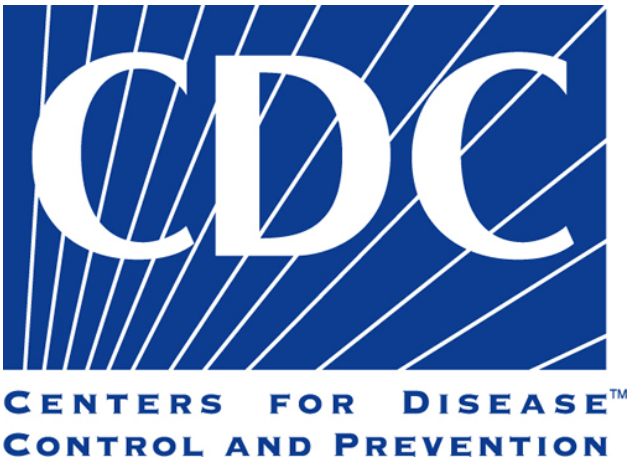

Centers for Disease Control and Prevention

NATIONAL CENTER FOR INJURY PREVENTION AND CONTROL

Overdose Data to Action: Limiting Overdose through Collaborative Actions in Localities (OD2A: LOCAL)

CDC-RFA-CE-23-0003

05/08/2023

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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-23-0003. 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: Limiting Overdose through Collaborative Actions in Localities (OD2A: LOCAL)

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)).

New-Type 1

D. Agency Notice of Funding Opportunity Number:

CDC-RFA-CE-23-0003

E. Assistance Listings Number:

93.136

F. Dates:

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

The LOI date will generate once the Synopsis is published if Days or a Date are entered.

Recommended but not Required

An LOI is requested, but not required. LOIs should indicate the intention to apply and to which components. The purpose of an LOI is to allow CDC program staff to estimate the number of applications and plan for the review of submitted applications. The LOI should contain the following information:

- Name of jurisdiction intending to apply to this NOFO.
- A preliminary decision about whether the applicant intends to apply for either or both of the optional and competitive surveillance components (Component B and/or Component C). This preliminary decision should be clearly and succinctly stated, "Plan to apply to Component B, but not Component C". If the applicant does not plan to apply for either Component B or Component C, please write, "Will not apply for Component B or Component C".

When submitting the LOI, please follow these instructions to help CDC rapidly identify and process your LOI:

- Send LOI via email to **OD2A_LOCAL@cdc.gov.**
- The subject of the email should be *"LOI Overdose Data to Action: Limiting Overdose through Collaborative Actions in Localities (OD2A: LOCAL)"*.
- The email with the LOI should be addressed to *"OD2A: LOCAL Team, Division of Overdose Prevention, CDC"*.

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

First Informational Call

When: March 13, 2023, 03:00 PM – 5: 00 PM Eastern Time (US and Canada)

Topic: OD2A: LOCAL First National Informational Call

Register in advance for this webinar:

https://us02web.zoom.us/webinar/register/WN_OAipA2W9Th-m9kB2TeKiHw

After registering, you will receive a confirmation email containing information about joining the webinar.

This two-hour call provides a comprehensive overview of the required strategies of the NOFO, presenting eligibility requirements, prevention strategies, a walk-through of the application and selection process, and a discussion of Component A, which is required for all applicants. 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.

Second Informational Call

When: March 14, 2023, 12:00 PM – 1:30 PM Eastern Time (US and Canada)

Topic: OD2A: LOCAL Second National Informational Call

Register in advance for this webinar:

https://us02web.zoom.us/webinar/register/WN_H3rwiCStRQi3_ikTOVJdWA

After registering, you will receive a confirmation email containing information about joining the webinar.

This 90- minute call focuses on the optional and competitive NOFO strategies in Components B (Drug product and/or paraphernalia testing) and C (Linkage to and retention in care surveillance). Throughout the session, participants will have the opportunity to ask questions about both optional and competitive strategies. All potential applicants are encouraged to attend this call, although it will be of particular benefit to jurisdictions planning to apply for optional strategies. A recording will be posted here following the webinar.

F. Executive Summary:

Summary Paragraph

Overdose Data to Action: Limiting Overdose through Collaborative Actions in Localities (OD2A: LOCAL) will support city or county local health departments (LHDs), special district health departments, and territories to use data to drive actions that reduce overdose morbidity and mortality in communities, with a primary focus on opioids and/or stimulants.

The NOFO has three components:

- Component A: Core Prevention and Surveillance Strategies (required)
- Component B: Drug Product and/or Paraphernalia Testing (optional)
- Component C: Linkage to and Retention in Care Surveillance (optional)

Within the five years, recipients will:

- Decrease nonfatal and fatal drug overdoses, overall and especially among disproportionately affected and underserved populations, with a primary focus on overdoses involving opioids and/or stimulants, including polysubstance use.
- Reduce health inequities related to overdose by closing gaps in access to care and services.
- Integrate harm reduction strategies and principles.
- Improve linkage to and re-engagement and retention in services, care, treatment, and recovery, focused on opioid use disorder (OUD) and stimulant use disorder (StUD).
- Build overdose surveillance infrastructure.
- Track and address emerging drug threats.

- Track linkage to and retention in care.

a. Eligible Applicants:
Open Competition

b. NOFO Type:
CA (Cooperative Agreement)

c. Approximate Number of Awards
40
Up to 40 recipients will be funded to conduct activities under Component A. Among those 40, up to 20 will be funded for Component B and up to 20 will be funded for Component C.

d. Total Period of Performance Funding:
$400,000,000

e. Average One Year Award Amount:
$80,000,000
Component A: $2,000,000
Component B: $250,000 - $325,000
Component C: $250,000 - $325,000

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 foundation funding, other U.S. government funding sources including programs supported by HHS or other agencies (e.g., Department of Justice, 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

U.S. drug overdose deaths increased to historic levels in recent years, with provisional estimates indicating over 108,000 predicted deaths occurring in the 12 months ending May 2022. While increases are seen across the U.S. and in most populations, recent increases were highest among certain racial/ethnic minority populations, including non-Hispanic Black (44%) and Native Hawaiian/Other Pacific Islander persons (44%). Systemic racism and its impacts on social determinants of health have resulted in disparities in access to, linkage to, and retention in treatment for substance use disorders, compounding risk in certain populations.

While most overdose deaths involve opioids, deaths involving stimulants alone or with opioids have also substantially increased. Data from substance use disorder treatment programs also show an increase in persons reporting stimulants as the primary substance of use at treatment admission.

There is an increasing need to support localities to build an infrastructure of overdose surveillance, harm reduction, recovery, and care in communities most impacted by the overdose crisis. The evolving drug problem is local, complex and dynamic, requiring locally tailored and culturally-relevant solutions. A strong foundation of cooperation and partnership across public health, behavioral health, health systems, community organizations, and public safety is necessary to build overdose infrastructure and cohesive programs that have multiple access points and address health inequities in overdose.

Addressing disparities in overdose is an overarching goal within every strategy in this NOFO. Activities must be culturally-relevant to those disproportionately affected by overdose and historically underserved, including persons recently released from incarceration, people experiencing homelessness, certain racial and ethnic groups, and anyone who has experienced a non-fatal overdose. Foundational to programmatic success, local health departments will need to leverage new and existing partners. Data generated through surveillance, prevention programs and by partners should be used to inform program implementation, focus on those at highest risk, and reduce health inequities.

This NOFO has three components:

- Component A (Required, up to 40 recipients selected): All applicants must apply to this component.
- Component B (Optional and competitive, up to 20 recipients selected from the 40 selected in Component A).
- Component C (Optional and competitive, up to 20 recipients selected from the 40 selected in Component A).

Funding for this NOFO will prioritize jurisdictions with higher drug overdose burdens and larger populations and ensure geographic diversity. Applicants must describe their catchment area and calculate their unintentional or undetermined drug overdose (UUDO) death burden and population size as outlined in **Appendix 1**. An optional sample form is provided in **Appendix 2b** with detailed instructions in **Appendix 2a** to help applicants calculate their UUDO death burden and population size. Applicants are not required to use this form. If a different format is used it must contain three required pieces of information: (1) counties, cities, or territories in their

service catchment area, (2) UUDO deaths, and (3) population. Upload this information to www.grants.gov in a document named "<Applicant Name> OD2A_ LOCAL_ Overdose_ Burden and Funding Form". If an Excel file is used, do not convert to PDF. Upload in its original format.

b. Statutory Authorities
Section 392A of the Public Health Service (PHS) Act (42 U.S.C. § 280b—1) and Section 311(c)(1) of the PHS Act (42 U.S.C. § 243).

c. Healthy People 2030
This NOFO supports the following Healthy People 2030 topic areas:

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
This NOFO supports the following national strategies:

HHS Overdose Prevention Strategy (https://www.hhs.gov/overdose-prevention/)
National Drug Control Strategy (https://www.whitehouse.gov/wp-content/uploads/2022/04/National-Drug-Control-2022Strategy.pdf)
Ending the HIV Epidemic (https://www.cdc.gov/endhiv/)
HHS Health Equity Action Plan (https://www.hhs.gov/sites/default/files/hhs-equity-action-plan.pdf)

e. Relevant Work
This program builds upon CDC's historical funding opportunities related to reducing overdose and related harms, including:

Prevention BOOST
Prevention for States: https://www.cdc.gov/drugoverdose/states/state_prevention.html
Data-Driven Prevention Initiative: Data-Driven Prevention Initiative (DDPI) | Drug Overdose | CDC Injury Center
Enhanced State Opioid Overdose Surveillance Program: https://www.cdc.gov/drugoverdose/foa/state-opioid-mm.html
Opioid Prevention in States – Surge Support via the Cooperative Agreement for Emergency Response: Opioid Funding - CDC
Overdose Data to Action: https://www.cdc.gov/drugoverdose/od2a/index.html
Implementing Overdose Prevention Strategies at the Local Level: Microsoft PowerPoint - RFA Info Webinar (naccho.org)

2. CDC Project Description

a. Approach

Bold indicates period of performance outcome.

Strategies and Activities	Short-term Outcomes (1-2 years)	Intermediate Outcomes (3-4 Years)	Long-term Outcomes (5+ years)
FOUNDATIONAL ACTIVITIES FOR ALL STRATEGIES in OD2A: LOCAL • Use data to inform action • Establish partnerships • Focus on health equity			
COMPONENT A *PREVENTION* <u>1A. Linkage to and retention in care (required):</u> Utilize navigators* to connect people to services; Initiate linkage to care activities, support retention in care, maintain recovery, and support reengagement in care <u>2A. Harm Reduction (required)</u>: Implement strategies that increase treatment entry, reduce drug use frequency and high-risk drug use practices, and improve the overall health of PWUD, with a focus on reducing overdose <u>3A. Stigma Reduction (optional)</u> Address stigma that exists among different audiences—individuals with SUD, public safety, healthcare, and the public—across community, healthcare, and public safety	More timely, detailed, comprehensive, and actionable surveillance data (6A) **Increased use of navigators to link PWUD to care and services (1A)** **Improved rapid and timely identification of changes in illicit drug market (B)** **Increased data sharing and data use that informs prevention and response efforts (1A-6A, B, C,)** **Increased partnerships, collaborations, and bidirectional referrals amongst**	**Enhanced ability of programs to respond to overdose trends for groups disproportionately affected by overdose (1A-6A, B, C)** **Increased use of standardized indicators on toxicologic findings and linkage to care to support local and national surveillance (B, C)** **Expanded and improved use of surveillance, program evaluation, and community data to drive prevention action that are community/population appropriate (1A-6A, B, C)** **Increased number of PWUD that are engaged in care and harm reduction services (1A-4A)** **Increased equitable delivery and improved access to care/services**	**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 the healthcare system **Decreased illicit opioid and stimulant use, including co-use with other substances, and decreased prevalence of OUD and StUD** **Improved health equity among groups disproportionately affected by overdose and those previously underserved by**

settings 4A. Clinician and health systems best practices (required) Improve clinical management of pain and of SUD and build healthcare infrastructure to improve care coordination, with a focus on providing guideline concordant care to reduce overdose 5A. Health IT enhancements (optional) Build health IT capacity to support clinicians *SURVEILLANCE* 6A. Overdose Surveillance Infrastructure(required) Improve and enhance overall capacity to conduct overdose-related surveillance **COMPONENT B** *Toxicologic Testing of Drug Product and/or Paraphernalia (optional and competitive)* Using CDC guidance, conduct laboratory toxicologic testing of drug products and/or drug paraphernalia to track the lethality of the illicit drug market **COMPONENT C**	**organizations working in overdose prevention (1A-4A)** **Improved identification of and outreach to people in need of care and services for SUD (1A-4A)** **Increased access to harm reduction services for PWUD, including increased distribution of naloxone across settings (2A, 3A)** **Increased capacity of staff within the workforce to connect PWUD to care and services (1A-4A)** Increased clinician capacity to initiate trauma sensitive and person-centered approaches (4A) Improved	**and long-term recovery among PWUD as well as those previously underserved by overdose prevention programs and the healthcare system (1A-4A)** Increased reports of supportive interactions between PWUD and community organizations, public safety partners, and clinicians (2A-4A) Decreased stigma experienced by PWUD (3A) **Decreased high risk opioid prescribing and increased use of evidence-based pain care (4A, 5A)** **Improved health system and clinician capacity to provide care for OUD and StUD (4A, 5A)**	**overdose prevention programs and the healthcare system, identifying and closing gaps in access to care and services** **Increased adoption of harm reduction strategies and principles, including those of empathy, non-judgment, and meeting people where they are** **Expanded identification, tracking, and mitigation of emerging drug threats** **Collection and use of data on linkage to and retention in care among people at high-risk of overdose to improve care.**

Surveillance of Linkage to and Retention in Care (optional and competitive) Collect and analyze standardized data on linkage to and retention in care among persons at high risk of overdose using CDC guidance	awareness of harm reduction services for PWUD among the general public (1A-4A) Increased public awareness of services, including treatment options and harm reduction support services among PWUD (1A-4A) Improved attitudes and knowledge about stigma among individuals with SUD and among public health practitioners, clinicians, public safety and other professionals working with PWUD (3A) **Increased clinician awareness of evidence-based practices for pain management (4A)** **Increased**		

	clinician expertise and confidence to provide equitable OUD and StUD care (4A)		

* 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.

Glossary of Acronyms
SUD – Substance use disorder
OUD – Opioid use disorder
MOUD – Medications for opioid use disorder
Health IT – health information technology
PWUD – Persons who use drugs
StUD – Stimulant use disorder

* 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.

i. Purpose
The central goal in OD2A: LOCAL is to use data to drive action steps that reduce overdose morbidity and mortality in communities quickly, while addressing health disparities, with a primary focus on opioid, stimulant, and polysubstance use involving opioids and/or stimulants.

ii. Outcomes
Measurable outcomes are essential for determining the extent to which the strategies and activities across the three NOFO components achieve the expected outcomes as described in the logic model. Recipients are expected to implement activities that will impact the logic model's relevant short-, intermediate, and long-term outcomes listed. 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 activities. To identify how activities address health equity, recipients will be expected to report on how they are closing gaps and working with groups disproportionately affected by overdose 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 the 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, who participate in the and could be affected by the program, and that collaborate as 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 activities. Recipients are encouraged to identify short-term outcomes associated with optional activities. Recipients will report on progress toward achieving selected short-term outcomes within the annual performance report (APR). Short-term outcomes include:

- Increased use of navigators to link PWUD to care and services (Strategy 1A)
    - 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.
- Improved rapid and timely identification of changes in illicit drug market (Component B)
- Increased data sharing and data use that informs prevention and response efforts (Strategies 1A-6A, Component B, Component C)
- Increased partnerships, collaborations, and bidirectional referrals amongst organizations working in overdose prevention (Strategies 1A-4A)
- Improved identification of and outreach to people in need of care and services for SUD (Strategies 1A-4A)
- Increased access to harm reduction services for PWUD, including increased distribution of naloxone across settings (Strategies 2A and 3A)

- Increased capacity of staff within the workforce to connect PWUD to care and services (Strategies 1A-4A)
- Increased clinician awareness of evidence-based practices for pain management (4A)
- Increased clinician expertise and confidence to provide equitable OUD and StUD care (4A)

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

- Enhanced ability of programs to respond to overdose trends for groups disproportionately affected by the overdose epidemic (Strategies 1A-6A, Component B, Component C)
- Increased use of standardized indicators on toxicologic findings and linkage to care to support local and national surveillance (Component B, Component C)
- Expanded and improved use of surveillance, program evaluation, and community data to drive prevention action that are community/population appropriate, to inform the implementation and improvement of prevention and response efforts, especially for groups disproportionately affected by the overdose epidemic (Strategies 1A-6A, Component B, Component C)
- Increased number of PWUD that are engaged in care and harm reduction services, especially for groups disproportionately affected by the overdose epidemic, accounting for 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 1A-4A)
- 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, recovery services) and long-term recovery among PWUD as well as those previously underserved by overdose prevention programs and the healthcare system (Strategies 1A-4A)
- Decreased high risk opioid prescribing and increased use of evidence-based pain care (Strategies 4A, 5A)
- Improved health system and clinician capacity to provide care for OUD and StUD (Strategies 4A, 5A

Across all components, all recipients should be positioned and are expected to impact **long-term** outcomes within five years or earlier after receiving funding. Long-term outcomes include:

- Decreased fatal drug overdoses, overall:
    - Primarily involving opioids and/or stimulants; and
    - 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; and
    - 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 (i.e., polysubstance use involving opioids and/or stimulants), and decreased prevalence of 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, identifying and closing gaps in access to care and services
- Increased adoption of harm reduction strategies and principles, including those of empathy, non-judgment, and meeting people where they are
- Expanded identification, tracking, and mitigation of emerging drug threats
- Collection and use of data on linkage to and retention in care among people at high risk of overdose to improve care

iii. Strategies and Activities

I. OVERVIEW OF COMPONENTS

This NOFO has three components, described below, that consist of required and optional strategies within Component A and two optional and competitive components (Component B and Component C) that fund surveillance enhancements (See Table 1).

- **Component A (Required)** will competitively fund up to 40 recipients to implement required and optional prevention strategies within three settings: the **community**, **public safety**, and **healthcare settings**. Linkage to and retention in care and recovery, and harm reduction are required strategies in all three settings, and clinician and health system best practices are required in health system settings. All other prevention strategies, although extremely important parts of a coordinated overdose response, are optional in this NOFO. In addition, this NOFO includes three specific required prevention activities:
    - Use of navigators is required for all linkage-related activities within both the linkage to and retention in care strategy, including linkage to evidence-based treatment for substance use disorder—to include medications for opioid use disorder (MOUD) and other treatment (e.g., cognitive behavioral therapy, contingency management) across all settings and linkage to services such as harm reduction across all settings.
        - Navigators are individuals familiar with the local public health landscape and who work directly with individuals with opioid use disorder (OUD) and/or stimulant use disorder (StUD) to ensure they have the tools to address barriers to seeking care and who support people accessing treatment and supporting their retention (and re-engagement 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.

- Naloxone distribution is required within the harm reduction strategy across all settings (purchase of naloxone is not allowed in this NOFO, but activities supporting distribution are required. See **Appendix 3** for a list of what is allowable under the harm reduction strategy).
- Strategies to support implementation of clinical care concordant with the *CDC Clinical Practice Guideline for Prescribing Opioids for Pain – United States, 2022* is required within the clinician and health system best practices strategy, specifically in the healthcare setting. Funding for the direct provision of clinical care is not allowed in this NOFO, but activities which support implementation of evidence-based care such as training and academic detailing may be supported.

This component also funds surveillance infrastructure to help jurisdictions collect essential data on drug overdose burden and health disparities as well as key characteristics of drug overdoses such as location, demographics, and trends.

- **Component B (Optional and Competitive)** will fund up to 20 of Component A recipients to conduct toxicologic testing of drug products and/or paraphernalia to track illicit drug market trends and identify emerging threats. Data collected from this component should support NOFO prevention activities.
- **Component C (Optional and Competitive)** will fund up to 20 of Component A recipients to establish a surveillance system to measure linkage to and retention in care for substance use disorder (SUD). Expanding and standardizing surveillance of linkage to and retention in care at the local level will complement prevention-focused activities by providing a better understanding of the cascade of care (CoC) for SUD, including referral to, initiation of, retention in, and loss to follow-up in evidence-based treatment for SUD and related support services. Data collected from this component should support NOFO prevention activities.

Table 1: Required and optional activities by three NOFO components

Component A: Required component with up to 40 recipients funded			
List of Strategies in Component A	**Strategy Required**		
Prevention (Strategies 1A– 5A)	*Prevention Settings*		
	Community	*Public Safety*	*Health Systems*
1A. Linkage to and retention in care	Required	Required	Required
2A. Harm reduction	Required	Required	Required
3A. Stigma reduction	Optional	Optional	Optional
4A. Clinician and health system best practices	N/A	N/A	Required
5A. Health IT enhancements	N/A	N/A	Optional

Surveillance (Strategy 6A): Overdose surveillance infrastructure	Required
Component B: Optional and competitive component to support drug product and/or paraphernalia testing with up to 20 recipients funded	
Component C: Optional and competitive component to support linkage to and retention in care surveillance with up to 20 recipients funded	

A. Foundational Activities Across All Components

Three foundational activities provide the lens through which all strategies and activities in all components are developed and implemented. All applicants funded in OD2A: LOCAL must clearly describe where and how these foundational activities will take place. It is through these activities that jurisdictions will achieve programmatic success.

- **Use data to inform action:**
    - **Component A:** Intentional, coordinated, and regular examination of local data sources will inform programmatic activities, strong partnerships, and a commitment to reducing disparities in overdose, access to and retention in evidence-based harm reduction, and SUD treatment and care.
    - **Component B:** Toxicologic findings from drug products and paraphernalia should be used to inform harm reduction and linkage to care prevention activities funded through Component A of this NOFO. Data can also be used to investigate how changes in the illicit drug market contribute to drug overdose trends, to identify, understand and respond to drug overdose outbreaks, and to raise awareness among persons who use drugs (PWUD), policymakers, public health, and the general public.
    - **Component C:** Linkage to and retention in care surveillance data should be used to improve and enhance linkage to care prevention activities funded through Component A of this NOFO.

- **Establish Partnerships**: For **Component A, Component B, and Component C** strong partnerships will be foundational for programmatic success. Recipients will need to leverage new and existing partners for successful program implementation, to engage with people with lived experience and community partners to address stigma, and to advance health equity by reaching populations at disproportionate risk of overdose and those historically underserved within the locality. Data generated through surveillance, by prevention programs, and by partners should be used to inform program implementation, to focus on those at highest risk and to reduce health disparities. Localities and states will be expected to coordinate and cooperate.
- **Focus on health equity**
    - **Component A:** Activities must identify and be tailored to those disproportionately affected by overdose, and work to overcome disparities in accessing services and care – including harm reduction.

- **Component B:** Recipients should conduct testing of drug products and paraphernalia that are commonly associated with drug overdose deaths in their jurisdiction and work with partners and people with lived experience to interpret and disseminate findings to those disproportionately at risk for overdose.
- **Component C:** Recipients should collect surveillance data to measure and improve linkage to and retention in care, especially among people at higher risk of overdose and/or historically underserved.

As described throughout this NOFO, these foundational activities will guide implementation of the three components across multiple settings—all with the desired objective to accomplish the central goal of reducing overdose morbidity and mortality among disproportionately affected and underserved populations (See **Figure 1, Appendix 12: Map of foundational activities, key settings, strategies and goals for the NOFO**).

A.1 Data to Action Framework

Underlying this NOFO is a four-stage data to action framework (synthesize and analyze, prioritize, implement, and evaluate) (See **Figure 2, Appendix 13: Data to Action Framework**). The data-to-action framework describes how multiple sources of data (e.g., surveillance data, process and outcome evaluation data, programmatic data, community data from partners including those with lived experience with drug use, and scientific evidence on effective programs) should be integrated and iteratively used to select, evaluate, improve, and scale-up 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). Through use of this framework, recipients will work together with their communities to use data and evidence to save lives, achieving significant reductions in overdose and in disparities in overdose, in five years.

Recipients will need to triangulate surveillance data, research on evidence-based and promising practices, feedback and interpretations of community partners, and evaluation findings to inform their prevention strategies. Examples of how to integrate the four data to action stages into your work are provided below:

- **Synthesize and Analyze**: Surveillance analyses and surveillance infrastructure funding will be used to synthesize and analyze data across multiple sources, and produce timely, easy-to-understand, actionable findings that assist in at least one of the following:
  - Inform the selection of prevention programs
  - Focus programs on areas and/or groups at high risk of overdose
  - Identify and respond to emerging drug threats
  - Improve prevention program implementation in other ways

- **Prioritize**: Allocation of resources to surveillance and prevention programs should be prioritized in conversation with partners to maximize impacts on drug overdose in the short-term while decreasing health disparities and expanding capacity over the five-year funding period. Recipients will need to develop a prioritization process to allocate OD2A: LOCAL funds by using different types of evidence (e.g., drug overdose burden including data on populations at greatest risk of overdose, literature on evidence-based or

evidence-informed programs (e.g., CDC's Evidence-based strategies to prevent fatal overdose), and analyses of current drug overdose trends) as well as community capacity, context, and knowledge (e.g., gaps analyses of service gaps and populations historically underserved, feasibility of implementation, potential program reach, and community insight, feedback and buy-in) in the prioritization process.

- **Implement:** Recipients must select prevention activities that are evidence-based or evidence-informed. The primary purpose of prevention activities must be to reduce drug overdoses and health disparities and focus on populations historically underserved and at disproportionate overdose risk based on the best data and evidence available. As the drug crisis and the science on how to address it are rapidly evolving, recipients may propose promising or evidence-informed programs or practices aligned with the strategies of this NOFO.
- **Evaluate:** Local evaluation efforts should be concentrated on critical prevention programs or key data gaps that can inform ongoing efforts to strengthen activities and improve the impact of the recipient's current prevention programs. Responding to evaluation requirements in OD2A: LOCAL will demonstrate use of this data to action stage. Recipients must participate in CDC's efforts to evaluate OD2A: LOCAL and engage in local evaluation activities that track progress on program activities and intermediate outcomes, measure program impact on drug overdoses and health disparities, identify implementation opportunities and barriers, and make adaptions to activities in response to findings, using surveillance, evaluation, and other program data.

Partnerships are a foundational activity and often rely on sharing and use of data. The next section provides in-depth guidance on how the data to action steps can be integrated into efforts to establish and strengthen partnerships.

Recipients are expected to document their progress on data to action in workplans and Annual Progress Reports submitted to CDC each year.

A.2 Establish Partnerships

Fundamental to data-to-action are the partnerships that enable it. Strong, multi-sectoral partnerships such as those between public health and public safety, harm reduction, health systems, and the involvement of persons who use drugs or have a history of OUD and/or StUD are essential for addressing overdose in the local setting. In an environment of increasing overdoses related to polysubstance use, 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. For example, partnerships should represent various demographic groups; ensure strategies that recruit and reach diverse participants from a variety of sectors, representing those disproportionately impacted by overdose, historically underserved, and including those who use drugs and those with lived experience; provide input on implementing programs (e.g., linkage to care, naloxone distribution, overdose education) and determine impact of these programs. Program planning and implementation should include ongoing social participation from populations of interests (under-resourced communities, groups that are at higher risk of overdose and individuals with lived experience) and foster shared decision-making among program participants. Table 2 provides guidance on how recipients will be expected to engage partners and people with lived experience through the four stages of the data-to-action model.

CDC has developed several related frameworks for addressing overdose through partnerships. The Public Health and Safety Team (PHAST) Toolkit and the Overdose Fatality Review Practitioner's Guide are two frameworks which build upon one another to engage partners in efforts to convene multi-sector groups including those that represent groups at higher risk for overdose, individuals with lived experience, specific racial and ethnic communities and other entities to share information on the overdose crisis. These frameworks support coalitions to work together to examine data and develop focused strategies and interventions for a local response and to monitor progress. Recipients should leverage and engage existing local partnerships, including OFRs and PHAST teams, and Drug Free Communities, building coalitions with clear objectives related to the strategies in this NOFO, and ensuring that key partners from public safety, public health, health systems, harm reduction, social services and persons who use drugs are among those engaged meaningfully. New partnerships will likely need to be developed to facilitate entry, trust, and engagement with communities that are historically underserved.

Table 2 – Engaging Partners through the Data-to-Action Framework

Four Stages	Description of use of data and evidence	Engage partners and people with lived experiences
Synthesize and Analyze	Recipients must analyze data to produce easy- to-understand and actionable findings that respond to data gaps and needs of key partners.	• Partners help document current harm reduction and treatment capacity, including critical gaps. • Partners provide data from non-traditional sources (e.g., syringe services programs (SSPs), SUD treatment programs, services for people experiencing homelessness, experiences of PWUD). • Partners help identify emerging threats. • Collaborate and coordinate with partners to interpret the data to become meaningful and actionable.
Prioritize	Allocation of resources to surveillance and prevention programs should be prioritized in conversation with partners to maximize impacts on drug overdose in the short-term while 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	• Partners and people with lived experience help identify realistic and actionable goals. • Program priorities align with priorities of partners. • Ensure activities are not duplicative. • Complement and/or expand other actions occurring in local jurisdictions. • Select most impactful approaches and programs.

Four Stages	Description of use of data and evidence	Engage partners and people with lived experiences
	investments, in consultation with partners, include local drug overdose burden, populations at greatest risk, populations historically underserved, feasibility of implementing programs to reduce drug overdoses, and partner support and buy-in.	
Implement	Recipients must implement prevention activities aimed to reduce drug overdoses and health disparities and focus on populations historically underserved and at disproportionate overdose risk based on the best data and evidence available. As the drug crisis and the science on how to address it are rapidly evolving, recipients may implement promising or evidence-informed programs or practices aligned with the strategies of this NOFO.	• Partners can share resources. • Partners help gain buy-in. • Coordinate with other programs. • Increase the reach of programs. • Partners can provide feedback on quality improvement measures and program monitoring efforts to ensure interventions have sufficient scope and high fidelity.
Evaluate	Recipients must measure 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 translate opportunities into improved interventions.

A.3 Health Equity

Advancing health equity and addressing disparities in overdose and access to SUD care and harm reduction services is a priority for CDC's Division of Overdose Prevention. This funding should be used to reduce and eliminate health disparities and advance health equity in public health efforts to address the overdose crisis. Thus, the work conducted by recipients should promote

interventions at the local level that address health disparities in overdose and improve equitable access to overdose prevention tools including MOUD and evidence-based treatment for StUD as well as harm reduction services. Recipients will utilize surveillance, evaluation, and other program data to identify the local populations at highest and most disparate risk of overdose, prioritize activities that focus on populations at disproportionate risk, clearly describe how activities and partners will engage historically underserved populations using culturally relevant messaging and interventions, and specify what efforts will improve health equity within the local jurisdiction. Applicants should describe experience working with historically underserved populations and populations of focus and include letters of support from organizations serving these groups. Please use the following title when submitting this LOS: "<Applicant_name> Component A: Organizational support from underserved population/population of focus – Letter 1." If multiple organizations will be providing a LOS, please number each letter sequentially (e.g., first letter is "Letter 1" and second letter is "Letter 2"). All letters should be uploaded as a PDF at www.grants.gov with the application

II. COMPONENT A: REQUIRED CORE PREVENTION AND SURVEILLANCE STRATEGIES

Component A of this NOFO requires 3 core prevention strategies (Strategy 1: Linkage to and retention in care; Strategy 2: Harm reduction; and Strategy 4: Clinician and health system best practices) to take place in 3 settings: the community, in public safety and in health systems. Applicants may also choose to implement two optional prevention strategies, Strategy 3: Stigma reduction and Strategy 5: Health IT enhancements. Finally, the NOFO requires one core surveillance strategy (Strategy 6: Overdose surveillance infrastructure). These six strategies are described in this section.

A. Prevention Strategies Overview (Strategies 1A – 5A)

Decreasing opioid- and stimulant-involved overdose morbidity and mortality through prevention programs is a primary objective of this NOFO. This will be accomplished through building data-informed programs that increase access to evidence-based care for substance use disorder, support re-engagement in care and long-term recovery, and ensure access to harm reduction tools such as naloxone and fentanyl test strips; highly effective strategies that can reduce loss of life resulting from overdose. In this NOFO, it is required that linkage to care and retention in care and recovery, and harm reduction activities take place in all 3 settings: the community, with public safety, and in health systems. Another required strategy is ensuring best practice standards for clinicians and health systems on effective pain management and SUD care in alignment with the *CDC Clinical Practice Guideline for Prescribing Opioids for Pain – United States, 2022*. Each of these strategies – linkage to and retention in care and recovery, harm reduction, clinician and health system best practices, as well optional strategies - stigma reduction and supporting health IT enhancements - are all components of a comprehensive approach to preventing overdose when they are implemented effectively, using an informed, data driven approach. The data-to-action framework will ensure programs are reaching the highest risk populations and addressing overdose disparities in local communities, and partnerships will strengthen programs and their reach. Ensuring each strategy takes place in a range of settings – in the community, in public safety, and in health systems –enables a comprehensive reach across jurisdictions to reduce and prevent overdose.

By ensuring strategies are taking place across systems and in a variety of settings, the opportunity for engagement from any location is increased, making all doors open doors to services and treatment. Under each setting, required and optional strategies are listed, along with required and suggested activities that would be appropriate for that setting.

Applications must clearly identify how proposed activities will directly reduce deaths from overdose, improve linkage to and retention in evidence-based treatment for OUD and StUD and address disparities in overdose. Applications must describe the populations activities are reaching, why and how the chosen population(s) have been selected (i.e., based on disproportionate morbidity/mortality, historically underserved), and explicitly state the activity goals. Applications will be scored on their feasibility and potential impact. They should include letters of support from organizations that work with populations of focus. See section A3 for appropriate naming convention for each letter. A brief overview of strategies is below, followed by more in-depth description of the setting in which these strategies will take place, along with setting-specific suggested activities. Proposed activities must not duplicate or overlap with activities supported by other federal funding sources or CDC mechanisms. However, coordination with other programs is heavily encouraged. This may include hiring liaison positions, cross-training, partnering, and sharing data.

Prevention (strategies 1A-5A)			
	Prevention Settings		
	Community	Public Safety	Healthcare
1A. Linkage to and retention in care[+]	Required	Required	Required
2A. Harm reduction[^]	Required	Required	Required
3A. Stigma reduction	Optional	Optional	Optional
4A. Clinician and health systems best practices**	NA	NA	Required
5A. Health IT enhancements	NA	NA	Optional

NA = not applicable to setting

[+]Must include use of navigators to facilitate linkage to services and care in all settings

^Must include activities to support naloxone distribution in all settings

**Must include activities to support implementation of care aligned with the *CDC Clinical Practice Guideline for Prescribing Opioids for Pain – United States, 2022*

A.1 Prevention Strategy 1A: Linkage to and retention in care (required)

Linking people with SUDs to evidence-based treatment and retaining individuals in treatment is a required activity in all settings in this NOFO. Recognizing a “no wrong door” approach, broad consideration should be paid to program development across the multitude of environments that may provide opportunities for care linkage. Specifically, recipients may propose prevention-focused activities for linkage to harm reduction, linkage to care, retention in care, and re-engagement in care when necessary and possible via partnerships with community organizations,

public safety, and in healthcare settings. Across all settings, recipients should implement activities that identify, examine, and address barriers to ensuring equity in access and delivery to services and care.

REQUIRED ACTIVITY #1: Utilization of linkage to care and re-engagement navigators is a required activity within linkage to and retention in care activities. *An application that does not include this activity may receive 0 points as part of the assessment of the Approach in Phase II review.* 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 people who use drugs (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 re-engagement 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. In this NOFO, funds may be used to pay for staff time and training, administrative work, and outreach efforts. Funds may not be used to pay for medications for treatment for substance use disorder or clinical care. Linkage to care activities should use navigators in all settings. They should ensure that the navigator is appropriate for the setting in training and title and collaborates closely with others working to support linkage to services and care in that setting. Applications should describe who navigators are in each setting in terms of title, training and experience, specific activities they will undertake, and their role within activities in that setting.

Funding for linkage to care in OD2A: LOCAL supports activities related to voluntary linkage to and retention and re-engagement in evidence-based treatment and support services for OUD, StUD and polysubstance use, including harm reduction services and recovery-oriented systems of care. Evidence-based treatment for OUD includes using FDA-approved medications for OUD (MOUD such as buprenorphine, methadone, or extended-release naltrexone) alone or in combination with behavioral health strategies such as counseling, motivational interviewing, and cognitive behavioral therapy. While currently there are no FDA-approved medications to treat StUD, there are evidence-based behavioral health strategies to support recovery, including motivational interviewing, contingency management, community reinforcement approach, and cognitive behavioral therapy. Linkage to care for StUD must be to services that offer such interventions. Limited funds may also be used to link individuals to care for comorbidities related to substance use such as mental health care, viral hepatitis, HIV, or skin infections, when OUD/StUD treatment is co-located within programs. Funds may also be used to provide transportation when it is a barrier to accessing MOUD and other treatment for SUD.

Although OD2A: LOCAL funding cannot be used to pay for medications or direct service delivery and care provision, recipients should develop innovative ways to ensure persons in need of care may be connected to necessary treatment, retained in treatment, and supported to re-engage in treatment should they disengage from care. Treatment, including medications, should be funded through other sources such as partnerships with SAMHSA-funded programs or

through insurance reimbursement. This NOFO does fund activities that support access to treatment and care. Numerous studies have demonstrated inequitable access to SUD care, and special attention should be paid to developing linkage to care frameworks that reduce inequities in access to and utilization of evidence-based treatment. Recipients are encouraged to propose activities that expand upon existing evidence-based programs in addition to new activities that may address the changing nature of the overdose epidemic. In addition, funded applicants must utilize surveillance and sociodemographic data to identify populations at disproportionate risk for overdose, implement strategies that prioritize these populations and aim to reduce drug overdose-related disparities. Strong, multi-sectoral partnerships can help, such as through the partnerships and data sharing described by the data-to-action framework.

To ensure all doors are open to accessing high quality, nonjudgmental and low-barrier evidence-based services, care and treatment for SUDs, and engagement in recovery, linkage to and retention in care, activities should take place in public safety, health systems and community settings. **All recipients must describe how navigators will be used in linkage to care activities in each setting**. CDC encourages a single program that works in multiple settings rather than multiple programs serving different settings. Programs that have touchpoints in all settings can streamline care, engage partners and build a strong infrastructure. Activities should ensure, through data to action, partnerships, and insights from persons who use drugs and historically underserved populations, that they are reaching populations most at risk of overdose, those traditionally underserved in SUD treatment settings and those disproportionately affected by overdose.

A.2 Prevention Strategy 2A: Harm reduction (required)

Harm reduction is a set of practical strategies and interventions aimed at reducing negative consequences associated with drug use and is one of the four pillars in the HHS overdose prevention strategy. These interventions are provided with compassion, without judgment and with low barriers. Harm reduction activities are required to take place in all prevention settings under this NOFO. **Under this NOFO, overdose prevention education and naloxone distribution are required harm reduction strategies (required activity #2)**. Other activities that can be supported through this NOFO include supporting syringe services programs to reach populations at high risk of overdose, populations disproportionately affected by overdose, and those historically underserved by prevention programs. This may include supporting mobile services, and syringe disposal services at places that use injectable naloxone (though no supplies used for drug injection, including syringes, may be funded under this NOFO) in jurisdictions which have a determination of need. Funding may also be used to support partnerships to facilitate low-threshold access to treatment for substance use disorder, including MOUD through co-location with harm reduction services to ensure PWUD are able to access necessary treatment without barriers; drug checking (for example, using fentanyl test strips [FTS]); and education about the local drug supply and safer drug use. **Appendix 3** provides a comprehensive list of allowable and unallowable harm reduction-related activities. Harm reduction spans a continuum; in addition to serving those currently using drugs, harm reduction can be included in primary prevention, treatment and recovery programs.

Recipients should focus on funding harm reduction activities that support populations who disproportionately experience overdose morbidity and mortality, and those underserved by harm reduction, prevention, and treatment programs. They should strive for health equity amongst

people who use drugs. All harm reduction activities must be within the bounds of federal, state, and local laws and regulations. High quality, nonjudgmental and low-barrier evidence-based harm reduction activities should take place in community, public safety, and health systems settings. Programs that have touchpoints in all settings are encouraged to streamline care, engage partners, and build a strong infrastructure. Harm reduction activities should ensure, through data to action, partnerships, and insights from and engagement with persons who use drugs, that they are reaching populations most at risk of overdose, those traditionally underserved in SUD treatment settings, and those disproportionately affected by overdose.

REQUIRED ACTIVITY #2: Funding services that support naloxone distribution to people who use drugs and/or people at risk of overdose is a required harm reduction activity in all settings. Although naloxone cannot be purchased under this NOFO, funds can be used to support education, staffing and infrastructure related to naloxone distribution. Appendix 3 includes a list of allowable harm reduction expenditures related to naloxone distribution under OD2A: LOCAL.

A.3 Prevention Strategy 3A: Stigma reduction (optional)

One major barrier to improving uptake of clinical care, treatment, and other recovery and harm reduction services is stigma surrounding substance use. Although CDC recognizes the deep impact stigma has on the lives of people who use drugs, stigma reduction activities under this NOFO are optional, allowing applicants to prioritize strategies which reduce overdose morbidity and mortality as fast as possible, given limited resources. Applicants are encouraged to infuse anti-stigma education in all trainings, communications and activities undertaken as a part of other strategies. Activities should be culturally relevant and designed to address stigma with the goal of improving engagement, care and support, and retention in care for people who use substances and within that population.

Development and implementation of anti-stigma messages that resonate with the identified audience and setting is necessary to address stigma and advance overdose prevention and harm reduction activities across settings, given that a lack of understanding of substance use, addiction, and treatment drives stigma, inhibits treatment, and impacts policies. Activities should be aimed at improving understanding, attitudes and behaviors towards persons who use drugs, overdose, substance use disorder, treatment, including MOUD, harm reduction and recovery. Anti-stigma activities under this NOFO must be evidence-based when possible, culturally relevant, and reach those at highest risk of overdose, those who serve people at risk of overdose or those in most need of education related to overdose. Activities must comply with health literacy guidelines (plain language) and best practices. Communication activities are also critical to successful development and implementation of these strategies, and can focus on people who use drugs, service providers working with people at risk for overdose, public safety, policymakers and the general public.

A.4 Prevention Strategy 4A: Clinician and Health Systems Best Practices (required)

Ensuring clinicians have the tools to provide effective pain care, while addressing and preventing SUDs is essential to achieving reductions in overdose-related morbidity and mortality. Without the proper tools and protocols in place to address overdose risk and manage acute, subacute, and chronic pain, opportunities for intervention are missed, especially among historically underserved populations. Providing evidence-based training and academic detailing will

strengthen systems of care and will be essential components of the interventions conducted within healthcare settings. Ensuring local clinicians are trained and competent to address overdose risk while managing pain will contribute to a healthier community.

REQUIRED ACTIVITY #3: Recipients are required to work with local health systems and community healthcare providers to support the implementation of evidence-based care aligned with the *CDC Clinical Practice Guideline for Prescribing Opioids for Pain – United States, 2022*. *An application that does not include this activity may receive 0 points.* The overdose epidemic has evolved from a primary focus on prescription opioids; however, opioid prescribing practices not rooted in evidence still persist, and prescription opioids continue to contribute to overdose deaths and opioid use disorder, necessitating continued efforts in educating clinicians on safer, scientifically-driven prescribing practices as one strategy to prevent harm to patients. In addition, many patients with pain, especially those with high-impact chronic pain do not receive optimal pain care. The *CDC Clinical Practice Guideline for Prescribing Opioids – United States, 2022* ("2022 CDC Clinical Practice Guideline") synthesizes the most current literature on evidence-based practice particularly in the use of prescription opioids to treat acute, subacute, and chronic pain, including offering naloxone to minimize overdose risk and providing support and guidance for linking patients to substance use disorder care as needed. Recipients are required to leverage local clinical leadership to implement the 2022 CDC Clinical Practice Guideline into health system practice. In addition to prescription opioids and other pain treatment modalities, clinician education should also prioritize content on OUD, polysubstance use, and StUD.

Infrastructure for educational activities should be sustainable and flexible to adapt to ongoing training needs as the overdose epidemic evolves and not viewed as a short-term one-time activity. Building a cadre of accessible educators who can regularly mobilize to reinforce key messages such as a team of trained academic detailers, and/or implementing an ongoing regularly scheduled lecture series and/or relevant communication campaigns, will be critical to the success of educational activities. Strong consideration should be given to offering continuing medical education credit as an added incentive to training participation to maximize its benefit. 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 Guideline's expansion of scope which also includes dentists, clinicians managing postoperative pain as outpatients, and clinicians providing pain management upon discharge from emergency departments and inpatient settings, not just primary care clinicians. Pharmacists are also important clinical partners.

Educational activities should also prioritize MOUD, polysubstance use, and StUD diagnosis and treatment to best support linkage to care and care access expansion, and ensure care continuity for people taking long-term opioid therapy for chronic pain and people with SUD Training on OUD and StUD screening/diagnosis/treatment options should pay special attention to raising awareness of specific community/local options for SUD care (e.g., opioid treatment programs [OTPs], local behavioral health networks, addiction medicine/psychiatry specialists, and other clinicians and settings equipped to provide care). Trained clinicians should feel empowered in understanding linkage options in the community for their patients especially if they do not provide that care themselves and/or to complement care provision. Also, to best support linkage

to care efforts in this NOFO, educational efforts should target multiple clinical specialties recognizing that any healthcare encounter can represent an opportunity to link a patient to needed care.

A.5 Prevention Strategy 5A: Health IT Enhancements (optional)

Enhancing health information technology ("health IT") capabilities may also facilitate clinician and health system ability to develop prevention-oriented solutions to the overdose epidemic by providing clinicians with timely, relevant information that can improve clinical decision-making, prevent errors, and enhance care. Relevant activities may work to integrate evidence-based recommendations on opioid prescribing, prescription drug monitoring program (PDMP) data, and support for SUD care into electronic health records (EHRs) to drive development of electronic clinical decision support (CDS) tools that can facilitate best-practice, data-driven, equitable care. 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. Through the sharing of ideas and resources in the local collaborative framework, this strategy aims to assist local health jurisdictions in their support of implementation of electronic CDS tools, quality improvement (QI) measures and coordinated care strategies in community practices and health systems to bring public health solutions to the point of care to assist in clinical decision-making. This strategy is optional, but funding may be used to support health IT enhancements that directly address overdose risk, access to care for SUDs, and improve disparities in overdose-related care.

B. Prevention Settings

Across settings—community, public safety, and healthcare—recipients will need to conduct at least one additional prevention activity apart from the required activities in each of several required strategies (i.e., naloxone distribution, linkage to care or harm reduction with navigators; training on guideline-concordant care). Recipients also will have the opportunity to conduct additional interventions in required as well as optional strategies.

B.1 Prevention in the Community

Examples of community settings include syringe services programs, public health departments, social services organizations, medical examiners, neighborhood groups, faith-based organizations, community-based organizations and other places in communities that may serve people at risk of overdose, as well as specific public places within a community where overdoses can be prevented (e.g., public parks, restrooms, libraries, schools). Many people disproportionately impacted by overdose may not access traditional health systems, making the community an essential setting to engage and link to services, care and treatment. **Required strategies in this setting include linkage to and retention in care (strategy 1A), harm reduction (strategy 2A) and provision of guideline-concordant care (strategy 4A).** Within these required activities, navigation to treatment for SUDs and to harm reduction services, and activities related to naloxone distribution, are required. Partnerships with syringe services programs (SSPs), mental and behavioral health programs, drug-free community coalitions and alliances, recovery communities and coalitions, and programs serving people experiencing homelessness or food insecurity will be necessary to successfully conduct work in community settings. Funded recipients will need to work with persons with lived (including current) experience of drug use, and those disproportionately impacted by overdose and/or underserved in

SUD treatment settings, in planning and execution phases to ensure that activities are effective, reaching the intended populations, and are culturally relevant. While stigma reduction activities are not required, recipients may conduct them as complementary or stand-alone activities in this setting. See **Appendix 4** for examples of activities to be conducted in the community setting (note this is not a comprehensive list).

B.2 Prevention in Public Safety

Public safety is broadly defined to include criminal justice professionals and first responders such as law enforcement, emergency medical technicians, jail/prison personnel, probation/parole officers, prosecutors and judiciary staff. A public safety setting is often the first and/or only setting PWUD encounter. Therefore, public safety agencies play a vital role in the prevention and intervention of overdose. Across public safety, from first responders to community corrections, public safety personnel directly engage with PWUD, including people with (SUDs). Strategies in a public safety setting offer unique opportunities and resources for effective and equitable prevention efforts. **Required strategies in this setting include linkage to and retention in care, and harm reduction. The use of navigation services for linkage to and retention in care and access to services, such as harm reduction, as well as naloxone distribution are required activities.** While stigma reduction activities are not required, recipients may propose these as complementary or stand-alone activities in this setting.

In this setting, strong, collaborative partnerships between public health and public safety (PH/PS) are critical. In an era where overdose is increasingly impacted by polysubstance use, PH/PS collaboration can address risks posed by opioids (particularly, illicitly-manufactured fentanyls), stimulants, and other drugs through increased information tracking and sharing, and programs that incorporate activities such as post-overdose outreach and community re-entry supports. Program planning and implementation in a public safety setting should include ongoing social participation from populations of interests, underserved and under-resourced communities, groups that are at higher and disproportionate risk of overdose and individuals with lived experience to foster shared decision-making among program participants.

An example of the important work in overdose prevention that happens through PH/PS partnerships includes initiating or expanding the use of the PHAST toolkit and/or overdose fatality review in efforts to convene across sectors, including those that represent groups at higher risk for overdose, groups disproportionately impacted by overdose, individuals with lived experience, diverse racial/ethnic communities and other entities to share information on the overdose crisis, and target strategies and interventions for a local response. Another example is monitoring progress, initiating, and/or enhancing response capacity through the use and coverage of novel public safety data systems, such as the High Intensity Drug Trafficking Area's (HIDTA) Overdose Detection Mapping Application (ODMAP), to monitor overdoses, detect overdose spikes, locate hotspots, and/or identify emerging drug threats. For the purposes of this NOFO opportunity, overdose prevention and response activities in a public safety setting must clearly include public health and public safety components, and directly address overdose or its proximal drivers. The way in which the activity includes both the public health sector, *and* the public safety sector must be clearly articulated and demonstrated.

Activities in public safety settings provide opportunities for recipients to develop new

partnerships, or build upon existing partnerships, between PH/PS entities at the local level. Recipients will be expected to demonstrate cooperation across public safety for proposed activities. Further, activities such as PHAST or overdose fatality reviews, should include surveillance, evaluation and community data (i.e., SSP utilization, patterns of naloxone distribution, etc.) and information, and work closely with surveillance subject-matter experts to interpret and understand the data, and use it to inform response activities. See **Appendix 5** for example activities to be conducted in the public safety/criminal justice setting (note this is not a comprehensive list).

B.3 Prevention in Healthcare Settings

Equipping clinicians and health systems with evidence-based responses to the worsening overdose epidemic is of paramount importance as a key prevention strategy. Health systems and clinicians are well-positioned to prevent overdose-related morbidity and mortality by ensuring safer and more effective pain management through evidence-based care; supporting linkage to care for OUD and StUD including training and education on screening and evidence-based treatment strategies; collocating harm reduction services within existing health settings; developing system-level organizational supports for trauma-informed care; and building electronic CDS tools in EHRs to facilitate integration of evidence-based strategies into clinical workflow to enhance uptake by clinicians.

In healthcare settings, required strategies under this NOFO include linkage to and retention in care, harm reduction, and clinician and health best practices, and within this framework, required activities include navigation services to support linkage to care; naloxone distribution as a harm reduction measure; and support for evidence-based care aligned with the 2022 *CDC Clinical Practice Guideline for Prescribing Opioids for Pain* ("CDC Clinical Practice Guideline") as a clinician/health system best practice. Activities addressing stigma reduction and health IT enhancements are highly encouraged but optional. Recipients should conduct activities that: 1) consider the range of settings where healthcare may be delivered, including inpatient settings, outpatient clinics including but not limited to primary care, and emergency departments, and 2) are proactive in identifying and addressing inequities in care delivery and retention.

Healthcare setting interventions may be best supported via the implementation of a local health department-led collaborative bringing together multiple community leaders and key partners in the local clinical and health system space who have the tools needed to implement and advance health system-level activities. Using this collaborative framework, funded recipients will implement and advance clinician/health system initiatives by providing overarching public health leadership, allowing for focused dialogue in sharing of best practices, success stories, resources, and ideas by collaborating with leaders most closely connected to the tools needed to implement health system- and practice-focused activities. Examples of key partners to engage for this strategy may include, but are not limited to, health system or community clinic representatives including information technology (IT) staff; public safety, leaders of relevant community-based organizations; local clinician leaders; local chapters of medical professional associations/societies, including pharmacists and dentists; leadership for public health-affiliated clinical care sites (where present); representatives from harm reduction coalitions and sites; and persons who use drugs. Existing community collaboratives and work groups may be leveraged

for OD2A purposes if similar representation is present.

Local health departments are well-positioned to understand the needs of their communities and to adapt clinician training opportunities to maximize engagement by appropriate clinical audiences within their jurisdictional borders. Planning and executing educational efforts via a local collaborative allows for focused attention to local clinical community needs. As such, recipients are encouraged to tailor the format of educational opportunities to best support clinicians and health systems. For example, public health-led lectures and forums may be the best way to leverage and support certain clinical partnerships; in smaller settings, focused trainings such as academic detailing using evidence-based implementation guidance may be most successful. Specific attention should be paid to interventions 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 who have experienced an overdose or are at high risk of overdose. Offering continuing medical education credits for clinician trainings is highly encouraged to incentivize participation.

Integrating CDC Clinical Practice Guideline-concordant care directly into clinical workflow via the creation of electronic CDS tools and other health IT enhancements (e.g., quality improvement (QI) measures and dashboards) has the potential power to enhance patient-centered and shared clinical decision-making to support safer opioid prescribing practices and improve pain care and outcomes. CDS tools can automate the gathering and filtering of data, targeting its presentation to help identify risks, inform clinical judgment, improve shared decision-making, and prevent errors without adding work or EHR alert fatigue. Data use agreements and/or memoranda of understanding with state health departments to facilitate community-level action of state-collected data (such as PDMP data) may be necessary to the extent possible.
See **Appendix 6** for examples of activities to be conducted in healthcare settings (note this is not a comprehensive list).

C. Surveillance Strategy 6A: Overdose surveillance infrastructure (required)

This is a required strategy of Component A. Recipients must conduct **activities that will improve their drug overdose surveillance infrastructure.** These improvements should help address critical data needs of the applicant, including data that can inform or enhance implementation of their proposed interventions in Component A. Activities must meet the following core requirements:

C.1 Requirements for overdose surveillance infrastructure, or Strategy 6A

Requirement	Description of Requirement
Support core overdose surveillance goals	Recipients must conduct activities which address at least one of two core surveillance goals: • Goal 1: Improving drug overdose morbidity surveillance • Goal 2: Improving drug overdose mortality surveillance

Requirement	Description of Requirement
Feasibility	Recipients must have strong capacity to implement the proposed surveillance activities. As activities will vary substantially based on the unique needs and strengths of applicants, limited implementation technical assistance from CDC will be available.
Budget maximum	• Recipients serving a population of 800,000 or more people may allocate no more than $200,000 of their Component A funding to surveillance infrastructure (See Appendix 1 for calculating resident population). • Recipients serving a population of less than 800,000 people may allocate no more than $150,000 of their Component A funding to surveillance infrastructure (See Appendix 1 for calculating resident population). • Funding for surveillance infrastructure activities must be clearly disaggregated in the proposed budget.
Avoid duplicating other federally funded activities	• Avoid duplicating activities supported by 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). • Braiding funding from multiple federal funding sources is allowed to the extent that the funding source permits, but the unique contribution of funding from OD2A: LOCAL should be clearly described.
Coordinate and collaborate with state health department funded through CDC's Overdose Data to Action in States (OD2A-S; CDC-RFA-CE-23-0002)	
Support state health department data collections funded through OD2A-S	Recipients will be required to: • Provide state health departments vital statistics death records and medical examiner and coroner report (ME/C) data, including toxicology reports, for drug overdose deaths as required by the State Unintentional Drug Overdose Reporting System (SUDORS). • Provide state health departments required data to support the Drug Overdose Surveillance and Epidemiology (DOSE) system, such as providing access to data collected through a local ESSENCE system.
Must not duplicate state health department data collections	Recipients must not duplicate surveillance activities funded through OD2A-S NOFO, including SUDORS, DOSE, and biosurveillance of nonfatal overdoses. Optional and allowable collaborations with state health departments are described in the collaboration section of this NOFO.

C.2 Description of two core surveillance goals for surveillance infrastructure funding
To help applicants link their proposed surveillance infrastructure activities to the two core surveillance goals, this section describes each surveillance goal and provides examples of possible activities. While guidance and parameters are provided, applicants are provided flexibility on how to spend their surveillance infrastructure funding to address their unique surveillance gaps and opportunities. Recipients are only required to address one of the two goals and are encouraged to focus their efforts on fewer feasible surveillance activities instead of diffusing efforts across many activities.

Example activities for Overdose Surveillance Infrastructure Goal 1: Improving drug overdose morbidity surveillance
Analyzing, maintaining, or enhancing timely surveillance of nonfatal drug overdoses to identify and track emerging overdose trends, geographic hotspots, health disparities and outbreaks. This can include, but is not limited to:

- Developing and automating monthly or quarterly updates on nonfatal drug overdose trends that are disseminated through a dashboard or web report.
- Rapidly identify local overdose hotspots or increases using syndromic surveillance of emergency department (ED) visits involving overdoses and/or data on emergency medical services (EMS) responses to suspected overdoses.
- Developing strategies for rapidly identifying and verifying overdose anomalies (i.e., suspected outbreaks) and notifying key partners who can respond to the anomaly.

Example activities for Overdose Surveillance Infrastructure Goal 2: Improving drug overdose mortality surveillance
Analyzing, maintaining, and enhancing surveillance of fatal overdose deaths to better describe and track trends in the drugs contributing to the overdose and characteristics of the overdose. This can include, but is not limited to:

- Tracking trends and health disparities in drug overdose death rates by type of drug, location, sex, age, and race/ethnicity.
- Tracking trends in drug overdose deaths overtime, including identifying chronic and emerging geographic hotspots.
- Collaborating with ME/Cs to improve investigations of drug overdose deaths, including toxicology testing, and/or improve the timeliness or quality of drug overdose death data.

C.3 Scope of surveillance infrastructure spending and allowable activities
Infrastructure spending is primarily designed to enhance the use, dissemination, and quality of existing drug overdose or risk or protective factor data (e.g., release from incarceration). Except for Component B, Component C, or collaborations with state health departments, applicants are not allowed to propose new data collections using Surveillance Strategy 6A funding. Below describes how these funds can be used:

- Enhancing EMS data and systems, which can include analysis of EMS data, funding for data sharing, and other general EMS data improvements.
- Hiring surveillance staff (FTEs, contractors, etc.), to conduct overdose surveillance including, performing data management and analysis and supporting overdose surveillance data dissemination.

- Building staff capacity by attending trainings and conferences for professional development.
- Participate in 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 or 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 the recipient may be allowed but will be determined in consultation with CDC.
    - Enhancing ED data and systems such as joining CDC's National Syndrome Surveillance Program (NSSP) or installing local instances of the ESSENCE platform

III. COMPONENT B: DRUG PRODUCT AND/OR PARAPHERNALIA TESTING (OPTIONAL AND COMPETITIVE)

This optional and competitive component will fund up to 20 recipients to establish a drug product and/or paraphernalia testing surveillance system. Applicants are not required to apply for this component and must clearly indicate in the project abstract of their application their intent to apply to surveillance Component B (i.e., "Applying for Surveillance Component B funding" or "Not Applying for Surveillance Component B funding").

- Component B will be scored separately from Component A and Component C.
    - To assist in the review of the Component B portion of your application, applicants choosing to apply to Component B should clearly indicate all text associated with Component B. Also, attachments related to Component B such as letters of support should be clearly marked as part of the Component B application. When submitting letters of support (LOS), MOUs, MOAs, and resumes, please use the naming conventions provided by CDC in this NOFO.
- Applicants choosing not to apply for Surveillance Component B funding should skip this section.

In their application, applicants seeking Surveillance Component B funding must demonstrate the capacity to meet three core requirements:

- **By September 2024, begin implementing a surveillance system that conducts in-depth toxicologic testing of at least 500 unique drug products and/or drug paraphernalia objects during a 12-month period and meets CDC surveillance collection and reporting guidelines, described below**. Toxicologic testing should focus

on testing drug products and/or paraphernalia that are commonly involved in nonfatal and fatal overdoses in the recipient's community (e.g., powdered substances, illicitly sold opioid pain reliever pills that may be counterfeit or diverted prescription pills, syringes used for injection, or bags to hold drugs) and are likely to contain or suspected to contain opioids and/or stimulants**. In their application, applicants must describe:**
    - What will be tested (e.g., drug products, syringes, and/or drug paraphernalia)?
    - How samples will be obtained, including describing the organization(s) that will be providing the samples. Applicants must provide at least one letter of support, memorandum(s) of agreement, and/or data sharing agreement(s) from a partner who will be providing drug and/or drug paraphernalia samples. If samples will be obtained from multiple partners, multiple letters of support are encouraged.
    - Identify the laboratory(ies) that will conduct the testing and describe their current capacity to test drug products and/or drug paraphernalia.

- **By April 2025, recipients must start to share case-level toxicologic findings with CDC on a quarterly basis, described in detail below.** See **Appendix 7** for data sharing information.
- **Analyze and disseminate findings that support prevention work funded through this NOFO in Component A**. This can include, but is not limited to:
    - Track distribution of illicitly manufactured fentanyl, fentanyl analogs, non-fentanyl synthetic opioids, cocaine, and methamphetamine over time.
    - Identify rapid changes in local illicit drug markets that involve drug combinations such as xylazine mixed with fentanyl.

Because of the rapid increases in drug overdose deaths, the national goal of reducing the number and rate of drug overdose deaths, and the desire to maximize the reach of the funding, funding for this component will be prioritized for applicants who:

- Have a larger number of unintentional or undetermined drug overdose deaths.
- Have a larger population.

A. Key requirements for Surveillance Component B: Drug product and/or paraphernalia testing

Requirement	Description of Requirement
Implementing the surveillance system	

Drug products and paraphernalia that can be tested	• Recipients must test samples to support public health and harm reduction strategies and have the goal of reducing nonfatal and fatal drug overdoses.
	• Recipients must test illicit drug products, drug paraphernalia (e.g., syringes, bags containing drugs, or cookers), or both that meet the following requirements:
	  ○ Drug products and/or drug paraphernalia must be used or obtained in the recipient's jurisdiction.
	  ○ Due to limited testing resources, testing should focus on: 1) drug products/paraphernalia (e.g., powders, diverted prescription pills, bags that hold drugs,

Requirement	Description of Requirement
	syringes, or drug crystals) commonly associated with overdoses in the jurisdiction and 2) drug products/paraphernalia that commonly contain or are suspected to contain opioids or stimulants. Most overdose deaths involve an opioid, stimulant, or both drugs. ○ Multiple forms and types of drug products (e.g., possible counterfeit pills, powder, or crystal) may be tested as illicit opioids and stimulants are disseminated in multiple forms and sometimes mixed with other drugs. ○ Sampling and testing should be de-identified to ensure data cannot be linked to individuals. The one exemption to this rule is that medical examiner and coroners may use findings from drug product and paraphernalia toxicologic tests as part of their investigations of suspected drug overdose deaths. ○ Law enforcement conducts testing of drug products and paraphernalia obtained by law enforcement to support criminal prosecutions and investigations. It is not allowable to support this type of testing with Component B funds. Samples obtained by law enforcement that are not submitted by law enforcement for toxicologic testing and are not part of an investigation or criminal prosecution, referred to as noncriminal samples, may be tested using Component B funds, but results must be de-identified.
Toxicologic testing requirements	• Toxicology testing must include qualitative laboratory testing for a list of core drugs identified by CDC including but not limited to fentanyl, heroin, methamphetamine, and cocaine. Testing for fentanyl analogs such as carfentanil and other emerging substances of concern should also be included in toxicologic panels (See **Appendix 8** for CDC guidance). ○ CDC testing guidance for this activity will be synchronized with the toxicology testing guidance provided by the State Unintentional Drug Overdose Reporting System (SUDORS) funded through OD2A-S (CDC-RFA-CE-23-0002). This enables comparisons of drug product and drug paraphernalia toxicologic findings with drug overdose death toxicologic findings. • Toxicologic test results obtained from rapid field tests such as fentanyl test strips or portable machines used outside the lab such as portable mass spectrometers will not meet the testing

Requirement	Description of Requirement
	requirements for this Component. These programs, however, may be funded under Component A as part of evidence-informed harm reduction efforts. • Funding can be used to support quantitative testing, but quantitative testing is not required. If quantitative testing is pursued, testing a subset of samples is strongly suggested due to the cost associated with quantitative testing.
Minimum number of drug products or paraphernalia tested	• Recipients must test at least 500 unique drug products or drug paraphernalia objects during a 12-month period, or 125 samples every three months. • Recipients who can test at least 750 unique drug products or drug paraphernalia objects during a 12-month period, or about 188 samples every three months are preferred and will receive more points.
Time to complete testing	• Recipients must test all samples within 3 months of collection of the sample. • Recipients demonstrating the capacity to complete testing of samples in <1 month are preferred and may receive more points during Phase II review.
Sampling of specimens	• Illicit drug products or drug paraphernalia may be obtained from a variety of sources such as harm reduction programs, medical examiner and coroner offices, law enforcement (noncriminal specimens), or other venues approved by CDC. o Illicit drug products or drug paraphernalia from geographic areas or groups at high risk for overdose should be prioritized for testing. o Testing of drug products or drug paraphernalia found at the scene of drug overdoses or associated with drug overdose outbreaks is allowed and encouraged. • CDC prefers, and may score higher during Phase II review, applicants that propose testing of drug products or paraphernalia from multiple sources. For example, testing drug paraphernalia collected by both harm reduction organizations and medical examiner or coroner offices and/or propose testing at multiple sites (e.g., testing syringes from four syringe services programs).

Requirement	Description of Requirement

Data on perceptions of the drug product	• Although not required, CDC prefers applicants that can link data on the drugs the person intended to use to the toxicologic results for the drug product or drug paraphernalia used. This provides important information about whether people are being unintentionally exposed to drugs such as fentanyl and xylazine. Applicants proposing these types of activities may receive more points during Phase II review.
	• Due to the challenges of obtaining this information, applicants can obtain these data on a subset of drug products and/or drug paraphernalia tested, as long as it includes ≥50% of samples.
	• For recipients collecting these data, they will be required to share:
	  ○ The list of drugs the respondent believed were in the product. This data can be compared with toxicologic findings.
	  ○ For drug paraphernalia only: The number of distinct occasions the paraphernalia was used (e.g., the person reported using the syringe more than once to inject drugs).

Required and optional LOS or MOU/MOA	Please see the OD2A: LOCAL Component B section, *1. Collaborations b. With organizations not funded by CDC,* for a description of two required Component B collaborations and optional collaborations.
Funding	Recipients' funding will depend on the population size of their catchment area. Appendix 1 describes the methods that must be used by the applicant to calculate population size. Funding by population size is listed below: • Population of ≥800,000 will be eligible for up to $325,000 • Population of <800,000 will be eligible for up to $250,000
Legal requirements	All acquisition of drug products and/or drug paraphernalia and testing procedures must be within the bounds of federal, state, and local laws and regulations.
Data Deliverables to CDC	

Requirement	Description of Requirement
Description of CDC data submission requirements	• CDC will provide recipients detailed guidance and a template that lists and describes the case-level data elements that recipients must share with CDC about the test results for each sample. Required data elements will include, but not be limited to: o A sample ID o Recipient name (e.g., name of city or county health department submitting the samples) o A description of the specimen tested (e.g., drug product, syringe, bags that hold drugs, cooker, or other drug paraphernalia) using standardized categories provided by CDC. o A list of drugs and metabolites detected in the sample. o The date the sample was submitted for testing. • All data should be de-identified. • Recipients will have to provide CDC descriptive metadata about their testing program, including, but not limited to: o A list of the drugs that are included in routine testing by the lab. o A description of the testing method used (e.g., Gas Chromatography–Mass Spectrometry [GC/MS]).
Date to begin testing	• Collection and toxicologic testing of samples must begin by September 2024. Recipients will be provided up to 12 months (9/2023–8/2024) to plan and build the infrastructure for their surveillance system. • Recipients are strongly encouraged to start testing as soon as possible.
Date required data submission to CDC must begin	• By April 2025, recipients must submit to CDC toxicologic findings from September – December 2024. • Applicants that can document their capacity to submit data to CDC before June 2024 are preferred and may receive more points during Phase II review.
Frequency of required data submission to CDC	Data must be submitted quarterly to CDC using the schedule outlined below. Recipients will be provided exact submission dates when funded. • Toxicologic findings from quarter 1 (January – March) should be reported by July of the same year. • Toxicologic findings from quarter 2 (April – June) should be reported by October of the same year. • Toxicologic findings from quarter 3 (July – September) should be reported by January of the following year.

Requirement	Description of Requirement
	• Toxicologic findings from quarter 4 (October - December) should be reported by April of the following year.
Agree to CDC sharing data publicly	• By applying for and accepting this funding, the recipient agrees to CDC sharing aggregated results with the public through publications, reports, alerts, and dashboards. Applicants not able to share toxicologic test results with CDC and publicly should not apply. • CDC will work closely with recipients to ensure any publicly reported data meets minimum data quality standards.
Required collaboration with CDC	• Recipients must designate at least one representative to attend ongoing workgroup meetings between CDC and all recipients where data quality, analysis and dissemination issues will be discussed. Workgroup meetings will be held at least quarterly. • Recipients must respond to CDC queries about data quality within one week of receipt, including a timeline for addressing data quality problems if more than a week is needed to address the issue(s) identified by CDC.
Dissemination requirements	
Produce data products	• Disseminate at least one data product during Year 2 of funding and one data product during Year 3. A data product is a public product or product widely disseminated to recipient's partners that provide findings from toxicologic testing, including highlighting important actionable items. This may include web pages, reports, presentations, white papers, alerts on emerging threats, or peer-reviewed manuscripts. • Disseminate at least two data products in Year 4 of funding. • Disseminate at least two products in Year 5 of funding. • Public data products should be shared with CDC within 2 weeks of release. This includes the launch of dashboards reporting data collected using Component B data.
Share results with key partners	Establish a system for sharing easy-to-understand toxicologic findings on an ongoing basis with your key partners including the harm reduction community and health system partners. This could include regularly presenting at partner meetings.

B. Other allowable activities

In addition to conducting toxicological testing, recipients are allowed, but not required, to use

funding to analyze existing toxicologic results obtained through routine testing of drug products submitted by law enforcement to forensic laboratories such as those participating in the National Forensic Laboratory System (NFLIS). Data must be acquired within three months of the laboratory testing of the drug product and include results for core drugs such as fentanyl, fentanyl analogs, heroin, methamphetamine, and cocaine.

C. Optional activity: Improve medical examiner and coroner investigation of drug overdose deaths

Based on availability of funding, the overall Component B score, and applicant interest in this optional activity, a subset of Component B recipients may receive between $100,000 - $200,000 in additional funding to support improvements of drug overdose death investigations by the medical examiners and coroners (ME/C) agency(ies) serving their jurisdiction. Funding level will be determined by population size with larger populations receiving more funding (See Appendix 1 for calculating resident population).

Due to the increases in drug overdose deaths and introduction of new emerging drugs, ME/C often confront challenges completing comprehensive and timely testing and investigation of drug overdose deaths. Data from ME/C drug overdose investigations is critical to inform public health's response to drug overdoses. Thus, the two goals of this optional funding are:

- Support the ME/C office(s) to improve investigations of drug overdose death by either:
    - Improving the comprehensiveness and/or timeliness of toxicologic testing of suspected drug overdose deaths. For instance, funding could support expanding toxicologic testing to include emerging drugs or decrease the time between sending samples for testing and receiving toxicologic findings, or
    - Improving investigations of suspected drug overdose deaths. Example activities include: 1) upgrading their ME/C case management system to improve tracking and certification of drug overdose deaths and 2) hiring staff to support more timely completion of autopsies and investigations.
- Increase collaboration and data sharing between the recipient and their ME/C agency. For instance, hire a forensic epidemiologist to help with data requests and ensure timely data are submitted to public health staff for timely analysis.

Applicants applying for this optional funding must:

- Clearly indicate in their application for Component B that they are also, "Applying for optional ME/C funding". Those not applying for this optional should write, "Not applying for optional ME/C funding", in their Component B application.
- Provide a letter of support from their ME/C agency that will be funded.
- Provide a brief description of how the funding will improve ME/C investigations of drug overdose deaths and the timeliness and/or quality of data sharing with the applicant.
- Ensure funding does not duplicate funding provided to ME/Cs by state health departments funding through OD2A-S (CDC-RFA-CE23-0002) or other federal funding sources.
- The ME/C agency must participate in the State Unintentional Drug Overdose Reporting System (SUDORS) funded by OD2A-S.

IV. COMPONENT C: LINKAGE TO AND RETENTION IN CARE SURVEILLANCE (OPTIONAL AND COMPETITIVE)

This optional component will fund up to 20 recipients to establish a surveillance system to measure linkage to and retention in care for substance use disorder (SUD). Applicants are not required to apply for this component and must clearly indicate in the project abstract of their application their intent to apply for Component C (i.e., "Applying for Component C funding" or "Not Applying for Component C funding").

- Component C will be scored separately from Component A and Component B.
- To assist in the review of the Component C portion of your application, applicants choosing to apply to Component C should clearly indicate all text associated with Component C. Also, attachments related to Component C such as letters of support should be clearly marked as part of the Component C application. When submitting letters of support, MOUs, MOAs, and resumes, please use the naming conventions provided by CDC in this NOFO.
- Applicants choosing not to apply for Surveillance Component C funding should skip this section.

Expanding and standardizing surveillance of linkage to and retention in care at the local level will complement prevention-focused activities by providing a better understanding of the cascade of care (CoC) for substance use disorder (SUD), including referral to, linked in (i.e., initiation of), retention in, and treatment interruptions in evidence-based treatment for SUD and related support services. Standardized indicators and data collection procedures also support public health agencies' efforts to evaluate linkage to and retention in care programmatic activities, track health disparities, and direct resources where they can most effectively reduce overdoses. Recipients selected for this component will be required to collect and share with CDC standardized indicators to measure linkage to and retention in care in their jurisdiction. CDC will provide recipients with detailed guidance and a template that lists and describes the aggregate linkage to care surveillance indicators that must be shared with CDC. These standardized indicators will assess the stages across the CoC for SUD with a primary focus on OUD and StUD, including: 1) identification of treatment need, 2) engagement with linkage to care programs, 3) referral to treatment (e.g., MOUD, behavioral health treatment) and other support services, 4) linkage to/initiation of treatment, and 5) treatment status 6 months following initiation, including retention and treatment interruptions.

In their application, applicants seeking Component C funding must demonstrate the capacity to meet four requirements:

- By September 2024, begin implementing a surveillance system that allows the recipient to collect and submit CDC-developed standardized indicators to measure linkage to and retention in care according to CDC requirements, as described below. Data collection should focus on individuals who experienced a nonfatal overdose and individuals identified via at least one other priority entry point to care. Priority entry points include the following: treated for a nonfatal overdose in the emergency department (ED), responded to for a nonfatal overdose by EMS, treated for signs or symptoms of a

substance use-related condition in the ED or other clinical setting, criminal justice-involved, harm reduction programs, self-referrals, or other community-based programs. In their application, applicants must:

- Describe the priority entry points to care for which they will conduct surveillance of linkage to and retention in care, which should include individuals who experience a nonfatal overdose and individuals identified through at least one other entry point. Applicants should also describe any existing or planned linkage to care prevention activities focusing on these entry points to care
- Describe the data sources that will be used to calculate required linkage to and retention in care surveillance indicators, including whether the recipient currently has access to these data sources.
- Describe whether the recipient plans to collect individual-level or aggregate linkage to care data, including treatment outcomes. Recipients who demonstrate the ability to collect individual-level data will be scored higher.
- Provide at least one letter of support, memorandum of understanding/agreement, and/or data sharing agreement from the agencies responsible for collecting and maintaining access to the data sources that will contribute to linkage to care surveillance (e.g., SUD treatment providers, health systems, corrections agencies, community-based organizations, state health department). Letters of support must demonstrate the agency's awareness of the data requested and deliverable dates; they should also include statements agreeing to data access, analysis, and dissemination (in accordance with federal and state regulations), and information on previous collaborations using this or similar data. If the applicant is the unit responsible for any of the data sources, this must be written into the application.

- By December 2024, recipients must begin submitting aggregate linkage to and retention in care surveillance data to CDC every 6 months, according to CDC reporting requirements. See Appendix 7 for data sharing information.
- Analyze linkage to and retention in care surveillance data and disseminate findings to partners, so they can be used to inform and assess prevention activities funded through this NOFO.
- Designate at least one representative to participate in required CDC workgroup meetings, held at least on a quarterly basis, that will discuss issues related to feasibility of collecting linkage to care data, data dissemination, and collaborate on updating guidance/requirements for reporting.

Because of the rapid increases in drug overdose deaths, the national goal of reducing the number and rate of drug overdose deaths, and the desire to maximize the reach of the funding, funding for this component will be prioritized for recipients who:

- Have a higher burden of unintentional or undetermined drug overdose deaths.
- Have a larger population.

Key Requirements for Surveillance Component C: Linkage to and Retention in Care Surveillance

Requirement	Description of Requirements
Required activities	• Create, enhance, or maintain systems to collect and submit standardized data on linkage to and retention in care among persons with a substance use disorder, with a primary focus on persons with opioid use disorder and/or stimulant use disorder. 1. Recipients will collect and submit aggregate data to CDC using standardized CDC-developed surveillance indicators. 2. To inform efforts to understand and reduce inequities in linkage to and retention in care, recipients will be required to focus data collection on populations at highest risk of experiencing an overdose, including persons who have previously experienced an overdose and persons identified via at least one other priority entry point to care. Priority entry points include the following: treated for a nonfatal overdose in the emergency department (ED), responded to a nonfatal overdose by EMS, treated for signs or symptoms of a substance use-related condition in the ED or other clinical setting, criminal justice-involved, harm reduction programs, self-referrals, or other community-based programs. 3. Recipients are encouraged to develop processes and systems that enable collection of individual-level data on linkage to and retention in care. 4. Examples of suggested sub-activities include but are not limited to: Designing or enhancing case management data systems; Developing and maintaining databases; Creating or enhancing existing data systems to collect data on CDC-identified indicators (described below); Hiring staff to perform data collection, entry, management, analysis, and dissemination; Implementing individual-level data linkages across divisions or agencies, but only to the extent to which these linkages enable measurement of linkage to and retention in care indicators (e.g., identify treatment outcomes for individuals referred to treatment). • Submit standardized linkage to and retention in care data to CDC on a specified schedule using CDC-developed guidance and data submission processes (description of data requirements below). • Analyze linkage to and retention in care surveillance data and disseminate findings to local partners so they can be used to inform and evaluate prevention activities funded through this NOFO.

Requirement	Description of Requirements
	• Collaborate with CDC to identify additional required or optional data elements for reporting in later years of the NOFO (e.g., Years 3-5) by designating at least one person to participate in a Linkage to Care Surveillance workgroup. The workgroup will discuss issues related to feasibility of collecting linkage to care data, data dissemination, and collaborating on updating guidance/requirements for data submission.
Description of CDC data submission requirements	• CDC will provide recipients with detailed guidance and a template that lists and describes the aggregate linkage to care surveillance indicators that must be submitted to CDC. These standardized indicators will assess the stages across the CoC for SUD with a primary focus on OUD and StUD, including: 1) identification of treatment need, 2) engagement with linkage to care program staff, 3) referral to treatment (e.g., MOUD, behavioral health treatment) and other support services (e.g., harm reduction services), 4) linkage to/initiation of treatment, 5) treatment status 6 months after initiation, including retention and treatment interruptions. • Indicators may be disaggregated by key characteristics, such as primary substance used, age, gender, race/ethnicity, and county of residence. • Given current challenges to collecting substance use treatment data, it is anticipated that some indicators and disaggregates will be required while others will be optional. Some optional indicators and disaggregates may become required later in the funding period. • Recipients will also be required to submit metadata (e.g., number and type of agencies contributing data, percent of treatment and service providers contributing data) to CDC using the timelines below.
Data collection start date	• Recipients will be provided a 12-month planning period (9/2023–8/2024) before required data collection begins in September 2024.
Date required data submissions to CDC must begin and frequency of reporting to CDC	• First data submission will be in December 2024. • Recipients that document their capacity to submit data to CDC earlier than December 2024 are preferred and will be scored higher. • Recipients will be required to submit aggregate data to CDC every 6 months, aggregated by quarter with a 2-month reporting lag. For example, data for 2024 Q4 (Oct–Dec 2024) and 2025 Q1 (Jan–Mar 2025) will be submitted in June 2025. Indicators that require a longer time lag (e.g., treatment initiation, treatment status 6 months after initiation) will be submitted in

Requirement	Description of Requirements
	later reporting periods. A data submission schedule with dates will be shared with recipients when awarded.
Agree to CDC sharing data publicly	• By applying for and accepting this funding, the recipient agrees to allow CDC to publicly share aggregated results to the public through publications, reports, alerts, and dashboards. Recipients not able to share aggregate data on required linkage to and retention in care surveillance indicators with CDC and publicly should not apply. • CDC will work closely with recipients to ensure any publicly reported data meets minimum data quality standards.
Required and optional LOS or MOU/MOA	• Please see the section: *1. Collaborations b. With organizations not funded by CDC* for a description of required and optional Component C collaborations.
Dissemination requirements	• Recipients will be required to disseminate at least one data product related to linkage to and retention in care each year to key local partners and/or the public starting in Year 2. A data product refers to a public product or a product widely disseminated to recipient's partners that provide findings from linkage to and retention in care surveillance data, including highlighting important actionable items. This may include web pages, reports, presentations, or peer-reviewed manuscripts. • Recipients must submit to CDC an annual bibliography of relevant data products that were produced and disseminated using data from this activity, and copies of or weblinks to all data products that were disseminated.
Funding	Recipients' funding will depend on the population size of their catchment area. Appendix 1 describes the methods that must be used by the applicant to calculate population size. Funding by population size is listed below: • Population of ≥800,000 will be eligible for up to $325,000 • Population of <800,000 will be eligible for up to $250,000

1. Collaborations

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

Component A, Component B, and Component C

The overdose epidemic is complex and requires a multi-sectoral response. Collaborations with other CDC programs will be essential to success. Applicants must commit to collaborate with state health departments applying for OD2A-S (CDC-RFA-CE-23-0002). A letter of support from the applicant's state health department is encouraged, but not required. If a letter from the state health department is included, please use the following title when submitting: "<Applicant_name> Component A: LOS from State Health Department." All letters should be uploaded as a pdf at www.grants.gov with the application.

Required collaborations are as follows:

- Applicants must not propose activities that duplicate state surveillance activities (i.e., implementing a data collection duplicative of SUDORS) funded in OD2A-State.
- Recipients will be required to:
    - Provide state health departments vital records and medical examiner and coroner report (ME/C) data, including toxicology, for drug overdose deaths as required by the State Unintentional Drug Overdose Reporting System (SUDORS).
    - Provide state health departments required data to support the Drug Overdose Surveillance and Epidemiology (DOSE) system, such as providing access to data collected through a local ESSENCE system.

- Recipients will be required to collaborate with the Drug Free Communities (DFC) support program (CDC-RFA-CE22-2205), the Overdose Response Strategy (ORS) (CSTLS NU38OT000288-03-08) and any other CDC-supported work within the jurisdiction that addresses overdose, works with populations disproportionately affected by overdose, or improves linkage to care at the local level. Programs are strongly encouraged to braid funding and collaborate with other CDC-funded local programs as allowed by the funding source and state and federal law. For example, they may have an SSP funded through CDC-RFA-PS22-2208 or Ending the Epidemic HIV program. Applications must include MOUs or letters of support when programs funded through separate CDC programs plan to collaborate. Please use the following title when submitting any LOS or MOU/MOA from other CDC programs: "<Applicant_name> Component A: Collaboration with Other CDC Programs – Letter 1." If multiple organizations will be providing a LOS or MOU/MOA, please number each letter sequentially (e.g., first letter is "Letter 1" and second letter is "Letter 2"). All letters should be uploaded as a pdf at www.grants.gov with the application.

Recommended and optional collaborations are as follows:

- In addition to the required collaborations with state health departments described above, applicants are encouraged but not required to collaborate with their state health departments in other ways and obtain a letter of support from their state health department. This can include braiding OD2A-LOCAL and OD2A-State funding contingent on CDC approval. Possible allowable and optional collaborations include:
    - Work with state health department to use DOSE data to identify overdose anomalies that may require an outbreak response.

- Co-fund or fund a SUDORS abstractor(s) to abstract drug overdose death data that occur in the applicant's jurisdictions into the state SUDORS system.
- Work with state health departments to gain access to relevant state-level data or data linkages including prescription drug monitoring program data, EMS data, or Medicaid data.
- Collect and conduct comprehensive toxicologic testing of samples from patients treated for nonfatal overdose in hospitals in your jurisdiction as part of state led efforts to conduct biosurveillance funded through OD2A-S.
- Work with coalitions developed through OD2A-S and other state-level activities intended to address overdose.
- Collaborate with data to action partners funded through OD2A-S.
- Work with state-level coalitions and programs to implement prevention programs at the local level.

- 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 with each other 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:

Component A

Given the importance of using data to inform the development and evaluation of prevention programs, all applications must include signed data use agreements/memorandums of commitment to share data from a minimum of 3 partners representing each of the settings in which strategies will take place: the community, public safety, and health systems. Agreements must explicitly include a commitment to data-sharing, active participation in Data to Action activities and meetings, and describe how the partnership will support activities listed in the application. Please use the following title when submitting Letters in Support of Data to Action Activities and Data Use Agreements: "<Applicant_name> Component A: Data Sharing and Partnership – Letter 1." Please number each letter sequentially (e.g., first letter is "Letter 1" and second letter is "Letter 2"). All letters should be uploaded as a pdf at www.grants.gov with the application.

Applicants should provide a LOS for each identified key partner and agency needed to fulfill NOFO requirements and proposed activities. These can include other federal, state, or local government agencies, local harm reduction organizations, and programs providing evidence-based treatment for OUD or StUD, among others. Applicants should also describe other strategic relationships that will strengthen work fulfilled under this NOFO, and whenever possible, provide documentation (e.g., MOU, LOS) to demonstrate the relationship and shared mission. Letters of support should also come from organizations working with underserved populations, and a commitment to partner in efforts to reduce overdose-related morbidity and mortality for that population. Although this program must provide staffing and structural support to ensure naloxone distribution to populations at high risk of overdose, medications including naloxone may not be purchased with money from this program. Applications must describe sources of naloxone, whether from another federal funding source, such as SAMHSA, health department support, private donation or through a buyer's club such as Remedy Alliance/For the People.

Applications should describe how funds will support naloxone distribution and must include letters of support or MOUs from an organization(s) they will partner with to ensure naloxone gets into the hands of people who use drugs and/or people likely to witness an overdose. Please use the following title when submitting this LOS or MOU/MOA: "<Applicant_name> Component A: Naloxone Distribution – Letter 1." If multiple organizations will be providing samples and submitting LOS or MOU/MOA, please number each letter sequentially (e.g., first letter is "Letter 1" and second letter is "Letter 2"). All letters should be uploaded as a PDF at www.grants.gov with the application.

Applications must also describe how they will engage and leverage other federally funded overdose prevention activities (e.g., those funded through SAMHSA, COSSAP) and include letters of support from those programs. Please use the following title when submitting this LOS or MOU/MOA: "<Applicant_name> Component A: Other Federal Partnership – Letter 1." If multiple organizations will be submitting LOS or MOU/MOA, please number each letter sequentially (e.g., first letter is "Letter 1" and second letter is "Letter 2"). All letters should be uploaded as a pdf at www.grants.gov with the application.

More broadly, multi-sector partnerships are essential to the success of this program and to reducing nonfatal and fatal overdoses. Applicants are required to submit a letter of support or MOU/MOA from each partner described in the application to demonstrate their commitment to the program. Please use the following title when submitting a LOS or MOU/MOA from a partner: "<Applicant_name> Component A: Partner Support – Letter 1." If multiple organizations will be submitting LOS or MOU/MOA, please number each letter sequentially (e.g., first letter is "Letter 1" and second letter is "Letter 2"). All letters should be uploaded as a pdf at www.grants.gov with the application.

Component B

Applicants must demonstrate in their application their ability to collaborate with key partners by submitting a LOS or MOU/MOA from the following key partners**:**

- At least one organization that will be supplying drug product and/or drug paraphernalia samples such as harm reduction organizations including syringe service programs, medical examiner or coroner agencies, and/or law enforcement agencies. The letter of support should describe whether the samples will be submitted from a single site (e.g., syringe service program) or multiple sites. If samples will be obtained from multiple partners, applicants are encouraged, but not required to provide LOS or MOU/MOA from all partners. Please use the following title when submitting this LOS or MOU/MOA: "<Applicant_name> Component B: Organizational support to provide drug product/paraphernalia samples for testing – Letter 1." If multiple organizations will be providing samples and submitting LOS or MOU/MOA, please number each letter sequentially (e.g., first letter is "Letter 1" and second letter is "Letter 2"). All letters should be uploaded as a pdf at www.grants.gov with the application.
- A laborator(ies) that will be conducting the toxicologic testing. If a public laboratory will conduct testing, please provide at least a letter of support. For private laboratories, documentation of a discussion with the laboratory, a bid for the work, or a contract will also meet this requirement. Please use the following title when submitting this information:" <Applicant_name> Component B: Laboratory support for drug product/paraphernalia testing – Letter 1." If multiple letters will be submitted, please

number each letter sequentially (e.g., first letter is “Letter 1” and second letter is “Letter 2”). All letters should be uploaded as a pdf at www.grants.gov with the application.

If the applicant is the unit responsible for collecting or testing the data samples, this must be written into the application. CDC still recommends submitting a LOS from the unit to describe the collaboration.

Recipients may collaborate and work with a wide range of other partners, including harm reduction, treatment agencies, people with lived experience, and navigators in interpreting, disseminating, and using Component B findings to support prevention efforts. Applicants may demonstrate these additional and optional collaborations by submitting LOS or MOU/MOAs with these organizations as part of their application. This type of LOS or MOU/MOA is encouraged but not required. Please use the following title if you choose to submit these types of LOS or MOU/MOAs: “ <Applicant_name> Component B: Other support for drug product/paraphernalia testing – Letter 1.” If multiple letters will be submitted, please number each letter sequentially (e.g., first letter is “Letter 1” and second letter is “Letter 2”). All letters should be uploaded as a pdf at www.grants.gov with the application.

Component C

Applicants must demonstrate in their application their ability to collaborate with key partners by submitting LOS, MOU/MOA, and/or data sharing agreements from at least one of the agencies responsible for collecting and maintaining access to the data sources that will contribute to linkage to care surveillance, which may include SUD treatment providers, healthcare systems, corrections agencies, community-based organizations, and the state health department. Please use the following title when submitting this LOS or MOU/MOA: “<Applicant_name> Component C: Organizational support for linkage to care surveillance data – Letter 1.” If multiple organizations will be providing data and submitting LOS or MOU/MOA, please number each letter sequentially (e.g., first letter is “Letter 1” and second letter is “Letter 2”). All letters should be uploaded as a pdf at www.grants.gov with the application. Partners’ LOS and MOU/MOA should:

- Demonstrate the partner’s awareness of the data requested and data submission frequency of Component C.
- Provide the applicant permission to access the relevant data, including permission to analyze and disseminate findings to meet Component C requirements, in accordance with federal and state regulations.
- Provide information on previous collaborations using these or similar data.

If the applicant is the unit responsible for any of the data sources, this must be written into the application. CDC still recommends submitting a LOS from the unit to describe the collaboration.

Recipients may collaborate and work with a wide range of other partners, including harm reduction, treatment agencies, people with lived experience, and navigators in interpreting, disseminating, and using Component C findings to support prevention efforts. Applicants may demonstrate these additional and optional collaborations by submitting LOS or MOU/MOAs with these organizations as part of their application. This type of LOS or MOU/MOA is encouraged but not required. Please use the following title if you choose to submit these types of LOS or MOU/MOAs:“ <Applicant_name> Component C: Other support for linkage to and retention in care surveillance – Letter 1.” If multiple letters will be submitted, please number

each letter sequentially (e.g., first letter is “Letter 1” and second letter is “Letter 2”). All letters should be uploaded as a pdf at www.grants.gov with the application.

2. Target Populations

Component A

The primary populations activities must focus on are people at high risk of overdose from opioids and/or stimulant use, including people disproportionately affected by overdose and underserved by treatment for substance use disorder, persons recently released from incarceration, people experiencing homelessness, and anyone who has experienced a non-fatal overdose. 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, 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., homelessness, a mental health condition, chronic pain, a disability, adverse childhood experiences, a history of suicidal ideation or suicide attempt or a history of substance use disorders and/or overdose).

Component B

This component focuses on providing data to improve services and awareness of people who are using illicit opioids and stimulants and persons at high-risk for overdose.

Component C

This component focuses on providing data to improve surveillance of linkage to and retention in care among individuals who have experienced a nonfatal overdose and among individuals identified via other entry points to care, such as harm reduction programs and criminal justice system.

a. Health Disparities

All activities across the three components should take place with a lens focused on reducing health disparities in overdose, and those historically underserved by substance use treatment and harm reduction programs. Applications must describe how they have identified the groups in their local jurisdictions that experience the most disparities in overdose prevention and treatment, and how activities directly work to improve health equity among people at highest overdose risk. Recipients will be required to conduct a needs assessment focused on addressing health equity and the needs of priority populations and people with lived experience within the first 6 months of the new NOFO. For recipients who have already conducted a recent comprehensive needs assessment within the last 2 years, a 3- to 5-page summary of results should be submitted with applications, and additional gaps can be discussed with CDC, if any. Once CDC reviews the assessment, and if it determines that it does not meet the requirements, CDC will work with funded recipients to revise their workplan to include an activity around the assessment. See **Appendix 9** for description of community assessment requirements.

Results from the needs assessment will be an initial use of data used to inform tailoring of

prevention activities to address these critical needs and will serve to strengthen applicants' implementation of OD2A: LOCAL activities focused on addressing health equity and the needs of priority populations and people with lived experience. As part of the Data to Action Framework, recipients will be required to address how their proposed interventions are reducing health disparities within their communities.

iv. Funding Strategy

This is a 3-component NOFO. Component A is required, and Components B and C are optional. Applicants may be funded as follows:

- Component A; or
- Components A and B; or
- Components A and C; or
- Components A, B and C

Component A Funding Strategy

Funding will be determined by formulas reflecting a base funding amount, based on jurisdiction population size, and overdose burden. CDC will prioritize funding for jurisdictions with a larger population and a higher fatal drug overdose burden. See **Appendix 1** for a description of the methods that must be used by applicants to calculate their unintentional or undetermined drug overdose (UUDO) death burden and population size. Funding ranges are shown in the table below:

POPULATION SIZE	**DRUG OVERDOSE DEATH COUNT AND AWARD RANGE**		
	<300 deaths	**300-749 deaths**	**≥750 deaths**
<600K	Up to $1,000,000	Up to $1,500,000	$1,000,000-$2,000,000
600k – <800K	Up to $1,000,000	Up to $1,750,000	Up to $2,500,000
≥800K	Approximately $1,000,000	$2,000,000-$2,500,000	$2,750,000-$3,250,000

Component B Funding Strategy

Funding will be based on population size of the catchment area. See **Appendix 1** for a description of the methods that must be used by applicants to calculate population size. Funding ranges are shown in the table below:

POPULATION SIZE	**AWARD RANGE**
<800K	Up to $250,000
≥800K	Up to $325,000

Component C Fundign Strategy

Funding will be based on the population size of the catchment area. See **Appendix 1** for a description of the methods that must be used by applicants to calculate population size. Funding ranges are shown in the table below:

POPULATION SIZE	AWARD RANGE
<800K	Up to $250,000
≥800K	Up to $325,000

Applicants must calculate their unintentional or undetermined drug overdose (UUDO) death burden and population size. An optional sample form is provided in Appendix 2b with detailed instructions in **Appendix 2a** to help applicants calculate their UUDO death burden and population size. Applicants are not required to use this form, if a different format is used it must contain three required pieces of information: (1) counties, cities, or territories in their service catchment area, (2) UUDO deaths, and (3) population. Upload this information to www.grants.gov a document named "**<Applicant Name> OD2A_ LOCAL_ Overdose_ Burden and Funding Form"**. Please keep in mind that if an Excel file is used, it should not be converted to PDF and should be uploaded in its original format.

b. Evaluation and Performance Measurement

i. CDC Evaluation and Performance Strategy

Data Management Plan
Applicants will need to supply a preliminary draft or outline of a Data Management Plan (DMP). The DMP may be outlined in a narrative format or as a checklist but, at a minimum, should include:

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

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.

Component A Evaluation and Performance Measurement
The following table outlines the evaluation requirements—activities and reporting requirements—that applicants must address as part of their OD2A: LOCAL application. These

requirements are described in greater detail below, and applicants should refer to **Appendix 7** for data sharing information. OD2A: LOCAL recipients also are encouraged to share evaluation findings and data with recipients of CDC's OD2A-S cooperative agreement to support state 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 priority populations (e.g., persons at increased risk of overdose) and people with lived experience, and health equity into their program/evaluation planning and development. They will be asked to describe how they will develop relevant evaluations tailored to their priority populations and how the findings will inform their work plan and relevant evaluations. Also, please see Appendix 9 for description of community assessment requirements.

Evaluation Activity	**Emphasis of 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 targeted evaluation project	Annual	APR
	Implementation of targeted evaluation project and evaluation of outcomes	Year 4 of the cooperative agreement	Products from 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, and 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 also will be required 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. Refinements to the Evaluation and Performance Measurement also will be informed by the community needs assessment.

2) Recipients will be expected to evaluate **all** required activities within each of the required prevention strategies in Component A 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, implementing guideline concordant care) performance measures primarily will 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.

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 priority populations. 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 10 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. During quarterly CoP calls/webinars, recipients will be invited to share progress and challenges faced with implementing evaluation activities required in the NOFO. Recipients will be encouraged to share questions and strategies used in their work on TEPs and collection and reporting of performance measures. Recipients also will be encouraged to share innovative evaluation methods.

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).

Component B Evaluation and Performance Measurement
Recipients will be required to meet the following evaluation requirements when they begin to collect and share data with CDC in Year 1 or Year 2 of funding:

- **Metadata provided for each quarterly data submission to CDC:** A description of how the drug product and/or drug paraphernalia data was collected, including identification of data quality challenges and list of drugs included in toxicology testing, must be submitted with each data submission as metadata. Specific guidance will be provided to funded recipients.
- **Report on dissemination efforts:** Recipients must share with CDC:
    - Public data products produced using drug product and/or drug paraphernalia data within 2 weeks of release.
    - A list of all data products including key internal reports, community alerts, and publications that used data collected using funding from Component B during the past year.

Component C Evaluation and Performance Measurement
Recipients will be required to meet the following evaluation requirements when they begin to collect and share data with CDC:

- **Metadata provided for each data submission to CDC:** A description of how the linkage to and retention in care surveillance data was collected, including identification of data quality challenges and populations of focus, must be submitted with each data submission as metadata. Specific guidance will be provided to funded recipients.
- **Report on dissemination efforts:** Recipients must share with CDC:
    - Public data products produced using surveillance of linkage to and retention in care data within 2 weeks of release.
    - A list of all data products including key internal reports, community alerts, and publications that used data collected using funding from Component C during the past year.

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.

Component A Evaluation and Performance Measurement
Recipients' overall evaluation strategy should be grounded in the CDC Evaluation Framework for Public Health, MMWR, September 18, 1999, Vol. 48 / No. RR-11. Recipients 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 for Component A 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 application package in response to this NOFO that describes their approach to conducting and completing all of the above-described evaluation requirements in Section 1. Applicants also will be required 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 priority populations 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. Recipients 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 to 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 are 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.
        - 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 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).

Component B Evaluation and Performance Measurement

For applicants applying to Component B, up to one-page of the applicant's evaluation plan should describe their planned evaluation activities for Component B. Applicants are encouraged, but not required, to use the CDC surveillance evaluation criteria (See http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5013a1.htm) to assist in developing their plan.

Evaluation plans should focus on measuring and enhancing the applicant's ability to collect high quality data in a timely fashion, including meeting CDC data submission deadlines, and ensure data is disseminated to and used by key partners and prevention programs funded through OD2A: LOCAL.

Component C Evaluation and Performance Measurement

For applicants applying to Component C, up to one-page of the applicant's evaluation plan should describe their planned evaluation activities for Component C. Applicants are encouraged, but not required, to use the CDC surveillance evaluation criteria (See http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5013a1.htm) to assist in developing their plan.

Evaluation plans should focus on measuring and enhancing the applicant's ability to collect high quality data in timely fashion, including meeting CDC data submission deadlines, and ensure data is disseminated to and used by key partners and prevention programs funded through OD2A: LOCAL.

Instructions for Submitting Evaluation Plan

Applicants must name this file "(<Applicant_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.

All components:

Applicant Catchment Area, Population Size, and Fatal Overdose Burden

A key goal of OD2A: LOCAL is fostering rapid national reductions in drug overdose deaths by surging resources to small geographic areas such as counties and cities heavily impacted by drug overdose deaths. To meet this goal, CDC will prioritize applicants with higher number of unintentional or undetermined drug overdose (UUDO) burden and larger populations.

Also, the total population and fatal UUDO burden reported by applicants will be used to calculate the applicant's funding and burden score during Phase II review. Thus, all applicants **are required** to provide detailed information about the counties, cities, or territories in their catchment area and must calculate their total 2021 unintentional or undetermined drug overdose (UUDO) death count and 2021 population size as outlined in **Appendix 1**. An optional sample form is provided in **Appendix 2b** with detailed instructions in **Appendix 2a** to help applicants calculate their UUDO death burden and population size. Applicants are not required to use this form. If a different format is used it must contain three required pieces of information: (1) counties, cities, or territories in their service catchment area, (2) UUDO deaths, and (3) population. Upload this information to www.grants.gov under the title "<Applicant Name> OD2A_ LOCAL_ Overdose_ Burden and Funding Form". Please keep in mind that if an Excel file is used, it should not be converted to PDF and should be uploaded in its original format.

Component A:

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

- Prior knowledge and experience working with the selected Component A strategies.
- Any existing programs that will expand under any of the strategies selected.
- Existing partnerships to support work and conduct data to action activities through MOUs or letters of support.
- Multi-sector engagement through MOUs or letters of support.
- Proven ability to collect data at a population level and use data to demonstrate impact.
- Experience with planning and implementing programs across the applicant's jurisdiction.
- Subject matter expertise to plan and implement strategies addressing opioid and stimulant use and use disorder, overdose and opioid and stimulant-related harms.
- Established or newly built partnerships with health systems, harm reduction, public safety and other relevant partner organizations with descriptions of experience addressing opioid and stimulant misuse, use disorder, overdose and opioid- and stimulant-related harms or working with identified high-risk or underserved populations.
- Existing partnerships with organizations serving people who use drugs and people at high risk of overdose, including viable evidence-based programs offering treatment for OUD and StUD that can take new patients with few to no barriers.
- Extensive knowledge of the identified historically underserved or high-risk populations.
- Experience implementing harm reduction services and familiarity with local, state and national policies around such services.
- Access to sufficient naloxone to conduct related activities.
- Ability to engage people who use drugs and people with lived experience in program planning and evaluation.
- Experience with evaluating programs.
- Experience analyzing nonfatal and fatal drug overdose data, including using the data to support strategic planning, to enhance public health interventions or to inform the public.

The applying organization should have sufficient existing staff (or relationships with external contractors/collaborators) with expertise in program implementation, surveillance, program and performance management, evaluation, policy and management of travel and program requirements, and the full capability to manage the required award. Applicants should identify key staff. Please document these capabilities with résumés of key staff. Applicants must name each document "(<Applicant_name>Key Staff_<Project Role>)" and upload it as a PDF file on www.grants.gov.

Applicants must include at least 1 (one) FTE evaluator 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.

Key staff must also include one program coordinator to manage partnerships, logistics, data sharing and analysis and ensure data to actions convenings take place at least quarterly.

Component B
Applicants must describe the following organizational capacities or skills to implement drug product and/or paraphernalia surveillance and meet the requirements of Component B. This description should include a staffing plan for Component B that is sufficient to meet Component B requirements and clearly defines staff roles and responsibilities.

- Experience conducting drug overdose surveillance
    - More than one year of experience collecting, analyzing and disseminating surveillance data on nonfatal and fatal drug overdose to key partners working to respond to and/or prevent drug overdoses.

- Collaborate with groups providing drug product and/or drug paraphernalia samples and people who misuse drugs.
    - More than one year of experience building and sustaining partnerships with the organizations or groups that will be providing drug product and/or drug paraphernalia samples for testing. This can be demonstrated by describing previous partnerships with these organizations and groups to collect data or implement public health programs.
    - Capacity to disseminate data to people who are misusing opioids and stimulants to reduce overdose risk. Applicants should describe specific experiences of disseminating data and how it was used.

The following organizational capacity or skills are desired, but not required, for Component B applicants:

- Experience collecting, testing, and disseminating data on >100 samples of drug products and/or drug paraphernalia during a 12-month period. The description should address the following questions:
    - What drug products and/or drug paraphernalia were obtained and tested?
    - How many drug products and/or drug paraphernalia were tested?
    - What laboratory conducted the toxicologic testing?
    - What types of toxicological tests were conducted?
    - How was data disseminated to people misusing opioids and stimulants as part of harm reduction activities designed to reduce overdoses?

The applicant should have sufficient existing staff (or relationships with external contractors/collaborators) with expertise in establishing and running surveillance systems, analyzing drug overdose data, and managing programs to reduce the harm caused by illicit drugs to implement Component B requirements. Applicants should identify and provide resumes of key staff working on Component B to demonstrate their ability to implement Component B requirements. Please use the following title when submitting resumes of key staff: "<Applicant_name>_Component B: Key staff for drug product/paraphernalia testing – Resume 1." If multiple resumes will be submitted, please number each resume sequentially (e.g., first

letter is “Resume 1” and second letter is “Resume 2”). All resumes should be uploaded as a pdf at www.grants.gov with the application.

Component C
Applicants must describe the following organizational capacities or skills to meet the requirements of Component C. This description should include a staffing plan for Component C that is sufficient to meet Component C requirements and clearly defines staff roles and responsibilities.

- More than one year of experience conducting surveillance of nonfatal drug overdoses.
- More than one year of experience conducting individual-level data linkages using surveillance data.
- Ability to submit required linkage to care surveillance indicators to CDC by or earlier than the first data submission date (December 2024). Applicants who demonstrate the ability to submit data earlier than December 2024 will be scored higher.
- More than one year of experience disseminating surveillance data to key partners working to respond to and/or prevent drug overdoses.

Applicants should also describe the following organizational capacity or skills, which are desired, but not required, for Component C applicants:

- Experience collecting, managing, and analyzing data to measure linkage to care (LTC) for substance use disorders. This may include collecting data on the following among individuals who had a nonfatal overdose and/or among individuals with substance use disorder identified via other entry points to care: engagement with LTC program staff, referrals to treatment, treatment initiation, and retention in treatment.
- Experience accessing and analyzing data on treatment for substance use disorders (e.g., MOUD, behavioral treatment).
- Experience linking data on treatment for substance use disorder (e.g., MOUD, behavioral treatment) with other data sources.

The applicant should have sufficient existing staff (or relationships with external contractors/collaborators) with expertise in establishing and running surveillance systems, analyzing drug overdose data, and managing programs to reduce the harm caused by illicit drugs to implement Component C requirements. Applicants should identify and provide resumes of key staff working on Component C to demonstrate their ability to implement Component C requirements. Please use the following title when submitting resumes of key staff: “<Applicant_name>_Component C: Key staff for linkage to and retention in care surveillance – Resume 1.” If multiple resumes will be submitted, please number each resume sequentially (e.g., first letter is “Resume 1” and second letter is “Resume 2”). All letters should be uploaded as a pdf at www.grants.gov with the application.

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 “Component A Work Plan” and upload it as a PDF file on

www.grants.gov. Applicants applying for the Optional and Competitive Strategies (Component B: Drug Product and/or Paraphernalia Testing and Component C: Linkage to and Retention in Care Surveillance) should submit separate narratives and workplans for each strategy. Please label the document "Component B_Work Plan" and "Component C_Work Plan" 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 activities to be conducted to meet the program outcomes for each of the chosen priority strategies.
2. Describe activities 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 milestones for each activity and assigns approximate dates for inception and completion.
4. Additionally, for each activity, applicants should describe the priority population(s) and how the selection of the priority population(s) addresses health equity or disproportionately affected populations. Applicants should describe how planned activities will reach and impact specific priority populations, 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 activities.
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/activity.
8. Explain administration and assessment processes to ensure successful implementation and quality assurance.

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.

CDC will provide recipients with technical assistance in creating and revising their annual work plans. After review of the first annual performance report, if the recipient is not conducting required recipient activities or not meeting process or outcome standards, CDC (NCIPC and Office of Grant Services [OGS]) will provide or facilitate technical/capacity building assistance for program improvement. Consistent with applicable grant regulations and other relevant provisions, recipients who are not on track to achieve program objectives within stated time frames will be placed on a time-phased Programmatic Improvement Plan (PIP). The PIP will be developed by the CDC Project Officer/Project Consultant/Science Officer in collaboration with OGS, OGC, and the recipient. The PIP is a comprehensive tool used to assist recipients to improve 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

Across all components, 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 recipient's Evaluation and Performance Measurement Plan;
- Providing technical assistance on recipient's Targeted Evaluation Projects;
- 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 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, meetings, surveillance measures, 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 for Component A around the funding announcement's guiding principles will be available to ensure that all recipients are able to:

- Collect data around community characteristics, including racial and ethnic composition, and conduct analyses with a health equity focus;
- 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 Technical Assistance Center (TAC) will leverage various modes of technical assistance, including group trainings, 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. DOP staff and DOP TAC subject matter experts will work with the recipients to provide scientific subject matter expertise and resources by:

- Providing guidance on using data to inform jurisdiction-level populations of focus, on selecting evidence-based overdose prevention interventions, and on implementation of best practices across all prevention strategies; and
- Providing support and technical assistance for implementation of all components (A, B & C)

Component B
The following additional support will be provided to Component B recipients:

- Guidance on the drugs that should be included in standard toxicologic testing. This guidance will be updated periodically or as needed in response to emerging trends. This will be done in consultations with recipients.
- Guidance for sharing toxicologic results with CDC in a standardized fashion to meet Component B reporting requirements.
- Provide support on collecting and analyzing the data through drug product and/or drug paraphernalia workgroup meetings that will be held at least quarterly. This may include presentations by CDC and external experts on topics of interest.

Component C
The following additional support will be provided to Component C recipients:

- Guidance on the required and optional standardized indicators for linkage to and retention in care surveillance. This guidance may be updated periodically or as needed in consultations with recipients.
- Guidance for sharing linkage to and retention in care surveillance indicators with CDC in a standardized format to meet Component C reporting requirements, including providing a data submission template.
- Provide support on collecting and analyzing data through the linkage to and retention in care surveillance workgroup meetings that will be held at least quarterly. This may include presentations by CDC, external experts, and recipients on topics of interest.

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:
H28

3. Fiscal Year:
2023
Estimated Total Funding:
$400,000,000

4. Approximate Total Fiscal Year Funding:
$80,000,000
This amount is subject to the availability of funds.

5. Approximate Period of Performance Funding:
$400,000,000
This amount is subject to availability of funding.

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

7. Expected Number of Awards:
40
Up to 40 recipients will be funded to conduct activities under Component A. Among those 40, up to 20 will be funded for Component B and up to 20 will be funded for Component C.

8. Approximate Average Award:

$2,300,000

Per Budget Period

Component A: $2,000,000
Component B: $250,000 - $325,000
Component C: $250,000 - $325,000

9. Award Ceiling:
$0
Per Budget Period

This NOFO does not have an award ceiling.

10. Award Floor:
$0
Per Budget Period

Although the NOFO does not have an award ceiling, award floor is as follows:

- Component A $400,000.00
- Component B $250,000.00
- Component C $250,000.00

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 not 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:
01 (County governments)

02 (City or township governments)

04 (Special district governments)

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

Additional Eligibility Category:

Government Organizations:

Local governments or their bona fide agents

Territorial governments or their bona fide agents in the Commonwealth of Puerto Rico, the Virgin Islands, the Commonwealth of the Northern Marianna Islands, American Samoa, Guam, the Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau

State controlled institutions of higher education

2. Additional Information on Eligibility

Per the statutory language under Section 311 of the PHS Act, PHSA § 311 (c)(1) and the SUPPORT Act, eligible applicants for this NOFO are city or county local health departments or bona fide agents, special district health departments and territorial governments.

In addition to Overdose Data to Action: LOCAL NOFO, CDC is concurrently offering an opportunity tailored to state jurisdictions, called CDC-RFA-CE-23-0002, Overdose Data to Action in States. Funding is also being provided 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 the statutory requirements.

Component A is required for all applicants. Components B and C are optional and competitive components. In the project abstract, applicants must identify the component(s) to which they are applying. If the applicant does not expressly state that they want to apply for Component B or Component C, their application will not be reviewed for the optional components.

CDC will not fund two applicants who serve the same county or city. Applicants who serve the same county or city are encouraged to apply together.

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 foundation funding, other U.S. government funding sources including programs supported by HHS or other agencies (e.g., Department of Justice, 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 04/06/2023

04/06/2023
An LOI is requested, but not required. LOIs should indicate the intention to apply and to which components. The purpose of an LOI is to allow CDC program staff to estimate the number of applications and plan for the review of submitted applications. The LOI should contain the following information:

- Name of jurisdiction intending to apply to this NOFO.
- A preliminary decision about whether the applicant intends to apply for either or both of the optional and competitive surveillance components (Component B and/or Component C). This preliminary decision should be clearly and succinctly stated, "Plan to apply to Component B, but not Component C". If the applicant does not plan to apply for either Component B or Component C, please write, "Will not apply for Component B or Component C".

When submitting the LOI, please follow these instructions to help CDC rapidly identify and process your LOI:

- Send LOI via email to **OD2A_LOCAL@cdc.gov.**
- The subject of the email should be *"LOI Overdose Data to Action: Limiting Overdose through Collaborative Actions in Localities (OD2A: LOCAL)"*.
- The email with the LOI should be addressed to *"OD2A: LOCAL Team, Division of Overdose Prevention, CDC"*.

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
First Informational Call

When: March 13, 2023, 03:00 PM – 5: 00 PM Eastern Time (US and Canada)

Topic: OD2A: LOCAL First National Informational Call

Register in advance for this webinar:

https://us02web.zoom.us/webinar/register/WN_OAipA2W9Th-m9kB2TeKiHw

After registering, you will receive a confirmation email containing information about joining the webinar.

This two-hour call provides a comprehensive overview of the required strategies of the NOFO, presenting eligibility requirements, prevention strategies, a walk-through of the application and selection process, and a discussion of Component A, which is required for all applicants. 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.

Second Informational Call

When: March 14, 2023, 12:00 PM – 1:30 PM Eastern Time (US and Canada)

Topic: OD2A: LOCAL Second National Informational Call

Register in advance for this webinar:

https://us02web.zoom.us/webinar/register/WN_H3rwiCStRQi3_ikTOVJdWA

After registering, you will receive a confirmation email containing information about joining the webinar.

This 90- minute call focuses on the optional and competitive NOFO strategies in Components B (Drug product and/or paraphernalia testing) and C (Linkage to and retention in care surveillance). Throughout the session, participants will have the opportunity to ask questions about both optional and competitive strategies. All potential applicants are encouraged to attend this call, although it will be of particular benefit to jurisdictions planning to apply for optional strategies. 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
Although a letter of intent (LOI) is not required and does not enter into the review of a subsequent application, the information that it contains allows CIO staff to estimate the potential review workload and plan the review. LOIs must include a descriptive title of the proposed project and the following application information:

- Name of jurisdiction intending to apply to this NOFO
- A preliminary decision about whether the applicant intends to apply for either or both of the optional and competitive surveillance components (Component B and/or Component

C). This preliminary decision should be clearly and succinctly stated, “Plan to apply to Component B, but not Component C”. If the applicant does not plan to apply for either Component B or Component C, please write, “Will not apply for Component B or Component C”.

When submitting the LOI, please follow these instructions to help CDC rapidly identify and process your LOI:

- Send LOI via email to **OD2A_LOCAL@cdc.gov.**
- The subject of the email should be *“LOI Overdose Data to Action: Limiting Overdose through Collaborative Actions in Localities (OD2A: LOCAL)”*.
- The email with the LOI should be addressed to *“OD2A: LOCAL Team, Division of Overdose Prevention, CDC”*.

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.

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.

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.

Component A, B, C
Budget narratives should justify all described budget items and explain how line items contribute to the NOFO's overall goals. Applicants must submit a separate budget for each component. The budget narrative(s) should be uploaded in grants.gov and named <Applicant_Name>_OD2A_LOCAL_Budget Narrative Component <X>. Applicants must include travel for at least two staff members in their proposed budget. If applying for optional components, budget for a minimum of four people to attend a two-day kickoff meeting at the CDC's National Center for Injury Prevention and Control in Atlanta, GA, at the beginning of the first year of the project. This meeting is required for all recipients. All recipient budgets for the remaining years of the performance period should include funding for annual reverse site visits for a minimum of two to four program staff.

Component A
In Year 1, recipients may not propose a budget for surveillance infrastructure (strategy 6) that exceeds $150,000 if recipient’s population is less than 800,000 people and $200,000 if the recipient’s population is 800,000 or more people. This restriction ensures that most Component A funding will support drug overdose prevention activities, the primary focus of this NOFO.

Funding for prevention activities in component A will not be prescribed but must be reasonable and adequate to implement the described activities.

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.

This is not a complete list of all unallowable activities. A more detailed list is provided in Appendix 11. Program funds cannot be used for certain strategy activities which includes the purchase of naloxone, contingency management, specific harm reduction activities such as provision of equipment to use drugs, provision of clinical care and the operation/management of programs in community-based linkage to care settings. 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.

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
Component A: 30 points
Component B: 30 points
Component C: 30 points

ii. Evaluation and Performance Measurement **Maximum Points:** 0
Component A: 30 points
Component B: 25 points
Component C: 25 points

iii. Applicant's Organizational Capacity to Implement the Approach **Maximum Points:** 0
Component A: 40 points
Component B: 45 points
Component C: 45 points

Budget **Maximum Points:** 0
Reviewed but not scored - all components

Details on how points may be allocated are provided below.

Component A	
i. Approach	Max Points: *30*
• The extent to which the approach is well-organized, realistic, evidence-based and feasible; clearly describes approach to all required strategies and how proposed prevention activities address overdose morbidity and mortality, resulting in a measurable impact within 5 years. **(8 Points)** • The extent to which the application clearly describes how proposed prevention activities address overdose-related health disparities and reaches those who have been historically underserved or disproportionately impacted by overdose. **(4 Points)** • The extent to which there is a clear description of how data will be used to inform action, including the role of partners. **(4 Points)**	

- The extent to which outcomes are presented consistent with the period of performance outcomes described in the CDC Project Description and logic model. **(4 Points)**
- The extent to which applications 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) **(5 Points).**
- The extent to which applications 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 **(5 Points).**

ii. Evaluation	Max Points: *30*

- The extent to which there is a clear evaluation plan that accounts for conducting evaluation of 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. **(5 Points)**
- The extent to which there is a detailed plan and description for reporting performance measures, including descriptions of available baseline measures, data sources required for reporting, utility of measures, feasibility of reporting measures to CDC every 6 months, and anticipated barriers to obtaining data and calculating performance measures. **(5 Points)**
- The extent to which the application clearly describes the prior completion (within the past 2 years) of a community needs assessment focused on health equity and the needs of priority populations and people with lived experience or clearly describes a plan to complete a needs assessment during the first 6 months of the cooperative agreement. **(5 Points)**
- The extent to which the application clearly describes how evaluation data from multiple data sources (e.g., surveillance, evaluation, community partners) will be used for program improvement and how evaluation data will be disseminated. Clearly describes plans for creating a translational product by the end of the period of performance that will relate to evaluation of prevention activities. **(5 Points)**
- The extent to which the plans for completing a targeted evaluation project focused on navigation activities are clearly described. **(5 Points)**
- Provides a clear evaluation plan that will measure impact on groups disproportionately affected by overdose and underserved by overdose prevention initiatives. **(5 Points)**

iii. Organizational Capacity	Max Points: *40*

- The extent to which the application provides evidence of support from local community, public safety and health systems partners through LOS, MOUs or data sharing agreements and provides clear plan to implement data to action activities. Shows prior experience with populations of focus. Demonstrates buy in and support from populations of focus with letters of support. **(4 Points)**

- The extent to which the application has the staffing or partnerships to implement activities upon receipt of funding, including a letter of commitment, that ensures access to naloxone for distribution activities, and access to populations disproportionately affected by overdose and/or historically underserved by prevention and treatment programs. **(4 Points)**
- Extent to which there is demonstrated capacity or partnerships to ensure low-barrier access to evidence-based treatment for OUD and StUD, and capacity to engage and support a cadre of navigators familiar with the local public health infrastructure. **(4 Points)**
- The extent to which the applicant has experience analyzing nonfatal and fatal drug overdose data, including using the data to support strategic planning, to enhance public health interventions or to inform the public. To get 4 points, applicant must provide specific examples. **(4 Points)**

Burden (24 Points)
Applicants must calculate their unintentional or undetermined drug overdose (UUDO) death burden and population size. Applicants must include this information in a document named <Applicant_Name>_OD2A_LOCAL_Overdose_Burden_and_Funding_Form.

Based on the total UUDO death count and population size reported by the applicant, points will be assigned to the applicant using the criteria below.

Population as of July 1, 2021

- <400,000 residents = 0 points
- 400,000 – 599,999 residents = 3 points
- 600,000 – 799,999 residents = 6 points
- 800,000 – 999,999 residents = 9 points
- ≥1,000,000 residents = 12 points

Number of resident UUDO Deaths during January 1, 2021 – December 31, 2021

- <100 deaths = 0 points
- 100 – 299 deaths = 3 points
- 300 – 499 deaths = 6 points
- 500 – 749 deaths = 9 points
- ≥750 deaths = 12 points

iv. Budget	
Budget will be reviewed but not scored.	
Component B	
i. Approach	Max Points: 30
The extent to which the applicant describes a feasible plan to:	

- Collect and test ≥500 samples over a 12-month period, including describing who will provide samples and the type of samples (e.g., drug products, syringes, cookers or plastic bags). **(6 Points)**
- Collaborate with a laboratory that can **(5 Points):**
    - Conduct drug testing that meets CDC Component B requirements.
    - Test ≥500 samples over a 12-month period.
    - Test samples ≤3 months of sample receipt.
- Disseminate toxicology findings (e.g., dashboards, alerts, or reports) to support OD2A: LOCAL interventions and inform people misusing drugs or organizations directly serving them of drug exposures. **(5 Points)**
- Gain support of governmental and community partners to conduct testing. **(6 Points)**
- Implement one to five preferred, but optional, program elements (listed below). Applicants implementing no elements should receive 0 points, 1 element up to 2 points, 2 to 3 elements up to 6 points, and 4 to 5 elements up to 8 points. **(8 Points)**
    - Obtain samples from multiple locations/sources.
    - Report toxicologic results to CDC by June 2024 instead of April 2025.
    - Match toxicologic results to the drugs the person intended to use.
    - Complete toxicologic testing ≤1 month of sample receipt.
    - Test ≥750 samples during a 12-month period.

ii. Evaluation	Max Points: 25

The extent to which the applicant describes an evaluation plan that will:

- Monitor and improve the quality and timeliness of data collected on drug products and/or drug paraphernalia. **(6 Points)**
- Support ongoing improvements in drug product and/or drug paraphernalia surveillance by identifying implementation, analysis, and dissemination challenges and communicating these challenges to applicant staff**. (7 Points)**
- Document the dissemination of drug product and/or drug paraphernalia surveillance data through data products such as web reports, publications, dashboards, presentations, or strategic plans. To receive three or more points, applicant must commit to share an updated list and brief description of all data products annually to CDC. **(5 Points)**
- Evaluate if and how key partners (e.g., OD2A: LOCAL prevention staff, harm reduction organizations, or treatment organizations) use findings from drug product and/or drug paraphernalia surveillance to support efforts to reduce fatal drug overdoses. To receive five or more points, applicants must include a feasible plan to identify data needs of key partners. **(7 Points)**

iii. Organizational Capacity	Max Points: 45

Experience (16 Points)
The extent to which an applicant describes substantial experience:

- Conducting nonfatal and fatal overdose surveillance. **(4 Points)**
- Conducting surveillance of drug products and/or paraphernalia. To receive three or more points, applicants must have tested >100 samples and disseminated findings. **(6 Points)**

- Collaborating with groups providing samples and people who misuse drugs. **(6 Points)**

Staffing (5 Points)
The extent to which the staffing plan:

- Clearly defines staff roles and responsibilities.
- Demonstrates sufficient staff experience to implement drug product and/or drug paraphernalia surveillance that meets Component B requirements.

Burden (24 Points)
Applicants must calculate their unintentional or undetermined drug overdose (UUDO) death burden and population size. Applicants must include this information in a document named <Applicant_Name>_OD2A_LOCAL_Overdose_Burden_and_Funding_Form.

Based on the total UUDO death count and population size reported by the applicant, points will be assigned to the applicant using the criteria below.

Population as of July 1, 2021

- <400,000 residents = 0 points
- 400,000 – 599,999 residents = 3 points
- 600,000 – 799,999 residents = 6 points
- 800,000 – 999,999 residents = 9 points
- ≥1,000,000 residents = 12 points

Number of resident UUDO Deaths during January 1, 2021 – December 31, 2021

- <100 deaths = 0 points
- 100 – 299 deaths = 3 points
- 300 – 499 deaths = 6 points
- 500 – 749 deaths = 9 points
- ≥750 deaths = 12 points

v. Budget

Budget will be reviewed but not scored.

Component C

i. Approach	Max Points: 30

CDC will evaluate the extent to which the applicant describes a feasible plan for collecting required linkage to and retention in care (LTC) surveillance data including: **(25 Points)**

- Describes the data sources that will be used to collect required LTC surveillance indicators and confirms they have access to these data sources. Data sources should include substance use disorder treatment data.
- Specifying whether required LTC indicators will be measured using individual-level data (e.g., case management system) and/or by conducting individual-level data linkages across multiple data sources.

- Describing how data will be collected on nonfatal overdoses, a required LTC surveillance entry point.
- Identifying at least one other entry point on which LTC data will be collected.
- Planning to collect, analyze, and submit required indicators to CDC on a 6-month basis.

Applicants will also be evaluated on: **(5 Points)**

- The number, type, and quality of letters of support, data sharing agreements, and/or memorandums of understanding obtained from key data owners and partners.
- The extent to which they describe plans to conduct LTC *prevention* activities in Component A that focus on the 2 entry points identified for LTC surveillance.
- The extent to which they describe a feasible and impactful plan for disseminating data to key partners working to improve linkage to and retention in care for substance use disorder, including key goals and the ability to share data with partners by Year 2.

ii. Evaluation	Max Points: 25

The extent to which the applicant describes an evaluation plan that will:

- Monitor and improve the quality and timeliness of data collected on linkage to and retention in care.
- Document the dissemination of linkage to and retention in care surveillance data through data products such as web reports, publications, dashboards, presentations, or strategic plans.
- Evaluate if and how key partners (e.g., OD2A: LOCAL prevention staff, harm reduction organizations, or treatment organizations) use findings from linkage to and retention in care surveillance to support efforts to reduce fatal drug overdoses.

iii. Organizational Capacity	Max Points: 45

Experience (16 Points)
CDC will evaluate the extent to which the applicant describes:

- Experience conducting surveillance of nonfatal drug overdoses.
- Experience conducting individual-level data linkages using any surveillance data.
- Experience collecting, managing, and analyzing data to measure linkage to care (LTC) for substance use disorder. This may include monitoring the following among individuals with substance use disorder: engagement with LTC program staff, referrals to treatment, treatment initiation, and/or retention in treatment.
- Experience accessing and analyzing SUD treatment data (e.g., MOUD, behavioral treatment), including experience linking treatment data with other data sources.
- Ability to submit required LTC surveillance indicators to CDC by December 2024. Applicants demonstrating the ability to submit required indicators earlier than December 2024 should receive more points.
- Experience disseminating surveillance data to key partners.

Staffing (5 Points)
The extent to which the staffing plan:

- Clearly defines staff roles and responsibilities.
- Demonstrates sufficient staff experience to implement linkage to and retention in care surveillance that meets Component C requirements.

Burden (24 Points)
Applicants must calculate their unintentional or undetermined drug overdose (UUDO) death burden and population size. Applicants must include this information in a document named <Applicant_Name>_OD2A_LOCAL_Overdose_Burden_and_Funding_Form.

Based on the total UUDO death count and population size reported by the applicant, points will be assigned to the applicant using the criteria below.

Population as of July 1, 2021

- <400,000 residents = 0 points
- 400,000 – 599,999 residents = 3 points
- 600,000 – 799,999 residents = 6 points
- 800,000 – 999,999 residents = 9 points
- ≥1,000,000 residents = 12 points

Number of resident UUDO Deaths during January 1, 2021 – December 31, 2021

- <100 deaths = 0 points
- 100 – 299 deaths = 3 points
- 300 – 499 deaths = 6 points
- 500 – 749 deaths = 9 points
- ≥750 deaths = 12 points

v. Budget

Budget will be reviewed but not scored.

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

- Applications for each of the components will be reviewed and scored separately in accordance with the Phase II review criteria. CDC will fund up to 40 applicants for Component A, up to 20 for Component B, and up to 20 for Component C. For each component, a separate rank-order list will be used.
- Only applicants approved and funded for Component A will be considered for Component B or C funding.
- CDC will not fund two applicants who serve the same county or city. Applicants who serve the same county or city are encouraged to apply together.
- CDC program officials will validate the information provided in the overdose burden and funding form, <Applicant_Name>_OD2A_LOCAL_Overdose_Burden_and_Funding_Form, submitted by the applicants using the data definitions and data sources described in **Appendix 1.**

Applications may be funded out of rank order for Components A, B, and C**.** The following factors may affect the funding decisions**:**

- *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 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 problematic.
    - 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).

- *Population and drug overdose burden*: Applicants may be funded out of rank order to select applicants with the highest burden. For the purposes of this NOFO, CDC considers the highest burden as 300 or more unintentional or undetermined drug overdose deaths in 2021 and population size of 600,000 or more persons in 2021.
- CDC will provide justification for any application scored out of rank order.

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

08/01/2023

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 award	Yes
Recipient Data Management Plan (DMP)	6 months into award	Yes
Annual Performance Report (APR)	No later than 120 days before end of the budget period. Serves as yearly continuation application.	Yes
Community Needs Assessment	6 months into 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
Federal Financial Reporting Forms	90 days after the end of the budget period	Yes

Final Performance and Financial Report	90 days after end of 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.

*Recipients will be required to conduct a needs assessment focused on addressing health equity and the needs of priority populations and people with lived experience within the first 6 months of the new NOFO. For recipients who have already conducted a recent comprehensive needs assessment within the last 2 years, a 3- to 5-page summary of results should be submitted with applications, and additional gaps can be discussed with CDC, if any. Once CDC reviews the assessment, and if it determines that it does not meet the requirements, CDC will work with funded recipients to revise their workplan to include an activity around the assessment. See Appendix 9 for description of community assessment requirements.

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.

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.

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 semi-annual reporting of performance measures. This may change over the period of 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:
Yarkasah
Last Name:
Paye
Project Officer
Department of Health and Human Services
Centers for Disease Control and Prevention

Address:
4770 Buford Highway NE
MS S106-8
Atlanta, GA 30341

Telephone:

Email:
od2a_local@cdc.gov

Grants Management Office Information

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

First Name:
Darryl
Last Name:
Mitchell
Grants Management Specialist
Department of Health and Human Services
Office of Grants Services

Address:

Centers for Disease Control and Prevention
2939 Brandywine Road
MS TV-2
Atlanta, GA 30341

Telephone:

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

Indirect Cost Rate, if applicable

Memorandum of Agreement (MOA)

Memorandum of Understanding (MOU)

Bona Fide Agent status documentation, if applicable

- Project Narrative (maximum 25 pages for Component A; 10 pages for Component B and 10 pages for Component C)
- Budget Narrative (maximum 5 pages for Component A; 3 pages for Component B and 3 pages for Component C)
- Data Use Agreement
- Applicants are required to calculate their unintentional or undetermined drug overdose (UUDO) death burden and population size. Upload this information to grants.gov under the title "<Applicant Name> OD2A_ LOCAL_ Overdose_ Burden and Funding Form". Please keep in mind that if an Excel file is used, it should not be converted to PDF and should be uploaded in its original format.

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.

CDS – Clinical decision support
DOSE – Drug Overdose Surveillance and Epidemiology
DMP – Data Management Plan
DUA – Data Use Agreement
EHR – Electronic health record
FTS – Fentanyl test strips
Health IT – Health information technology

LTC – Linkage to Care
LOS – Letter of Support
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 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.
Partners: Individuals and entities with a vested interest in the program, who participate in the program, and could be affected by the program, and that collaborate as supporters and partners for the operation of the program
OD2A: LOCAL – Overdose Data to Action: Limiting Overdose through Collaborative Actions in Localities
OD2A-S – Overdose Data to Action in States
OUD – Opioid use disorder
PDMP – Prescription drug monitoring program
PWUD – Persons who use drugs
SDOH – Social determinants of health
SSPs - Syringe services programs
StUD – Stimulant use disorder
SUD – Substance use disorder
SUDORS – State Unintentional Drug Overdose Reporting System
TEPs – Targeted evaluation projects
UUDO – Unintentional or undetermined drug overdoses

Appendices:
1. Calculating resident population and drug overdose deaths for an applicant's service catchment area
2a. Detailed instructions for calculating resident population, drug overdose deaths, and maximum funding
2b. OD2A: LOCAL Overdose Burden and Funding Form
3. Harm Reduction Resource Guide
4. Example activities to be conducted in the community setting (note this is not a comprehensive list)
5. Example of activities to be conducted in the public safety/criminal justice setting (note this is not a comprehensive list)
6. Example of activities to be conducted in healthcare settings
7. Data dissemination and data sharing requirements for recipients
8. Comprehensive Toxicology Guidance

9. Community Needs Assessment Guidance
10. Targeted Evaluation Project (TEP)
11. Unallowable Activities and Expenditures
12. Figure 1: Map of foundational activities, key settings, strategies, and goals for the NOFO
13. Figure 2: OD2A Data to Action Framework