State-based Cardiovascular Disease Surveillance Data Pilot Project
Questions and Answers

1.10.10

1. I understood the application itself could not exceed more than 8 pages + CVs and LOSs. From the guideline, it is not clear if we could include other material in the appendices. I have some org charts, data dictionary, and a bunch of other documents that support our application. Is it OK to include them?

You may include additional information as appendices. However, since they are not part of the actual application, we cannot guarantee that they will be reviewed. We suggest putting all relevant information in the application. The appendices should only include information that the reviewer may use as a reference.

1.5.10

1. For CVs of epi staff on page 3, Vii appendices, should those be limited to personnel on the previous page, or can be expanded to all participating staff?

You may include all participating staff if you prefer. Please include essential staff to the project.

2. Is the deadline of Jan 15 Post-marked or receipt?

The deadline is receipt on January 15th – you may fax or email if absolutely necessary.

12.10.09

1. Does the linkage need to occur at the person-level? In 2008-09 [State] completed a county-level BRFSS survey that was sampled to produce 62 county-specific estimates. Would combining behavioral data on risk factors associated with CVD and high blood pressure control (in particular) at the county level with county level data on relevant hospitalization indicators meet the definition of a linkage project?

Yes, this example seems relevant as long as there is a justification as to the value and use of the data and information that is gleaned from the linkage.

2. Second, does the linkage need to be a physical merging of files and result in a new data set? In [State] (ED) data and in patient hospitalization data are collected through the same system and stored in different datasets. There is a natural linkage between the ED data and inpatient data such that the inpatient file indicates whether a patient was admitted through the ED. However, because a patient would not have a separate record in the ED data file and the in-patient file, we would not need to physically merge the files to generate new indicators to examine (e.g., % of patients seen at the ED for uncontrolled hypertension who are then admitted for hospitalization). Does the linkage need to result in a "new dataset" or would it be OK to use two separate data sets to generate new indicators?

Generating new indicators from separate data sets seem appropriate given justification as to the value and use of the data and information that is gleaned from the process.

12.17.09

1. I published a study in 2007 showing a relationship between statewide cigarette smoking bans and reductions in hospitalizations for heart attack. This study and several others like it were recently reviewed in an Institute of Medicine report (*Secondhand Smoke Exposure and Cardiovascular Effects: Making Sense of the Evidence*, http://www.iom.edu/Reports/2009/Secondhand-Smoke-Exposure-and-Cardiovascular-Effects-Making-Sense-of-the-Evidence.aspx). We realize that the time series models we developed would be stronger if we included data on particulate matter in the environment as an additional predictor of cardiac events. Second hand smoke and particulate matter are independently associated with heart attacks and particulate matter is just one of the cardiotoxic agents in second hand smoke. We are proposing to link levels of particulate matter in four states and the presence/absence of smoking bans to hospitalization rates for heart attack and stroke. We will control for changes over time, geography, and seasonality. We will conduct an interrupted time series analysis comparing rates of hospital admission for acute cardiac events and their association with environmental air pollution and exposure to secondhand smoke controlling for time, geographic differences, and time of the year. The specific linkage will be environmental air quality data as measured by PM2.5 (particulate matter of 2.5 microns or smaller) and hospitalization for cardiac events. I hope this is enough information for you to suggest whether we should or should not pursue an application for this grant.

This sounds more like an epidemiological association study. However, if you can show that the data linkage will result in formation that can be used for program planning or policy change for their HDSP programs, then we suppose it should be ok.

Overview Information

Issuing Organization

Council of State and Territorial Epidemiologists (CSTE) at www.cste.org

Participating Organizations

Centers for Disease Control and Prevention (CDC), at http://www.cdc.gov/

Components of Participating Organizations

National Center for Chronic Disease Prevention and Health Promotion
Division for Heart Disease and Stroke Prevention (DHDSP)
Epidemiology and Surveillance Branch

Title: State-based Cardiovascular Disease Surveillance Data Pilot Project

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Full text of announcement

FULL TEXT OF ANNOUNCEMENT

Section 1: Funding opportunity description

Background: Surveillance data needs to be representative of the people in the geographic area for which policy and program decisions are being made. State health departments have access to many sources of data to determine trends and patterns of chronic diseases and related risk factors. Some of these data sources include emergency medical services (EMS), hospitalizations, vital statistics, census, Medicare and Medicaid, health plans, disease registries, state-based surveys (e.g., Behavioral Risk Factor Surveillance System, Cardiovascular Health Examination Survey, Youth Tobacco Survey), etc.

These surveillance data may be used to inform decisions surrounding strategies and recommendations for enhancing public health policies in the area of cardiovascular disease (CVD) surveillance, prevention, and mortality reduction. There are currently gaps in state CVD surveillance, but also many opportunities to improve CVD surveillance and the applicability of these data for public health action. Integration and linkage of data collected from various sources is one such opportunity that may create new datasets providing new information useful to public health programs.

Objectives: To fund states to link existing data sources to generate new data and information needed for monitoring CVD morbidity, mortality, or its risk factors.

Types of data linkage might include, but are not limited to:

1) Linking CVD-related EMS, hospital discharge, and mortality data;
2) Tracking CVD related deaths that occur outside of the healthcare setting;
3) Linking CVD-related hospital discharge with rehabilitation data; and
4) Linking CVD-related health outcomes with environmental data, etc.

The major products from this project will include:

1) Aggregated de-identified data[1] that could be included on the CDC DHDSP surveillance website
2) A final report that includes:
    - Linkage methodology – including lessons learned and recommendations for other states who might pursue similar endeavors
    - A data analysis and dissemination plan for turning the new data into information that will be useful for program support

CSTE will provide further instructions on the format of the final report after the project period begins. Applicants should be aware that the final report may be widely disseminated by CSTE to CSTE members, CSTE stakeholders, and State Health Agencies.

Section 2: Award information

Mechanism(s) of support: CSTE will manage all matters related to financial support for this project.

Funds available: CSTE intends to commit $75,000 - $90,000 per site for up to three sites.

The project period will begin February 15, 2010 and will end February 14, 2011. The project performance end date is December 31, 2010. All final reports and deliverables are due February 14, 2011.

Section 3: Eligibility information

Eligible applicants: Eligible applicants are all states currently funded by the CDC Heart Disease and Stroke Prevention Program (FOA# DP07-704)

Section 4: Application and submission information

Those interested in participating in the State-based Cardiovascular Disease Surveillance Data Pilot Project should submit an application addressing the objectives, components, and eligibility requirements stated in Section 1 and Section 3, respectively.

Content and form of application submission: Applications should include the following headings in the order listed and should address the issues included under each heading:

i. Contact information (1/2 page maximum)

[1] CDC will work with the states to identify data generated from the project that would be appropriate for display on the national surveillance website (currently under development). All of the data displayed is de-identified, aggregated data that represents a key indicator of the public health burden of cardiovascular diseases and associated risk factors.

Include primary contact and any additional key contributors. Information should include email, mailing address (no PO boxes) and contact phone number of the primary contact. All correspondence will be sent to the primary contact indicated.

ii. Personnel and Experience (1 page maximum)

Describe project staffing and qualifications. Include prior epidemiology, surveillance, and data linkage experience that demonstrates the ability to successfully participate in this pilot project. Details should also include a description of the experience and qualifications of each staff who will be involved, and their anticipated roles in the project.

iii. Methods (2-4 pages maximum)

- Include a description of databases to be linked
- Provide rationale for the benefit of these databases being linked and the potential impact the resulting data would have
- Provide a brief description of what type of analyses could be done on the linked dataset
- Describe the methods for *how* the linking will be completed
- Describe how this project would be in line with any of the 6 priority areas listed in the State Heart Disease and Stroke Prevention Programs Program Announcement:
    1. Increase control of high blood pressure primarily in adults and older adults.
    2. Increase control of high blood cholesterol primarily in adults and older adults.
    3. Increase knowledge of signs and symptoms for heart attack and stroke and the importance of calling 9-1-1.
    4. Improve emergency response.
    5. Improve quality of heart disease and stroke care.
    6. Eliminate health disparities in terms of race, ethnicity, gender, geography, or socio-economic status.

iv. IRB (1/2 page maximum if needed)

Human subject review process for the applicant if necessary.

v. Project timeline (1 page maximum)

Include a brief description of the timeline needed to complete the project with inclusion of key aspects of the project.

vi. Budget (1 page maximum)

Provide a budget and justification consistent with the stated objectives and project activities. The applicant should also provide a detailed line-item budget with justifications consistent with the purpose and proposed objectives. The proposed budget should include the following categories:

- Personnel: Salaries, wages and on-costs of personnel who have responsibility for managing and implementing the project.
- Project Support: Includes all non-staff expenditure for the administration and day to day management of the project
- Project Activities: Expenses directly linked to project deliverables
- Supplies: Expenses such as paper, phone lines, or other items needed
- Other: Other expenses or in kind contributions

vii. Appendices

- Letters of support from partners
- CVs of the epidemiology staff participating on the project

For further assistance, technical questions, or inquiries about the application, contact Jennifer Lemmings at CSTE (jlemmings@cste.org). Representatives from CSTE will be available to speak to potential applicants to discuss technical or administrative questions. All questions and answers will be made available to all potential applicants. The funding announcement and questions and answers will be available at www.cste.org/CVDPilot.asp.

Submission, review, and anticipated start dates

a. Letter of intent (requested, but not required): December 21, 2009
b. Application submission receipt date: January 15,2010
c. Follow-up interview conference call for highly qualified applicants: January 29, 2010
d. Award notification date: January 31, 2010
e. Project begin date: February 15, 2010
f. Project performance end date: December 31, 2010
g. Final deliverables due: February 14, 2011

Submitting an application: Two copies of the completed application should be sent to the Council of State and Territorial Epidemiologists at the following address by January 15, 2010. Copies should not be stapled. Notification will be sent to the applicant upon successful receipt of the application if *requested*.

Jennifer Lemmings
Council of State and Territorial Epidemiologists
2872 Woodcock Blvd., Suite 303
Atlanta, GA 30341
770-458-3811 (phone)
770-458-8516 (fax)
jlemmings@cste.org

Application processing: All applications received by the deadline will be reviewed by January 29, 2010. Applications will be reviewed based on criteria described in Section 5.

Section 5: Application review information

Criteria: The review criteria described below will be considered in the review process.

a. Understanding of the project and deliverables (15%)
b. Scientific merit of the proposed project as determined by peer review (50%)
c. Extent to which the budget is justified (15%)
d. Completeness of application and ability to meet project objectives (20%)

Review and selection process: Eligible applications that are complete will be evaluated for scientific and technical merit by CDC and CSTE in accordance with the review criteria stated in this document. A review panel of CDC, CSTE and subject matter experts will be created to ensure the completeness and appropriateness of the proposal. Funding awards will be made based upon the quality of the submitted proposal and the ability of the applicant to meet the objectives stated.

Section 6: Award administration information

Award notices: Applicants will be notified via email or phone no later than February 15, 2010.

Recipient rights and responsibilities: The award recipient will have primary responsibility for the following:

a. Completion of the goals and objectives in the submitted application and funding announcement
b. Provide written progress reports and invoices to CSTE. One progress report will be due six months after the start of the project period. Funding will be distributed at three points during the length of the project (project initiation, project midpoint, and project end date)
c. Participate in conference calls with CSTE and CDC Subject Matter Experts during the project period (bimonthly)
d. Provide products (dissemination plan, de-identified data, etc.) to CDC or CSTE as appropriate

CDC Responsibilities:

During the established grant period, CDC is responsible for:

a. Participating in a review panel of experts responsible for approving and ensuring the completeness of the final product
b. Providing technical feedback during the project
c. Participating in reviewing applications submitted in response to this RFP
d. Working with the states to identify data generated from the project that would be appropriate for display on the national surveillance website (currently under development). All of the data displayed is de-identified, aggregated data that represents a key indicator of the public health burden of cardiovascular diseases and associated risk factors.

CSTE responsibilities:

During the established grant period, CSTE is responsible for:

a. Providing the primary point of contact for the agreement
b. Monitoring the terms of the contract agreement between the recipient and CSTE
c. Collecting invoices from the recipient and paying invoices according to the terms of the contract agreement between the recipient and CSTE
d. Providing information about the progress of the program to the CSTE Executive Board and to CDC
e. Reviewing and distributing progress reports and the final products
f. Providing technical expertise when requested.
g. Supporting regular workgroup conference calls if needed (up to one per month).

Section 7: Contact Information

For more information contact:

Jennifer Lemmings
Council of State and Territorial Epidemiologists
2872 Woodcock Blvd., Suite 303
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770-458-3811 (phone)
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