**2016 CORE State Violence and Injury Prevention Program (SVIPP) Funding Opportunity Announcement (FOA) - QUESTIONS AND ANSWERS**

**PAGE NUMBER LIMITS QUESTION:**

What are the page limits for the application?

**A:** Based on feedback from our webinar, we have changed the page limits for applications. All pages must be single spaced, Calibri 12 point, 1-inch margins, number all pages. Please see the page limits below and only follow these instructions for the page limits, not what is listed in the FOA. There are no page limits for the attachments.

BASE: (Total 40 pages) Maximum of 25 pages for project narrative & work plan.
Maximum of 15 pages for evaluation plan. Content beyond these pages will not be considered.

SQI: (Total 15 pages) Maximum of 10 pages for project narrative & work plan.
Maximum of 5 pages for evaluation plan. Content beyond these pages will not be considered.

RNCO: (Total 15 pages) Maximum of 10 pages for project narrative & work plan.
Maximum of 5 pages for evaluation plan. Content beyond these pages will not be considered.

**ATTACHMENT QUESTION:**

The FOA and scoring indicates to attach the 1) state plan 2) evidence of injury indicator submission (letters/data) 3) Work plan (e.g. "Applicants must name this file "Work Plan" and upload it as a PDF file on www.grants.gov ) and 4) evidence for coalition including list of coalition members/meeting minutes. However, in the FOA on page 50. Under H. Other it lists the allowable attachments. The instructions indicate "Applicants may not attach documents other than those listed; if other documents are attached, applications will not be reviewed". Can you please clarify how to correctly label and attach the documents to assure that application will be accepted and reviewed?

**A:** CDC has added the following documents to the allowable attachments for this FOA to ensure that your application will be reviewed:

BASE:
State Injury and Violence Plan - "XX State Plan BASE" (XX = 2 letter state abbreviation)

BASE & SQI:
Emergency Room data – "XX ER Data"
Hospital Discharge data – XX Hospital Data"
Vital Statistics data – "XX Vital Data"

BASE & RNCO:
ICIG Coalition Minutes - "XX 15 ICIG Minutes"

RNCO:
Evidence of a state injury and violence program in place for at least 5 years - "XX IVP Program History RNCO"

All three components:
State Injury Indicator Reports – "XX Indicator Reports"

**ELIGIBILITY QUESTIONS:**

**Q:** We are not a tribal government but we are a tribal health consortium involving 18 tribes that pooled their compact funding to support the health needs across the region. Addressing and impacting injury prevention is one of our strategic goals over the next two years. Would we be eligible to apply for this opportunity?

**A:** Competition is limited to State Governments or their Bona Fide Agents (includes the District of Columbia), 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 Governments, and American Indian or Alaska Native Tribal Governments (federally-recognized or state-recognized). Eligibility is limited because State Health Departments, or their bona fide agents, Territories, and Tribes because they maintain public health responsibility for injury and violence prevention, and their infrastructure and surveillance systems are essential to statewide injury and violence prevention efforts. This program focuses on supporting State Health Departments/Tribes/Territories (SHD/T/T) in their efforts to ensure widespread adoption of best practices by disseminating and implementing statewide interventions and monitoring their impact. Therefore, if they are not one of the aforementioned entities, they would not be eligible to apply unless they are serving as the Bona Fide Agent. A consortia representing multiple tribal organizations would only be eligible to apply as the Bona Fide Agent for a Tribal Government. A letter identifying the consortia as the Tribal Bona Fide Agent would have to be submitted with the application by the Tribal Government.

**Q:** Would we be ineligible if we do not have an active tribal Injury Community Implementation Group (ICIG)?

**A:** This is an implementation cooperative agreement, therefore the expectation is that applicants have an existing body that could serve in this role. Many states, including Core states, already have a group similar to the ICIG as defined in the FOA. Others currently have planning bodies and that could transition into implementation bodies. Consider submitting application with current bodies in your tribe that could serve in this role and propose plan for creating or reconstituting a more comprehensive group.

**Q:** Does a "special requirement" mean non-ICIG states would not be eligible to apply? Or does it only mean we would be at a 5 point penalty? Either way, this makes it extremely challenging for non-core states or I question if this was the intent of the wording. We are probably typical in that we had an advisory group when we had core funding but it could not be sustained when the staff was lost during the last funding round. Non-core states should be given the opportunity to create or reconstitute an ICIG without penalty, otherwise they would be at a major competitive disadvantage for core funding.

**A:** The special requirement does not exclude non-core states. This is an implementation cooperative agreement, therefore the expectation is that applicants have an existing body to serve in this role. Scoring (between 1-5 points) is based on whether the applicant has an established statewide injury and violence prevention collaborative that includes key partners and related coalitions (e.g., ICIG) or a *similar* statewide IVP collaborative group in place. Many

states already have a group similar to the ICIG as defined in the FOA. Others currently have planning bodies and those could transition into implementation bodies. Consider submitting application with the current bodies in your state that could serve in this role and propose a plan for creating or reconstituting a more comprehensive group.

**Q:** Do you have to have had Base funding already in a previous round to apply for SSQI or RNCO in this round? The wording is confusing.
**A:** No, the requirement to have Base funding is for this Cooperative agreement only. You must successfully compete for Base funding under CE16-1602 before being considered for either SQI or RNCO.

**Q:** Is this opportunity available only to the existing 20 core states already participating in this program?
**A:** This new funding opportunity is an open competition and not limited to previously funded core states. Please see FOA for additional eligibility criteria.

**Q:** On Page 6 (the cover page being page 1), last paragraph under "e. Relevant Work. This FOA builds upon the previous work of the Core VIPP program (CE11-1101) which focused on supporting infrastructure and capacity development for IVP in 20 funded states". Some people are interpreting that to mean CDC is only funding states that were previously funded. Is this a correct interpretation?
**A:** The statement under "e. Relevant Work." is not meant to exclude any states from applying as CDC supports infrastructure and capacity building of both funded and unfunded states. The intent is to demonstrate the movement from capacity building in the previous FOA to implementation in the current one.

**FUNDING QUESTIONS:**
**Q:** Can other federal funding sources (i.e., MIECHV) be used as "match"?
**A:** Yes, applicants are encouraged to use match.

**Q:** Can states meet the requirement to provide funding for each of the CDC priority injury areas identified in the RFA by dedicating only in-kind financial support?
**A:** The budget that will be submitted with the application does not differentiate which of the focus areas the financial support is going towards. Therefore, in-kind support is encouraged and can be utilized, as long as the applicant is clear that the loss of those external funds does not excuse the grantee from meeting all of the focus area programmatic requirements of the FOA.

**Q:** Is the expectation that CORE funds are supplementing existing funds for in-progress projects?
**A:** CORE funds are meant to be complementary and/or supplemental to existing funding and programming, not duplicative.

**Q:** Is RPE funding going away- addressing sexual violence in CORE seems duplicative. Since every state gets funded for RPE why is intimate partner sexual violence a priority for this FOA?
**A:** The Core SVIPP FOA provides the opportunity to support and expand the intimate partner/sexual violence work within RPE by supporting evaluation and surveillance-related activities. Some RPE grantees experience evaluation-related challenges due to limited funding. Further, the Violence Against Women Act, which funds RPE, prohibits use of funds for surveillance. Therefore, this FOA is an opportunity for RPE grantees to receive specific evaluation and/or surveillance support.

**Q:** Can Core SVIPP grant funds be used to purchase incentives or stipends?
**A:** Refer to C.17 – Funding Restrictions in the FOA. Incentives/stipends are not an allowable expense.

**Q:** Do we need allocate funds to attend the grantee meeting?
**A:** Applicant should include funds in the budget of each component to cover travel for one person to attend the annual meeting with CDC. Therefore, if applying for all three components, the individual budgets should all include travel for one staff member to attend the annual CDC meeting.

**INJURY INDICATOR QUESTION:**
Will the annual injury indicators report moving forward still include the same injury/violence indicators, or will others be added (especially with the priorities of child maltreatment, intimate partner & sexual violence)?
**A:** The annual Injury Indicator instructions will still include the same injury/violence indicators and there is a possibility that others will be added to reflect the new priorities. In addition, the current hospitalization and emergency department indicators will be updated because of the transition of morbidity data to ICD-10-CM codes.

**LOGIC MODEL QUESTION:**
Are applicants required to submit a logic model as part of the base component? Page 8 makes reference to a state logic model, but it is not clear whether that will be developed during the first few months of funding or as part of the application.
**A:** A logic model is not required to be submitted with the application.

**OUTCOMES QUESTION:**
**Q:** Per the FOA, bottom of page 20: "Long-term outcomes must, at minimum, include those listed in the Table below. Applicants may also add long-term outcomes that are relevant to state and local stakeholders." Should we take this literately, meaning that we should evaluate the long-term outcomes explicitly listed in the table? Or is the sentence meant in general terms, that simply grantees are required to evaluate long-term outcomes? Essentially, the "PRESCRIBED" long-term Motor Vehicle Crash examples are only alcohol-related. If the statement is meant literally, please note that the remaining two motor vehicle strategies are missing from the table.

**A:** Yes, you are required to track all prescribed long-term outcomes listed in the table. The remaining strategies are not missing, these are to be developed by the applicant. Refer to page 15 of the FOA for sample strategies that can be proposed OR you may propose alternative strategies as long as they are based on the best available evidence.

**Q:** In a state without a centralized 911 system, is CDC hoping to collect statewide 911 data on domestic violence calls? Or would a state be required to reach out to the 300+ law enforcement agencies?
**A:** It is up to the applicant to develop a method for reporting this information to CDC. CDC will not be collecting the data and each state must propose a strategy for addressing each of the long term outcomes. (A representative sample of data from high-burden counties is an example of an approach.)

**Q.** On page 20, you call for a short term reduction in morbidity and mortality? How are you expecting to measure impact in the short-term?
**A:** Applicants must develop short term outcomes to measure strategy specific impacts as part of their application. The proposed short-term and intermediate term outcomes should have a logical relationship to the ultimate long-term health impact measure. This does not mean that short-term and intermediate-term outcomes should reflect a direct impact on morbidity and mortality, rather they should impact risk and/or protective factors/behaviors that will logically lead to the long-term impact. Refer to page 21 (Child abuse and neglect) of the FOA for an example of a short-term outcome based on IVP strategy selection for ultimately having an impact on reduction of morbidity and mortality.

**STATE PLAN QUESTIONS:**

**Q:** Our state has a plan that expired in 2015. We have been in process on updating the plan for the past six months, do we need to have a current one to apply for the CORE? What if the current state plan doesn't cover all of the priorities listed under this cooperative agreement funding opportunity? Will we be required to submit a state plan that addresses these priorities, or will one that already exists be adequate, even if it covers other items?
**A:** The requirement is that there is a plan in place. If the plan is older and you are in the process of updating the plan, please note that in your application. It is not required that all priorities listed under this cooperative agreement are in the current plan, however, there is an expectation that there will be an update to include all priorities in the future.

**Q:** If we do not have a written tribal Injury and Violence Prevention Plan are we still eligible to apply?
**A:** As this is an implementation FOA, applicants must have a plan in place. It is not required that all priorities listed under this cooperative agreement are in the current plan, however, there is an expectation that there will be an update to include all priorities in the future.

**FOCUS AREA PRIORITIES QUESTION:**

Is the expectation that we have to address all of the areas in the FOA? A bit of background: This particular state only has MVC in their state plan out of the components listed in the FOA and

they receive other funding for the other injury areas included in the FOA so they don't necessarily think it would be worthwhile to spend this money towards the other injury areas.
**A:** Yes, it is the expectation that applicants address all four of the priority focus areas in the FOA. How applicants distribute the funds for each of the focus areas is left to the applicant's discretion, as long as there are a portion of resources (through the cooperative agreement, match, in-kind) directed at each focus area.

**REVIEW CRITERIA QUESTIONS:**

**Q:** BASE Component Evaluation Criteria: 26-points can be received within the 'Collaboration Section". I assume that each sub-section will be reviewed and weighted separately? A sub-section of the "Collaborative Section" says that 5-points could be obtained if the applicant has an established statewide injury and violence prevention collaborative (e.g., injury community implementation group) that includes key partners and related coalitions. Could an applicant receive 1-4 points based on their response, or is it all or nothing?
**A:** Each sub-section will be reviewed and weighed separately. If a specific criteria has a maximum of 5 points available, the reviewer can award anywhere from 0-5 points based on the response that the applicant provided. So, if the applicant partially fulfills the evaluation criteria, the reviewer can provide partial points.

**Q:** In the scoring criteria there doesn't appear to be points related to the work plan.
**A:** The work plan should be a restatement of the information already presented by the awardee in the approach section and the evaluation and performance measurement strategy section. That is, any objectives or measures in the work plan should be consistent with and aligned with the work described in these other sections.

**Q:** The point criteria for access to data state, "access to timely…" but it doesn't state what timely means. What data year is considered timely for full points? Is it up to individual reviewers?
**A:** Historically, states have been expected to submit data within 18 months of the close of the calendar year. For an application being submitted in 2016, we would expect that the data that is used to support the application should be from at least 2013. Reviewers will be given this guidance.

**BASE COMPONENT OVERALL STRATEGIES QUESTION:**

In the list of 7 strategies, do we pick 3 of the 7 strategies, or do we need to implement all 7 strategies?
**A:** You need to implement all 7 strategies.

**TRAUMATIC BRAIN INJURY (TBI) QUESTIONS:**

**Q:** For TBI, the FOA mentions Pediatric Mild TBI Guidelines. I've followed the link in the FOA and it takes me to a page discussing the work group, but I cannot find any Pediatric Mild TBI guidelines. Can you provide a source for that?

**A:** CDC has engaged a Federal Advisory Committee to produce a set of pediatric mild TBI guidelines that is planned to release in early 2017. The intention is for states to provide dissemination of these guidelines.

**Q:** Under the TBI focus area, can states disseminate their own evidence-based pediatric mild TBI guidelines, or will there be specific CDC pediatric mild TBI guidelines to be distributed?
**A:** CDC has engaged a Federal Advisory Committee to produce a set of pediatric mild TBI guidelines that is planned to release in early 2017. The intention is for states to provide dissemination of these guidelines.

**Q:** Our TBI lead is asking how TBI is being defined for purposes of this grant. Is it using the recommended ICD injury codes (Type I, II, and III) or in another way?
**A:** The TBI classification of Type I, II, and III is specific to the ICD-9-CM based TBI definition. The ICD-10-CM was implemented in hospitals nationwide on October 1, 2015. The ICD-10-CM based proposed TBI case definition can be found in Table C. of the "Proposed Framework for Presenting Injury Data Using the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD_10-CM) Diagnosis Codes" which can be found at: http://www.cdc.gov/nchs/data/nhsr/nhsr089.pdf. This definition does not contain any type of stratification.

**EVALUATION PLAN QUESTIONS:**

**Q:** Are applicants expected to submit a detailed 5 year evaluation plan (this question applies to BASE and Enhanced components)?
**A:** Applicants are expected to submit a general 5 year plan and a more detailed one-year evaluation plan.

**Q:** For the evaluation plan, is it required for the entire base core grant, or just for the strategies that the states select? Or, do we need it for both?
**A:** The evaluation plan is required for the entire BASE core cooperative agreement. In addition, if you are applying for enhanced components, they will also need separate evaluation plans.

**Q:** Regarding the performance management (PM) plan – if applying for the enhanced component does one write the PM plan for just that component? Are there specific outcomes related to the enhance components?
**A:** Yes, a separate PM plan is required for Enhanced components. Refer to the first (Page Limit) Section of the FAQ for page limits of each component's PM plan. For additional information, please refer to 10.c. Applicant Evaluation and Performance Measurement Plan for information about what should be addressed in the evaluation plans for each component. In addition, refer to the rating criteria for additional guidance for each component.

**Q:** Are the partners expected to do their own evaluations (since they have their own plans)?
**A:** One of the goals of this funding is to enhance the ability of public health departments to apply a public health approach to preventing injuries and violence, including the implementation and evaluation of evidence-based prevention strategies. Thus, the awardee is

responsible for evaluating the activities submitted in their proposal. In accordance with the CDC Framework for Program Evaluation (http://www.cdc.gov/eval/framework), engaging stakeholders throughout evaluation planning and implementation is key. The awardee will determine the level of engagement of individual stakeholders. CDC and a technical assistance provider will also be available to provide technical assistance and to evaluate the overall Core SVIPP program.

**Q:** Under the "Topic Selection and Methods Development Process (5 pts) bullet 1: "Does the applicant propose a plan for topic selection and methods development that will result in feasible investigations? (5 pts)?". As part of the application, does a state need to identify a YR1 State project or just the process for the selection of a state project?
A: The Annual Activities section states that Awardee will conduct state-specific and multi-state annual injury surveillance evaluations. Surveillance evaluation potential topics are listed in 3.a. (page 15). The applicant should explain their plan for selecting topics and developing methodologies in the context of the group consensus process.

**ADMINISTRATIVE QUESTIONS:**

**Q:** Can a list of references cited and list of abbreviations be included in the table of contents file?
**A:** Yes, a list of references cited and list of abbreviations can be included in the table of contents file.

**Q:** Do we need to include a logic model in the application? Or only a work plan and evaluation plan?
**A:** Applicants do not need to include a logic model with the application. Applicants are required to submit a work plan and an evaluation plan.

**Q:** Is it okay for applicants to modify the work plan and evaluation plan templates?
**A:** The work plan and evaluation plan provided were suggested templates and applicants can modify these documents to meet the needs of their application content.

**Q:** Are applicants from developing countries like Kenya eligible to apply for funding?
**A:** This funding opportunity is domestic and not open to international applicants.

**Q:** Is there the ability to hire someone centrally to help coordinate the rest of the grant activities?
**A:** Staffing decisions for the cooperative agreement are the ultimately the decision of the grantee. At a minimum, grantees are expected to have at least 1 full time equivalent. See c. "Organizational Capacity of Awardees to Implement the Approach" pages 23-24 for more information about staffing.

**Q:** An Injury Research Center is considering partnering with the Dept. of Health to apply for the SVIPP funds. The Injury Research Center would be either a bona fide agent or subcontractor. Would you be able to point me in the direction of where to find CDC's rules about indirect rate limits, if any, for bona fide agents or subcontracts? .
**A:** With regard to indirect cost rates, information can be found here: HHS Grants Policy Statement: http://www.hhs.gov/asfr/ogapa/aboutog/hhsgps107.pdf The Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards (45 CFR 75: http://www.ecfr.gov/cgi-bin/text-idx?node=pt45.1.75&rgn=div5 more specifically, "Direct and Indirect (F&A) Costs" beginning with 75.412. In addition to the above information, please read the Funding Opportunity Announcement thoroughly for additional guidance.

**Q:** Are the special requirements required to apply for the funding?
**A:** Yes, the special requirements section of the FOA are the minimum criteria necessary to be eligible to apply for all components. Please note that you must meet the BASE component special requirements to apply for all three components. Please note that there are additional special requirements listed for the expanded components (RNCO and SQI) as well.

**Q:** Does a program area applying for the Core SVIPP that already has a CDC funded program (such as NVDRS) have to send a letter of support?
**A:** Yes, please reference Section C. 'Eligibility Information' Part 2. 'Additional Information on Eligibility' where letters of support from appropriate divisions within the health department involved with related IVP programs are listed, including NVDRS.

**Q:** The sample work plan and evaluation plan have a different font style and size than Calibri - 12 that is the criteria for the project narrative. Is it ok to use the fonts that are in the same documents (Times new roman -10 or Calibri -11, depending on the document)?
**A:** Applicant should use Calibri 12 font for all documents submitted.

**Q:** The requirements for the work plan stated on page 24 of the FOA differ a little than what is included in the sample work plan. Are we required to include the following in the work plan document: 1. Describe the multi-sector collaboration that will be formed to assist in carrying out the proposed activities; 2. Describe staff and administrative roles and functions to support implementation of the award, including evaluation functions and; 3. Explain administration and assessment processes to ensure successful implementation and quality assurance?
**A:** The sample work plan is just a guiding document. The requirements listed below must be addressed in your application.

1. Describe the multi-sector collaboration that will be formed to assist in carrying out the proposed activities;
2. Describe staff and administrative roles and functions to support implementation of the award, including evaluation functions and;
3. Explain administration and assessment processes to ensure successful implementation and quality assurance.

**BEST AVAILABLE EVIDENCE STRATEGY QUESTIONS:**

**Q:** Please explain the need for three strategies in four areas, listed under BASE component - Strategy 4. Does this mean we need to have 12 strategies (three in each of the four areas)? Or three only that cover all four areas.
**A:** You only need three strategies that cover the four focus areas. Therefore, one of your strategies will cover two of the focus areas and you will have two additional strategies that cover each of the other two focus areas.

**Q:** If the selected strategy that has shared risk factors/protective factors is one listed in Table 1 (IVP strategies), do we need to include evidence (peer reviewed publications) about that strategy?
**A:** If you choose a strategy listed in Table 1, there is no need to include evidence about that strategy.

**Q:** We are considering home visiting as the evidence based strategy for CAN and IPV/SA. We'd like to continue to build on our partnership with the Maternal and Infant Home Visiting Program (under the Maternal and Child Health Branch) from the current Core VIPP grant. Is that acceptable?
**A:** Yes, home visitation is listed as our first example of evidence based strategies in of the FOA.

**Q:** Clarification on what is a strategy. Is the strategy home visitation or safe care?
**A:** Home visitation is the overarching strategy category and safe care is a specific programmatic strategy that is included within the overarching home visiting strategy.

**Q:** Are states restricted to the example programs that have been provided in the FOA (pages 12-15), or can we propose other evidence-based programs in the given strategy area?
**A:** The applicant should propose evidence based strategies that are in line with the prescribed long term outcomes listed in the FOA. The example programs include best available evidence. If proposing other programs, the strategies based on the best available evidence should be justified in the form of a peer-reviewed publication or evaluation report from a rigorous evaluation.

**Q:** The FOA mentioned “motor vehicle crash injury and death” as a priority area. Does this include all types of MV crash injuries, e.g., MV-Pedestrians, MV-Pedal Cyclists and MV-Motorcyclist injuries?
**A:** Motor vehicle crash injury and death is a broad focus area which may include all types of MV crash injuries, e.g., MV-Pedestrians, MV-Pedal Cyclists and MV-Motorcyclist injuries. However, for the purpose of this FOA, you must, at a minimum, propose strategies that will address all three of the prescribed motor vehicle crash injury and death long term outcomes listed on page 22. While the types of motor vehicle crash injuries you are asking about would not have an impact on these outcomes, you could include these other types, but would need to propose additional strategies and long term outcome(s) to capture the inclusion of MV-Pedestrians, MV-Pedal Cyclists and/or MV-Motorcyclist injuries.

**Q:** Are the strategies listed under each of the focus areas within the FOA the only strategies that CDC will consider to be competitive for the announcement? Specifically, does Motor Vehicle include pedestrians or the interlock systems topics that are a part of the larger MVC topic arena? Or, for the purposes of this announcement, should we stick to strategies listed in the FOA?
**A:** Strategy selection is up to the applicant, however, they should propose strategies based on the best available evidence that are in line with the outcomes listed in the FOA. Ignition interlock is listed on our website, and meets both of these criteria as an effective strategy to reduce or prevent drunk driving:
http://www.cdc.gov/motorvehiclesafety/impaired_driving/strategies.html. The same criteria applies to the pedestrian related strategy. Proposed strategies should be evidence based and impact the expected outcomes expressed in the FOA, specifically:

- Decrease in rate of alcohol-related motor vehicle crashes
- Decrease in the rate of alcohol-related motor vehicle fatalities
- Decrease in rater of motor vehicle occupant fatalities

**Q:** Can an applicant propose a CDC strategy like Dating Matters even though it's not listed as an example?
**A:** The examples listed in the FOA are for illustrative purposes. Applicants may propose strategies that impact injury and violence if they can demonstrates in the application that there is evidence through a peer reviewed publication or evaluation report or similar resource that the strategy impacts the areas of interest.

**Q:** Can Core SVIPP funds be used to support evidence-informed strategies? For example, there are limited evidence-based strategies available for the primary prevention of sexual violence. Given this limitation, are evidence-informed strategies eligible?
**A:** SV is the area with the narrowest evidence base, so where there isn't an evidence base, strategies based on the best available evidence may be considered. However, strategies that have evidence of impacting a risk or protective factor related to SV would be preferred. In addition, including any evaluation findings – whether they be local/in-house or from another organization/state, would strengthen the proposed use of a certain strategy.

**Q:** Can grantees carryover a current focus area (with proper adjustments to SMART objectives, activities, etc.)? For example, we would like to continue working on motor vehicle occupant protection.
**A:** Yes, strategy selection is up to the applicant, however, they should propose strategies base4d on the best available evidence that are in line with the prescribed long-term outcomes listed in the FOA. Strategies based on the best available evidence can be justified in the form of a peer-reviewed publication or evaluation report from a rigorous evaluation of shared impact (for strategy addressing two focus areas).

**Q:** Does this grant support funding of therapeutic treatment services, such as cognitive behavioral therapy and multisystem therapy?

**A:** The applicant should propose strategies based on the best available evidence that are in line with the prescribed long term outcomes listed in the FOA. These strategies can be justified in the form of a peer-reviewed publication or evaluation report from a rigorous evaluation of shared impact (for strategy addressing two focus areas). How the applicant meets all the requirements within the FOA addressing the priority focus areas and prescribed long term outcomes within the budget is left to the applicant.

**Q:** Clarify how safe sleep activities impact TBI?
**A:** Safe Sleep activities address multiple risks to infants related to sleep environments including falls from high places due to unsafe sleeping surfaces like adult beds or changing tables. Safe Sleep activities address many shared risk and protective factors for both child abuse and neglect and TBI.

**Q:** Can safe sleep also be for the general community?
**A:** Yes, safe sleep can also be for the general community.

**Q:** For the purposes of the FOA would Essentials for Parenting Toddlers and Preschoolers be considered a component of Essentials for Childhood (EfC)?
**A:** EfC is a comprehensive approach to child abuse and neglect prevention (http://www.cdc.gov/violenceprevention/childmaltreatment/essentials.html) Parenting Essentials for Toddlers and Preschoolers is considered to be a piece of the Essentials effort – specifically enhancing parenting skills (EfC goal area 3). Applicants proposing this strategy should include proposed activities beyond enhancing parenting skills to include another one of the four goal areas of EfC: 1. Raising awareness and commitment to promote safe, stable, nurturing relationships and environments and prevent child abuse and neglect; 2. Use data to inform actions; 3. Create the context for healthy children and families through norms change and programs; 4. Create the context for healthy children and families through policies.

**Q:** Within the given IVP focus area strategies (child maltreatment, TBI, intimate partner/sexual violence, motor vehicle crashes), is there room for states to innovate – for example, to develop programming which bridges interpersonal violence and traumatic brain injury?
**A:** We encourage this type of innovation as long as the programming is based on the best available evidence (as demonstrated by at least one peer-reviewed publication or evaluation report from a rigorous evaluation) and has an impact on the prescribed long term outcomes listed for the two priority focus areas.

**Q:** Would a teen outreach program fall into a social, emotional, learning strategy, under sexual/intimate partner violence?
**A:** Possibly. The applicant should propose strategies based on the best available evidence that are in line with the prescribed long term outcomes listed in the FOA. These strategies can be justified in the form of a peer-reviewed publication or evaluation report from a rigorous evaluation of shared impact (for strategy addressing two focus areas).

**Q:** Will new evaluation support for existing efforts in one of the four focus areas (Child maltreatment, SV/IPV, TBI, and MV) meet the minimum requirements of the Core SVIPP FOA? For example, if Core SVIPP funds were used to evaluate an existing RPE program, such as Coaching Boys Into Men.
**A:** Yes, this would be an acceptable use of funds.

**Q:** Is there an expectation that funds be allocated for community level interventions?
**A:** It is up to the applicant to decide how to best allocate resources in the FOA to meet all of the requirements.

**FALLS QUESTION:**
Why is Older Adult Falls (OAF) not one of the focus Areas listed in the Cooperative agreement? Is there any leeway with age groups in MVP or TBI that would allow an OAF focus? Are states still being supported in some way to implement Falls activities being promoted by DUIP?
**A:** This FOA is in line with the current top priority areas of the National Center for Injury and Violence Prevention and Control (NCIPC). Elder falls continues to be an area in injury and violence prevention that NCIPC works on, however, the main focus of this FOA is limited to the following four priority areas: 1) Motor Vehicle Injury, 2) Child Abuse and Neglect, 3) Intimate Partner and Sexual Violence, and 4) TBI – Youth Sports Concussion. Successful applicants still have the opportunity to conduct innovative programming with 10% of the budget, which could be applied to innovative older adult falls work.

**PROGRAMMATIC QUESTIONS:**
**Q.** Please explain where we can find more information about "risk and protective factors".
**A:** We have several resources in the FTP site noted in the FOA (http://ftp.cdc.gov/pub/TBI/2016_CORE_SVIPP_FOA/).

**Q:** Can funds be used to conduct surveillance of other injuries that do not fall under the four priority areas listed in the FOA?
**A:** For the most part, funds may not be used to conduct surveillance of other injuries that do not fall under the four priority focus areas listed in the FOA. The FOA does have a 10% innovation funding allowance that permits some flexibility to the applicant, however, prescription drug overdose or other illicit drug surveillance would not be eligible for this allowance.

**Q:** For Strategies 1, 2, 3; there are required activities listed under Year 1 and then annually. For the activities listed annually – are these to also to occur in Year 1 of the funding period?
**A:** Yes, activities listed as annually are also to occur in Year 1 of the funding period.

**Q:** For the first activity listed under annual Strategy 1, it says: "Conduct or support activities that inform policy in the four Core SVIPP priority focus areas as appropriate. Activities may include, but are not limited to: draft a cost benefit analysis of an existing/proposed law; draft a health impact analysis; evaluate existing/new policies including an assessment of effectiveness; meet with stakeholders to inform or educate on the burden of injuries and

violence;……." Does these mean there must a separate activity for each priority focus (4 policy activities) each year?
**A:** There must be at least one strategy per focus area. There is no requirement about the number of policy-related activities. This language was to emphasize that a policy activity should be conducted if appropriate and necessary.

**Q:** Page 22 mentions the Fatality Analysis Reporting System? Is this a specific system we are to use or a general term?
**A:** This is a data system of the National Highway Traffic Safety Administration (see http://www.nhtsa.gov/FARS)

**Q:** Under strategy 1, annual activities, it says: "Analyze data to identify trends and opportunities for evidenced based prevention" as this appears to fall under a strategy addressing policy, is this activity supposed to be related to policy activities?
**A:** Yes, this activity is related to policy activities.

**Q**: Under the section SQI-Awardee Activities, ANNUALLY, 4th bullet, 3.a.6, it says "Evaluation of Syndromic Surveillance." Is this referring to evaluating the actual syndromic surveillance system or does it mean evaluating PH Indicator(s) captured through syndromic surveillance system?
**A**: This section lists potential topics for consideration for either multi-state or state specific projects that may include, but are not limited to the topics listed. As such, applicants can define the parameters of individual study topics.

**ICIG QUESTIONS:**
**Q:** On page 27: "Have a current, active Injury Community Implementation Group (ICIG) or similar statewide IVP collaborative group in place". Is there a minimum number of meetings that had to occur in 2015 (for which we would attach minutes to the proposal)?
**A:** No, there is not a minimum number of meetings required of the Injury Community Implementation Group (ICIG) or similar statewide IVP collaborative group.

**Q:** Page 27, Special Requirements, the FOA states that an ICIG group must have met in 2015. Then on page 28 it states "Domestic Violence and Sexual Violence Coalitions exist in all 50 states and must be included in the ICIG". Is this meant to say that the existing ICIG must have had DVSV members during 2015, or can DVSV be added to the group as part of our proposal, should we decide to apply?
**A:** There is no requirement that the ICIG must have had DVSV members in 2015. The ICIG can have the DVSV members added to the group as part of the proposal.

**Q:** Strategy 1 of the FOA calls for the development of a structure with relevant stakeholders to strategically assess policy and focus on state injury and violence priorities. If a state has separate but well established groups that are already working on state and organizational policies related to sexual abuse, child abuse and maltreatment, child sexual abuse, and transportation safety, would it be acceptable to propose a structure that has representation

from these separate policy groups as well as representation from other stakeholders suggested in the FOA (internal legislative liaisons, communications, other key agencies, etc.) and which acts to collaborate with the existing policy groups, conduct the activities listed, and achieve the outcomes described in the logic model?
**A:** Yes, this would be acceptable.

**ICRC/RESEARCH CENTER QUESTIONS**
**Q:** Is the FOA requiring collaboration with an ICRC specifically or are existing relationships with academic institutions in the state be allowable for this requirement?
**A:** As noted (on pages 9, 17, 18) in the CORE SVIPP FOA, the requirement is for collaboration with an ICRC or other injury research institute/similar research entity. This is inclusive of collaboration with academic institutions within the state that conduct injury research.

**Q:** Regarding ICRCs and academic institutions; do applicants have the option to do both or is it one or the other?
**A:** Collaboration is a vital part of this work and key stakeholders should include an ICRC and/or other injury research institutes.