and CDC with a substantially greater understanding of facilitators and barriers to implementing navigation activities across settings with different types of navigators:

- Navigators can include peer navigators, certified peer recovery specialists, peer support specialists, case managers, patient navigators, community health workers, persons with lived experience, and other individuals who link PWUD to care and harm reduction resources.
- Navigators are individuals familiar with the local public health landscape and who work directly with individuals with OUD and/or StUD to ensure they have the tools to address barriers to seeking care and who support people accessing treatment and their retention (and reengagement if necessary) in SUD treatment and care, as well as support access to other services, such as harm reduction and social supports.
- CDC defines linkage using navigators as: 1) linkage to evidence-based treatment for substance use disorders- to include MOUD and other treatment (e.g., cognitive behavioral therapy [CBT], contingency management) and 2) linkage to harm reduction services.

The TEP will provide each recipient with an opportunity for in-depth investigation, learning, and sharing with local partners and the community of NOFO recipients; this shared understanding will help strengthen and tailor navigation activities within and across jurisdictions and inform progress on achieving the aim of establishing linkages for different populations of focus. CDC will review and provide feedback on proposed TEPs, including methods and final products. Throughout the cooperative agreement, recipients will be expected to share progress on developing and conducting TEPs within a community of practice (described below in evaluation requirement #5) to exchange lessons learned and guidance across jurisdictions. During the 4th year of the cooperative agreement, recipients will be required to share the resulting products from their targeted evaluation project with CDC and other recipients to promote inter-program learning (see Appendix 8 on Targeted Evaluation Project).

5) To promote sharing between jurisdictions and between CDC and funded recipients, recipients will participate in a community of practice (CoP) specifically focused on evaluating their overdose prevention activities. The CoP will meet quarterly, beginning the first year of the cooperative agreement.

6) By the end of the period of performance, all recipients will be required to create one

translational product related to the evaluation of prevention activities. Translational products can include but are not limited to detailed reports, training or technical assistance resources, case studies, or peer-reviewed publications. More information will be forthcoming about the focus of translational products and the types of acceptable formats.

7) Finally, recipients will be expected to participate in a CDC-sponsored cross-site evaluation by sharing data already collected (e.g., required performance measures) and/or participating in new data collection activities (e.g., qualitative interviews). Recipients will be expected to share data collected via a cross-site evaluation with CDC and/or its designee (e.g., contractor).

Data Management Plan

Applicants must submit a preliminary draft or outline of a Data Management Plan (DMP) with their application package. At a minimum, the DMP must describe the following:

1. The data to be collected or generated in the proposed project
2. The standards to be used for collected or generated data
3. The mechanisms for providing access to and sharing of the data (including provisions for the protection of privacy, confidentiality, security, intellectual property, or other rights)
4. The plans to share the data with CDC that meet CDC reporting and surveillance requirements
5. The use of data standards that ensure all released data have appropriate documentation that describes the method of collection, what the data represent, and potential limitations for use
6. The plans for archival and long-term data preservation or explaining why long-term preservation and access are not justified

Applicants are encouraged to include a DMP that is as complete as possible. **If funded, recipients will be required to submit a more detailed DMP within the first 6 months of award**, as described in the Reporting Section of this NOFO (see CDC DMP policy https://www.cdc.gov/grants/additional-requirements/ar-25.html.) CDC OMB-approved templates may be used (e.g., NCCDPHP template https://www.cdc.gov/chronicdisease/pdf/nofo/DMP-Template-508.docx). Other examples of DMPs may be found here: USGS, http://www.usgs.gov//products/data-and-tools/data-management/data-management-plans.

ii. Applicant Evaluation and Performance Measurement Plan

Applicants must provide an evaluation and performance measurement plan that demonstrates how the recipient will fulfill the requirements described in the CDC Evaluation and Performance Measurement and Project Description sections of this NOFO. At a minimum, the plan must describe:

- How the applicant will collect the performance measures, respond to the evaluation questions, and use evaluation findings for continuous program quality improvement.
- How key program partners will participate in the evaluation and performance measurement planning processes.

- Available data sources, feasibility of collecting appropriate evaluation and performance data, and other relevant data information (e.g., performance measures proposed by the applicant)
- Plans for updating the Data Management Plan (DMP) as new pertinent information becomes available. If applicable, throughout the lifecycle of the project. Updates to DMP should be provided in annual progress reports. The DMP should provide a description of the data that will be produced using these NOFO funds; access to data; data standards ensuring released data have documentation describing methods of collection, what the data represent, and data limitations; and archival and long-term data preservation plans. For more information about CDC's policy on the DMP, see https://www.cdc.gov/grants/additional-requirements/ar-25.html.

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

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

Recipients will be required to submit a more detailed Evaluation and Performance Measurement plan, including a DMP, if applicable, within the first 6 months of award, as described in the Reporting Section of this NOFO.

Applicants' overall evaluation strategy should be grounded in the CDC Evaluation Framework for Public Health, MMWR, September 18, 1999, Vol. 48 / No. RR-11. Applicants should also reference the Overdose Data to Action (OD2A) Evaluation Profiles for guidance on the types of evaluation questions, indicators, data sources, and data collection methods that can be used to evaluate various overdose prevention efforts.

The Evaluation and Performance Measurement Plan must be no longer than 20 pages. In concert with the requirements mentioned above, applicants must submit an **initial** Evaluation and Performance Measurement Plan as part of their NOFO application package that describes their approach to conducting and completing all of the above-described evaluation requirements in **section i**. Recipients will also be required to use a CDC-provided template to provide an updated Evaluation and Performance Measurement Plan 6 months post-award that provides additional details and refinement of their approach to conducting and completing all of the above-described evaluation requirements.

In addition to the above stated requirements, the Evaluation and Performance Measurement Plan must include the following:

- Describe the general approach to conducting evaluation over the period of performance.
- Describe the approach to considering the needs of populations of focus and people with lived experience during program/evaluation planning and development.
- Describe the process for identifying and deciding what aspect of their program they will evaluate.

- Describe how required and other selected interventions within each of the required prevention strategies will be evaluated and how process and outcome evaluation findings will guide ongoing intervention development and refinement.
- Define the associated short-term, intermediate-term, and long-term outcomes related to required and other selected interventions. Applicants may also add long-term outcomes that are relevant to state and local partners.
- Describe key evaluation questions.
- Describe how the evaluation will measure the impact of tailored activities on groups disproportionately affected by overdose.
- Describe how evaluation data will be used and disseminated to various partners, collaborators, and affected groups. Dissemination methods should vary depending on the audience.
- ***Approach for reporting performance measures***
    - For the proposed outcome measures described above, applicants should describe each of the following:
        - Any available baseline measures (including definitions for numerators and denominators used and the latest reporting year or timeframe).
        - Source(s) of data needed to calculate the measures (i.e., which programs or agencies "own" the data).
        - How the performance measures currently being used or would be used by the applicant.
        - How feasible it would be for the applicant to report on the measures and to do so every 6 months.
        - Any anticipated barriers to obtaining and calculating the proposed measures.
        - Any other comments or questions the applicant has about the proposed measures at this time.
    - Applicants are encouraged to list measures they would find useful in addressing logic model-driven outcomes and for required prevention activities. CDC may consider applicant-identified performance measures in the final set of standardized performance measures for this NOFO.
- ***Approach for creating targeted evaluation project***
    - CDC expects recipients to complete one TEP over the period of performance. Applicants should:
        - Describe the process for addressing navigation activities that will be evaluated through the TEP.
            - Navigators can include peer navigators, certified peer recovery specialists, peer support specialists, case managers, patient navigators, community health workers, persons with lived experience, and other individuals who link PWUD to care and harm reduction resources.
            - Navigators are individuals familiar with the local public health landscape and who work directly with individuals with OUD and/or StUD to ensure they have the tools to address barriers to

seeking care and who support people accessing treatment and supporting their retention (and reengagement if necessary) in SUD treatment and care, as well as support access to other services, such as harm reduction and social supports.
        - CDC defines linkage using navigators as: 1) linkage to evidence-based treatment for substance use disorders- to include MOUD and other treatment (e.g., cognitive behavioral therapy [CBT], contingency management) and 2) linkage to harm reduction services.

    - Provide a brief description of the proposed TEP, including:
        - Evaluation design and key evaluation questions
        - Methods, scale, and scope of the evaluation
        - Plan for conducting TEP, including approximate duration and timeline

- ***Approach for creating one translational product***
    - Describe the intent and plans to create a translational product that will relate to the evaluation of prevention activities by the end of the period of performance.
    - Describe the proposed type of product that will be created with the understanding that this can change over time (e.g., detailed report, training or technical assistance resource, case study, peer-reviewed publication).

Applicants must name this file "(<Jurisdiction_name>Evaluation Plan)" and upload it as a PDF file on www.grants.gov.

c. Organizational Capacity of Recipients to Implement the Approach

Applicants need to demonstrate the capacity to complete all activities proposed. "Organizational capacity" demonstrates the applicant's ability to successfully execute the funding opportunity 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. Applicant description should include:

- 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 at the state level, statewide, or at a systems level.
- Subject matter expertise to plan and implement strategies addressing opioid and stimulant use and misuse, stimulant use disorder, opioid use disorder, overdose, and opioid/stimulant-related harms.
- Established or newly built partnerships with health systems and other relevant partner organizations with demonstrated experience addressing opioid and stimulant use and misuse disorder, overdose, and opioid and stimulant-related harms or working with identified high-risk populations.

- Extensive knowledge and expertise in health equity and addressing disparities within identified populations of focus or communities that have been underserved, or working with organizations that serve high-risk populations and underserved communities.
- Ability to engage people who use drugs and people with lived experience in program planning and evaluation.
- Experience with evaluating programs at the state level and/or statewide.
- Ability to access at least 80% of ED visits within their jurisdiction by September 2023 and share ED overdose indicator data with CDC on a monthly or annual basis using CDC guidance.
- Capacity to collect ME/C reports, including toxicology and death certificate data on all UUDO deaths, in compliance with CDC guidelines and timelines.
- Capacity to use the NVDRS web-based data entry system to enter SUDORS data.
- Experience in disseminating morbidity and mortality data to support public health action.
- Capacity to use overdose data to support NOFO interventions.
- Capacity and expertise in surveillance and program implementation, program and performance management, evaluation, policy, and management of travel and program requirements. Applicants should identify key staff. Please document these capabilities with the résumés of key staff. Please label uploaded resumes with appropriate functional role for the project. For example, “Surveillance PI CV” or “Evaluation Lead CV.” Upload required CVs/resumes as PDFs and upload to grants.gov.
- Capability to manage the required award, including the ability to manage the required procurement efforts, including the ability to write and award contracts in accordance with applicable grant regulations. Applicants should identify key staff. Please document these capabilities with the résumés of key staff. Please label uploaded resumes with appropriate functional role for the project. For example, “Surveillance PI CV” or “Evaluation Lead CV.” Upload required CVs/resumes as PDFs and upload to grants.gov.

Each applicant must also include the appropriate amount of staffing needed to complete their workplan activities each budget period. At a minimum key staff must include:

- A PI for surveillance to oversee all surveillance strategies (i.e., surveillance infrastructure, DOSE, SUDORS, biosurveillance, and data linkage).
- A PI for prevention to oversee the implementation of the required intervention strategies. Please label CV/resume of the PI for Prevention Component as “PI Prevention” and upload as a PDF to grants.gov.
- SUDORS project manager/lead. Please label CV/resume of the SUDORS project manager as “SUDORS Lead” and upload as a PDF to grants.gov.
- Program evaluator: one FTE OR contracted program evaluator (e.g., contract with academic institution) with training in and experience applying: 1) evaluation theory, concepts, standards, methods, and tools to assess the effectiveness and efficiency of programs, policies, and organizations; 2) methods, techniques, and tools used to analyze program, organizational, and mission performance; 3) performance measurement principles and methods to evaluate program or organizational performance using metrics and outcomes; 4) principles, methods, and tools of quality assurance, quality control, and reliability; 5) concepts, practices, and techniques used to effectively engage with partners internal to the applicant’s organization as well as external partners; 6) principles of health

equity relevant to program evaluation; and 7) methods for disseminating findings from program evaluations through peer-reviewed and other publications, conference abstracts, and clear communication materials targeted appropriately to a variety of partners. Please label CV/resume as "Evaluation Lead" and upload as a PDF to grants.gov.

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 applying for the Optional and Competitive Strategies (Biosurveillance and Data Linkage) should submit separate narratives and workplans for each strategy. Please label the document "S4 Biosurveillance" and "S5 Data Linkage" respectively.

Applicants should organize the work plan according to the strategies and interventions outlined in the Project Narrative (strategies and activities section).

The work plan, at a minimum, should:

1. Describe major strategies and interventions to be conducted to meet the program outcomes for each of the chosen priority strategies.
2. Describe interventions 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.
3. Provide a timeline that identifies key activities for each intervention and assigns approximate dates for inception and completion.
4. Additionally, for each intervention, applicants should describe the population of focus and how the selection of this population addresses health equity or disproportionately affected populations. Applicants should provide a disparity impact statement to address how planned interventions will reach specific populations of focus, including underserved communities and/or disproportionally impacted populations.
5. Describe the partnerships that will be utilized to assist in carrying out the proposed activities and how partners were engaged in developing this intervention.
6. Describe possible barriers to or facilitators for reaching each outcome.
7. Describe the data source types that will be used to inform each strategy/intervention.
8. Explain administration and assessment processes to ensure successful implementation and quality assurance.

Recipients will be provided a sample workplan template to assist in the development of their workplan. By December 7, 2023, all recipients will be required to have entered their workplan into the NCIPC Partner's Portal, an interactive reporting tool that will be used by the recipient and CDC staff to manage workplans throughout the period of performance. Recipients will need access to CDC's Secure Access Management System (SAMS) to use the tool. Recipients will work with CDC staff to gain access to the system.

e. CDC Monitoring and Accountability Approach

Monitoring activities include routine and ongoing communication between CDC and recipients, site visits, and recipient 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 recipient progress in achieving the desired outcomes.
- Ensuring the adequacy of recipient 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 deemed necessary to monitor the award:

- Ensuring that work plans are feasible based on the budget and consistent with the intent of the award.
- Ensuring that recipients are performing at a sufficient level to achieve outcomes within stated timeframes.
- Working with recipients 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.

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 recipients.

At the start of the cooperative agreement, recipients will receive a technical review of their workplan with recommendations and suggested improvements. After review of the first annual performance report, if the recipient is not conducting required activities or not meeting process or outcome standards, CDC will provide or facilitate technical/capacity-building assistance for program improvement. Consistent with applicable grant regulations and other relevant provisions, recipients performing at less than appropriate levels to achieve program objectives within stated timeframes will be placed on a time-phased Performance Improvement Plan (PIP) developed by the CDC Project Officer/Science Officer in conjunction with OGS and OGC and in collaboration with the recipient. The PIP is a comprehensive tool used to assist recipients in improving program performance by identifying factors contributing to less than sufficient performance and developing specific action steps to address areas in need of improvement. If placed on a PIP, the recipient will have an opportunity to document a plan of action to improve the performance of program activities. In subsequent budget periods, funding may be affected based on performance.

f. CDC Program Support to Recipients

CDC will provide substantial involvement beyond regular performance and financial monitoring during the period of performance. Substantial involvement means that recipients can expect federal programmatic partnership in carrying out the effort under the award. CDC's Division of Overdose Prevention (DOP), with support from the DOP Technical Assistance Center (TAC), will work in partnership with recipients to ensure the success of the cooperative agreement by:

- Assisting in advancing program activities to achieve project outcomes;
- Providing technical assistance on data management plans;
- Collaborating with recipients to develop evaluation plans that align with CDC evaluation activities;
- Providing technical assistance on the recipient's Evaluation and Performance Measurement Plan;
- Providing technical assistance on recipient's Targeted Evaluation Project;
- Providing technical assistance to define and operationalize performance measures;
- Facilitating the sharing of information among recipients;
- Participating in relevant meetings, committees, conference calls, and working groups related to the cooperative agreement requirements;
- Coordinating communication and program linkages with other CDC programs and Federal agencies, such as the Centers for Medicare and Medicaid Services (CMS), Food and Drug Administration (FDA), the National Institutes of Health (NIH), Substance Abuse and Mental Health Services Administration (SAMHSA), the Department of Justice (DOJ), and the HHS Office of the National Coordinator for Health Information Technology (ONC);
- Translating and disseminating lessons learned and best practices through publications, reports, technical packages, meetings, and other means to expand the evidence base; and
- Identifying and awarding a partner organization to expand and strengthen recipients' capacity to implement surveillance and prevention activities through jurisdiction-level staffing support.

Additionally, technical assistance around the funding announcement's guiding principles (see Logic Model) will be available to ensure that all recipients are able to:

- Collect data around community and demographic characteristics, including race and ethnicity, and conduct analyses that consider social determinants of health and use a health equity lens;
- Use data to inform and tailor prevention programs, with emphasis on reaching groups disproportionately affected by the overdose epidemic; and
- Ensure implementation of culturally relevant interventions and equitable delivery of prevention services.

The TAC will leverage various modes of technical assistance, including group training, webinars, communities of practice, individualized one-on-one assistance, peer-to-peer interactions, and asynchronous learning to increase recipient capacity to implement evidence-based interventions and successfully execute NOFO strategies. DOP staff and DOP TAC subject matter experts will work with the recipients to provide scientific subject matter expertise and resources by:

- Providing cross-site and recipient-specific surveillance technical assistance, such as providing tools to identify nonfatal overdoses using standardized discharge diagnosis coding (i.e., ICD-10-CM) and unstandardized free text (e.g., chief complaint);

- Providing cross-site and recipient-specific surveillance technical assistance, such as providing tools to identify fatal drug poisonings using ICD-10 cause of death codes and free text from the medical examiner and coroner reports;
- Providing guidance on SUDORS data abstraction, use of necessary data sharing platforms (e.g., NVDRS, NSSP ESSENCE), and CDC processes to collect required nonfatal data;
- Supporting the use of CDC's nonfatal overdose case definitions by providing recipients computer programming code such as SAS, R, and ESSENCE to implement the cases definitions if resources are available;
- Providing ongoing data quality reviews and feedback on required nonfatal and fatal overdose data submissions;
- Providing guidance and technical assistance for Biosurveillance and Data Linkage projects to jurisdictions funded through the respective optional and competitive surveillance strategies;
- Coordinating health information technology and prescription drug monitoring program (PDMP) communication, program linkages, and technical assistance (TA) with other CDC programs, TA providers, and federal agencies, such as the Bureau of Justice Assistance (BJA), the HHS Office of the National Coordinator for Health Information Technology (ONC), and the PDMP Training and Technical Assistance Center (TTAC); and
- Providing guidance on using data to inform jurisdiction-level populations of focus, with a health equity lens, selecting evidence-based overdose prevention interventions, and implementing best practices across all four prevention strategies.

B. Award Information

1. Funding Instrument Type:
CA (Cooperative Agreement)
CDC's substantial involvement in this program appears in the CDC Program Support to Recipients Section.

2. Award Mechanism:
U17

3. Fiscal Year:
2023

Estimated Total Funding:
$995,000,000

4. Approximate Total Fiscal Year Funding:
$199,000,000
This amount is subject to the availability of funds.

5. Approximate Period of Performance Funding:
$995,000,000

6. Total Period of Performance Length:

5 year(s)

7. Expected Number of Awards:
51

8. Approximate Average Award:

$3,753,774
Per Budget Period

9. Award Ceiling:
$7,000,000
Per Budget Period

10. Award Floor:
$1,400,000
Per Budget Period

11. Estimated Award Date:
August 01, 2023
Throughout the project period, CDC will continue the award based on the availability of funds, the evidence of satisfactory progress by the recipient (as documented in required reports), and the determination that continued funding is in the best interest of the federal government. 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 period of performance 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 available through this NOFO.

If you are successful and receive a Notice of Award, in accepting the award, you agree that the award and any activities thereunder are subject to all provisions of 45 CFR Part 75, currently in effect or implemented during the period of the award, other Department regulations and policies in effect at the time of the award, and applicable statutory provisions.

C. Eligibility Information

1. Eligible Applicants

Eligibility Category:
00 (State governments)

25 (Others (see text field entitled "Additional Information on Eligibility" for clarification))

Additional Eligibility Category:

Government Organizations:

State (includes the District of Columbia)

2. Additional Information on Eligibility

Per the statutory language under Section 311 of the PHS Act, PHSA § 311 (c)(1) and the SUPPORT Act this funding opportunity is open to all state health departments (SHDs), including the District of Columbia, or their bona fide agents. CDC is concurrently offering an opportunity tailored to local jurisdictions and territories called Overdose Data to Action: Limiting Overdose through Collaborative Actions in Localities (OD2A: LOCAL; CDC-RFA-CE-23-0003) and also provides funding to tribes or tribal-serving organizations via the cooperative agreement " Strengthening Public Health Systems and Services in Indian Country (CDC-RFA-TO-23-0001)," thereby meeting statutory requirements.

Applicants interested in applying for the optional and competitive strategies 4 & 5 must indicate which strategy(ies) they are applying for in the Project Abstract. If they do not specify this, CDC will assume they are not interested in the optional and competitive strategies.

3. Justification for Less than Maximum Competition

N/A

4. Cost Sharing or Matching

Cost Sharing / Matching Requirement:
No
Cost sharing or matching funds are not required for this program. Although no statutory matching requirement for this NOFO 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 CDC 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, National 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

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.

PLEASE NOTE: Effective April 4, 2022, applicants must have a Unique Entity Identifier (UEI) at the time of application submission (SF-424, field 8c). The UEI is generated as part of SAM.gov registration. Current SAM.gov registrants have already been assigned their UEI and can view it in SAM.gov and Grants.gov. Additional information is available on the GSA website, SAM.gov, and Grants.gov- Finding the UEI.

a. Unique Entity Identifier (UEI):

All applicant organizations must obtain a Unique Entity Identifier (UEI) number by registering in SAM.gov prior to submitting an application. A UEI number is a unique twelve-digit identification number assigned to the registering organization.

If funds are awarded to an applicant organization that includes sub-recipients, those sub-recipients must provide their UEI 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 a recipient. All applicant organizations must register with SAM, and will be assigned a SAM number and a Unique Entity Identifier (UEI). 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 can require 10 or more business days, and registration must be renewed annually. Additional information about registration procedures may be found at SAM.gov and the SAM.gov Knowledge Base.

c. Grants.gov: The first step in submitting an application online is registering your organization atwww.grants.gov, the official HHS E-grant Web site. Registration information is located at the "Applicant Registration" option atwww.grants.gov.

All applicant organizations must register at www.grants.gov. The one-time registration process usually takes not more

than five days to complete. Applicants should start the registration process as early as possible.

Step	System	Requirements	Duration	Follow Up
1	System for Award Management (SAM)	1. Go to SAM.gov and designate an E-Biz POC (You will need to have an active SAM account before you can register on grants.gov). The UEI is generated as part of your registration.	3-5 Business Days but up to 2 weeks and must be renewed once a year	For SAM Customer Service Contact https://fsd.gov/ fsd-gov/

				home.do Calls: 866-606-8220
2	Grants.gov	1. Set up an individual account in Grants.gov using organization's new UEI number to become an Authorized Organization Representative (AOR) 2. Once the account is set up the E-BIZ POC will be notified via email 3. Log into grants.gov using the password the E-BIZ POC received and create new password 4. This authorizes the AOR to submit applications on behalf of the organization	It takes one day (after you enter the EBiz POC name and EBiz POC email in SAM) to receive a UEI (SAM) which will allow you to register with Grants.gov and apply for federal funding.	Register early! Applicants can register within minutes.

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.

4. Submission Dates and Times

If the application is not submitted by the deadline published in the NOFO, it will not be processed. Office of Grants Services (OGS) 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 OGS.

a. Letter of Intent Deadline (must be emailed)

Due Date for Letter Of Intent 03/27/2023

03/27/2023
The purpose of an LOI is to allow CDC program staff to estimate the number of and plan for the review of submitted applications. An LOI is requested and encouraged as part of the application for this NOFO. In addition, applicants eligible for optional and competitive Surveillance Strategies 4 and 5, who intend to apply for these strategies, should indicate their intention in their LOI (see Strategies and Activities section for additional guidance).
LOI must be sent via email to:

Overdose Data to Action in States Mailbox od2a-states@cdc.gov
Please include the following information in your Letter of Intent:

- Descriptive title of proposed project
- Number and title of this NOFO
- Indicate intent to apply to optional and competitive Surveillance Strategies 4 and 5

b. Application Deadline

Due Date for Applications 05/08/2023

05/08/2023
11:59 pm U.S. Eastern 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.

Due Date for Informational Conference Call
Overdose Data to Action in States Informational Call

March 16, 2023, 3:00 p.m. – 5:00 p.m. EST.

Use the link below to join the webinar:

https://us02web.zoom.us/j/82995126349?pwd=QnNMNS9nN1NxM2JDMWxyU3pJL0RzQT09

Passcode: 064355

Or One tap mobile :

US: +13017158592,,82995126349#,,,,*064355# or +13092053325,,82995126349#,,,,*064355#

Or Telephone:

Dial (for higher quality, dial a number based on your current location):

US: +1 301 715 8592 or +1 309 205 3325 or +1 312 626 6799 or +1 646 931 3860 or +1 929 205 6099 or +1 305 224 1968 or +1 669 900 6833 or +1 689 278 1000 or +1 719 359 4580 or +1 253 205 0468 or +1 253 215 8782 or +1 346 248 7799 or +1 360 209 5623 or +1 386 347 5053 or +1 507 473 4847 or +1 564 217 2000 or +1 669 444 9171

Webinar ID: 829 9512 6349

Passcode: 064355

International numbers available: https://us02web.zoom.us/u/ket1wbuwAz

This two-hour call will provide a comprehensive overview of all the NOFO strategies. Attendees will learn about eligibility requirements, the surveillance and prevention components, and the application and selection process for required and optional competitive strategies. Throughout the session, participants will have the opportunity to ask questions. All potential applicants are encouraged to attend this call. A recording will be posted here following the webinar.

5. Pre-Award Assessments

Risk Assessment Questionnaire Requirement

CDC is required to conduct pre-award risk assessments to determine the risk an applicant poses to meeting federal programmatic and administrative requirements by taking into account issues such as financial instability, insufficient management systems, non-compliance with award conditions, the charging of unallowable costs, and inexperience. The risk assessment will include an evaluation of the applicant's CDC Risk Questionnaire, located at https://www.cdc.gov/grants/documents/PPMR-G-CDC-Risk-Questionnaire.pdf, as well as a review of the applicant's history in all available systems; including OMB-designated repositories of government-wide eligibility and financial integrity systems (see 45 CFR 75.205(a)), and other sources of historical information. These systems include, but are not limited to: FAPIIS (https://www.fapiis.gov/), including past performance on federal contracts as per Duncan Hunter National Defense Authorization Act of 2009; Do Not Pay list; and System for Award Management (SAM) exclusions.

CDC requires all applicants to complete the Risk Questionnaire, OMB Control Number 0920-1132 annually. This questionnaire, which is located at https://www.cdc.gov/grants/documents/PPMR-G-CDC-Risk-Questionnaire.pdf, along with supporting documentation must be submitted with your application by the closing date of the Notice of Funding Opportunity Announcement. If your organization has completed CDC's Risk Questionnaire within the past 12 months of the closing date of this NOFO, then you must submit a copy of that questionnaire, or submit a letter signed by the authorized organization representative to include the original submission date, organization's EIN and UEI.

When uploading supporting documentation for the Risk Questionnaire into this application package, clearly label the documents for easy identification of the type of documentation. For example, a copy of Procurement policy submitted in response to the questionnaire may be labeled using the following format: Risk Questionnaire Supporting Documents _ Procurement Policy.

Duplication of Efforts

Applicants are responsible for reporting if this application will result in programmatic, budgetary, or commitment overlap with another application or award (i.e. grant, cooperative agreement, or contract) submitted to another funding source in the same fiscal year. Programmatic overlap occurs when (1) substantially the same project is proposed in more than one application or is submitted to two or more funding sources for review and funding consideration or (2) a specific objective and the project design for accomplishing the objective are the same or closely related in two or more applications or awards, regardless of the funding source. Budgetary overlap occurs when duplicate or equivalent budgetary items (e.g., equipment, salaries) are requested in an application but already are provided by another source. Commitment overlap occurs when an individual's time commitment exceeds 100 percent, whether or not salary support is requested in the application. Overlap, whether programmatic, budgetary, or commitment of an individual's effort greater than 100 percent, is not permitted. Any overlap will be resolved by the CDC with the applicant and the PD/PI prior to award.

Report Submission: The applicant must upload the report in Grants.gov under “Other Attachment Forms.” The document should be labeled: "Report on Programmatic, Budgetary, and Commitment Overlap.”

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

Is a LOI:
Recommended but not Required
The purpose of an LOI is to allow CDC program staff to estimate the number of and plan for the review of submitted applications. An LOI is requested and encouraged as part of the application for this NOFO. In addition, applicants eligible for optional and competitive Surveillance Strategies 4 and 5, who intend to apply for these strategies, should indicate their intention in their LOI (see Strategies and Activities section for additional guidance).
LOI must be sent via email to:
Overdose Data to Action in States Mailbox: od2a-states@cdc.gov
Please include the following information in your Letter of Intent:

- Descriptive title of proposed project
- Number and title of this NOFO
- Indicate intent to apply to optional and competitive Surveillance Strategies 4 and 5

8. Table of Contents

(There is no page limit. The table of contents is not included in the project narrative page 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

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

Multi-component NOFOs may have a maximum of 15 pages for the “base” (subsections of the Project Description that the components share with each other, which may include target population, inclusion, collaboration, etc.); and up to 4 additional pages per component for

Project Narrative subsections that are specific to each component.

Text should be single spaced, 12 point font, 1-inch margins, and number all pages. Page limits include work plan; content beyond specified limits may not be reviewed.

Applicants should use the federal plain language guidelines and Clear Communication Index to respond to this Notice of Funding Opportunity Announcement. Note that recipients should also use these tools when creating public communication materials supported by this NOFO. Failure to follow the guidance and format may negatively impact scoring of the application.

Applicants applying for the Optional and Competitive Strategies are permitted an additional 4 pages per optional strategy (i.e., Biosurveillance and/or Data Linkage).

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 period of performance. 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 period of performance 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 period of performance. (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 address the Collaboration requirements as described in the CDC Project Description.

2. Target Populations and Health Disparities

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. The applicants must also address how they will include specific populations that can benefit from the program that is described in the Approach section. Applicants must address the Target Populations and Health Disparities requirements as described in the CDC Project Description.

c. Applicant Evaluation and Performance Measurement Plan

Applicants must provide an evaluation and performance measurement plan that demonstrates how the recipient will fulfill the requirements described in the CDC Evaluation and Performance Measurement and Project Description sections of this NOFO. At a minimum, the plan must describe:

- How applicant will collect the performance measures, respond to the evaluation questions, and use evaluation findings for continuous program quality improvement. The Paperwork Reduction Act of 1995 (PRA): Applicants are advised that any activities involving information collections (e.g., surveys, questionnaires, applications, audits, data requests, reporting, recordkeeping and disclosure requirements) from 10 or more individuals or non-Federal entities, including State and local governmental agencies, and funded or sponsored by the Federal Government are subject to review and approval by the Office of Management and Budget. For further information about CDC's requirements under PRA see https://www.cdc.gov/od/science/integrity/reducePublicBurden/.
- How key program partners will participate in the evaluation and performance measurement planning processes.
- Available data sources, feasibility of collecting appropriate evaluation and performance data, data management plan (DMP), and other relevant data information (e.g., performance measures proposed by the applicant).

Where the applicant chooses to, or is expected to, take on specific evaluation studies, they should be directed to:

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

Recipients will be required to submit a more detailed Evaluation and Performance Measurement plan (including the DMP elements) within the first 6 months of award, as described in the Reporting Section of this NOFO.

d. Organizational Capacity of Applicants to Implement the Approach

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

11. Work Plan

(Included in the Project Narrative's 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 recipient plans to carry out achieving the period of performance outcomes, strategies and activities, evaluation and performance measurement.

Applicants applying for the Optional and Competitive Strategies (Biosurveillance and Data Linkage) should submit separate documents (narratives, workplans, and budgets) for each strategy. Documents should be labeled correctly to ensure they are evaluated by reviewers. All documents related to Biosurveillance should be labeled as "S4 Biosurveillance XX," for example, "S4 Biosurveillance Budget." Similarly, documents related to the Data Linkage strategy should be labelled "S5 Data Linkage XX," for example, "S5 Data Linkage Budget." Labelling instructions have been included in the relevant sections (Workplan, Project Narrative, Collaborations and Letters of Support, and Budget Narrative) for each strategy.

12. Budget Narrative

Applicants must submit an itemized budget narrative. 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 could include the cost of collecting, managing, sharing and preserving data.

Indirect costs on grants awarded to foreign organizations and foreign public entities and performed fully outside of the territorial limits of the U.S. may be paid to support the costs of compliance with federal requirements at a fixed rate of eight percent of MTDC exclusive of tuition and related fees, direct expenditures for equipment, and subawards in excess of $25,000. Negotiated indirect costs may be paid to the American University, Beirut, and the World Health Organization.

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 NOFO 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 Marianna 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 NOFO. Proposed activities must be included in the budget narrative and must indicate which standards will be addressed.

Vital records data, including births and deaths, are used to inform public health program and policy decisions. If applicable and consistent with the cited statutory authority for this NOFO, applicant entities are encouraged to collaborate with and support their jurisdiction's vital records office (VRO) to improve vital records data timeliness, quality and access, and to advance public health goals. Recipients may, for example, use funds to support efforts to build VRO capacity through partnerships; provide technical and/or financial assistance to improve vital records timeliness, quality or access; or support vital records improvement efforts, as approved by CDC.

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 Recipients under such a plan. Applicants must name this file "Indirect Cost Rate" and upload it at www.grants.gov.

Applicants will be provided a recommended funding amount for surveillance and prevention (see Appendix 9). Recipients will have the ability to move funds between the surveillance component and prevention component, but they are required to detail their funding levels for Strategy 1-3.

Applicant budgets should include travel for a minimum of three to four staff, including both surveillance and prevention staff, to attend a two-day recipient meeting at CDC's National Center for Injury Prevention and Control in Atlanta, GA, during the first year of the project. All recipients must attend this meeting. For the remaining years of the period of performance, the budget should include annual reverse site visits for a minimum of two program staff to visit Atlanta and meet with CDC staff.

The budget narrative must also meet the following requirements:

Strategy 1: Surveillance Infrastructure: Specify how funding will be used to build and sustain the necessary infrastructure to complete required OD2A-S surveillance activities. Funding must not duplicate or overlap with resources provided under other federal funding sources or CDC mechanisms and must not exceed $250,000 dedicated to surveillance infrastructure.

Strategy 2: Morbidity Surveillance: Please see Appendix 2: Checklist for Surveillance

Component to determine the surveillance budget. The budget narrative must reflect proposed activities and demonstrate a feasible and appropriate funding plan to meet the requirements for morbidity activities.

Strategy 3: Mortality Surveillance: Please see Appendix 2: Checklist for Surveillance Component to determine the surveillance budget. The budget narrative must reflect proposed activities and demonstrate a feasible and appropriate funding plan to meet the requirements for mortality activities.

1. Clearly indicate in the budget the amount of funding allocated to support enhanced toxicological testing of opioid and stimulant overdose deaths by their medical examiner and coroner community (see testing guidance in appendix 4 and budget guidance in appendix 5) and provide an itemized list of activities.
2. The funding can be provided directly to forensic toxicology labs supporting medical examiners and coroners or directly to medical examiners and coroners. If allocated to forensic laboratories, the budget narrative should explain how the funding will be used and how it will directly impact the work of medical examiners and coroners.

Strategy 4: Biosurveillance (optional and competitive): Budget narrative must reflect proposed activities and demonstrate a feasible and appropriate funding plan to meet the requirements for Biosurveillance activities. Applicants who successfully compete for this strategy will receive an additional $350,000 in their award. The Biosurveillance budget narrative should be submitted separately. Applicants should label the document "S4 Biosurveillance Budget" and upload as a PDF.

Strategy 5: Data Linkages (optional and competitive): Budget narrative must reflect proposed activities and demonstrate feasible and appropriate funding to meet the requirements for data linkages activities. Applicants who successfully compete for this strategy will receive an additional $200,000 in their award. The Data Linkage budget narrative should be submitted separately. Applicants should label the document "S5 Data Linkage Budget" and upload as a PDF.

Strategy 6: Clinician/Health System Engagement and Health IT/PDMP Enhancement: Budget narrative must reflect proposed activities and demonstrate a feasible and appropriate funding plan to meet the requirements for the required interventions. A recipient may spend up to 20% of its overall prevention budget on Health IT/PDMP Enhancement activities. If a recipient's PDMP system meets the requirements of a qualified PDMP with open standards and open architecture in alignment 45 CFR part 170, Subpart B: Standards and Implementation Specifications for Health Information Technology, then a recipient may spend up to 30% of its overall prevention budget on Health IT/PDMP Enhancement activities. Requests to spend over these percentages will be handled on a case-by-case basis in discussion with CDC.

Strategies 7-9: The budget narrative must reflect proposed activities and demonstrate feasible and appropriate funding to meet the requirements for the required interventions.

13. Pilot Program for Enhancement of Employee Whistleblowers 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 Code of Federal Regulations

(CFR) section 3.908 to the award and requires that recipients 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.

13a. Funds Tracking

Proper fiscal oversight is critical to maintaining public trust in the stewardship of federal funds. Effective October 1, 2013, a new HHS policy on subaccounts requires the CDC to set up payment subaccounts within the Payment Management System (PMS) for all new grant awards. Funds awarded in support of approved activities and drawdown instructions will be identified on the Notice of Award in a newly established PMS subaccount (P subaccount). Recipients will be required to draw down funds from award-specific accounts in the PMS. Ultimately, the subaccounts will provide recipients and CDC a more detailed and precise understanding of financial transactions. The successful applicant will be required to track funds by P-accounts/sub accounts for each project/cooperative agreement awarded.

Applicants are encouraged to demonstrate a record of fiscal responsibility and the ability to provide sufficient and effective oversight. Financial management systems must meet the requirements as described 45 CFR 75 which include, but are not limited to, the following:

- Records that identify adequately the source and application of funds for federally-funded activities.
- Effective control over, and accountability for, all funds, property, and other assets.
- Comparison of expenditures with budget amounts for each Federal award.
- Written procedures to implement payment requirements.
- Written procedures for determining cost allowability.
- Written procedures for financial reporting and monitoring.

13b. Copyright Interests Provisions

This provision is intended to ensure that the public has access to the results and accomplishments of public health activities funded by CDC. Pursuant to applicable grant regulations and CDC's Public Access Policy, Recipient agrees to submit into the National Institutes of Health (NIH) Manuscript Submission (NIHMS) system an electronic version of the final, peer-reviewed manuscript of any such work developed under this award upon acceptance for publication, to be made publicly available no later than 12 months after the official date of publication. Also at the time of submission, Recipient and/or the Recipient's submitting author must specify the date the final manuscript will be publicly accessible through PubMed Central (PMC). Recipient and/or Recipient's submitting author must also post the manuscript through PMC within twelve (12) months of the publisher's official date of final publication; however the author is strongly encouraged to make the subject manuscript available as soon as possible. The recipient must obtain prior approval from the CDC for any exception to this provision.

The author's final, peer-reviewed manuscript is defined as the final version accepted for journal publication, and includes all modifications from the publishing peer review process, and all graphics and supplemental material associated with the article. Recipient and its submitting authors working under this award are responsible for ensuring that any publishing or copyright agreements concerning submitted articles reserve adequate right to fully comply with this

provision and the license reserved by CDC. The manuscript will be hosted in both PMC and the CDC Stacks institutional repository system. In progress reports for this award, recipient must identify publications subject to the CDC Public Access Policy by using the applicable NIHMS identification number for up to three (3) months after the publication date and the PubMed Central identification number (PMCID) thereafter.

13c. Data Management Plan

As identified in the Evaluation and Performance Measurement section, applications involving data collection or generation must include a Data Management Plan (DMP) as part of their evaluation and performance measurement plan unless CDC has stated that CDC will take on the responsibility of creating the DMP. The DMP describes plans for assurance of the quality of the public health data through the data's lifecycle and plans to deposit the data in a repository to preserve and to make the data accessible in a timely manner. See web link for additional information: https://www.cdc.gov/grants/additional-requirements/ar-25.html.

14. Funding Restrictions

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

- Recipients may not use funds for research.
- Recipients may not use funds for clinical care except as allowed by law.
- Recipients may use funds only for reasonable program purposes, including personnel, travel, supplies, and services.
- Generally, recipients 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 generally is not allowed, unless the CDC provides written approval to the recipient.
- 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 Additional Requirement (AR) 12 for detailed guidance on this prohibition andadditional guidance on lobbying for CDC recipients.
- 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.

The purchase of naloxone is a restricted activity unless otherwise noted by CDC in a Notice of Award or Grant Note.

In addition, funding cannot be used to directly fund or expand the direct provision of substance use disorder treatment. Such activities are outside the scope of this NOFO. Funding must also

not duplicate or overlap with resources provided under other federal funding sources or CDC mechanisms, including – but not limited to - Epidemiology and Laboratory Capacity for Prevention and Control of Emerging Infectious Diseases (ELC), Data Modernization Initiative (DMI), and efforts to strengthen the overall U.S. public health infrastructure, workforce, and data systems (i.e., CDC-RFA-OE22-2203).
Additionally, program funds cannot be used for certain strategy activities, including but not limited to the following examples (see below). As part of the technical process, CDC will review all recipients' workplans, and activities deemed outside the scope of this cooperative agreement will not be allowed.

Surveillance Unallowable Activities

1. Funding for data collection or data analysis through Behavioral Risk Factor Surveillance System (BRFSS) or Youth Risk Behavior Surveillance System (YRBS) surveys.
2. Funding for neonatal abstinence syndrome (NAS) surveillance, or Hep C/HIV surveillance.
3. Funding for wastewater/sewage testing and drug testing for deaths due to motor vehicle crashes.

Prevention Unallowable Activities

- **Clinician/Health System Engagement and Health IT/PDMP Enhancement**
    1. Purchasing and distributing fentanyl test strips for testing in biological samples for clinical decision-making purposes.
    2. Provision of SUD treatment that includes MOUD and the purchase of medications such as methadone, buprenorphine, and naltrexone.
    3. Any PDMP enhancements that involve providing direct care for substance use disorders (SUDs) treatment.
    4. Providing medical/clinical care, including behavioral therapy (e.g., cognitive behavioral therapy) and/or specialized clinical care, if indicated, such as pain management.
    5. Paying for fees associated with clinicians obtaining Drug Enforcement Agency (DEA) registration to prescribe controlled substances, including buprenorphine.
    6. Financial incentives to encourage clinicians to participate in educational sessions and training activities (e.g., participation in academic detailing, attending seminars, completion of post-session surveys).
    7. Financial incentives for integrated PDMP- health IT (e.g., EHR) connections.
    8. Purchasing basic food, health, or personal items even if intended to support outreach or engage individuals in venue-based programs (e.g., meal or grocery cards, first aid kits, hygiene items, clothes, etc.).
    9. Purchasing, leasing, or renting equipment intended to help EMS and other clinicians treat and manage overdose.

- **Public Safety Partnerships/Interventions**
    1. Public safety activities that do not include overlap/collaboration with public health partners and objectives.

2. Purchase of handheld drug testing machines such as TruNarc, Fourier-transform infrared (FTIR) machines, or HPMS machines for the purposes of reducing possible law enforcement exposure to fentanyl.

- **Harm Reduction**
    1. Establishing new SSPs.
    2. Infrastructure costs for SSPs that are not associated with the co-location of treatment (e.g., rent, utilities, etc.).
    3. Drug disposal, including the implementation or expansion of drug disposal programs, including drug take-back programs, drug drop boxes, and drug disposal bags.
    4. Provision of equipment solely intended for illegal drug use such as cookers/spoons, syringes, and pipes.
    5. Procurement of other equipment solely intended for preparing drugs for illegal drug injection.
    6. Safe injection sites (controlled environments that facilitate safer use of illicit drugs by providing medical staff, clean facilities, and education.) Developing educational outreach and guidance or materials about supervised/safe injection sites.
    7. Purchase of syringes, including pharmacy voucher programs and safe syringe disposal programs.

- **Community-Based Linkage to Care**
    1. Housing assistance
    2. Food assistance
    3. HIV/HCV and other STD/STI testing
    4. Funding or subsidizing costs associated with programs other than those specifically targeting overdose prevention.
    5. Safer sex kits (condoms and lubricant)
    6. Child care and child care-related purchases (e.g., pack-n-play)
    7. Furniture or equipment (purchase or leasing vehicles may be allowable expenses for linkage to care activities)
    8. Prevention of adverse childhood experiences (ACEs) as a standalone activity

15. Other Submission Requirements

a. Electronic Submission: Applications must be submitted electronically by using the forms and instructions posted for this notice of funding opportunity atwww.grants.gov. Applicants can complete the application package using Workspace, which allows forms to be filled out online or offline. All application attachments must be submitted using a PDF file format. Instructions and training for using Workspace can be found at www.grants.gov under the "Workspace Overview" option.

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 whenwww.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 bywww.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 NOFO. 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 Grants.gov Online User Guide.
https://www.grants.gov/help/html/help/index.htm?callingApp=custom#t=GetStarted%2FGetStarted.htm

d. Technical Difficulties: If technical difficulties are encountered at www.grants.gov, applicants should contact Customer Service atwww.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@grants.gov. Application submissions sent by e-mail or fax, or on CDs or thumb drives will not be accepted. Please note thatwww.grants.gov is managed by HHS.

e. Paper Submission: If technical difficulties are encountered at www.grants.gov, applicants should call thewww.grants.gov Contact Center at 1-800-518-4726 or e-mail them

at support@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 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 received via e-mail to the GMS/GMO listed below 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, OGS will advise the applicant of specific instructions for submitting the application via email.

E. Review and Selection Process

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

a. Phase 1 Review

All applications will be initially reviewed for eligibility and completeness by the Office of Grants Services. Complete applications will be reviewed for responsiveness by Grants Management Officials and Program Officials. Non-responsive applications will not advance to Phase II review. Applicants will be notified that their applications did not meet eligibility and/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

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.

i. Approach **Maximum Points:** 0

Applications for the Surveillance and Prevention Components will not be scored. A technical review will be conducted by the CDC Program staff using the criteria noted in the Phase II Review Criteria sections noted Surveillance and Prevention.

Optional strategies, Biosurveillance and Data Linkage, will be scored using the criteria noted in the Phase II Review criteria sections noted as Biosurveillance and Data Linkage.

Surveillance and Prevention

1. The applicant's Background, Purpose, Outcomes, Strategies and Interventions, and Health Equity components must meet the following:
    1. **Background:** Applicants must describe relevant background information that includes the context of the problem, particularly in the applicant's jurisdiction.
    2. **Purpose:** Applicants must describe in 2-3 sentences how their application will specifically address the problem as described in the Background section of this NOFO.
    3. **Outcomes**: Applicants must clearly identify the outcomes they expect to achieve by the end of the period of performance. Outcomes are the results that the program intends to achieve. All outcomes must indicate the intended direction of change (e.g., increase, decrease, maintain).
    4. **Strategies and Interventions:**

1. Applicants must provide a clear and concise description of surveillance strategies and interventions they will use to achieve the period of performance outcomes for the surveillance component.
    1. Applicants must clearly describe their capacity to obtain and share nonfatal and fatal surveillance data successfully.
    2. Applicants must specify their proposed DOSE and SUDORS coverage.
    3. Applicants must provide a clear, concise description that aligns with the NOFO requirements.
2. Applicants must provide a clear and concise description of prevention strategies and interventions they will use to achieve the period of performance outcomes for the prevention component.

5. **Health Equity:**
    1. Applicants should describe use of data, including social determinants of health data, measures of disparities, and planned or completed community needs assessment to identify communities within their jurisdictions that are disproportionately affected by overdose and historically underserved by prevention and treatment programs (i.e., persons with SUDs, persons recently released from incarceration, people experiencing homelessness, anyone who has experienced a non-fatal overdose, and people in certain ethnic and racial groups).
    2. Applicants should clearly articulate how activities will address health inequities, be culturally relevant, and be tailored in collaboration with relevant partners to help eliminate health disparities in overdose and increase equitable access to OUD and StUD treatment and services.
    3. Applicants should provide a clear plan to evaluate strategies and required activities that will measure impact on groups disproportionately affected by overdose and those previously underserved by overdose prevention initiatives.
    4. Applicants should present a comprehensive, feasible, and rigorous description of their plan to address health equity across this component. Applicant's description of their health equity efforts must, at minimum, include the following:
        1. Populations of Focus: Applicants must describe how the interventions proposed and/or evaluated prioritize communities at greatest risk, including 1) Persons who have experienced an overdose or with a history of substance use disorder, 2) Persons experiencing incarceration or recently released from incarceration, 3) Persons experiencing homelessness; to achieve the greatest health impact, as described in the "Target Populations" section of this NOFO.
        2. Knowledge of populations disproportionately affected by overdose and/or historically underserved by prevention and treatment programs.

3. Experience working with populations disproportionately affected by overdose and/or historically underserved by prevention and treatment programs.
4. A clear evaluation plan that will measure impact on groups disproportionately affected by overdose and those previously underserved by overdose prevention initiatives.

2. **Work Plan**: Applicant must submit a work plan that is responsive to the requirements outlined in the NOFO "Work Plan" section. Applicants must include a detailed first-year work plan and a high-level plan for subsequent years. The work plan is the applicant's opportunity to clearly identify what activities they plan to implement and how they plan to do so using the funds provided.
    1. **Surveillance component work plan**: Applicants' work plan should be well-organized and have a high probability of collecting and sharing surveillance data that will inform its NOFO prevention programs and meet CDC reporting deadlines. Applicants work plan should be responsive to the requirements outlined under the surveillance component section.
    2. **Prevention component work plan**: Applicants work plan should be well organized, should describe feasible work, should be consistent with the strategies outlined in this Notice of Funding Opportunity (NOFO), and should be expected to lead to the long-term outcomes required by this award.

3. **Collaborations:** Applicants should demonstrate strong, multi-sector collaborations to support their work, including:
    1. Submitting all required Letters of Support (LOS) under the "Collaboration" section of this NOFO.
    2. Demonstrating substantial evidence of collaboration with key partners. When evaluating the strength of collaborations, reviewers should assess: 1) the inclusion of any recommended MOAs/MOUs/LOSs that demonstrate strategic partnerships and collaborations with organizations that have a role in achieving the NOFO outcomes and proposed activities, 2) strong evidence of previous or ongoing collaborations that support required surveillance data collections, and 3) demonstration of collaborations with other CDC programs, including Core SIPP states, R01 awards, Core SIPP regional networks, and Injury Control Research Centers, as applicable.
    3. Surveillance component collaborations: SHDs and DC who do not include required surveillance LOS from the staffing unit or supervisor supplying DOSE data, the NSSP PI when applicable, and NVDRS PI will still be deemed responsive, but the applicant should explain why the LOS was not submitted and how these applicants will still be able to share nonfatal and fatal data despite not having a LOS included in their application.

Prevention component collaborations: Applicants that do not include LOS from appropriate partners should explain why the LOS was not submitted and how these challenges will be addressed if they receive funding.

ii. Evaluation and Performance Measurement **Maximum Points:** 0

Surveillance and Prevention

Applicants Evaluation and Performance Measurement Plan should be well organized, feasible, and likely to inform surveillance and prevention strategies using data from multiple sources (e.g., surveillance, evaluation, community partners). Applicants should provide critical information about the needs of populations of focus and persons with lived experience to further guide prevention activities. Applicants should demonstrate an understanding and provide a well-defined plan for meeting all stated evaluation and performance measurement requirements, including: conducting evaluations of all required prevention activities, reporting on performance measures that will be further outlined upon award, completing one required targeted evaluation project, and creating one evaluation translational product.

Applicants should present a comprehensive and rigorous evaluation plan for their prevention component following the criteria below:

- Clearly presents a detailed plan and description for reporting performance measures, including descriptions of any available baseline measures, data sources required for reporting, the utility of measures to the applicant, feasibility of reporting measures to CDC every 6 months, and any anticipated barriers to obtaining data and calculating performance measures.
- Clearly describes the approach to considering the needs of populations of focus and people with lived experience in program/evaluation planning and development.
- Clearly presents an overall Evaluation and Performance Measurement Plan that accounts for evaluating all required prevention activities across the period of performance, focusing on short-, intermediate-, and long-term outcomes, in concert with descriptions of key evaluation questions.
- Clearly describes how evaluation data will be used for program improvement and how evaluation data will be disseminated to various partners, collaborators, and affected groups. Additionally, clearly describes the intent and plans for creating a Translational product by the end of the period of performance that will relate to the evaluation of prevention activities.
- Clearly describes feasible plans for completing a targeted evaluation project focused on navigation activities specifically.

iii. Applicant's Organizational Capacity to Implement the Approach **Maximum Points:** 0

Surveillance and Prevention

Applicant’s organizational capacity will be evaluated per the guidelines listed below.

- Applicants must describe their organizational capacity to carry out the strategies and activities proposed. Applicant description should include:
- 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 at the state level, statewide, or at a systems level.

- Subject matter expertise to plan and implement strategies addressing opioid and stimulant use and misuse, stimulant use disorder, opioid use disorder, overdose, and opioid/stimulant-related harms.
- Established or newly built partnerships with health systems and other relevant partner organizations with demonstrated experience addressing opioid and stimulant use and misuse disorder, overdose, and opioid and stimulant-related harms or working with identified high-risk populations.
- Extensive knowledge and expertise in health equity and addressing disparities within identified populations of focus or communities that have been underserved, or working with organizations that serve high-risk populations and underserved communities.
- Ability to engage people who use drugs and people with lived experience in program planning and evaluation.
- Experience with evaluating programs at the state level and/or statewide.
- Ability to access at least 80% of ED visits within their jurisdiction by September 2023 and share ED overdose indicator data with CDC on a monthly or annual basis using CDC guidance.
- Capacity to collect ME/C reports, including toxicology and death certificate data on all UUDO deaths, in compliance with CDC guidelines and timelines.
- Capacity to use the NVDRS web-based data entry system to enter SUDORS data.
- Experience in disseminating morbidity and mortality data to support public health action.
- Capacity to use overdose data to support NOFO interventions.
- Capacity and expertise in surveillance and program implementation, program and performance management, evaluation, policy, and management of travel and program requirements. Applicants should identify key staff. Please document these capabilities with the resumes of key staff.
- Capability to manage the required award, including the ability to manage the required procurement efforts, including the ability to write and award contracts in accordance with applicable grant regulations. Applicants should identify key staff. Please document these capabilities with the resumes of key staff.

Each applicant must also include the appropriate amount of staffing needed to complete their workplan activities each budget period. At a minimum key staff must include:

- A PI for surveillance to oversee all surveillance strategies (i.e., surveillance infrastructure, DOSE, SUDORS, biosurveillance, and data linkage).
- A PI for prevention to oversee the implementation of the required intervention strategies.
- SUDORS project manager/lead.
- Program evaluator: one FTE OR contracted program evaluator (e.g., contract with academic institution) with training in and experience applying: 1) evaluation theory, concepts, standards, methods, and tools to assess the effectiveness and efficiency of programs, policies, and organizations; 2) methods, techniques, and tools used to analyze program, organizational, and mission performance; 3) performance measurement principles and methods to evaluate program or organizational performance using metrics and outcomes; 4) principles, methods, and tools of quality assurance, quality control, and

reliability; 5) concepts, practices, and techniques used to effectively engage with partners internal to the applicant's organization as well as external partners; 6) principles of health equity relevant to program evaluation; and 7) methods for disseminating findings from program evaluations through peer-reviewed and other publications, conference abstracts, and clear communication materials targeted appropriately to a variety of partners.

Budget **Maximum Points:** 0

Optional and Competitive Strategy: Biosurveillance (Strategy 4) **Maximum Points:** 100

i. Approach	**Maximum Points: 50**

Biosurveillance

The optional Biosurveillance strategy will be scored using the criteria noted below.

CDC will evaluate the extent to which the applicant describes their plan for conducting biosurveillance as described in Strategy 4 of the NOFO. Applicants must describe (**25 points**):

1. At least one partner hospital (or hospital system) which will provide leftover specimens from patients presenting to the ED with an overdose and required data related to this patient and specimen (A letter of support is required from each hospital identified, indicating an understanding of the requirements of the NOFO and agreement to meet those requirements).
2. A capable laboratory for definitive testing of these specimens. (If this laboratory is a public health laboratory (PHL), they must provide a letter of support from their Laboratory Response Network for Chemical Threats (LRN-C) indicating awareness and support of the required activities in this NOFO for this strategy.) An LOS should be received from this laboratory indicating an understanding of the requirements of this NOFO and indicating support for meeting those requirements.
3. A plan that indicates an understanding of testing a required minimum of 20 specimens per week; this can include steps to be taken to achieve this if not immediately feasible.
4. The timeline for collecting and testing samples that meets CDC data submission requirements (at minimum, quarterly reporting of results and associated patient/specimen data and any required metadata).
5. How samples will be tested in a timely manner (at least within 2-4 weeks of receipt of sample).
6. A plan that indicates an understanding of the use of a common testing panel (which will be determined by CDC) that all recipients will be using and a willingness to use this panel or an equivalent.
7. A plan that indicates an understanding that systematic sampling may be required if too many specimens are available and suggested options for this will be provided by CDC; realistic challenges can be noted, but plan should indicate an intention to use these options to sample.

CDC will evaluate the extent to which the applicant describes a feasible plan for analyzing and disseminating the data in a timely manner as described in Strategy 4. Applicants must describe (**10 points**):

1. The specific staff that will conduct analyses.

2. A clear plan to use biosurveillance testing results and associated specimen and patient data to inform overdose prevention interventions.
3. A plan to disseminate findings by producing at least 2 data products per year by the end of funding Year 3. Data products include (but are not limited to): inclusion of testing data in dashboards, internal or external reports to partners, or alerts about overdose-associated laboratory findings.

CDC will evaluate the applicant's approach to addressing preferred, but optional, program characteristics. Applicants must describe (**15 points**):

1. A feasible plan to exceed the minimum requirements for participation and specimen testing (i.e., number of hospital partners providing LOS, ability to start in Year 1 testing greater than the minimum 20 specimens/week (**3 points**)
2. DUAs or MOUs provided related to hospitals providing specimens for biosurveillance or agencies providing data sets (**2 points**)
3. The testing laboratory, which is a PHL and is already part of the state public health system (**5 points**)
4. If laboratory partner is a PHL, LRN-C reporting is proposed as the mechanism through which data will be shared (**3 points**)
5. A feasible plan to exceed the required 2 data products per year, either by disseminating data earlier or by planning more than the minimum data products (**2 points**)

ii. Evaluation and Performance Measurement	**Maximum Points: 10**

1. Outlines an effective and feasible plan for monitoring the timeliness and quality of data collected from hospitals and generated by testing activities as described in Strategy 4. This should include meeting deadlines to share data with CDC.
2. Outlines an effective and feasible plan for tracking dissemination of data.
3. Has a plan to collect information about how external partners and/or OD2A prevention programs use biosurveillance findings to inform interventions.

iii. Applicant's Organizational Capacity to Implement the Approach	**Maximum Points: 40**

Experience (**20 points**)

1. General experience establishing and managing surveillance systems, especially those related to drug overdose such as surveillance of fatal or nonfatal drug overdoses. Applicants should have experience managing surveillance systems related to drug overdose.
2. Experience conducting biosurveillance. Applicants must describe their experience including number of specimens tested, toxicologic tests conducted, and how they have dissemination of the data. Strong applicants will have conducted comprehensive testing of >100 human clinical specimens and disseminated the data. Applicants that have conducted smaller pilot programs or not conducted human clinical testing but may have experience in testing drug products or paraphernalia should be scored lower.

3. Demonstrated ability to work collaboratively. Applicants will possess experience in the following areas:
    - Laboratory and epidemiology collaboration, such as interpretation and sharing of laboratory data and collaborative analyses for data use.
    - Collaborations with hospitals, particularly EDs.
    - Expertise working with internal and external partners in the prevention of overdose and substance use disorders.

Staffing (**10 points**)

1. Roles and responsibilities of staff must be clearly delineated. Applicants must have a staffing plan that is feasible and will support implementing the required elements of biosurveillance, including conducting quality laboratory testing and analysis of data.
2. Curriculum vitae for the staff who will be implementing biosurveillance activities should be included in the application. These should be reviewed for appropriateness and competence for the roles they will be filling.

Demonstrate organizational capacity through preferred, but optional, program characteristics. Applicants should describe the following: (**10 points)**:

1. Results from recent (past 1-2 years) proficiency tests related to testing of drugs (**5 points**)
2. Providing reference to data products (such as presentations, abstracts, dashboards, reports, or publications) related to biosurveillance for substances used in overdose patients (**5 points**) or if that is not available, any drug testing surveillance (**2 points**) (**maximum of 5 points**)

Budget
Budgets are not scored.

Optional and Competitive Strategy: Data Linkage (Strategy 5) **Maximum Points:** 100

i. Approach	**Maximum Points: 45**

Data Linkage

The optional Data Linkage strategy will be scored using the criteria noted below.

Based on the activities described in Strategy 5, CDC will evaluate the extent to which the applicant:

1. Describes why they selected their proposed data linkages and how they believe their proposed activities will better their understanding of nonfatal and fatal overdoses occurring in their jurisdictions **(maximum 10 points).**
2. Describes an effective and feasible approach for each of the data linkages proposed, including the required individual-level data linkage (i.e., at least one nonfatal data source linked with at least one fatal data source) and at least one of the data linkages described in Requirement 2 in the Strategy 5 section of the NOFO **(maximum 20 points).** For each identified data linkage, this should include:

1. A description of each data source that will be used to conduct the linkages **(7.5 points)**.
2. A description of the method(s) that will be used to link the data (e.g., probabilistic linkage, deterministic linkage), including the variables used in the linkage procedure (e.g., name, date of birth) **(7.5 points)**.
3. Additional points **(5 points)** will be given for the use of data warehouse(s), cube(s), or similar data infrastructure.

3. Describes the geographic area for each data source, including data from individuals in the entire state, a large portion of the state, or one large city **(maximum 15 points).**
    1. A description of the geographic area for each data source **(5 points)**.
    2. Additional points **(5 points)** will be given for evidence of including data from the entire state (as opposed to only a portion of the state) for all data sources being used in the linkage.
    3. Additional points **(5 points)** will be given for patient-level linkages with SDOH data (as opposed to linking at the county level or other aggregate level).

ii. Evaluation and Performance Measurement	**Maximum Points: 15**

1. Describes how data linkage success will be assessed (e.g., what will be done to confirm that cases were linked correctly) **(7.5 points).**
2. Describes how results and findings will be disseminated, including the form of the two required products (e.g., journal article, state report for the website, presentation to policy makers) and intended audience **(7.5 points).**

iii. Applicant's Organizational Capacity to Implement the Approach	**Maximum Points: 40**

1. Documents the ability to access the following data sources **(maximum 10 points)**:
    1. Identified individual-level data from at least one nonfatal overdose data source (e.g., EMS, ED syndromic, ED discharge/billing, or inpatient records,
    2. Identified individual-level data from at least one fatal overdose data source (i.e., SUDORS, death certificates via vital records office), and
    3. At least one of the following:
        1. Identified individual-level criminal justice data
        2. Identified individual-level prescription drug monitoring program data and/or
        3. Individual- or county-level data on social determinants of health (e.g., experiencing housing instability, receiving food assistance).

2. Indicates commitment/ability to perform linkages within one year of the date of a nonfatal or fatal drug overdose, beginning in year 2, and mentions updating data linkage throughout the calendar year **(maximum 5 points).**
    1. Allot up to **2.5 points** for identifying the ability to link data within 6 months of the date of a fatal or nonfatal drug overdose.

3. Indicates commitment/ability to access data on fatal overdoses occurring January 1, 2022, or sooner AND access data on nonfatal overdoses for the year prior **(5 points).**
4. If using fatal data for requirement 2, then indicates commitment/ability to access data on fatal overdoses occurring January 1, 2022, or sooner; if using nonfatal data for requirement 2, then indicates commitment/ability to access data on nonfatal overdoses occurring on January 1, 2023, or sooner **(5 points)**.
5. Includes at least letters of support from agencies that will be sharing data as part of the proposed data linkages. It could also include data sharing agreements or MOUs **(2.5 points).**
6. Indicates dedicated staff person(s) and sufficient staff time to complete the data linkages, analyze the linked data, and disseminate the findings **(2.5 points).**
7. Additional points may be awarded for historic capacity and prior experience conducting data linkages **(maximum 10 points)**:
    1. Additional points **(5 points)** if applicant can link historical baseline data on nonfatal or fatal overdoses occurring during 2021–2022.
    2. Additional points **(5 points)** will be given for evidence of performing the proposed data linkages in the past year.

Budget
Budgets are not scored.

c. Phase III Review
Applications will be reviewed and scored using the following criteria:

Surveillance and Prevention Components – A technical review will be conducted by CDC Program staff using the criteria noted in the Phase II Review Criteria.

Optional Biosurveillance and Data Linkage Strategies - Applications for these optional strategies will be reviewed and scored separately in accordance with the Phase II Review Criteria. The CDC will fund up to 20 applicants for each of the Biosurveillance and Data Linkage strategies. For each optional strategy, a separate rank-order list will be used. The following criteria may affect the funding decision. CDC may fund out of rank order using the following criteria:

- Geographic diversity: To ensure funding is provided across the country, CDC may use the following criteria to fund out of rank order.
    - Ensure there is at least one recipient in each of the nine United States census divisions (New England Division, Middle Atlantic Division, East North Central Division, West North Central Division, South Atlantic Division, East South Central Division, West South-Central Division, Mountain Division, and Pacific Division).
    - Based on fatal drug overdose rate and population, ensure there is not substantially disproportionate funding of applicants in any of the four United States census

regions (Midwest, Northeast, South, and West). For instance, having more than half of the recipients in any one census region would be considered potentially problematic.

Review of risk posed by applicants.
Prior to making a Federal award, CDC is required by 31 U.S.C. 3321 and 41 U.S.C. 2313 to review information available through any OMB-designated repositories of government-wide eligibility qualification or financial integrity information as appropriate. See also suspension and debarment requirements at 2 CFR parts 180 and 376.

In accordance 41 U.S.C. 2313, CDC is required to review the non-public segment of the OMB-designated integrity and performance system accessible through SAM (currently the Federal Recipient Performance and Integrity Information System (FAPIIS)) prior to making a Federal award where the Federal share is expected to exceed the simplified acquisition threshold, defined in 41 U.S.C. 134, over the period of performance. At a minimum, the information in the system for a prior Federal award recipient must demonstrate a satisfactory record of executing programs or activities under Federal grants, cooperative agreements, or procurement awards; and integrity and business ethics. CDC may make a Federal award to a recipient who does not fully meet these standards, if it is determined that the information is not relevant to the current Federal award under consideration or there are specific conditions that can appropriately mitigate the effects of the non-Federal entity's risk in accordance with 45 CFR §75.207.

CDC’s framework for evaluating the risks posed by an applicant may incorporate results of the evaluation of the applicant's eligibility or the quality of its application. If it is determined that a Federal award will be made, special conditions that correspond to the degree of risk assessed may be applied to the Federal award. The evaluation criteria is described in this Notice of Funding Opportunity.

In evaluating risks posed by applicants, CDC will use a risk-based approach and may consider any items such as the following:

(1) Financial stability;

(2) Quality of management systems and ability to meet the management standards prescribed in this part;

(3) History of performance. The applicant's record in managing Federal awards, if it is a prior recipient of Federal awards, including timeliness of compliance with applicable reporting requirements, conformance to the terms and conditions of previous Federal awards, and if applicable, the extent to which any previously awarded amounts will be expended prior to future awards;

(4) Reports and findings from audits performed under subpart F 45 CFR 75 or the reports and findings of any other available audits; and

(5) The applicant's ability to effectively implement statutory, regulatory, or other requirements imposed on non-Federal entities.

CDC must comply with the guidelines on government-wide suspension and debarment in 2 CFR part 180, and require non-Federal entities to comply with these provisions. These provisions

restrict Federal awards, subawards and contracts with certain parties that are debarred, suspended or otherwise excluded from or ineligible for participation in Federal programs or activities.

2. Announcement and Anticipated Award Dates

The anticipated award date is August 1, 2023. Recipients will receive an electronic copy of the Notice of Award (NOA) from CDC OGS. The NOA shall be the only binding, authorizing document between the recipient and CDC. The NOA will be signed by an authorized GMO and emailed to the Recipient Business Officer listed in the application and the Program Director.

F. Award Administration Information

1. Award Notices

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

Any applicant awarded funds in response to this Notice of Funding Opportunity will be subject to annual 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.

2. Administrative and National Policy Requirements

Recipients must comply with the administrative and public policy requirements outlined in 45 CFR Part 75 and the HHS Grants Policy Statement, as appropriate.

Brief descriptions of relevant provisions are available at https://www.cdc.gov/grants/additional-requirements/index.html.

The HHS Grants Policy Statement is available at http://www.hhs.gov/sites/default/files/grants/grants/policies-regulations/hhsgps107.pdf.

- AR-25: Data Management and Access
- AR-37: Prohibition on certain telecommunications and video surveillance services or equipment for all awards issued on or after August 13, 2020

The full text of the Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards, 45 CFR 75, can be found at: https://www.ecfr.gov/cgi-bin/text-idx?node=pt45.1.75

Should you successfully compete for an award, recipients of federal financial assistance (FFA) from HHS will be required to complete an HHS Assurance of Compliance form (HHS 690) in which you agree, as a condition of receiving the grant, to administer your programs in compliance with federal civil rights laws that prohibit discrimination on the basis of race, color, national origin, age, sex and disability, and agreeing to comply with federal conscience laws, where applicable. This includes ensuring that entities take meaningful steps to provide

meaningful access to persons with limited English proficiency; and ensuring effective communication with persons with disabilities. Where applicable, Title XI and Section 1557 prohibit discrimination on the basis of sexual orientation, and gender identity. The HHS Office for Civil Rights provides guidance on complying with civil rights laws enforced by HHS. See https://www.hhs.gov/civil-rights/for-providers/provider- obligations/index.html and https://www.hhs.gov/civil-rights/for- individuals/nondiscrimination/index.html.

- For guidance on meeting your legal obligation to take reasonable steps to ensure meaningful access to your programs or activities by limited English proficient individuals, see https://www.hhs.gov/civil-rights/for-individuals/special-topics/limited-english-proficiency/fact-sheet-guidance/index.html and https://www.lep.gov.
- For information on your specific legal obligations for serving qualified individuals with disabilities, including providing program access, reasonable modifications, and to provide effective communication, see http://www.hhs.gov/ocr/civilrights/understanding/disability/index.html.
- HHS funded health and education programs must be administered in an environment free of sexual harassment, see https://www.hhs.gov/civil-rights/for-individuals/sex-discrimination/index.html.
- For guidance on administering your project in compliance with applicable federal religious nondiscrimination laws and applicable federal conscience protection and associated anti-discrimination laws, see https://www.hhs.gov/conscience/conscience-protections/index.html and https://www.hhs.gov/conscience/religious-freedom/index.html.

3. Reporting

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

- Helps target support to recipients;
- Provides CDC with periodic data to monitor recipient progress toward meeting the Notice of Funding Opportunity outcomes and overall performance;
- Allows CDC to track performance measures and evaluation findings for continuous quality and program improvement throughout the period of performance 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 NOFO.

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 NOFO copying the CDC Project Officer.

Report	When?	Required?

Recipient Evaluation and Performance Measurement Plan	6 months into the award	Yes
Recipient Data Management Plan (DMP)	6 months into the award	Yes
Data on Performance Measures	Annual/Semi-annual reporting beginning in Year 2 of the cooperative agreement*	Yes
Targeted Evaluation Project (TEP)	TEP submitted by Year 4 of the cooperative agreement	Yes
Evaluation translational product	The final year of the cooperative agreement	Yes
Annual Performance Report (APR), Work Plan, and Budget	No later than 120 days before the end of the budget period. Serves as a yearly continuation application.	Yes
Federal Financial Reporting Forms	90 days after the end of the budget period	Yes
Final Performance and Financial Report	90 days after the end of the period of performance	Yes

*Specific performance measures for required activities, such as naloxone distribution and linkage to care, will be prioritized for semi-annual reporting to inform CDC about these critical efforts in reducing overdose deaths. CDC will confirm the frequency of all performance measure reporting based on reporting needs and the feasibility of reporting more frequently than annually.

a. Recipient Evaluation and Performance Measurement Plan (required)

With support from CDC, recipients must elaborate on their initial applicant evaluation and performance measurement plan. This plan must be no more than 20 pages; recipients must submit the plan 6 months into the award. HHS/CDC will review and approve the recipient's monitoring and evaluation plan to ensure that it is appropriate for the activities to be undertaken as part of the agreement, for compliance with the monitoring and evaluation guidance established by HHS/CDC, or other guidance otherwise applicable to this Agreement.

Recipients will be required to enter their evaluation plan into NCIPC Partner's Portal an interactive reporting tool that will be used by the recipient and CDC staff to manage plans throughout the period of performance. Recipients will need access to CDC's Secure Access Management System (SAMS) to use the tool. Recipients will work with CDC staff to gain access to the system.

Recipient Evaluation and Performance Measurement Plan (required): This plan should provide additional detail on the following:

Performance Measurement

• Performance measures and targets

• The frequency that performance data are to be collected.

• How performance data will be reported.

• How quality of performance data will be assured.

• How performance measurement will yield findings to demonstrate progress towards achieving NOFO goals (e.g., reaching target populations or achieving expected outcomes).

• Dissemination channels and audiences.

• Other information requested as determined by the CDC program.

Evaluation

• The types of evaluations to be conducted (e.g. process or outcome evaluations).

• The frequency that evaluations will be conducted.

• How evaluation reports will be published on a publicly available website.

• How evaluation findings will be used to ensure continuous quality and program improvement.

• How evaluation will yield findings to demonstrate the value of the NOFO (e.g., effect on improving public health outcomes, effectiveness of NOFO, cost-effectiveness or cost-benefit).

• Dissemination channels and audiences.

HHS/CDC or its designee will also undertake monitoring and evaluation of the defined activities within the agreement. The recipient must ensure reasonable access by HHS/CDC or its designee to all necessary sites, documentation, individuals and information to monitor, evaluate and verify the appropriate implementation the activities and use of HHS/CDC funding under this Agreement.

b. Annual Performance Report (APR) (required)
The recipient must submit the APR via www.Grantsolutions.gov no later than120 days prior to the end of the budget period. This report must not exceed 45 pages excluding administrative reporting. Attachments are not allowed, but web links are allowed.

This report must include the following:

- **Performance Measures:** Recipients must report on performance measures for each budget period and update measures, if needed.
- **Evaluation Results:** Recipients must report evaluation results for the work completed to date (including findings from process or outcome evaluations).
- **Work Plan:** Recipients must update work plan each budget period to reflect any changes in period of performance outcomes, activities, timeline, etc.
- **Successes**
    - Recipients must report progress on completing activities and progress towards achieving the period of performance outcomes described in the logic model and work plan.
    - Recipients must describe any additional successes (e.g. identified through evaluation results or lessons learned) achieved in the past year.

- Recipients must describe success stories.

- **Challenges**
  - Recipients must describe any challenges that hindered or might hinder their ability to complete the work plan activities and achieve the period of performance outcomes.
  - Recipients must describe any additional challenges (e.g., identified through evaluation results or lessons learned) encountered in the past year.

- **CDC Program Support to Recipients**
  - Recipients must describe how CDC could help them overcome challenges to complete activities in the work plan and achieving period of performance 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.

The recipient must submit the Annual Performance Report via https://www.grantsolutions.gov 120 days prior to the end of the budget period.

Recipients will be required to enter their workplan, APR and elements of evaluation and surveillance data into NCIPC Partner's Portal an interactive reporting tool that will be used by the recipient and CDC staff to manage plans throughout the period of performance. Recipients will need access to CDC's Secure Access Management System (SAMS) to use the tool. Recipients will work with CDC staff to gain access to the system.

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 recipients at the beginning of the award period.

CDC expects annual/semi-annual reporting of performance measures. This may change throughout the award. The program will provide the format, platform, and data fields for reporting at the beginning of the award.

d. Federal Financial Reporting (FFR) (required)

The annual FFR form (SF-425) is required and must be submitted 90 days after the end of the budget period through the Payment Management System (PMS). 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, recipients are required to submit a letter of explanation to OGS and include the date by which the Grants Officer will receive information.

e. Final Performance and Financial Report (required)

The Final Performance Report is due 90 days after the end of the period of performance. The Final FFR is due 90 days after the end of the period of performance and must be submitted through the Payment Management System (PMS). CDC programs must indicate that this report should not exceed 40 pages. This report covers the entire period of performance and can include information previously reported in APRs. At a minimum, this report must include the following:

- Performance Measures – Recipients must report final performance data for all process and outcome performance measures.
- Evaluation Results – Recipients must report final evaluation results for the period of performance for any evaluations conducted.
- Impact/Results/Success Stories – Recipients must use their performance measure results and their evaluation findings to describe the effects or results of the work completed over the period of performance, and can include some success stories.
- A final Data Management Plan that includes the location of the data collected during the funded period, for example, repository name and link data set(s)
- Additional forms as described in the Notice of Award (e.g., Equipment Inventory Report, Final Invention Statement).

CDC will require recipients to update and report their performance and evaluation measures utilizing program-approved data platforms and templates.

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

Federal Funding Accountability and Transparency Act of 2006 (FFATA), P.L. 109–282, as amended by section 6202 of P.L. 110–252 requires full disclosure of all entities and organizations receiving Federal funds including awards, contracts, loans, other assistance, and payments through a single publicly accessible Web site, http://www.USASpending.gov.

Compliance with this law is primarily the responsibility of the Federal agency. However, two elements of the law require information to be collected and reported by applicants: 1) information on executive compensation when not already reported through the SAM, and 2) similar information on all sub-awards/subcontracts/consortiums over $25,000.

For the full text of the requirements under the FFATA and HHS guidelines, go to:

- https://www.gpo.gov/fdsys/pkg/PLAW-109publ282/pdf/PLAW-109publ282.pdf,
- https://www. fsrs.gov/documents /ffata_legislation_ 110_252.pdf
- http://www.hhs.gov/grants/grants/grants-policies-regulations/index.html#FFATA.

5. Reporting of Foreign Taxes (International/Foreign projects only)

A. Valued Added Tax (VAT) and Customs Duties – Customs and import duties, consular fees, customs surtax, valued added taxes, and other related charges are hereby authorized as an allowable cost for costs incurred for non-host governmental entities operating where no

applicable tax exemption exists. This waiver does not apply to countries where a bilateral agreement (or similar legal document) is already in place providing applicable tax exemptions and it is not applicable to Ministries of Health. Successful applicants will receive information on VAT requirements via their Notice of Award.

B. The U.S. Department of State requires that agencies collect and report information on the amount of taxes assessed, reimbursed and not reimbursed by a foreign government against commodities financed with funds appropriated by the U.S. Department of State, Foreign Operations and Related Programs Appropriations Act (SFOAA) ("United States foreign assistance funds"). Outlined below are the specifics of this requirement:

1) Annual Report: The recipient must submit a report on or before November 16 for each foreign country on the amount of foreign taxes charged, as of September 30 of the same year, by a foreign government on commodity purchase transactions valued at 500 USD or more financed with United States foreign assistance funds under this grant during the prior United States fiscal year (October 1 – September 30), and the amount reimbursed and unreimbursed by the foreign government. [Reports are required even if the recipient did not pay any taxes during the reporting period.]

2) Quarterly Report: The recipient must quarterly submit a report on the amount of foreign taxes charged by a foreign government on commodity purchase transactions valued at 500 USD or more financed with United States foreign assistance funds under this grant. This report shall be submitted no later than two weeks following the end of each quarter: April 15, July 15, October 15 and January 15.

3) Terms: For purposes of this clause:
"Commodity" means any material, article, supplies, goods, or equipment;
"Foreign government" includes any foreign government entity;
"Foreign taxes" means value-added taxes and custom duties assessed by a foreign government on a commodity. It does not include foreign sales taxes.

4) Where: Submit the reports to the Director and Deputy Director of the CDC office in the country(ies) in which you are carrying out the activities associated with this cooperative agreement. In countries where there is no CDC office, send reports to VATreporting@cdc.gov.

5) Contents of Reports: The reports must contain:

a. recipient name;
b. contact name with phone, fax, and e-mail;
c. agreement number(s) if reporting by agreement(s);
d. reporting period;
e. amount of foreign taxes assessed by each foreign government;
f. amount of any foreign taxes reimbursed by each foreign government;
g. amount of foreign taxes unreimbursed by each foreign government.

6) Subagreements. The recipient must include this reporting requirement in all applicable subgrants and other subagreements.

6. Termination

CDC may impose other enforcement actions in accordance with 45 CFR 75.371- Remedies for Noncompliance, as appropriate.

The Federal award may be terminated in whole or in part as follows:

(1) By the HHS awarding agency or pass-through entity, if the non-Federal entity fails to comply with the terms and conditions of the award;

(2) By the HHS awarding agency or pass-through entity for cause;

(3) By the HHS awarding agency or pass-through entity with the consent of the non-Federal entity, in which case the two parties must agree upon the termination conditions, including the effective date and, in the case of partial termination, the portion to be terminated; or

(4) By the non-Federal entity upon sending to the HHS awarding agency or pass-through entity written notification setting forth the reasons for such termination, the effective date, and, in the case of partial termination, the portion to be terminated. However, if the HHS awarding agency or pass-through entity determines in the case of partial termination that the reduced or modified portion of the Federal award or subaward will not accomplish the purposes for which the Federal award was made, the HHS awarding agency or pass-through entity may terminate the Federal award in its entirety.

G. Agency Contacts

CDC encourages inquiries concerning this NOFO.

Program Office Contact

For programmatic technical assistance, contact:

First Name:
Jamie

Last Name:
Mells
Project Officer
Department of Health and Human Services
Centers for Disease Control and Prevention

Address:
4770 Buford Highway, NE; Mail Stop F62
Atlanta, GA 30341

Telephone:
(770) 488-7388

Email:
od2a-states@cdc.gov

Grants Management Office Information

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

First Name:
Keisha

Last Name:
Thompson
Grants Management Specialist
Department of Health and Human Services
Office of Grants Services

Address:
2939 Flowers Road South, Mailstop TV-2

Telephone:
770-488-2681

Email:
DVM1@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.

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
- Report on Programmatic, Budgetary and Commitment Overlap
- Table of Contents for Entire Submission

For international NOFOs:

- SF424
- SF424A
- Funding Preference Deliverables

Optional attachments, as determined by CDC programs:
Resumes / CVs

Position descriptions

Letters of Support

Organization 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

OD2A-S is a multi-component NOFO. Applicants are permitted up to 15 pages to respond to the base requirements of the NOFO and an additional 4 pages for the project narrative subsections that are specific to each component (i.e., 4 additional pages for Surveillance and 4 additional pages for Prevention).

Applicants applying for the Optional and Competitive Strategies are permitted an additional 4 pages per optional strategy. Applicants applying for the Optional and Competitive Strategies (Biosurveillance and Data Linkage) should submit separate documents for each strategy. Documents should be labelled correctly to ensure they are evaluated by reviewers. All documents related to Biosurveillance should be labelled as "S4 Biosurveillance XX" for example "S4 Biosurveillance Budget". Similarly documents related to the data linkage strategy should be labelled "S5 Data Linkage XX" for example "S5 Data Linkage Budget". Labelling instructions have been included in the relevant sections (Workplan, Project Narrative, Collaborations and Letters of Support, and Budget Narrative) for each strategy.

Please see the following attachments:

- Appendix 1: Data dissemination and data sharing requirements for recipients
- Appendix 2: Checklist for Surveillance Component
- Appendix 3: Overdose Reporting Timelines for Strategy 2 (Morbidity Surveillance) and Strategy 3 (Mortality Surveillance)
- Appendix 4: Updated Guidance Document for Implementation of Comprehensive Toxicological Testing of Drug Overdose Deaths Suspected to Involve Opioids and/or Stimulants
- Appendix 5: SUDORS Anticipated Funding Amounts
- Appendix 6: State Unintentional Drug Overdose Reporting System (SUDORS) Abstractor Staffing Guidance
- Appendix 7: Required Metadata and Indicators for Data Linkage Competitive Surveillance (Strategy 5)
- Appendix 8: Targeted Evaluation Project (TEP)
- Appendix 9: Surveillance and Prevention Anticipated Funding Amounts

- Appendix 10: Figures
- References

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 75 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 NOFO; recipients must comply with the ARs listed in the NOFO. To view brief descriptions of relevant provisions, see https://www.cdc.gov/grants/additional-requirements/index.html. Note that 2 CFR 200 supersedes the administrative requirements (A-110 & A-102), cost principles (A-21, A-87 & A-122) and audit requirements (A-50, A-89 & A-133).

Approved but Unfunded: Approved but unfunded refers to applications recommended for approval during the objective review process; however, they were not recommended for funding by the program office and/or the grants management office.

Assistance Listings: A government-wide collection of federal programs, projects, services, and activities that provide assistance or benefits to the American public.

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

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 period of performance. 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.

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 recipients. It may include the value of allowable third-party, in-kind contributions, as well as expenditures by the recipient.

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. https://www.cdc.gov/grants/additional-requirements/index.html.

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 NOFO evaluation plan is used to describe how the recipient 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.

Health Equity: Striving for the highest possible standard of health for all people and giving special attention to the needs of those at greatest risk of poor health, based on social conditions.
Health Inequities: Systematic, unfair, and avoidable differences in health outcomes and their determinants between segments of the population, such as by socioeconomic status (SES), demographics, or geography.

Healthy People 2030: 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.

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 educations, 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.

Period of performance –formerly known as the project period - : The time during which the recipient may incur obligations to carry out the work authorized under the Federal award. The start and end dates of the period of performance must be included in the Federal award.

Period of Performance Outcome: An outcome that will occur by the end of the NOFO's funding period

Plain Writing Act of 2010: The Plain Writing Act of 2010 requires that federal agencies use clear communication that the public can understand and use. NOFOs must be written in clear, consistent language so that any reader can understand expectations and intended outcomes of the funded program. CDC programs should use NOFO plain writing tips when writing NOFOs. **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 NOFO; can be either a project officer, program manager, branch chief, division leader, policy official, center leader, or similar staff member.

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.

Social Determinants of Health: Conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

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.

UEI: The Unique Entity Identifier (UEI) number is a twelve-digit number assigned by SAM.gov. When applying for Federal awards or cooperative agreements, all applicant organizations must obtain a UEI number as the Universal Identifier. UEI number assignment is free. If an organization does not know its UEI number or needs to register for one, visit www.sam.gov.

Work Plan: The summary of period of performance 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.

Program Specific Glossary:

APR – Annual Performance Peport
BJA – Bureau of Justice Assistance
CBT – Cognitive Behavioral Therapy
CoP – Community of Practice
CDS – Clinical Decision Support
DATA 2000 – Drug Addiction Treatment Act of 2000
DMP – Data Management Plan
DOJ – Department of Justice
DUA – Data Use Agreement
EHR – Electronic Health Record
ELC – Epidemiology and Laboratory Capacity for Prevention and Control of Emerging Infectious Diseases

HIE – Health Information Exchanges
HIN – Health Information Networks
Health IT – Health Information Technology
Integration – The inclusion of PDMP data into EHRs, PDS systems, and HIEs through automated queries
Interstate Interoperability – The ability of a state to share PDMP data across state lines
LOS – Letter of Support
ME/C – Medical Examiners and Coroners
MME – Morphine Milligram Equivalence
MOU – Memorandum of Understanding
MOUD – Medications for Opioid use Disorder
Navigators – Includes peer navigators, certified peer recovery specialists, peer support specialists, case managers, patient navigators, community health workers, persons with lived experience, and other individuals who link PWUD to care and harm reduction resources. These are individuals familiar with the local public health landscape and who work directly with individuals with OUD and/or StUD to ensure they have the tools to address barriers to seeking care and who support people accessing treatment and their retention (and reengagement if necessary) in SUD treatment and care, as well as support access to other services, such as harm reduction and social supports. CDC defines linkage using navigators as: 1) linkage to evidence-based treatment for substance use disorders- to include MOUD and other treatment (e.g., cognitive behavioral therapy [CBT], contingency management) and 2) linkage to harm reduction services.
NOFO – Notice of Funding Opportunity
NVDRS – National Violent Death Reporting System
OD2A-S – Overdose Data to Action in States
ONC – Office of the National Coordinator for Health Information Technology
OUD – Opioid Use Disorder
PDMP – Prescription Drug Monitoring Programs
PDMP Hub – BJA's designated PDMP data sharing system, RxCheck
PDS System – Pharmacy Dispensing Software System
PH/PS – Public Health and Public Safety
Proactive Reporting – A product of a PDMP where the prescription information is analyzed by PDMP staff, and activities are then reported to appropriate personnel or clinicians based on indicators/thresholds established by the PDMP.
PWUD – Persons Who Use Drugs
SDOH – Social Determinants of Health
SMART – Specific, Measurable, Achievable, Realistic, and Timely
StUD – Stimulant Use Disorder
SUD – Substance Use Disorder
SUDORS – State Unintentional Drug Overdose Reporting System
SSPs - Syringe Services Programs
TEP – Targeted Evaluation Project
UUDO – Unintentional and Undetermined Drug Overdose