

**Funding Opportunity Announcement (FOA)
New, Non-research, Domestic**

***Improving Sexually Transmitted Disease
Programs through Assessment, Assurance,
Policy Development, and Prevention
Strategies (STD AAPPS)***

CDC-RFA-PS14-1402



Amendment 1, dated July 8, 2013 is being made to part II, Monitor and Screening rates (pg. 13) “program” is changed to “plan”; With CDC-Funded Programs (pg. 20) the sentence “DASH provides a list of funded national, state, local, territorial, & tribal programs, and non-governmental organizations at: <http://www.cdc.gov/healthyyouth/partners/index.htm>.” is added; Work Plan (pg. 22) the sentence “The work plan is the only attachment that can be submitted on legal-sized paper. Please note that all application attachments must be submitted using a PDF file format, including the work plan, via www.grants.gov” is added; Organizational Capacity of Awardees to Execute the Approach (pg. 51) the sentence “The applicant will be scored based on their ability to execute the plan, the plan will be scored according to section c below.” is added; Evaluation Plan (pg. 52) is corrected to 15 points.

Contents

Part I. Overview Information	1
A. Federal Agency Name	1
B. Funding Opportunity Title.....	1
C. Announcement Type.....	1
D. Agency Funding Opportunity Number	1
E. Catalog of Federal Domestic Assistance Number	1
F. Dates.....	1
G. Executive Summary	1
Part II. Full Text	3
A. Funding Opportunity Description.....	3
1. Background	3
a. Statutory Authorities	6
b. Problem Statement	6
c. Healthy People 2020.....	7
d. Other National Public Health Priorities and Strategies.....	7
e. Relevant Work.....	8
2. CDC Project Description	8
a. Approach	8
i. Purpose	10
ii. Outcomes.....	10
iii. Program Strategy	11

iv. Work Plan	21
b. Organizational Capacity of Awardees to Execute the Approach	23
c. Evaluation and Performance Measurement	25
d. CDC Monitoring and Accountability Approach	28
e. CDC Program Support to Awardees	29
B. Award Information.....	31
1. Type of Award	31
2. Award Mechanism	31
3. Fiscal Year.....	31
4. Approximate Total Fiscal Year Funding.....	31
5. Approximate Total Project Period Funding.....	31
6. Approximate Number of Awards	31
7. Approximate Average Award	31
8. Floor of Individual Award Range.....	31
9. Ceiling of Individual Award Range	31
10. Anticipated Award Date.....	34
11. Budget Period Length	34
12. Project Period Length.....	34
13. Direct Assistance	35
C. Eligibility Information.....	35
1. Eligible applicants	35
2. Special Eligibility Requirements.....	35
3. Justification for Less than Maximum Competition	35
4. Other	36
5. Cost Sharing or Matching.....	36
6. Maintenance of Effort.....	36
D. Application and Submission Information	36
1. Required Registrations	36
a. Data Universal Numbering System	36
b. System Award Management.....	36
c. Grants.gov	37
2. Request Application Package.....	37

3. Application Package	37
4. Submission Dates and Times	38
5. CDC Assurance and Certifications.....	39
6. Content and Form of Application Submission	39
7. Letter of Intent.....	39
8. Table of Contents.....	39
9. Project Abstract Summary	39
10. Project Narrative.....	39
a. Background.....	40
b. Approach.....	40
c. Organizational Capacity of Awardee to Execute the Approach Statement	41
d. Evaluation and Performance Measurement.....	42
11. Work Plan.....	43
12. Budget Narrative.....	44
13. Tobacco and Nutrition Policies	45
14. Intergovernmental Review	46
15. Funding Restrictions.....	46
16. Other Submission Requirements	47
a. Electronic Submission	47
b. Tracking Number.....	47
c. Validation Process	47
d. Technical Difficulties	48
e. Paper Submission.....	48
E. Application Review Information	48
1. Criteria.....	48
2. Review and Selection Process.....	53
a. Phase I Review	53
b. Phase II Review	53
c. Phase III Review	53
3. Anticipated Announcement and Award Dates	53
F. Award Administration Information.....	54
1. Award Notices.....	54

2. Administrative and National Policy Requirements 54

3. Reporting 55

4. Federal Funding Accountability and Transparency Act of 2006 58

G. Agency Contacts 58

H. Other Information 59

I. Glossary..... 60

Part I. Overview Information

To receive notifications of any changes to CDC-RFA-PS14-1402, return to synopsis page of this announcement at: www.grants.gov and check on the "Send Me Change Notifications Emails" link. Applicants must provide an email address to www.grants.gov to receive notifications.

- A. Federal Agency Name:** Centers for Disease Control and Prevention (CDC)
- B. Funding Opportunity Title:** Improving Sexually Transmitted Disease Programs through Assessment, Assurance, Policy Development, and Prevention Strategies (STD AAPPS)
- C. Announcement Type:** New—Type 1
- D. Agency Funding Opportunity Number:** CDC-RFA-PS14-1402
- E. Catalog of Federal Domestic Assistance Number:** 93.977, Cooperative Agreements to Improve Sexually Transmitted Disease Programs through Assessment, Assurance, Policy Development, and Prevention Strategies (STD AAPPS)

F. Dates:

Application Deadline Date: September 12, 2013, 11:59 p.m. U.S. Eastern Standard Time, on www.grants.gov

This announcement is only for non-research domestic activities supported by CDC. If research is proposed, the application will not be reviewed. For the definition of research, visit:

<http://www.cdc.gov/od/science/integrity/docs/cdc-policy-distinguishing-public-health-research-nonresearch.pdf>.

G. Executive Summary:

The Centers for Disease Control and Prevention announces the availability of Fiscal Year (FY) 2014 funds to implement FOA PS-14-1402, Improving Sexually Transmitted Disease Programs through Assessment, Assurance, Policy Development, and Prevention Strategies (STD AAPPS). **Project period:** 5 years. **Budget period:** 12-months. **Anticipated award date:** January 1, 2014. **Type of Award:** Cooperative Agreement. **Application Deadline:** September 12, 2013, 11:59 p.m. U.S. Eastern Standard Time on www.grants.gov. A letter of intent is not required. Cost sharing and/or matching is not required.

Problem statement: In the face of an ongoing STD syndemic with adverse outcomes that contribute to health disparities, the changing health care landscape and information technology advances present opportunities and challenges to improve STD prevention programs in the US. CDC estimates

that approximately 20 million new sexually transmitted infections occur each year and that almost half of them are among young people ages 15 to 24.¹ Three bacterial STDs—chlamydia (CT), gonorrhea (GC), and syphilis—are the focus of federally funded prevention and control programs throughout the United States. In 2011, over 1.3 million cases of CT and 0.3 million cases of GC were reported to the CDC.² Untreated CT and GC increase a woman’s risk for pelvic inflammatory disease (PID), infertility and further transmission of the infection. Growing evidence suggests that GC is showing emerging resistance to the last line of antibiotic treatment. Syphilis, a genital ulcerative disease, remains a major health problem in the South and urban areas. Increases in cases among men who have sex with men (MSM), including men having sex with both men and women, have occurred.³ Untreated early syphilis in pregnant women can lead to infection of the fetus in 80% of cases. Untreated STDs facilitate HIV transmission.

Substantial changes in the health care delivery system require STD programs to adopt new strategies to maximize the many opportunities created by the expansion of insured individuals and coverage of many STD screenings without cost sharing. These investments in the health care system are predicted to significantly increase the proportion of insured individuals and to shift some vulnerable and at risk populations (traditionally part of STD safety net services) to an expanded network of primary care providers and patient-centered medical homes. Significant American Recovery and Reinvestment Act of 2009 (ARRA) and Patient Protection and Affordable Care Act (ACA) investments and incentives in health information technology (HIT) present an unprecedented opportunity for STD programs to incorporate important epidemiological, clinical preventive services, social and behavioral data through linkage with electronic health records (EHRs) and information through regional health information organizations.⁴ In addition, electronic laboratory reporting (ELR) potentially provides a rich source of information for more rapid and thorough monitoring of disease incidence. Health departments will need to invest in the information technologies necessary to receive these data electronically and develop the analytical capacity to demonstrate meaningful use of data⁵ for public health action.

The purpose of this FOA is to strengthen STD prevention programs in eligible jurisdictions. By the end of this five year project period the following primary outcomes will be achieved: 1) Increased community screening and treatment per CDC guidance; 2) Improved services for STD clients and their partners including linkages to care; 3) Reduced re-infection; and 4) Increased community and provider knowledge of STD-related treatment, prevention, epidemiology and effective polices. The

¹ Satterwhite CL, et al. Sexually transmitted infections among U.S. women and men: Prevalence and incidence estimates, 2008. *Sex Transm Dis* 2013; 40(3): pp. 187-193

² Centers for Disease Control and Prevention, Sexually Transmitted Disease Surveillance 2011. Atlanta: U.S. Department of Health and Human Services; 2012 <http://www.cdc.gov/std/stats11/toc.htm>

³ *Ibid*

⁴ Regional Health Information: see website for further information

<http://searchhealthit.techtarget.com/definition/Regional-Health-Information-Organization-RHIO>

⁵ <http://www.healthit.gov/providers-professionals/meaningful-use-definition-objectives>

long-term goals are to 1) Reduce the incidence of CT, GC, and syphilis and their respective sequelae; 2) Improve the integration of STD services into clinical care across the healthcare system; 3) Increase access to STD services for those populations most at-risk; and 4) Reduce the threats of antibiotic-resistant GC, other emerging STDs, and congenital syphilis.

Part A of this FOA is Improving Sexually Transmitted Disease Programs through Assessment, Assurance, Policy Development, and Prevention (STD AAPPS). It emphasizes the core public health functions of assessment, assurance, and policy development and focuses on key STD prevention program activities within each of the public health functions. Four priority activities are identified within the core function of assessment: surveillance, monitoring of screening rates, assessing gaps in service, and capacity to address antibiotic resistance to GC, congenital syphilis, and other emerging STD threats. Within the assurance function, three activities are prioritized: screening and treatment; partner services, including linkage to care; and health education and promotion. Three activities are identified within the core public health function of policy development: monitoring and evaluating impact of relevant policies; educating the public, providers and key stakeholders on effective policy approaches; and enhancing collaboration with primary care, as a means to expand access to STD prevention services. Awardees will develop specific plans based on their local epidemiology to achieve the desired outputs and outcomes. They are expected to use continuous quality improvement (QI) methods to evaluate their progress. Ultimately each program awardee will implement a high impact, cost-effective, and sustainable STD prevention program.

Part B of this FOA is the Gonococcal Isolate Surveillance Project (GISP). This competitive project is a collaborative project involving CDC, regional GISP laboratories, and local or state STD programs and their affiliated STD clinic(s) and local public health laboratories. The primary activities are the collection of urethral specimens and epidemiologic data from men attending STD clinics and transport of specimens to the local public health laboratory, which in turn processes and sends the GC isolates to a regional GISP laboratory. The goal of GISP is to establish a scientific basis for the selection of treatment options and allow changes in gonococcal treatment recommendations and practices before widespread treatment failures due to resistance occur.

Number of Awards: Part A- STD AAPPS: 59 awards; Part B- GISP: up to 25 awards. **Eligible Applicants for both Parts A and B:** 50 State public health agencies; Los Angeles, CA; San Francisco, CA; District of Columbia; Chicago, IL; Baltimore, MD; New York City, NY; Philadelphia, PA; Puerto Rico; and the U.S. Virgin Islands. **Approximate Total Project Period Funding:** Part A- STD AAPPS: \$550,000,000; Part B- GISP: \$1,500,000. **Average one year award:** Part A – STD AAPPS: \$1,610,921; Part B- GISP: \$10,000. **Awards will be announced via the Division of STD Prevention’s web link on December 1, 2013.**

Part II. Full Text

A. Funding Opportunity Description

1. Background:

CDC estimates that approximately 20 million new sexually transmitted infections occur each year and that almost half of them are among young people ages 15 to 24.⁶ Three bacterial STDs--CT, GC, and syphilis--are the focus of federally funded STD prevention programs throughout the U.S. In 2011, over 1.3 million cases of CT and 0.3 million cases of GC were reported to the CDC⁷. Untreated CT and GC increase a woman's risk for pelvic inflammatory disease (PID) and infertility. Syphilis remains a major health problem in the South and urban areas. Untreated early syphilis in pregnant women can lead to infection of the fetus in 80% of cases. Untreated bacterial STDs indicate risk for and facilitate the sexual transmission of HIV. These three STDs have effective testing and treatment modalities that make it possible to avoid costly long-term consequences. However, *Neisseria gonorrhoeae*, the causative bacterium in GC, is acquiring resistance to cephalosporins, the last class of antibiotics known to be effective. In addition to the physical and psychological consequences of STDs, these diseases exact a tremendous economic toll; direct medical costs associated with STDs in the United States are estimated to be as much as \$15.6 billion annually.⁸

Certain populations are disproportionately affected by STDs: 1) adolescents and young adults and 2) MSM, with disparities in racial and ethnic minorities in both populations. Even though youth aged 15-24 years represent only 25% of the sexually active population, they acquire nearly half of all new STDs. Because STDs increase the likelihood of acquiring HIV infection, MSM with new STDs are also a priority population for STD prevention programs. Race and ethnicity are not risk factors for STDs but are correlated with other fundamental determinants of health status. For example, stigma, high rates of poverty, income inequality, unemployment, lack of health care coverage and low educational attainment can make it more difficult for individuals to protect their sexual health. In communities where STD prevalence is higher, individuals may have a more difficult time reducing their risk for infection. With each sexual encounter, they face a greater chance of encountering an infected partner than those in lower prevalence settings.⁹

Changes in the health care delivery system require STD programs to adopt new strategies. The ACA is anticipated to expand health insurance coverage to 14 million currently uninsured individuals in 2014 and to 25 million by 2018.¹⁰ The ACA also provides \$11 billion over five years

⁶Satterwhite CL, et al. Sexually transmitted infections among U.S. women and men: Prevalence and incidence estimates, 2008. *Sex Transm Dis* 2013; 40(3): pp. 187-193

⁷ Centers for Disease Control and Prevention, Sexually Transmitted Disease Surveillance 2011. Atlanta: U.S. Department of Health and Human Services; 2012 <http://www.cdc.gov/std/stats11/toc.htm>

⁸ Owusu-Edusei K, Chesson HW, Gift TL, et al. The estimated direct medical cost of selected sexually transmitted infections in the United States, 2008. *Sexually Transmitted Diseases*. 40(3):197-201, March, 2013

⁹ Centers for Disease Control and Prevention, Sexually Transmitted Disease Surveillance 2011. Atlanta: U.S. Department of Health and Human Services; 2012 <http://www.cdc.gov/std/stats11/toc.htm>

¹⁰ CBO's May 2013 Estimate of the Effects of the Affordable Care Act on Health Insurance Coverage. http://www.cbo.gov/sites/default/files/cbofiles/attachments/44190_EffectsAffordableCareActHealthInsuranceCoverage_2.pdf

to increase the capacity of community health centers (CHCs). These changes in the health care system are predicted to significantly increase the proportion of insured individuals and to shift some vulnerable and at risk populations (traditionally part of STD safety net services) to an expanded network of primary care providers, such as community health centers, and patient-centered medical homes.¹¹

The ACA has also expanded coverage of STD preventive services. Since 2010, the ACA required non-grandfathered private health plans to provide coverage without cost-sharing for preventive services rated A or B by the U.S. Preventive Services Task Force (USPSTF)¹², recommended by the Advisory Committee on Immunization Practice (ACIP), or included in the Health Resources and Services Administration (HRSA)'s Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents¹³ or Women's Preventive Services: Required Health Plan Coverage Guidelines.¹⁴ These services include CT screening for females ages younger than 25 years; prenatal screening for syphilis, GC, CT, HIV and hepatitis B; behavioral counseling and syphilis, GC, and CT screening for high risk individuals; HIV screening for individuals ages 15-65 and human papillomavirus (HPV) and hepatitis B vaccines.¹⁵

A 2012 report of the Institute of Medicine entitled "Primary Care and Public Health: Exploring Integration to Improve Population Health" stresses the need for better collaboration between public health and primary care settings to ensure a broader reach of prevention services, avoid duplication of services, and maximize the use of limited resources.¹⁶ The report identifies a set of core principles derived from successful integration models that incorporate traditional public health services in the overall health care delivery system – including a common goal of improving population health, as well as involving the community in defining and addressing its needs. Increasingly, STD programs must work with primary care settings to assure quality STD prevention services are delivered as public health programs play a fundamental role in creating healthy communities. To be successful, STD programs must partner with other federally funded prevention programs (especially HIV/AIDS, viral hepatitis, immunization and teen pregnancy prevention programs) to develop integrated prevention packages for primary care.

Finally, investments in health information technology (HIT) present an unprecedented opportunity for STD programs to capture important epidemiological, clinical, social and

¹¹ Hall, Mark A., and Rosenbaum, Sara. The Health Care "Safety Net" in a Post-Reform World. New Brunswick: Rutgers UP, 2012. Print.

¹² <http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm>

¹³ http://brightfutures.aap.org/pdfs/BF3%20pocket%20guide_final.pdf

¹⁴ <http://www.hrsa.gov/womensguidelines/>

¹⁵ Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, 124 Stat. 119, amended by Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (codified as amended in scattered sections of 42 U.S.C.).

¹⁶ Institute of Medicine. 2012. Primary Care and Public Health: Exploring Integration to Improve Population Health. Washington, DC. The National Academies Press.

behavioral data through linkage with electronic health records (EHRs) and regional health information organizations.¹⁷ Electronic laboratory reporting (ELR) potentially provides a rich source of information for more rapid and thorough monitoring of disease incidence burden. Health departments will need to invest in the information technologies necessary to receive these data, conduct the necessary procedures to de-duplicate and verify records, integrate disease reporting across platforms, and develop the analytical capacity to demonstrate meaningful use of data¹⁸ for public health action.

For all of these reasons, STD programs increasingly need to focus on activities that are directed to population health. They need to forge public/private partnerships and monitor the use of health care services, rather than focusing solely on providing direct services and individual-level interventions. STD programs must become leaders in the core public health functions of assessment, assurance and policy.

a. Statutory Authorities:

This program is authorized under Section 318 (a) (b) (c) of the Public Health Service Act [42 U.S.C. Section 247c (a) (b) and (c)], as amended.

b. Problem Statement:

Part A- STD AAPPs: In the face of an ongoing STD syndemic with adverse outcomes that contribute to health disparities, the changing health care landscape and information technology advances present opportunities and challenges to improve STD prevention programs in the US. High prevalence in geographic areas and populations (adolescents and young adults and MSM including racial/ethnic minorities among these populations) exacerbate the negative health effects of STDs. Emerging antibiotic resistance of GC presents a major threat. Cases of congenital syphilis are sentinel events reflecting a failure of the public health and health care system. Consequently, STD programs must have the public health capability (e.g. surveillance, epidemiology, disease investigation, laboratory, policy and communication) to employ different packages of interventions (e.g. screening and treatment, partner services including outreach and linkage to care, and health promotion) depending on the STD epidemic phase and context to address this significant population health problem.¹⁹

Part B- GISP: Prevention and control of GC relies on prompt and effective antibiotic treatment, but effective treatment is challenged by the ability of *N. gonorrhoeae* to mutate and develop resistance to antibiotics. To keep pace with the emergence of new resistance patterns and

¹⁷ Promotion of Health Information Technology 2009, Pub. L. No. 111–5, Stat. 227

¹⁸ <http://www.healthit.gov/providers-professionals/meaningful-use-definition-objectives>

¹⁹ Wasserheit, J.N. and Aral, S.O. 1996. The Dynamic Typology of Sexually Transmitted Disease Epidemics: Implications for Prevention Strategies. *Journal of Infectious Diseases* 174 (Suppl 2); S201-13.

support effective treatment, surveillance of gonococcal antibiotic susceptibility is necessary. This surveillance informs national GC treatment recommendations.

c. Healthy People 2020:

This FOA addresses the Healthy People 2020 focus area of Sexually Transmitted Diseases. It also addresses Access to Quality Health Services; Cancer; HIV Infection; Immunization and Infectious Diseases; Maternal, Infant and Child Health; and Public Health Infrastructure.

http://www.cdc.gov/nchs/healthy_people/hp2020.htm.

d. Other National Public Health Priorities and Strategies:

This FOA addresses the CDC Health Protection Goals of healthy people in every stage of life, and healthy people in healthy places. This FOA supports CDC's strategic priorities of: 1) excellence in surveillance, epidemiology, and laboratory services and 2) strengthening support for state, tribal, local, and territorial public health:

<http://www.cdc.gov/stltpublichealth/Strategy/index.html>. It also addresses CDC's "Global Winnable Battle" to eliminate congenital syphilis: <http://www.cdc.gov/winnablebattles/Mother-to-ChildTransmission/>; the National Prevention Strategy:

<http://www.surgeongeneral.gov/initiatives/prevention/strategy/report.pdf>; the National HIV/AIDS Strategy: <http://aids.gov/federal-resources/national-hiv-aids-strategy/nhas.pdf>; and the National Partnership for Action to End Health Disparities:

<http://minorityhealth.hhs.gov/npa/>.

Priorities of the National Centers for HIV/AIDS, Viral Hepatitis, STD and TB Prevention

(NCHHSTP): This FOA is in alignment with performance goals for NCHHSTP: 1) reduce the rate of non-HIV STDs; 2) reduce the rate of new HIV infections; and 3) reduce the rates of viral hepatitis. This FOA supports NCHHSTP imperatives calling for Program Collaboration and Service Integration (PCSI) and Prevention through Healthcare (PTH). PCSI and PTH promote improved integrated HIV, viral hepatitis, STD, and TB prevention and treatment services at the client level through enhanced collaboration at the health care service delivery level. This FOA also supports NCHHSTP imperatives of Health Equity (HE) and Sexual Health (SH) by defining program goals and strategies to eliminate health disparities and promote a wellness framework. The SH framework emphasizes the importance of health promotion to support and enhance core public health disease control and prevention efforts addressing HIV, STD, viral hepatitis, teen and unplanned pregnancy, and sexual violence. It has the potential to engage diverse partners, to normalize dialogue regarding sexuality and sexual health, enhance efficiency and effectiveness of prevention messages and services and to reduce the fear, discrimination, and stigma often associated with STDs including HIV. <http://www.cdc.gov/nchhstp>

This FOA addresses the strategic goals of the Division of STD Prevention, including reducing the burden of STDs among adolescents and young people and MSM; addressing the threat of

antibiotic-resistant *N. gonorrhoeae* and the capacity to respond to other emerging STD threats; and eliminating congenital syphilis in the United States: <http://www.cdc.gov/std/dstdp>.

e. Relevant Work:

Part A- STD AAPPs: This FOA builds on significant past STD prevention programmatic and scientific efforts by prioritizing the use of evidence-based or practice-based strategies or interventions. (See Program Tools: <http://www.cdc.gov/std/program/default.htm>.) Through on-going review of existing literature, the Division of STD Prevention has begun to catalogue “promising practices” or practice-based STD prevention strategies that, if implemented, will require a robust evaluation component to build the evidence for effectiveness. In addition, DSTDP is pioneering a program science approach to working with programs. This approach engages program leaders and scientists in developing the evidence needed for the optimal packaging of interventions by epidemic phase, in the context of social determinants of health (SDH), sexual health (SH), and workforce capacity and in strengthening program assessment and outcome evaluation.²⁰

Part B- GISP: This section of the FOA builds on the epidemiological, laboratory-based, and programmatic knowledge provided by GISP during the past 25 years.

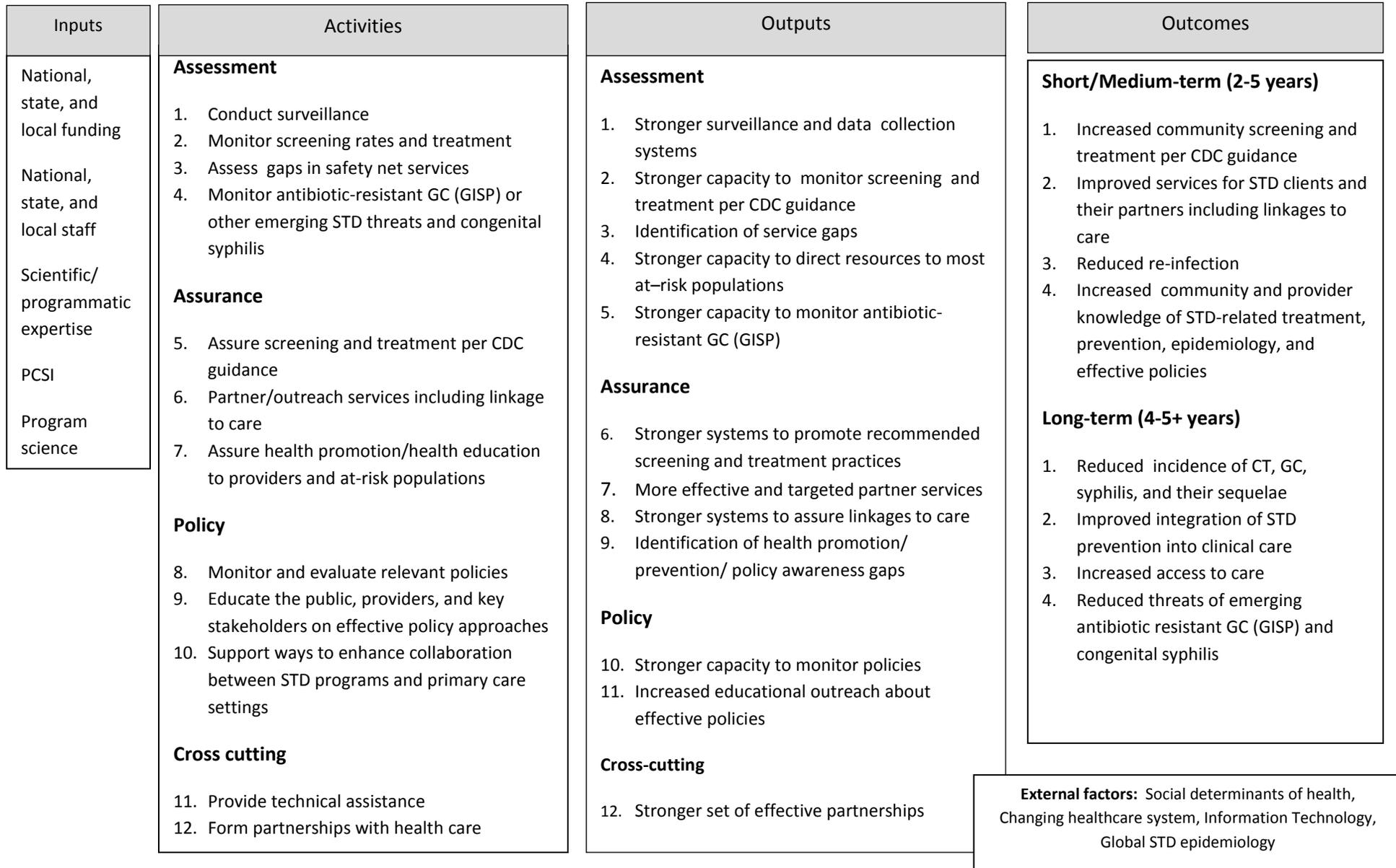
2. CDC Project Description

a. Approach:

The following Logic Model is a graphic representation of the FOA’s general approach (Figure 1). It depicts how awardees’ activities will directly result in a series of outputs, which in turn will contribute significantly to positive health outcomes for both project areas and the nation as a whole. Various factors influence these pathways, including the availability of key resources or inputs such as funding and scientific/ technical expertise, as well as external factors well beyond the control of awardees, such as the social determinants of health and the changing healthcare system.

²⁰ Blanchard, J.F. and Aral, S.O. 2010. Program Science: an initiative to improve the planning, implementation and evaluation of HIV/sexually transmitted infection prevention programmes. *Sexually Transmitted Infections* 2012 87:2-3.

Figure 1: 2014 STD AAPPS Logic Model



i. Purpose:

Part A- STD AAPPs: The purpose of this five year FOA is to strengthen STD prevention programs for eligible jurisdictions in order to reduce the burden of STDs in the United States. To maximize the reach, impact, efficiency and sustainability of STD prevention programs to achieve optimal population health, this FOA seeks to leverage aspects of the evolving health care system. Accordingly, this FOA emphasizes the core public health functions of assessment, assurance, and policy development in the context of the four national STD program priorities: 1) preventing STDs among adolescents and young adults; 2) preventing STDs among MSM; 3) monitoring emergence of antibiotic-resistant GC; and 4) eliminating congenital syphilis. The FOA establishes specific activities, outputs and evidence-based interventions, and calls for robust evaluation plans that include meaningful performance and outcomes measures. These priorities and activities may change during the five year project period based on scientific advancements, epidemiological trends and emerging patterns of resistance or other STD threats, so programs must be able to modify strategies to address emerging issues in their jurisdictions, if needed.

PART B- GISP: The Gonococcal Isolate Surveillance Project (GISP) monitors trends in antimicrobial susceptibilities of strains of *N. gonorrhoeae* in the United States to establish a scientific basis for the selection of treatment options and allow changes in gonococcal treatment recommendations and practices before widespread treatment failures due to resistance occur.

ii. Outcomes:

Part A- STD AAPPs: National project period outcomes are based on current epidemiology and trends, and the need to strengthen STD programs' role in core public health functions. These outcomes may be altered as threats to STD prevention and control emerge. By the end of this five year project period the following primary outcomes will be achieved: 1) Increased community screening and treatment per CDC guidance (e.g., more sexually active young women ages 15-24 screened for CT and more MSM screened for STDs); 2) Improved services for STD clients and their partners including linkages to care (e.g., more HIV-syphilis and HIV-GC co-infected clients and HIV infected partners identified and linked to appropriate HIV care); 3) Reduced re-infection (e.g., in CT, GC, and syphilis, through partner services and appropriate treatment); and 4) Increased community and provider knowledge of STD-related treatment, prevention, epidemiology and effective policies. The long-term goals are to: 1) Reduce the incidence of CT, GC, and syphilis and their respective sequelae; 2) Improve the integration of STD services into clinical care across the healthcare system; 3) Increase access to STD services for those populations most at-risk and 4) Reduce the threats of antibiotic-resistant GC, other emerging STDs, and congenital syphilis.

Part B- GISP: By the end of the five year project period, the following outcomes will be achieved: 1) Improve GC antibiotic resistance surveillance and data collection systems to assess national rates of antibiotic-resistant GC and inform national treatment recommendations; and

2) Maintain a CDC GISP isolate reference specimen bank to facilitate quality antimicrobial susceptibility testing capacity and GC diagnostic and therapeutic development.

iii. Program Strategy:

The CDC approach for the STD AAPPS FOA includes developing priority program strategies, including public health capabilities and interventions, to achieve the project period outcomes, and providing inputs in the form of funding resources to support awardees' personnel, equipment, supplies and contracts needed to support the programmatic strategies that are to address the priority STDs in the populations of significance, according to local epidemiology and health care environment in their project area.

There are two components to the FOA. **Part A– STD AAPPS:** this component comprises the bulk of the FOA and is the flagship federal cooperative agreement for national STD prevention and control in the United States. **Part B– GISP:** the GISP component funds health departments with a STD clinic and public health laboratory to obtain and transport specimens to reference laboratories to monitor emerging antimicrobial resistance to GC.

Program Strategy: Part A– STD AAPPS

The overarching strategy is displayed in the logic model (Figure 1). The logic model focuses on key STD prevention program activities within each of the public health functions of assessment, assurance and policy development. This FOA relies on the premise that the activities and outputs of awardees are critical catalysts for achieving the program's short-term and long-term outcomes. Under this program, awardees will further strengthen their capacity and position within their healthcare landscape to influence other health care providers, community members, at-risk populations, and other stakeholders to reach these outcomes. In the project period, awardees are expected to achieve the stated outputs and show significant gains in the short/medium-term outcomes outlined above.

Awardees should implement activities/interventions that are prioritized based on the epidemiology and the public health needs in the jurisdiction, and aligned with DSTDP high priority populations and diseases. STD evidenced-based and practiced-based interventions are being identified by DSTDP, including those in The Community Guide²¹, and this resource will be updated as additional evidence becomes available. Each awardee will use continuous QI and other program evaluation methods to evaluate their work by measuring the program outputs and outcomes. Ultimately, each awardee will implement high impact, cost-effective, and sustainable STD prevention services that lead to long term outcomes.

²¹ <http://www.thecommunityguide.org/index.html>

This FOA supports a holistic PCSI framework that enables STD prevention programs to more comprehensively address the broader, cross-cutting issues of health and wellness by addressing health equity and advancing public health approaches to improve reproductive and sexual health. Project areas are expected to identify approaches, activities and interventions (including outputs), in the work and evaluation plans to assess, assure and develop policy, using continuous QI, to measure and scale-up the selected prevention interventions to achieve maximum population impact. If the effectiveness of an intervention is unknown, then the intervention must be more rigorously evaluated. Project areas may also identify additional program activities/ interventions beyond those listed in the FOA to support project outcomes as resources permit. As public health and health care evolves and scientific findings and other issues emerge, prioritized activities must be reviewed annually, and adjusted accordingly. STD programs must build core surveillance, assessment, assurance and policy development infrastructure that is flexible and adaptable to changing needs.

The required and suggested program activities are further described below:

I. Assessment:

Assessment is defined as determining community strengths and identifying current and emerging threats to the community's health through regular and systematic surveillance and review of health indicators with public health and health care system partners.²² To put it simply, assessment means measuring the resilience and the problem. Assessment should be managed through surveillance, periodic analyses of service needs, community structure and provision of prevention strategies. Core assessment strategies for STD prevention programs are grouped into four activities: A) conducting surveillance; B) monitoring screening rates; C) assessing gaps in service; and D) monitoring antibiotic-resistant GC, congenital syphilis and other emerging STD threats. At a minimum, in the area of assessment, awardees should achieve the following outputs: 1) Strengthened surveillance and data collection systems (for example, by investing in information technologies and linking to EHRs, HIEs, health plan and Medicaid data); 2) Stronger capacity to monitor screening and treatment per CDC guidance; 3) Identification of service gaps; and 4) Stronger capacity to direct resources to most at-risk populations.

A. Conduct Surveillance:

Surveillance is the ongoing and systematic collection, analysis, interpretation, and dissemination of standardized health data for the purpose of public health action²³. Accurate, timely, and robust notifiable disease surveillance is the backbone of public health and should be used to guide all STD program activities. To be useful, surveillance information must be expanded to include information that will increase our understanding of transmission, sexual and social

²² Institute of Medicine. 1988. The Future of Public Health. Washington, DC: National Academy Press

²³ *Ibid*

networks, syndemics, and healthcare access. Analysis of surveillance data must also be expanded. With the advent of electronic health records (EHRs) and electronic laboratory reporting (ELR), STD programs will need to build an infrastructure that can receive and analyze these data for public health action. **At a minimum, all STD programs must include the following surveillance activities:**

1. Ensure confidentiality and security guidelines for the collection, storage, and use of all surveillance data according to NCHHSTP guidance.²⁴
2. 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.
3. Geocode case-based surveillance data to target interventions to providers serving a high volume of patients with STDs and to populations in geographic areas with high numbers of reported infections.
4. 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.
5. Disseminate surveillance information to affected populations, communities, providers and key stakeholders.

Other suggested activities include:

6. Increase the number of STD cases and surveillance data received through electronic laboratory reports and electronic health records in the surveillance system.
7. Expand surveillance systems beyond case-based reporting to sentinel systems and population-based approaches.

B. Monitor Screening Rates:

The majority of STDs are identified through routine screening rather than through symptomatic or diagnostic testing. Therefore, monitoring of screening rates is particularly important for understanding trends in CT, GC, syphilis, and congenital syphilis. **At a minimum, all STD programs must include the following monitoring activities:**

1. Measure annual CT screening rates among young females (15-24 years) enrolled in Medicaid **plans**, and seen in Title X and other family planning clinics, ideally using the CT HEDIS measure.
2. Measure annual syphilis and rectal GC screening rates among MSM seen in high volume HIV care settings.

²⁴ Data Security and Confidentiality Guidelines for NCHHSTP.
<http://www.cdc.gov/nchhstp/programintegration/docs/PCSIDataSecurityGuidelines.pdf>

Other suggested activities include:

3. Measure annual CT screening rates among young females (15-24 years) enrolled in large health plans, ideally using the CT HEDIS measure.
4. Measure syphilis and rectal GC screening rates among MSM seen in settings providing health care to MSM.
5. In jurisdictions with congenital syphilis: measure screening for syphilis among pregnant females in prenatal care and birthing facilities.

C. Assess Gaps in Safety Net Services:

Due to the ACA, increasing numbers of individuals who traditionally utilize STD safety net services are expected to be linked to ongoing health care through an expanded network of primary care providers and patient-centered medical homes. **At a minimum, all STD programs must partner with others to accomplish these activities:**

1. Determine where uninsured or underinsured, at-risk clients are receiving safety net services.
2. Identify the clinical and prevention service gaps for at-risk individuals who are receiving care (e.g., missed opportunities by providers including safety net providers).

Other suggested activities include:

3. Estimate the proportion of uninsured or underinsured, at-risk individuals in the jurisdiction.

D. Monitor Antibiotic-Resistant Gonorrhea or Other Emerging STD Threats and Congenital Syphilis:

The combination of persistently high GC morbidity in some populations and the threat of cephalosporin-resistant *N. gonorrhoeae* increases the need for laboratory culture and antimicrobial susceptibility testing (AST) capacity to detect resistance. Also programs must target intervention efforts toward highest risk communities to reduce the burden of GC and eliminate health disparities. In addition, building capacity to monitor whether patients with GC are treated appropriately with the most effective treatment regimen is an important component of an effective response to the threat of antibiotic-resistant GC^{25, 26}. **At a minimum, STD programs must accomplish these activities in jurisdictions with high gonorrhea morbidity:**

1. Assess the proportion of GC cases that are treated correctly according to current CDC STD Treatment Guidelines, stratified by provider type.

²⁵ Centers for Disease Control and Prevention. Update to CDC's Sexually Transmitted Diseases Treatment Guidelines, 2010: Oral Cephalosporins No Longer a Recommended Treatment for Gonococcal Infections. MMWR 2012; 61: 590-594. http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6131a3.htm?s_cid=mm6131a3_w

²⁶ Cephalosporin-Resistant Neisseria gonorrhoeae Public Health Response Plan: <http://www.cdc.gov/std/treatment/Ceph-R-ResponsePlanJuly30-2012.pdf>

2. Determine the number of private or public health laboratories in the jurisdiction that have the capacity to conduct *N. gonorrhoeae* culture and AST. Specify the transport/culture media used. If AST is done, specify the method such as disk diffusion (Kirby-Bauer), Etest, or agar dilution.

At a minimum, STD programs must accomplish these activities in jurisdictions with high number of congenital syphilis cases:

3. Assess congenital syphilis cases to determine the epidemiologic and health care factors associated with the cases to inform interventions.

Other suggested activities include:

4. Establish surveillance capacity to detect emerging STD threats.

II. Assurance:

Assurance is defined as addressing current and emerging community health needs and threats through leadership and action with partners; taking necessary and reasonable action through prevention interventions, regulations and enforcement (if authorized for a specific program); evaluating an improvement plan; and providing feedback to the community²⁷. In simpler terms, assurance moves beyond measuring the activity or problem to actively taking steps to improve the activity or reduce or solve the problem. Prevention strategies are an array of interventions used by STD programs to: 1) promote healthy behaviors and prevent the acquisition of STDs; 2) identify and promptly treat infections to prevent further transmission and avoid personal health consequences; 3) identify and treat sexual partners and other individuals at risk for infection; and 4) provide or improve structural conditions that facilitate healthy behavior or prompt treatment. This coheres with a public health framework for action ranging from individual-level interventions for persons in need, to “changing the context” to facilitate healthy behavioral choices²⁸. This FOA does not seek to change the factor with the highest population-level impact (socioeconomics), but measurement of this factor along with other social determinants of health falls within the scope of assurance.

Some public health services are predominately implemented by the health care system (e.g. screening and treatment, high intensity behavioral counseling) and others by the public health system (e.g. field investigation, outbreak response). Project areas are expected to select the most effective prevention interventions for the assurance areas to achieve project period outcomes based on local epidemiology, public health and health care structure in the jurisdiction and resources. STD programs must build a core assurance infrastructure that is

²⁷ Institute of Medicine. 1988. The Future of Public Health. Washington, DC: National Academy Press

²⁸ Frieden, T.R. 2010. A framework for public health action: The health impact pyramid. American Journal of Public Health. 100(4):590-595

nimble so other strategies can be implemented and brought to scale, as needed. At a minimum, in the area of assurance, awardees should achieve the following outputs: 1) Stronger systems to promote recommended screening and treatment practices; 2) More targeted and effective partner services; 3) Stronger systems to assure linkages to care and other services; and 4) Identification of gaps in health promotion/prevention education as well as gaps in policy awareness.

A. Screening and Treatment of Individuals per CDC guidance:

At a minimum, STD programs must address these four priority assurance activities:

1. 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.
2. Provide assistance (at least 13.5 percent of the overall award amount) to non-profit organizations that have demonstrated their ability to provide safety net STD clinical preventive services. This assistance could be used to screen and treat women and their partners for CT and GC to prevent infertility. Note: CDC may reduce the allowable amount (13.5% in year one) that may be used to support safety net services for years 2-5, pending results of a modeling study and STD program survey; yearly reductions will not exceed 1.5%.
3. Increase syphilis and rectal GC screening rates among MSM seen in high volume HIV care settings.
4. Increase the proportion of patients with GC that are correctly treated according to current CDC guidelines in areas of high GC morbidity.

Other suggested activities include:

5. Increase annual CT screening rates among young females seen in large health plans, ideally using the CT HEDIS measure.
6. Increase syphilis and rectal GC screening rates among MSM seen in settings providing health care to MSM.
7. In jurisdictions with congenital syphilis: increase screening for syphilis among pregnant females in prenatal care and birthing facilities

B. Partner Services/Outreach Services and Linkage to Care:

At a minimum, STD programs must accomplish the following:

1. Increase the provision of targeted and effective health department Disease Intervention Specialist (DIS) partner services for:
 - a. Primary and secondary syphilis cases.
 - b. HIV co-infected GC and syphilis cases.

- c. GC cases with possible GC treatment failure or suspected or probable cephalosporin-resistant *N. gonorrhoeae* isolate using the criteria in the Cephalosporin-Resistant *N. gonorrhoeae* Public Health Response Plan.²⁹
2. Link partners contacted who have not been diagnosed previously with HIV who test positive for HIV to care.

Other suggested activities include:

3. Within state law, increase the provision of expedited partner therapy (EPT) for CT and GC according to current CDC treatment guidelines.
4. Increase the provision of effective partner services provided through social media websites and other digital or communication technologies (e.g. internet partner services).
5. Link newly identified HIV-infected individuals in STD clinics to HIV care.
6. Link uninsured or underinsured partners to safety net services.

C. Health Promotion and Prevention Education:

At a minimum, STD programs must accomplish these two priority assurance activities:

1. Maintain a website where surveillance information and basic information about STDs is available to the public, health care providers, health planners and policy makers.
2. Collaborate with other organizations to implement STD health promotion and prevention education activities for safety net or other clinical providers who see at-risk patients.

Other suggested activities include:

3. Collaborate with other organizations to implement STD health promotion and prevention education activities for at-risk populations or communities.
4. Provide and promote the use of high intensity behavioral counseling (HIBC) in clinical settings serving at-risk patients.

III. Policy Development:

Policy development is defined as working with partners to promote and protect the health of the community through formal and informal policies, program guidelines, and environmental changes.³⁰ Policy development is a key function of governmental public health. STD programs are in a unique position to convene key constituencies and partners in promoting the use of a scientific knowledge base in decision-making priorities and policies. As the healthcare system is transformed, it is especially important for STD programs to establish active partnerships with

²⁹ Cephalosporin-Resistant Neisseria gonorrhoeae Public Health Response Plan:

<http://www.cdc.gov/std/treatment/Ceph-R-ResponsePlanJuly30-2012.pdf>

³⁰ Institute of Medicine. 1988. The Future of Public Health. Washington, DC: National Academy Press

healthcare and community-based organizations, to educate the public, providers and other key stakeholders on the potential or proven impacts of policies aimed at reducing sexually transmitted infections. To further these policies, STD programs will also need to use their considerable technical expertise in translating, synthesizing, and packaging of complex scientific information for the public, providers and key stakeholders, including members of the executive branch of state or local governments. With the implementation of the Affordable Care Act, millions of individuals are expected to gravitate to primary care settings. This means that many STD prevention services previously provided in the public sector will increasingly need to be incorporated into routine primary care visits. STD programs will need to partner with HIV, viral hepatitis and reproductive health programs in the development of integrated clinical preventive services for primary care settings.

At a minimum, in the area of policy, awardees should achieve the following outputs: 1) Stronger capacity to monitor and evaluate policies and 2) Increased educational outreach about effective policies. At a minimum, all STD programs must address these three priority policy development activities:

1. Monitor and evaluate impact of relevant policies.
2. Educate public, providers and key stakeholders on the positive potential or proven impacts of policies on reducing sexually transmitted infections.
3. Work with external partners and other agencies within the executive branch of state or local governments to improve access and quality of STD prevention services through enhanced collaboration with primary care.

Program Strategy: Part B- GISP

GISP STD clinics will collect urethral *N. gonorrhoeae* isolates from the first 25 men with gonococcal urethritis seen in the STD clinic each month. Gonococcal isolates will be subcultured from the selective primary medium to a non-inhibitory medium in the local public health laboratory, as described in the GISP protocol. (<http://www.cdc.gov/std/gisp/GISP-Protocol07-15-2010.pdf>) Isolates will be assigned sequential identifiers, frozen and shipped monthly to the assigned GISP Regional reference laboratory for antibiotic susceptibility testing. De-identified specified demographic and clinical data elements associated with each isolate will be collected and electronically submitted to CDC. Participants should maintain adequate specimen handling quality control to maximize isolate viability. These activities should result directly in stronger capacity to monitor antibiotic-resistant GC.

1. Target Populations:

Part A- STD AAPPs: The priority populations of this FOA are adolescents and young adults and MSM, including racial and ethnic minorities among these populations. Thus, plans must clearly explain how the project area will allocate resources to serve adolescents and young adults and

MSM at the greatest STD risk in their project areas to achieve the greatest health impact and reduce health disparities. Additionally, they should describe how additional data such as geography and SDH will be used to allocate resources for the most cost-effective impact. Project areas should describe a minimum prevalence threshold by which CT and GC screening activities for young females will be assessed and assured.

Part B- GISP: GISP applicants are expected to identify men with symptomatic gonococcal urethritis, the target population of this component of the FOA, including racial, ethnic, and sexual minorities seen in categorical STD clinics for the purposes of GC surveillance. Surveillance of antibiotic susceptibility among gonococcal isolates from women and from extragenital sites among MSM may be conducted, if additional resources are available in the future.

2. Inclusion:

Among the target populations identified above, applicants should strive to be inclusive with regards to uninsured or underinsured populations, transgender populations, people with limited health literacy, non-English or limited English speaking populations, people with disabilities, or other vulnerable people in the target population that may otherwise be missed by the program. Applicants should propose specific strategies to reach these populations.

3. Collaborations:

Under this program, awardees are expected to achieve a stronger set of effective partnerships. Collaborations and partnerships are crucial to implement program interventions and sustain outcomes. They allow for more efficient use of existing resources and exchange of information between experts working in various areas of public health, health care and other sectors. Use of evidence-based collaboration models (e.g. PRECEDE/PROCEED model³¹ or Mobilizing for Action through Planning and Partnerships [MAPP]³²) are encouraged, as appropriate. STD programs must foster mutually beneficial strategic relationships with other individuals, organizations, and networks that strengthen STD prevention and control, producing solutions that no individual entity working independently can accomplish. Applicants must describe how they will collaborate with CDC funded programs in their project area as well as with organizations external to CDC, such as Medicaid programs, health plans, primary care settings, safety-net providers, not-for-profit clinics, correctional settings, community-based organizations, tribal communities, academic experts and others in their project area. Memoranda of Understanding (MOUs)/ Memoranda of Agreement (MOAs) are not required for the FOA but are strongly recommended if the project area determines formalization of collaboration is needed with an

³¹ Green, Lawrence W. and Marshall W. Kreuter. Health Program Planning: An Educational and Ecological Approach. New York: McGraw-Hill, 2005. Print.

³² <http://www.naccho.org/topics/infrastructure/mapp/index.cfm?c=1369771180628>

organization. If a project area chooses to develop MOUs/MOAs they can be submitted as attachments.

a. With CDC-Funded Programs:

Part A- STD AAPPs: Applicants must develop a plan and timeline for working with other relevant CDC-funded programs in their jurisdiction that are targeting the same populations. At a minimum, applicants must develop a plan and timeline for working with HIV prevention programs on integrating STD and HIV data; integrating and enhancing STD screening among populations at risk for STDs and HIV such as populations receiving pre-exposure prophylaxis (PreP) or other HIV prevention interventions; integrating STD and HIV partner services; and implementing targeted condom distribution programs. Applicants must also collaborate with those funded by the Division of Adolescent School Health (DASH). **DASH provides a list of funded national, state, local, territorial, & tribal programs, and non-governmental organizations at: <http://www.cdc.gov/healthyyouth/partners/index.htm>.** Other partners that STD programs should collaborate with include those funded by 1) the Division of Viral Hepatitis, 2) the Division of TB Elimination, and 3) the Immunization Services Division.

To facilitate program collaboration and service integration, funds can be used to hire a part-time PCSI coordinator and PCSI data analyst who can be placed in the organizational structure so they have the authority to influence PCSI activities. If a PCSI coordinator and/or PCSI data analyst is proposed, the placement of the position should be described and highlighted in the organization chart that is to be submitted as one of the required attachments.

Part B- GISP: Applicants should describe their plans to transport isolates to a CDC-funded GISP regional reference laboratory and work closely with the GISP reference laboratory to achieve timely transport of viable and non-contaminated isolates.

b. With organizations external to CDC:

Part A- STD AAPPs: 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.

In addition, applicants must partner with and are strongly recommended to fund organizations external to health departments that have access to target populations, especially community-based organizations, including not-for-profit clinics working with adolescents and young adults and MSM. Applicants must describe how they propose to include and fund these organizations

in the planning and prioritization of activities to ensure that the needs of target populations are addressed. Applicants should also partner with organizations funded by other federal agencies. These include Health Resources Services Administration (HRSA) programs such as a) Ryan White HIV/AIDS programs, b) federally qualified health centers, and c) state maternal and child health programs. Applicants should work with other 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 that STD programs should work with, depending on the needs of the program, 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.

Part B- GISP: N/A

iv. Work Plan:

Part A- AAPPs and Part B- GISP:

Applicants must prepare a detailed work plan for the first year of the award and a high-level plan for subsequent years. CDC will provide feedback and TA to awardees to finalize the work plan post-award. Awardees must update the work plan every budget period, as necessary. The work plan should describe how the project area will implement the proposed STD activities/interventions to meet the national project period outputs and outcomes. The work plan should be tailored by project areas according to local epidemiologic context, public health and health care environment and resources. Selected interventions and activities should be strategically focused and have strong justification. They should be designed for maximum impact on the project area's epidemiology, in terms of disease burden, populations disproportionately affected, health disparities and the specific strategies used. Applicants must develop work plans which focus resources on a few of the highest priority diseases/areas/populations, rather than work plans that disperse resources across the entire jurisdiction.

The work plan must at a minimum include:

1. Activities and timelines to support achievement of FOA outcomes. These activities should be in alignment with the FOA logic model and should have appropriate performance measures for accomplishing tasks.
2. Staff, contracts and administrative roles and functions to support implementation of the award.
3. Administration and assessment processes to ensure successful implementation and quality assurance.

4. Additional contextual information and rationale for proposing the portfolio in year 1 and briefly outline proposed activities for years 2-5.

DSTDP provides a work plan template for this FOA to allow applicants to efficiently describe the basic elements of each activity selected in year 1 of this award (See program tools: <http://www.cdc.gov/std/program/default.htm>.) This template also incorporates aspects of program evaluation planning (e.g., identification of data sources and performance measures), since work plans and evaluation plans are often best developed jointly, to ensure strong alignment. **The work plan is the only attachment that can be submitted on legal-sized paper. Please note that all application attachments must be submitted using a PDF file format, including the work plan, via www.grants.gov.**

Part A- AAPPs:

Applicants are required to describe a work plan for priority assessment, including surveillance; assurance, including prevention interventions and policy development activities. Priority strategies and requirements are identified in Section: Part II. Full Text, A. Funding Opportunity Description, 2. CDC Project Description, a. Approach, iii. Program Strategy.

Assessment:

Surveillance:

At a minimum, applicants must describe plans to implement the five surveillance activities described previously in Section: Part II. Full Text, A. Funding Opportunity Description, 2. CDC Project Description, a. Approach, iii. Program Strategy, I. Assessment, A. Surveillance.

Monitor Screening Rates:

At a minimum, applicants must describe plans to implement the two monitoring screening activities described previously in Section: Part II.A.2.a.iii.I.B. Monitor Screening Rates.

Assess Gaps in Safety Net Services:

At a minimum, applicants must describe plans to demonstrate how they will partner with others to accomplish the two activities to assess gaps in safety net services described previously in Section: Part II.A.2.a.iii.I.C. Assess Gaps in Safety Net Services.

Monitor Antibiotic-Resistant Gonorrhea or Other Emerging STD Threats and Congenital Syphilis:

At a minimum, applicants with jurisdictions with high GC morbidity must describe plans to implement the two monitoring antibiotic-resistant GC activities described previously in Section: Part II.A.2.a.iii.I.D. Monitor Antibiotic-Resistant Gonorrhea or Other Emerging STD Threats and Congenital Syphilis.

At a minimum, applicants with jurisdictions with a high number of congenital syphilis cases must describe plans to accomplish the activity described previously in Section: Part II.A.2.a.iii.I.D. Monitor Antibiotic-Resistant Gonorrhea or Other Emerging STD Threats and Congenital Syphilis.

Assurance:

Screening and Treatment of Individuals per CDC guidance:

At a minimum, applicants must describe plans to address the four priority screening and treatment activities described in Section: Part II.A.2.a.iii.II.A. Screening and Treatment of Individuals per CDC Guidance.

Partner Services/Outreach Services and Linkage to Care:

At a minimum, STD programs must describe plans to implement the two partner services and linkage to care activities described in Section: Part II.A.2.a.iii.II.B. Partner Services/Outreach Services and Linkage to Care.

Health Promotion and Prevention Education:

At a minimum, applicants must describe plans to address the two health promotion and prevention education activities as described in Section: Part II.A.2.a.iii.II.C. Health Promotion and Prevention Education.

Policy:

At a minimum, applicants must describe plans to address the three policy activities as described previously in Section: Part II.A.2.a.iii.III. Policy Development.

Part B- GISP:

Applicants are required to provide a separate work plan based on the AAPPS approach for GISP activities, which includes the plan and timeline for: identifying men with gonococcal urethritis; collecting urethral specimens for culture; handling, storing and shipping isolates; and collecting and electronically submitting demographic and clinical data to CDC.

b. Organizational Capacity of Awardees to Execute the Approach:

Organizational and program management capacity ensures applicants demonstrate the ability to execute the CDC program strategies and meet project period outcomes as outlined in the FOA approach. Where existing organizational and program management capacity is currently insufficient to successfully implement STD AAPPS or GISP activities, awardees must describe detailed and specific hiring, training, workforce development, contracts or other procurement plans and timelines to develop needed capacity within the first year of the project.

i. Organizational Capacity Statement:

Part A- STD AAPPS: Applicants must have 1) the statutory authority to conduct communicable disease (CD) or infectious disease surveillance and investigations in their project area and 2) the organizational structure and capacity to execute the program approach and strategies and meet the project period outcomes. The anticipated level of specific organizational capacity needed to execute the STD AAPPS approach successfully includes capacity in:

- a. Organizational structure and management that supports the STD AAPPS approach.

- b. Public health prevention program leadership.
- c. Surveillance; information technology; epidemiology; program planning, management and evaluation; disease investigation; partner services including linkage to care and outbreak response.
- d. Public health assessment including safety net needs assessments, assurance including continuous QI methods and policy development.
- e. Coalition building and development of strong sustainable, collaborative partnerships between STD prevention programs and other health department programs and other governmental agencies, and a wide array of community, healthcare and academic partners.
- f. Establishment and maintenance of public health accreditation of the health department.

Part B- GISP: Applicants must have the organizational capacity to support and/or operate a STD specialty clinic and a public health laboratory over the course of the project period to execute the program strategies and meet the project period outcomes. The anticipated level of specific organizational capacity needed to execute the GISP approach successfully includes capacity in:

- a. Organizational structure and management that supports the GISP approach.
- b. Clinic and public health laboratory staffing structure and expertise that support the GISP approach.
- c. Surveillance, IT, and epidemiology.

ii. Project Management:

Part A- STD AAPPs: Applicants must have the project management capacity to execute the program approach and strategies and meet the project period outcomes. The anticipated level of specific project management capacity needed to execute the STD AAPPs approach successfully includes capacity in:

- Program and performance management that includes organizational leadership and lines of authority to support the STD AAPPs approach.
- Public health prevention program management.
- Human resource management, including the authority to hire or contract for adequate personnel resources with applicable skills and expertise in a timely fashion, to conduct routine assessments of staff competencies, and to develop a plan to address gaps through staffing plans, organizational and individual training and work force development opportunities.
- Project and financial management including full capability, accountability and expertise to meet deadlines, track funds, submit reports and manage the required procurement efforts including the ability to write and award contracts in accordance with 45 CFR (or 74) in a timely fashion.

Part B- GISP: Applicants must have the project management capacity to execute the program approach, strategies and meet the project period outcomes. The anticipated level of specific project management capacity needed to execute the GISP approach successfully includes capacity in:

- Enrollment of up to 25 men with gonococcal urethritis each month and collection of urethral specimens for culture in the STD clinic.
- Collection and electronic transmission of requested demographic and clinical data elements to CDC.
- Culture isolation of *N. gonorrhoeae*, storage of duplicate isolates in the local public health laboratory and shipment of viable and non-contaminated isolates to a CDC-funded GISP regional reference laboratory.
- Program and performance management structures and expertise that include organizational leadership and support and lines of authority to support the GISP approach.
- Human resource management and financial management to support the GISP approach.

c. Evaluation and Performance Measurement:

Evaluation and performance measurements help demonstrate achievement of program outcomes; build a stronger evidence base for specific program interventions; clarify applicability of the evidence base to different populations, settings, and contexts; and drive continuous program improvement. Evaluation and performance measurement also can determine if program activities are scalable and effective at reaching target populations.

DSTDP's evaluation strategy is grounded in CDC's Evaluation Framework for Public Health (MMWR, September 18, 1999, Vol. 48 / No. RR-11, <http://www.cdc.gov/mmwr/PDF/RR/RR4811.pdf>). See also DSTDP's "Practical Use of Program Evaluation among STD Programs" (<http://www.cdc.gov/std/program/pupestd.htm>). DSTDP also values the concepts and methods of QI, as a process whereby awardees continuously seek ways to improve their services to improve key outcomes. DSTDP endorses the Plan-Do-Study-Act approach as one among others that helps guide this process.³³

i. CDC Evaluation and Performance Measurement Strategy:

During the planning phase of the first year of this award, awardees and CDC's DSTDP will work together to finalize a set of national measures that will be required under this award. National measures will include both output and outcome measures. DSTDP will require baseline data on the highest priority measures from every grantee at the end of the first year of award. DSTDP will provide a system for awardees to report and access the required performance measures

³³ <http://www.ihl.org/knowledge/Pages/HowtoImprove/default.aspx>

and work with awardees to analyze and use the data from their performance measures, as needed.

DSTDP expects that programs will track additional performance, output and outcome measures as part of their own internal program monitoring, management and QI system. DSTDP may request additional measures or additional evaluation study when awardees demonstrate little progress on their key outcomes, to help identify ways to improve the program and outcomes.

During the first year of this award, as awardees develop their own detailed evaluation plans, DSTDP plans to do the same, as part of its effort to better track and assess outputs and outcomes of the FOA as a whole, across project areas. To that end, DSTDP will develop and disseminate annual reports based on performance measures provided by awardees and share best practices related to key outputs and outcomes. DSTDP will use its own evaluation resources to carry out more in-depth evaluation studies in collaboration with project areas, on high priority topics and issues. Project areas are also encouraged to use their own resources under this award to conduct more in-depth or comprehensive evaluation studies, to conduct QI and to further develop the evidence-base for effective programs and practices.

Part A- AAPPS:

Over the course of this award, DSTDP will require awardees to report to CDC a select number of high priority outcome measures on an annual basis. These priorities will include measures related to:

- CT screening, for example:
 - Proportion/number of sexually active females ages 15-24 years who are screened annually for CT in Medicaid programs
 - Proportion/number of uninsured or underinsured sexually active females ages 15-24 years who are screened for CT/GC with DSTDP AAPPS funding support
- Identification of new HIV-infected persons through STD prevention and control efforts, for example:
 - Proportion/number of STD clinic clients who had not been diagnosed with HIV previously who test positive for HIV
 - Proportion/number of partners of individuals co-infected with STDs and HIV who had not been diagnosed with HIV previously who test positive for HIV
 - Among those newly identified HIV-infected individuals, proportion/number who are linked to HIV care
 - Among those partners who are known to be HIV-infected but are not in care, proportion/number who are linked to HIV care

Specific measures for these and other outcomes, as well as for priority outputs, will be developed during the first year of the award with awardees.

Part B- GISP:

To document progress towards achieving GISP project outcomes, awardees are expected to monitor and report on process measures. At a minimum, awardees are expected to monitor and report annually on the following measures:

- Number of cases of gonococcal urethritis diagnosed in men attending the STD clinic.
- Number of isolates submitted to the GISP reference laboratory.
- Percentage of submitted isolates that were found by the GISP reference laboratory to be non-viable or contaminated.
- Percentage of monthly isolate batches shipped to the GISP reference laboratory within one week after the end of monthly collection.
- Percentage of monthly data transmissions that were submitted to CDC within 4 weeks after the end of the month in which the corresponding isolates were collected.
- Percentage of collected isolates for which the following data elements were reported: (a) age, (b) race/ethnicity, (c) gender of sex partner/sexual orientation, (d) HIV status, (e) antibiotic use, and (f) treatment.

In addition, awardees should describe their plans to address challenges faced in enrollment, specimen quality and viability, timeliness of specimen or data transmission, and data completeness.

ii. Applicant Evaluation and Performance Measurement Plan:**Part A- STD AAPPS and Part B- GISP:**

Applicants must provide an overall jurisdiction-/community-specific evaluation and performance measurement plan. Completion of the work plan should help meet this requirement. The work plan template includes fields requesting specific activities and objectives, proposed performance measures and related data sources, and a strong rationale, which may include baseline measures. That information should directly inform the evaluation plans developed in Year 1.

In the narrative portion of the application, the applicant evaluation and performance measurement plan must address the following points:

- Describe how key program partners will be engaged in the evaluation and performance measurement planning processes.
- Describe the types of evaluations to be conducted (i.e. process and/or outcome) and how evaluations will be conducted and reported.
- Describe key evaluation questions to be answered.
- Describe potentially available data sources and feasibility of collecting appropriate evaluation and performance data.

- Describe how evaluation and performance measurement will contribute to development of the program evidence base, where program strategies are being employed that lack a strong evidence base of effectiveness.
- Describe what QI system and resources will be in place to support program improvement over the life of the award.
- Describe how evaluation findings will be used for continuous program and QI.
- Describe other information, as determined by the CDC program (e.g. performance measures to be developed by the applicant) that should be included.

iii. Awardee Evaluation and Performance Measurement Plan:

Part A- STD AAPPS and Part B- GISP

Awardees must provide a more detailed plan within the first year of programmatic funding. This more detailed evaluation and performance measurement plan should be developed by awardees with support from CDC as part of first year project activities. This more detailed evaluation plan will build on the elements stated in the initial plan. At a minimum, and in addition to the elements of the initial plan, it must:

- Describe the methodologies to be used to collect the evaluation and performance data such as sources of data and definitions of measures.
- Describe the frequency that evaluation and performance data are to be collected.
- Describe how data will be reported.
- Describe how evaluation findings will be used for continuous program and QI.
- Describe how evaluation and performance measurement will yield findings to demonstrate the value of the FOA (e.g., impact on improving public health outcomes, effectiveness of FOA, cost-effectiveness or cost benefit).
- Describe dissemination channels and audiences (including public dissemination).
- Describe other information requested, as determined by the CDC program.

In developing evaluation and performance measurement plans, applicants are encouraged to use the following resource: Introduction to Program Evaluation for Public Health Programs: A Self-Study Guide, <http://www.cdc.gov/eval/guide/index.htm>.

d. CDC Monitoring and Accountability Approach:

Part A- STD AAPPS and Part B- GISP:

CDC will monitor cooperative agreement awards in partnership with the funded project area to ensure the mutual success of CDC and the awardees in achieving the FOA project period

outcomes. The funded project area and CDC staff, including PGO Grants Management Officer (GMO)/Grants Management Specialist (GMS), CDC project officer/program consultant and other CDC subject matter experts, will work together to assess and monitor key program capabilities and strategies to determine program performance and impact over time. The work and evaluation plans will guide program improvement activities and be used to ensure programmatic strategies are selected and prioritized for the greatest reach, scalability, and cost efficiency and effectiveness to achieve maximum population health.

Monitoring will occur routinely through ongoing communication between CDC and awardees, such as conference calls, webinars, site visits, meetings and awardees' reporting (including work plans, process and outcome performance measures, and financial reports). Post-award monitoring for cooperative agreements will follow the AAGAM³⁴ and HHS expectations and include:

- Tracking of awardees' progress in achieving the project period outcomes of the award.
- Ensuring the adequacy of awardee systems that underlie and generate data and reports.
- Creating an environment that fosters integrity in program performance and results.
- Ensuring that work plans are feasible based on the budget and consistent with the intent of the award.
- Working with awardees on adjusting the work plan based on achievement of strategies and outcomes, challenges encountered and changing budgets.
- Monitoring performance measures (both programmatic and financial) to ensure satisfactory program performance and improvement levels given timelines.

e. CDC Program Support to Awardees:

Part A- STD AAPPS and Part B- GISP:

The CDC program will provide substantial involvement beyond site visits and regular performance and financial monitoring during the project period. Substantial involvement means that the awardee can expect CDC collaboration or participation in carrying out the effort under the award. CDC will support awardees by providing scientific, programmatic, and evaluation expertise and technical and capacity building assistance; and a program science approach to developing evidence-based practices and implementing high impact, cost-effective and efficient STD prevention programs. (See logic model, Figure 1). The CDC program will work in partnership with the awardees to ensure a shared responsibility for the successful implementation of the cooperative agreement and attainment of the project period outcomes. Areas of substantial CDC involvement include:

i. Technical Assistance:

³⁴ <http://www.hhs.gov/asfr/ogapa/aboutog/index.html>

- Support awardees in implementing the core public health function requirements of the cooperative agreement, selecting or prioritizing prevention intervention/activities and meeting identified outcomes.
- Provide technical assistance (TA) to develop and implement the annual work, evaluation and performance measurement plans.
- Provide CDC or other subject matter experts to assist awardees in technical areas such as surveillance, IT, informatics, program evaluation and measurement, continuous QI methods, community engagement and collaboration models and the integration of public health and primary care to advance the reach, scale, effectiveness and efficiency of STD program activities to achieve outcomes.
- Provide CDC or other subject matter experts to assist awardees with a program science approach to program strategy selection, implementation and adaptation.
- Assist awardees with enhancing health department workforce capacity and infrastructure by providing training and TA around skills assessment, core competencies and workforce development.
- Disseminating current knowledge and information, including surveillance, epidemiologic, behavioral, and health care services data, and scientific advances in STD prevention.
- Provide STD clinical and laboratory consultation and STD reference diagnostic services.
- Support and facilitate activities relevant to Program Collaboration and Service Integration (PCSI), Sexual Health (SH), Prevention through Healthcare (PHC) and Health Equity.
- Coordinate communication and program linkages with other CDC programs and federal agencies, mainly CDC's DHAP, DASH, DVH, and Immunization Program and DHHS's OAH, OPA and HRSA Programs.

ii. Information Sharing between Awardees:

- Facilitate sharing of best and promising practices, lessons learned, challenges and innovations among awardees by using webinars and other media (e.g., phConnect) for partners and CDC to communicate and share.
- Support peer to peer TA and capacity building.
- Facilitate dissemination of evidence- and practice-based interventions, through publications, guidelines and meetings.
- Convene relevant CDC meetings, committees, conference calls, and working groups related to the cooperative agreement activities and requirements to achieve proposed outcomes.
- Key STD program staff are required to attend one bi-annual STD Prevention Conference and one annual awardee meeting including 1-2 staff for small project areas, 2-3 for medium sized areas and 3-4 for larger project areas for Part A-STD AAPPs and 1-2 staff for Part B-GISP sites. FOA budgets should include travel for staff to attend these meetings.
- Key STD program staff are encouraged to participate in other national and regional meetings and training workshops related to STD prevention and control such as those sponsored by the National Coalition of STD Directors (NCSD), Council of State and Territorial

Epidemiologists (CSTE), Association of Public Health Laboratories (APHL) and the National Network of STD/HIV Prevention Training Centers (NNPTCs) to more effectively and efficiently implement and manage cooperative agreement strategies over the project period.

B. Award Information

- 1. Type of Award:** Cooperative Agreement - New-Type 1. CDC substantial involvement in this program appears in the CDC Program Support to Awardees Section.
- 2. Award Mechanism:** H25 Venereal Disease
- 3. Fiscal Year 1:** 2014
- 4. Approximate Total Fiscal Year 1 Funding:** For Part A: \$110,000,000; For Part B: \$300,000. (subject to the availability of funds)
- 5. Approximate Total Project Period Funding:** For Part A: \$550,000,000 and for Part B \$1,500,000 for the project period of 5 years. (subject to the availability of funds)
- 6. Approximate Number of Awards:** For Part A: 59; For Part B: 25
- 7. Approximate Average Award for Fiscal Year 1:** For Part A: \$1,610,921; For Part B: \$10,000. (subject to the availability of funds)
- 8. Floor of Individual Award Range:** For Part A: \$164,653; For Part B: \$5,000. (subject to the availability of funds)
- 9. Ceiling of Individual Award Range:** For Part A: \$7,251,076; For Part B: \$25,000. (subject to the availability of funds)

Part A- AAPPS:

- i. STD funds are allocated as follows, by project area:
 - a. 50% based upon state, territorial, or city population aged 15-44 years.
 - b. 50% based upon disease burden, broken out by:
 - 80% based on the number of reported cases of STDs from 2007-2011 (primary and secondary (P&S) syphilis, GC, and CT).
 - 20% based on rates of reported STDs from 2007-2011 (primary and secondary (P&S) syphilis, GC, and CT).
 - Resources vary for health department follow-up on different STDs, so these disease burden allocations were weighted by STD as follows:
CT = 1; GC = 4.4; P&S Syphilis = 107.6
- ii. For the total amounts by project area, the following limits are applied:
 - a. Two caps on losses were applied:

- 25% loss, applied evenly over the five year period (i.e. loss of 5% per year).
 - If 25% loss exceeds \$1 million, cap of \$1 million, applied evenly over the five year period (i.e. loss of \$200,000 per year).
 - Gains were capped at \$500,000 per grantee, applied evenly over the five year period (i.e. gain of \$100,000 per year).
- iii. Funding increases or decreases per grantee will be proportional each of the consecutive years of the cooperative agreement.
- iv. GISP award per year is stable and amounts are not included in the formula.

Part A- AAPPS:

Jurisdiction	Floor of Individual Award Range Year 1	Ceiling of Individual Award Range Year 1	Average Award Year 1
Alabama	\$1,668,612	\$1,919,801	\$1,794,207
Alaska	\$367,449	\$422,764	\$395,107
Arizona	\$1,300,414	\$1,496,175	\$1,398,294
Arkansas	\$1,100,646	\$1,266,335	\$1,183,490
Baltimore, MD	\$1,236,216	\$1,422,314	\$1,329,265
California	\$5,126,092	\$5,897,762	\$5,511,927
Chicago, IL	\$1,997,534	\$2,298,238	\$2,147,886
Colorado	\$1,021,325	\$1,175,073	\$1,098,199
Connecticut	\$703,366	\$809,249	\$756,307
Delaware	\$336,302	\$386,928	\$361,615
District of Columbia	\$1,055,523	\$1,214,418	\$1,134,971
Florida	\$4,074,137	\$4,687,448	\$4,380,793
Georgia	\$3,396,558	\$3,907,868	\$3,652,213
Hawaii	\$343,446	\$395,147	\$369,297
Idaho	\$359,716	\$413,867	\$386,792
Illinois	\$2,006,811	\$2,308,912	\$2,157,862

Indiana	\$1,571,857	\$1,808,481	\$1,690,169
Iowa	\$674,395	\$775,916	\$725,156
Kansas	\$727,970	\$837,557	\$782,764
Kentucky	\$895,703	\$1,030,539	\$963,121
Los Angeles, CA	\$3,244,150	\$3,732,517	\$3,488,334
Louisiana	\$2,038,070	\$2,344,876	\$2,191,473
Maine	\$264,783	\$304,643	\$284,713
Maryland	\$1,180,148	\$1,357,804	\$1,268,976
Massachusetts	\$1,416,554	\$1,629,799	\$1,523,176
Michigan	\$2,457,086	\$2,826,970	\$2,642,028
Minnesota	\$982,197	\$1,130,055	\$1,056,126
Mississippi	\$1,275,857	\$1,467,922	\$1,371,889
Missouri	\$1,800,497	\$2,071,539	\$1,936,018
Montana	\$257,752	\$296,554	\$277,153
Nebraska	\$409,806	\$471,497	\$440,652
Nevada	\$650,856	\$748,834	\$699,845
New Hampshire	\$253,172	\$291,284	\$272,228
New Jersey	\$2,717,112	\$3,126,139	\$2,921,626
New Mexico	\$664,227	\$764,218	\$714,223
New York	\$2,493,876	\$2,869,298	\$2,681,587
New York City, NY	\$5,575,906	\$6,415,290	\$5,995,598
North Carolina	\$2,659,681	\$3,060,063	\$2,859,872
North Dakota	\$221,266	\$254,575	\$237,920
Ohio	\$2,961,053	\$3,406,803	\$3,183,928

Oklahoma	\$1,031,228	\$1,186,467	\$1,108,848
Oregon	\$879,624	\$1,012,040	\$945,832
Pennsylvania	\$1,887,030	\$2,171,099	\$2,029,064
Philadelphia, PA	\$2,143,914	\$2,466,654	\$2,305,284
Puerto Rico	\$1,191,780	\$1,371,188	\$1,281,484
Rhode Island	\$345,940	\$398,017	\$371,979
San Francisco, CA	\$1,286,020	\$1,479,615	\$1,382,818
South Carolina	\$1,437,002	\$1,653,325	\$1,545,164
South Dakota	\$251,435	\$289,286	\$270,361
Tennessee	\$2,029,856	\$2,335,425	\$2,182,641
Texas	\$5,948,390	\$6,843,846	\$6,396,118
Utah	\$453,405	\$521,659	\$487,532
Vermont	\$164,653	\$189,439	\$177,046
Virgin Islands	\$171,378	\$197,177	\$184,278
Virginia	\$1,756,455	\$2,020,868	\$1,888,662
Washington	\$2,163,172	\$2,488,811	\$2,325,992
West Virginia	\$596,665	\$686,486	\$641,576
Wisconsin	\$941,173	\$1,082,854	\$1,012,014
Wyoming	\$224,005	\$257,726	\$240,866

10. Anticipated Award Date: January 1, 2014

11. Budget Period Length: 12 Months

12. Project Period Length: 5 Years

Throughout the project period, CDC's commitment to continuation of awards will be conditioned on the availability of funds, evidence of satisfactory progress by the awardee (as documented in required reports), and the determination that continued funding is in the best interest of the Federal government. This does not constitute a commitment by the Federal government to fund the entire period. The total project period comprises the initial competitive segment, any subsequent competitive segments resulting from a competing continuation award(s), and any no-cost or low-cost extension(s).

13. Direct Assistance:

Direct assistance (DA), for personnel only, is available through this FOA.

An applicant from an official state, Tribal Nation, local, or territorial organization may request that the Centers for Disease Control and Prevention (CDC) or Agency for Toxic Substances Disease Registry (ATSDR) provide direct assistance (DA) in the form of Federal personnel as a part of the grant awarded through this funding opportunity announcement. If your request for direct assistance is approved as a part of your award, CDC or ATSDR may reduce the amount of funding provided directly to you as a part of your award. The amount by which your award is reduced to provide DA shall be deemed as part of the award and shall be deemed to have been paid to you, the awardee. For further information on direct assistance, visit:

http://www.cdc.gov/stltpublichealth/GrantsFunding/direct_assistance.html

C. Eligibility Information

1. Eligible Applicants: For Parts A- STD AAPPS and Part B- GISP

Eligible public health agencies include all 50 states; Los Angeles, CA; San Francisco, CA; District of Columbia; Chicago, IL; Baltimore, MD; New York City, NY; Philadelphia, PA; Commonwealth of Puerto Rico; and the U.S. Virgin Islands or their Bona Fide Agents. A Bona Fide Agent is an agency/organization identified by the state or local government as eligible to submit an application under the state or local eligibility in lieu of a state application. If applying as a bona fide agent of a state or local government, a legal, binding agreement from the state or local government as documentation of the status is required.

2. Special Eligibility Requirements: N/A

3. Justification for Less than Maximum Competition:

In order to provide a coordinated and complete public health approach to STD prevention, the funded entity must already have in place the necessary public health infrastructure. Existing infrastructure must be focused on STD-specific prevention approaches having experience with successfully completing the required functions. The selected cities chosen for eligibility (Baltimore, Chicago, Los Angeles, New York, Philadelphia, San Francisco, and Washington, DC) are the top 7 cities for overall primary and secondary syphilis cases, GC cases, and CT cases for years 2006 to 2010 combined. The selection factor was the burden of reportable STDs.

Specifically, cities were considered to be eligible based on disease burden if they reported at least 500 primary and secondary syphilis cases, at least 10,000 GC cases, and at least 20,000 CT cases for years 2006 to 2010 combined. This limited eligibility justification was approved on January 14, 2013.

4. Other: N/A

5. Cost Sharing or Matching:

Cost sharing or matching funds are not required for this program. Although there is no statutory match requirement for this FOA, leveraging other resources and related ongoing efforts to promote sustainability is strongly encouraged.

6. Maintenance of Effort:

Maintenance of Effort is not required for this program.

D. Application and Submission Information

1. Required Registrations: There are a total of three registrations needed to submit an application on www.grants.gov.

a. Data Universal Numbering System: All applicant organizations must obtain a Dun and Bradstreet (D&B) Data Universal Numbering System (DUNS) number as the Universal Identifier when applying for Federal awards or cooperative agreements. The DUNS number is a nine-digit number assigned by Dun and Bradstreet Information Services. An Authorized Organization Representative (AOR) should be consulted to determine the appropriate number. If requested by telephone, a DUNS number will be provided immediately at no charge. If requested via the internet, obtaining a DUNS number may take one to two days at no charge. If your organization does not know its DUNS number or needs to register for one, visit Dun & Bradstreet at <http://fedgov.dnb.com/webform/displayHomePage.do>. An AOR should complete the US D&B D-U-N-S Number Request Form online or contact Dun and Bradstreet by telephone directly at 1-866-705-5711 (toll-free) to obtain one. This is an organizational number. Individual Program Directors do not need to register for a DUNS number.

If funds are awarded to an applicant organization that includes sub-awardees, sub-awardees' must provide their DUNS numbers prior to accepting any sub-awards.

b. System for Award Management: All applicant organizations must register in the System for Award Management (SAM), prior to registering on www.grants.gov. The SAM is the primary registrant database for the Federal government and is the repository into which an entity must provide information required for the conduct of business as an awardee. The SAM number must be maintained with current information at all times during which it has an application under consideration for funding by CDC, and if an award is made, until a final financial report is submitted or the final payment is received, whichever is later. The SAM registration process requires three to five business days to complete. SAM registration must be renewed annually. Additional information about registration procedures may be found at www.SAM.gov.

c. **Grants.gov:** Registering your organization through www.grants.gov, the official HHS E-grant website, is the first step in submitting an application online. Registration information is located on the “Get Registered” screen of www.grants.gov.

All applicant organizations must register with www.grants.gov. The “one-time” registration process will take three to five days to complete. However, it is best to start the registration process as early as possible such as at least 30 days before submitting the application.

2. Request Application Package: Download the application package from www.grants.gov

3. Application Package: Applicants must download the SF-424 application package associated with this funding opportunity from www.grants.gov. If access to the Internet is not available or if the applicant encounters difficulty in accessing the forms online, contact the HHS/CDC Procurement and Grant Office Technical Information Management Section (PGO TIMS) staff at (770) 488-2700 for further instruction. CDC Telecommunications for individuals with hearing loss is available at: TTY 1.888.232.6348.

4. Submission Dates and Times: If the application is not submitted by the deadline published herein, it will not be processed by www.grants.gov and the applicant will be notified by www.grants.gov. If the applicant has received authorization to submit a paper application, it must be received by the deadline provided by PGO TIMS.

a. Letter of Intent Deadline Date (must be postmarked by): N/A

b. Notice of Application Technical Assistance Activities:

CDC will conduct two Web workshop conference sessions for applicants interested in applying for this funding opportunity announcement.

PRE-APPLICATION WEB WORKSHOP CONFERENCE CALL DATE(S)

i. **STD AAPPS Orientation: Monday, June 17th- 3:00 PM – 5:00 PM EST**

THE PURPOSE OF THE FIRST PRE-APPLICATION WEB WORKSHOP CONFERENCE CALL IS TO:

- Provide a forum for discussion of details regarding this funding opportunity announcement
- Discuss technical assistance and resources available to applicants during the application process
- Discuss details of the procurement and grants process

This Pre-Application Web Workshop Conference Call Agenda will be as follows:

1. Welcome and Opening Remarks
2. Introduction, Purpose and Objectives of the Conference Call
3. Review of Program Announcement PS14-1402
 - Purpose and goals

- Eligibility
- Activities, outputs and outcomes
- Evaluation and work plan
- Funding formula
- Award Information
- Deadlines
- Technical Assistance

4. Question/Answer

5. Adjourn

ii. STD AAPPS Q&A: Wednesday, June 26th-3:00 PM – 5:00 PM EST

THE PURPOSES OF THE SECOND PRE-APPLICATION WEB WORKSHOP CONFERENCE CALL IS TO:

- Provide an opportunity for applicants to ask questions or request clarification regarding this funding opportunity announcement

PARTICIPANT ACCESS:

Call Leader: Gail Bolan

Web Access: <http://www.cdc.gov/std/foa/aapps/webinars.htm> (to register in advance for the webinars)

The Web conference calls will be recorded and instructions for accessing recorded calls will be available at www.cdc.gov/std/foa/aapps/webinars.htm. Eligible applicants may submit questions in writing to STDAAPPSFOA@cdc.gov at least 48 hours prior to the second call and these questions will be answered on the call if received in time. Questions that are broadly applicable will also be answered on the DSTDP AAPPS FOA FAQs site at www.cdc.gov/std/foa/aapps.htm.

c. Application Deadline Date: September 12, 2013 11:59 p.m. U.S. Eastern Standard Time, on www.grants.gov. The application deadline date is the date when the application is validated by www.grants.gov and not the date the application is submitted.

5. CDC Assurances and Certifications: All applicants are required to sign and submit CDC Assurances and Certifications that can be found on the CDC Web site at the following Internet address: www.cdc.gov/od/pgo/funding/grants/foamain.shtm

Applicants must name this file ‘Assurances and Certifications’ and upload as a PDF file under “Other Attachment Forms”: on www.grants.gov.

Recipients awarded a grant or cooperative agreement must comply with section 317P(c)(2) of the Public Health Service Act which requires medical accuracy when educational materials about

sexually transmitted diseases (STDs) are created and distributed by DHHS and its grantees. Such materials must contain “medically accurate” information regarding the effectiveness or lack of effectiveness of condoms in preventing STDs (42 U.S.C. § 247b-17(c)(2) (2000)).

6. Content and Form of Application Submission: Applicants are required to submit all of the documents outlined below as their application package on www.grants.gov.

7. Letter of Intent: A Letter of intent is not applicable to this funding opportunity announcement.

8. Table of Contents (No page limit): Provide a detailed table of contents for the entire submission package that includes all of the documents being submitted in the application and headers in the project narrative section. Name the file ‘Table of Contents’ and upload it as a PDF under “Other Attachment Forms” on www.grants.gov.

9. 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 margins): A project abstract must be submitted in the www.grants.gov mandatory documents list. The project abstract should be a self-contained, brief description of the proposed project to include the purpose and outcomes. This summary must not include any proprietary/confidential information; it is a public document so should be written for a public audience. Applicants should enter the “Project Abstract Summary” into the textbox on www.grants.gov.

10. Project Narrative (Maximum of 15 pages for Part A- STD AAPPs and maximum of 3 pages for Part B- GISP; single spaced, Calibri 12 point, 1-inch margins, all pages numbered, content beyond 15 pages for Part A-STD AAPPs or 3 pages for Part B- GISP will not be reviewed):

The project narrative for Part A- STD AAPPs and Part B- GISP must include all the bolded headers outlined under this section. The project narrative should be succinct, self-explanatory and organized in the order outlined in this section so reviewers can understand the proposed project. The description should address activities to be conducted over the entire project period.

A project narrative must be submitted with the application forms. Applicants should name the file “Project Narrative” and upload it as a PDF file under “Project Narrative” in the mandatory documents on www.grants.gov

a. Background (Part A- STD AAPPs and Part B- GISP): For your jurisdiction or the population served, the applicant must describe the core information to understand how the FOA will address the public health problem and support the public health priorities.

b. Approach (Part A- STD AAPPs and Part B- GISP)

i. Purpose (Part A- STD AAPPs and Part B- GISP): The applicant must briefly describe how their application will address the problem statement in their project area as described in Part II, the Funding Opportunity Description section under Problem Statement of this FOA.

ii. Outcomes (Part A- STD AAPPs and Part B- GISP): The applicant must clearly identify the outputs and outcomes the applicant expects to achieve by the end of the project period for Part A and Part B. Outcomes (see Figure 1) are the intended results that are expected as a consequence of the Part A and Part B program and its strategies. All outcomes should indicate the direction of desired change (i.e., increase, decrease, maintain).

In addition to the project period outcomes required by CDC, include any additional outcomes that are significant results for the project area.

iii. Program Strategy (Part A- STD AAPPs and Part B- GISP): The applicant must provide a clear and concise description of the Part A and Part B program strategies and activities the applicant intends to use to meet the project period outputs and outcomes. As applicable, applicants should use and explicitly reference The Community Guide³⁵ as a source of evidence-based program strategies whenever possible. In addition, applicants may propose additional program strategies to support the outcomes. Applicants should select existing evidence-based strategies that meet their needs, or describe the rationale for developing and evaluating new strategies or practice-based innovations or strategies.

1. Target Populations: Applicants must describe the specific target population(s) to be addressed in their jurisdiction to allocate limited resources, target those at greatest health risk, and achieve the greatest health impact. Applicants should use data, including social determinants data, to identify communities within their jurisdictions or communities served that are disproportionately affected by the public health problem, and plan activities to reduce or eliminate these disparities. Disparities by race, ethnicity, gender identity, sexual orientation, geography, socioeconomic status, disability status, primary language, health literacy, and other relevant dimensions (e.g., tribal communities) should be considered.

2. Inclusion: Applicants should address how they will be inclusive of the specific target populations described above who can benefit from the programmatic strategies especially those with the greatest health disparities who may otherwise be missed by the program such as the uninsured or underinsured, the non-English speaking, the disabled, those with limited health literacy or other vulnerable populations in their jurisdiction.

3. Collaborations: Applicants must describe how they will collaborate with CDC-funded programs as well as with organizations external of CDC.

MOUs/MOAs, if existing, can be provided. Name the file either “Part A- STD AAPPs MOUs/MOAs or Part B- GISP MOUs/MOAs” and upload as PDF files under “Other Attachment Forms” on www.grants.gov

³⁵ <http://www.thecommunityguide.org/index.html>

No MOUs/MOAs are required in the first year of the project period. They may be required in subsequent years.

c. Organizational Capacity of Awardees to Execute the Approach (Part A- STD AAPPS and Part B-GISP):

i. Organizational Capacity Statement (Part A- STD AAPPS and Part B- GISP):

Applicants must describe their organizational capacity to achieve the outcomes of the award and describe their organization's program evaluation capacity. The organizational capacity statement should describe how the applicant agency (or the particular division of a larger agency with responsibility for this project) is organized, the nature and scope of its work and/or the public health capabilities it possesses. Applicants should include a detailed description of the entity's experience, program management components, the entity's readiness to establish contracts in a timely manner, and a plan for long-term sustainability of the project, if applicable. Applicants should describe how they will assess staff competencies and develop a plan to address gaps through organizational and individual training and development opportunities. Also, applicants may describe their current status in applying for public health department accreditation or evidence of accreditation. Information on accreditation may be found at <http://www.phaboard.org>.

Part A- STD AAPPS applicants must also include an agency organization chart, clearly identifying the organizational placement of the STD program and PCSI personnel, if proposed, management structure, supervisory chain of the STD program and its relationship to other programs within the health department. Applicants should name the file "Part A- AAPPS Organizational Charts" and upload as a PDF file under "Other Attachment Forms" on www.grants.gov. Applicants must also include their itemized state and local STD prevention budget.

Part B- GISP applicants must also include an agency organization chart, clearly identifying the organizational placement and management structure of the STD clinic and public health laboratory and their relationship to the STD program within the health department. Applicants should name the file "Part B- GISP Organizational Charts" and upload as a PDF file under "Other Attachment Forms" on www.grants.gov.

ii. Project Management (Part A- STD AAPPS and Part B- GISP):

Applicants must describe the core elements of the project management required to execute the award, including roles and responsibilities of project staff. This section should include a clear delineation of the roles and responsibilities of project staff and their qualifications. Also, how consultants and partner organizations will contribute to achieving the project's outcomes should be described. Include information about any contractual organization(s) that will have a significant role(s) in implementing or evaluating program strategies and achieving project outcomes. Specify who will have day-to-day responsibility for key tasks

such as: leadership of project; monitoring the project's on-going progress; preparation of reports; program evaluation; and communication with other partners and CDC.

Part A- STD AAPPS applicants must include a Curriculum Vitae (CV) or resume for the FOA principle investigator or program director and the program manager. Applicants should name the file "Part A- STD AAPPS CVs/Resumes" and upload as a PDF file under "Other Attachment Forms" on www.grants.gov.

Part B- GISP applicants must include a CV or resume for the STD Clinic Medical Director and the Public Health Laboratory Director.

Applicants should name the file "Part B- GISP CVs/Resumes" and upload as a PDF file under "Other Attachment Forms" on www.grants.gov.

d. Evaluation and Performance Measurement (Part A- STD AAPPS and Part B- GISP):

Evaluation and performance measurement help demonstrate achievement of program outcomes; build a stronger evidence base for specific program interventions, clarify applicability of the evidence base to different populations, settings, and contexts, and drive continuous program improvement. Evaluation and performance measurement also can determine if program strategies are scalable and effective at reaching target populations.

i. Applicant Evaluation and Performance Measurement Plan

Applicants must provide an overall jurisdiction/community specific evaluation and performance measurement plan that is based on the FOA logic model and consistent with the CDC evaluation and performance measurement strategy as described in Part II. Full Text, A. Funding Opportunity Description, 2. CDC Project Description, c. Evaluation and Performance Measurement, ii. Applicant Evaluation and Performance Measurement Plan.

A separate evaluation plan document or attachment is not required as part of this application. The narrative portion of the evaluation and performance measurement plan should complement, not repeat, the information provided in the work plan.

ii. Awardee Evaluation and Performance Measurement Plan:

If awarded **Part A- STD AAPPS or Part B- GISP** funds, awardees must provide a more detailed plan within the first year of programmatic funding. This more detailed evaluation and performance measurement plan should be developed by awardees with support from CDC as part of first year project activities. This more detailed evaluation plan will build on the elements stated in the initial plan. This more detailed plan should not exceed 30 pages for Part A- STD AAPPS and 3 pages for Part B- GISP; single spaced, Calibri 12 point, 1-inch margins, and all pages numbered and content beyond 30 pages for Part A- STD AAPPS and 3 pages for Part B- GISP will not be reviewed. Awardees must address the evaluation and performance measurement plan activities described earlier in Part II. Full Text, A. Funding

Opportunity Description, 2. CDC Project Description, c. Evaluation and Performance Measurement, iii. Awardee Evaluation and Performance Measurement Plan.

Applicants are encouraged to work with professional evaluators and/or DSTDP on all evaluation activities.

11. Work Plan (Maximum of 20 pages for Part A- STD AAPPs and maximum of 3 pages for Part B- GISP; single spaced, Calibri 12 point, 1-inch margins, all pages numbered and content beyond 20 pages for Part A-STD AAPPs or 3 pages for Part B- GISP will not be reviewed):

Applicants must prepare a work plan for the first year of the award and a high-level plan for subsequent years. CDC will provide feedback and technical assistance to awardees to finalize the work plan post-award. Applicants must update the work plan every budget period, as necessary.

The work plan should describe how the project area will implement the proposed STD strategies (e.g., public health programmatic capabilities and prevention strategies) to meet the project period outcomes. The work plan should be tailored by project areas according to local issues and resources.

Applicants need to address the Work Plan as described in the earlier section: Part II. Full Test, A. Funding Opportunity Description, 2. CDC Project Description, a. Approach, iv. Work Plan. A work plan template is available at <http://www.cdc.gov/std/program/default.htm>. Work Plans should include:

- Rationale for each activity proposed. Local epidemiology should drive most of the proposed activities, and that should be provided within the work plan template.
- Linkages with required and recommended program activities
- Description of key parameters of the activity area or intervention proposed (e.g., geographic scope, population focus, key partners involved)
- Specific activities/objectives, proposed measures, proposed data sources, and baseline measures (if available at the time of application).

Applicants must name this file “Part A- STD AAPPs Work Plan” and upload it as a PDF file under “Other Attachment Forms” on www.grants.gov.

Applicants must name this file “Part B- GISP Work Plan” and upload it as a PDF file under “Other Attachment Forms” on www.grants.gov.

12. Budget Narrative: An itemized budget narrative is required as part of an applicant’s submission and will be scored as part of the Organizational Capacity of Awardees to Execute the Approach. When developing the budget narrative, applicants should consider whether the proposed budget is reasonable and consistent with the purpose, outcomes and program strategy outlined in the project narrative. The budget must include the following headers:

- Salaries and wages
- Fringe benefits
- Consultant costs
- Equipment
- Supplies
- Travel
- Other categories
- Direct costs
- Indirect costs
- Contractual costs

For guidance on completing a detailed justified budget, see:

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

State and local governments or their Bona Fide Agents (this includes the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands) may, if consistent with statutory authority, use funds for activities, as they relate to the intent of this FOA, to meet national standards and/or seek health department accreditation through the Public Health Accreditation Board (<http://phaboard.org>). This includes activities that enable a public health organization to deliver public health services such as activities that ensure: a capable and qualified workforce, up-to-date information systems, and the capability to assess and respond to public health needs. Use of these funds should focus on achieving one or more national standards that support the intent of this FOA. Proposed activities must be included in the budget narrative and must indicate which standards will be addressed.

Applicants should name this “Budget Narrative” and upload as a PDF file under “Budget Narrative” in the mandatory documents on www.grants.gov. If requesting indirect costs in the budget, a copy of the indirect cost rate agreement is required. If the indirect cost rate is a provisional rate, the agreement should be less than 12 months of age. Applicants should name this file “Indirect Cost Rate” and upload as a PDF file under “Other Attachment Forms” on www.grants.gov.

13. Tobacco and Nutrition Policies: Awardees are encouraged to implement tobacco and nutrition policies.

Unless otherwise explicitly permitted under the terms of a specific CDC award, no funds associated with this FOA can be used to implement the optional policies, and no applicants will be evaluated or scored on whether they choose to participate in implementing these optional policies.

The CDC supports implementing evidence-based programs and policies to reduce tobacco use and secondhand smoke exposure, and to promote healthy nutrition. CDC encourages all awardees to implement the following optional recommended evidence-based tobacco and nutrition policies within their own organizations. This builds upon the current federal commitment to reduce exposure to secondhand smoke, which includes The Pro-Children Act, 20 U.S.C. 7181-7184, that prohibits smoking in certain facilities that receive Federal funds in which education, library, day care, health care, or early childhood development services are provided to children.

Tobacco Policies:

1. Tobacco-free indoors – no use of any tobacco products (including smokeless tobacco) or electronic cigarettes in any indoor facilities under the control of the awardee
2. Tobacco-free indoors and in adjacent outdoor areas – no use of any tobacco products or electronic cigarettes in any indoor facilities, within 50 feet of doorways and air intake ducts, and in courtyards under the control of the awardee
3. Tobacco-free campus – no use of any tobacco products or electronic cigarettes in any indoor facilities and anywhere on grounds or in outdoor space under the control of the awardee

Nutrition Policies:

1. Healthy food service guidelines should at a minimum, align with Health and Human Services and General Services Administration Health and Sustainability Guidelines for Federal Concessions and Vending Operations for cafeterias, snack bars, and vending machines in any facility under the control of the awardee and in accordance with contractual obligations for these services

(http://www.gsa.gov/graphics/pbs/Guidelines_for_Federal_Concessions_and_Vending_Operations.pdf)

2. The following are resources for healthy eating and tobacco free workplaces:

<http://www.cdc.gov/nccdphp/dnpao/hwi/toolkits/tobacco/index.htm>

<http://www.thecommunityguide.org/tobacco/index.html>

<http://www.cdc.gov/chronicdisease/resources/guidelines/food-service-guidelines.htm>

14. Intergovernmental Review:

The application is subject to Intergovernmental Review of Federal Programs, as governed by Executive Order 12372. This order sets up a system for state and local governmental review of proposed federal assistance applications. Contact the state single point of contact (SPOC) as early as possible to alert the SPOC to prospective applications and to receive instructions on the State's process. Visit the following Web address to get the current SPOC list:

http://www.whitehouse.gov/omb/grants_spoc/.

15. Funding Restrictions: Restrictions, which must be taken into account while planning the programs and writing the budget, are as follows:

- Awardees may not use funds for research.

- Awardees may not use funds for clinical care, except as follows:

In order to assure that the awardee continues to serve low income, uninsured and underinsured women, applicants must describe a plan for providing assistance (at least 13.5 percent of the overall award amount) to non-profit organizations that have demonstrated their ability to provide such safety net STD clinical preventive services. This assistance could be used to screen and treat women and their partners for CT and GC to prevent infertility. If this percentage is less than 13.5 percent, a justification must be provided. CDC may reduce the allowable amount (13.5 % in year one) that may be used to support safety net STD clinical preventive services for years 2-5, pending results of a modeling study and STD program survey; yearly reductions will not exceed 1.5%.

- Awardees may only expend funds for reasonable program purposes, including personnel, travel, supplies, and services, such as contractual.
- In most cases, awardees may not use HHS/CDC/ATSDR funding for the purchase of furniture or equipment. Any such proposed spending must be clearly identified in the budget.
- Reimbursement of pre-award costs is not allowed.
- Awardees may not use funds for any kind of impermissible lobbying activity designed to influence proposed or pending legislation, appropriations, regulations, administrative actions, or Executive Orders (“legislation and other orders”). These restrictions include grass roots lobbying efforts and direct lobbying. Certain activities within the normal and recognized executive-legislative relationships within the executive branch of that government are permissible. See Additional Requirement (AR) 12 for further guidance on this prohibition.
- Awardees may not use funds for food purchases.

The direct and primary recipient in a cooperative agreement program must perform a substantial role in carrying out project outcomes and not merely serve as a conduit for an award to another party or provider who is ineligible.

16. Other Submission Requirements:

a. Electronic Submission: Applications must be submitted electronically at www.grants.gov. Electronic applications will be considered as having met the deadline if the application has been successfully made available to and validated by CDC for processing from www.grants.gov on the deadline date. The application package can be downloaded from www.grants.gov. Applicants can complete the application package off-line, and then upload and submit the application via the www.grants.gov website. The applicant must submit all application attachments using a PDF file format when submitting via www.grants.gov. Directions for creating PDF files can be found on the

www.grants.gov website. Use of file formats other than PDF may result in the file being unreadable by staff.

Submit the application electronically by using the forms and instructions posted for this funding opportunity on www.grants.gov. If access to the Internet is not available or if the applicant encounters difficulty in accessing the forms on-line, contact the HHS/CDC, PGO TIMS staff at 770. 488.2700 or email pgotim@cdc.gov Monday-Friday 7:30am-4:30pm.

b. Tracking Number: Applications submitted through www.grants.gov, are electronically time/date stamped and assigned a tracking number. The Authorized Organization Representative (AOR) will receive an email notice of initial receipt when www.grants.gov receives the application and assigns the tracking number. The tracking number serves to document submission and initiates the electronic validation process which must be done before the application is made available to CDC.

c. Validation Process: Application submission is not concluded and considered complete until the date of the successful completion of the validation process. After submission of the application package, applicants will receive a “submission receipt and tracking number” email generated by www.grants.gov. The www.grants.gov site will then generate a second email message to applicants which will either validate or reject their submitted application package. This validation process may take as long as two (2) business days. Applicants are strongly encouraged to check the status of their application to ensure submission of their application package is validated and complete and no submission errors exist. To guarantee that you comply with the application deadline published in the FOA (the date by which the application is validated), applicants are also strongly encouraged allocating additional days prior to the published deadline to file their application. **Non-validated applications will not be accepted after the published application deadline date.**

In the event that you do not receive a “validation” email within two (2) business days of application submission, please contact www.grants.gov. Refer to the email message generated at the time of application submission for instructions on how to track your application or the Application User Guide, Version 3.0 page 57.

d. Technical Difficulties: If the applicant encounters technical difficulties with www.grants.gov, the applicant should contact www.grants.gov Customer Service. The www.grants.gov Contact Center is available 24 hours a day, 7 days a week, with the exception of Federal Holidays. You can reach the www.grants.gov Contact Center at 1-800-518-4726 or by email at support@www.grants.gov. Submissions sent by email, fax, CD's or thumb drives of applications will not be accepted. Please note that www.grants.gov is managed by the U.S. Department of Health and Human Services.

e. Paper Submission: Organizations that encounter technical difficulties in using www.grants.gov to submit their application must attempt to overcome those difficulties by contacting the www.grants.gov Contact Center (1-800-518-4726, support@www.grants.gov). After consulting with the www.grants.gov Contact Center, if the technical difficulties remain unresolved and electronic submission is not possible to meet the established deadline, organizations may submit a request prior to the application deadline by email to CDC GMO/GMS for permission to submit a paper application. However, please note that this request may not be approved.

An organization's request for permission must:

1. Include the www.grants.gov case number assigned to the inquiry
2. Describe the difficulties that prevent electronic submission and the efforts taken with the www.grants.gov Contact Center to submit electronically
3. Be submitted to the GMO/GMS at least three (3) calendar days prior to the application deadline. Paper applications submitted without prior approval will not be considered. If a paper application is authorized, the applicant will receive instructions from PGO TIMS to submit the original and two hard copies of the application by mail or express delivery service.

E. Application Review Information

1. **Review Criteria:** In scoring applications, eligible applications will be evaluated against the following criteria during Phase II review:

Part A- STD AAPPS:

a. Approach [70 points]:

- i. **Background and Purpose:** 1) Describes the core information to understand how the application addresses the CDC identified health problem and 2) Describes how the application addresses the public health problem in the project area that was identified in the problem statement. (3 points)
- ii. **Outcomes:** Describes the project period outcomes and the project area plans to achieve. (2 points)
- iii. **Program Strategy:** Describes the overarching priority program strategies, including public health capabilities and prevention interventions, the project area will employ to achieve the outputs/outcomes. Indicates if an intervention is evidence-based or practice-based. Describes how the interventions are designed to achieve maximum population impact and are targeted to high morbidity/disparity populations and/or providers in the jurisdiction. (10 points). The specific program activities proposed are to be reviewed under the work plan section below (Part II.E. 1).

1. Target Populations: 1) uses data, including social determinants of health data, to describe the specific target populations within the jurisdiction that are disproportionately affected by CT, GC, and syphilis; and 2) proposes strategies and activities to address the health disparities in the jurisdiction. (5 points)
 2. Collaborations: 1) describes collaborations with HIV prevention programs on integration of STD and HIV data, integration and enhancement of STD screening among populations at risk for STDs and HIV, collaborations on the design of PreP or other HIV prevention strategies to ensure routine STD screening is consistently offered, integration of STD and HIV partner services and implementation of target condom distribution programs; 2) describes the purpose and extent of collaborations with DASH and any other CDC-funded programs; and 3) describes the purpose and extent of collaborations with programs not funded by CDC; 4) specifically addresses how they will adhere to policies surrounding collaborations with Tribal entities. (10 points)
- iv. Work plan:** Provides strong rationale and specific year-one activities or objectives for each of the 12 required activities and any other activities proposed. (See Figure 1. 2014 STD AAPPs Logic Model) Describes plans to achieve the required activities in each of the three core function areas. Plans for any suggested activities clearly build on existing capacity and experience.
- a. Assessment:** (15 points). The extent to which the applicant describes plans to:
- Surveillance: 1) Ensure confidentiality and security guidelines for the collection, storage, and use of all surveillance data according to NCHHSTP guidance; 2) Improve the quality of case-based data collection by routinely obtaining information on gender of sex partners, pregnancy status, HIV status, treatment given, patient address and provider information; 3) Geocode case-based surveillance data to target interventions to providers serving a high volume of patients with STDs and to populations in geographic areas with high numbers of reported infections; 4) Conduct automated matching of STD and HIV cases for identification of syndemics and for targeting health department DIS partner services for co-infected individuals; and 5) Disseminate surveillance information to affected populations, communities, providers and key stakeholders. If resources permit, applicants may include plans to conduct other suggested activities, including: 6) Increase the number of STD cases and surveillance data received through electronic laboratory reports and electronic health records in the surveillance system; and 7) Increase surveillance systems beyond case-based reporting to sentinel systems and population-based approaches.
- Monitoring screening rates: 1) Measure annual CT screening rates among young females (15-24 years) enrolled in Medicaid programs, and Title X and other family planning clinics, ideally using the CT HEDIS measure; and 2) Measure annual syphilis and rectal GC screening rates among MSM seen in high volume HIV care settings. If resources permit, applicants may include plans to conduct other suggested activities, including: 3) Measure annual CT screening rates among young females (15-24 years) enrolled in large health plans, ideally using the CT HEDIS measure; 4) Measure syphilis and rectal GC screening rates among MSM seen in

settings providing health care to MSM; and 5) In jurisdictions with congenital syphilis: measure screening for syphilis among pregnant females in prenatal care and birthing facilities.

Assessing gaps in services: 1) Determine where uninsured or underinsured clients are receiving safety net service; 2) Identify the clinical and prevention service gaps for patients who are receiving care (e.g., missed opportunities by providers). If resources permit, applicants may include plans to conduct other suggested activities, including: 3) Estimate the proportion of uninsured or underinsured, at-risk individuals in the jurisdiction.

Antibiotic resistant gonorrhea or other emerging STD threats and congenital syphilis:

Applicants with jurisdictions with high GC morbidity: 1) Assess the proportion of GC cases that are treated correctly according to current CDC STD Treatment Guidelines, stratified by provider type; and 2) Determine the number of private or public health laboratories in the jurisdiction that have the capacity to conduct *N. gonorrhoeae* culture and AST. Specify the transport/culture media used. If AST is done, specify the method such as disk diffusion (Kirby-Bauer), Etest, or agar dilution. Applicants with jurisdictions with high number of congenital syphilis cases: assess congenital syphilis cases to determine the epidemiologic and health care factors associated with the cases to inform interventions. If resources permit, applicants may include plans to conduct other suggested activities, including: Establishing surveillance capacity to detect emerging STD threats.

b. Assurance: (15 points). The extent to which the applicant describes plans to:

Screening and treatment of individuals per CDC guidance: (1) Increase CT screening rates among young females (15-24 years) seen in Medicaid programs, and Title X and other family planning clinics, ideally using the CT HEDIS measure; (2) Provide assistance (at least 13.5 percent of the overall award amount) to non-profit organizations that have demonstrated their ability to provide such safety net STD clinical preventive services and provide a methodology to document the number of uninsured or underinsured females screened for CT/GC through this assistance; (3) Increase syphilis and rectal GC rates among MSM seen in high volume HIV care settings; (4) Increase the proportion of patients with GC that are correctly treated according to current CDC guidelines in areas of high GC morbidity. If resources permit, applicants may include plans to conduct other suggested activities, including: (5) Increase annual CT screening rates among young females seen in large health plans, ideally using the CT HEDIS measure; (6) Increase syphilis and rectal GC screening rates among MSM seen in settings providing health care to MSM, and (7) In jurisdictions with congenital syphilis: increase screening for syphilis among pregnant females in prenatal care and birthing facilities.

Partner services and linkage to care: 1. Increase the provision of targeted and effective health department Disease Intervention Specialist (DIS) partner services for: (a) Primary and secondary syphilis cases; (b) HIV co-infected GC and syphilis cases; (c) GC cases with possible GC treatment failure or suspected or probable cephalosporin-resistant *N. gonorrhoeae* isolate

using the criteria in the Cephalosporin-Resistant *N. gonorrhoeae* Public Health Response Plan. 2. Link partners contacted who have not been diagnosed previously with HIV who test positive for HIV to care. Other suggested activities include: 3. Within state law, increase the provision of expedited partner therapy (EPT) for CT and GC according to current CDC treatment guidelines. 4. Increase the provision of effective partner services provided through social media websites and other digital or communication technologies (e.g. internet partner services). 5. Link newly identified HIV-infected individuals in STD clinics to HIV care. 6. Link uninsured or underinsured partners to safety net services.

Health promotion and prevention education: 1) Maintain a website where surveillance information and basic information about STDs is available to the public, health care providers, health planners and policy maker; and 2) Collaborate with other organizations to implement STD health promotion and prevention education activities for safety net or other providers who see many at-risk patients. If resources permit, applicants may include plans to conduct other suggested activities, including: 3) Collaborate with other organizations to implement STD health promotion and prevention education activities for at-risk populations or communities; and 4) Provide and promote the use of high intensity behavioral counseling (HIBC) in clinical settings serving at-risk patients.

c. Policy: (10 points). The extent to which the applicant describes plans to:
(1) Monitor and evaluate policies relevant to STD prevention and control in the project area;
(2) Share findings from policy assessment and evaluation studies with key stakeholders; (3) Educate the public, providers and key stakeholders on the positive potential or proven impacts of relevant state and local policies on improving access to STD services and reducing sexually transmitted infections; (4) Improve access to quality STD clinical preventive services in primary care settings in your project area; and (5) Establish active partnerships with health care, community-based organizations, key stakeholders, and other agencies within the executive branch of the applicant's state or local governments to promote increased collaboration between STD prevention programs and primary care.

b. Organizational Capacity of Awardees to Execute the Approach [15 points]:

- i. Organizational Capacity Statement: The applicant has the demonstrated organizational capacity to achieve the outputs and outcomes of the award and the evaluation capacity as evidenced by a strong evaluation and performance measurement program plan. **The applicant will be scored based on their ability to execute the plan; the plan itself will be scored according to section c below.** (5 points)
- ii. Project Management: The applicant has the demonstrated project management capacity to execute the award. (5 points)
- iii. Budget: The budget is well aligned with the proposed approach and evaluation and work plans (5 points)

c. Evaluation and Performance Measurement [15 points]:

Evaluation Plan (15 points): The applicant describes: (A) How key program partners will be engaged in the evaluation and performance measurement processes; (B) The type of evaluation to be conducted (process and/or outcome); (C) Key evaluation question to be answered; (D) Potentially available data sources and feasibility of collecting appropriate evaluation and performance data; (E) How data are used to guide programmatic action and includes specific examples of how surveillance data have been used to target high risk populations and high prevalence venues; (F) How evaluation findings will be used for continuous program and QI and the applicant's resources for conducting QI; and (G) How evaluation and performance measurement will contribute to development of evidence base where program strategies are proposed that lack strong evidence of effectiveness. Describes the process that will be used to obtain evaluation expertise to assist in completion of all evaluation activities.

Part B- GISP:

a. Approach: (35 points)

The applicant adequately describes a quality method for adequate enrollment of male patients with gonococcal urethritis and documented evidence of successful enrollment of STD clinic patients in surveillance or evaluation projects. (15 points)

The applicant adequately describes a quality method for the standardized collection of requested demographic and clinical data including whether the requested data elements are currently collected, evidence of completeness of these data elements in the current clinical data system and ability to electronically transmission clinic and laboratory data in a timely manner. (20 points)

b. Organizational Capacity of Awardees to Execute the Award (55 points):

The applicant's affiliated STD clinic and public health laboratory have significant experience performing culture for *N. gonorrhoeae*. (5 points)

The applicant demonstrates a willingness and commitment to collect urethral swabs for culture as a part of surveillance for *N. gonorrhoeae* antibiotic resistance and demonstrates an ability to follow standardized protocols. (10 points)

The applicant demonstrates the ability to collect viable *N. gonorrhoeae* isolates per month from men with gonococcal urethritis using clinic data from 2012. (25 points)

- a. 0-10 isolates (0 points)
- b. 11-20 (10 points)
- c. 21-25 (20 points)
- d. >25 (25 points)

The extent to which the applicant represents strategic importance to U.S. surveillance of *N. gonorrhoeae* antibiotic susceptibility. (15 points)

- The applicant is in relatively close geographic proximity to Asia or geographically located in a region where gonococcal antibiotic resistance has initially emerged. (5 points)
- A large number of GC cases in the applicant's jurisdiction are diagnosed in MSM. (10 points)

c. Evaluation and Performance Measurement (10 points):

The applicant describes a quality method to collect the requisite specimens and epidemiologic data, process isolates and report the evaluation measures that will be used to monitor progress.

2. Review and Selection Process

- a. Phase I Review:** All eligible applications will be initially reviewed for completeness by the CDC's Procurement and Grants Office (PGO) staff. In addition, eligible applications will be jointly reviewed for responsiveness by the CDC NCHHSTP and PGO. Incomplete applications and applications that are non-responsive to the eligibility criteria will not advance to Phase II review. Applicants will be notified that the application did not meet eligibility and/or published submission requirements.
- b. Phase II Review:** An objective review panel will evaluate complete and responsive applications according to the criteria listed in the criteria section of the FOA. Applicants will be notified electronically if the application did not meet eligibility and/or published submission requirements thirty (30) days after the completion of Phase II review.
- c. Phase III Review: Part B- GISP only:** Applications may be funded by score and rank determined by the review panel. However, applications may not be funded by score and rank based on the need for broad geographic coverage, adequate representation of the Western US, where resistance in *Neisseria gonorrhoeae* in the United States has consistently first appeared, racial/ethnic diversity, and inclusion of sexual minorities, particularly MSM.

3. Anticipated Announcement and Award Dates:

Awards will be announced via the Division of STD Prevention's web link by December 1, 2013.

F. Award Administration Information

1. Award Notices: Awardees will receive an electronic copy of the Notice of Award (NoA) from the CDC PGO. The NoA shall be the only binding, authorizing document between the awardee and CDC. The NoA will be signed by an authorized GMO and emailed to the awardee program director.

Any application awarded in response to this FOA will be subject to the DUNS, SAM Registration and Federal Funding Accountability And Transparency Act Of 2006 (FFATA) requirements.

Unsuccessful applicants will receive notification of the results of the application review by email with delivery receipt or by mail.

2. Administrative and National Policy Requirements: Awardees must comply with the administrative requirements outlined in 45 Code of Federal Regulations (CFR) Part 74 or Part 92, as appropriate. To view brief descriptions of relevant provisions visit the CDC website at: http://www.cdc.gov/od/pgo/funding/grants/additional_req.shtm

The following administrative requirements apply to this project:

Generally applicable administrative requirements (ARs):

- AR-7: Executive Order 12372
- AR-9: Paperwork Reduction Act
- AR-10: Smoke-Free Workplace
- AR-11: Healthy People 2010
- AR-12: Lobbying Restrictions
- AR-13: Prohibition on Use of CDC Funds for Certain Gun Control Activities
- AR-14: Accounting System Requirements
- AR-16: Security Clearance Requirement
- AR-21: Small, Minority, And Women-owned Business
- AR-24: Health Insurance Portability and Accountability Act
- AR-25: Release and Sharing of Data
- AR-26: National Historic Preservation Act of 1966
- AR-29: Compliance with EO13513, "Federal Leadership on Reducing Text Messaging while Driving," October 1, 2009
- AR-30: Compliance with Section 508 of the Rehabilitation Act of 1973
- AR-32: Executive Order 131410: Promoting Quality and Efficient Health Care in Federal Government (If applicable applicants should be aware of the program's current business needs and how they align with nationally adopted Public Health Information Network (PHIN) standards, services, practices, and policies when implementing, acquiring, and updating public health information systems.)
- AR-33: Plain Writing Act of 2010
- AR-34: Patient Protection and Affordable Care Act (e.g. a tobacco-free campus policy and a lactation policy consistent with S4207)

ARs applicable to HIV/AIDS Awards:

- AR-4: HIV/AIDS Confidentiality Provisions
- AR-5: HIV Program Panel Review
- AR-6: Patient Care

For more information on the Code of Federal Regulations, visit the National Archives and Records Administration at: <http://www.access.gpo.gov/nara/cfr/cfr-table-search.html>

3. Reporting:

a. Reporting allows for continuous program monitoring and identifies successes and challenges that awardees encounter throughout the award. Reporting is also necessary for awardees to apply for yearly continuation of funding. In addition, reporting is helpful to CDC and awardees because it:

- Helps target support to awardees, particularly for cooperative agreements
- Provides CDC with periodic data to monitor awardee progress towards meeting the FOA outcomes and overall performance
- Allows CDC to track performance measures and evaluation findings for continuous program improvement throughout the project period and to determine applicability of evidence-based approaches to different populations, settings, and contexts
- Enables the assessment of the overall effectiveness and impact of the FOA

As described below, awardees must submit one report per year; ongoing performance measures data, administrative reports, and a final performance and financial report.

Below are the specific reporting requirements:

b. Annual Performance Report (due 120 days before the end of the budget period and serves as a continuation application). This report must not exceed 25 pages for Part A-STD AAPPS and 5 pages for Part B-GISP (single spaced, Calibri 12 point, 1-inch margins, all pages numbered and content beyond 35 pages will not be reviewed) excluding work plan and administrative reporting. Attachments are not permitted when submitting this report. Awardees may insert web links in this report.

This report must include the following:

- **Performance Measures (including outcomes)** – Awardees must report on performance measures for each budget period and update measures, if needed
- **Evaluation Results –Awardees must report evaluation results for the work completed to date** (including any impact data)
- **Work Plan (Maximum 20 pages Part A- STD AAPPS and 3 pages Part B- GISP; single spaced, Calibri 12 point, 1-inch margins, all pages numbered and content beyond 20 and 3 pages, respectively, will not be reviewed)**. Awardees should update work plan each budget period
- **Successes**
 - ✓ Awardees must report progress on completing activities outlined in the work plan
 - ✓ Awardees must describe any additional successes (e.g., identified through evaluation results or lessons learned) achieved in the past year
 - ✓ Awardees must describe success stories
- **Challenges**
 - ✓ Awardees must describe any challenges that hinder achievement of both annual and project period outcomes, performance measures, or their ability to complete the activities in the work plan

- ✓ Awardees must describe any additional challenges (e.g., identified through evaluation results or lessons learned) encountered in the past year
- **CDC Program Support to Awardees**
 - ✓ Awardees should describe how CDC could assist them in overcoming any challenges to achieve both annual and project period outcomes and performance measures, and complete activities outlined in the work plan
- **Administrative Reporting (not subject to page limits)**
 - ✓ SF-424A Budget Information-Non-Construction Programs
 - ✓ Budget Narrative – Must use the format outlined in Part II, the Application and Submission Information Section under Budget Narrative of this FOA
 - ✓ Indirect Cost Rate Agreement

Awardees may request up to 75% of their estimated unobligated funds to be carried forward into the next budget period. The carryover request must:

- Express a bona fide need for permission to use an unobligated balance
- Include a signed, dated, and accurate FFR for the budget period from which the fund will be transferred
- Include a list of proposed activities, an itemized budget, and a narrative justification of those activities

The awardee must submit the Annual Performance Report via www.grants.gov 120 days before the end of the budget period.

c. Performance Measure Reporting: CDC programs must require awardees to submit performance measures at least annually. CDC may require more frequent reporting of performance measures. Performance measure reporting should be limited to the collection of data. CDC programs should specify reporting frequency, required data fields, and format for awardees at the beginning of the award.

d. Federal Financial Reporting: The Annual Federal Financial Report (FFR) SF 425 is required and must be submitted through eRA Commons 36 within 90 days after the end of each budget period. The FFR should only include those funds authorized and disbursed during the timeframe covered by the report. The final FFR must indicate the exact balance of unobligated funds and may not reflect any unliquidated obligations. There must be no discrepancies between the final FFR expenditure data and the Payment Management System's (PMS) cash transaction data. Failure to submit the

³⁶<https://commons.era.nih.gov/commons/>

required information in a timely manner may adversely affect the future funding of this project. If the information cannot be provided by the due date, you are required to submit a letter explaining the reason and date by which the Grants Management Officer will receive the information.

e. Final Performance and Financial Report: At the end of the project period, awardees should submit a final report to include a final performance and financial report. This report is due 90 days after the end of the project period and is not to exceed 35 pages for Part A- STD AAPPS and 5 pages for Part B- GISP (single spaced, Calibri 12 point, 1-inch margins, all pages numbered).

At a minimum, this report must include the following:

- Performance Measures (including outcomes) – Awardees should report final performance data for all performance measures for the project period.
- Evaluation results – Awardees should report final evaluation results for the project period
- Impact/Results – Awardees should describe the impact/results of the work completed over the project period, including success stories.
- FFR (SF-425)

The report should be emailed to the CDC Project Officer and the GMS listed in ‘Agency Contacts’ section of the FOA.

4. Federal Funding Accountability and Transparency Act of 2006: Federal Funding Accountability And Transparency Act Of 2006 (FFATA), Public Law 109-282, the Federal Funding Accountability and Transparency Act of 2006 as amended (FFATA), requires full disclosure of all entities and organizations receiving Federal funds including awards, contracts, loans, other assistance, and payments through a single publicly accessible Web site, www.USASpending.gov.

Compliance with this law is primarily the responsibility of the Federal agency. However, two elements of the law require information to be collected and reported by applicants: 1) information on executive compensation when not already reported through the SAM, and 2) similar information on all sub-awards/subcontracts/consortiums over \$25,000.

For the full text of the requirements under the FFATA, go to:

<http://www.gpo.gov/fdsys/pkg/BILLS-109s2590enr/pdf/BILLS-109s2590enr.pdf>

G. Agency Contacts

CDC encourages inquiries concerning this announcement.

For programmatic technical assistance, contact:

Project Officers: Part A- STD AAPPs: Bruce Heath; and B- GISP: Robert D. Kirkcaldy
Department of Health and Human Services
Centers for Disease Control and Prevention
1600 Clifton Rd. NE M/S EO7
Atlanta, GA 30333

Telephone: Part A: 404-639-1938; Part B: 404-639-8659

Email: Part A: RBH5@CDC.gov; Part B: HGL8@CDC.gov

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

Sheila Edwards, Grants Management Officer
Department of Health and Human Services
CDC Procurement and Grants Office
2920 Brandywine Road, MS E15
Atlanta, GA 30341
Telephone: 770-488-1644
Email: SEdwards@cdc.gov

For assistance with submission difficulties related to www.grants.gov, contact:

www.grants.gov Contact Center: 1-800-518-4726.

Hours of Operation: 24 hours a day, 7 days a week. Closed on Federal holidays.

For all other **submission** questions, contact:

Technical Information Management Section
Department of Health and Human Services
CDC Procurement and Grants Office
2920 Brandywine Road, MS E-14
Atlanta, GA 30341
Telephone: 770-488-2700
Email: pgotim@cdc.gov

CDC Telecommunications for individuals with hearing loss is available at:

TTY 1.888.232.6348

H. Other Information

Below is a list of acceptable attachments for applicants to upload as part of their www.grants.gov application as PDF files. Applicants may not attach other documents. If applicants do so, they will not be reviewed.

Mandatory documents per www.grants.gov

- Project Abstract

- Project Narrative
- Budget Narrative

Mandatory attachments for all CDC FOAs and include under “Other Attachment Forms” on www.grants.gov:

- CDC Assurances and Certifications
- Work Plan
- Table of Contents for Entire Submission

Other required attachments and include under “Other Attachment Forms” on www.grants.gov:

- Resumes/CVs
- Organizational Charts
- Indirect Cost Rate
- Bona Fide Agent, if applicable
- State and Local Budgets

Other optional attachments and include under “Other Attachment Forms” on www.grants.gov:

- Memorandum of Agreement (MOA)
- Memorandum of Understanding (MOU)
- Letter of Support

I. Glossary

Administrative and National Policy Requirements, Additional Requirements (ARs):

Outline the Administrative requirements found in 45 CFR Part 74 and Part 92 and other requirements as mandated by statute or CDC policy. CDC programs must indicate which ARs are relevant to the FOA. All ARs are listed in the template for CDC programs. Awardees must then comply with the ARs listed in the FOA. To view brief descriptions of relevant provisions visit the CDC website at:

http://www.cdc.gov/od/pgo/funding/grants/additional_req.shtm.

Authority: Legal authorizations that outline the legal basis for the components of each individual FOA. An OGC representative may assist in choosing the authorities appropriate to any given program.

Award: Financial assistance that provides support or stimulation to accomplish a public purpose. Awards include grants and other agreements (e.g., cooperative agreements) in the form of money, or property in lieu of money, by the Federal Government to an eligible recipient.

Bona Fide Agent: An agency/organization identified by the state or local government as eligible to submit an application under the state or local eligibility in lieu of a state application. If applying as a bona fide agent of a state or local government, a legal, binding agreement from the state or local government as documentation of the status is required.

Budget Period/Year: The duration of each individual funding period within the project period. Traditionally, budget period length is 12 months or 1 year.

Carryover: Unobligated Federal funds remaining at the end of any budget period that, with the approval of the GMO or under an automatic authority, may be carried forward to another budget period to cover allowable costs of that budget period (whether as an offset or additional authorization). Obligated, but unliquidated, funds are not considered carryover.

Catalog of Federal Domestic Assistance (CFDA): A catalog published twice a year which describes domestic assistance programs administered by the federal government. This government-wide compendium of Federal programs lists projects, services, and activities which provide assistance or benefits to the American public.
<https://www.cfda.gov/index?s=agency&mode=form&id=0bebbc3b3261e255dc82002b83094717&tab=programs&tabmode=list&subtab=list&subtabmode=list>.

CDC Assurances and Certifications: Standard government-wide grant application forms.

CFDA Number: The CFDA number is a unique number assigned to each program/FOA throughout its lifecycle that enables data and funding tracking and transparency.

Clinical Preventive Service: A history or physical assessment, screening, diagnostic, treatment or counseling service provided in a clinical setting.

Competing Continuation Award: An award of financial assistance which adds funds to a grant and extends one or more budget periods beyond the currently established project period.

Continuous Quality Improvement: A system that seeks to improve the provision of services with an emphasis on future results.

Contracts: An award instrument establishing a binding legal procurement relationship between CDC and a recipient obligating the latter to furnish a product.

Cooperative Agreement: An award of financial assistance that is used to enter into the same kind of relationship as a grant; and is distinguished from a grant in that it provides for substantial involvement between the Federal agency and the awardee in carrying out the activity contemplated by the award.

Cost Sharing or Matching: Refers to program costs not borne by the Federal government but required of awardees. It may include the value of allowable third-party in-kind contributions, as well as expenditures by the awardee.

Diagnostic Testing: Obtaining an STD test in a clinical setting from a client with symptoms to identify the cause of the symptoms.

Direct Assistance: Assistance given to an applicant such as federal personnel or supplies. See http://www.cdc.gov/stltpublichealth/GrantsFunding/direct_assistance.html

Evidence-based Intervention: Interventions that evaluation research has shown to be effective or efficacious. The evidence typically has been published in peer-reviewed journals, showing positive effects on key outcomes, among the target population. The evidence is regarded by experts as meeting the standards of scientific rigor.

Federal Funding Accountability And Transparency Act Of 2006 (FFATA): Requires information on Federal awards, including awards, contracts, loans, and other assistance and payments, be made available to the public on a single website, www.USAspending.gov.

Fiscal Year: The year that budget dollars are allocated to fund program activities. The fiscal year starts October 1st and goes through September 30th.

Grant: A legal instrument used by the Federal government to enter into a relationship, the principal purpose of which is to transfer anything of value to a recipient to carry out a public purpose of support or stimulation authorized by statute. The financial assistance may be in the form of money, or property in lieu of money. The term does not include: a Federal procurement subject to the Federal Acquisition Regulation; technical assistance (which provides services instead of money); or assistance in the form of revenue sharing, loans, loan guarantees, interest subsidies, insurance, or direct payments of any kind to individuals. The main difference between a grant and a cooperative agreement is that there is no anticipated substantial programmatic involvement by the Federal Government under an award.

Grants.gov: A "storefront" web portal for use in electronic collection of data (forms and reports) for Federal grant-making agencies through the www.grants.gov site, www.grants.gov.

Health Disparities: Differences in health outcomes and their determinants between segments of the population, as defined by social, demographic, environmental, and geographic attributes.

Healthy People 2020: Provides national health objectives for improving the health of all Americans by encouraging collaborations across sectors, guiding individuals toward making informed health decisions, and measuring the impact of prevention activities.

Inclusion: Inclusion refers to both the meaningful involvement of community members in all stages of the program process, and maximum involvement of the target population in the benefits of the intervention. An inclusive process assures that the views, perspectives, and needs of affected communities, care providers, and key partners are actively included.

Indirect Costs: Those costs that are incurred for common or joint objectives and therefore cannot be identified readily and specifically with a particular sponsored project, program, or activity but are nevertheless necessary to the operations of the organization. For example, the costs of operating and maintaining facilities, depreciation, and administrative salaries are generally treated as indirect costs.

Lobbying: Direct lobbying includes any attempt to influence legislation, appropriations, regulations, administrative actions or Executive Orders ("legislation or other orders"), or other similar deliberations at all levels of government through communications that directly express a view on proposed or pending legislation or other orders and which are directed to members of staff, or other employees of a legislative body or to government officials or employees who participate in the formulation of legislation or other orders. Grass Roots lobbying includes efforts directed at inducing or encouraging members of the public to contact their elected representatives at the Federal, State or local levels to urge support of, or opposition to, proposed or pending legislative proposals.

Maintenance of Effort: A requirement contained in authorizing legislation, regulation stating that to receive Federal grant funds a recipient must agree to contribute and maintain a specified level of financial effort for the award from its own resources or other non-Federal sources. This requirement is typically given in terms of meeting a previous base-year dollar amount.

Meaningful Use (MU): Meaningful Use is using certified electronic health record (EHR) technology to: 1) improve quality, safety, efficiency, and reduce health disparities; 2) engage patients and family; 3) improve care coordination, and population and public health; and 4) maintain privacy and security of patient health information. The Office of the National Coordinator for Health Information Technology (ONC) Certification Program

provides a defined process to ensure that Electronic Health Record (EHR) technologies meet the adopted standards and certification criteria to help providers and hospitals achieve Meaningful Use (MU) objectives and measures established by the Centers for Medicare and Medicaid Services (CMS).

Memorandum of Understanding (MOU)/Memorandum of Agreement (MOA): Is a document describing a bilateral or multilateral agreement between parties. It expresses a convergence of will between the parties, indicating an intended common line of action. It is often used in cases where parties either do not imply a legal commitment or in situations where the parties cannot create a legally enforceable agreement.

New FOA: Any FOA that is not a continuation or supplemental award.

Non-Governmental Organization (NGO): A non-governmental organization is any non-profit, voluntary citizens' group which is organized on a local, national or international level.

Notice of Award (NoA): The only binding, authorizing document between the recipient and CDC confirming issue of award funding. The NoA will be signed by an authorized Grants Management Officer, and provided to the recipient fiscal officer identified in the application.

Objective Review: A process that involves the thorough and consistent examination of applications based on an unbiased evaluation of scientific or technical merit or other relevant aspects of the proposal. The review is intended to provide advice to the individuals responsible for making award decisions.

OGC: Office of the General Counsel (OGC) is the legal team for the Department of Health and Human Services (HHS), providing representation and legal advice on a wide range of national issues. OGC supports the development and implementation of HHS's programs by providing legal services to the Secretary of HHS and the organization's various agencies and divisions.

Outputs: What the DPH/STD program itself should achieve.

Outcome: The observable benefits or changes for populations that will result from a particular program strategy.

Outreach Service: A service such as STD testing, treatment, education or counseling provided outside of a clinical setting for someone who did not access clinical services in a timely fashion for a variety of reasons.

Performance Measures: Performance measurement is the ongoing monitoring and reporting of program accomplishments, particularly progress toward pre-established goals.

It is typically conducted by program or agency management. Performance measures may address the type or level of program activities conducted (process), the direct products and services delivered by a program (outputs), or the results of those products and services (outcomes). A “program” may be any activity, project, function, or policy that has an identifiable purpose or set of objectives.

Plain Writing Act of 2010: The Plain Writing Act requires federal agencies to communicate with the public in plain language to make information and communication more accessible and understandable by intended users, especially people with limited health literacy skills or limited English proficiency. www.plainlanguage.gov.

Practice-based Intervention: Interventions that practice has shown to be effective. These interventions typically do not have evidence of effectiveness or efficacy drawn from evaluation research or published in peer-reviewed journals. These interventions reflect the collective wisdom of experienced practitioners.

Program Official: The person responsible for developing the FOA – whether a project officer, program manager, branch chief, division leadership, policy official, center leadership or similar.

Program Science: An emerging systems initiative that uses scientific approaches to understand and help answer programmatic questions, incorporates program questions and data into the research question, works with totality of program, rather than through single interventions and is designed to maximize translation, adaptation, and dissemination.

Program Strategies: Public health interventions or public health capabilities or services, activities and outputs

Project Period Outcome: An outcome that will result by the end of the FOA period of funding.

Public Health Accreditation Board: PHAB is the national accrediting organization for public health departments. A nonprofit organization, PHAB is dedicated to advancing the continuous QI of Tribal, state, local, and territorial public health departments by advancing the quality and performance of all public health departments in the United States through national public health department accreditation.

SAM: The System for Award Management (SAM) is the primary vendor database for the U.S. Federal Government. SAM validates applicant information and electronically shares the secure and encrypted data with the Federal agencies' finance offices to facilitate paperless payments through Electronic Funds Transfer (EFT). The SAM stores organizational information, allowing www.grants.gov to verify your identity and to pre-fill organizational information on grant applications.

STD Screening: Obtaining an STD test in either the clinical or outreach setting to identify an asymptomatic infection that the client was not aware they had.

Statute: An act of a legislature that declares, proscribes, or commands something; a specific law, expressed in writing. A statute is a written law passed by a legislature on the state or federal level. Statutes set forth general propositions of law that courts apply to specific situations.

Statutory Authority: A legal statute that provides the authority to establish a Federal financial assistance program or award.

Strategy: A carefully devised plan of action to achieve a goal, or the art of developing or carrying out such a plan.

Syndemics: Two or more afflictions, interacting synergistically, contributing to increased transmission and/or worsened outcomes of either disease in a population.

Technical Assistance: The providing of advice, assistance, and training pertaining to the development, implementation, maintenance, and/or evaluation of programs.