STD AAPPS FAQs

CDC received many questions from STD AAPPS applicants during the application period for the FOA. Those questions and responses can be found on this page. Many questions were similar in nature, so Division staff combined these questions. Several questions were also edited for clarity.

The application period for this FOA closed on Thursday, September 12, 2013 at 11:59 p.m. U.S. E.S.T. The information on the Frequently Asked Questions pages is for historical and educational purposes only.

This document was last updated on November 4, 2013.

About STD AAPPS:

1. What is STD AAPPS?

Improving Sexually Transmitted Disease Programs through Assessment, Assurance, Policy Development, and Prevention Strategies, or STD AAPPS, is a new funding opportunity from CDC's Division of STD Prevention.

STD AAPPS was published on grants.gov on June 14, 2013. All FOA applications are due by 11:59 pm current Eastern Time on September 12, 2013.

2. What are the major changes in the new FOA?

Although the public health foundations of STD AAPPS and the expiring cooperative agreement are similar, there are some notable differences:

- STD AAPPS eliminates separate program components for the infertility prevention project and syphilis elimination, thereby providing greater flexibility to grantees to direct resources to support STD prevention that reflect their local situation.
- STD AAPPS provides awardees the opportunity to develop work plans, performance measures, and evaluation activities that are focused on program efficiency, cost-effectiveness and scalable interventions with high health impact.
- STD AAPPS incorporates a funding formula that balances the need to direct resources to populations with the greatest burden of infections with the need to maintain efficient and effective infrastructure. Funding is equally divided to address each of these needs.
- STD AAPPS makes changes that support STD programs taking advantage of opportunities created by changes in the health care delivery system:

- Opportunity for improvement of STD surveillance, electronic laboratory reporting, electronic health record case reporting and integrated data systems;
- Opportunity for meaningful use of data for public health purposes;
- Opportunity for participating in public health department billing efforts to receive reimbursement for services provided;
- Opportunity for public health and primary care to collaborate in new ways to expand STD prevention services and quality of existing services;
- Opportunity to collaborate with state Medicaid programs choosing to expand and health insurance exchanges as they prepare for the changes that will take place in January 2014.

- STD AAPPS enhances program capacity and supports modernization of the STD public health work force so they are fit for purpose.

3. Who should I contact if I have additional questions about STD AAPPS?

Please send your questions to stdaappsfoa@cdc.gov. DSTDP staff monitors this inbox on an ongoing basis and will assign your question to the appropriate staff. Frequently asked questions will be posted to the STD AAPPS FAQ webpage.

Additionally, DSTDP has scheduled a series of webinars over the course of the coming months for applicants. Webinar schedules, registration information, and recordings are available at the STD AAPPS Webinar page.

Funding:

1. How was the funding formula applied to states with independently funded cities?

The independently funded city counts were EXCLUDED from the state calculation.
For example, California's funding calculation:

- did NOT include the population for Los Angeles or San Francisco; and
- did NOT include the burden for Los Angeles or San Francisco.
- San Francisco and Los Angeles were calculated separately.

2. Should jurisdictions applying for SSuN, or waiting for decisions regarding the use of carry forward funds include those activities as part of the STD AAPPS application?

SSuN is a fully competitive cooperative agreement with a completely separate scope of work and should be considered distinct and separate from STD AAPPS.

Applicants for STD AAPPS should make no assumptions about additional funding, including SSuN.

STD AAPPS supports the state core infrastructure for STD prevention, therefore the application should include all staff needed to support the core infrastructure.

3. Do state applicants need to fund all counties in the state, or can they fund certain counties to carry out STD-AAPPS grant activities?

Applicants must consider state and local needs when proposing counties that will be supported by this grant.

Applicants should use data to identify communities that are disproportionately affected by burden of disease and focus resources accordingly.

Applicants should consider supporting counties providing safety net STD clinical preventive services in high need areas.

4. Once we've accounted for the minimum required activities, can applicants fund activities not included in the suggested list?

Yes, however, the applicant must address how the required activities will be handled.

The applicant should also include any suggested activities they plan to undertake with an explanation of why those activities have been selected.

The applicant may propose activities not included in the FOA, in order to address state/local needs; however, justification for these activities should be included.

5. If an awardee has, for example, a 5% increase in the first year of funding (2014), according to "average award" listed in the funding table, should that awardee expect a 5% increase each year after 2014?

Funding is dependent upon the Division of STD Prevention's budget in future years.

The funding formula phases in changes in funding evenly over the five year project period.

For example, if your program has a listed increase of 5% in 2014 (not including the sequestration reduction), you should plan for similar increases each of the following years.

Here is an example:
Grantee A was funded $100,000 in 2012.
Grantee A anticipates that after applying the sequestration (5%) in 2013, their 2013 funding amount will be $95,000 [$100,000-($100,000x.05)=$95,000]
Note: Grantee A will also have a 0.398% rescission in 2013, but this occurred after release of the FOA, and so was not included in the formula calculations.

The AAPPS FOA table lists $99,750 for "average award" and $106,733 for "ceiling" for Grantee A.
$99,750 is a 5% increase over $95,000 [$95,000+($95,000x.05)=$99,750], so Grantee A plans for a similar increase each year (dependent upon available funding).

However, Grantee A should apply for the $106,733 listed for Grantee A under "ceiling" in the FOA funding table.

The same logic can be applied to programs with decreases listed for year one.

These anticipated amounts do not include any additional sequestration or other budget reductions that may occur.

6. The FOA contains very little language regarding the support of Hepatitis B and C services. Can applicants use these funds to support Hepatitis B and C services in our jurisdiction?

This grant is primarily to support STD core infrastructure and to address limited clinical services for uninsured and underinsured populations.

In areas with documented syndemics (syphilis and GC with hepatitis C) where STD infrastructure needs have been met, applicants may consider supporting hepatitis B and C services.

- Applicants are expected to articulate their needs and leverage resources by working with the state immunization program.

7. Why did CDC update the funding allocation assessment?

Current funding does not appropriately align funding with burden and need. In November 2011, CDC began active solicitation and collection of formal comments as part of DSTDP's consultative process. Grantees requested moving funding to be more in alignment with disease burden, while mitigating harm to programs. In order to give full consideration of all stakeholder input, DSTDP's modelers developed a robust system to compare various formulas

and considered more than 100 different formulas before applying the one outlined in STD AAPPS FOA.

The proposed formula is a conservative approach that begins to balance need while minimizing harm to established efficient and effective programs. This change is also essential to support program adaptation and integration with the changing public health and health care environment. In addition, CDC is committed to defining the parameters and resources needed to support efficient and cost-effective STD prevention programs at the state and local level during the next five years of this FOA.

8. Why wasn't funding based solely on burden?

DSTDP noted several problems with basing a funding formula solely on burden:

- A funding formula based solely on burden would create a radical change in funding (more so than the proposed formula). In some cases it could cause large decreases in funding for some programs over the course of the project period. In other cases, the implementation of a burden-only formula does not allow much time for programs that would be getting large increases to prepare ;
- A burden-only formula did not take into account resources that would be required to maintain minimum core public health functions for STD prevention in a jurisdiction;
- A funding formula based solely on burden did not take into account anticipated cases based upon population changes; and
- A burden-only formula could potentially penalize programs that are doing a good job preventing STD among at-risk populations in their jurisdictions.

After assessing multiple approaches and combinations of the formula using size of population, disease burden, and rates of disease, a formula that took into account both burden/rates and population, rose to the top as being the most balanced approach.

9. Why did CDC eliminate funding for the Infertility Prevention Project (IPP)?

As with STD AAPPS overall, removing separate program components for IPP reflects the increasing proportion of STD prevention activities occurring in private clinical venues. Infertility prevention remains a core priority of CDC's STD prevention funding. STD AAPPS simply allows that funding to expand infertility prevention services wherever they are needed, including private venues.

10. Do the amounts noted in the FOA for floor, average, and ceiling include the sequestration reductions? Or will applicants be required to reduce these by the sequester amount?

Yes, the amounts noted in the FOA for floor, average, and ceiling include the sequestration reductions but not the 2013 rescission amount of 0.398.

This rescission amount will need to be applied to the floor, average, and ceiling amounts in the FOA.

11. What do the funding ranges mean?

CDC does not yet know funding levels for 2014.

We anticipate that awardees will apply for the ceiling award listed in the table for STD AAPPS but should plan for the average minus the rescission amount of .398, which may be more likely if funding remains constant.

Applicants should not apply for an amount above the ceiling listed for their jurisdiction in the funding table in the FOA because if they do their application will be considered non-responsive.

Applications that are non-responsive will not advance to the Phase II review for further consideration. These applicants will be notified that the application did not meet published submission requirements.

12. To which entities does the 25% cap apply, meaning which jurisdictions should plan for their award amounts being decreased at the maximum of 5% annually? In the first webinar, Dr. Bolan mentioned this cap was applied to 11 entities.

The Health Commissioners for the capped entities were notified by CDC. If your area did not receive notification, then the 25% cap does not apply.

If you compare your final 2013 award to the average 2014 award for your jurisdiction in the FOA, we anticipate that the difference is the amount by which your award will increase or decrease each year if STD prevention funding does not change. This is assuming 2014 funding with be comparable to 2013 funding. CDC does not yet know funding levels for 2014.

13. Can applicants get more details on the funding formula so that we can apply it to funding our local health departments using the same formula? Assuming DSTDP created a spreadsheet with formulas, can we receive a copy of the spreadsheet with the project area data removed?

The tool CDC developed is for a national program, uses national inputs and complex algorithms to handle limits to funding increases and decreases by jurisdiction, and accommodates only exactly the number of jurisdictions CDC funds. Therefore, it is not applicable for use by state or local jurisdictions. It is up to the applicant to determine how best to distribute funds according to need, and applicants may develop tools to assist them.

14. Will there be additional opportunities to apply for funds to support innovative programs, program evaluation, or other special projects? In particular, will additional funds be available to prepare for and respond to emerging drug resistant gonorrhea?

At this time there are no additional funds to support innovation, program evaluation or special projects, or to step up preparations for and response to the threat of emerging drug resistant gonorrhea. Existing STD AAPPS resources are to be used to support these important areas.

15. The STD AAPPS FOA funding formula indicates that a jurisdiction's morbidity for primary and secondary syphilis, gonorrhea, and chlamydia is taken into account when calculating the award amount. The FOA states that data from 2007-2011 was used. Will the calculations be fixed for the entire project period based upon the 2007-2011 data?

Yes, the calculations will be fixed for the entire project period, but award amounts will be dependent upon CDC funding.

16. PGO stated that project areas should use the same indirect cost rate for all grants. That is not what occurs in our jurisdiction. If a program has a large budget, they may chooses to pay the entire city indirect cost rate. Programs with a limited budget ask to have their rate reduced so that they can provide more direct services. Is this going to be a mandated requirement?

Include the indirect cost rate regardless of the similarity between other grants.

17. Should applicants provide a written policy outlining their fringe benefit rate?

Yes, CDC requires applicants to provide information on the fringe benefit rate used and the basis for their calculation.

If a fringe benefit rate is used, applicants should itemize how the fringe benefit rate is computed.

Instructions for computing budgets can be found at:
www.cdc.gov/od/pgo/funding/budgetguide.htm

18. Regarding the Administrative Requirements list, AR-5 (HIV Program Panel Review) is mentioned. To what extent does this AR impact project/product development that would be developed under the STD AAPPS cooperative agreement? The specific funding source(s) of this FOA is unclear.

Ten percent of each award is supported by CDC's HIV funding. Untreated STDs facilitate HIV transmission. Also, STD programs identify new HIV infections, and can help provide linkage to care for HIV-positive individuals.

All written materials, audiovisual materials, pictorials, questionnaires, survey instruments, websites, educational curricula and other relevant program materials must be reviewed and approved by an established program review panel. A list of reviewed materials and approval dates must be submitted to the CDC Grants Management Specialist. This is an HIV Program Review Panel requirement.

19. In the Direct Assistance section, it states that an applicant may request that the CDC or ATSDR provide direct assistance in the form of Federal personnel as part of the grant awarded through this FOA. Can applicants reduce the number of Federal personnel in order to gain more funds?

No. Applicants cannot request a direct assistance (DA) to financial assistance (FA) conversion. The funding formula has been applied in order to ensure an equitable distribution of funding. A similar approach is in the planning stage for direct assistance to ensure a similar distribution of DA resources.

Partner Services:

1. The CDC Project Description/Approach/Program Strategy/Assurance_Partner Services/Outreach Services and Linkage to Care section of the FOA states Partner Services activities conducted by DIS do not include early latent syphilis unless they are HIV co-infected. Should awardees provide partner services to a 16 year old female patient with a 1:512 but no signs/symptoms of syphilis, who is not pregnant, and HIV negative?

Awardees should use local epidemiology and policies to follow up with those most likely to transmit disease in the community.**2. What is the rationale behind conducting partner services for HIV co-infected gonorrhea cases? Does CDC have any recommendations on how to prioritize gonorrhea cases when the volume of cases is so high?**

Partners of HIV co-infected gonorrhea cases should be prioritized for Disease Intervention Specialist (DIS) partner services because they represent a group at high risk for HIV infection, and provision of partner services should facilitate diagnosis and linkage to care.

Other gonorrhea cases that should be prioritized for partner services are cases with possible gonorrhea treatment failure or suspected or probable cephalosporin-resistant *N. gonorrhoeae* infection, using the criteria in the Cephalosporin-Resistant *N. gonorrhoeae* Public Health Response Plan (http://www.cdc.gov/std/treatment/Ceph-R-ResponsePlanJuly30-2012.pdf).

STD programs are encouraged to conduct automated matching of STD and HIV cases to identify co-infected individuals and target these cases for partner services, and to improve data available for additional epidemiologic studies.

CDC staff can assist awardees with prioritization.

3. Are jurisdictions with large syphilis morbidity required to conduct HIV/gonorrhea co-infected partner services?

Yes, jurisdictions with large syphilis morbidity are required to do HIV/gonorrhea co-infected partner services.

Clinical Preventive Services:

1. Please provide examples of "STD clinical preventive services" that can be supported with grant funds.

STD clinical preventive services are those services that are provided in clinical settings to:

- prevent the onset of an STD (e.g. high intensity behavioral counseling);
- identify (screen) and treat asymptomatic persons at risk of acquiring an STD;
- treat and manage persons diagnosed with an STD.

(Source: Guide to Clinical Preventive Services, Report of the USPSTF)

Awardees should focus on those clinical preventive services that have been outlined under the Assessment and Assurance sections of the FOA.

2. What is high intensity behavioral counseling?

High Intensity Behavioral Counseling (HIBC) is a service intended to promote sexual risk reduction or avoidance, and may include:

- education;
- skills training; and
- guidance on how to change sexual behavior.

HIBC is a suggested activity under the Assurance/Health Promotion and Prevention Education section of the FOA and therefore is not required.

The U.S. Preventive Services Task Force (USPSTF) recommends HIBC to prevent STIs for all sexually active adolescents, and for adults at increased risk for STIs. HIBC is considered a USPSTF grade "B" recommendation.

3. The FOA states, "at least 13.5% of the award must go to non-profit organizations that provide safety net STD clinical services." How do applicants account for STD program staff who conduct testing at non-profit clinics?

STD programs are required to provide assistance (at least 13.5% of the overall award amount) to non-profit organizations that have demonstrated their ability to provide safety net STD clinical preventive services.

This assistance may include in-kind support (including federally funded STD program staff time and/or resources) to screen and treat women and their partners for chlamydia and gonorrhea to prevent infertility. This can be reported as part of the 13.5% contribution.

Programs must also collect data documenting the number of uninsured and underinsured screened and treated with this portion of the award.

If 13.5% is not spent on safety net services, a justification must be provided.

4. The FOA states that the 13.5% funding can be provided to non-profits providing clinical services, what about local health departments or similar settings?

For the purposes of this grant, clinical sites must be:

- non-profits with 501(c)(3) designation
- non-profits without 501(c)(3) designation
- health department clinics

If applicant proposes to support other clinical sites, a justification must be provided.

5. My project area will need technical assistance to assess gaps in safety net services. We are unsure what evidence CDC suggests would address this and how to approach quantifying something that is not occurring (i.e., provision of safety net services). Also, would CDC prefer to identify methods to conduct gap assessment that could be used uniformly by all states so that CDC will get a comparable national estimate?

- This is a new area of assessment for STD prevention programs and CDC will share best practices and provide technical assistance for programs that need assistance with this activity.

- CDC will work with NCSD on national assessment measures during the first year of the project period and discuss which local assessments should be standardized, collected uniformly, and reported to CDC for a national measure.
- Gaps in safety net services may be considered an important national measure but those decisions will be made in collaboration with CDC awardees and NCSD.

6. If an adolescent does not know if he/she has insurance, does not know all of his/her personal information (social security number for examples) or does not want to give information to maintain confidentiality for STD services, can he/she be considered uninsured or underinsured?

Yes, depending upon professional judgment and the applicable laws for the jurisdiction, this type of patient may be provided no-cost care as if he/she were uninsured or underinsured.

Surveillance:

1. What does CDC consider a high number of congenital syphilis cases for a project area?

Applicants should treat any number of cases greater than zero as a high number of congenital syphilis cases.

Congenital syphilis is a serious but rare disease, with fewer than 500 cases reported nationwide for each of the last 10 years (range of 339 – 460 cases).

In 2011, only 23 states reported any cases of congenital syphilis.

2. What is the CDC definition of high gonorrhea morbidity?

Applicants should treat counties and independent cities with more than 1,000 reported cases of gonorrhea in the previous calendar year as high gonorrhea morbidity jurisdictions.

Applicants can consider counties and independent cities to be jurisdictions.

Jurisdictions with more than 1,000 reported cases of gonorrhea have accounted for approximately half of all cases reported nationwide for the last five years.

3. The minimum required activities for monitoring screening rates are very similar to SSuN grant activities for facility-based sentinel surveillance. Unlike SSuN, there are no minimum facilities mentioned in the STD AAPPS FOA. Does that mean applicants have to assess chlamydia, syphilis and rectal gonorrhea screening rates throughout our entire jurisdiction?

Programs must describe how they will monitor chlamydia screening rates:

- among young females enrolled in Medicaid (preferably using the HEDIS measure); and
- those seen in Title X and other family planning clinics.

Programs must also describe how they will monitor annual syphilis and rectal gonorrhea screening among men who have sex with men seen in high volume HIV care settings.

4. What is the definition of "health disparities?" Is there a specific case rate or number of cases that will determine which project areas are required to perform these activities?

Health disparities may be defined as differences in health outcomes and their determinants between segments of the population, as defined by social, demographic, environmental, and geographic attributes.

Disparities must be measured from a reference point.

What constitutes an important disparity that deserves attention and programmatic action may be influenced by the size of the differences involved and the populations impacted by the disparity.

5. Which HIV data need to be integrated with STD data?

STD cases reported through notifiable disease surveillance should be matched with reported cases of HIV.

Demographic, mode of transmission, and risk factor information should be included in the match.

6. If the applicant's jurisdiction is not considered high morbidity for gonorrhea, what activities are required?

Document that the jurisdiction is not a high morbidity area in the application.

Applicants must follow CDC's Cephalosporin-Resistant Neisseria Gonorrhoeae Public Health Response Plan before allocating resources to other activities.

7. For Part B GISP applications, could you clarify if it is permissible to have more than one STD clinic contribute to the 25 monthly isolates from men with urethritis?

More than one STD clinic can be used to contribute to the 25 monthly isolates.

The isolates should be submitted together to the reference laboratory for susceptibility testing each month, and accompanying demographic and epidemiological data should be aggregated and submitted to CDC as one data submission.

8. What constitutes a 'high volume HIV care settings?'

High volume HIV care settings are places where a significant number of HIV-infected patients receive care for HIV and other medical issues, and where STD screening can be provided. The denominator is the total number of reported HIV-infected individuals in the targeted or selected geographic area. This could be determined by local HIV surveillance data or Ryan White data.

HIV surveillance data could rank providers in a geographic area by number of HIV patients.

Depending on resources, the applicant will have to use their discretion to determine a limit for what is considered a high volume HIV care setting.

9. Can a jurisdiction propose the same activities in its STD AAPPS application and its SSuN application?

- SSuN is a fully competitive cooperative agreement with a completely separate scope of work and should be considered distinct and separate from STD AAPPS.
- STD AAPPS supports core STD prevention infrastructure.
- Applicants for STD AAPPS should make no assumptions about SSuN funding. Applicants must include all necessary activities and human resources for STD AAPPS in the AAPPS application and budget. Thus, some of the same activities and staff can be proposed for both SSuN and AAPPS.

10. The FOA states awardees are to "…measure annual chlamydia screening rates among young females (15-24 years) enrolled in Medicaid programs, and seen in Title X and other family planning clinics, ideally using the chlamydia HEDIS measure." Does this mean awardees are to measure chlamydia screening rates among young females seen in family planning clinics that are also on Medicaid or does it expand this measurement to non-family planning sites?

- Programs must describe how they will monitor chlamydia screening rates preferably using the HEDIS measure: among young females enrolled in Medicaid, and those seen in Title X and other family planning clinics.
- Measurement should be at the systems level using available administrative data rather than collecting data at the provider level.

- For # 1, the measurement is chlamydia screening rates among the young females enrolled in the state Medicaid program overall in the jurisdiction. Further stratification of rates by geographic units and providers will allow programs to target chlamydia screening assurance activities.
- For # 2, the measurement is chlamydia screening among the young females seen in family planning clinics.
- Further stratification of rates by geographic units and clinic will allow programs to target chlamydia screening assurance activities.
- Some young females enrolled in Medicaid will be included in both measurements.

11. Under Assessment, item #2, the FOA states 'Improve the quality and timeliness of case-based data collection to routinely obtain information on gender of sex partners, pregnancy status, HIV status, treatment given, patient's address and provider information.' Is this expected for all reported conditions (namely, sex of sex partners, pregnancy status and HIV status)?

- Initially, this is expected for all cases of primary and secondary syphilis.
- Over the project period, these data should be collected on a representative sample of gonorrhea and chlamydia cases as surveillance systems are strengthened.
- This information should be collected from provider report or EMR, not patient interviews.

12. Under the 'Assessment/Conduct Surveillance' section of the FOA, it states that a required surveillance activity is to 'ensure confidentiality and security guidelines for the collection, storage, and use of all surveillance data according to NCHHSTP guidelines.' Are jurisdictions expected to have completed implementation of the PCSI Data Security and Confidentiality Guidelines by the time of grant submission, or simply to certify that any elements not yet implemented and standards not yet met are being addressed?

If guidelines or standards have not yet been met, awardees should include in their applications how these standards are being addressed and a timeline for implementation within the first year.

13. The "Assessment/Conduct Surveillance" section of the FOA discusses required surveillance activities and the automated HIV match – applicants are under the impression that CDC strictly regulates HIV case data release, and we believe that using the Enhanced HIV/AIDS Reporting System (e-HARS) for this purpose would violate DHAP provisions. Can

you please clarify? If our state HIV surveillance program wants something in writing from CDC's Division of HIV/AIDS Prevention (DHAP), will this be forthcoming?

- The NCHHSTP Data Security and Confidentiality Guidelines state that sharing of confidential or identifiable information should be limited to those with a justifiable public health need but any data sharing restrictions should not compromise or impede public health programs or disease surveillance activities.
- As long as the standards of these guidelines are adhered to by both HIV and STD programs and the ORP approves data access, routine matching of case registries is permitted.
- Any older DHAP provisions to the contrary are superseded by these latest guidelines, and this is stated in the guidelines themselves. Nothing else is needed in writing as these guidelines come from all divisions, including DHAP, within NCHHSTP.

14. Do GISP-funded states provide funding to sentinel sites or do all the funds go to the state lab?

States may the apportion GISP funds however they are best needed to accomplish the required tasks as stated in the STD AAPPS FOA.

15. The Target Populations/Part A- STD AAPPS section of the FOA states that "project areas should describe a minimum prevalence threshold by which chlamydia and gonorrhea screening activities for young females will be assessed and assured." Please clarify.

Does this apply only to those screening activities that are financially supported with federal dollars such as safety net clinical services? Can only screening programs be supported if the morbidity is at least the minimum threshold?

This requirement should apply to all screening activities in your jurisdiction. Assessing prevalence and assuring minimum thresholds for only those activities supported by federal dollars will not provide enough information or data to accurately access community prevalence, nor guide project area-wide STD prevention activities. Assessing private sector prevalence is expected and essential to program success.

16. In the required and suggested activities under Assessment and Assurance sections of the FOA, there is little mention of monitoring and improving upon the quality of PID and/or chlamydia and gonorrhea re-testing. Can applicants include these activities in our proposal?

Yes, these are activities that CDC anticipates grantees would be likely to include in their proposal.

17. Under the Assessment/Conduct Surveillance section of the FOA, a required activity is "improve the quality and timeliness of case-based data collection to routinely obtain information on gender of sex partners, pregnancy status, HIV status, treatment given, patient's address and provider information." Does this include all STDs (e.g. chlamydia, gonorrhea, and syphilis)?

This information should be gathered for all early syphilis cases, as well as all gonorrhea cases. This information should be gathered for chlamydia only if resources allow.

18. Under the Assessment/Conduct Surveillance section of the FOA, a required activity is "conduct automated matching of STD and HIV cases for identification of syndemics and for targeting health department partner services for co-infected individuals to identify new HIV infections and other HIV infected individuals who are not in care." Please clarify. Are these HIV cases those that have been reported to HIV Surveillance and housed in the eHARS data system or are these persons newly diagnosed with HIV who have accepted partner services? Which data/variables need to be integrated? And should data be integrated from HIV surveillance or HIV prevention?

We are encouraging matching of STD and HIV cases that have been reported to STD and HIV surveillance, respectively. We would hope that basic demographic and risk behavior variables could be integrated where possible in the respective surveillance systems.

Evaluation, Work Plan, and Performance Measure Plan:

1. Are applicants required to complete and submit the work plan template posted on the STD AAPPS resource page, or is the template meant to serve as a guide?

Yes, CDC expects all applicants to complete and submit the provided work plan template as a PDF attachment.

CDC is working to harmonize evaluation and performance measurement with the work plan to reduce paperwork.

CDC is interested in your feedback on the template; please share any concerns via email (STDAAPPSFOA@cdc.gov).

There will also be a webinar on Thursday, July 11, 2-3 pm (ET) to discuss the work plan template as well as the FOA program evaluation requirements.

For more information about the webinar, visit the STD AAPPS web page: http://www.cdc.gov/std/foa/aapps/default.htm

2. The FOA suggests that the Awardee Evaluation and Performance Measurement Plan is not meant to be submitted with the initial application but will be developed later, during year one of the project period. Please confirm that only the Applicant Evaluation and Performance Measurement Plan is to be submitted with the initial application and not the Awardee Plan.

Applicants should focus only on the Applicant Evaluation and Performance Measurement Plan during the application process.

The Awardee Evaluation and Performance Measurement Plan is not part of the initial application (done during 1st year of grant).

This information is noted in the FOA so that applicants are aware that, if awarded funds, a more detailed Evaluation and Performance Measurement Plan will be required as a work product for the cooperative agreement.

3. The Project Narrative/Organization Capacity of Awardees to Execute the Approach section of the FOA states applicants should have a strong evaluation and performance measurement plan. Should an evaluation and performance measurement plan be includedin the Evaluation and Performance Measurement section instead?

The Evaluation and Performance Measurement section in the review criteria describes how the Evaluation and Performance Measurement Plan will be scored.

Under the Organizational Capacity section, applicants are scored based on their ability to execute the plan, not the plan itself.

4. What is the relationship between the Program Narrative and the Work Plan? We are concerned that there will be a duplication of the explanation as it is difficult to discuss our program's outcomes, strategy and evaluation without having our objectives in the same place.

While there may be some duplication between sections of the Program Narrative and Work Plan, duplication should be minimized in order to keep within the page limit of the narrative portion and to avoid unnecessary effort.

The Program Narrative could offer a broad description of the content in the Work Plan. The narrative could reference the Work Plan as appropriate.

The Program Narrative could also provide additional information that the template does not provide sufficient space for, particularly related to the rationale for selecting certain program

strategies in general, barriers, plans for later years, and any other contextual information applicants feel would be useful.

5. It is clear in the FOA that we can use Year 1 to conduct the assessment and develop an approach for our activities. However, it seems as if a listing of programmatic activities is required for the Work Plan for Year one. Should applicants list the activities that we know we will conduct during Year one and state that we will reassess whether these activities will be scaled up, reduced, or remain the same after a thorough assessment is conducted? Or, does the Work Plan for Year one describe the assessment activities that will be conducted in order to develop a program plan for Years two through five?

The Work Plan should focus on those activities that the applicant plans to carry out in Year one that aligns with those outlined in the FOA.

The section of the template that relates to 'Plans for years 2-5' can include some information about intentions to re-assess certain activities.

The narrative portion of the application related to Evaluation and Performance Measurement is also an appropriate place to discuss, in more detail, applicant plans to assess particular programmatic activities in Year one and determine what direction they should take.

6. What size paper is allowed for the Work Plan? The template defaults to printing on legal size paper. Are applicants permitted to use legal size paper towards the 20-page maximum, should the template be reduced to fit on 8.5 x 11 inch paper?

The applicant must submit all application attachments using a PDF file format when submitting via www.grants.gov.

For the Work Plan attachment only, the pages in the PDF can be legal sized. Applicants can reduce the size of the Work Plan template to letter sized, if they choose.

For all others documents required to be submitted, as listed in the FOA, the PDF should be letter size.

7. Should applicants list the activities included on the Work Plan verbatim and transfer them into the table under Year one activities?

Applicants should not copy the activities verbatim into the Work Plan tables. The Work Plan row entries for each of the tables should be more detailed than the activities listed above each table. CDC is not looking for great detail, but at least more than what each required activity says. The cover page to the Work Plan document instructs applicants to list up to 3-4 objectives or activities per required item.

The first column of each Work Plan table asks applicants to reference which required activity a proposed activity or set of activities relates to. That cross-reference should be enough to show how proposed activities or objectives align with the required items.

To further clarify these issues, please reference the example provided on the FOA resource website and plan to attend the webinar on July 11 related to responding to the Work Plan and Evaluation and Performance Measurement sections of the STD AAPPS FOA.

8. Can CDC clarify expectations related to developing an evaluation plan? Specifically, is the expectation that a global (e.g., program science) plan be proposed or a general approach to evaluating individual interventions that lack an evidence- or practice-base? Alternatively, is the expectation that each new program include a detailed evaluation component?

For the application process, applicants need to describe an evaluation plan, following the questions provided in the FOA related to "Applicant evaluation and performance measurement strategy." The Work Plan template also includes components related to evaluation. Completing those two sections are sufficient for the application process.

In the narrative portion of the application related to evaluation and performance measurement, applicants can describe their general approach to evaluation, as well as how they plan to focus their evaluation efforts.

It is not expected that every single program or activity has a detailed evaluation plan. Part of the process of developing a fuller evaluation plan will involve making decisions about what parts of the program most need evaluation. Applicants that already have a sense of how they would focus their efforts should describe that in the narrative portion of the application.

Awardees must provide a detailed global STD AAPPS evaluation and performance plan within the first year of funding, including the development of program performance measures. This plan should be developed by awardees with support from CDC staff as part of first year activities and will be an iterative process.

Since evaluation including performance measurement is an important component of the STD AAPPS FOA for the entire project period, funds should be allocated for evaluation expertise through personnel or contracts, as appropriate to the project area.

9. Given that the required policy activity #1 says "monitor and evaluate impact" and #2 is to educate stakeholders on the "positive potential or proven impact of policies," what kind of evaluation is expected? Is it acceptable to conduct process evaluation in #1? For policy required activity #1, what is considered "relevant policies?"

To determine whether a policy achieved its intended goals, programs are expected to conduct outcomes evaluation.

The evaluation may include policies that will impact any or all of the outcomes identified in the sequence presented in the logic model (i.e. short/medium- and long-term outcomes), including:

a) changes in community and provider knowledge of STD-related policies);
b) increased community screening and treatment;
c) changes in the environment (e.g. increase access to care or improved integration of STD prevention into clinical care; and
d) changes in trends in morbidity (e.g. reduced incidence of chlamydia, gonorrhea, and syphilis) and their sequelae.

Relevant policies are those that may impact morbidity and mortality directly or indirectly, for example policies that improve access to STD prevention and treatment services for populations at risk.

10. When are the detailed evaluation and performance measure plans due?

A due date for the detailed evaluation and performance measure plans has not yet been determined.

The detailed evaluation and performance measure plans will be developed and finalized as soon as is reasonable depending on the awardees initial plan and CDC input.

Optimally, they will be completed by the middle of year one, so that evaluation and performance measurement activities can be implementing during part of year one.

11. Which year of data should applicants use as baseline data for the STD-AAPPS application?

For any baseline data provided in the application (e.g., as part of the rationale for some Work Plan activities), applicants should use the latest annual data available, which we anticipate is 2012 figures.

Performance measures will be further developed as part of the evaluation and performance plan during 2014, the first year of this project. As part of this process, applicants will collect data for (at least part of) 2014, for both the proposed project area's performance measures and national outcome measures.

12. When will the new national performance measures be released and how close do they mirror the examples provided in the Evaluation and Performance Measurement section of the FOA?

CDC will launch a process to obtain input on a set of national AAPPS outcome measures soon after funding has been awarded.
The process is intended to be collaborative with funded project areas and NCSD and thus will likely take a few months.

It is not clear how closely they will reflect the examples provided in the FOA with the exception of the need to measure the number of females who are screened using funds from this cooperative agreement including the number uninsured and underinsured and the number of new HIV infections identified as the result of STD prevention efforts supported by this cooperative agreement. These will be defined for Project Areas after award.

13. What are the total points for the Evaluation and Performance Measurement section? The Evaluation and Performance Measurement states 15 points and the sub-section, Evaluation Plan states 10 points. Not all the points are accounted for.

The Evaluation and Performance Measurement section is correct: 15 points.

The sub-section, Evaluation Plan should read 15 points and encompasses performance measurement.

14. Is there a Work Plan template for the Part B- GISP application?

No, CDC has not provided a work plan template for Part B of the application. However, a work plan is required as part of the Part B GISP application.

15. The organizational capacity section in the FOA states, "readiness to establish contracts in a timely manner" is necessary. What is the expectation for timeliness?

The contract time period should be within the budget/project period. Therefore, based on the scope of work, the applicant should plan to procure the contract so that the work is scheduled for completion prior to or at the end of the budget/project period.

16. May a suggested activity be substituted for a required activity if a required activity is not feasible with available resources?

If a required activity is not feasible with available resources, a detailed explanation must be provided as to why not.

A suggested activity may be included, if the other minimum activity requirements of STD AAPPS have been addressed and funds remain to support the implementation and evaluation of the suggested activity.

The suggested activity must be an essential public health capability or implementation of an effective intervention that can be brought to scale with population impact.

A justification as to why this suggested activity is a local priority and how it fits into the overall awardee's STD prevention program approach must be provided.

17. If a project area is only allowed to fund certain counties rather than all counties, would they only be required to work with Tribal Governments in those funded counties?

Federally Recognized Tribal governments are Indian Tribes with whom the Federal Government maintains an official government-to-government relationship; usually established by a Federal treaty, statute, executive order, court order, or a Federal Administrative Action. The Bureau of Indian Affairs (BIA) maintains and regularly publishes the list of federally recognized Indian Tribes.

Awardees are required to work directly with Tribal Governments in their project area. The FOA notes requirements related to working with Tribal Governments, "At a minimum, applicants must describe their plans and provide a timeline to work with and/or support Tribal Governments, if there are any in their project areas."

Tribal Governments should be considered full partners during the design and implementation of programs supported with DSTDP funds.

In accordance with the United States Department of Health and Human Services (HHS) Tribal consultation policy it is the responsibility of states (or other funded programs) to consult with Tribes when HHS has transferred the authority and funding for programs to state governments that are intended to benefit Tribes.

The applicant must address how they are proposing to work with and support Tribal Governments, regardless of whether they are in funded counties or not.

It should also be noted that awardees are not prohibited from funding all counties but resources should be matched with burden of disease and need. Thus, funds should be directed to counties with the greatest burden and need.

18. If a jurisdiction has already accomplished an activity that is required in the FOA, are they required to repeat the activity, report on what has already been achieved, or propose a slightly different but related activity that builds on work already completed?

If activities are already completed, report on what has been achieved and how it will be maintained.

Resources can then be directed to related activities that build on the work completed or to alternative priority activities.

19. How much do you expect applicants' evaluations, being conducted with minimal resources, to inform programmatic decisions at our state or a national level?

CDC does not expect funded project areas will independently launch major evaluation initiatives that will assess long-term outcomes (e.g., decreased incidence).
Smaller scale evaluations are encouraged and expected; these help evaluate smaller components of your project, looking at whether and how certain outputs were achieved and, in some cases, some shorter-term outcomes (e.g. increased screening rates).

Quality improvement efforts are also expected and are in the same spirit. CDC will direct some of its own evaluation resources towards tracking short/long term outcomes as well. In fact, CDC is planning that now and hopes to collaborate with some project areas on this area of evaluation.

20. Should applicants include the FOA required activities and suggested activities on the Work Plan? I understand applicants will have their own. But do you want to see them at the top of the work plan like the template?

If space permits, applicants are advised to leave the activities listed at the top of each table in the template. If you are adding an activity, you do not also have to add an item to the list that appears at the top of each table. However, please make it clear on any new Work Plan table where that set of objectives fit. The application narrative should also explain and justify any additional activities and how they fit into the FOA's activity domains.

21. What are the required activities for an applicant whose jurisdiction is not considered high morbidity for gonorrhea?

The applicant should first document that the entire jurisdiction is not a high morbidity area, and does not contain any major metropolitan service areas that meet the definition of a high gonorrhea morbidity area. Activities should include the following:

- Establishing an outbreak response infrastructure to respond to any emerging threats is essential for all STD prevention programs.
- Awardees in project areas not considered high gonorrhea morbidity, should be able to respond and investigate suspected gonorrhea treatment failure cases and their partners and have a laboratory with gonorrhea culture capacity.

- Keeping providers informed of current STD treatment guidelines recommendations including recommended gonorrhea treatment is an important activity and falls under the required policies activities.
- Monitoring effective treatment of STDs (including gonorrhea cases) through surveillance activities is recommended and should be done as STD surveillance systems are strengthened.

22. We agree that the four priority activities under the "Assurance/Screening and Treatment of Individuals per CDC Guidance" section of the STD AAPPS FOA are very important for a quality STD Program but we are concerned that we will have difficulty complying with them. Three of the priority activities (i.e. increase chlamydia screening among 15-24 year old females; increase syphilis and rectal gonorrhea screening in high volume HIV providers; increase proportion of gonorrhea patients correctly treated) hold applicants responsible for individual physician/provider behavior. While grantees can certainly attempt to change this behavior, ultimately it is not within our control. How should we address this?

- STD prevention programs will need to develop collaborations with Medicaid programs, FQHCs and HIV clinical settings funded by HRSA or with others in the Health Department working with these providers to facilitate the assessment of chlamydia screening among young females and STD screening rates among MSM.
- The goal over the project period is to work with electronic health record systems or other administrative data systems to best monitor screening rates.
- CDC will share best practices and provide technical assistance for programs that need assistance with this activity.

23. One of the four priority assurance activities is, "Increase CT screening rates among young females (15–24 years) enrolled in Medicaid programs, and seen in Title X and other family planning clinics, as ideally measured by the CT HEDIS measure." The HEDIS measure is for women aged 16–24. Why is there an age discrepancy?

CDC recommends using the latest HEDIS measure for standardization purposes, recognizing that it does not include 15-year-olds (and recognizing it often also includes 25-year-olds). At the same time, CDC encourages project areas to include 15-year-olds in their screening efforts, given burden of illness among that age also.

24. Under the Assurance/Screening and Treatment of Individuals per CDC Guidance section of the FOA, a suggested activity is, "increase syphilis and rectal GC screening rates among MSM

seen in setting providing health care to MSM." Is CDC collaborating with HRSA to adjust the core clinical measures used by Ryan White programs?

Yes, CDC is trying to collaborate with HRSA to adjust the core measures.

25. Since the FOA requires activities associated with HIV, what portion of the funding was determined with HIV-related weighting?

Only the three priority STDs (chlamydia, gonorrhea, and syphilis) were used to determine the formula. HIV-related data was not used as a factor. However, HIV funding represents approximately 10% of the overall funding for each project area, and applicants may take that into consideration in their planning and application.

Application Requirements:

1. When is the FOA due?

All FOA applications are due by 11:59 pm current Eastern Time on September 12, 2013.

CDC encourages applicants to submit well in advance of the deadline, in case there are any technical difficulties that need to be resolved.

Applications received after the deadline will not be considered. There will be no exceptions.

Allow time for the validation process, as detailed in the Other Submission Requirements of the FOA.

2. Are applicants required to complete and submit the work plan template posted on the STD AAPPS resource page, or is the template meant to serve as a guide?

Yes, CDC expects all applicants to complete and submit the provided work plan template as a PDF attachment.

CDC is working to harmonize evaluation and performance measurement with the work plan to reduce paperwork.

CDC is interested in your feedback on the template; please share any concerns via email (STDAAPPSFOA@cdc.gov).

There will also be a webinar on Thursday, July 11, 2-3 pm (ET) to discuss the work plan template as well as the FOA program evaluation requirements.

For more information about the webinar, visit the STD AAPPS web page: http://www.cdc.gov/std/foa/aapps/default.htm

3. The Project Narrative/Organization Capacity of Awardees to Execute the Approach section of the FOA states applicants should have a strong evaluation and performance measurement plan. Should an evaluation and performance measurement plan be includedin the Evaluation and Performance Measurement section instead?

The Evaluation and Performance Measurement section in the review criteria describes how the Evaluation and Performance Measurement Plan will be scored.

Under the Organizational Capacity section, applicants are scored based on their ability to execute the plan, not the plan itself.

4. What size paper is allowed for the Work Plan? The template defaults to printing on legal size paper. Are applicants permitted to use legal size paper towards the 20-page maximum, should the template be reduced to fit on 8.5 x 11 inch paper?

The applicant must submit all application attachments using a PDF file format when submitting via www.grants.gov.

For the Work Plan attachment only, the pages in the PDF can be legal sized. Applicants can reduce the size of the Work Plan template to letter sized, if they choose.

For all others documents required to be submitted, as listed in the FOA, the PDF should be letter size.

5. Are there specific requirements for font, margins and spacing?

Certain sections of the FOA include specific font, margin, and spacing requirements. If no specifications are noted for a particular portion of the application, there are no requirements for font, margins, and spacing.

6. Should applicants complete the 424 form for year one and another for years two through five? Should applicants complete a budget narrative for years two through five in addition to the budget narrative for year one?

Yes, it is mandatory to complete form 424 for year one—this is the applicant's page that contains all the legal information needed.

The budget narrative should be completed for year one—see guidance on completing a budget: http://www.cdc.gov/od/pgo/funding/budgetguide.htm.

For years two through five, it is not mandatory to complete a 424 or a budget narrative, but the applicant is free to expand on additional information for the entire five year cycle.

Awardees will be required to submit a budget narrative each continuing year during the cooperative agreement period.

7. Please provide applicants with guidance on key letters of support and MOUs that CDC suggests should/could be submitted with the application?

Letters of support should be on agency/organization letterhead and signed by whoever is providing the letter of support.

No additional information (e.g., sample) can be provided, nor can CDC suggest who can provide the applicants their letters of support.

8. Should jurisdictions that are submitting both Part A and Part B application submit two separate applications on grants.gov; or just one application including Parts A and B?

- Applicants applying to both Parts A and B should submit one application that includes Part A and Part B.
- The Part B Abstract and 424 form can be uploaded in the attachments. Please be sure to make a distinction in the Part names as indicated in the FOA guidance under Section D 'Application and Submission Information.'

9. Is there a limit on attachments (page limit or number of attachments)?

There are page limits for certain parts of the application:

- *Table of Contents:* No page limit.
- *Project Abstract Summary:* Maximum of 2 paragraphs with word count of no more than 300 for Part A- STD AAPPS and maximum of 1 paragraph with word count of no more than 150 for Part B- GISP; single spaced, Calibri 12 point, 1-inch margin.
- *Project Narrative:* Maximum of 15 pages for Part A- STD AAPPS and maximum of 3 pages for Part B- GISP.
- *Work Plan:* Maximum of 20 pages.

10. Is there a page limit for the budget?

The format for the budget submission is form 424; the form does not have a limit.

11. Are 2013 progress reports for the CSPS cooperative agreement required with this application?

Since this is a new cooperative agreement, no 2013 CSPS progress reports are required.

To close out the CSPS cooperative agreement, 2013 progress on CSPS objectives should be provided as part of five-year final CSPS performance and financial report which is due 90 days after the end of the CSPS project period, e.g., on March 31, 2014.

12. There are several attachments listed such as AAPPS org chart, MOU/MOA (not required the first year), CV, Part A- STD AAPPS Work Plan on file other attachments. Is there a limit on attachments or will only those mentioned in the FOA be allowed?

Only attachments mentioned in the FOA will be allowed.

13. A signed "Assurances and Certifications" document was submitted in May 2013 for the SSuN grant application. Can this be used for the STD AAPPS FOA application?

Yes. PGO has established a website (wwwn.cdc.gov/grantassurances/Homepage.aspx) where applicants can upload their assurance documents on an annual basis and it will be kept on file so that the signed document does not have to be submitted with each individual application. Applicants may either submit the signed assurances document to this website or as a part of the application for PS14-1402.

14. Are applicants required to apply for both Part A: STD AAPPS FOA and Part B: GISP?

No. Grantees may choose to apply to one, both, or neither parts of the STD AAPPS FOA. However, applying is not a guarantee for funding, if the project area does not apply for one or both sections, they will not be funded for one or both sections.

15. Is only one logic model required as part of the application? Would it be useful to include a total of three logic models, one for chlamydia, one for gonorrhea, and one for syphilis?

Project areas do not have to provide a logic model as part of their application, although they are encouraged to develop and have one for themselves to help plan and evaluate their work. Work plans should generally align with the STD AAPPS FOA logic model. It is often useful to have logic models for particular parts of a program (e.g., one for each major infection, if that makes sense to the program), but that is not required.

16. Is there a template for the logic model? Is using a template for the logic model required?

Project areas are not required to develop a logic model for their program as part of the application. Work plans should generally align with the STD AAPPS FOA logic model. There is no template for the logic model, and no template or specific format is required.

17. If a grantee is not able to apply for GISP funding in year one, will it be possible to apply for GISP funding in year two?

No. Applicants for GISP must apply by the deadline stated in the FOA, and must be able to conduct the required activities every year for the entire five-year project period.

18. The FOA submission instructions reference a table of contents, but do not specify separate ones Part A- STD AAPPS and Part B- GISP. How should applicants handle table of contents for Part B- GISP?

There should be only one table of contents that references the entire application. If the applicant is applying for parts A & B, it should be reflected in the table of contents.

19. Who should I contact with questions about which forms to submit and how to submit them?

For technical submission questions, contact:
Technical Information Management Section
CDC Procurement and Grants Office
Telephone: 770-488-2700
Email: pgotim@cdc.gov

20. Would it be possible to post a copy of the required Assurances and Certifications form on the website? When the link is accessed on page 38 of the guidance, it appears there are two forms (assurances non-construction and certifications), not just one.

The two assurances and certifications applicable to this FOA can be found at:
http://www.cdc.gov/od/pgo/funding/docs/CertificationsForm.pdf and
http://apply07.grants.gov/apply/forms/sample/SF424B-V1.1.pdf

21. Should the Project Narrative be one document distinguishing Part A and Part B or should each narrative be uploaded separately as "Part A – Project Narrative" and "Part B – Project Narrative?"

Part A and Part B should each have their own Project Narrative and should be uploaded as such.

22. Should form SF 424A be completed with the Parts A and B funding separated out or should the total amount requested for the entire year 1 budget period be shown?

Form SF 424A should be completed with Part A and B funding separated.

Miscellaneous:

1. The FOA mentions public/private partnerships; can you list some examples?

Examples are included in the Project Description/Approach/Program Strategy section of the FOA:

- Health Resources Services Administration (HRSA) programs such as Ryan White HIV/AIDS programs; federally qualified health centers; and state maternal and child health programs.
- Programs funded by the HHS Office of Population Affairs and Office of Adolescent Health, such as family planning clinics and teen pregnancy prevention programs, and their state Medicaid program.
- Other organizations may include: 1) health plans; 2) state primary care associations; 3) professional medical and nursing organizations; 4) state and local education agencies; 5) organizations providing services to incarcerated populations; and 6) schools of public health and other academic institutions.
- Innovative partnerships with the business community or others are also encouraged.

2. What appropriate and evidence-based interventions are available to reduce reinfections among high-risk clients?

DSTDP recognizes the need to build upon the evidence base for STD interventions and is in the planning process for how to do so.

We are compiling existing evidence for a variety of interventions and have developed a resource that is available on the FOA resource webpage.

This resource will be updated as additional evidence becomes available.

3. How do I know if my project area meets the CDC definition of high morbidity for congenital syphilis?

Applicants should treat any number of cases greater than zero as a high number of congenital syphilis cases.

Congenital syphilis is a serious but rare disease, with fewer than 500 cases reported nationwide for each of the last 10 years (range of 339 – 460 cases).

In 2011, only 23 states reported any cases.

4. What constitutes a 'large health plan,' as listed in the Assessment/Monitor Screening Rates section of the FOA?

A large health plan is a plan that has a significant share of the health insurance market in a given geographic area.

5. What percentage of 15-24 year-olds are sexually active?

Given the differences in sexual activity between 15-19 and 20-24 year olds, CDC typically publishes data from national surveys separately for these age groups.

The most recent data on sexual activity for these age groups is from the 2006-2008 National Survey of Family Growth.

Consistent with CDC STD screening recommendations, CDC defines sexually active as 'sex in the past 12 months.'

Using data from *Sexual Behavior, Sexual Attraction, and Sexual Identity in the United States: Data From the 2006–2008 National Survey of Family Growth*, the percentages of sexually active adolescents and young adults are estimated as follows:

- Females 15-19 years of age: 48.7%
- Females 20-24 years of age: 84.2%
- Males 15-19 years of age: 51.1%
- Males 20-24 years of age: 81.7%

6. Will CDC provide a Word version of the FOA?

No, CDC will not provide a Word version of the FOA.

7. Will awardees be required to submit an interim report each year for STD AAPPS?

No, interim reports are not required.

Awardees must submit one annual report per year.

More information can be found in the 'Reporting' section of the FOA. If progress towards outputs and outcomes is not being made then additional reports may be required by CDC.

8. The FOA states that awardees will only be required to submit an Annual Performance Report, but also state that the Report is due 120 days (4 months) before the end of the budget period. With this timeline, awardees will only be able to report on 8 months of data. Is this correct? Is it expected that the Annual Performance Report will be submitted with future grant applications?

The annual performance report will serve as the continuation application.

The Annual Performance Report is due 120 days prior to the end of the budget period in order for CDC to process the continuation applications in time for the next budget period.
The data to report and the time period to include in this report has not yet been established.

This will be determined during the first year of the project and the process is intended to be collaborative with funded project areas and NCSD. It will be part of the evaluation and performance measure plan process as described under the Evaluation and Performance Measure Plan FAQs.

9. Please define STD Clinic.

A clinic or clinical setting where quality STD services are provided.

10. Is it recommended that project areas partner with other federally funded prevention programs "to develop integrated prevention packages for primary care?" Please define "prevention packages."

Yes, CDC recommends local and state STD programs partner with other federally funded programs, such as local and state HIV and hepatitis prevention programs, to develop prevention packages for integration into primary care. Prevention packages are any combination of services (e.g. screening and treatment services, health education materials, and partner services) across programs (e.g., STD, HIV, and Hepatitis) that address the needs of our at-risk populations (e.g., MSM) seeking services at key primary care providers.

11. In the Gonococcal Isolate Surveillance Project (GISP) portions of the FOA, there are several references to the "local public health laboratory." Are applicants required to utilize the health department laboratory for processing GISP specimens? If a relationship with another reputable lab exists, is it acceptable to utilize this site for the GISP application?

An appropriate clinical site can use another laboratory (besides a local public health laboratory) if the other laboratory is proficient at performing culture for N. gonorrhoeae, proficient at

handling, storing, and shipping N. gonorrhoeae, supports participating in GISP, is able to handle the volume of culture specimens generated by participation in GISP, is willing to work closely with the clinical site to properly assign GISP identification numbers and monitor progress, is willing to ship isolates to the appropriate reference laboratory monthly, and follow the GISP protocol.

12. Will the scoring of project area applications impact their funding allocation?

Scoring of project area applications will not impact funding allocation for year one. CDC is considering options to reward and incentivize innovation and quality in future years. Additionally, all project areas should keep in mind that CDC reserves the right to take action if grantees are not meeting expectations, which may include funding-related actions. Funding amounts are dependent on the availability of funds.