FREQUENTLY ASKED QUESTIONS AND ANSWERS FOR APPLICANTS TO PS19-1907 STD SURVEILLANCE NETWORK (SSuN)

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**GENERAL/DOCUMENT ACCESS**

1. Hello, I am attempting to download the information for the grant, but when I click on the link it is taking me to a blank page. This is regarding Funding opportunity number: CDC-RFA-PS19-1907. The link that was provided to us: [https://www.grants.gov/web/grants/view-opportunity.html?oppid=309297](https://www.grants.gov/web/grants/view-opportunity.html?oppid=309297). Although I was able to search and see the information that way, I am unable to click on the application.

   **Answer:** Due to a system error, the original link to CDC-RFA-PS19-1907 on Grants.gov was updated on Feb 21st. The correct link is: [https://www.grants.gov/web/grants/view-opportunity.html?oppid=313105](https://www.grants.gov/web/grants/view-opportunity.html?oppid=313105)

2. This morning our team received a message that the NOFO for SSuN Cycle 4 has been “deleted” and we are no longer able to access the NOFO. Will a revised NOFO be available?

   **Answer:** Due to a system error, the original link to CDC-RFA-PS19-1907 on Grants.gov was updated on Feb 21st. The correct link is: [https://www.grants.gov/web/grants/view-opportunity.html?oppid=313105](https://www.grants.gov/web/grants/view-opportunity.html?oppid=313105)
**ELIGIBILITY**

1. If a state health department and a city/county health department within that state are both applying to this grant independently, is the state application still expected to include that city/county’s geography within the jurisdiction of their state application?

   Answer: Yes. However, if state-level applicants are collaborating with a political sub-division (e.g. county or city) within their jurisdiction to submit an application for SSuN funding independently, the state should describe this collaboration in their narrative and present work plans and budget narrative based on two contingencies; a) both areas successfully competing for funding, and, b) only the state-level applicant receiving funding. In the event that both applicants are successful in being awarded funding, the state would not be expected to conduct (or be responsible for) activities in the separately funded area.

2. We would like to clarify this sentence from p. 16, section 10.6: “All recipients must implement Strategy B activities within their entire jurisdiction or proposed geographic area”. Does this sentence mean the same thing as the following sentence: “All recipients must either implement Strategy B activities within their entire jurisdiction or within a proposed geographic area...”? In other words, does this mean that a state government applying may choose to propose to conduct Strategy B within a smaller geographic area within their administrative boundaries, rather than including all city and county health departments within their entire state jurisdiction? If choosing a smaller proposed geographic area is allowable, I believe that answers our question to #1 above as well.

   Answer: On page 16 of the NOFO, under activity 10.6, jurisdiction is defined: “For state governments, this includes all counties and cities in that state regardless of independent funding status. ... City or county health department applicants (regardless of independent funding status under PS19-1901), in consultation with state health department STD programs, may propose to conduct activities in broader geographic areas. The geographic extent must be specified and formal proxy authority for access to HIV/STD surveillance data throughout the entire geographic area proposed must be documented. ... All recipients must implement Strategy B activities within their entire jurisdiction or proposed geographic area, and may choose to include STD-specific clinical facilities for Strategy A activities from any location within their jurisdiction or proposed geographic area.”

   The phrase ‘...or proposed geographic area.’ refers to proxy applicants proposing a broader geographic area than their administrative catchment. Please see answer to number 1 above for additional clarification on the responsibility of state-level applicants in the event that political sub-divisions are successful in their application for funding.

3. In previous cycles, the eligibility criteria was “State and local governments or their Bona Fide Agents that are current recipients of funding for Comprehensive STD Prevention Systems Cooperative Agreements (this includes the 50 states, the District of Columbia, the Commonwealth of Puerto Rico, Virgin Islands, Baltimore City, City of Chicago, New York City, Philadelphia, Los Angeles, and San Francisco) or American Indian/Alaska Native tribal governments (federally recognized or state-recognized).” However in this NOFO, the eligibility
criteria is defined as “Eligibility is limited to the following types of entities, per the program’s authorizing statute: States and, in consultation with the State health authority, the political subdivisions of States.” Does this mean that local jurisdictions who are independently funded are still eligible as long as we provide some documentation that this decision was made with our State health department OR does it mean that only States are eligible to apply?

Answer: City and/or county-level health departments are eligible to apply independently for this notice of funding opportunity (NOFO). Consultation with the state health authority for independent applications may be demonstrated through a simple letter of concurrence (included as an attachment) or through a more formal MOU/MOA if significant collaboration is proposed. For applications where a political subdivision such as a city or county health department proposes to implement activities for a broader geographic area (such as statewide) a formal MOU/MOA granting proxy authority to access relevant surveillance records for the broader geographic area must be attached.

4. I received the CDC-PS19-1907 RFA this morning via a grants.gov email. I have a few questions for clarification related to this RFA prior to beginning the application process. Are the only eligible entities state and/or local governments or governmental organizations (local DOH)? If so, could that governing body subcontract with a separate local entity to assist in the work? For example, our local health department would act as the STD clinic and collect all pertinent data, but they would contract with another entity to perform all of the data analysis. Is it imperative that an applicant apply to all 3 Strategies, or can an applicant focus upon one or two of the strategies (e.g. only Strategy A or only A&B)? ➔ I’m looking for a little clarity on pages 6-7

Answer: As outlined in the text of our notice of funding opportunity (NOFO), eligibility is restricted to states, and in consultation with the state health authority, the political subdivisions of states. Eligible entities would include states, counties and cities, in collaboration with their respective state health departments. Recipients of funding under this NOFO may sub-contract with any appropriate entity to accomplish the stated scope of work.

Applicants must apply for, and demonstrate capacity to fully implement, Strategies A and Strategy B and also must propose to conduct at least one Strategy C activity to be considered for funding. We certainly encourage all interested agencies and organizations to engage with state/local health department STD programs regarding this funding opportunity and, where appropriate, to collaborate in developing applications for funding.
STRATEGY A – SENTINEL SURVEILLANCE IN STD CLINICS

1. Can you provide us with a short summary outlining the overall goal/outcome of matching all visits to the STD clinic with eHARS? We are meeting with our clinic and we have some major concerns about reporting information on clients without a positive diagnosis to the state health department. Do you have any “talking points” to share with patients? How do we explain to patients that test negative for all STDs they are still sharing their information to our state surveillance team?

Answer: In this new cycle of SSuN, we are requesting that recipients securely match the full census of clinic patients presenting for care in participating STD clinics against information contained in their local HIV surveillance registry (eHARS, or similar county/city level registry). This activity is designed to capture information that will directly improve our understanding of opportunities and gaps in STD & HIV preventive services in STD-specific clinical settings. Specifically, this activity will enhance our ability to:

I. monitor the eligibility for and provision of HIV preventive services among persons seeking care in STD clinics (PEP, PrEP, viral suppression), a patient population at plausibly higher risk for HIV incidence and transmission

II. monitor the incidence of syphilis, gonorrhea and other STDs among HIV-positive persons by HIV-primary care status and by viral suppression and to stratify these outcomes by multiple demographic, behavioral and healthcare factors

III. improve our understanding of the proportion of patients tested for HIV who are not already known to be HIV positive

We fully understand and recognize that there are legitimate concerns regarding patient privacy and confidentiality, especially in the absence of diagnosed infection, and are requiring certification that matching procedures are in full compliance with Data Security and Confidentiality Guidelines published by our national center. Each SSuN site is free to negotiate methods for managing data exchange between health departments and clinic partners that is responsive to local concerns and meets the extraordinarily stringent HIV surveillance standards for the protection of sensitive health information.

The aggregate information that this activity will yield substantial benefits both patient care and the larger population at risk for HIV infection and is responsive to national priorities to dramatically reduce new HIV diagnoses. The acceptability of exchanging this type of information between STD clinics and their respective health departments may be more successful if the following patient concerns are addressed and resolved as part of developing a formal memorandum of agreement:

a) Clarify the limited scope and type of information exchanged
b) **State the security protection measures that are in place to protect the information exchanged (encryption, secure transport, etc.)**

c) **Addressing any concerns about confidentiality of patient information (limited access, secure storage, non-use for any other purpose)**

d) **Describing the public health benefits (identifying barriers to care, facilitating linkage to HIV preventive care, engagement and retention of HIV–infected person in care, etc.)**

2. **For the requirement to match STD clinic patients to the HIV surveillance database – what about patients who attend the clinic who are outside of the jurisdiction? Does their data need to be matched to the HIV surveillance data as well?** For example, we will be applying as [City A]. The clinic is in [City A]. We see some patients who are not City residents. Does their data need to be matched to the HIV surveillance data? This is do-able for us, but would impact our protocol for matching the STD patients to HIV surveillance data and affects what we discuss with [our] state regarding the matching protocols.

**Answer:** Many patients receive care in the same jurisdiction they live in. However, there are circumstances where a patient may live in one jurisdiction and receive care in another. Our expectation is that all clinic patients are matched to the HIV surveillance data regardless of their residence. Some of these patients may have a record in the state eHARS registry – even if they are considered an out-of-state case because they may have received HIV-related care within the sites jurisdiction and been reported to the HIV surveillance unit at some point in the past. We do not expect that recipients will attempt to procure surveillance information from other states. However, in the case where a city or county-level registry is a subset of their state’s registry, these data may be accessible. SSuN data formats and data elements documenting registry matching will include appropriate response options to capture reasons for not submitting a specific record to registry matching.

3. **Clinic survey questions – will those be developed by CDC (and go through OMB) or developed by the sites?**

**Answer:** The periodic patient surveys will be designed and conducted in collaboration with CDC staff (Health Services Research and Evaluation Branch). OMB approval will be obtained and managed at CDC. We anticipate that several approved iterations of the survey instrument will be developed throughout the 5-year SSuN project period. Jurisdictions, at their discretion, may elect to include brief supplemental questions related to issues of specific local interest. However, this supplemental information would not be transmitted to CDC or require additional OMB approval. The survey to be implemented in the initial performance period has been approved by OMB and is available for review on the SSuN Funding webpage: (https://www.cdc.gov/std/funding/docs/SSuN_BPNote_PatientSurveys.pdf)
4. We have a question related to Strategy A and the application requirement to include an MOU or LOC with at least one STD specialty clinic that meets the strategy requirements. Background: It is possible that there may only be non-government clinical agencies in our project area that both meet the Strategy A requirements and are willing to partner with us on this NOFO. In that case, our state government contracting protocols will require us to go through a formal Request For Proposal (RFP) process in order to solicit eligible clinics for partnership and contracting. However, we are prohibited from initiating this RFP process until we have received our Notice of Award (NOA) for the NOFO. In lieu of an MOU or LOC reflecting a formal partnership already in place, may we solicit and submit with our SSuN application one or more Letters of Collaboration from eligible and interested private STD specialty clinics in our project area that state their intent to apply to our SSuN Strategy A RFP (in the event we are awarded)? The letters would include explicit documentation of how each clinic meets the Strategy A requirements outlined in the NOFO Guidance p. 7-9 and 18. What other information would be valuable for us to include related to this process in order to make our application most competitive? For example, we could provide an estimated timeline for the RFP process through contract execution?

Answer: Applicants are asked to include a number of attachments with their application, including a MOU/MOA/LOC with proposed clinics. This document is not one of the required documents for responsiveness criteria; the absence of this document does not necessarily mean that your application will not be reviewed and scored. However, we want to make sure that the STD clinic(s) proposed in your application meet the requirements as outlined by the NOFO and have a complete understanding of specific information that will be required of them to fulfill the goals in Strategy A. In lieu of the MOU/MOA, I would highly encourage you include the following information related to this process in Letters of Collaboration from clinics intending to apply for Strategy A activities:

I. The clinic’s intention to collaborate in meeting the goals of Strategy A
II. The willingness of clinic leadership to provide the necessary patient identifiers on all patients to conduct frequent eHARS matching
III. The anticipated time frame by which you expect all of the necessary contracts to be in place, and,
IV. A realistic time frame by which you anticipate the clinic to be able to transmit STD clinic data following the RFP process

5. Can you provide examples of questions desired/planned to be asked in the clinic survey(s)?

Answer: Examples of the kinds of information that might be included in the surveys are reasons for visit, why that clinic was chosen, questions about the patient’s regular medical home, health insurance, accompanying basic demographic data, i.e. race, ethnicity, age, employment, etc. The survey to be implemented in the initial performance period has been approved by OMB and is
6. Is there a requirement for the STD clinic to use an EHR system?

Answer: No, there is no strict requirement that clinics use an electronic medical record but this is highly encouraged.

7. Do we have to do surveys in all of our STD clinics?

Answer: No. However you may propose to rotate clinics for administration throughout the course of the cooperative agreement, choose a specific clinic based on volume, patient population characteristics or location. Whatever clinic is proposed, this location must be able to meet the target for completed interviews (350 consecutive patients). Interview targets are specific to each clinic, not cumulative across multiple clinics.

8. How many periodic surveys are expected in year 2?

Answer: 2 survey administrations are required per recipient in each project year 2 – 5.

9. In putting together our SSuN Cycle 4 application, [our state] has a point of clarification to seek regarding submission of SSuN data, specifically for Strategy A. Our intention at this point is to work with a single STD clinic, [which] has the capacity to collect, QA, and transmit the data to CDC directly on their end. Would that be acceptable under the terms of the grant, or does the data need to come directly from the designated grantee? If it is technically possible, would you have a preference one way or the other?

Answer: SSuN would prefer to have a single point of contact (POC) and responsibility for all required Strategy A & B data transmissions; a single POC will facilitate data quality assurance processes as well as provide for an appropriately limited chain of data stewardship, especially important given HIV registry matching requirements across both of these core strategies.
**Strategy B – Enhanced, Case-based Surveillance**

1. For the surveillance requirements (Strategy B of the NOFO, 2.1), chlamydia and chancroid are mentioned in the first paragraph, but then not in any of the required activities. We did see the one optional activity for chlamydia. Are you requiring any data on chlamydia and chancroid? I am confused about what the requirements are.

   **Answer:** Chlamydia and chancroid cases are not required to be reported in SSuN datasets at this time. The intention reflected in 2.1 is for SSuN collaborators to develop the capacity (‘implement processes’) to sample cases of all notifiable STDs for investigation to provide flexibility for future activities. The current focus of SSuN Strategy B activities remains the universe of gonorrhea and adult syphilis cases.

   All gonorrhea and adult syphilis cases should be extracted from local surveillance systems for reporting in the SSuN case file. All associated lab observations for these cases should be included in the SSuN Laboratory File and providers reporting these cases included in the SSuN provider reference file.

2. I’m a little confused by the “look-back” investigations mentioned in 2.5, page 10. Where can we get more information about exactly what this is and what is required? We are currently interpreting this as making sure each case reported in our surveillance data set includes previous infections of gonorrhea and syphilis. Does it include chlamydia (and chancroid) as well? Going back over what length of time?

   **Answer:** “Look-back” investigations in SSuN have several principal components:

   A. **De-duplicating persons** – SSuN is a ‘person centric’ surveillance project and requires that funded site create a unique patient ID (regardless of specific disease reported) that is static, and remains the same across the entire project period.

   B. **De-duplicating cases** – this refers to assuring that only a single case-record is reported in the event that more than one lab/case report is received for this person’s diagnosis (any report of the same disease within 28 days), or in the event that multiple anatomic sites are tested and possibly reported separately. Each case record should represent a unique, single episode of disease.

   C. **History of previous STDs** – limited to those reported in the previous 12-month period from the date of the current case, with the exception of HIV. Previous reported HIV diagnoses (from registry match or similar source) should be indicated regardless of time elapsed to the current STD diagnosis.
3. I’m confused by the requirements for syphilis reporting. It’s my current understanding that we are to report all of our adult syphilis cases, but no provider or patient interviews are required. Is that correct? Do we know yet if the variables we need to report for syphilis cases match the variables required for STD-PCHD reporting? We want to make sure to collect all required variables.

Answer: Correct. All adult (non-congenital) syphilis cases of all stages should be recorded in the SSuN Case file, with associated laboratory observations included in the SSuN Laboratory file and the reporting provider listed in the Provider Reference file. Data elements are congruent; SSuN staff are collaborating with STD-PCHD to assure that there is no burden of duplicate reporting. At this time, no provider or patient investigations are required for syphilis cases.

4. As outlined in NOFO PS19-1907, SSuN recipients are required to implement project activities in collaboration with their jurisdiction’s STD or relevant infectious disease prevention and surveillance programs funded under PS19-1901 (STD PCHD). We are hoping you could provide further clarification on the language below – in terms of funding for staff that are assigned to both projects, what are the restrictions? For example, Year 01 of SSuN Cycle 4 is scheduled to begin 3 months before the completion of Year 01 of STD-PCHD— if staff are currently built in STD-PCHD, but would be working on SSuN activities, would including them in the Year 01 SSuN Cycle 4 budget be in violation of the terms below? Are you able to provide an example of supplanting or replacing resources in PCHD, so we can better understand the policy? (Page 17, 1. Collaborations a. With other CDC programs and CDC-funded organizations: Applicants must assure that resources for SSuN Strategy B do not supplant or replace resources funded under PS19-1907. Activities and funds from SSuN are required to be additive rather than subtractive of STD-PCHD funding. For jurisdictions funded under SSuN, performance measure reporting to CDC (for the enhanced gonorrhea surveillance activity funded under STD-PCHD) will be streamlined to reduce duplication of effort.)

Answer: You may propose to fund staff in your SSuN application that are also currently funded through STD-PCHD, keeping in mind that at least some portion of their activity should continue to be funded by STD-PCHD because they are helping to meet the enhanced gonorrhea surveillance strategy 2B in STD-PCHD. SSuN funding cannot completely replace STD-PCDH funding for enhance gonorrhea surveillance. Shifting all of the burden for enhanced gonorrhea to SSuN is not allowable; the minimum activity needed to fulfill STD-PCHD requirements should continue to be funded under STD-PCHD.

5. Can the Random Sample used for Strategy B be the same random sample required for the enhanced gonorrhea surveillance activity (Strategy 2B) in STD-PCHD?

Answer: Yes! Only a single sample should be drawn. SSuN recipients will fulfill the requirements for
STD-PCHD using their SSuN random sample.

6. How does SSuN differ from PCHD 2B? Isn’t this just the same thing?

Answer: While SSuN Strategy B is similar to the requirement for enhanced gonorrhea surveillance in STD-PCHD, there are key differences. SSuN requires that investigations on a random sample of cases be implemented throughout the full geographic extent of the recipient jurisdiction, implements rigorous protocols for data collection, data management and full transmission of these data to CDC every 2 months (six times each year). For independently funded counties/cities, the geographic extent may be the same, but SSuN protocols will be implemented and the sample fraction will be increased (20% versus the minimum of 10% required for STD-PCHD).

7. How is it determined how many people are chosen for the random sample?

Answer: Prior experience in SSuN has determined that a sample size of 10% of all diagnosed and reported cases is the minimum required to provide robust, stable estimates with 95% confidence intervals of case characteristics for comparison between gender, racial, ethnic, age and sexual minority groups within a recipient jurisdiction.
**STRATEGY C – SURVEILLANCE FOCUS ACTIVITIES**

1. **For Strategy C, should we apply for only those activities we propose to conduct in Year 1, or should we also include applications for activities we would propose to conduct in future years of the funding cycle?**

   **Answer:** Proposals for Strategy C activities are expected to include budgets and work plans for the *initial period of performance only*, September 30th 2019 to September 29th 2020.

2. **For Strategy C - Activity 4, what is the expected minimum number of completed chlamydia case interviews?**

   **Answer:** No minimum number of completed interviews is specified; applicants for this Focus Activity should determine their targets based on the underlying morbidity in the geographic area proposed and should justify this in their narrative for this activity. Targets should be sufficiently robust to fulfill the primary objectives of evaluating the efficacy of different patient and contact methodologies and in ascertaining representative estimates of desired information (such as chlamydia treatment).

3. **We understand that the budget and work plans for the Strategy C activities should cover just that initial period of performance. However, can you give us a sense of how likely funding is to continue being available for any given Strategy C activity over the remaining 4 years of the cycle, if awarded initially for that first year? This would be especially helpful to have a sense of for the purposes of longer-term planning.**

   **Answer:** Strategy C activities are all designed to be single year projects, though some of these may be re-solicited in a continuation year as part of a new menu of Strategy C activities. Funding for Strategy C activities will be based on the availability of funds as well as division priorities; it is possible that not all activities will be funded, nor will all recipients necessarily be funded for Strategy C activities in any given budget period. For the purposes of long-term planning, please consider Strategy A & B activities as representing the ‘core’ activities to be funded throughout the five-year cooperative agreement.

4. **A 2 page limit for the Strategy C activities was mentioned on the webinar – page 7 outlines a 1 page limit...can you clarify?**

   **Answer:** Please prepare a 1-page narrative and a 1-page budget justification for each Strategy C activity proposed.

5. **Can we submit more than 1 “Activity 9” (surveillance activity that we propose) or is only one Activity 9 permitted?**

   **Answer:** More than one project may be proposed under Strategy C Activity 9, however the combined budget for all proposed projects under this specific Strategy C activity must not exceed $75,000.
**HIV Matching**

1. **Do we only do HIV matches on cases not known to be HIV positive?**

   Answer: The ID number (Stateno) from the HIV surveillance registry will be needed to extract relevant HIV laboratory test data and for obtaining the earliest known HIV positive date and mode of transmission from the HIV registry, all patients should be matched regardless of known HIV status in the clinic or case report information.

2. **Is the frequency of eHARS matching to STD data to be done annually? Or quarterly?**

   Answer: Frequent matches allow for more timely information about persons newly diagnosed and/or reported to be included in the SSuN datasets and to allow for updating recent HIV laboratory data to establish in-care status and viral suppression. SSuN protocols recommend matches be conducted at least quarterly.

3. **Can you please clarify the following requirements on data abstraction from eHARS?**

   - **Under Strategy A 1.7,** the RFP states “Recipients will obtain available HIV diagnostic and HIV laboratory data for matching patients (limited to earliest recorded initial HIV-positive diagnostic test and date, HIV viral load tests/dates within one year of patient STD clinic visit date, CD4+ test/dates within one year of patient STD clinic visit date).”
     - **Does “within one year” refer to the year prior or year after the STD clinic visit date?**
     - **For example, would we extract from eHARS, for someone seen at an STD clinic on 4/1/2019 who matches to eHARS, viral load and CD4+ data from 4/1/2018 - 4/1/2019 or 4/1/2019 – 4/1/2020?**
   - **Under strategy B 2.6,** the RFP states “…to obtain and retain local HIV case number, earliest documented date of HIV infection, transmission category (as captured in HIV case record), most recent viral load testing (date and result), and most recent CD4+ testing (date and result).”
     - **Is “most recent” the closest date prior to the morbidity or matching date?**
     - **Additionally, is there an expectation that the local HIV case number be submitted to CDC, or can a random ID be sent to CDC as long as we retain the key for the random ID link to the local HIV case number?**

   **There are three primary reasons SSuN is asking sites to collect these HIV-related laboratory data:**

   1. **to establish earliest documented date of HIV infection;**
   2. **to determine if the patient has had recent engagement with HIV primary care (as evidenced by lab testing within the last 12 months), and;**
   3. **to provide evidence of viral suppression at or near the time of their clinic visit (Strategy A) or STD diagnosis (Strategy B).**

   **We plan to work with our funded recipients in the initial collaborator’s meeting to establish more definitive date ranges and protocols for the desired laboratory data, but for viral loads/CD4+ tests we do want retrospective data looking back over the last year so that we can make evidence-
based assumptions about whether the patient is engaged with HIV care and to monitor this cohort of patient’s ongoing engagement with care and their VL over the course of the cooperative agreement. Part of our protocol development will be to collaboratively arrive at specific guidance for accumulating HIV-related lab data over time for matched patients.

We appreciate the numerous challenges this may present locally and will certainly be open to suggestions from our funded partners about how best to achieve these goals in a way that will allow for the anticipated analyses, respects local sensibilities and assures comparability of data across all of our funded sites. While the requirements in the NOFO appear somewhat different between strategy A and B, we do hope to arrive at a uniform matching and lab data protocol that would be implemented the same way for patients visiting the clinics as for persons diagnosed and reported with STDs in the broader population activity.

With respect to a unique HIV registry case number, we do not need the eHARS specific “stateno” identifier (there are certainly no plans to match with HIV surveillance here at CDC!) so a locally-derived unique proxy number will be fine as long as this remains static for individual patients throughout the project period.
FORM AND CONTENT OF APPLICATION

1. Is there a preference for the applicants to get MOUs, MOAs, or LOCs for any of the required attachments? (asking if a MOU is preferred over a MOA or LOC.)

   Answer: MOUs and MOAs may have specific legal requirements in different jurisdictions, which may require more time to implement. The option of a Letter of Collaboration is included to allow for less formal documentation of partnerships. MOU/MOA are preferred but LOCs are acceptable if there isn’t sufficient time to execute a formal MOU/MOA.

2. I was just looking over new NOFO and want to make sure I am understanding correctly. When referring to Logic Model in the workplan template for example - do you mean the CDC logic model on page 5 of the nofo or do we need to develop the logic model as part of the application?

   Answer: You do not need to develop your own logic model – we have provided this as a high-level overview of SSuN activities. You may refer to the logic model in your application (if needed) to link a proposed activity or specific budget item to your overall project outcomes. Moreover, the outputs and outcomes listed in the logic model and in the NOFO narrative should be used in the development of your year-one and five-year work plans.

3. We also wanted to clarify the narrative structure in terms of what needs to be in its own section/listed in the table contents (not including supporting documents). Based on what’s written throughout the NOFO, is the below correct in terms of each of these being its own identified section?

   Background
   Approach
   Purpose
   Outcomes
   Strategies and Activities (A & B only – Strategy C will be a separate 2-page attachment [Narrative + Budget Narrative])
   Collaborations
   Target Populations and Health Disparities
   Applicant Evaluation and Performance Measurement Plan
   Data Management Plan
   Organizational Capacity of Applicants to Implement the Approach
   Work Plan
   5-Year Work Plan Narrative
   1-Year Work Plan Table (copied from CDC’s template) for Strategies A, B, AND C

   Does the Work Plan for Strategy C need to be included in the 20-page narrative limit or is it a separate document like the Strategy C narrative?
Does the 5-Year Work Plan Excel template need to be completed and attached to the document in addition to the 5-Year Work Plan narrative section answering the listed questions in the NOFO, and if so does it count towards the 20-page limit?

Given that it is “strongly recommended” to use the templates, should the 1-Year Work Plan Excel template tables be copied over verbatim into the narrative? However, these tables on their own are over 20 pages when keeping to the 1-inch margin and 12-pt font requirement. Are we allowed to shorten the items?

Answer: Yes, please follow the instructions on pages 35 – 37 of the NOFO for the structure of your project narrative, as you have indicated below. You may be succinct with respect to ‘Background’ as needed.

You may imbed your work plan as a table with a smaller font and you may truncate text in cells as long as the number of the activity/outcome is indicated, however it must be legible for reviewers.

Alternatively, if you are concerned about the page limitations, you may consolidate your work plans (strategy A, B and C) as a single PDF and upload as an attachment (under miscellaneous documents). Please name the file as ‘WORKPLAN.PDF’ if you include as an attachment. Be sure to refer to this attachment in your narrative as well.

Please note, budget narratives are NOT included in the page count.

4. I was just looking at the Excel template for the work plan and it does not match the Logic Model (although the NOFO repeatedly refers to it). Should we defer to the Logic Model Template or the NOFO? Also the NOFO states - "Bold indicates period of performance outcome." whereas the template contains all outcomes. Please let me know how to proceed. Thanks.

And given the Work Plan excel sheet has multiple tabs, how are you expecting this be submitted? Inserted into the narrative as a PDF or as an attachment? or??

Answer: The template CDC uses for developing all NOFOs is generic and covers complex community prevention programs that are less focused on specific outputs and more on outcomes. Our logic model is suggestive of these outcomes but our activities are more focused on specific outputs.

The work plan template is organized around each specific activity with separate tabs for Strategy A, B & C and refers to the outputs listed in the logic model for each strategy, though with greater specificity than presented in the logic model. The primary goal of this document is for the applicant to demonstrate that they have considered specific assignments and explicit timelines for implementing the required activities and producing expected output(s) from each activity. Because our cooperative agreement is a surveillance activity that involves very specific data outputs, recipient performance measurement is based almost entirely on process measures based on expected outputs.

To conserve space, you may imbed your work plan as tables in your narrative with a smaller font and you may truncate text in cells as long as the number of the activity/outcome is indicated,
however it must be legible for reviewers. Alternately, if you are concerned about the page limitations, you may consolidate your work plans (strategy A, B and C) as a single PDF and upload as an attachment (under miscellaneous documents). Please name the file as ‘WORKPLAN.PDF’ if you include as an attachment. Be sure to refer to this attachment in your narrative as well.
Regarding the required document “MOU/MOA/Certification of Compliance documenting that the jurisdiction's Overall Responsible Party (ORP) for HIV/STD has reviewed the applicant's proposed activities and Data Management Plan for compliance with NCHHSTP Data Security and Confidentiality standards”, we would like to confirm that the attached sample form can be used.

We would also like to confirm if the ORP for this grant needs to be the same as on the PS18-1802: Integrated HIV Surveillance and Prevention Program grant because of the required HIV-related activities, or if it just needs to be the overall person responsible for this SSuN grant/project. In our situation, these would not be the same people as our STD and HIV programs at the state are in separate divisions?

Answer: You are correct, the ORP designated for PS18-1802 is required for your Certification of Compliance. Please have your project plan reviewed by your state/jurisdiction’s HIV Surveillance program. The overall responsible party (ORP) is usually a higher-ranking official who accepts overall responsibility for implementing and enforcing data security standards. This official should have the authority to make decisions about program operations that might affect programs accessing or using the data, and should serve as contacts for public health professionals regarding security and confidentiality policies and practices. The ORP is responsible for assuring the protection of data as they are collected, stored, analyzed, and released and must certify annually that all security program requirements are being met. The state/jurisdiction’s security policy must indicate the ORP(s) by name. This person is often the HIV Program Manager in many states/jurisdictions, but may also someone at the assistant health officer, division director or similar administrative level. Your HIV surveillance program will be able to identify your jurisdiction’s ORP.

The template we have posted on the SSuN funding web page may be used to document ORP certification. A similar local template is acceptable if all of the same elements of compliance are present.

Please refer to the Data Security and Confidentiality Guidelines for HIV, Viral Hepatitis, Sexually Transmitted Disease, and Tuberculosis Programs: (https://www.cdc.gov/nchhstp/programintegration/data-security.htm) for additional information.

We have a question regarding the required attachment “STDProgramMOU”, as described on pages 17-18 of the NOFO. It is stated that “Applicants must provide an MOA/MOU verifying collaborations with the STD program within their health department”. However, if the jurisdiction applying for SSuN now is the same as the jurisdiction already funded by PS19-1901 STD-PCHD, in lieu of an MOU/MOA can a letter be submitted for this requirement detailing how SSuN will be additive to PCHD activities (because there are not two different health departments working on SSuN and PCHD in our case)?

Answer: This requirement is to assure that SSuN activities are implemented in full collaboration with the recipient of STD-PCHD funding in the applicant agency or jurisdiction; a letter documenting this collaboration from the STD program manager/acting manager, program director/acting director is acceptable.
BUDGET

1. On page 39 of NOFO PS19-1907, there is language to prepare separate budget justifications per Strategy C focus activity—should we prepare Strategy A and Strategy B budget narratives separately, similar to the current cycle’s Part A and B?

   Answer: Please prepare separate budget justifications and narratives for Strategy A & B as well as for any proposed Strategy C activities. Combine totals from all of these into a single SF424 A.

2. Is there a cap on the indirect cost rate allowed or are we allowed to budget for our DHHS negotiated rate?

   Answer: There is no pre-established indirect cost rate for PS19-1907. You should consider your DHHS negotiated rate for 2019 to be the maximum indirect rate allowable for PS19-1907; documentation of your official negotiated rate should be included as an attachment.
1. What is the maximum score an applicant can receive?

Based on the maximums listed for each section Approach (max 25), Evaluation and Performance Measurement (max 25), and Applicant’s Organization Capacity to Implement the Approach (max 50), the total should be 100. However, it is not clear how points will be awarded for the first bullet point of the Applicant’s Organization Capacity to Implement the Approach section (page 44). How many points will be lost if applicant’s proposed STD clinic (with >5,000 visits annually) will only provide information on a subset of patients for HIV registry matching?

Answer: Thank you for your question; we are aware of the mathematical error in scoring. The maximum point value across all criteria remains 100 points. To address the mathematical error, and to assure that all applicants are scored fairly on the published criteria, 10 points will be awarded by default to all reviewed applications for the ‘Organizational Capacity’ section to arrive at the stated total of 50 points maximum for that section. The remaining 40 points under ‘Organizational Capacity’ will be distributed by the reviewers according to the stated criteria 1 through 7.

Under criteria 1 listed in the ‘Organizational Capacity’ section, a maximum of 15 points is available if applicant’s clearly document that the full census of patients presenting for care in at least one collaborating STD clinic with >5,000 annual visits will be matched with eHARS. Anything less than that desired outcome will result in a reduced score, by 5 points if only a subset of patients are matched, and by 15 points if there is no documentation or ambiguity with respect to HIV registry matching and/or if it is not clearly documented that the collaborating STD clinic has sufficient patient volume (>5,000 visits annually).