

**U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR DISEASE CONTROL AND PREVENTION**

**Pandemic Influenza Funding Announcement for  
Competitive Proposals (Activities)**

**Announcement Type:** New

**Funding Opportunity Number:** CDC-RFA-TP08-802

**Catalog of Federal Domestic Assistance Number:** 93.069

**Letter of Intent:**

**Key Dates:**

**Letter of Intent Deadline:** The Letter of Intent is due on January 16, 2008. Awardees should submit their Letter of Intent to the following email address: [panflucomp@od.cdc.gov](mailto:panflucomp@od.cdc.gov). Awardees that intend to apply for one or more projects should submit a Letter of Intent listing all the projects for which they intend to apply. The Letter of Intent is not a binding agreement, nor will the absence of one exclude an awardee from applying. The Letter of Intent will be used by the Centers for Disease Control and Prevention (CDC) to estimate the number of applications it will have to review.

**Application Deadline:** Application is due March 17, 2008.

**Executive Summary:** In 2005, Congress appropriated \$350 million for upgrading state and local capacity to prepare for and respond to an influenza pandemic. These funds have been awarded by the Department of Health and Human Services (HHS) in phases. In March 2006, CDC awarded \$100 million (Phase I) to 62 jurisdictions to identify gaps in their preparedness. As of July 2006, CDC had awarded an additional \$225 million to the same jurisdictions to address these preparedness gaps (Phase II). Of the remaining \$25 million, \$24 million is to fund demonstration projects that, once properly evaluated, might represent replicable approaches. This money is available to states, counties, cities, and U.S. territories that currently are awardees of the Public Health Emergency Preparedness Cooperative Agreement AA154 and will be distributed by use of a competitive application process. However, the funds are not supplemental to AA154 but are stand-alone funds provided through the pandemic influenza supplemental appropriations. Eligible applicants should apply for these funds through [www.grants.gov](http://www.grants.gov). The budget period for these funds will be from May 1, 2008 to April 30, 2009. Applications for the projects described below will be due March 17, 2008.

**Funding Opportunity Description:** \$24 million to fund:

- Demonstration projects for use of public engagement as part of the public health decision-making process
- Electronic laboratory data exchange to support pandemic influenza surveillance
- Integration of state-based immunization information systems to track pandemic influenza countermeasures
- Development of statewide Public Health Information Network (PHIN)-compliant electronic mortality reporting systems
- Demonstration projects for collaborative planning among healthcare providers to ensure the delivery of essential services during a pandemic influenza outbreak
- Development of interventions that promote preparedness for pandemic disease among identified at-risk populations
- Exploration of processes whereby antiviral drugs can be distributed and dispensed to isolated or quarantined persons in a pandemic influenza event

This announcement is only for non-research activities supported by CDC. If research is proposed, the application will not be reviewed. For the definition of research, please see the CDC Web site at the following Internet address:

<http://www.cdc.gov/od/science/regs/hrpp/researchDefinition.htm>.

**Authority:** 317(k)(2) of the Public Health Service Act

**Purpose:** This document provides guidance for applying for competitive funding for demonstration projects designed to further pandemic influenza preparedness and response.

Measurable outcomes of the program will be in alignment with one (or more) of the following performance goal(s) for the Coordinating Office for Terrorism Preparedness and Emergency Response:

Goals 1-9

Goal 1: Increase the use and development of interventions known to prevent human illness from chemical, biological, radiological agents and naturally-occurring health threats.

Goal 2: Decrease the time needed to classify health events as terrorism or naturally-occurring in partnership with other agencies.

Goal 3: Decrease the time needed to detect and report chemical, biological, radiological agents in tissue, food or environmental samples that cause threats to the public's health.

Goal 4: Improve the timeliness and accuracy of communications regarding threats to the public's health.

Goal 5: Decrease the time to identify causes, risk factors, and appropriate interventions for those affected by threats to the public's health.

Goal 6: Decrease the time needed to provide countermeasures and health guidance to those affected by threats to the public's health.

Goal 7: Decrease the time needed to restore health services and environmental safety to pre-event levels.

Goal 8: Increase the long-term follow-up provided to those affected by threats to the public's health.

Goal 9: Decrease the time needed to implement recommendations from after-action reports following threats to the public's health.

This announcement is only for non-research activities supported by CDC. If research is proposed, the application will not be reviewed. For the definition of research, please see the CDC Web site at the following Internet address:

<http://www.cdc.gov/od/science/regs/hrpp/researchDefinition.htm>

**Anticipated Award Date:** April 18, 2008

**Award Mechanism:** U90 Cooperative Agreements for Special Projects of National Significance.

**Budget Period Length:** The budget period for the Pandemic Influenza Competitive Projects is one year, beginning May 1, 2008 and ending April 30, 2009.

**Fiscal Year Funds:** These are "No Year" funds.

**Eligibility:** Eligible applicants are limited to the current 62 awardees that receive funding through the Public Health Emergency Preparedness (PHEP) Cooperative Agreement (AA154). Awardees can apply for more than one project but must apply for each project separately.

**National Representation:** The purpose of the awards is to fund innovative projects, and disseminate successful findings nationally. CDC's intent is to fund awardees that represent a geographic distribution of awards within the United States and territories, acknowledging the existence of varying populations, population densities, and other variables that define the diversity of the country.

Only states and localities under AA154 are eligible to apply for these funds. A state may apply for any or all of the seven funding opportunities listed above by application representing large city and urban communities, or small city and rural communities as described below. If a PHEP funded grant recipient chooses to apply for projects under both community characteristics, separate applications must be submitted.

Large city and urban community areas within a PHEP funded grant recipient jurisdiction

Any contiguous geographic areas (including counties) with a population exceeding 400,000 persons. Localities under AA154 are eligible to apply for funding under this section of the program as large city and urban community applicants.

States/territories that have at least one area that meets this definition may apply as a large city and urban community applicant as long as the proposed project(s) is conducted solely in the large city and urban community that meets the above definition.

State-coordinated small city and rural communities within a PHEP funded grant recipient jurisdiction

Areas must be geographically contiguous and include a minimum population of 10,000 persons, with no more than 400,000 persons. Applicants must have at least one area that meets this definition. Applicants may apply as a state-coordinated small city and rural community project as long as the city or community project is conducted in meets the above definition for a small city and rural community.

Additionally, grant recipients can request funds to conduct one or more of these projects with a federally recognized tribal government, Regional Area Indian Health Board, an Urban Indian organization, or consortia of tribes and tribal organizations that serve 10,000 or more American Indians/Alaskan Natives in its catchment area.

**Multi-state Submissions:** Applicants may apply as a consortium of geographic areas. The application may be submitted by one PHEP grant recipient. The grant recipient must provide letters of support, the geographic relationship between the members of the consortium, and a plan that demonstrates how the proposed project will be implemented across and within communities included in the plan.

All applications must describe coordination with Tribal Government, Regional Area Indian Health Board, an Urban Indian organization, or consortia of tribes and tribal organizations that are located within an area for proposed activity.

# Pandemic Influenza Funding Guidance for Competitive Proposals

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## **A. General Award Information**

**Fiscal Year Funds:** Awards from this cooperative agreement are funds that will be applied to a Budget Period beginning May 1, 2008 and ending April 30, 2009.

**Measuring Effectiveness:** Applicants are required to provide measures of effectiveness that will demonstrate the accomplishment of the various identified objectives of the cooperative agreement. Measures of effectiveness must relate to the performance goals stated in the “Purpose” section of each project. Measures must be objective and quantitative and must measure the intended outcome. The measures of effectiveness must be submitted with the application. How an awardee intends to measure the effectiveness of its plan should be included in the plan narrative. (See “Selection Criteria” for each of the projects.) The awardee’s approach to measuring effectiveness will contribute to the overall score for the plan section.

## **B. Project Descriptions**

### **1. Public Engagement Demonstration Projects on Pandemic Influenza**

#### **a. Funding Opportunity Description**

**Purpose:** The public engagement demonstration project on pandemic influenza has five purposes:

1. To inform and assist state and local level decision-makers involved in pending, values-oriented policy decisions related to pandemic influenza planning
2. To evaluate the effectiveness of engaging both citizens-at-large and other stakeholders in public health policy decisions
3. To increase state and local capacity to effectively engage the public on policy choices
4. To empower citizens to participate effectively in public decision-making work
5. To achieve results that enhance public trust in public health decisions regarding policy choices

Awardees should consider developing a public engagement model similar to the model used recently by CDC to obtain public input on priorities for pandemic influenza vaccine and on tradeoffs associated with community control measures for pandemic influenza, or they can develop their own innovative approach that engages both citizens-at-large and stakeholders on real-life policy decisions facing public health and other officials.

Examples of values-oriented policy decisions facing state, local, territorial, or tribal officials may include:

- a) Who should receive vaccine in the early days of a pandemic when supplies are limited?
- b) A pandemic can cause numerous deaths, school closings, and high absenteeism. Should schools be closed and important social activities cancelled before there is

evidence of disease in the local area in an effort to slow down the spread of the disease?

- c) Who should receive access to limited supplies of respirators, ICU beds, and other life-sustaining equipment or medical treatments during a pandemic?
- d) To what extent should jurisdictions in a different city, county, states, or region act as one unit to implement uniform pandemic influenza policies? Is consistency across areas more important than tailored policies meeting the specific needs of particular areas?

By collaborating with and learning from public engagement experts and CDC, the awardees that participate in the project will enhance their capacity for conducting similar public engagement activities in the future and develop approaches to public engagement that could benefit other awardees.

**Background:** Pandemic influenza planning calls for state, local, territorial, and tribal public health agencies and many other stakeholders to consider federal recommendations in several pandemic influenza preparedness areas, such as vaccination and social distancing policies, and to adopt or modify the federal guidance on these topics to address their residents' needs. Public health agencies and other decision-makers may exercise different degrees of autonomy in making decisions about these individual issues.

Pandemic influenza planning requires making difficult choices: Who should be the first to receive limited supplies or equipment? How aggressively should disease-control strategies be implemented early on when disease is not yet prevalent? These decisions are not purely technical in nature, for they require consideration of societal values. An approach to public engagement should:

- Address decision-oriented work where both values and facts are relevant, where tradeoffs between positive benefits and challenging consequences are required, and where there is no one “scientifically right” answer or solution that can be anticipated
- Involve representatives of stakeholder organizations, such as protection and advocacy groups, with recognized interests and citizens-at-large without agendas for the issue at hand
- Involve stakeholders from at-risk and special-needs populations, including new immigrants and non-English speakers, as well as cross-border international partners
- Require the participation of decision-makers or their representatives to be responsible for the issue being worked on
- Utilize neutral facilitation and respectful listening to all voices
- Provide information that is balanced to all participants, ensuring that enough detail is included to aid in comprehension of the issues
- Provide a structured forum for genuine dialogue, mutual learning, and deliberation including, when necessary, sign language and other language services
- Require integration of the viewpoints of representatives from stakeholder organizations and citizens-at-large into one report describing the “societal perspective”
- Provide feedback to the participants about the final decisions made and the reasons for them



- Be diverse and inclusive of all populations including at-risk individuals and special-needs populations represented within a state’s citizenry

At present, many states, localities, territories, and tribes do not have the capability or mechanisms in place to routinely engage citizens in a highly interactive dialogue about the difficult decisions and tradeoffs that go hand-in-hand with pandemic influenza response planning.

A U.S.–Canada summit meeting entitled “Disease, Disaster, and Democracy — The Public’s Stake in Health Emergency Planning” was held in May 2006. It highlighted the need for greater government interaction with citizens and stakeholders. The purpose of the summit, sponsored by the Center for Biosecurity of the University of Pittsburgh Medical Center, was to advise leaders in government, public health, and disaster management on the feasibility and societal benefits of actively engaging citizens in health emergency planning. [Schoch-Spana M, Franco C, Nuzzo J, & Usenza C on behalf of the Working Group on Community Engagement in Health Emergency Planning. “Community Engagement: Leadership Tool for Catastrophic Health Events,” *Biosecurity & Bioterrorism* 2007; 5(1) – in press] [[http://www.upmcbiosecurity.org/website/focus/community\\_engage/2007\\_working\\_group/full\\_report.html](http://www.upmcbiosecurity.org/website/focus/community_engage/2007_working_group/full_report.html)]

In 2005, a national-level public engagement project partly supported by 14 organizations pilot-tested a federal-level model for public engagement. It considered the question of which population should be first to receive vaccination in the event of a pandemic. The project showed that citizens and stakeholders could be successfully recruited, engaged in meaningful give-and-take discussions, weigh difficult tradeoffs, and reach a conclusion that could be useful in informing decision-makers. [*Citizen Voices on Pandemic Flu Choices — A Report of the Public Engagement Pilot Project on Pandemic Influenza*, December 2005 at <http://www.keystone.org/spp/health-pandemic.html>]

The federal-level model also was used successfully, in 2006, in obtaining public input on which control measures should be implemented in the early days of a pandemic of influenza. [*The Public Engagement Project On Community Control Measures for Pandemic Influenza, Findings and Recommendations from Citizen and Stakeholder Deliberation Days in Atlanta, GA, Lincoln, NE, Seattle WA, Syracuse NY, and Washington DC*, December 2006 at [http://www.keystone.org/Public\\_Policy/pandemic\\_control.html](http://www.keystone.org/Public_Policy/pandemic_control.html)]

Using this model or implementing a similar model emphasizing the benefits of public engagement for pandemic influenza planning might generate novel ideas that would otherwise be unavailable to decision-makers. It also might increase buy-in and public support for eventual policy decisions. Public support is critical for successful implementation of disaster management or disease management strategies during an emergency. If a public engagement model is successful, its key elements might be replicated for other pending decisions and/or be adopted by other awardees to assist in their health emergency planning.

**Recipient Activities:**

1. Establish an overall steering committee for the project
2. Provide infrastructure to fulfill public engagement and logistical support
3. Implement an existing public engagement model or develop a new approach, both of which must be representative of the diversity of the local community in collaboration with public health partners

In a cooperative agreement, CDC staff are substantially involved in the program activities, above and beyond routine grant monitoring.

**CDC Activities:**

1. Assist in establishing an overall steering committee for the project
2. Provide technical assistance in finalizing the design for the project
3. Assist in recruiting appropriate stakeholders
4. Assist in convening stakeholders
5. Assist in recruiting citizens-at-large
6. Assist in convening citizens-at-large
7. Assist in providing information to stakeholders and citizens-at-large, including alternate formats
8. Provide neutral facilitation
9. Assist in integrating the contributions of stakeholders and citizens-at-large into a single report
10. Evaluate the effectiveness and safety of the overall project
11. Organize a workgroup, which includes representatives from jurisdictions, to monitor the project, exchange information, and obtain lessons learned for future work
12. Both citizens-at-large and stakeholders should include at-risk populations

**b. Award Information**

**Approximate Current Fiscal Year Funding:** Between \$1 million and \$2 million

**Approximate Total Project Period Funding:** Between \$1 million and \$2 million (Includes direct and indirect costs.)

**Approximate Number of Awards:** 5 to 10

**Approximate Average Award:** \$100,000 to \$200,000 (Includes direct and indirect costs.)

**Floor of Individual Award Range:** None

**Ceiling of Individual Award Range:** None

**Anticipated Award Date:** April 18, 2008

**Budget Period Length:** The budget period for the Pandemic Influenza Competitive Projects is one year, beginning May 1, 2008 and ending April 30, 2009.

**Project Period Length:** The project period for the Pandemic Influenza Competitive Projects is one year, beginning May 1, 2008 and ending April 30, 2009.

Throughout the project period, CDC's commitment to continuation of awards will be conditioned on the availability of funds, 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.

**Additional Information for Narrative:** To assist in the development of applications for this proposal, awardees should consider including the items below in their narratives, which reflect elements of safe and effective public engagement.

1. The pending decision at the state level on which the awardee wishes to receive meaningful public input. Ideally, this pending decision will involve an important pending policy choice or a decision related to pandemic influenza planning that requires having some technical knowledge or information about influenza and requires weighing of competing societal values to arrive at a decision. Choices that are broad in scope (“upstream” or early decisions) are preferred to choices that are narrow (“downstream” or late decisions) because broad choices 1) can benefit the most from the knowledge and experience of the stakeholders and citizens, 2) will be most satisfying and empowering for the participants to contribute to, and 3) will be the most likely to earn participant buy-in and support for implementation. Very often, but not always, these broad choices are values-driven (“should-type”) decisions about ends, rather than more narrow technical (“how to”) decisions about means. The narrative should make clear the specific product that is desired as the outcome from the consultation.
2. How both citizens-at-large and stakeholders representing different organizations with a recognizable interest in the decision will be recruited to participate in the consultation. The narrative should explain how the applicant will encourage diverse participation (including by age, race, sex, disability status, and principal region), so that overall participation will be large and diverse enough to produce results seen as legitimate.
3. The types of linkage that decision-makers will have with the project. At a minimum, the narrative should describe the level of support for and commitment to the project, the type of participation that decision-makers or their representatives will contribute or engage in with the public participants, and the type of feedback to participants that decision-makers will give after the decision is taken.
4. How the awardee will convene citizens and stakeholders to participate in group processes designed to address the pending decision of interest. Since collaboration with local health departments is anticipated as a means of successfully recruiting citizens and hosting the meetings, the narrative should describe which local health departments have been selected to participate and the reasons for selection. Letters of support from public health officials of those health departments should be included, if available, and the letters should describe how meetings will be hosted.
5. How the awardee will provide or assure that balanced information on all sides of the issue is presented to the participants and that the information is adequate for them to reach informed opinions on the decision at hand. This may include information in alternate formats and languages or the use of a sign or other language interpreter.
6. How the group process used will encourage dialogue among the participants.
7. How decision-makers will provide feedback to participants in the process, including the reasons behind the decision. The project will be based on the assumption that the decision-makers will, at a minimum, give serious consideration to the results of the citizen and stakeholder deliberations.
8. How the awardee will establish an overall steering committee for the project, to be composed of the key contributors to the project.

9. When the awardee refers to citizens and stakeholders, it will include the concerns of at-risk individuals and special needs populations.

### **c. Selection Criteria**

The following criteria will be used to rank awardees for this project:

1. **Plan.** Does the plan adequately address each of the objectives described in the Purpose section? More specifically, how well does the narrative describe how the applicant will address each of the elements of good public engagement? How complete and comprehensive is the plan for carrying out the project? Does the plan clearly describe the population characteristics of the state, city, or community in which the project will take place? Does the plan include quantitative and/or qualitative performance measures? What measures of effectiveness are in place to show progress and performance? (60 points)
2. **Methods.** Are the proposed methods feasible? To what extent will they accomplish the program goals? (30 Points)
3. **Personnel.** Do the staff members have appropriate experience? Are the staff roles clearly defined? As described, will the staff be sufficient to accomplish the program goals? (10 Points)
4. **Budget and Justification.** (Reviewed, but not scored)

## **2. Electronic Laboratory Data Exchange to Support Pandemic Influenza Surveillance and Laboratory Testing Surge Capacity**

### **a. Funding Opportunity Description**

**Purpose:** To facilitate electronic exchange of laboratory orders and test results among public health laboratories, their surveillance partners, and CDC. This project is intended to support demonstrations of laboratory and state information systems capable of performing the following functions incorporating PHIN-compliant approaches:

1. Sharing of influenza surveillance laboratory test results from state laboratories with state and local and cross-border international public health partners, as well as with CDC
2. Ordering influenza reference tests and sharing electronic reference test results between partners and CDC
3. Interstate and intrastate and bi-national laboratory test result and test order exchange supporting surge capacity among laboratories

**Background:** Laboratory test results will play a critical role in detecting and defining the presence of disease attributable to a pandemic strain in an area, and defining strain variability during a pandemic. State public health laboratories will be key participants in performing such testing and/or forwarding specimens for testing by other reference laboratories, or for triaging specimens to surge capacity laboratories when local capacity is overwhelmed. In addition to conducting the testing, laboratories must be able to order tests and electronically transmit patient- or specimen-level test results to relevant partners, such as CDC, state and local health departments, and cross-border international partners as well as receive results from other laboratory partners, including commercial laboratories and other facilities that do testing on behalf of a public health lab to meet surge capacity needs. Equally important is the need to link laboratory results to related epidemiologic data, including local or state health departments, quarantine stations, and bi-national partners. Nearly two-thirds of state public health laboratories transmit influenza laboratory results to CDC as aggregate data, a form that would not meet information needs during the early phases of a pandemic.

#### **Recipient Activities:**

1. Development, implementation, and licensing of a laboratory information system that will support pandemic influenza surveillance and surge capacity testing
2. Implementation of influenza modules in existing systems
3. Development of electronic interfaces for bi-directional data exchange of laboratory test orders and results
  - a. Tools and services for message mapping and appropriate terminology implementation
  - b. Tools and services for data transformation and brokering tools
4. Conduct assessments of influenza and influenza-like illness laboratory-based surveillance data exchange practices between laboratories as well other relevant partners, such as CDC, state, local and tribal health departments and cross-border international partners; to include reviewing the connectivity among these laboratories with a view toward

enhancing or establishing laboratory information sharing regional networks to facilitate prompt reporting of laboratory results in support of U.S. efforts for the implementation of World Health Organization's 2005 revised International Health Regulations.

5. Improve or develop regional interoperable electronic laboratory information sharing networks among state laboratories and health departments for influenza viruses to boost preparedness for early detection, situational awareness, rapid reporting, and quick response as well as prompt management of potential human-to-human transmission of highly pathogenic novel influenza viruses with pandemic potential.

In a cooperative agreement, CDC staff are substantially involved in the program activities, above and beyond routine grant monitoring.

#### **CDC Activities:**

1. Work directly with awardees to facilitate bi-directional data exchange with CDC and between state and local labs for surge testing capacity

#### **b. Award Information**

**Approximate Current Fiscal Year Funding:** Between \$7 million and \$8 million

**Approximate Total Project Period Funding:** Between \$7 million and \$8 million (This amount is an estimate, and it is subject to availability of funds. Includes direct and indirect costs.)

**Approximate Number of Awards:** 8 to 10

**Approximate Average Award:** \$700,000 to \$800,000 (Includes both direct and indirect costs.)

**Floor of Individual Award Range:** None

**Ceiling of Individual Award Range:** None

**Anticipated Award Date:** April 18, 2008

**Budget Period Length:** The budget period for the Pandemic Influenza Competitive Projects is one year, beginning May 1, 2008 and ending April 30, 2009.

**Project Period Length:** The project period for the Pandemic Influenza Competitive Projects is one year, beginning May 1, 2008 and ending April 30, 2009.

Throughout the project period, CDC's commitment to continuation of awards will be conditioned on the availability of funds, 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.

#### **c. Selection Criteria**

The following criteria will be used to rank awardees for this project:

1. **Plan.** Does the plan adequately address each of the objectives described in the Purpose section (facilitate electronic exchange of laboratory orders and test results among public health laboratories, their surveillance partners, and CDC)? For example, does the plan address electronic laboratory results reporting of influenza test results, creation of electronic test orders, and the creation of interfaces/modules for commonly used Laboratory Information Management Systems (LIMS)? Does the plan clearly describe the population characteristics of the state, city, or community in which the project will

take place? Does the plan include quantitative and/or qualitative performance measures? What measures of effectiveness are in place to show progress and performance? (60 Points)

2. **Methods.** Are the proposed methods feasible? To what extent will they accomplish the program goals? (20 Points)
3. **Personnel.** Do the staff members have appropriate experience? Are the staff roles clearly defined? As described, will the staff be sufficient to accomplish the program goals? (20 Points)
4. **Budget and Justification.** (Reviewed, but not scored)

### **3. Countermeasure and State Immunization Information Systems Integration**

#### **a. Funding Opportunity Description**

**Purpose:** The purpose of this project is to provide selected states with funds to explore ways to integrate existing state-based immunization information systems (IISs) with National Countermeasure and Response Administration (CRA) systems for tracking doses of pandemic influenza vaccine. States, territories, and local public health agencies awarded funds will develop and implement state-based IISs (also known as immunization registries) for pandemic influenza data collection in order to track vaccine doses. A state-based system will help stakeholders in pandemic disease preparedness, including states and CDC, gain insight on how pandemic influenza vaccine is distributed, the date of administration for both first and second doses, the age of recipients, and the administration of vaccine to priority groups. Awardees should strive to achieve 100% participation of providers administering pandemic vaccine; develop an approach that will yield reporting of 100% of pandemic vaccine data within one week from the date of vaccination, and show collaboration between state immunization and bioterrorism programs and other state preparedness stakeholders.

The benefits described above will allow public health officials to gather data that will assist in decision-making and planning regarding vaccine distribution and the shifting vaccine supply to ensure statewide efficiency. This information will be used at national and state levels to communicate the progress of pandemic influenza countermeasure activities, will identify the appropriate use of countermeasure materials, and will adjust or reallocate resources, if needed. The demonstration will result in improved national preparedness for a pandemic event, as well as help states improve vaccine distribution. CDC will help awardees manage their information, as well as provide regional aggregated data.

CDC will provide a standardized data exchange format as a means to share data with other states, partners, and CDC. Developed systems, experiences, and lessons learned from this project will serve as a resource for other awardees to reference when developing similar systems to address CRA for pandemic influenza in their own states.

While not a requirement for participation in this project, CDC also is interested in demonstrations involving awardees with experience in linking their IIS with an active surveillance system, such as CDC's Emerging Infections Program, to facilitate the assessment of pandemic vaccine effectiveness among selected populations within the state or jurisdiction.

**Background:** Pandemic influenza planning requires awardees to consider several areas of pandemic influenza preparedness, such as tracking vaccine doses administered and to adopt or modify the federal guidance in these areas to unique state circumstances. Most awardees have IIS systems that can be used to meet some or all of the pandemic influenza tracking requirements for administered vaccination doses. Many state IISs have high functionality and extensive utilization. However, awardees will need to expand their efforts in developing infrastructure to achieve complete and timely reporting systems, data aggregation, and data exchange systems. At present, states do not have the capability or the mechanisms needed to broadly launch and sustain



developmental activities targeted to pandemic influenza-related tracking systems. The “lessons learned” via the funded IIS states will help other states with IIS in their pursuit of CRA for pandemic influenza in a more directed and efficient way.

**Recipient Activities:**

1. Implement and/or develop programming resources (software and personnel) to add vaccine priority group and other fields, such as anti-viral drug use to current IIS applications and to implement programming resources to institute data aggregation and reporting
2. Implement programming resources to meet reporting and certification needs for data sharing
3. Pilot-test the use of IIS in vaccination sites in public and private settings
4. Develop data linkages with state and local designated pandemic influenza vaccine administration and antiviral drug dispensing sites (reporting, lookup, data exchange)
5. Conduct outreach and training to groups administering vaccine on data collection and transmission, full reporting, and timeliness of reporting
6. Explore extension of IIS data collection and reporting to additional traditional and non-traditional settings in case the need to expand the tracking system occurs
7. Develop linkages, when possible, between IIS and active surveillance systems, particularly active surveillance systems such as CDC's Emerging Infections Program, and facilitate the assessment of pandemic vaccine effectiveness among selected populations within the state or jurisdiction

In a cooperative agreement, CDC staff are substantially involved in the program activities, above and beyond routine grant monitoring.

**CDC Activities:**

1. Provide “Pandemic Influenza Aggregate Vaccine Doses Data Exchange Requirements” to project participants
2. Provide advice regarding CRA issues
3. Develop and provide multiple formats needed to transmit data
4. Assist in the facilitation and adaptation of aggregated data to meet PHIN requirements
5. Certify that systems, submitting personnel, and data are PHIN-compliant
6. Test each system for reliability and inter-connectivity
7. Develop an analytical package to assist awardees in interpreting and presenting gathered data
8. Develop and assist in the methods and systems needed to enable the assessment of pandemic influenza vaccine effectiveness in the event of a pandemic in areas with existing active surveillance systems, such as CDC's Emerging Infections Program

**b. Award Information**

**Approximate Current Fiscal Year Funding:** \$2 million to \$3 million

**Approximate Total Project Period Funding:** \$2 million to \$3 million (This amount is an estimate, and is subject to availability of funds. Includes direct and indirect costs.)

**Approximate Number of Awards:** 8 to 9

**Approximate Average Award:** \$300,000 (Includes both direct and indirect costs.)

**Floor of Individual Award Range:** None

**Ceiling of Individual Award Range:** None

**Anticipated Award Date:** April 18, 2008

**Budget Period Length:** The budget period for the Pandemic Influenza Competitive Projects is one year, beginning May 1, 2008 and ending April 30, 2009.

**Project Period Length:** The project period for the Pandemic Influenza Competitive Projects is one year, beginning May 1, 2008 and ending April 30, 2009.

Throughout the project period, CDC's commitment to continuation of awards will be conditioned on the availability of funds, 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.

### **c. Selection Criteria**

The following criteria will be used to rank awardees for this project:

1. **Plan.** Does the plan adequately address each of the objectives described in the Purpose section (to integrate existing state-based immunization information systems (IISs) and CRA systems for tracking doses of pandemic influenza vaccine)? For example, the plan should demonstrate the ability to be population-based — denominator is populated with vital records data in a timely manor — and be inclusive of all ages (lifespan); it should demonstrate how it will achieve 100% participation of providers administering pandemic vaccine; it should develop an approach that will yield reporting of 100% of pandemic vaccine doses administered within one week from the date of vaccination; and it should show collaboration between state immunization and bioterrorism programs, and with other state preparedness stakeholders. Does the plan clearly describe the population characteristics of the state, city, or community in which the project will take place? Does the plan include quantitative and/or qualitative performance measures? What measures of effectiveness are in place to show progress and performance? (45 Points) Is the awardee currently linking its active surveillance systems with IIS, or does the awardee have a plan to do so? (5 Points)
2. **Methods.** Are the proposed methods feasible? To what extent will they accomplish the program goals? (30 Points)
3. **Personnel.** Do the staff members have appropriate experience? Are the staff roles clearly defined? As described, will the staff be sufficient to accomplish the program goals? (20 Points)
4. **Budget and Justification.** (Reviewed, but not scored)

## 4. Electronic Death Reporting

### a. Funding Opportunity Description

**Purpose:** Implement a statewide PHIN-compliant electronic mortality reporting system that is capable of transmission of fact of death and demographic information within five days and also the cause of death information within 10 days in 80% of all deaths in the awardee's jurisdiction. The developed system should be created in accordance with National Center for Health Statistics (NCHS) standards and use the PHIN-compliant systems. Awardees should engage the National Association of Public Health Statistics and Information Systems (NAPHSIS) for expertise in electronic death reporting systems implementation, stakeholder education, and systems evaluation. The electronic death reporting system should allow for immediate reporting of fact of death and demographic information on the deceased with the addition of cause of death information as it becomes available. The reporting system should promote funeral directors' electronic submission of at least 80% of death certificate data to the appropriate public health authority in the state.

Ideally, the developed death reporting system should demonstrate inter-jurisdictional transmission of mortality data and allow for fact of death data reporting to federal partners within five days of death for at least 80% of deaths occurring in the state.

Awardees may be awarded funding for completion or expansion of existing electronic death reporting systems or for development of new systems in states where no system currently exists or is under development. Awardees from international border states should implement systems allowing the cross-border electronic transfer of mortality data.

**Background:** Rapid tracking of influenza-related mortality currently is obtained through the 122 Cities Mortality Reporting System. The current system collects weekly summary information from 122 U.S. cities covering between one-quarter to one-third of U.S. deaths. The average lag time from death to reporting is 15 days. Data collected include the weekly number of death certificates filed and the number with pneumonia or influenza listed anywhere on the death certificate by age group. The percentage of deaths with pneumonia or influenza listed is calculated and compared to an expected percentage for that week, as derived through mathematical modeling. While this allows for rapid tracking of influenza-related deaths, it does not allow for estimation of the total number of influenza-related deaths, rates of influenza-associated deaths, or state-level analysis, and the system is not designed to collect daily data. Data from the NCHS national vital statistics system are used for these more detailed analyses, but these data typically are not available for a given influenza season until 2 to 3 years later.

NCHS, in collaboration with NAPHSIS and the Social Security Administration, has prepared standards for electronic death reporting systems; the standards allow funeral directors and physicians to complete the death certificate electronically, rather than using the traditional paper record. An electronic death registration system is expected to reduce reporting delays, improve data quality, and increase the utility of death information. Many states have begun developing electronic death reporting systems. A small number of states currently have fully operational systems, but projects for the completion of such systems have stalled in other states because of a

lack of funding. Completion of these projects and expansion of electronic death surveillance to more states would allow rapid assessment of age-specific mortality rates during a pandemic.

**Recipient Activities:**

1. Develop and/or implement a state-wide electronic death reporting system
2. Work with bi-national public health partners to rapidly share cross-border mortality information
3. Monitor system for meeting time frames
4. The developed death reporting system should demonstrate inter-jurisdictional transmission of mortality data and allow for fact of death data reporting to federal partners within 5 days of death for at least 80% of deaths occurring in the state
5. Demonstrate the ability to transmit death certificate data including cause of death data for at least 80% of deaths occurring in the state to appropriate federal agencies within 10 days of the occurrence
6. Any engagement with cross-border international partners should be consistent and integrated with existing international agreements and related activities

In a cooperative agreement, CDC staff are substantially involved in the program activities, above and beyond routine grant monitoring.

**CDC Activities:**

1. Assist awardees in managing and reviewing data sent to federal partners
2. Provide subject matter advice in the development of mortality reporting standards

**b. Award Information**

**Approximate Current Fiscal Year Funding:** \$2.5 million to \$4 million

**Approximate Total Project Period Funding:** \$2.5 million to \$4 million (Includes direct and indirect costs.)

**Approximate Number of Awards:** 3 to 5

**Approximate Average Award:** \$850,000 to \$950,000 (Includes direct and indirect costs.)

**Floor of Individual Award Range:** None

**Ceiling of Individual Award Range:** None

**Anticipated Award Date:** April 18, 2008

**Budget Period Length:** The budget period for the Pandemic Influenza Competitive Projects is one year, beginning May 1, 2008 and ending April 30, 2009.

**Project Period Length** The project period for the Pandemic Influenza Competitive Projects is one year, beginning May 1, 2008 and ending April 30, 2009.

Throughout the project period, CDC's commitment to continuation of awards will be conditioned on the availability of funds, 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.

### c. Selection Criteria

The following criteria will be used to rank awardees for this project:

1. **Plan.** Does the plan adequately address each of the objectives described in the Purpose section (implement a statewide PHIN-compliant electronic mortality reporting system that is capable of transmission of fact of death and demographic information within five days and the cause of death information within ten days in 80% of all deaths in the awardee's jurisdiction)? For example, does the plan demonstrate how it will develop a system in accordance with NCHS standards; how the system will allow for immediate reporting of fact of death and demographic information; how it will achieve 80% compliance with electronic submission of death certificate data to the appropriate public health authority in the state by funeral directors; how it will transmit death certificate data from at least 80% of deaths that occur in the awardee's jurisdiction to a central data repository within 10 days of the occurrence of death? Does the plan clearly describe the population characteristics of the state, city, or community in which the project will take place? Does the plan include quantitative and/or qualitative performance measures? What measures of effectiveness are in place to show progress and performance? (50 Points)
2. **Methods.** Are the proposed methods feasible? To what extent will they accomplish the program goals? (30 Points)
3. **Personnel.** Do the staff members have appropriate experience? Are the staff roles clearly defined? As described, will the staff be sufficient to accomplish the program goals? (20 Points)
4. **Budget and Justification.** (Reviewed, but not scored)

## 5. Collaborative Planning for Delivery of Essential Healthcare Services

### a. Funding Opportunity Description

**Purpose:** The purpose of the program is to demonstrate and evaluate methods for coordination of healthcare delivery that will function despite disruptions during a pandemic. The intended outcome is for a jurisdiction to be able to coordinate various unrelated healthcare delivery resources and maintain delivery of essential services while providing care for large numbers of influenza patients during a pandemic.

**Background:** Healthcare surge capacity is currently inadequate. During an influenza pandemic, large numbers of patients will require care during a short period of time. Concurrently, healthcare personnel will be affected by community-acquired infections leading to as much as 40% absenteeism, based on several models and projections. In addition, supply and support systems on which healthcare systems rely will be affected by similar absenteeism, further reducing the ability of this critical infrastructure (i.e., the healthcare and public health systems) to function normally. Additionally, there will be a surge in home healthcare delivery and need of services. Home health agencies likely will be called upon to provide care for patients who do not require hospitalization for pandemic influenza, or for whom hospitalization is not an option because hospitals have reached their capacity to admit patients. These agencies may become overburdened very quickly and shortages of personnel and supplies for providing home healthcare may occur.

Awardees selected for this program will provide a clear description of how essential healthcare services will be prioritized during the crisis period and what the ethical ramifications of selecting those services will be. Once those are identified, it will be necessary for the awardee to devise optimal locations, staffing plans, cross-system collaborations, and triage and care plans for successful delivery of essential healthcare services, including homebound healthcare services, while simultaneously providing appropriate care for large numbers of patients with influenza.

#### **Recipient Activities:**

1. Define which “essential services” will be priorities for your community (e.g. labor and delivery, trauma care, acute cardiac and neurological care, etc.) and which services will be curtailed
2. Evaluate and summarize in writing the ethical ramifications and population impact of the essential services selected and those services that are not available
3. For border states, develop collaborative activities with bi-national health authorities to address healthcare access issues. Any engagement with cross-border international partners should be consistent and integrated with existing international agreements and related activities.
4. Determine minimum staffing and personnel types and the supplies and resources required to deliver the essential services and also to care for patients with influenza during a Severity Index 5 pandemic influenza event. Provide a written plan covering an 8-week period (i.e., a single wave of a pandemic).

5. Provide a written description of the roles and activities of state and local public health departments in addressing the above vulnerable links
6. Identify how through collaborative planning multiple affected healthcare facilities will share personnel and other resources during a pandemic. Develop a written plan on how the sharing will work to reconstitute the capacity to deliver essential services and provide appropriate care for influenza patients. Include in the plan the identification of vulnerable links in other sectors that support healthcare delivery (e.g., contracts for waste removal, laundry, food services, behavioral health, off-site laboratory analysis, etc.) that will be affected by a pandemic; propose solutions for each to support essential services for an 8-week period.
7. Identify legal issues related to licensure of professional staff, legal liability of professional staff and of healthcare institutions related to standards of care and other legal issues that might prevent collaborations or delivery of care; formalize in writing how state and local health departments will address these issues
8. Provide a written plan for how telephone and other public health triage and public information mechanisms will be integrated with healthcare delivery during a pandemic including alternate formats and language translations for public information.
9. Provide a written plan for development and implementation of technology support to manage the components of this process and the information collected
10. In the plan, include a description of how home healthcare services will be considered and addressed.

In a cooperative agreement, CDC staff are substantially involved in the program activities, above and beyond routine grant monitoring.

**CDC Activities:**

1. Facilitate the inclusion of non-governmental and tribal, military, international, and federal (i.e., Department of Homeland Security) partners into the project efforts by identifying, upon request, non-governmental and governmental contacts outside of CDC that could provide technical assistance or resources
2. Link awardees to the Department of Health and Human Services and other partners to assist in overcoming barriers within healthcare systems

**b. Award Information**

**Approximate Current Fiscal Year Funding:** \$8 million to \$10 million

**Approximate Total Project Period Funding:** \$8 million to \$10 million (Includes direct and indirect costs.)

**Approximate Number of Awards:** 6 to 10

**Approximate Average Award:** \$800,000 to \$1 million (Includes direct and indirect costs.)

**Floor of Individual Award Range:** None

**Ceiling of Individual Award Range:** None

**Anticipated Award Date:** April 18, 2008

**Budget Period Length:** The budget period for the Pandemic Influenza Competitive Projects is one year, beginning May 1, 2008 and ending April 30, 2009.

**Project Period Length:** The project period for the Pandemic Influenza Competitive Projects is one year, beginning May 1, 2008 and ending April 30, 2009.

Throughout the project period, CDC's commitment to continuation of awards will be conditioned on the availability of funds, 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.

### **c. Selection Criteria**

The following criteria will be used to rank awardees for this project:

1. **Plan.** Does the plan adequately address each of the objectives described in the Purpose section (to demonstrate and evaluate methods for healthcare delivery that will function despite large-scale disruptions during a pandemic), and the topics described under Activities? How complete and comprehensive is the plan in integrating healthcare systems, support systems, and public health systems? Does the plan clearly describe the population characteristics of the state, city, or community in which the project will take place? Does the plan include quantitative and/or qualitative performance measures? What measures of effectiveness are in place to show progress and performance? (50 Points)
2. **Methods.** Are the proposed methods feasible? To what extent will they accomplish the program goals? (30 Points)
3. **Personnel.** Do the staff members have appropriate experience? Are the staff roles clearly defined? As described, will the staff be sufficient to accomplish the program goals? (20 Points)
4. **Budget and Justification.** (Reviewed, but not scored)



## 6. Addressing Vulnerabilities in Populations

### a. Funding Opportunity Description

**Purpose:** The purpose of this program is to identify replicable practices and model interventions that promote preparedness in populations with vulnerabilities during public health emergencies, particularly during a pandemic disease event. The awardee should employ an approach that has been proven to be successful in the awardee's jurisdiction, such as demonstrating existing relationships and/or projects with one of the prioritized at-risk populations. An evaluation with measures of effectiveness should be included in the plan.

**Background:** In a disaster or an emergency event, groups of people are at risk of becoming isolated from important information and key messages. These at-risk populations – which can be defined by race/ethnicity, socio-economic status, geography (including international borders), gender, age, disability, and other factors that place a group at-risk for health disparities as defined in the Pandemic All-Hazards Preparedness Act legislation – need to be considered in public health emergency planning. In preparation for a public health emergency, including pandemic influenza, state, local and tribal health agencies should plan to reach and communicate effective messages to the entire community. Recent “All-Hazard” events (September 11, 2001, Hurricanes Katrina and Rita, mudslides in the West, and diseases such as SARS and West Nile virus) have highlighted the importance of assessing a multitude of human service needs and planning for them so that communities can prepare for, respond to, and recover from natural and man made disasters. CDC recognizes the need for communities to prepare their high priority at-risk populations for such events. Many communities have conducted the necessary steps of defining, locating, and reaching at-risk populations, but they have not had the funds to develop program interventions that address training, communication, or coordination to ensure readiness and the ability to assist at-risk populations to recover from an event.

#### **Recipient Activities:**

1. Utilize existing or establish new partnerships with community organizations that represent or serve specific populations with vulnerabilities (as defined above) in your community
2. Document the use of the existing mapping of at-risk populations or, if such mapping does not already exist, document and disseminate what practices would be used to map at-risk populations
3. Develop and implement an intervention that results in improved public health preparedness in the population that the applicant proposes to serve
4. Disseminate promising practices and lessons learned through available methods, channels, and venues that also include alternative formats (Section 508)

In a cooperative agreement, CDC staff are substantially involved in the program activities, above and beyond routine grant monitoring.

#### **CDC Activities:**

1. Review the proposed activities and assist in the development of interventions with awardees

2. Coordinate subject matter advice and technical assistance in the implementation or evaluation of interventions that could improve project outcomes
3. Monitor overall awardee activities to identify trends that may prove useful in the implementation of similar interventions nationwide
4. Disseminate findings from innovative programs in one or more CDC forums

## **b. Award Information**

**Approximate Current Fiscal Year Funding:** \$3 million to \$4 million

**Approximate Total Project Period Funding:** \$3 million to \$4 million (This amount is an estimate, and it is subject to availability of funds. Includes direct and indirect costs.)

**Approximate Number of Awards:** 5 to 8

**Approximate Average Award:** \$100,000 to \$500,000 (Includes both direct and indirect costs.)

**Floor of Individual Award Range:** None

**Ceiling of Individual Award Range:** None

**Anticipated Award Date:** April 18, 2008

**Budget Period Length:** The budget period for the Pandemic Influenza Competitive Projects is one year, beginning May 1, 2008 and ending April 30, 2009.

**Project Period Length:** The project period for the Pandemic Influenza Competitive Projects is one year, beginning May 1, 2008 and ending April 30, 2009.

Throughout the project period, CDC's commitment to continuation of awards will be conditioned on the availability of funds, 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.

## **c. Selection Criteria**

The following criteria will be used to rank awardees for this project:

1. **Plan.** Does the plan adequately address each of the objectives described in the Purpose section (identify replicable practices and model interventions that promote preparedness in populations with vulnerabilities during public health emergencies, particularly in a pandemic disease event), and the topics described under Activities? How complete and comprehensive is the plan in identifying at-risk populations and showing support from organizations (letters of support) that represent these groups? Does the plan explain the specific project's benefit to the specific at-risk population? Does the plan clearly describe the population characteristics of the state, city, or community in which the project will take place? Does the plan include quantitative and/or qualitative performance measures? What measures of effectiveness are in place to show progress and performance? (50 Points)
2. **Methods.** Are the proposed methods feasible? To what extent will they accomplish the program goals? (30 Points)
3. **Personnel.** Do the staff members have appropriate experience? Are the staff roles clearly defined? As described, will the staff be sufficient to accomplish the program goals? (20 Points)
4. **Budget and Justification.** (Reviewed, but not scored)

## 7. Distribution and Dispensing of Antiviral Drugs to Self-Isolated or Self-Quarantined Persons as Part of a Community Containment Strategy

### a. Funding Opportunity Description

**Purpose:** In addition to treatment strategies, federal and state stockpiles of antiviral drugs may be available to support prophylaxis for containing initial outbreaks and complementing other community mitigation actions. The purpose of this funding opportunity is to explore various methodologies that allow for the distribution and dispensing of influenza antiviral medications to self-isolated or self-quarantined individuals as part of a targeted, layered community containment plan. The methodologies explored should be developed and planned with current state and local laws in mind. Options that can be pursued include, but are not limited to, strategies such as:

1. Having physicians prescribe antiviral drugs for the entire household on the basis of an office or clinic visit with only the patient being ill, if such practice is allowable under state law
2. Having physicians make house calls for apparent influenza patients and, if warranted, interview individuals and prescribe antiviral drugs, as appropriate, for the entire household
3. Having physicians (or other healthcare providers as deemed legal by the state) prescribe influenza antiviral drugs, as appropriate, to individuals in advance of an influenza pandemic for use only in a pandemic influenza, in accordance with advice from state or local public health officials and state and local laws
4. Other alternative modalities of distribution (including home healthcare workers, visiting nurses, etc.) and dispensing to self-isolated or self-quarantined symptomatic patients and their household contacts
5. Having home healthcare workers identify households with apparent influenza patients

Having explored methodologies for distributing antiviral drugs to entire households based on office visits and house calls, states will be expected to exercise their distribution methods, prepare after action reports, and share their findings with other awardees to assist in pandemic influenza planning.

**Background:** In February 2007, CDC published “*Interim Pre-pandemic Planning Guidance: Community Strategy for Pandemic Influenza Mitigation in the United States*” ([http://www2a.cdc.gov/phlp/docs/community\\_mitigation.pdf](http://www2a.cdc.gov/phlp/docs/community_mitigation.pdf)). The strategies described in this guidance are predicated on an early, targeted, and layered application of multiple partially effective non-pharmaceutical measures. Two of the interventions described in this document include:

1. Isolation and treatment (as appropriate) with influenza antiviral medications of all persons with confirmed or probable pandemic influenza, and
2. Voluntary home quarantine of members of households with confirmed or probable influenza case(s) and consideration of combining this intervention with the prophylactic use of antiviral medications, providing that sufficient quantities of effective medications exist and that a feasible means of distributing them is in place.

The short intergeneration time of influenza disease suggests that household members living with an ill individual (and thus at increased risk of infection with pandemic virus) would need to be identified rapidly and targeted for appropriate intervention to limit community spread. This can include the use of targeted antivirals in this population. The role of influenza antiviral medications as therapy for symptomatic individuals is primarily to improve individual outcomes, not to limit the further transmission of disease, although recent clinical trials have demonstrated that prophylaxis of household contacts of symptomatic individuals with neuraminidase inhibitors can reduce household transmission. However, the feasibility of rapidly (within 48 hours after exposure) providing these medications to ill individuals and to those who live in households with ill individuals has not been tested, and mechanisms to support such distribution and dispensing need to be developed.

**Recipient Activities:**

1. Explore the logistical challenges and opportunities associated with one or more of the strategies identified in the Purpose section above
2. Prepare a final report to be shared with other awardees regarding the suggested approach, execution, and lessons learned from exercises. The report should include a description of the awardee's state laws affecting antiviral distribution and dispensing; information about barriers to antiviral drug distribution and dispensing; lists of working groups and committees used to research various aspects of the issue, including the development of a distribution and dispensing model; the methodology for the development of exercises to test the proposed antiviral distribution and dispensing approach; exercise results; and after action reports

**CDC Activities:**

1. Provide technical assistance from subject matter experts in the arenas of public health law, isolation and quarantine, pharmaceutical stockpiling, and evaluating clinical (or laboratory-confirmed) pandemic influenza in finalizing the design for the project
2. Assist in the evaluation of the effectiveness of the overall project
3. Disseminate findings from innovative projects in one or more CDC forums

**b. Award Information**

**Approximate Current Fiscal year Funding:** \$500,000 to \$1 million

**Approximate Total Project Period Funding:** \$500,000 to \$1 million (Includes indirect costs.)

**Approximate Number of Awards:** 3 to 5

**Approximate Average Award:** \$100,000 to \$200,000 (Includes both direct and indirect costs.)

**Floor of Individual Award Range:** None

**Ceiling of Individual Award Range:** None

**Anticipated Award Date:** April 18, 2008

**Budget Period Length:** The budget period for the Pandemic Influenza Competitive Projects is one year, beginning May 1, 2008 and ending April 30, 2009.

**Project Period Length:** The project period for the Pandemic Influenza Competitive Projects is one year, beginning May 1, 2008 and ending April 30, 2009.

Throughout the project period, CDC's commitment to continuation of awards will be conditioned on the availability of funds, 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.

### c. Selection Criteria

The following criteria will be used to rank awardees for this project:

1. **Plan.** Does the plan adequately address each of the objectives described in the Purpose section (allow for the delivery/distribution and dispensing of influenza antiviral medications to isolated or quarantined individuals as part of a targeted, layered community containment plan that is compatible with state and local law)? For example, does the plan address developing a strategy for having a physician prescribe antiviral drugs to an entire household based upon an office or clinic visit by one ill family member? Does the plan include early identification of affected households and describe the link between identification and dispensing? Does the plan clearly describe the population characteristics of the state, city, or community in which the project will take place? What measures of effectiveness are in place to show progress and performance? (50 Points)
2. **Methods.** Are the proposed methods feasible? To what extent will they accomplish the program goals? (30 Points)
3. **Personnel.** Do the staff members have appropriate experience? Are the staff roles clearly defined? As described, will the staff be sufficient to accomplish the program goals? (20 Points)
4. **Budget and Justification.** (Reviewed, but not scored)

## **C. Eligibility Information for All Projects**

### **Eligible Applicants**

Eligible applicants that can apply for this funding opportunity include awardees receiving direct funding through the Cooperative Agreement for Public Health Emergency Preparedness AA154.

### **Cost Sharing or Matching**

Matching funds are not required for this program.

### **Other**

CDC will accept and review applications with budgets greater than the ceiling of the award range.

### **Special Requirements**

If the application is incomplete or non-responsive to the special requirements listed in this section, it will not be entered into the review process. The applicant will be notified the application did not meet submission requirements.

- Late applications will be considered non-responsive. See section “D. Submission Dates and Times” for more information on deadlines.
- Note: Title 2 of the United States Code Section 1611 states that an organization described in Section 501(c)(4) of the Internal Revenue Code that engages in lobbying activities is not eligible to receive Federal funds constituting a grant, loan, or an award.

## **D. Application and Submission Information**

### **Letter of Intent**

Awardees that intend to apply for one or more projects should submit a Letter of Intent listing all the projects for which they intend to apply. The Letter of Intent is not a binding agreement, nor will the absence of one exclude an awardee from applying. The Letter of Intent will be used by CDC to estimate the number of applications it will have to review. The Letter of Intent is due on January 16, 2008. Awardees should submit their Letter of Intent to the following email address: [panflucomp@cdc.gov](mailto:panflucomp@cdc.gov).

Prospective applicants are asked to submit a letter of intent that includes the following information:

- Descriptive title of proposed project.
- Name, address, and telephone number of the Principal Investigator/Project Director.
- Names of other key personnel.
- Participating institutions.

Format of Letter of Intent:

- Microsoft Word format
- Length: 1 page
- Font size: 12 point un-reduced, Times New Roman
- Single-spaced

- All projects that a awardee intends to apply should be included in a single Letter of Intent

### **Application Submission Address:**

#### **Electronic Submission**

Public Health Emergency Preparedness Cooperative Agreement awardees that wish to apply for these funds are required to submit their narrative and budget information to [www.grants.gov](http://www.grants.gov). Awardees that wish to apply for more than one project must apply for each project separately. CDC requires the applicant to submit the application electronically by utilizing the forms and instructions posted for this announcement on [www.Grants.gov](http://www.Grants.gov), the official Federal agency wide E-grant Web site.

Registering your organization through [www.Grants.gov](http://www.Grants.gov) is the first step in submitting applications online. Registration information is located in the “Get Registered” screen of [www.Grants.gov](http://www.Grants.gov).

Please visit [www.Grants.gov](http://www.Grants.gov) at least 30 days prior to filing your application to familiarize yourself with the registration and submission processes. Under “Get Registered,” the one-time registration process will take three to five days to complete; however, as part of the Grants.gov registration process, registering your organization with the Central Contractor Registry (CCR) annually, could take an additional one to two days to complete. We suggest submitting electronic applications prior to the closing date so if difficulties are encountered, you can submit a hard copy of the application prior to the deadline.

Awardees that are selected for funding in one or more of the projects will be required to enter their project information, including a detailed budget into PERFORMS, the management information system maintained by the Coordinating Office for Terrorism Preparedness and Emergency Response’s Division of State and Local Readiness.

#### **Paper Submission as a Backup**

Submission through **www.grants.gov is required**, but awardees have the option of submitting the original and two hard copies of the application as a backup by mail or express delivery service to:

Technical Information Management – CDC-RFA-TP08-802  
Department of Health and Human Services  
CDC Procurement and Grants Office  
2920 Brandywine Road  
Atlanta, GA 30341

Application forms and instructions are available on the CDC Web site, at the following Internet address: [http://www.cdc.gov/od/pgo/funding/grants/app\\_and\\_forms.shtm](http://www.cdc.gov/od/pgo/funding/grants/app_and_forms.shtm)

If access to the Internet is not available, or if there is difficulty accessing the forms on-line, contact the CDC Procurement and Grants Office Technical Information Management Section (PGO-TIMS) staff at 770-488-2700 and the application forms can be mailed.

### **Content and Form of Submission**

**Application:** A project abstract must be submitted with the application forms. All electronic project abstracts must be uploaded in a PDF file format when submitting via Grants.gov. The abstract must be submitted in the following format, if submitting a paper application:

- Maximum of 2-3 paragraphs.
- Font size: 12 point unreduced, Times New Roman
- Single spaced
- Paper size: 8.5 by 11 inches
- Page margin size: One inch

The project abstract must contain a summary of the proposed activity suitable for dissemination to the public. It should be a self-contained description of the project and should contain a statement of objectives and methods to be employed. It should be informative to other persons working in the same or related fields and insofar as possible understandable to a technically literate lay reader. This Abstract must not include any proprietary/confidential information.

A project narrative must be submitted with the application forms. All electronic narratives must be uploaded in a PDF file format when submitting via Grants.gov. The narrative must be submitted in the following format, if submitting a paper application:

- Maximum number of pages: 20. If your narrative exceeds the page limit, only the first pages which are within the page limit will be reviewed.
- Font size: 12 point unreduced, Times New Roman
- Single spaced
- Paper size: 8.5 by 11 inches
- Page margin size: One inch
- Printed only on one side of page.
- Number all narrative pages; not to exceed the maximum number of pages.

The narrative should address activities to be conducted over the entire project period and must include the following items in the order listed:

1. Plan
2. Objectives
3. Methods
4. 12-month Project Timeline
5. Staff
6. Performance Measures
7. Budget Justification

### **Submission Dates and Times**

**Letter of Intent Deadline:** January 16, 2008

**Application Deadline Date:** March 17, 2008



**Explanation of Deadlines:** Electronic applications must be received in the CDC Procurement and Grants Office by 5:00 p.m. Eastern Time on the deadline date.

Applications must be submitted electronically at [www.Grants.gov](http://www.Grants.gov). Applications completed online through Grants.gov are considered formally submitted when the applicant organization's Authorizing Organization Representative (AOR) electronically submits the application to [www.Grants.gov](http://www.Grants.gov). Electronic applications will be considered as having met the deadline if the application has been successfully submitted electronically by the applicant organization's AOR to Grants.gov on or before the deadline date and time.

When submission of the application is done electronically through Grants.gov (<http://www.grants.gov>), the application will be electronically time/date stamped and a tracking number will be assigned, which will serve as receipt of submission. The AOR will receive an e-mail notice of receipt when HHS/CDC receives the application.

This announcement is the definitive guide on LOI and application content, submission address, and deadline. It supersedes information provided in the application instructions. If the application submission does not meet the deadline above, it will not be eligible for review. The application face page will be returned by HHS/CDC with a written explanation of the reason for non-acceptance. The applicant will be notified the application did not meet the submission requirements.

### **Funding Restrictions**

Restrictions that must be taken into account while writing the budget are as follows:

- Recipients may not use funds for research
- Recipients may not use funds for clinical care
- Recipients may expend funds only for reasonable program purposes, including personnel, travel, supplies, and contractual services
- Awardees may not generally use HHS/CDC/ATSDR funding for the purchase of furniture or equipment. Any such proposed spending must be identified in the budget
- The direct and primary recipient in a cooperative agreement program must perform a substantial role in carrying out project objectives and not merely serve as a conduit for an award to another party or provider who is ineligible
- Reimbursement of pre-award costs is not allowed

If requesting indirect costs in the budget, a copy of the indirect cost rate agreement is required. If the indirect cost rate is a provisional rate, the agreement should be less than 12 months of age. The indirect cost rate agreement should be uploaded as a PDF file with "Other Attachment Forms" when submitting via Grants.gov.

The recommended guidance for completing a detailed justified budget can be found on the CDC Web site, at <http://www.cdc.gov/od/pgo/funding/budgetguide.htm>.

## **E. Other Submission Requirements**

**LOI Submission Address:** Submit the to the following email address: [panflucomp@cdc.gov](mailto:panflucomp@cdc.gov).

**Application Submission Address:** HHS/CDC requires applicants to submit applications electronically at [www.Grants.gov](http://www.Grants.gov). The application package can be downloaded from [www.Grants.gov](http://www.Grants.gov). Applicants are able to complete it off-line, and then upload and submit the application via the Grants.gov Web site. E-mail submissions will not be accepted. If the applicant has technical difficulties in Grants.gov, customer service can be reached by E-mail at [support@grants.gov](mailto:support@grants.gov) or by phone at 1-800-518-4726 (1-800-518-GRANTS). The Customer Support Center is open from 7:00a.m. to 9:00p.m. Eastern Time, Monday through Friday.

HHS/CDC recommends that submittal of the application to Grants.gov should be prior to the closing date to resolve any unanticipated difficulties prior to the deadline. Applicants may also submit a back-up paper submission of the application. Any such paper submission must be received in accordance with the requirements for timely submission detailed in Section D. Application and Submission Information of the grant announcement. The paper submission must be clearly marked: "BACK-UP FOR ELECTRONIC SUBMISSION." The paper submission must conform to all requirements for non-electronic submissions. If both electronic and back-up paper submissions are received by the deadline, the electronic version will be considered the official submission.

## **F. Application Review Information**

### **Review and Selection Process**

Applications will be reviewed for completeness by the Procurement and Grants Office staff, and for responsiveness jointly by the Coordinating Office for Terrorism Preparedness and Emergency Response and the Procurement and Grants Office. Incomplete applications and applications that do not meet the eligibility criteria will not advance through the review process. Applicants will be notified that the application did not meet submission requirements.

**Application review information:** Applications will be reviewed and ranked through an objective review process. Each funding opportunity application pool will be reviewed in two separate panels - a panel for states submitting an application for densely populated areas and a panel for states submitting an application for less densely populated areas.

Following the conclusion of the panels and the creation of the rank order list, the geographic funding preference will be applied.

An objective review panel will evaluate complete and responsive applications according to the criteria listed. The objective review process will follow the HHS policy requirements. The review panel will evaluate applications according to the criteria listed in the Selection Criteria section of each project description.

### **Anticipated Announcement Award Dates**

Notices of Grant Award for the Pandemic Influenza Competitive Projects will be announced on or about April 18, 2008.

## **G. Award Administration Information**

## Award Notices

Successful applicants will receive a Notice of Award (NoA) from the CDC Procurement and Grants Office. The Notice of Award shall be the only binding, authorizing document between the recipient and CDC. The Notice of Award will be signed by an authorized Grants Management Officer and emailed to the program director, with a hard copy mailed to the recipient fiscal officer identified in the application.

Unsuccessful applicants will receive notification of the results of the application review by mail.

## Reporting Requirements

The applicant must provide CDC with an original plus two hard copies of the following reports:

1. A progress report will be due no later than 45 days after the midway point of the project (6 months). The progress report must contain the following elements:
  - a. Current Budget Period Activities Objectives
  - b. Current Budget Period Financial Progress
  - c. New Budget Period Program Proposed Activity Objectives
  - d. Budget
  - e. Measures of Effectiveness
  - f. Additional Requested Information
2. Financial status report and annual progress report, no more than 90 days after the end of the budget period
3. Final performance and Financial Status reports, no more than 90 days after the end of the project period

The reports must be mailed to the Grants Management Specialist listed in the Agency Contacts section of this announcement.

## H. Agency Contacts

CDC encourages inquiries concerning this announcement. For program technical assistance regarding each project, contact the CDC Subject Matter Experts (SME) assigned to the project for which you are applying, as listed below:

<b>Project</b>	<b>SME</b>	<b>Phone</b>	<b>Email</b>
Public Engagement	Roger Bernier	404-639-8875	<a href="mailto:RBernier@cdc.gov">RBernier@cdc.gov</a>
Electronic Lab Reporting Countermeasures & State ISS Integration	Tim Morris	404-498-2450	<a href="mailto:TMorris@cdc.gov">TMorris@cdc.gov</a>
Electronic Death Reporting	Ed Brink	404-639-8822	<a href="mailto:EBrink@cdc.gov">EBrink@cdc.gov</a>
Collaborative Planning for Healthcare Services	Lynette Brammer	404-639-1303	<a href="mailto:LBrammer@cdc.gov">LBrammer@cdc.gov</a>
A-VIP	Deborah Levy	404-639-4086	<a href="mailto:DLevy@cdc.gov">DLevy@cdc.gov</a>
Anti-Viral Drug Distribution	Karen Willis Galloway	404-639-7451	<a href="mailto:KWillisGalloway@cdc.gov">KWillisGalloway@cdc.gov</a>
	Linda Neff	404-639-2409	<a href="mailto:LNeff@cdc.gov">LNeff@cdc.gov</a>

For general questions, contact:

Technical Information Management

Department of Health and Human Services  
CDC Procurement and Grants Office  
2920 Brandywine Road  
Atlanta, GA 30341  
Telephone: 770-488-2700  
Email Address: [pgotim@cdc.gov](mailto:pgotim@cdc.gov)

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

Sharon Robertson, Grants Management Specialist  
Department of Health and Human Services  
CDC Procurement and Grants Office  
Acquisition and Assistance, Branch VI  
2920 Brandywine Road, MS K-75  
Atlanta, GA 30341-4146  
Telephone: 770-488-2748  
Email Address: [sqr2@cdc.gov](mailto:sqr2@cdc.gov)

Angela Webb, Grants Management Specialist  
Department of Health and Human Services  
CDC Procurement and Grants Office  
Acquisition and Assistance, Branch VI  
2920 Brandywine Road, MS K-75  
Atlanta, GA 30341-4146  
Telephone: 770-488-2784  
Email Address: [aq6@cdc.gov](mailto:aq6@cdc.gov)

Kaleema McLean, Grants Management Specialist  
Department of Health and Human Services  
CDC Procurement and Grants Office  
Acquisition and Assistance, Branch VI  
2920 Brandywine Road, MS K-75  
Atlanta, GA 30341-4146  
Telephone: 770-488-2742  
Email Address: [fya3@cdc.gov](mailto:fya3@cdc.gov)

CDC Telecommunications for the hearing impaired or disabled is available at: TTY 770-488-2783.

## **I. Other Information**

*Other CDC funding opportunity announcements can be found on the CDC Web site, Internet address:*

*<http://www.cdc.gov/od/pgo/funding/FOAs.htm>*