IHSP Questions and Answers

Updated 5.5.10

Q. Can we submit a letter of intent after the deadline?
A. Yes – a letter of intent is not required so it may be submitted after the deadline.

Q. I am interested to learn more about the intent of Objective # 5 that states: Examine risk and protective factors for severe sequelae of influenza infections, including co-morbid conditions and statin medications. Is this something that will be outlined in the protocol developed for this FOA? Or included in the surveillance tool as specific questions?
A. Statin collection will end at the end of this season. CDC monitors ICU and death so severe outcomes are examined and we have and will continue to collect co-morbid conditions.

Q. Can we send lab specimens to a private lab? Is it expected they will need patient consent to collect certain information – such as statin use?
A. You can use commercial lab but you would need to build in cost. We advise not to get too hung up on the PCR. EIP identifies cases from MD-initiated testing...but it would be good if state lab can test few specimens w/ PCR so it is known what flu type/subtype is in circulation. The statin question will be dropped for 2010-11. New for fall is the inclusion of nosocomial cases.

Q. Are large cities eligible?
A. Yes

Q. How will the data be reported to CDC and do you have a data extraction form?
A. CDC provides the database that participants should use. Currently data are posted to CDC on a set schedule, using a ftp site. The case report form provided is from the past season (eg, statin med collected) and it will change for next season.

Q. We are applying for the influenza hospitalization surveillance project. One of the requirements of the application is to travel to a meeting in June. Our budget person indicates we will be unable to participate due to the lengthy approval process and account creation. Is the June meeting set in stone?
A. Yes, the date has been set.

Q. I had a question about the IHSP grant that is due very soon. In reading the eligibility requirements, I noticed that one of the bullets listed that we had needed to have participated in CDC's hospitalization surveillance from the pandemic season using lab-confirmed hospitalization numbers. We did participate in this surveillance, but provided numbers based on a syndromic definition of ILI. Does this exclude us from being eligible for this grant? Subsequently, we did participate in the project similar to this one last season (EIP-Like) and are wondering if that would count as a lab-confirmed hospital based surveillance project.

A. The eligibility states you must have the proven ability (proven ability to conduct population-based, laboratory confirmed influenza hospitalization surveillance including identification of catchment area (ie, counties or cities from which population estimates can be obtained for rate calculations). If you can demonstrate your jurisdictions ability – then you are eligible to apply.

Q. If we are doing medical chart reviews looking for co-morbidities etc. will informed consent from the patient be necessary? Or an IRB? Or is there some reason that this grant is excluded from that sort of a thing?

A. IRB will be up to your jurisdiction to determine. CDC will assist you in completing any IRB approval you may need to do.

Updated 4.29.10

Q**.** Eligible applicants include state or large local health departments. How would you define large?

A. We don't have a definition for large. If you can meet the other eligibility requirements then you are eligible to apply.

Q. The budget for this seems to be less than what it would actually cost to implement - EIP requirements are far beyond what is reasonable for the funding tied to it.

A. We encourage you to provide an accurate budget estimate of your cost for this project. You should scale your proposal to make your budget request competitive. So, for example, we know you currently perform state-wide surveillance. CDC is more interested in having high quality data rather than lots of data.

Q. Are military and VA hospitals in the catchment area included in the project?

A. If catchment area residents go to VA/military facilities for care, they should be included. If those facilities are excluded, then case ascertainment will be incomplete. Each site knows their local situation best; they should take all that into consideration when choosing their catchment area. Also, we are asking sites to do a completeness assessment.

4.22.10

Q. I have a quick question regarding the IHSP grant opportunity. Is the intention to capture ALL influenza hospitalizations in the state or is a subset acceptable?

A. Doesn't need to be state-wide. Complete case ascertainment for a defined population is the goal.

Q. Are only 'EIP like' states being considered for this?

A. No – All states that meet the eligibility will be considered for this project.

Q. The IHSP announcement indicates that eligible applicants must have

- Proven ability to conduct population-based, laboratory confirmed influenza hospitalization surveillance including identification of catchment area (i.e., counties or cities from which population estimates can be obtained for rate calculations)
- Provided age-specific (<12mo, 1-4 years, 5-14 years, 15-24 years, 25-44 years, 45-64 years and ≥65 years) hospitalization rates obtained from laboratory-confirmed influenza hospitalization surveillance conducted during the pandemic.

This sounds like it describes states that submitted lab confirmed hospitalization data for AHDRA. Our state submitted syndromic data, and therefore would not qualify if the intent is to limit it to states that submitted lab confirmed counts. What is the intent?

A. I have attached last year's EIP protocol – it will be modified this year but it may help you. AHDRA did not include chart abstraction and sending that data in.

Q. The deadline is May 14…does that mean post-marked by May 14 or in your hands by May 14?

A. We prefer to have it in the office by May 14th so you may email it to CSTE on May 14th and send a hard copy overnight so it arrives on May 15th.