

Centers for Disease Control and Prevention

National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention

Health Department Demonstration Projects for Comprehensive Prevention, Care, Behavioral Health, and Social Services for Men Who Have Sex with Men of Color at Risk for and Living with HIV Infection

CDC-RFA-PS15-1509

Application Due Date: 06/01/2015

Health Department Demonstration Projects for Comprehensive Prevention, Care, Behavioral Health, and Social Services for Men Who Have Sex with Men of Color at Risk for and Living with HIV Infection

CDC-RFA-PS15-1509

TABLE OF CONTENTS

Part I. Overview Information

A. Federal Agency Name
B. Funding Opportunity Title
C. Announcement Type
D. Agency Funding Opportunity Number
E. Catalog of Federal Domestic Assistance (CFDA) Number
F. Dates
G. Executive Summary

Part II. Full Text

A. Funding Opportunity Description
B. Award Information
C. Eligibility Information
D. Required Registrations
E. Review and Selection Process
F. Award Administration Information
G. Agency Contacts
H. Other Information
I. Glossary

Part I. Overview Information

Applicants must go to the synopsis page of this announcement at www.grants.gov and click on the "Send Me Change Notifications Emails" link to ensure they receive notifications of any changes to CDC-RFA-PS15-1509. Applicants also must provide an e-mail address to www.grants.gov to receive notifications of changes.

A. Federal Agency Name:

Centers for Disease Control and Prevention (CDC)

B. Funding Opportunity Title:

Health Department Demonstration Projects for Comprehensive Prevention, Care, Behavioral Health, and Social Services for Men Who Have Sex with Men of Color at Risk for and Living with HIV Infection

C. Announcement Type: New - Type 1

This announcement is only for non-research domestic activities supported by CDC. If research is proposed, the application will not be considered Research for this purpose is defined at http://www.cdc.gov/od/science/integrity/docs/cdc-policy-distinguishing-public-health-research-nonresearch.pdf.

D. Agency Funding Opportunity Number:

CDC-RFA-PS15-1509

E. Catalog of Federal Domestic Assistance (CFDA) Number:

93.940

F. Dates:

1. Due Date for Letter of Intent (LOI):	**N/A**
2. Due Date for Applications:	**06/01/2015**, 11:59 p.m. U.S. Eastern Standard Time, at www.grants.gov.
3. Date for Informational Conference Call:	**N/A**

http://www.cdc.gov/hiv/policies/funding/announcements/ps15-1509/index.html

G. Executive Summary:

1. Summary Paragraph:

Gay, bisexual, and other men who have sex with men (MSM) remain the population most affected by HIV infection in the United States (US). Among MSM, those who are black and Hispanic comprise 58% of all new infections. The purpose of this FOA is to support state and localhealth departments and their community partners to provide comprehensive models of HIV prevention and care services for MSM of color. Antiretroviral (ARV) medications can be used for HIV prevention by MSM at substantial risk for HIV acquisition (pre-exposure prophylaxis (PrEP)) or for those with a risk event that occurred in the past 72 hours (post-exposure prophylaxis (nPEP)). ARV treatment for persons living with HIV (PLWH) is also a potent prevention tool that suppresses HIV viral load, improving health outcomes and reducing the risk of transmission. The effectiveness of HIV treatment to prevent transmission has led to increased focus on interventions and strategies to link, retain, and re-engage PLWH in healthcare, and to support medication adherence. Given the high incidence of HIV among MSM of color, those who are sexually active are considered at risk for HIV acquisition and could benefit from screening with 4 th generation HIV tests and should be assessed for PrEP or nPEP indications. MSM of color at risk for HIV acquisition and living with HIV would benefit from screening for sexually transmitted diseases (STDs), partner services, and behavioral risk reduction interventions. These ***high impact*** HIV prevention services will be implemented by state, local, and territorial health departments to reduce HIV infections and improve HIV outcomes for MSM of color. In addition, the health benefits of HIV prevention and care services will be enhanced by addressing social,

economic, and structural factors influencing HIV health outcomes, through linkage to mental health, substance abuse, housing, and employment services.

a. Eligible Applicants:	Limited
b. FOA Type:	Cooperative Agreement
c. Approximate Number of Awards:	6

Up to 8 awards

d. Total Project Period Funding:	$60,500,000
e. Average One Year Award Amount:	$0

1st year: $ $1,750,000; 2nd year: $1,812,500; 3rd year: $1,937,500; 4th year: $; $2,062,500

f. Number of Years of Award:	4
g. Estimated Award Date:	09/30/2015
h. Cost Sharing and / or Matching Requirements:	N

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

Part II. Full Text

A. Funding Opportunity Description

1. Background

a. Overview

Approximately 50,000 people in the United States (US) are newly infected with HIV each year. Gay, bisexual, and other men who have sex with men (MSM) remain the US population most heavily affected by HIV infection. Among MSM, those who are black and Hispanic comprise 58% of all new infections. To address the burden of HIV in this population, ***high impact*** HIV prevention approaches should be implemented by state, local, and territorial health departments to reduce new HIV infections among MSM of color, and to improve outcomes along the HIV continuum of care for MSM of color living with HIV.

Antiretroviral (ARV) medications can be used for HIV prevention by MSM at substantial risk for HIV acquisition (pre-exposure prophylaxis (PrEP)) or by those with a possible HIV exposure in the past 72 hours (post-exposure prophylaxis (nPEP)). The daily use of co-formulated tenofovir disoproxil fumarate and emtricitabine (marketed as Truvada) for PrEP has been proven to significantly reduce the risk of HIV acquisition among sexually active MSM. In July 2012, the US Food and Drug Administration approved an HIV prevention indication for Truvada, and in May 2014 CDC published clinical practice guidelines for provision of PrEP. Given the high incidence of HIV among MSM of color, those who are sexually active are considered at risk for HIV acquisition and thus could benefit from prevention services such as routine and frequent HIV screening with lab-based 4th generation HIV tests, rountine screening for STDs, assessment of PrEP eligibility, provision of PrEP (if at substantial risk for HIV acquisition), provision of nPEP (if a possible HIV exposure occurred in the past 72 hours), and/or other risk reduction interventions.

Among PLWH, ARV treatment is a potent prevention tool than can suppress HIV viral load, which both improves health outcomes of individuals and reduces the risk of HIV transmission. A study that demonstrated the effectiveness of ARV treatment in preventing HIV transmission has led to increased public health focus on interventions and strategies designed to link, retain, and re-engage PLWH in HIVcare, and to provide support for adherence to ARV medications.

The purpose of this FOA is to support state and local health departments to develop and implement demonstration projects for provision of comprehensive HIV prevention and care services for MSM of color by creating a collaborative with CBOs, clinics and other health care providers, and behavioral health and social services providers in their jurisdiction (Figure 1). Behavioral health services include mental health and substance abuse treatment to enable MSM of color to utilize HIV prevention and care services; social services include services that promote access to housing, job counseling, and employment services to enable MSM of color to utilize HIV prevention and care services. The models should, ultimately, be sustainable beyond the duration of the project period, with resources provided for ongoing HIV prevention and care in the jurisdiction.

Health departments will develop the capacity to train members of the collaboratives to provide culturally competent and linguistically appropriate prevention, care, and behavioral health and social services for MSM of color using a curriculum that will be developed in a companion FOA (CDC-RFA-15-1510) that will support the efforts described in this FOA. The health benefits of HIV prevention and care services can be enhanced by addressing the social, economic, and structural factors influencing prevention of HIV acquisition among MSM of color and HIV-related health outcomes among those living with HIV. This FOA requires that collaboratives assess the needs of MSM of color for mental health, substance abuse, housing, and employment services, and provide linkages to these services in the community.



Figure 1. The health department, community-based organization(s), clinical care providers, and behavioral health and social services providers collaborate to provide comprehensive HIV prevention and care for MSM of color.

b. Statutory Authorities

This program is authorized under Section 301(a) (42 U.S.C Section 241(a)

c. Healthy People 2020

This FOA addresses the following "Healthy People 2020" objectives:

https://www.healthypeople.gov/2020/topics-objectives/topic/hiv

HIV-2 Reduce the number of new HIV infections among adolescents and adults

HIV-3 Reduce the rate of HIV transmission among adolescents and adults

HIV-13 Increase the proportion of persons living with HIV who know their serostatus

HIV-14 Increase the proportion of adolescents and adults who have been tested for HIV in the past 12 months

HIV-19 (Developmental) Increase the proportion of persons who are linked to HIV medical care (had a routine HIV medical visit) within 3 months of HIV diagnosis

HIV-20 (Developmental) Increase the proportion of persons with an HIV diagnosis who had at least one HIV medical care visit in each 6 month period of the 24 month measurement period, with a minimum of 60 days between medical visits

HIV-21 (Developmental) Increase the proportion of persons with an HIV diagnosis in medical care who were prescribed antiretroviral therapy for the treatment of HIV infection at any time in the 12-month measurement period

d. Other National Public Health Priorities and Strategies

1. The National HIV/AIDS Strategy: http://www.whitehouse.gov/sites/default/files/uploads/NHAS.pdf

2. CDC Division of HIV/AIDS Prevention (DHAP) Strategic Plan: http://www.cdc.gov/hiv/pdf/policies_DHAP-strategic-plan.pdf

3. Executive Order (July 15, 2013): http://www.whitehouse.gov/the-press-office/2013/07/15/executive-order-hiv-care-continuum-initiative

4. Minority AIDS Initiative (MAI): http://www.hhs.gov/ash/ohaidp/initiatives/

5. CDC Winnable Battles: http://www.cdc.gov/winnablebattles/hiv/index.html

6. Affordable Care Act: http://aids.gov/federal-resources/policies/health-care-reform

7. The Rehabilitation Act and the Americans with Disabilities Act (ADA): http://www.ada.gov/cguide.htm

8. Standards for Privacy of Individually Identifiable Health Information: http://privacyruleandresearch.nih.gov/

9. This FOA supports a holistic framework that enables NCHHSTP to address the broader, cross-cutting issues of health and wellness by addressing Health Equity, Program Collaboration and Service Integration (PCSI), and Advancing Public Health Approaches to Improve Sexual Health. Additional information about these imperatives is available: http://www.cdc.gov/nchhstp

e. Relevant Work

This FOA builds upon current HIV prevention programs, projects, and technical assistance efforts including:

• CDC-RFA-PS-12-1201, "Comprehensive HIV Prevention Programs for Health Departments" http://www.cdc.gov/hiv/policies/funding/announcements/ps12-1201/index.html

• CDC-RFA-PS-12-1210, "Secretary's Minority AIDS Initiative Funding for Care and Prevention in the United States (CAPUS) Demonstration Project http://www.cdc.gov/hiv/policies/funding/announcements/ps12-1210/index.html

• CDC-RFA-PS13-1302, " National HIV Surveillance System (NHSS)" http://www.cdc.gov/hiv/policies/funding/announcements/ps13-1302/index.html

• CDC-RFA-PS14-1403, "Capacity Building Assistance (CBA) to Improve the Delivery and Effectiveness of Human Immunodeficiency Virus (HIV) Prevention Services for High-risk and/or Racial/Ethnic Minority Populations, Category C: CBA for Health Departments" http://www.cdc.gov/hiv/topics/funding/PS14-1403

/index.htm

• CDC-RFA- PS15-1502, "Comprehensive High-Impact HIV Prevention Projects for Community-Based Organizations" http://www.cdc.gov/hiv/policies/funding/announcements/ps15-1502/index.html

• CDC-RFA- PS15-1506, "Health Department Demonstration Projects to Reduce HIV Infections and Improve Engagement in HIV Medical Care among Men Who Have Sex with Men (MSM) and Transgender Persons" (in development).

• CDC-RFA-PS15-1510, "Training and Technical Assistance for Health Department Demonstration Projects for Comprehensive Prevention, Care, Behavioral, and Social Services for Men Who Have Sex with Men (MSM) of Color At Risk for and Living with HIV Infection" **(in development).**

Resources available online:

Centers for Disease Control and Prevention: Preexposure Prophylaxis for the Prevention of HIV Infection in the United States – 2014 Clinical Practice Guideline. Available at: http://www.cdc.gov/hiv/pdf/guidelines/PrEPguidelines2014.pdf

Centers for Disease Control and Prevention, Health Resources and Services Administration, National Institutes of Health, American Academy of HIV Medicine, Association of Nurses in AIDS Care, International Association of Providers of AIDS Care, the National Minority AIDS Council, and Urban Coalition for HIV/AIDS Prevention Services. Recommendations for HIV Prevention with Adults and Adolescents with HIV in the United States, 2014. Available at: http://stacks.cdc.gov/view/cdc/26062

Evidence-based and evidence-informed interventions are available at: http://www.cdc.gov/hiv/prevention/research/compendium/lrc/index.htmlhttps://www.effectiveinterventions.org/

Centers for Disease Control and Prevention: Sexually Transmitted Diseases Treatment Guidelines, 2010. Available at: http://www.cdc.gov/std/treatment/2010/default.htm

Relevant citations:

Bradley H, Hall HI, Wolitski RJ, et al. Vital Signs: HIV Diagnosis, Care, and Treatment Among

Persons Living with HIV — United States, 2011. MMWR 2014;63(47):1113-1117.

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State HIV Prevention Progress Report, 2014. Available at http://www.cdc.gov/hiv/policies/progressreports/index.html

Cohen MS, Chen YQ, McCauley M, et al. Prevention of HIV-1 infection with early antiretroviral therapy. N Engl J Med 2011;365(6):493-505.

Dietz P.M., Krueger A.L., Wolitski R.J. et al. State HIV Prevention Progress Report, 2014 http://www.cdc.gov/hiv/policies/progressreports/index.html. Published August 2014. Accessed December 30, 2014.

Grant RM, Lama JR, Anderson PL, et al. Preexposure chemoprophylaxis for HIV prevention in men who have sex with men. N Engl J Med 2010;363(27):2587-2599.

Johnson AS, Hall HI, Hu X, et al. Trends in Diagnoses of HIV Infection in the United States, 2002-2011. JAMA. 2014; 312(4):432-434.

2. CDC Project Description

a. Approach

Strategies and Activities	Short Term Outcomes	Medium Term Outcomes	Long Term Outcomes
Health department creates new/expands existing partnerships with CBOs, health care providers, and social services providers to implement comprehensive HIV prevention and care for MSM of color: - Lab-based 4th generation HIV testing - Routine and frequent HIV screening - PrEP/nPEP services if at substantial risk for HIV acquisition - PrEP/nPEP adherence support - Immediate linkage and ARV initiation if diagnosed with acute HIV - Expedient linkage and ARV initiation if diagnosed with established HIV - Retention and re-engagement interventions if living with HIV - Adherence interventions if living with HIV - STD screening - Partner services - Behavioral risk reduction services - Screening for behavioral health and social services needs - Linking to behavioral health and social services - Navigation for HIV prevention, care, and behavioral health and social services - Navigation for enrollment in a health plan	**Collaborative implemented protocols and strategies for comprehensive HIV prevention and care for MSM of color to increase the number who are:** - **Screened with lab-based 4th generation HIV tests** - **Screened at least annually for HIV** - **Screened more often if at substantial risk for HIV acquisition** - **Prescribed PrEP/nPEP** - **Provided appropriate clinical management if prescribed PrEP/nPEP** - **Provided medication adherence support for PrEP/nPEP** - **Immediately linked to care and initiated on ARVs if diagnosed with acute HIV** - **Expediently linked to care and initiated on ARVs if diagnosed with established HIV** - **Provided retention interventions if living with HIV and engaged in care** - **Provided re-engagement interventions if living with HIV and lost to care** - **Provided medication adherence support/interventions if living with HIV** - **Routinely screened for STDs** - **Provided timely partner services** - **Provided behavioral risk reduction services** - **Screened for behavioral health and social services needs** - **Linked to behavioral health and social services** - **Provided navigation services**	**Collaborative increased the number of MSM of color who are/have:** - **Diagnosed with acute HIV among all HIV diagnoses** - **Adherent to PrEP/nPEP** - **Retained in HIV care** - **Re-engaged in HIV care** - **Adherent to ARV medications** - **Received appropriate STD treatment** - **Sex partners who received HIV testing and linkage to care and STD testing and treatment** - **Received behavioral risk reduction services** - **Received behavioral health and social services** - **Enrolled in a health plan**	Among MSM of color: - Increased proportion of HIV diagnosed in the acute stage - Decreased incidence of HIV and STDs - Increased number living with HIV who are virally suppressed **Collaborative:** **Comprehensive HIV prevention, care, and behavioral health and social services for MSM of color**
Health department provides: - Technical assistance and support to build collaborative capacity to provide sustainable lab-based 4th generation HIV testing, STD testing, PrEP/nPEP services - Training of collaborative members to provide HIV prevention and care services that are culturally competent for MSM of color	**Health department trained collaborative in:** - **Healthcare billing and reimbursement procedures** - **Provision of culturally competent HIV prevention and care for MSM of color** **Health department supported collaborative to:** - **Designate/hire staff to perform billing and reimbursement activities** - **Implement billing for HIV tests, STD tests and treatment, and PrEP/nPEP services** - **Designate/hire navigators for accessing HIV prevention, care, and behavioral health and social services** - **Develop/implement tools to facilitate patient utilization of assistance programs for PrEP/nPEP medication costs**	**Collaborative has:** - **Expanded billing for HIV tests, STD tests and treatment, and laboratory tests required for PrEP/nPEP services** - **Increased proportion of HIV tests that are reimbursed by a third party payer** - **Increased proportion of STD tests and treatment and PrEP/nPEP services that are reimbursed by a third party payer** - **Developed business models for long term sustainability of HIV testing, STD testing and treatment, and PrEP/nPEP services** - **Developed service models for provision of culturally competent HIV prevention, care, and behavioral health and social services for MSM of color**	Collaborative has: - Sustainable service models for HIV testing, STD testing and treatment, and PrEP/nPEP for MSM of color at risk for HIV - Culturally competent service models for HIV prevention, care, and behavioral health and social services for MSM of color

Outcomes in **bold type** should be accomplished during the project period

i. Purpose

To decrease the burden of HIV among MSM of color, this FOA supports health departments to collaborate with CBOs clinics or health care providers, and social services (i.e., mental health services, substance abuse services, housing programs, and job training or employment services) providers to implement models of comprehensive HIV prevention and care services for MSM of color who are at substantial risk for or living with HIV infection.

ii. Outcomes

Key outcomes to be expected by the end of the project period are illustrated in the logic model for the provision of comprehensive HIV prevention and care for MSM of color. Potential indicators that quantify these outcomes are described in Section b. Evaluation and Performance Measurement. Only project period outcomes are listed below.

Short term outcomes

Collaborative increases the number of MSM of color who are:

• Screened with lab-based 4th generation HIV tests

• Screened at least annually for HIV

• Screened more often if at substantial risk for HIV (e.g., every 3-6 months)

• Prescribed PrEP or nPEP if at substantial risk for HIV acquisition

• Provided appropriate clinical management if prescribed PrEP or nPEP

• Provided medication adherence support for PrEP or nPEP

• Immediately linked to care (within 7 days) and initiated on ARV treatment (within 14 days) if diagnosed with acute HIV

• Expediently linked to care (within 30 days) and initiated on ARV treatment (within 60 days) if diagnosed with established HIV

• Provided retention interventions if living with HIV and engaged in care

• Provided Data to Care re-engagement interventions if living with HIV and lost to care

• Provided medication adherence support/interventions if living with HIV

• Routinely screened for STDs

• Provided timely partner services

• Provided behavioral risk reduction services

• Routinely screened for behavioral health and social services needs

• Linked to behavioral health and social services

• Provided navigation to access HIV prevention, care, and behavioral health and social services

• Provided navigation to enroll in a health plan

Health department trained collaborative in:

• Healthcare billing and reimbursement procedures

• Provision of culturally competent HIV prevention and care for MSM of color

Health department supported collaborative to:

• Designate/hire staff to perform billing and reimbursement activities

• Implement billing for HIV tests, STD tests and treatment, and PrEP or nPEP services

• Designate/hire navigators to assist patients to access HIV prevention, care, and social services and to enroll in a health care plan

• Develop/implement tools to facilitate patient utilization of assistance programs for PrEP or nPEP medication costs

Medium term outcomes

Collaborative increased the number of MSM of color who are/have:

• Diagnosed with acute HIV among all HIV diagnoses

• Adherent to PrEP or nPEP medications

• Retained in HIV care

• Re-engaged in care

• Adherent to ARV treatment medications

• Received appropriate STD treatment

• Sex partners who received lab-based 4th generation HIV testing and linkage to HIV care and STD testing and treatment

• Received behavioral health and social services

• Enrolled in a health plan

Collaborative has:

• Expanded billing for HIV tests, STD tests and treatment, and laboratory tests required for PrEP and nPEP services

• Increased proportion of HIV tests that are reimbursed by a third party payer

• Increased proportion of STD tests and treatment and PrEP and nPEP clinical services that are reimbursed by a third party payer

• Developed business models for long term sustainability of HIV testing and treatment, STD testing, and PrEP or nPEP services beyond the project period

• Developed service models for provision of culturally competent HIV prevention and care for MSM of color

iii. Strategies and Activities

Comprehensive models of HIV prevention and care for MSM of color will be developed and implemented by a collaborative that is led by the jurisdiction's health department and includes the following: health care providers (e.g., federally qualified health centers (FQHCs), FQHC Look-Alikes, other clinics, or health care providers); HIV care providers (e.g., clinics funded through the Ryan White HIV/AIDS Program (RWHAP clinics), other HIV care clinics, or HIV care providers); behavioral health and social services providers (i.e., mental health and substance abuse services, housing programs, and job training or employment services); and community based organizations (CBOs). Principles of high impact prevention should guide the selection and implementation of activities and strategies to focus on MSM of color at substantial risk for HIV infection (i.e., eligible for prevention with PrEP), and those living with HIV. MSM of color who are at risk for HIV acquisition (i.e., sexually active) but not eligible for or decline PrEP will be provided risk reduction interventions, partner services if diagnosed with an STD, re-testing for HIV and STDs in 3-6 months, and behavioral health and social services (Figure 3). The risk of HIV acquisition should be assessed at every encounter with an individual, and MSM of color at substantial risk of HIV acquisition should be offered PrEP when indicated by the risk assessment.

The health department will form, lead, and coordinate the collaborative; provide partner services; and provide cultural competency training for the collaborative that is supported by a separate FOA (CDC-RFA-PS15-1510). Depending on its capacity, the health department can also directly provide other required services and activities.

Screening for behavioral health and social services needs and linkages to behavioral health and social services, which acts as the means to address social determinants of health, are components of comprehensive models of prevention and care services. Behavioral health and social services that will be available to MSM of color at risk for HIV acquisition or living with HIV include mental health and substance abuse services (i.e., illicit drugs and alcohol treatment) including those funded by the Substance Abuse and Mental Health Services Administration (SAMHSA); housing programs including those supported by the Department of Housing and Urban Development (HUD); and job training or employment services including those supported by the Department of Labor (DOL).

HIV Prevention Services

The following 13 HIV prevention services that must be provided by the collaborative for MSM of color at substantial risk for HIV infection include:

1. HIV testing services that use lab-based 4th generation HIV tests
2. Assessment of indications for PrEP and nPEP
3. Provision of PrEP and nPEP
4. Adherence interventions for PrEP and nPEP
5. Immediate linkage to care, ARV treatment, and partner services for those diagnosed with acute HIV infection
6. Expedient linkage to care, ARV treatment, and partner services for those diagnosed with established HIV infection
7. STD screening and treatment
8. Partner services for patients with STDs
9. Behavioral risk reduction interventions
10. Screening for behavioral health and social services needs
11. Linkage to behavioral health and social services
12. Navigators to assist accessing HIV prevention and behavioral health and social services
13. Navigators to assist enrollment in a health plan

For each of the 13 required services (above), the following examples are provided for illustration. These examples are not a comprehensive list of all potential activities that might be developed in response to the required HIV prevention services.

HIV testing services include but are not limited to:

• Screening at least annually for HIV with lab-based 4th generation tests, and more frequently those at substantial risk for acquiring HIV infection (e.g., every 3–6 months)

PrEP and nPEP services and activities include but are not limited to:

• Identifying or creating educational materials and tools for nPEP and PrEP for providers and consumers

• Training of CBO staff, clinic staff, and health care providers in provision of nPEP and PrEP for HIV prevention

• Increasing awareness of MSM of color of PrEP and nPEP for HIV prevention

• Implementing screening tools for assessment of HIV risk, including self-assessment, to guide prevention activities

• Developing algorithms for offering PrEP based on risk assessment and STD test results

• Providing screening for PrEP indications as a routine procedure in conjunction with receiving HIV-negative tests results

• Developing protocols to transition patients from nPEP to PrEP if they have substantial ongoing risk of HIV acquisition

• Developing protocols to assure appropriate clinical management if prescribed PrEP or nPEP

• Developing the capacity to bill for laboratory tests required for PrEP and nPEP services

• Developing/implementing tools to facilitate patient utilization of assistance programs for PrEP or nPEP medication costs

HIV linkage and treatment services include but are not limited to:

• Developing protocols for immediately/expediently linking to care and initiating ARV treatment if diagnosed with acute/established HIV infection

• Developing protocols for provision of ARV treatment starter packs if diagnosed with acute or early HIV infection

STD screening and treatment services for MSM of color at risk of acquiring HIV include but are not limited to:

• Screening sexually active MSM of color at risk for HIV acquisition for STDs at least annually but more frequently (e.g., every 3–6 months) if at substantial risk for STD acquisition, including syphilis testing and genital and nongenital chlamydia and gonorrhea testing at anatomic sites of exposure using nucleic acid amplification tests (NAATs)

• Facilitating access to chlamydia and gonorrhea NAATs for nongenital specimens (e.g., rectal, oropharyngeal)

• Ensuring appropriate treatment of MSM of color diagnosed with syphilis, chlamydia, or gonorrhea

• Developing the capacity to bill for STD tests and treatment

Behavioral risk reduction intervention for MSM of color at risk of acquiring HIV includes but is not limited to:

• Providing free condoms, counseling, and behavioral interventions for all MSM of color

Activities for bebavioral health and social services for MSM of color at risk of acquiring HIV include but are not limited to:

• Developing/implementing tools to assess MSM of color needs and eligibility for behavioral health and social services

• Developing procedures to link MSM of color to behavioral health and social services

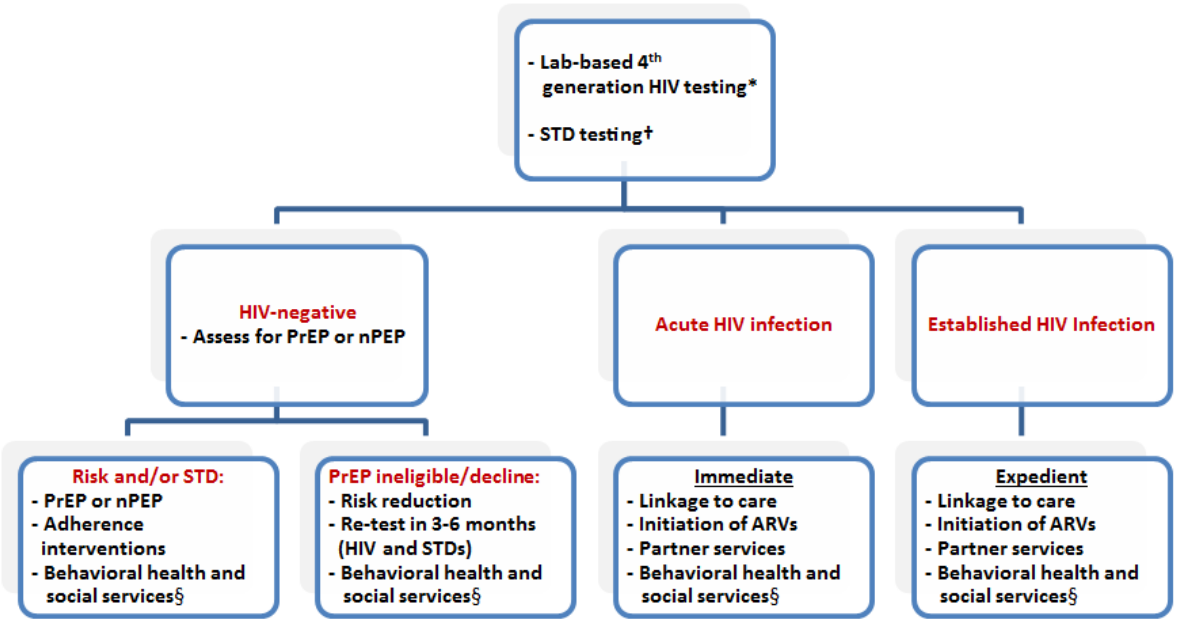


Figure 3. Summary of HIV prevention services for MSM of color at risk for HIV acquisition

* Alternative testing strategies with high sensitivity for acute HIV infection may be used (e.g., HIV-1 RNA testing)

† STD testing includes syphilis serology and chlamydia and gonorrhea NAATs at all anatomic sites of exposure

§ Behavioral health services include mental health and substance abuse services; social services include housing programs, and job training or employment services

HIV Care Services

The following 11 HIV care services that must be provided by the collaborative for MSM of color living with HIV infection include:

1. HIV primary care, including ARV treatment
2. Retention interventions
3. Re-engagement interventions
4. Adherence interventions
5. STD screening and treatment
6. Partner services
7. Behavioral risk reduction interventions
8. Screening patients for behavioral health and social services needs
9. Linkage to behavioral health and social services
10. Navigators to assist linking to care and accessing behavioral health and social services
11. Navigators to assist enrollment in a heath plan

The following are examples for some of the required services that may be provided for MSM of color living with HIV infection:

For each of the 11 required services (above), the following examples are provided for illustration. These examples are not a comprehensive list of all potential activities that might be developed in response to the required HIV care services.

Retention, re-engagement, and adherence interventions and activities include but are not limited to:

• Training of CBO staff, clinic staff, and health care providers in provision of retention, re-engagement, risk reduction, and adherence interventions

• Re-engaging in HIV care previously diagnosed MSM of color with HIV infection who have been named as partners in a partner services investigation

STD screening and treatment services for MSM of color living with HIV include but are not limited to:

• Screening sexually active MSM of color at risk for STDs at least annually but more frequently (e.g., every 3–6 months) if at substantial risk for STD acquisition, including syphilis testing and genital and nongenital chlamydia and gonorrhea testing at anatomic sites of exposure using nucleic acid amplification tests (NAATs)

• Facilitating access to chlamydia and gonorrhea NAATs for nongenital specimens (e.g., rectal, oropharyngeal)

• Ensuring appropriate treatment of MSM of color diagnosed with syphilis, chlamydia, or gonorrhea

• Developing the capacity to bill for STD tests and treatment

Partner services MSM of color living with HIV include but are not limited to:

• Providing immediate partner services for MSM of color diagnosed with acute HIV infection

• Providing partner services for MSM of color diagnosed with established HIV infection or STDs

• Implementing novel partner services that utilize the internet or mobile device apps

•Embedding health department partner services at the CBO and/or clinics that are providing HIV testing

Behavioral risk reduction intervention MSM of color living with HIV includes but is not limited to:
• Providing free condoms, counseling, and behavioral interventions for all MSM of color

Activities for behavioral health and social services for MSM of color living with HIV include but are not limited to:
• Developing/implementing tools to assess MSM of color needs and eligibility for behavioral health and social services
• Developing procedures to link MSM of color to behavioral health and social services

1.Collaborations

a. With CDC-funded programs:

Health department awardees are required to collaboratively partner with CDC. In addition, awardees should collaborate with other CDC-funded programs, where appropriate, to apply programmatic successes and lessons learned.

b. With organizations external to CDC:

For models of providing comprehensive HIV prevention and care services for MSM of color, it is important that health departments partner with HIV and other health care providers and organizations with experience or interest in providing nPEP and PrEP, STD screening and treatment, and reaching and engaging MSM of color in the jurisdiction. Health departments will create new or expand existing partnerships (as needed) with CBOs, LGBT organizations, FQHCs, RWHAP clinics, STD clinics, other clinics or health care providers, and behavioral health and social services providers (i.e., mental health and substance abuse services, housing programs, and job training or employment services) to form a collaborative, as described above. Collaboratives should be proposed for the eligible MSA only (see "Eligibility" section below).

Collaborative CBOs must have the ability to serve as an access point to the community of MSM of color, and to effectively reach MSM of color to engage or re-engage them in prevention, care, and behavioral health and social services. Specific roles for CBOs in the collaborative might include raising community awareness of the project and services provided; conducting community outreach; and providing peer navigation to engage MSM of color in HIV prevention and care, and screen and link them to behavioral health and social services. Many CBOs are suited to deliver interventions for medication adherence to PrEP or ARV treatment; retention in care; and behavioral risk reduction. Some CBOs might also provide clinical services such as lab-based 4th generation HIV testing and linkage to HIV care, STD screening and/or treatment, provision of PrEP and nPEP, or HIV primary care. CBOs might also have public health authority, granted by the health department, to conduct partner services or field investigations (Disease Intervention Specialist).

Clinics and health care providers must have the ability to provide HIV prevention and clinical care activities that the health department or CBO(s) do not offer, and might include: lab-based 4th generation HIV testing; STD testing and treatment; prescribing PrEP and nPEP; clinical management of PrEP and nPEP patients; linkage to HIV care; ARV treatment; HIV primary care; retention interventions; re-engagement interventions; adherence interventions; behavioral risk reduction; screening for behavioral health and social services needs; linkage to behavioral health and social services. Awardees may use funds to pay for STD testing. However, awardees should coordinate these services and seek payment first from other sources where available. Possible payment sources include Medicaid, Medicare, and commercial health insurance.

The component agencies of the collaborative must include a health department as the primary awardee, and the health department will award at least 25% of these funds to one or more CBOs. Other partners within the collaborative should be included to ensure delivery of comprehensive HIV prevention, care, and behavioral health and social services for MSM of color. Only the health department and its CBO partner(s) in the collaborative will receive funding for this project; other collaborative partners are expected to have in place, or under development, mechanisms to support providing and billing for HIV prevention and care services. The health department will develop service agreements between collaborating partners.

Applicants must submit an MOU, MOA, or Letter of Support for each member of the collaborative. Each document should describe the proposed collaboration, specific activities, and responsiblities of the collaborative members for the intended outcomes and benefits for the overall proposed program. These documents should be on official letterhead, signed by the collaborating member, and electronically submitted with the application. Name the file using “MOU-Name of Collaborative Member”. If the name of the collaborative member is "HIV Service Organization" the file would be titled "MOU-HIV Service Organization". Upload it as a PDF file at www.grants.gov

CDC expects to collaborate with (although not provide funds to) the following partners:

• HHS partners: HRSA/HAB, HRSA/BPHC, SAMHSA, IHS, OMH, and OHAIDP

• U.S. government partners: HUD and DOL

To ensure culturally competent delivery of HIV prevention and care services for MSM of color, a curriculum and a training-of-trainers model for a certificate-based training program will be developed for health department awardees of this FOA through a separate FOA (CDC-RFA-PS15-1510). The health department

will in turn, train staff in the collaborative.

2. Target Populations

Health departments should focus their activities on gay, bisexual, and other MSM of color to achieve optimal impact of the activities in this FOA on the health of this population and health equity. Applicants should describe how the work plan would impact the local HIV epidemic among this population.

a. Inclusion

All applicants should design models of HIV prevention, care, and social services that are accessible and available to persons regardless of age, gender, race, ethnicity, sexual orientation, gender identity, or socio-economic status. Additionally, all applicants' activities should result in measurable improvements in HIV prevention and care among the target population of underserved subpopulations of MSM of color, including but not limited to individuals with disabilities, and individuals with limited English proficiency.

iv. Funding Strategy (for multi-component FOAs only)

Only the health department will receive funding for this project; health department awardees must provide at least 25% of the FOA award to the collaborative CBO(s). Also, 10% of the FOA award must be used for program evaluation.

Funding preferences will be given to jurisdictions that do not have similar and effective models in place; the intent of this FOA is not to provide more funding to programs that are established but to develop more models or test existing models in new places. Funding preferences will also consider geographic diversity.

b. Evaluation and Performance Measurement

i. CDC Evaluation and Performance Measurement Strategy

CDC requires evaluation of the program and measurement of the awardee's performance. Health department awardees will collect, and report to CDC, process and outcome data that are consistent with the logic model and strategies and activities presented above. Health department awardees will also be responsible for using evaluation data for continuous quality improvement of the program. The CDC evaluation and performance measurement strategy requires that awardees use 10% of the overall budget to support local program evaluation of funded activities, including: collaborate with CDC to develop evaluation plans and data collection activities as appropriate; participate in data collection activities as appropriate; submit progress reports; conduct real-time documentation and tracking of program activities using existing health department and partnering agency IT applications; and periodically enter and electronically submit to CDC data and other reporting information using a CDC approved system.

When possible, program effectiveness will be assessed using short and medium term outcome measures. Where appropriate, outcomes can be calculated using existing HHS-supported data sources (e.g., HIV case surveillance and HIV testing). CDC will also require health department staff, and staff from partnering agencies (as appropriate), to collect and report data to measure additional program processes and outcomes. Guidance on program monitoring and evaluation and performance measures will be provided by CDC on an ongoing basis throughout the project period.

ii. Applicant Evaluation and Performance Measurement Plan

In collaboration with the CDC, the awardee will design an evaluation and performance measurement plan that includes both outcome and process measures. The applicant, as well as CDC, may suggest additional performance measures. As part of the development of an evaluation and measurement plan, CDC and awardees will develop a core set of indicators post-award. Specific evaluation questions and performance measures, data sources, and program targets for the required 24 activities will be developed post-award in collaboration between the awardee and CDC.

The awardee will monitor program performance throughout the project period. Program outcome and process data will be submitted to CDC annually.

Implementation of lab-based 4th generation HIV testing

Outcome: Increased number of MSM of color residing in a jurisdiction who were screened for HIV infection with a lab-based 4th generation HIV test in 12 months
• Indicator: Number of MSM of color who were screened with a lab-based 4th generation HIV test over 12 months

Outcome: Increased percentage of newly diagnosed HIV infections in MSM of color that were diagnosed in the acute phase of infection
• Indicator: Percentage of MSM of color with newly diagnosed HIV infections that were in the acute phase of infection

Outcome: Increased percentage of HIV tests that were reimbursed by a third party payer
• Indicator: Percentage of lab-based 4th generation HIV tests of MSM of color at risk for HIV that were reimbursed by a third party payer

Implementation of nPEP

Outcome: Increased number of MSM of color with a risk event who presented within 72 hours of the event and were linked to an nPEP provider for clinical evaluation on the same day they presented

• Indicator: Number of MSM of color with a risk event who presented within 72 hours of the event and were linked to an nPEP provider for clinical evaluation on the same day they presented

Implementation of PrEP

Outcome: Increased number of MSM of color with a negative HIV test and at substantial risk for HIV who were linked to a PrEP provider for clinical evaluation

• Indicator: Number of MSM of color with a negative HIV test and at substantial risk for HIV who were linked to a PrEP provider for clinical evaluation

Linkage to care

Outcome: Increased percentage of MSM of color diagnosed with acute HIV infection who were linked to care within 7 days of diagnosis (immediate linkage)
• Indicator: Percentage of MSM of color diagnosed with acute HIV infection who were linked to care within 7 days of diagnosis

Outcome: Increased percentage of MSM of color diagnosed with acute HIV infection who were initiated on ART within 14 days of diagnosis (immediate treatment)

• Indicator: Percentage of MSM of color diagnosed with acute HIV infection who were initiated on ARVs within 14 days of diagnosis

Outcome: Increased percentage of MSM of color diagnosed with established HIV infection who were linked to care within 30 days of diagnosis (expedient linkage)
• Indicator: Percentage of MSM of color diagnosed with established HIV infection who were linked to care within 30 days of diagnosis

Outcome: Decreased median time to viral load suppression among all MSM of color diagnosed with acute/established HIV infection
• Indicator: Median time to viral load suppression among all MSM of color diagnosed with acute/established HIV infection

Retention interventions

Outcome: Increased percentage of MSM of color living with HIV who received retention interventions
• Indicator: Percentage of MSM of color living with HIV who received retention interventions and who subsequently had at least 1 medical visit in each 6 month period of a 12 month follow up with a minimum of 60 days between visits

Outcome: Increased percentage of MSM of color diagnosed with HIV who were retained in HIV medical care
• Indicator: Percentage of MSM of color living with HIV who had a least 1 HIV medical care visit in each 6 month period of the 24 month measurement period, with a minimum of 60 days between the first medical visit in the prior 6 month period and the last medical visit in the subsequent 6 month period among MSM of color living with HIV with at least 1 HIV medical care visit in the first 6 months of the 24-month measurement period.

• Indicator: Percentage of MSM of color living with HIV who received retention interventions and who subsequently received two or more CD4 or VL tests performed at least 3 months apart in the 12 month follow up period

Data to Care re-engagement interventions

Outcome: Increased percentage of MSM of color living with HIV who were re-engaged in careusing the Data to Care strategy
• Indicator: Percentage of MSM of color living with HIV identified as out of care using the Data to Care strategy
• Indicator: Percentage of MSM of color living with HIV identified as out of care who were subsequently contacted/received outreach by program staff
• Indicator: Percentage of MSM of color living with HIV identified as out of care who attended at least 1 clinic visit within 90 days of receiving outreach from program staff (re-engaged)

Adherence interventions:

Outcome: Increased percentage of MSM of color living with HIV who received adherence interventions and had HIV viral loads reduced to less than 200 copies/mL
• Indicator: Percentage of MSM of color who received adherence intervention(s) who had an HIV viral load less than 200 copies/mL at last HIV viral load test during the 12 month follow-up period

STD screening and treatment

Outcome: Increased percentage of MSM of color at risk for HIV acquisition or living with HIV who were screened for syphilis
• Indicator: Percentage of MSM of color at risk for HIV who were screened for syphilis
• Indicator: Percentage of MSM of color living with HIV who were screened for syphilis

Outcome: Increased percentage of MSM of color at risk for HIV acquisition or living with HIV who were diagnosed with syphilis and appropriately treated for syphilis
• Indicator: Percentage of MSM at risk for HIV acquisition who were diagnosed withsyphilis and appropriately treated for syphilis
• Indicator: Percentage of MSM living with HIV who were diagnosed with syphilis and appropriately treated

Outcome: Increased percentage of MSM of color at risk for or living with HIV who reported insertive/receptive anal/oral sex who were screened for chlamydia and gonorrhea by site of exposure:
• Indicator: Percentage of MSM at risk for HIV who reported insertive/receptive anal/oral sex who were screened for chlamydia and gonorrhea by site of exposure
• Indicator: Percentage of MSM living with HIV who reported insertive/receptive anal/oral sex who were screened for chlamydia and gonorrhea by site of exposure

Outcome: Increased percentage of MSM of color at risk for or living with HIV diagnosed with chlamydia and/or gonorrhea who were appropriately treated
• Indicator: Percentage of MSM at risk for HIV diagnosed with chlamydia and/or gonorrhea who were appropriately treated
• Indicator: Percentage of MSM living with HIV diagnosed with chlamydia and/or gonorrhea who were appropriately treated

Partner services

Outcome: Increased percentage of MSM of color who received timely partner service interviews after receiving a positive HIV test result
• Indicator: Percentage of MSM of color interviewed for partner services within 30 days of receiving a positive HIV test result
• Indicator: Percentage of partners of MSM of color who are newly diagnosed with HIV infection
• Indicator: Percentage of partners of MSM of color with newly diagnosed with HIV infection who are linked to care
• Indicator: Percentage of partners of MSM of color with previously diagnosed with HIV infection who are re-engaged in care

Risk reduction services

Outcome: Increased percentage of MSM of color at risk for or living with HIV who received risk reduction interventions
• Indicator: Percentage of MSM of color at risk for HIV acquisition who received risk reduction interventions
• Indicator: Percentage of MSM of color living with HIV acquisition who received risk reduction interventions

Behavioral Health and Social services

Outcome: Increased percentage of MSM of color at risk for HIV acquisition or living with HIV who were screened for behavioral health and social services needs (i.e., mental health and substance abuse services, housing programs, and job training or employment services))
• Indicator: Percentage of MSM of color at risk for HIV acquisition who were screened for behavioral health and social services needs
• Indicator: Percentage of MSM of color living with HIV who were screened for behavioral health and social services needs

Outcome: Increased percentage of MSM of color at risk for HIV acquisition or living with HIV who needed any specified behavioral and social service (i.e., mental health services, substance abuse services, housing

programs, job training, employment services) and were linked to the service
• Indicator: Percentage of MSM of color at risk for HIV acquisition who needed any specified behavior and social service and were linked to the service
• Indicator: Percentage of MSM of color living with HIV who needed any specified behavioral and social service and were linked to the service

Enrollment in a health plan

Outcome: Increased percentage of MSM of color at risk for HIV acquisition or living with HIV who needed health insurance and were linked to the service

- Indicator: Percentage of MSM of color at risk for HIV acquisition who needed health insurance and were linked to the service

Indicator: Percentage of MSM of color living with HIV who needed health insurance and were linked to the service

c. Organizational Capacity of Awardees to Execute the Approach

The applicant should describe its prior experience and its current capacity to execute the program strategies and meet the program outcomes outlined in this FOA. These include:

• Identifying and conducting outreach to MSM of color at risk for HIV acquisition

• Identifying and conducting outreach to and clinical linkages for MSM of color living with HIV

• Using peer navigators to link MSM of color to HIV prevention, care, and social services

• Conducting the applicant's selected interventions and strategies for: HIV testing with lab-based 4th generation tests; nPEP and PrEP provision; immediate linkage and initiation of ARV treatment for those diagnosed with acute HIV infection; expedient linkage and initiation of ARV treatment for those diagnosed with established HIV infection; retention services if engaged in care; Data to Care re-engagement services if lost to care; medication adherence support; and behavioral risk reduction services

• Providing training and technical assistance for selected interventions and strategies

• Conducting partner services

• Screening for need for behavioral health and social services

• Linking to behavioral health and social services

• Linking to health insurance service

• Managing multi-agency projects and coordination of multi-activity programs

• Leading and coordinating community collaboratives that include CBOs, clinics, and behavioral health and social services

• Collaborating with CDC to develop an evaluation plan

• Conducting program performance monitoring, including collection of outcome and performance data and use of performance data for program improvement

• Writing, awarding, and managing any necessary sub-contracts

This section should also include a clear delineation of the roles and responsibilities of project staff and their qualifications. Also, the applicant should describe each organization that will join the collaborative, and how it will contribute to achieving the project's outcomes. This description should specify staff day-to-day responsibility for key tasks such as: leadership of the project; monitoring the project's on-going progress; preparation of reports; program evaluation; and communication with CDC other partners. Applicants may

describe how they will assess staff competencies and develop a plan to address gaps through organizational and individual training and development opportunities.

d. Work Plan

The applicant should develop a work plan for all four years of the award. The work plan should describe how the applicant intends to implement the proposed strategies to meet the outcomes of this FOA. As a cooperative agreement, CDC will provide post-award feedback and technical assistance to the awardee to finalize the work plan.
The work plan must, at a minimum, include the following:

• A detailed plan for identifying and conducting outreach to MSM of color at risk for HIV acquisition or living with HIV for program interventions and services. The plan should include each collaborative partner's roles and responsibilities.

• The specific services and interventions that the collaborative will conduct.

• A detailed plan for implementation of each of the 24 required activities for MSM of color at risk for HIV acquisition or living with HIV. The plan should include activities and timelines for each service and intervention. The activities should parallel the FOA logic model and include appropriate performance measures and milestones for accomplishing tasks. The plan should include the role and responsibilities of each partner in the collaborative.

• Administration and assessment processes to ensure successful implementation of services and interventions for MSM of color at risk for HIV acquisition or living with HIV

• A management plan outlining proposed staff; their roles and responsibilities for accomplishing program activities; and the amount of time each staff member will dedicate to the FOA activities. Staff experience and educational background should be included. In addition, a diagram illustrating the relationships between all collaborative partners should be included.

• A management plan that describes how the applicant will manage, monitor, and coordinate collaborative activities; how the applicant will address program implementation problems.

• A plan for intervention sustainability throughout and after the project period.

• The applicant describes the estimated number of MSM of color at risk for HIV acquisition and living with HIV that will be reached through each selected intervention and service.

SAMPLE WORK PLAN:

Project Period Outcome:[from Outcomes section and/or logic model]	**Outcome Measure:**[from Evaluation and Performance Measurement section] **OR SMART Outcome Objective:** [should draw on measures in Evaluation and Performance Measurement section]		
Strategies/Activities	**Process Measure**[from Evaluation and Performance Measurement section] **OR** **SMART Process Objective:**[should draw on measures in Evaluation and Performance Measurement section]	**Responsible Position / Party**	**Completion Date**
1.			

2.			
3.			
4.			
5.			
6.			
7.			

e. CDC Monitoring and Accountability Approach

Monitoring activities include routine and ongoing communication between CDC and awardees, site visits, and awardee reporting (including work plans, performance, and financial reporting). Consistent with applicable grants regulations and policies, CDC expects the following to be included in post-award monitoring for grants and cooperative agreements:

- Tracking awardee progress in achieving the desired outcomes.
- Ensuring the adequacy of awardee systems that underlie and generate data reports.
- Creating an environment that fosters integrity in program performance and results.

Monitoring may also include the following activities:

- Ensuring that work plans are feasible based on the budget and consistent with the
- intent of the award.
- Ensuring that awardees are performing at a sufficient level to achieve outcomes within stated timeframes.
- Working with awardees on adjusting the work plan based on achievement of outcomes, evaluation results and changing budgets.
- Monitoring performance measures (both programmatic and financial) to assure satisfactory performance levels.

Other activities deemed necessary to monitor the award, if applicable.

These activities may include monitoring and reporting activities that assist grants management staff (e.g., grants management officers and specialists, and project officers) in the identification, notification, and management of high-risk grantees.

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f. CDC Program Support to Awardees (THIS SECTION APPLIES ONLY TO COOPERATIVE AGREEMENTS)

In a cooperative agreement, HHS/CDC staff members are substantially involved in the program activities, above and beyond routine grant monitoring. HHS/CDC activities for this program are as follows:

A. Provide consultation and technical assistance to awardees on all aspects of the implementation of the funding program as well as all protocols, procedures, and instruments related to the plan, both directly and through CDC's network of awardees and partners.

B. Work with awardees to address training, capacity building, and technical assistance needs that are crucial to the successful execution of the plan, and that are not addressed by other funding sources.

C. Facilitate coordination, collaboration, and, where feasible, service integration among other CDC programs, health departments and their programmatic divisions, local planning groups, directly-funded CBOs, national capacity building assistance providers, care providers, and other critical partners working with at risk populations and towards common goals of risk reduction, disease detection, and a continuum of HIV

prevention, care, and treatment.

D. Monitor awardee progress in implementing the program and work with awardees through consultation via site visits, email, telephone, and review of progress reports to support implementation of the project.

E. Monitor awardee progress in developing and conducting monitoring and evaluation activities through consultation via site visits, email, telephone, and review of progress reports and other data reports to support progress, program improvement, and reductions in HIV incidence

F. Provide requirements and expectations for standardized and other data reporting and support monitoring and evaluation activities with technical assistance, web-based training on M&E, M&E-related materials such as data collection tools, and on-line TA via the National HIV Monitoring and Evaluation Service Center as appropriate.

G. Facilitate necessary CDC and other clearances.
Plan, convene, and facilitate joint awardee meetings during the project period

B. Award Information

1. Funding Instrument Type: Cooperative Agreement

CDC's substantial involvement in this program appears in the CDC Program Support to Awardees Section.

2. Award Mechanism: U62

U62 Prevention/Surveillance Activities/Studies of AIDS

In cooperation with the State and local public health authorities and other non-profit organizations, to assist in detecting and preventing the further spread of AIDS through active surveillance and epidemiologic investigation, sero-prevalence surveys, laboratory services, public information campaigns, health education and risk reduction activities, and counseling, testing and partner notification.

3. Fiscal Year: 2015

Estimated Total Funding: $14,000,000

4. Approximate Total Fiscal Year Funding: $14,000,000

5. Approximate Project Period Funding: $60,500,000

6. Total Project Period Length: 4 year(s)

7. Expected Number of Awards: 6

Up to 8 awards

8. Approximate Average Award: $0 Per Budget Period

1st year: $ $1,750,000; 2nd year: $1,812,500; 3rd year: $1,937,500; 4th year: $; $2,062,500

9. Award Ceiling: $2,333,333 Per Budget Period

Year 1: $2,333,333; Year 2: $2,416,667; Year 3: $2,583,333; Year 4: $2,750,000 (These amounts are *subject to the availability of funds.)*

10. Award Floor: $1,750,000 Per Budget Period

Year 1: $1,750,000; Year 2: $1,812,500; Year 3: $1,937,500; Year 4: $2,062,500 (These amounts are subject to the availability of funds.)

11. Estimated Award Date: 09/30/2015

Throughout the project period, CDC will continue the award based on the availability of funds, the 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. The total number of years for which federal support has been approved (project period) will be shown in the "Notice of Award." This information does not constitute a commitment by the federal government to fund the entire period. The total project period comprises the initial competitive segment and any subsequent non-competitive continuation award(s).

12. Budget Period Length: 12 month(s)

13. Direct Assistance

Direct Assistance (DA) is not available through this FOA.

C. Eligibility Information

1. Eligible Applicants

Eligibility Category:

State governments
County governments
City or township governments

Government Organizations:

State (includes the District of Columbia)
Local governments or their bona fide agents
Territorial governments or their bona fide agents in the Commonwealth of Puerto Rico, the Virgin Islands, the Commonwealth of the Northern Marianna Islands, American Samoa, Guam, the Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau.

2. Additional Information on Eligibility

1. Eligible Applicants:

Applicants must meet **one** of the following **two** criteria:

-**Morbidity Criteria**: Metropolitan Statistical Areas/Divisions with >2,000 Black and/or Hispanic MSM living with diagnosed HIV

o Focuses on MSA targets areas where most MSM are accessible

o Threshold of 2,000 ensures a large participant pool to robustly demonstrate the prevention and care service models

-**Mortality Criteria**: States in the 4th quartile for mortality rates as reported in the State Progress Report and have >1,000 Black and/or Hispanic MSM living with diagnosed HIV in a specified MSA

Jurisdictions eligible under the morbidity criteria cannot apply under the mortality criteria.

State health departments with one eligible MSA are required to work in the specified eligible MSA or MD. States that have more than one eligible MSA may elect to work in all or a reduced number of eligible MSAs, in order of prevalence.

States that have local health departments directly funded by CDC are not eligible to apply for the MSAs or MDs that contain locally funded health departments within the state.

Funding will be awarded to **up to 2** health department that meets the Mortality Criteria.

CDC will not consider any application that is submitted: after the due date of June 1, 2015, 11:59 p.m. U.S. Eastern Standard Time; incomplete; missing descriptions of any of the required 24 services for comprehensive HIV prevention and care (Strategies and Activities section); or missing MOAs, MOUs, or letters of support for service agreements from each collaborative partners (Strategies and Activities section).

Please see additional information on eligiblity criteria in Section 3 Justification for Less than Maximum Competition

The award ceiling for this FOA is $2,333,333. CDC will consider any application requesting an award higher than this amount as non- responsive and it will receive no further review. If a pre-application is required, then specify here and include it in the special eligibility requirements section. (http:// www.hhs.gov/ asfr/ ogapa/ aboutog/ hhsgps107.pdf)

3. Justification for Less than Maximum Competition

Applicants for this FOA will be limited to health departments. Health departments are uniquely qualified to lead and coordinate the collaboratives to develop comprehensive models of HIV prevention, care, and behavioral health and social services, because of their responsibility to prevent and control HIV in their communities. In addition, health departments will develop the capacity to train members of the collaboratives to provide culturally competent and linguistically appropriate prevention, care, and behavioral health and social services for MSM of color using a curriculum that will be developed in a companion FOA (CDC-RFA-15-1510) that will support the efforts described in this FOA.

As both NHAS and DHAP's Strategic Plan (2011-2015) note, in the face of increasingly constrained resources and a concentrated, inequitably distributed epidemic, HIV prevention funding must be allocated to those communities and regions with the greatest share of the national burden. Gay, bisexual, and other MSM remain the population most affected by HIV infection in the United States. Among MSM, those who are black and Hispanic comprise 58% of all new infections. In order to reduce HIV among this population we propose the following eligibility requirements for this FOA that target black and Hispanic MSM living with diagnosed HIV:

Morbidity Criteria: Metropolitan Statistical Areas/Divisions with >2,000 Black and/or Hispanic MSM living with diagnosed HIV

- Focuses on MSAs target areas where most MSM are accessible
- Threshold of 2,000 ensures that the participant pool to robustly demonstrate the prevention and care service models

Mortality Criteria: States in the 4thquartile for mortality rates as reported in the State Progress Report and that have >1,000 Black and/or Hispanic MSM living with diagnosed HIV in a specified MSA

The following organizations are eligible to apply:

Morbidity Criteria	
Health Department Applicant	**Area of residence**
New York City Dept. of Health and Mental Hygiene	New York–White Plains–Wayne Division
Los Angeles County Public Health Dept.	Los Angeles Division

Florida State Dept. of Health	Miami Division
Fulton County Dept. of Health and Wellness	Atlanta-Sandy Springs-Marietta, GA
Chicago Dept. of Public Health	Chicago Division
District of Columbia Dept. of Health	Washington Division
Houston Dept. of Health and Human Services	Houston-Baytown-Sugar Land, TX
Texas State Dept. of Health Services	Dallas Division
City of Philadelphia Public Health Dept.	Philadelphia Division
California Dept. of Public Health (Office on AIDS)	San Diego-Carlsbad-San Marcos, CA
Baltimore Dept. of Health	Baltimore-Towson, MD
San Francisco Dept. of Public Health	San Francisco Division
Florida State Dept. of Health	Fort Lauderdale Division
Michigan Dept. of Community Health	Detroit Division
Tennessee Dept. of Health	Memphis, TN-MS-AR
New Jersey Dept. of Health and Senior Services	Newark Division
Florida State Dept. of Health	Orlando, FL
Puerto Rico Dept. of Health	San Juan-Caguas-Guaynabo, PR*
Arizona Dept. of Health	Phoenix-Mesa-Scottsdale, AZ
Texas State Dept. of Health Services	San Antonio, TX
Virginia State Dept. of Health	Virginia Beach-Norfolk-Newport News, VA
California Dept. of Public Health (Office on AIDS)	Santa Ana Division
California Dept. of Public Health (Office on AIDS)	Oakland Division
Missouri Dept. of Health and Senior Services	St. Louis, MO-IL
Mortality Criteria*	
Louisiana Dept. of Health	New Orleans–Metairie, LA
South Carolina Dept. of Health and Environmental Control	Columbia, SC
Alabama Dept. of Public Health	Birmingham–Hoover, AL
Mississippi State Dept. of Health	Jackson, MS

* Does not include states already included by the morbidity criteria

The award ceiling for this FOA is: Year 1: $2,333,333; Year 2: $2,416,667; Year 3: $2,583,333; Year 4: $2,750,000 (These amounts are *subject to the availability of funds.)*. CDC will consider any application requesting an award higher than this amount as non-responsive and it will receive no further review. (http://www.hhs.gov/asfr/ogapa/aboutog/hhsgps107.pdf)

The folowing must submited on official letterhead: 1) The applicant must state whether they are applying

under the Morbidity or Mortality Criteria listed in this section; 2) The applicant must state they will provide all 24 services for comprehensive HIV prevention and care (listed in Strategies and Activities Section). The applicant must list each of the 24 services and give a short description of how they will address each service (one or two sentences). 3) The applicant must provide the names and addresses for each member of their collaborative. The applicant must also state that MOUs/MOAs have been provided for each member of the collaborative listed. The applicant should name this letter "Proof of Eligibility Letter" and upload it as a PDF file at www.grants.gov

Applicants must submit an MOU, MOA, or Letter of Support for each member of the collaborative. Each document should describe the proposed collaboration, specific activities, and responsiblities of the collaborative members for the intended outcomes and benefits for the overall proposed program. These documents should be on official letterhead, signed by the collaborating member, and electronically submitted with the application. Name the file using "MOU-Name of Collaborative Member". If the name of the collaborative member is "HIV Service Organization" the file would be titled "MOU-HIV Service Organization". Upload it as a PDF file at www.grants.gov

4. Cost Sharing or Matching

Cost Sharing / Matching Requirement: No

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

5. Maintenance of Effort

Maintenance of effort is not required for this program.

D. Required Registrations

Additional materials that may be helpful to applicants: http://www.cdc.gov/od/pgo/funding/docs/FinancialReferenceGuide.pdf.

1. Required Registrations

An organization must be registered at the three following locations before it can submit an application for funding at www.grants.gov.

a. Data Universal Numbering System: All applicant organizations must obtain a Data Universal Numbering System (DUNS) number. A DUNS number is a unique nine-digit identification number provided by Dun & Bradstreet (D&B). It will be used as the Universal Identifier when applying for federal awards or cooperative agreements.

The applicant organization may request a DUNS number by telephone at 1-866-705-5711 (toll free) or Internet athttp:// fedgov.dnb.com/webform/displayHomePage.do. The DUNS number will be provided at no charge.If funds are awarded to an applicant organization that includes sub-awardees, those sub-awardees must provide their DUNS numbers before accepting any funds.

b. System for Award Management (SAM): The SAM is the primary registrant database for the federal government and the repository into which an entity must submit information required to conduct business as an awardee. All applicant organizations must register with SAM, and will be assigned a SAM number. All information relevant to the SAM number must be current at all times during which the applicant has an application under consideration for funding by CDC. If an award is made, the SAM information must be maintained until a final financial report is submitted or the final payment is received, whichever is later. The SAM registration process usually requires not more than five business days, and registration must be renewed annually. Additional information about registration procedures may be found at www.SAM.gov.

c. Grants.gov: The first step in submitting an application online is registering your organization through www.grants.gov, the official HHS E-grant website. Registration information is located at the "Get Registered" option atwww.grants.gov.

All applicant organizations must register with www.grants.gov. The one-time registration process usually takes not more than five days to complete. Applicants must start the registration process as early as possible.

2. Request Application Package

Applicants may access the application package at www.grants.gov.

3. Application Package

Applicants must download the SF-424, Application for Federal Assistance, package associated with this funding opportunity at www.grants.gov. If Internet access is not available, or if the online forms cannot be accessed, applicants may call the CDC PGO staff at 770-488-2700 or e-mail PGO PGOTIM@cdc.gov for assistance. Persons with hearing loss may access CDC telecommunications at TTY 1-888-232-6348.

4. Submission Dates and Times

If the application is not submitted by the deadline published in the FOA, it will not be processed. PGO personnel will notify the applicant that their application did not meet the deadline. The applicant must receive pre-approval to submit a paper application (see Other Submission Requirements section for additional details). If the applicant is authorized to submit a paper application, it must be received by the deadline provided by PGO.

a. Letter of Intent Deadline (must be emailed or postmarked by)

N/A

b. Application Deadline

Due Date for Applications: **06/01/2015**, 11:59 p.m. U.S. Eastern Standard Time, at www.grants.gov. If Grants.gov is inoperable and cannot receive applications, and circumstances preclude advance notification of an extension, then applications must be submitted by the first business day on which grants.gov operations resume.

http://www.cdc.gov/hiv/policies/funding/announcements/ps15-1509/index.html

5. CDC Assurances and Certifications

All applicants are required to sign and submit "Assurances and Certifications" documents indicated at http://www.cdc.gov/grants/interestedinapplying/applicationprocess.html.

- Complete the applicable assurances and certifications on an annual basis, name the file "Assurances and Certifications" and upload it as a PDF file at www.grants.gov
- Complete the applicable assurances and certifications and submit them directly to CDC on an annual basis at http://wwwn.cdc. gov/grantassurances/(S(mj444mxct51lnrv1hljjjmaa))/ Homepage.aspx

  Assurances and certifications submitted directly to CDC will be kept on file for one year and will apply to all applications submitted to CDC by the applicant within one year of the submission date.

6. Content and Form of Application Submission

Applicants are required to include all of the following documents with their application package at www.grants.gov.

7. Letter of Intent

A LOI is optional as part of the application for this FOA. The purpose of an LOI is to allow CDC program staff to estimate the number of and plan for the review of submitted applications. LOI must be emailed by April 21, 2015 to:

Karen Hoover, Team Lead

Health Services Research for Prevention with Negatives Team, Epidemiology Branch

CDC, NCHHSTP, DHAP

Email address: ffw6@cdc.gov

8. Table of Contents

(No page limit and not included in Project Narrative limit): The applicant must provide, as a separate attachment, the "Table of Contents" for the entire submission package.

Provide a detailed table of contents for the entire submission package that includes all of the documents in the application and headings in the "Project Narrative" section. Name the file "Table of Contents" and upload it as a PDF file under "Other Attachment Forms" at www.grants.gov.

9. Project Abstract Summary

(Maximum 1 page)

A project abstract is included on the mandatory documents list and must be submitted at www.grants.gov. The project abstract must be a self-contained, brief summary of the proposed project including the purpose and outcomes. This summary must not include any proprietary or confidential information. Applicants must enter the summary in the "Project Abstract Summary" text box at www.grants.gov.

10. Project Narrative

(Maximum of 20 pages, single spaced, Calibri 12 point, 1-inch margins, number all pages. Content beyond 20 pages will not be considered. The 20 page limit includes the work plan. For a multi-component FOA, maximum page limit is 25.)

The Project Narrative must include all of the bolded headings shown in this section. The Project Narrative must be succinct, self-explanatory, and in the order outlined in this section. It must address outcomes and activities to be conducted over the entire project period as identified in the CDC Project Description section. Applicants must submit a Project Narrative with the application forms. Applicants must name this file "Project Narrative" and upload it at www.grants.gov.

a. Background

Applicants must provide a description of relevant background information that includes the context of the problem (See CDC Background).

b. Approach

i. Purpose

Applicants must describe in 2-3 sentences specifically how their application will address the problem as described in the CDC Background section.

ii. Outcomes

Applicants must clearly identify the outcomes they expect to achieve by the end of the project period. Outcomes are the results that the program intends to achieve. All outcomes must indicate the intended direction of change (e.g., increase, decrease, maintain). (See the logic model in the Approach section of the CDC Project Description.)

iii. Strategies and Activities
Applicants must provide a clear and concise description of the strategies and activities they will use to achieve the project period outcomes. Applicants must select existing evidence-based strategies that meet their needs, or describe in the Applicant Evaluation and Performance Measurement Plan, how these strategies will be evaluated over the course of the project period. (See CDC Project Description: Strategies and Activities section.)

1. Collaborations
Applicants must describe how they will collaborate with programs and organizations either internal or external to CDC.

Applicants must describe how they will collaborate with programs and organizations either internal or external to CDC.

Applicants must file an MOU, MOA, or Letter of Support for each member of the collaborative. Name the file using "MOU-Name of Collaborative Member". So if the collaborative member was named "HIV Service Organization" the file would be titled "MOU-HIV Service Organization". Upload it as a PDF file at www.grants.gov

**Additional info Project Narrative section 10:

Maximum of 20 pages, single spaced, Calibri 12 point, 1-inch margins, number all pages. Content beyond 20 pages will not be considered. The 20 page limit includes the work plan. State health departments that have more than one eligible MSA (California, Florida, and Texas), and elect to work in more than one specified eligible MSA, will be allowed a maximum of 20 pages per MSA.

2. Target Populations
Applicants must describe the specific target population(s) in their jurisdiction and explain how such a target will achieve the goals of the award and/or alleviate health disparities. Refer back to the CDC Project Description section – Approach: Target Population.

a. Inclusion: Applicants must address how they will include specific populations who can benefit from the program, refer back to the CDC Project Description section – Approach: Inclusion, if applicable

c. Applicant Evaluation and Performance Measurement Plan
Applicants must provide an overall evaluation and performance measurement plan that is consistent with the CDC Evaluation and Performance Measurement Strategy section of the CDC Project Description of this FOA. Data collected must be used for ongoing monitoring of the award to evaluate its effectiveness, and for continuous program improvement.

The plan must:

- Affirm the ability to collect the performance measures and respond to the evaluation questions specified in the CDC strategy. (For guidance regarding the Paperwork Reduction Act, please visit http://www.hhs.gov/ocio/policy/collection/infocollectfaq.html)
- Describe how key program partners will participate in the evaluation and performance measurement planning processes.
- Describe how evaluation findings will be used for continuous program quality improvement.

Where the applicant chooses to, or is expected to, take on specific evaluation studies:

- Describe the type of evaluation(s) (i.e., process, outcome, or both) to be conducted.
- Describe key evaluation questions to be addressed by these evaluations.
- Describe other information relevant to the evaluation (e.g., measures, data sources)

• Describe potentially available data sources and feasibility of collecting appropriate evaluation and performance data.
• Describe how evaluation findings will be used for continuous program and quality improvement.
• Describe how evaluation and performance measurement will contribute to development of that evidence base, where program strategies are being employed that lack a strong evidence base of effectiveness

Awardees will be required to submit a more detailed evaluation and performance measurement plan within the first 6 months of the project, as outlined in the reporting section of the FOA.

d. Organizational Capacity of Applicants to Implement the Approach

Applicant must address the organizational capacity requirements as described in the CDC Project Description.

Applicants must name this file "CVs/Resumes" or "Organizational Charts" and upload it at www.grants.gov.

11. Work Plan

(Included in the Project Narrative's 20 page limit)

Applicants must prepare a work plan consistent with the CDC Project Description Work Plan section. The work plan integrates and delineates more specifically how the awardee plans to carry out achieving the project period outcomes, strategies and activities, evaluation and performance measurement.

Applicants must name this file "Work Plan" and upload it as a PDF file at www.grants.gov.

12. Budget Narrative

Applicants must submit an itemized budget narrative, which may be scored as part of the Organizational Capacity of Awardees to Execute the Approach. When developing the budget narrative, applicants must 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:

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

Indirect costs will not be reimbursed under grants to foreign organizations, international organizations, and foreign components of grants to domestic organizations (does not affect indirect cost reimbursement to the domestic entity for domestic activities). The CDC will not reimburse indirect costs unless the recipient has an indirect cost rate covering the applicable activities and period.

For guidance on completing a detailed budget, see Budget Preparation Guidelines at:http://www.cdc.gov/grants/interestedinapplying/applicationresources.html .

If applicable and consistent with the cited statutory authority for this announcement, applicant entities may use funds for activities as they relate to the intent of this FOA to meet national standards or seek health department accreditation through the Public Health Accreditation Board (see: http://www.phaboard.org).

Applicant entities to whom this provision applies include state, local, territorial governments (including the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, the Commonwealth of the Northern Marianna Islands, American Samoa, Guam, the Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau), or their bona fide agents, political subdivisions of states (in consultation with states), federally recognized or state-recognized American Indian or Alaska Native tribal governments, and American Indian or Alaska Native tribally designated organizations. Activities include those 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 must focus on achieving a minimum of one national standard that supports the intent of the FOA. Proposed activities must be included in the budget narrative and must indicate which standards will be addressed.

Applicants must name this file "Budget Narrative" and upload it as a PDF file at www.grants.gov. If requesting indirect costs in the budget, a copy of the indirect cost-rate agreement is required. If the indirect costs are requested, include a copy of the current negotiated federal indirect cost rate agreement or a cost allocation plan approval letter for those Grantees under such a plan. Applicants must name this file "Indirect Cost Rate" and upload it at www.grants.gov.

State health departments that have more than one eligible MSA (California, Florida, and Texas), and elect to work in more than one specified eligible MSA, must submit a budget for each MSA in addition to a budget for the state.

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 may be used to implement the optional policies, and no applicants will be evaluated or scored on whether they choose to implement these optional policies.

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. The tobacco policies build upon the current federal commitment to reduce exposure to secondhand smoke, specifically 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: Use of any tobacco products (including smokeless tobacco) or electronic cigarettes is not allowed in any indoor facilities under the control of the awardee.
2. Tobacco-free indoors and in adjacent outdoor areas: Use of any tobacco products or electronic cigarettes is not allowed 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: Use of any tobacco products or electronic cigarettes is not allowed in any indoor facilities or anywhere on grounds or in outdoor space under the control of the awardee.

Nutrition Policies:

1. Healthy food-service guidelines must, at a minimum, align with HHS and General Services Administration Health and Sustainability Guidelines for Federal Concessions and Vending Operations. These guidelines apply to cafeterias, snack bars, and vending machines in any facility under the control

of the awardee and in accordance with contractual obligations for these services (see: http://www.gsa.gov/ graphics/pbs/Guidelines_for__Federal__Concessions_and_Vending__Operations.pdf).

2. Resources that provide guidance for healthy eating and tobacco-free workplaces are:

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

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

http:// www.cdc.gov /obesity /strategies /food-serv-guide.html

14. Health Insurance Marketplaces

A healthier country is one in which Americans are able to access the care they need to prevent the onset of disease and manage disease when it is present. The Affordable Care Act, the health care law of 2010, creates new Health Insurance Marketplaces, also known as Exchanges, to offer millions of Americans affordable health insurance coverage. In addition, the law helps make prevention affordable and accessible for Americans by requiring health plans to cover certain recommended preventive services without cost sharing. Outreach efforts will help families and communities understand these new options and provide eligible individuals the assistance they need to secure and retain coverage as smoothly as possible. For more information on the Marketplaces and the health care law, visit: www.HealthCare.gov.

15. Intergovernmental Review

Executive Order 12372 does not apply to this program.

16. Pilot Program for Enhancement of Employee Whistleblower Protections

Pilot Program for Enhancement of Employee Whistleblower Protections: All applicants will be subject to a term and condition that applies the terms of 48 CFR section 3.908 to the award and requires that grantees inform their employees in writing (in the predominant native language of the workforce) of employee whistleblower rights and protections under 41 U.S.C. 4712.

17. Funding Restrictions

Restrictions that must be considered while planning the programs and writing the budget are:

- Awardees may not use funds for research.
- Awardees may not use funds for clinical care.
- Awardees may use funds only for reasonable program purposes, including personnel, travel, supplies, and services.
- Generally, awardees may not use funds to purchase furniture or equipment. Any such proposed spending must be clearly identified in the budget.
- Reimbursement of pre-award costs is not allowed.
- Other than for normal and recognized executive-legislative relationships, no funds may be used for:
    - publicity or propaganda purposes, for the preparation, distribution, or use of any material designed to support or defeat the enactment of legislation before any legislative body
    - the salary or expenses of any grant or contract recipient, or agent acting for such recipient, related to any activity designed to influence the enactment of legislation, appropriations, regulation, administrative action, or Executive order proposed or pending before any legislative body
- See http:// www.cdc.gov /grants /additional requirements /index.htm l#ar12 for detailed guidance on this prohibition and http://intranet.cdc.gov/od/adp/docs/ImplementationofAnti-LobbyingProvisions-June2012.pdf

- 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.

Additional Restrictions that must be considered while planning the programs and writing the budget are:

• Awardees may not use funds for HIV medications (ARVs) for the treatment of HIV infection.

• Awardees may not use funds for PrEP medications (i.e., Truvada).

• Awardees may not use funds for laboratory testing related to PrEP (e.g., creatinine tests, liver function tests, pregnancy tests, and additional clinical tests that could result from evaluation of side effects or toxicities).

Project activities that involve the collection of information from 10 or more individuals/entities and are funded by a grant/cooperative agreement will be subject to review and approval by the Office of Management and Budget (OMB) under the Paperwork Reduction Act

18. Other Submission Requirements

a. Electronic Submission: Applications must be submitted electronically at www.grants.gov. The application package can be downloaded at www.grants.gov. Applicants can complete the application package off-line and submit the application by uploading it at www.grants.gov. All application attachments must be submitted using a PDF file format. Directions for creating PDF files can be found at www.grants.gov. File formats other than PDF may not be readable by PGO Technical Information Management Section (TIMS) staff.

Applications must be submitted electronically by using the forms and instructions posted for this funding opportunity at www.grants.gov.

If Internet access is not available or if the forms cannot be accessed online, applicants may contact the PGO TIMS staff at 770- 488-2700 or by e-mail at pgotim@cdc.gov, Monday through Friday, 7:30 a.m.–4:30 p.m., except federal holidays. Electronic applications will be considered successful if they are available to PGO TIMS staff for processing from www.grants.gov on the deadline date.

b. Tracking Number: Applications submitted through www.grants.gov are time/date stamped electronically and assigned a tracking number. The applicant's Authorized Organization Representative (AOR) will be sent an e-mail notice of receipt when www.grants.gov receives the application. The tracking number documents that the application has been submitted and initiates the required electronic validation process before the application is made available to CDC.

c. Validation Process: Application submission is not concluded until the validation process is completed successfully. After the application package is submitted, the applicant will receive a "submission receipt" e-mail generated by www.grants.gov. A second e-mail message to applicants will then be generated by www.grants.gov that will either validate or reject the submitted application package. This validation process may take as long as two business days. Applicants are strongly encouraged to check the status of their application to ensure that submission of their package has been completed and no submission errors have occurred. Applicants also are strongly encouraged to allocate ample time for filing to guarantee that their application can be submitted and validated by the deadline published in the FOA. Non-validated applications will not be accepted after the published application deadline date.

If you do not receive a "validation" e-mail within two business days of application submission, please contact www.grants.gov. For instructions on how to track your application, refer to the e-mail message generated at the time of application submission or the Applicant User Guide, Version 1.1, page 102.

http:// www.grants.gov /documents /19/18243 /Grantsgov ApplicantUserGuide .pdf /ce754626

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d. Technical Difficulties: If technical difficulties are encountered at www.grants.gov, applicants should contact Customer Service at www.grants.gov. The www.grants.gov Contact Center is available 24 hours a day, 7 days a week, except federal holidays. The Contact Center is available by phone at 1-800-518-4726 or by e-mail at support@www.grants.gov. Application submissions sent by e-mail or fax, or on CDs or thumb drives will not be accepted. Please note that www.grants.gov is managed by HHS.

e. Paper Submission: If technical difficulties are encountered at www.grants.gov, applicants should call the www.grants.gov Contact Center at 1-800-518-4726 or e-mail them at support@www.grants.gov for assistance. After consulting with the Contact Center, if the technical difficulties remain unresolved and electronic submission is not possible, applicants may e-mail or call CDC GMO/GMS, before the deadline, and request permission to submit a paper application. Such requests are handled on a case-by-case basis.

An applicant's request for permission to submit a paper application 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; and
3. Be postmarked at least three calendar days before the application deadline. Paper applications submitted without prior approval will not be considered. If a paper application is authorized, PGO will advise the applicant of specific instructions for submitting the application (e.g., original and two hard copies of the application by U.S. mail or express delivery service).

E. Review and Selection Process

1. Review and Selection Process: Applications will be reviewed in three phases.

a. Phase I Review

All applications will be reviewed initially for completeness by CDC PGO staff and will be reviewed jointly for eligibility by the CDC NCHHSTP and PGO. Incomplete applications and applications that do not meet the eligibility criteria will not advance to Phase II review. Applicants will be notified that their applications did not meet eligibility or published submission requirements.

b. Phase II Review

A review panel will evaluate complete, eligible applications in accordance with the criteria below.

i. Approach
ii. Evaluation and Performance Measurement
iii. Applicant's Organizational Capacity to Implement the Approach

Approach (50 points)	**Maximum Points: 50**

i. Approach

• Does the applicant describe required services and interventions they plan to implement for comprehensive HIV prevention for MSM of color at risk for HIV acquisition?

• Does the applicant describe required services and interventions they plan to implement for comprehensive HIV care for MSM of color living with HIV?

• To what extent does the applicant describe a detailed plan to implement each of the 24 required activities? Does applicant describe key activities, milestones and timelines to accomplish these tasks?

– Does the applicant describe a plan for creation of service agreements, MOAs, MOUs, and financial agreements and timelines for completion?

– Does the applicant describe a detailed plan for identification of and outreach to MSM of color at risk for HIV acquisition?

– Does the applicant describe a detailed plan for identification of and linkage to care for MSM of color living with HIV?

– Does the applicant describe, in detail, their plans to develop intervention materials, protocols and linkage mechanisms?

– Does the applicant describe how collaborative CBO competencies will be assessed and do they describe a plan to address deficiencies?

– Does the applicant describe a detailed plan on how they will manage, monitor and coordinate activities conducted by collaborative partners?

– Does the applicant describe plans to ensure collection of required performance measures?

– Does the applicant describe the technical assistance they will give to the collaborative partners?

• To what extent does the applicant describe plans to implement lab-based 4th generation HIV testing?

• To what extent does the applicant describe plans to implement nPEP for MSM of color at risk for HIV acquisition?

• To what extent does the applicant describe plans to implement PrEP for MSM of color at substantial risk for HIV acquisition?

• To what extent does the applicant describe plans to implement immediate linkage to care and initiation of ARV treatment for MSM of color diagnosed with acute HIV infection?

• To what extent does the applicant describe plans to implement expedient linkage to care and initiation of ARV treatment for MSM of color diagnosed with established HIV?

• To what extent does the applicant describe plans to implement a Data to Care strategy to identify out of care MSM of color living with HIV and to re-engage these persons into care?

• To what extent does the applicant describe plans to conduct STD screening and treatment of MSM of color at risk for or living with HIV?

• To what extent does the applicant describe plans to provide partner services and to link MSM of color at risk for HIV acquisition or living with HIV to behavioral health and social services?

• To what extent does the applicant describe plans to screen MSM of color at risk for or living with HIV for behavioral health and social services needs?

• To what extent does the applicant describe plans to link MSM of color at risk for or living with HIV to behavioral health and social services?

• To what extent does the applicant describe plans to provide peer navigation for MSM of color at risk for or living with HIV to access HIV prevention, care, and behavioral health and social services?

•To what extent does the applicant describe plans to link MSM of color at risk for or living with HIV to health insurance?

• To what extent does the applicant describe plans for sustainability of the program interventions throughout the project period?

• Does the applicant describe the estimated number of MSM of color living with HIV who will be reached through each intervention and service?

• Does the applicant's jurisdiction have similar models in place? If so, to what extent are the models described?

ii. Evaluation and Performance Management (20 points)	**Maximum Points: 20**

• Does the applicant describe, in detail, a process for collecting performance and outcome measures, data quality control procedures, data security, and secure transmission of data to CDC?

• Does the applicant describe potentially available data sources and feasibility of collecting appropriate outcome and performance measures?

• Does the applicant describe how performance measurement will be used for program improvement?

• Does the applicant describe how they will comply with the project's data reporting requirements?

iii. Applicants Organizational Capacity to Implement the Approach (30 points):	**Maximum Points: 30**

• To what extent does the applicant describe their capacity to identify and reach MSM of color at risk for HIV acquisition or living with HIV?

• To what extent does the applicant describe their capacity to implement each of the required 24 activities and each service for MSM of color at risk for HIV acquisition and those living with HIV?

- Does the applicant describe each member of the collaborative and describe in detail the role and responsibilities of each collaborative member in implementing each intervention and service?

- Does the applicant describe, in detail, what training and/or experience in conducting the selected interventions each collaborative member has?

- Does the applicant describe, in detail, the experience with partner services each collaborative member has?

- Does the applicant describe, in detail, the experience with linkage to behavioral heallth and social services each collaborative member has?

• To what extent does the applicant describe their capacity to manage and coordinate collaborative activities?

• To what extent does the applicant propose a staffing plan that includes the following: staff with experience managing, monitoring and coordinating multiple groups and activities; staff with experience conducting performance monitoring; staff with experience writing, awarding, and managing contracts

- Does the applicant provide a description of duties, percentage-of-time commitments, and responsibilities of project personnel including clear lines of authority and supervisory capacity to successfully conduct the program activities? Is an organizational chart included in the application? Is a diagram illustrating the relationship between collaborative partners included?

– If the applicant intends to use consultants to assist with project activities, the applicant describes the consultant(s)' area(s) of expertise, relevant experience and specific roles in assisting with project activities. The applicant includes, in the application, Curriculum Vitas of the proposed consultants. The applicant includes, in the application, Letters of Support from the proposed consultant(s).

• Curricula vitas are included for existing staff. For staff that are proposed to be hired for the program, position descriptions, timelines for staffing, qualifications for each position, and methods for recruiting qualified candidates are described. Applicant explains the feasibility of their hiring plan in relation to project timelines.

Not more than thirty days after the Phase II review is completed, applicants will be notified electronically if their application does not meet eligibility or published submission requirements.

c. Phase III Review

Funding preferences will be given to jurisdictions that do not have similar and effective models in place; the intent of this FOA is not to provide more funding to programs that are established but to develop more models or test existing models in new places. Funding preferences will also consider geographic diversity and duplication of funding from other FOAs. Funding will be awarded to at least one health department that meets the mortality criteria of 4 th quartile state mortality and at least 1,000 total combined Black and/or Hispanic MSM living with diagnosed HIV in the specified MSA or MD.

2. Announcement and Anticipated Award Dates

The anticipated award date is September 30, 2015

F. Award Administration Information

1. Award Notices

Awardees will receive an electronic copy of the Notice of Award (NOA) from 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 Business Officer listed in application and the Program Director.

Any applicant awarded funds 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 these results by e-mail with delivery receipt or by U.S. mail.

2. Administrative and National Policy Requirements

Awardees must comply with the administrative and public policy requirements outlined in 45 C.F.R. Part 74 or Part 92 and the HHS Grants Policy Statement, as appropriate.

Brief descriptions of relevant provisions are available at http://www.cdc.gov/grants/additionalrequirements/index.html

The HHS Grants Policy Statement is available at http://www.hhs.gov/asfr/ogapa/aboutog/hhsgps107.pdf.

*Note that 2 CFR 200 will supersede the administrative requirements (A-110 & A-102), cost principles (A-21, A-87 & A-122) and audit requirements (A-50, A-89 & A-133).

The following Administrative Requirements (AR) apply to this project:

Generally applicable ARs:

•AR-7: Executive Order 12372

•AR-9: Paperwork Reduction Act http://www.hhs.gov/ocio/policy/collection/infocollectfaq.html

•AR-10: Smoke-Free Workplace

•AR-11: Healthy People 2020

•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-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)

•AR-35: Nutrition Policies

ARs applicable to awards associated with HIV/AIDS issues:

•AR-4: HIV/AIDS Confidentiality Provisions

•AR-5: HIV Program Review Panel

•AR-6: Patient Care

ARs applicable to awards by ATSDR:

•AR-18: Cost Recovery – ATSDR

•AR-19: Third Party Agreements – ATSDR

ARs applicable to awards related to conferences:

•AR-20: Conference Support

•AR-27: Conference Disclaimer and Use of Logos

Organization-specific ARs:

•AR-8: Public Health System Reporting (community-based, nongovernment organizations)

•AR-15: Proof of Non-profit Status (nonprofit organizations)

•AR 23: Compliance with 45 C.F.R. Part 87 (faith-based organizations)]

For more information on the C.F.R. visit http://www.ecfr.gov/cgi-bin/ECFR?page=browse.

3. Reporting

Reporting provides continuous program monitoring and identifies successes and challenges that awardees encounter throughout the project period. Also, reporting is a requirement for awardees who want to apply for yearly continuation of funding. Reporting helps CDC and awardees because it:

- Helps target support to awardees;
- Provides CDC with periodic data to monitor awardee progress toward meeting the FOA outcomes and overall performance;
- Allows CDC to track performance measures and evaluation findings for continuous quality and program improvement throughout the project period and to determine applicability of evidence-based approaches to different populations, settings, and contexts; and
- Enables CDC to assess the overall effectiveness and influence of the FOA.

The table below summarizes required and optional reports. All required reports must be sent electronically to GMS listed in the "Agency Contacts" section of the FOA copying the CDC Project Officer.

Report	When?	Required?
Awardee Evaluation and Performance Measurement Plan	6 months into award	Yes
Annual Performance Report (APR)	120 days before end of budget period. Serves as yearly continuation application.	Yes
Data on Performance Measures	CDC program determines. Only if program wants more frequent performance measure reporting than annually in APR.	No
Federal Financial Reporting Forms	90 days after end of calendar quarter in which budget period ends	Yes

Final Performance and Financial Report	90 days after end of project period.	Yes

Activities that involve the collection of information from 10 or more individuals/entities and are funded by a grant/cooperative agreement will be subject to review and approval by the Office of Management and Budget (OMB) under the Paperwork Reduction Act.

a. Awardee Evaluation and Performance Measurement Plan (required)
With support from CDC, awardees must elaborate on their initial applicant evaluation and performance measurement plan. This plan must be no more than 20 pages; awardees must submit the plan 6 months into the award.

This plan should provide additional detail on the following:

- The frequency that evaluation and performance data are to be collected.
- How data will be reported.
- How evaluation findings will be used for continuous quality and program improvement.
- How evaluation and performance measurement will yield findings to demonstrate the value of the FOA (e.g., improved public health outcomes, effectiveness of FOA, cost-effectiveness or cost benefit).
- Dissemination channels and audiences.
- Other information requested as determined by the CDC program.

b. Annual Performance Report (APR) (required)
The awardee must submit the APR via www.grants.gov 120 days before the end of the budget period. This report must not exceed 45 pages excluding administrative reporting. Attachments are not allowed, but weblinks are allowed.

This report must include the following:

- **Performance Measures:** 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 findings from process or outcome evaluations).
- **Work Plan:** Awardees must update work plan each budget period to reflect any changes in project period outcomes, activities, timeline, etc.
- **Successes**
    - Awardees must report progress on completing activities and progress towards achieving the project period outcomes described in the logic model and 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 hindered or might hinder their ability to complete the work plan activities and achieve the project period outcomes.
    - 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 must describe how CDC could help them overcome challenges to complete activities in the work plan and achieving project period outcomes.
- **Administrative Reporting** (No page limit)
    - SF-424A Budget Information-Non-Construction Programs.
    - Budget Narrative – Must use the format outlined in "Content and Form of Application Submission, Budget Narrative" section.
    - Indirect Cost Rate Agreement.

For year 2 and beyond of the award awardees may request that as much as 75% of their estimated unobligated funds be carried over 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 Federal Financial Report (FFR) for the budget period from which funds will be transferred (as much as 75% of unobligated balances);
- and Include a list of proposed activities, an itemized budget, and a narrative justification for 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 (optional)
CDC programs may require more frequent reporting of performance measures than annually in the APR. If this is the case, CDC programs must specify reporting frequency, data fields, and format for awardees at the beginning of the award period.

d. Federal Financial Reporting (FFR) (required)
The annual FFR form (SF-425) is required and must be submitted through eRA Commons 90 days after the end of the calendar quarter in which the budget period ends. The report must include only 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 required information by the due date may adversely affect the future funding of the project. If the information cannot be provided by the due date, awardees are required to submit a letter of explanation to PGO and include the date by which the Grants Officer will receive information.

e. Final Performance and Financial Report (required)
This report is due 90 days after the end of the project period. CDC programs must indicate that this report should not exceed 40 pages. This report covers the entire project period and can include information previously reported in APRs. At a minimum, this report must include the following:

- Performance Measures – Awardees must report final performance data for all process and outcome performance measures.
- Evaluation Results – Awardees must report final evaluation results for the project period for any evaluations conducted.
- Impact/Results/Success Stories – Awardees must use their performance measure results and their evaluation findings to describe the effects or results of the work completed over the project period, and

can include some success stories.
- Additional forms as described in the Notice of Award (e.g., Equipment Inventory Report, Final Invention Statement).

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4. Federal Funding Accountability and Transparency Act of 2006 (FFATA)

The FFATA and Public Law 109-282, which amends the FFATA, require full disclosure of all entities and organizations that receive federal funds including awards, contracts, loans, other assistance, and payments. This information must be submitted through the single, publicly accessible website, www.USASpending.gov.

Compliance with these mandates is primarily the responsibility of the federal agency. However, two elements of these mandates require information to be collected and reported by applicants: 1) information on executive compensation when not already reported through SAM; and 2) similar information on all sub-awards, subcontracts, or consortiums for greater than $25,000. For the full text of these requirements, see: http://www.gpo.gov /fdsys/browse/ collection.action?collectionCode= BILLS.

G. Agency Contacts

CDC encourages inquiries concerning this FOA.

Program Office Contact

For programmatic technical assistance, contact:

Dr. Karen Hoover, Project Officer
Department of Health and Human Services
Centers for Disease Control and Prevention
1600 Clifton Road, NE MS E45
Atlanta, GA 30329
Telephone: (404) 718-8895
Email: HIP1509@cdc.gov

Grants Staff Contact

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

Shirley Byrd, Grants Management Specialist
Department of Health and Human Services
CDC Procurement and Grants Office
1600 Clifton Road, NE MS E-15
Atlanta, GA 30329
Telephone: (770) 488-2591
Email: skbyrd@cdc.gov

For assistance with **submission difficulties related to** www.grants.gov, contact the Contact Center by phone at 1-800-518-4726.

Hours of Operation: 24 hours a day, 7 days a week, except 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
E-mail: pgotim@cdc.gov

CDC Telecommunications for persons with hearing loss is available at: TTY 1-888-232-6348.

H. Other Information

Following is a list of acceptable attachments **applicants** can upload as PDF files as part of their application at www.grants.gov. Applicants may not attach documents other than those listed; if other documents are attached, applications will not be reviewed.

- Project Abstract
- Project Narrative
- Budget Narrative
- CDC Assurances and Certifications
- Table of Contents for Entire Submission

Optional attachments, as determined by CDC programs

- Resumes/CVs
- Position descriptions
- Letters of Support
- Organizational Charts
- Non-profit organization IRS status forms, if applicable
- Indirect Cost Rate , if applicable
- Memorandum of Agreement (MOA)
- Memorandum of Understanding (MOU)
- Bona Fide Agent status documentation, if applicable

I. Glossary

Activities: The actual events or actions that take place as a part of the program.

Administrative and National Policy Requirements, Additional Requirements (ARs): Administrative requirements found in 45 CFR Part 74 and Part 92 and other requirements mandated by statute or CDC policy. All ARs are listed in the Template for CDC programs. CDC programs must indicate which ARs are relevant to the FOA; awardees must comply with the ARs listed in the FOA. To view brief descriptions of relevant provisions, see http://www.cdc.gov/grants/additionalrequirements/index.html

. Note that 2 CFR 200 will supersede the administrative requirements (A-110 & A-102), cost principles (A-21, A-87 & A-122) and audit requirements (A-50, A-89 & A-133).

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 applicant.

Budget Period or Budget Year: The duration of each individual funding period within the project period.Traditionally, budget periods are 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 over to another budget period to cover allowable costs of that budget period either as an offset or additional authorization. Obligated but liquidated funds are not considered carryover.

Catalog of Federal Domestic Assistance (CFDA): A government-wide compendium published by the General Services Administration (available on-line in searchable format as well as in printable format as a .pdf file) that describes domestic assistance programs administered by the Federal Government.

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

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

Competing Continuation Award: A financial assistance mechanism that adds funds to a grant and adds one or more budget periods to the previously established project period (i.e., extends the "life" of the award).

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

Contracts: An award instrument used to acquire (by purchase, lease, or barter) property or services for the direct benefit or use of the Federal Government.

Cooperative Agreement: A financial assistance award with the same kind of interagency relationship as a grant except that it provides for substantial involvement by the federal agency funding the award. Substantial involvement means that the recipient can expect federal programmatic collaboration or participation in carrying out the effort under the award.

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

Direct Assistance: A financial assistance mechanism, which must be specifically authorized by statute, whereby goods or services are provided to recipients in lieu of cash. DA generally involves the assignment of federal personnel or the provision of equipment or supplies, such as vaccines. DA is primarily used to support payroll and travel expenses of CDC employees assigned to state, tribal, local, and territorial (STLT) health agencies that are recipients of grants and cooperative agreements. Most legislative authorities that provide financial assistance to STLT health agencies allow for the use of DA. http:// www.cdc.gov /grants /additionalrequirements /index.html.

DUNS: The Dun and Bradstreet (D&B) Data Universal Numbering System (DUNS) number is a nine-digit number assigned by Dun and Bradstreet Information Services. When applying for Federal awards or cooperative agreements, all applicant organizations must obtain a DUNS number as the Universal Identifier. DUNS number assignment is free. 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 an organization does not know its DUNS number or needs to register for one, visit Dun & Bradstreet at

http://fedgov.dnb.com/ webform/displayHomePage.do.

Evaluation (program evaluation): The systematic collection of information about the activities, characteristics, and outcomes of programs (which may include interventions, policies, and specific projects) to make judgments about that program, improve program effectiveness, and/or inform decisions about future program development.

Evaluation Plan: A written document describing the overall approach that will be used to guide an evaluation, including why the evaluation is being conducted, how the findings will likely be used, and the design and data collection sources and methods. The plan specifies what will be done, how it will be done, who will do it, and when it will be done. The FOA evaluation plan is used to describe how the awardee and/or CDC will determine whether activities are implemented appropriately and outcomes are achieved.

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

Fiscal Year: The year for which budget dollars are allocated annually. The federal fiscal year starts October 1 and ends September 30.

Grant: A legal instrument used by the federal government to transfer anything of value to a recipient for public support or stimulation authorized by statute. Financial assistance may be money or property. The definition 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 a person or persons. The main difference between a grant and a cooperative agreement is that in a grant there is no anticipated substantial programmatic involvement by the federal government under the award.

Grants.gov: A "storefront" web portal for electronic data collection (forms and reports) for federal grant-making agencies at www.grants.gov.

Grants Management Officer (GMO): The individual designated to serve as the HHS official responsible for the business management aspects of a particular grant(s) or cooperative agreement(s). The GMO serves as the counterpart to the business officer of the recipient organization. In this capacity, the GMO is responsible for all business management matters associated with the review, negotiation, award, and administration of grants and interprets grants administration policies and provisions. The GMO works closely with the program or project officer who is responsible for the scientific, technical, and programmatic aspects of the grant.

Grants Management Specialist (GMS): A federal staff member who oversees the business and other non-programmatic aspects of one or more grants and/or cooperative agreements. These activities include, but are not limited to, evaluating grant applications for administrative content and compliance with regulations and guidelines, negotiating grants, providing consultation and technical assistance to recipients, post-award administration and closing out grants.

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

Healthy People 2020: National health objectives aimed at improving the health of all Americans by encouraging collaboration across sectors, guiding people toward making informed health decisions, and measuring the effects of prevention activities.

Inclusion: Both the meaningful involvement of a community's members in all stages of the program process and the maximum involvement of the target population that the intervention will benefit. Inclusion ensures that the views, perspectives, and needs of affected communities, care providers, and key partners are considered.

Indirect Costs: Costs that are incurred for common or joint objectives and not readily and specifically identifiable with a particular sponsored project, program, or activity; nevertheless, these costs are necessary to the operations of the organization. For example, the costs of operating and maintaining facilities, depreciation, and administrative salaries generally are considered indirect costs.

Intergovernmental Review: Executive Order 12372 governs applications subject to Intergovernmental Review of Federal Programs. 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) 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/.

Letter of Intent (LOI): A preliminary, non-binding indication of an organization's intent to submit an application.

Lobbying: Direct lobbying includes any attempt to influence legislation, appropriations, regulations, administrative actions, executive orders (legislation or other orders), or other similar deliberations at any level of government through communication that directly expresses a view on proposed or pending legislation or other orders, and which is directed to staff members or other employees of a legislative body, government officials, or employees who participate in formulating 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.

Logic Model: A visual representation showing the sequence of related events connecting the activities of a program with the programs' desired outcomes and results.

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

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

Nonprofit Organization: Any corporation, trust, association, cooperative, or other organization that is

operated primarily for scientific, educational, service, charitable, or similar purposes in the public interest; is not organized for profit; and uses net proceeds to maintain, improve, or expand the operations of the organization. Nonprofit organizations include institutions of higher educations, hospitals, and tribal organizations (that is, Indian entities other than federally recognized Indian tribal governments).

Notice of Award (NoA): The official document, signed (or the electronic equivalent of signature) by a Grants Management Officer that: (1) notifies the recipient of the award of a grant; (2) contains or references all the terms and conditions of the grant and Federal funding limits and obligations; and (3) provides the documentary basis for recording the obligation of Federal funds in the HHS accounting system.

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 persons responsible for making award decisions.

Outcome: The results of program operations or activites; the effects triggered by the program. For example, increased knowledge, changed attitudes or beliefs, reduced tobacco use, reduced morbidity and mortality.

Performance Measurement: The ongoing monitoring and reporting of program accomplishments, particularly progress toward pre-established goals, typically conducted by program or agency management. Performance measurement 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: Requires federal agencies to communicate with the public in plain language to make information more accessible and understandable by intended users, especially people with limited health literacy skills or limited English proficiency. The Plain Writing Act is available at www.plainlanguage.gov.

Program Strategies: Strategies are groupings of related activities, usually expressed as general headers (e.g., Partnerships, Assessment, Policy) or as brief statements (e.g., Form partnerships, Conduct assessments, Formulate policies).

Program Official: Person responsible for developing the FOA; can be either a project officer, program manager, branch chief, division leader, policy official, center leader, or similar staff member.

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

Public Health Accreditation Board (PHAB): A nonprofit organization that works to promote and protect the health of the public by advancing the quality and performance of public health departments in the U.S. through national public health department accreditation http://www.phaboard.org.

Statute: An act of the legislature; a particular law enacted and established by the will of the legislative department of government, expressed with the requisite formalities. In foreign or civil law any particular municipal law or usage, though resting for its authority on judicial decisions, or the practice of nations.

Statutory Authority: Authority provided by legal statute that establishes a federal financial assistance program or award.

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

Technical Assistance: Advice, assistance, or training pertaining to program development, implementation, maintenance, or evaluation that is provided by the funding agency.

Work Plan: The summary of project period outcomes, strategies and activities, personnel and/or partners who will complete the activities, and the timeline for completion. The work plan will outline the details of all necessary activities that will be supported through the approved budget.

Expedient linkage to care: Linkage to health care services for the management of established HIV infection within 30 days of diagnosis.

Expedient initiation of ARV treatment: Initiation of ARV treatment of established HIV infection within 60 days of diagnosis.

High-impact HIV prevention: An approach to HIV preventions that uses a combination of scientifically proven, cost-effective, and scalable interventions targeted to the right populations in the right geographic areas.
http://www.cdc.gov/hiv/policies/hip.html

Immediate linkage to care: Linkage to health care services for the management of acute HIV infection within 7 days of diagnosis.

Immediate initiation of ARV treatment: Initiation of ARV treatment of acute HIV infection within 14 days of diagnosis.

Partner services: Partner services include a set of confidential, voluntary services to help persons with HIV and/or STDs notify their sex and drug-injection partners of possible HIV and/or STD exposure, to offer services that can protect the health of partners, and to prevent sexually transmitted disease (STD) reinfection in persons with HIV.

Risk for HIV acquisition: MSM of color are considered at risk of acquiring HIV is they are sexually active

Social services: Social services include mental health and substance abuse services (including illicit drugs and alcohol treatment) funded by the Substance Abuse and Mental Health Services Administration; housing programs supported by the Department of Housing and Urban Development (HUD); and job training or employment services supported by the Department of Labor (DOL).

Substantial risk for HIV acquisition: MSM are considered at substantial risk of acquiring HIV infection if they have/had: an HIV-positive sexual partner; a recent bacterial STD; a high number of sex partners; a history of inconsistent or no condom use; or engaged in commercial sex work. MSM who are injection drug users are at substantial risk of acquiring HIV infection if they have/had: an HIV-positive infecting partner; shared injection equipment; or recent drug treatment but are currently injecting. http://www.cdc.gov/hiv/pdf/guidelines/PrEPguidelines2014.pdf