

STD NNPTC FAQs

Last Updated: April 29, 2014

Applicants for the National Network of STD Clinical Prevention Training Centers (NNPTC) funding opportunity announcement can find answers to questions submitted via webinars or the nnptcfoa@cdc.gov mailbox on this page. Questions similar in nature were combined and/or edited for clarity.

The deadline to submit application questions to nnptcfoa@cdc.gov is April 4, 2014. The application period for this FOA closes on May 6, 2014.

APPLICATION

1. Is there a specific template to be used for the work plan (as described on page 43)?

There is no specific template.

2. On page 36, under subsection d, “Organizational Capacity of Applicants,” it states that applicants must include a CV or resume for the PI, Director, and other key faculty. Are NIH format biosketches also acceptable?

NIH format biosketches are acceptable.

3. If an applicant is applying for both A and (one or more) B components, and there are sections such as, “organizational capacity,” or, “ability to execute a national program,” that would be almost entirely duplicative for both A and B, must both project narratives include the same information?

Yes, applicants must submit a complete project narrative, itemized budget, and budget narrative for each component or strategy for which they apply. While this may require duplicating some sections, it also allows for greater specificity, for example, in justifying ones' capacity for a given content expertise. In addition, each component and strategy will be reviewed and scored by a separate review panel, who will not be required to read other sections. There is no need to submit separate LOIs, Project Abstract, CDC Assurances and Certifications, Table of Contents, Resumes/CVs for medical director of component A; and for PI and faculty SMEs of both component A and B, Letters of Support, Proof of Ability for National Program, Organizational Charts, Nonprofit organization IRS status forms, if applicable, Memorandum of Agreement (MOA), Memorandum of Understanding (MOU), and Bona Fide Agent status documentation.

4. Some training centers may want to collaborate to deliver certain strategies. If two organizations collaborate in such a way that one organization is a subcontractor (not a lead) on another PTC’s application, would that count against the three total strategies in

which an applicant can apply? For example, can an organization apply for three strategies (such as Curriculum, Evaluation, and Q.I.) and be a subcontractor for another organization's application for Technological Innovation?

Each application will be scored separately. Therefore, one organization could apply for the maximum three Component B strategies, and could also be listed as a subcontractor for another organization. Collaboration is encouraged.

5. Is there a specified page limit for the attachments?

Although there are no page limits for many of the attachments, applicants should be advised that reviewers are not required to read all attachments, and cannot use the attachments to circumvent the narrative page limits. Although the FOA template allows a work plan to be uploaded as a separate attachment, we discourage this. The complete work plan must be included in the project narrative.

6. Should the work plan reflect seven months?

Yes, the year one budget, narrative, activities, and work plan should each reflect the seven-month period.

7. Are references required for either or both applications (i.e., Component A, Component B)?

References are appreciated, but not required for either or both applications.

8. If applying for a regional center and one or more national centers, are all attachments combined, or should each national center have a separate set of attachments?

Abstracts and additional attachments may cover all components and strategies, and need only be submitted once.

9. The FOA states (pages 34 and 36) that *all* narratives (A and/or Bs) and *all* budgets (A and/or Bs) have to be made into *one* narrative PDF and *one* budget PDF. Given that Component A and Component B applications are separate, is this accurate to combine into one PDF?

If applying for multiple national centers, should it be submitted as one Component B application or individual applications for each national center, with separate budgets?

Though applicants may submit individual applications for components A and B (as per the FOA), we have learned that it is possible to upload multiple documents for each FOA requirement within a single application. As such, applicants are allowed (and encouraged) to submit one application in response to this FOA. Application documents for each Component (A or B), or National Strategy, may be uploaded as individual documents within the single application.

For example, if applying for multiple components or strategies, documents may be labeled Project Narrative A, Project Narrative B1(strategy name), Project Narrative B2 (strategy name), Project Narrative B3 (strategy name). Abstracts and additional attachments cover all components and strategies, and need only be submitted once.

Component B applicants should develop a separate itemized budget narrative for each of the core functional strategies for which they are applying. Each itemized budget narrative can be uploaded as separate documents. Applicants are encouraged to use a naming convention such as PIname_BudgetNarrativeB1_strategy.

For example, let's say that PI is Jane Smith, and Jane Smith is applying for Component A, and two strategies under Component B; the documents Jane Smith should submit to grants.gov are as follows:

Abstract (All Components and Strategies)

Smith_Project Narrative A

Approach

Evaluation and Performance Management

Organizational Capacity

Smith_Project Narrative B1_Coordination

Approach

Evaluation and Performance Management

Organizational Capacity

Smith_Project Narrative B2_Curriculum

Approach

Evaluation and Performance Management

Organizational Capacity)

Smith_Budget Narrative A

Smith_Budget Narrative B1_Coordination

Smith_Budget Narrative B2_Curriculum

10. The FOA states that national centers need to show proof of ability for a national program by providing the following: a.) a list of faculty who are content experts in the respective center’s work; and b.) evidence of the ability to implement a national program. What qualifies as “evidence” for the ability to implement a national program?

Articles of incorporation, board resolution, and by-laws, among other forms of written evidence, are considered acceptable.

11. Page 34 of the FOA shows a slightly different format than is outlined on page 42 of the FOA. While both of these templates require the same information, the information is presented differently. Further, in the response to question #5 of the FAQs regarding the application, it indicates that the Work Plan should be included in the Narrative, so which of these templates should we use?

The template on page 42 is correct. The Work Plan is included in the Narrative, and does not need to be uploaded separately:

- i. Approach
 - a. Background and Purpose
 - b. Outcomes
 - c. Program Strategy
 - d. Work Plan
- ii. Evaluation and Performance Management
- iii. Applicant’s Organizational Capacity...
 - a. Demonstrates experience...to achieve goals
 - b. Demonstrates experience...to implement evaluation
 - c. Project Management
 - d. Budget

12. Will there be an application submission checklist for PS14-107 like there was for PS14-1403?

An application submission checklist will not be provided for this FOA.

13. Page 36 of the FOA describes including CVs/resumes for various personnel and an organizational chart. Are these documents considered an addendum or are they included in the project narrative page limit of 25 pages for the regional centers?

These files are considered “Other Attachment Forms,” and should be uploaded separately from the project narrative, and do not count toward the 25-page project narrative page limit.

14. With regard to the request in the FOA to provide proof of capacity to execute a national program, I work at a University for which I can find nothing regarding bylaws, articles of incorporation, etc. Can you perhaps clarify exactly what is being asked for here, and if it applies to all entities who apply? What would “other forms of written evidence” be and by whom would it be written?

Acceptable forms of written evidence will indicate to reviewers that the applicant has experience with and/or the capacity for national program implementation. This may take the form of the above-mentioned documents, but may also be documentation of national activities in which the applicant is currently engaged, a letter of support or backing from the academic institution, etc.

15. Regarding document submission for this FOA, if I am reading it correctly, if an applicant is applying for three components (A and two Bs), then a total of three separate PDFs would be submitted for narratives (Comp. A Project Narrative PDF, Comp. B1 Project Narrative PDF, and Comp. B2 Project Narrative PDF). In the grants.gov package, however, there is only space to upload one “Mandatory Project Narrative File” and one “Optional Project Narrative File.” Can you please clarify which of the three narratives in the example above would be the “Mandatory Project Narrative” and which would be the “Optional Project Narrative?”

The application package allows for the uploading of additional narratives. All narratives will be received and reviewed by CDC staff. Their upload order will not matter.

16. As stated on page 25 for the Work Plan, applicants are to include, “Administration and assessment processes to ensure successful implementation and quality assurance.” Can you please provide more detail on what this is referring to?

In this context, quality assurance is the strategic process by which the applicant will ensure the fidelity of the program. This includes systems for proactively avoiding problems with program implementation, and midprogram correction. Applicants may detail plans for systematic measurement, comparison with a standard, monitoring of programmatic processes, feedback loops, etc.

17. The revised FAQ instructed applicants to follow the outline format found on page 42 of the FOA for Comp. A. Can you now clarify specifically where the Target Populations and Inclusion sections should be?

These sections should follow the Collaborations section, and should be toward the end of the Approach section (all of which are considered aspects of Program Strategy), but before the Work Plan.

STAFFING

1. Regarding the Ph.D.-level requirements for the Component B programs (pages 26–27), can persons with Master’s degrees, and with five, or seven, or ten, or more years of subject-matter experience be substituted in lieu of the .25 Ph.D. requirement?

No, the FOA specifically requires a Ph.D.

2. Are clinical faculty with M.D. degrees, with expertise in the subject matter, qualify as individuals with doctoral-level expertise?

Yes, an M.D. qualifies as doctoral-level experience.

3. For the personnel requirements under any component (pages 25–27 of the FOA), can these positions be in the form of consultants on subcontracts, or must they be in-house staff hires?

These positions could be filled by consultants, subcontracts, or in-house hires.

4. For the personnel requirements under any component (pages 25–27 of the FOA), are they required to be on staff at the time of the start of the funding (September 1, 2014), or can the work plan include a timeline for hiring?

If all personnel are not on-staff at the start of the award, it is reasonable to include a timeline for hiring in the work plan, as long as the position can be filled within the first three months of funding.

5. Please define mid-level faculty (as described on page 25). Is this a junior faculty member, as in an M.D., Ph.D., or something else, or does the mid-level refer to an N.P., R.N., or P.A.?

"Mid-level" refers to members of clinical faculty who are neither fresh graduates nor established senior faculty. In academic settings, mid-level means faculty who are mid-career, or hold an assistant or associate professor status. This usually refers to M.D.s, but some advanced practice nurses may also qualify.

6. Does the mid-level faculty member need to work at a level III STD site?

No, the mid-level faculty need not be currently working at a level III STD site. The person should have significant STD subject matter expertise and work in a setting that cares for persons at risk for STDs. The goal is to have this person provide mentorship to students and junior faculty, and to assist the CDC to develop guidelines and other clinical materials.

7. Are the listed personnel limited to just the lines of the Medical Director, Mid-Level Faculty, Fellow, and Coordinator, or can other lines, such as data coordinator, be listed?

In addition to the required personnel, applicants may include other types that help achieve the FOA goals.

8. For component B curriculum, it says that you must have a 0.25 FTE doctoral-level expert in curriculum development and adult learning theory. Can you please state what would show as expert in curriculum development and adult learning theory, and also, if this person can be in-kind?

The 0.25 doctoral-level expert can be fulfilled with any doctoral degree (i.e., M.D., Ph.D., Dr.P.H.), however, the person should have significant national recognition and publications in the content area. These positions could be filled by consultants, subcontracts, or in-house hires. We prefer that the expertise be funded at 0.25; however, with sufficient documentation of commitment, in-kind donation of time would be considered.

9. On page 25, it states that for Component A, a 1.0 medical fellow is required. Does this have to be a single individual at 1.0 FTE, or could it be, for example, two individuals, each at 0.5 FTE?

Is this person 100% full-time for one year, or could it be .5 FTE for two people?

Applicants can fulfill the 1.0 FTE requirement for a fellow by splitting the FTE among one or two persons (see also line 30).

10. On page 25, it states that for Component A, a 0.5 midlevel faculty is required. Does this have to be a single individual at 0.5 FTE, or could it be, for example, two individuals each at 0.25 FTE?

Applicants can fulfill the 0.5 FTE requirement for a faculty by splitting the FTE among one or two persons.

11. Training centers may have experienced mid-level staff without a current academic appointment. Since receiving an academic appointment is not an immediate process, is it expected that these mid-level staff will have an academic appointment at the time of application (to meet the detailed staffing requirements of Component A) or would it be acceptable to indicate that the identified mid-level staff are going through the appointment process?

It is acceptable to indicate on the work plan and timeline that the identified mid-level staff are going through the appointment process.

12. Can any staff positions be “in-kind?” If so, are there any minimum or maximum percentage of FTEs requirements for in kind?

We prefer that staff positions be funded; however, with sufficient documentation of commitment, in-kind donations of time will be considered.

13. Page 4 of the FAQ states, “applicants can fulfill the 0.5 FTE requirements for faculty by splitting the FTE among one or two persons.” Can the FTE be split among 3 persons? 4 persons?

Applicants can fulfill the 0.5 FTE requirements for a faculty by splitting the FTE among one or two persons. We will consider other models only if they are well justified.

14. The FOA requires Component A regional center staff to include support for at least a 0.3 FTE medical director with recognized STD expertise. Can that 0.3 FTE medical director be split between two people? For instance, can there be two individuals that meet the requirements for the position, but each counted at a 0.2 FTE for a total of 0.4 FTE between the two?

Ideally, we prefer a single medical director for each center. Another model will only be considered if it is well-justified.

FELLOWSHIP REQUIREMENT

1. Can currently hired Part I medical staff be considered in lieu of the required STD medical fellow staffing requirement?

The medical fellow should be in a training program and not be part of an established medical staff.

2. Can you please provide more details regarding the role of the fellow? What are the core aspects/role of this person’s work?

The goal of including a required medical fellow is to build the next generation of STD experts. We expect the medical fellow to be an integral part of the PTC, to learn STD care from the PTC experts, and to participate in developing, delivering, and improving PTC training. We expect fellows to spend about 20% in clinical care and the rest supporting PTC activities. After fellowship, we expect these fellows to be equipped to be experts in clinical, academic, or public health STD programs.

3. Is this person’s work part of a formal fellowship program? Or is this an informal position?

A formal relationship with a fellowship training program is preferred, with the PTC providing some funding for clinical training and evaluation work. However, a more informal relationship might be acceptable.

4. Is there an expected length of term for the fellowship? Is this a rotation that could last a month or a few months?

Short (one-month to three-month) rotations for multiple fellows would not allow each fellow sufficient opportunity to build STD expertise or develop, deliver, and improve PTC training. Ideally, we prefer a single fellow for one year, or two fellows at six months each. Other models will only be considered if they are well justified.

5. We appreciate the inclusion of an STD fellow. However, given that the average award of Component A is anticipated to be \$300,000, and that the cost of a full-time STD fellow could (with salary, benefits, and indirects) approach or, in some areas of the country, exceed half of the total award, does the fellow’s full expense need to be solely funded off of this grant? For example, a typical STD fellow may spend 35% of their time seeing patients in a Level III STD clinical setting; spend 10%–15% of their time cross-training in program collaboration service integration (PCSI) related areas such as HIV, TB, and immunization; 20% of their time on STD research projects; and 30% of their time delivering training and/or providing clinical consultation services for the PTCs. In such a scenario, there might be complementary support to make up the 1.0 FTE of the STD fellow position. Is it the intent of this FOA that 100% of the fellow’s salary and benefits be supported by this grant, or can centers examine other ways in which to build the 1.0 FTE position?

PTCs are required to include a medical fellow in order to build STD training into post-residency training. This moves training upstream from a past focus on retraining clinicians already in practice. Applicants may propose alternative strategies to fund the 1.0 FTE fellowship position.

6. Can a portion of the support for the 1.0 FTE STD fellow be “in-kind” with a partner, if the Statement of Work addresses STDs and allots time for work with the Prevention Training Center?

Applicants may propose alternative strategies to fund the 1.0 FTE fellowship position, however, the fellow’s full appointment must support the work of the Prevention Training Center.

7. For the required STD fellow, can this person be an NP or does the fellow need to be a physician?

The required post residency medical STD fellow must be a physician.

8. The FAQ page 4 states that “applicants can fulfill the 1.0 FTE requirement for a fellow by splitting the FTE among one or two persons.” Can the FTE be split among 3 persons? 4 persons?

Short (one-month to three-month) rotations for multiple fellows would not allow each fellow sufficient opportunity to build STD expertise or develop, deliver, and improve PTC training. Ideally, we prefer a single fellow for one year, or two fellows at six months each. Another model will only be considered if it is well justified.

GENERAL

1. To be awarded a Component B National Center, do you need to have also been awarded a Component A Regional PTC?

No. To clarify, you may apply for Component A only or for Component B only or for both components. You may apply for up to three strategies under Component B.

2. What is a Level III STD site? Can you give examples and provide more specific detail than what is in the definition provided? Further, what is, “complex STD care,” as stated in the Level III definition?

Level III STD sites offer Level I (basic screening and treatment) and Level II care, which encompasses onsite point-of-care diagnostic testing for symptomatic individuals, same day empiric treatment (including injectable antimicrobials) for those with symptoms suggestive of an STD, or for contacts to a partner with an STD. Providers have expertise in serving the needs of vulnerable or stigmatized high-risk individuals, such as MSM and transgender people, or those concerned about confidentiality, such as minors. Level III providers also have the ability to diagnose, treat, and provide follow-up for complex STD cases, such as HIV/STD coinfection (e.g., syphilis case coinfecting with HIV, with rising titers and prior LP), rare clinical syndromes (e.g., persistent genital ulcers, syphilis in PCN-allergic pregnant patient), and persistent or resistant infections (such as gonorrhea). At a Level III site, clinicians have extensive training/experience in complex STD care. In addition to providing complex STD care, Level III sites are those that provide training to medical and nursing students, residents, and fellows, and may conduct research. Level III sites are viewed by their peers as the experts in the community.

3. Page 14 states, “For the purposes of the application only, each Component A applicant should define its regional coverage areas as the HHS region in which it is located.” In the previous funding cycle, the CDC assigned additional states outside of HHS regions to the training territories of some PTCs. While this initially created (not insignificant) programmatic challenges, over the past three years these centers have spent considerable effort making inroads, building relationships, delivering training, and building capacity in those states. Restricting applications in such a way that doesn’t allow those centers to expand (and expound) upon current projects, ongoing relationships, and opportunities presented by those efforts creates potential challenges in writing and in

equitable evaluation. Is it possible to redefine this statement to say that centers may opt to include additional states currently assigned to their training territory?

Asking each applicant to describe their plan for the HHS region (<http://www.hhs.gov/about/regionmap.html>) in which they are located provides an even playing field for new and experienced applicants. Therefore, all applicants should describe their plans for year one based on the HHS region in which they are located. Current PTC awardees can include work in states outside their region in the organizational capacity section. In this new FOA, the CDC will award funding based on the quality of each applicant, available funding, geography, and programmatic needs. Thus, the exact coverage area (and number of states) for each regional PTC will be determined after the awardees are chosen.

4. Should Category A Regional Centers expect to assist with staffing a national STD Warmline as proposed in the Category B Coordination Strategy?

We expect that the Regional PTC faculty will provide some expertise for the warm-line, but the regional PTCs will not provide direct funding.

5. Is the national coordination center expected to provide CEs for all regional activities, or just national activities or nationally standardized curriculum?

All CEs should be coordinated through the national center, as this will conserve resources.

6. Will each regional center be expected to have a learning management system of some type, in addition to the registration system included in the National Coordination Center?

No. The National Coordination Center is expected to develop/maintain a system that all regional centers can easily work with.

7. For the National Center on Technological Innovation, are the expectations solely based on developing new technology and its dissemination, or could the focus be on coaching healthcare settings on how to use technology to improve the delivery of STD clinical care?

The Technological Innovation center is expected to focus on developing new technology. While there is some overlap, disseminating and coaching healthcare settings on how to use technology to improve the delivery of STD clinical care would be a Quality Improvement Center Activity coordinated with the regional level.

8. Should Regional PTCs describe how they will work with *all* national centers in their work plan?

The national and regional centers are required to work collaboratively. Thus, each regional PTC should describe a high-level plan to collaborate with each national center.

9. If Regional PTCs only need to identify how they will work with the curriculum and evaluation centers, then who is the customer for the QI and TI centers and what is the nature of the relationship between these centers and the Regional PTCs? This will affect the work plan.

The national and regional centers are required to work collaboratively. Thus each regional PTC should describe a high level plan to collaborate with each national center.

10. Will the national evaluation center be charged with development of a database or using a system at CDC?

The national evaluation center could propose developing an independent database or could use an existing system.

11. If we are already working with safety net providers who are not part of our region, but are part of a current state AAPPS grant for our area, can we discuss these activities to show capacity?

Yes, any current activities outside your HHS area can be included under organizational capacity.

12. With regard to the Component B National Technology Center, could tools developed include patient-focused tools that help the provider, ultimately leading to better STD clinical care?

Yes, this is acceptable.

13. In Component B for Quality Improvement, it is stated that, "Quality Improvement experts are required to promote the development of a national 'learning network' for the provision of STD clinical preventive services." Can you please clarify how you would define a national "learning network?"

A learning network connects STD prevention stakeholders (e.g. individuals, facilities, states, regions, etc.) in communities of, and opportunities for, structured learning that focuses on large-scale behavior change. This allows for the rapid and synergistic transmission of wisdom, energies, resources, and advancements in the field.

The article *Learning Networks for Sustainable, Large-Scale Improvement* by C. Joseph McCannon and Rocco J. Perla, EdD, MA, offers a detailed description of learning networks, their characteristics, and examples of their use.

FUNDING AND BUDGETING

1. How much of Year One could be devoted to needs assessment/planning versus delivering trainings? If Year One is devoted to planning, the budget is likely to be very different from subsequent years. Is the U62 Cooperative Agreement mechanism flexible enough to allow for this significant shift?

As Year One is a short year (seven months), and will, of necessity, involve reassignment of states, some planning is expected. The evaluation center is expected to design the tools for needs assessment for the regions to use. Some training is expected as PTCs get to know their regions. Since the CDC has published a wide funding range, we have flexibility to adjust budgets each year.

2. What would CDC PGO prefer or require, a Year One budget application that is 7/12 of the *total* typical annual budget, or should an application be written as if Year One is 12 months long? Is the budget for the application to be for one full year, or only for seven months?

Applicants should apply for a seven-month budget, as only seven months will be awarded. Thus, there will be less need for lengthy budget renegotiations.

3. Page 13 states that the funding for Component A ranges from \$200,000 to \$450,000. Page 29 states that the floor amount for Component A is \$200,000, and the ceiling amount is \$700,000. Can you please clarify the maximum amount that applicants can request for Component A?

For Component A, the higher ceiling (\$700,000) listed on page 29 of the FOA is correct.

4. Can you please clarify the floor and ceiling amounts of funding for each individual Component B part?

The ranges for individual Component B strategies are as follows:

- Coordination functional strategy: \$100,000 to \$200,000
- Curriculum, Evaluation, Quality Improvement, or Technologic Innovation functional strategies: \$100,000 to \$400,000 each
- Total Component B: \$100,000 to \$650,000. The total component B award cannot be more than \$650,000.

Two examples:

Applicant XYZ decides to apply for two strategies: the maximum Coordination (\$200,000), plus the maximum Curriculum (\$400,000), for a total of \$600,000.

Applicant ABC decides to apply for three strategies, so they must propose a budget that stays under the Component B \$650,000 cap. They propose Evaluation (\$250,000), Quality Improvement (\$250,000), plus Technologic Innovation (\$100,000).

5. Do funding amounts differ in Year One (seven months) and years Two through Five (12 months each), given the difference in length of years? If so, can you clarify the exact funding ceilings for Year One and for years Two through Five for both Component A and Component B?

The floors and ceilings of the awards are the same, regardless of the funding year.

6. Should Category A Regional Centers budget for CME for regional efforts, or will that be covered under the Coordination Center?

All CE should be coordinated through the national center, as this will conserve resources.

7. Is the expressed average annual award expected to be prorated for the seven-month period?

Yes, the Year One award will be prorated at 7/12 of the annual award.

8. In prior funding cycles, CDC has granted the same award dollar amount to all eight training centers. Might these awards be weighted according to population, STD morbidity, and size of geographic area?

Award amounts may differ based on factors including, but not limited to population, STD morbidity, and size of geographic area.

9. The response to question #5 in the FAQs regarding budget states that applicants can assume the first year ceiling is \$700,000, even though that amount represents the budget for a 7-month time frame. Does this mean applicants can apply for the full \$700,000 for the first year (7 months)?

Although we did not publish a different ceiling for Year One, applicants are advised to apply for a seven-month budget, as the award will be pro-rated at 7/12 of the award amount.

10. In the FOA, and in the FAQ, it indicates that all continuing education (CE) must be coordinated through a national center to conserve resources. My University School of Medicine (SOM) requires that all SOM projects conferring continuing medical education (CME) do so through the SOM Office of CME. It is an across-the-board SOM requirement and has attached nonnegotiable fees. Can I budget for CME fees in this case?

Applicants from institutions requiring in-house CME may include CME fees in their budgets.

11. It remains unclear, due to multiple, and slightly differing, answers exactly how much we are allowed to apply for in Year One, Component A. As an example, if I were applying for the maximum amount possible for Year One, should my actual budget be for \$700,000 or \$408,331?

The ceiling's prorated value would be 7/12 of \$700,000 (or \$408,333.33). Applicants are encouraged to submit budgets reflecting the first year's prorated value to prevent lengthy budgetary renegotiations. As such, please note in your budget narrative whether or not your requested amount already reflects the seven-month prorating.

12. The 30% physician's effort, as required in the grant, will require our physician to reduce clinic time. This will therefore reduce the amount of his/her annual compensation.

Is it within budget policy to cover the loss of revenue generating time through grant resources, so that our physician does not experience a reduction in salary due to participation on the grant? If so, what is the acceptable mechanism for listing this salary off-set if allowed?

We asked that 30% effort (and salary) be directed to this FOA. Therefore whatever you have documented as the physician's total compensation would be considered the base for the 30%.

As for clinical revenue generated, it is unlikely that the CDC would approve a budget line item that stated offset for lost clinical time.

Please be reassured that the budget is only scored 5 points, and budget re-negotiations post award are standard practice.