STD PCHD

Strengthening STD Prevention and Control for Health Departments

Technical Assistance Note #18| Up to 10% funding for safety net assistance

From Strategy Area III: Promote CDC-Recommended Screening, Diagnosis, and Treatment

Assistance for STD clinical prevention services

In addition, applicants may provide assistance, no more than 10 percent of the overall award amount without prior approval from CDC, to not-for-profit or governmental clinics that can document their ability to provide safety-net STD clinical preventive services as per CDC guidance. At a minimum, clinics receiving assistance should have the capacity to rapidly diagnose and treat bacterial STDs. This assistance could be used to screen, diagnose, or treat uninsured and underinsured people. Applicants must have memoranda of understandings (MOU), contracts, or other forms of written agreements describing the terms of this assistance with the organizations that receive it. CDC may request copies of these agreements throughout the period of performance.

These activities should be conducted in compliance with CDC's STD Treatment Guidelines, and as permitted under relevant federal, state, and local laws and regulations. CDC reserves the right to reduce the allowable amount that may be used to support these services in subsequent years.

Why DSTDP included these strategies

State and local STD programs have an important role in promoting and supporting STD clinical preventive services for uninsured and underinsured individuals who lack access to clinical services. Support for these services can help strengthen STD programs' ability to influence health care practices and to collaborate with other key partners in the STD prevention landscape in their project areas. However, the primary purpose of federal funds for health department STD programs should not be routine clinical care, but surveillance and other core strategies outlined in STD PCHD, such as disease investigation. Federal funding from STD PCHD should be used to strategically leverage funding from other sources to increase access to STD clinical preventive services for under/uninsured individuals. Those sources may include state and local governments; federally funded HRSA programs such as Health Centers; MCH; FQHCs; school-based, public housing, homeless, and migrant health centers; and Ryan White HIV/AIDS programs; Title X-funded programs, third party payers, including state Medicaid programs; and others.

The funding target of 10% or less for this safety net assistance is flexible, so programs can implement comprehensive STD prevention and control programs of highest impact tailored to local epidemiology and context. This clinical safety net assistance is also optional under STD PCHD. Funded STD programs can choose not to use any STD PCHD funds for clinical safety net services.

Key Definitions

Safety net: In this case, the safety net refers to clinical service providers who offer subsidized, free, or sliding scale services for individuals who have limited access to health care service by virtue of being uninsured or underinsured.

Clinical preventive services: These services include screening, testing, diagnosis, and treatment that support STD prevention and control and are recommended by CDC. The support can include screening for CT, GC, or syphilis for individuals at risk, as well as treatment for those under/uninsured individuals infected and their partners (includes expedited partner therapy (EPT), where permitted by law).

Capacity to rapidly diagnose and treat: Such clinics should have on-site testing and treatment for bacterial STDs and should not rely on referral for treatment. However, they do not have to provide the level of care available at STD specialty care clinics. For example, testing may be done by external laboratories, but providers still need to ensure timely follow-up and treatment of infected patients.

Underinsured: Being "underinsured" takes many forms, may be location-specific, and is not easy to define in simple terms. Underinsured individuals may have health insurance coverage for a highly limited set of services or conditions (e.g., for prenatal care and delivery only) or face high deductibles or co-pays that strongly influence their health care seeking behavior and restricts their access to preventive health care services. This may include patients who seek STD care in the private sector and cannot afford the cost of treatment or co-pays.

Considerations for implementation

Deciding which providers and preventive services to support

- Identifying safety net clinics or providers in a project area should start with epidemiologic analyses of morbidity by geographic area, priority populations and type of clinical setting where cases are identified. Updated surveillance data to identify new areas of high burden and/or notable STD increases should be used in the decision-making process.
- This process should also include profiles of safety net providers. These profiles may include a summary of the patient population served by each provider, including number and percent of patients stratified by age, gender, sexual orientation, race/ethnicity and insurance status.
- Given resource limitations, project areas likely need to prioritize among those safety net providers or clinics, based on volume, need, population, and likely public health impact of the assistance provided.
- Data should drive decisions about whom to support under STD PCHD. This safety net assistance should be directed at the following priority populations: pregnant women at risk for STDs, adolescent and young adults (particularly women), and MSM, in accordance with CDC and USPSTF screening recommendations.

What kind of assistance can be provided

- All assistance under this program must be directed at serving under/uninsured individuals and at addressing aspects of CT, GC, and/or syphilis clinical preventive services
- The assistance does not have to be committed to a single program of assistance; providers who participate in the program do not have to receive the same type of assistance. For example, 3% of total funding could go to one set of safety net providers for syphilis treatment, while another 5% of total funding could support three high volume providers that serve priority under/uninsured females for limited use of the public health laboratory for cervical/vaginal screening for CT/GC in young females.
- This safety net assistance for under/uninsured individuals can take various forms, and it could be indirect and/or direct or in-kind, including:
    - Funding public health laboratories for routine CT/GC/syphilis screening or testing services
    - Purchasing test kits for CT/GC for clinics that meet the program criteria
    - Purchasing syphilis testing reagents for clinics that meet the program criteria
    - Purchasing Benzathine penicillin G for infected patients and partners at risk of not receiving timely recommended treatment for syphilis

- Purchasing medication for CT or GC for infected patients and partners at risk of not receiving timely recommended treatment, including expedited partner therapy (EPT)
- Contracts or health department staff time needed to implement the MOUs and collect the data requirements of the above programs or services

- This assistance should not be used to cover:
  - Testing or treatment related to infections other than CT, GC, and syphilis
  - CT/GC/syphilis clinical preventive services for individuals who are not under/uninsured
  - Salary, stipends, or benefits for health professionals providing direct care
  - Condom purchases and condom distribution programs
  - Expedited Partner Therapy when part of a EPT program that targets populations other than just the under/uninsured (see TA Notes #8)
  - Social marketing campaigns to reach target population and promote awareness and use of services for the under/uninsured

Establishing MOUs, contracts, or other written agreements with the providers

- Written agreements should govern assistance for safety net services to ensure that the funding is used as intended, and to allow the STD programs to adequately monitor the use and value of any assistance provided
- It is essential that any MOU, contract, or other written agreement clearly stipulates the intent of the program -- i.e. to serve under/uninsured individuals -- and that the agreements place responsibility for documenting that is the case on the recipient providers
- Each STD program should consult their respective contracting/procurement/legal offices to identify the most efficient way to establish written agreements. Memoranda of Understanding may be sufficient in some cases, while formal contracts may be merited in others
- Written agreements should be used to outline the assistance provided by the STD program, what the providers will do, and what information or data the STD programs needs in return. The type of program monitoring and evaluation required under an assistance program will differ depending on what kind of assistance is being offered. Generally, STD programs should be able to assess, when possible, what they "bought" (e.g., tests purchased or paid for) & what they "got" as a result, or outcomes associated (e.g., screening, diagnosis, treatment)
- DSTDP may request copies of these written agreements
- DSTDP will request information and data about how these funds are used, populations served and associated screening, diagnosis, and treatment outcomes. Details on this information are forthcoming

Justification to devote more than 10% to this asssistance

- Justification for using more than 10% of STD PCHD funding for this purpose must be strong and based on the STD epidemiology, local context, and available resources. Such proposals will be reviewed by DSTDP and considered in the context of the entire prevention and control program supported under STD PCHD.
- Discussion of proposals to exceed 10% will cover the following:
  - Evidence that other parts of STD PCHD implementation are not being under-supported as a result of spending more in this particular area
  - A description of the priority population(s) that will benefit from this assistance
  - The geographic area(s) or clinical partner(s) that will be receiving assistance
  - Documentation of need (e.g., insurance status of target population)
  - Any other concrete benefits to the STD program that the additional funding provides (e.g., by virtue of partnerships strengthened through the funding)
  - Anticipated impact of limiting assistance to 10%

- A data collection plan to assess populations served and public health outcomes obtained through the assistance
- Historical funding for such safety net assistance and what efforts were made to identify other funding sources, programs or strategies
- Reasons that other funding sources or programs at the state/local level cannot be used or leverage to meet the expressed need
- Intention and plans to decrease the project area's allocation over the course of the period of performance towards 10% of budget through other funding sources, programs or strategies

For more information or feedback on this document, contact your DSTDP Prevention Specialist or email STD_PCHD@cdc.gov. CDC's Division of STD Prevention, Program Development and Quality Improvement Branch, developed this document for recipients of PS19-1901 STD PCHD to provide additional clarification of strategies outlined in that NOFO and to support program implementation. The content here does not represent additional NOFO requirements nor official CDC recommendations. Issue date: April 2019