Centers for Disease Control

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

STD Surveillance Network (SSuN)
CDC-RFA-PS19-1907
Application Due Date: 05/15/2019

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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-PS19-1907. 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) / Agency for Toxic Substances and Disease Registry (ATSDR)

B. Notice of Funding Opportunity (NOFO) Title:

STD Surveillance Network (SSuN)

C. Announcement Type: New - Type 1

This announcement is only for non-research activities supported by CDC. If research is proposed, the application will not be considered. For this purpose, research is defined at https://www.gpo.gov/fdsys/pkg/CFR-2007-title42-vol1/pdf/CFR-2007-title42-vol1-sec52-2.pdf. Guidance on how CDC interprets the definition of research in the context of public health can be found at https://www.hhs.gov/ohrp/regulations-and-policy/regulations/45-cfr-46/index.html (See section 45 CFR 46.102(d)).

New - Type 1

D. Agency Notice of Funding Opportunity Number:

CDC-RFA-PS19-1907

E. Assistance Listings (CFDA) Number:

93.977

F. Dates:

1. Due Date for Letter of Intent (LOI):	**04/15/2019**
2. Due Date for Applications:	**05/15/2019**, 11:59 p.m. U.S. Eastern Standard Time, at www.grants.gov.

3. Date for Informational Conference Call:

Two identical webinars will be held to provide information about this NOFO. Dates, times, and registration links are as follows:

(1) Tuesday, March 12, 1 - 2 PM Eastern Standard Time (https://cc.readytalk.com/r/r7myqz6hdrfp&;eom), and,

(2) Tuesday March 19, 3:30 - 4:30 PM Eastern Standard Time (https://cc.readytalk.com/r/mi2qiecr329i&;eom).

G. Executive Summary:

1. Summary Paragraph:

CDC announces availability of fiscal year 2019 funding for a cooperative agreement for the STD Surveillance Network (SSuN). In light of resurgent sexually transmitted diseases (STDs), and a public health imperative to respond to related epidemics such as HIV, this program proposes new approaches to community-based enhanced and sentinel surveillance that integrates monitoring of STDs, HIV and behavioral data. The data will be used to identify

opportunities and gaps in prevention and control efforts. Systematic, ongoing collection of patient-level information to monitor the occurrence of, and factors associated with, STDs is the foundation upon which STD control programs are based. Reporting by clinicians, laboratories and healthcare facilities is limited and does not provide information needed to characterize STDs and co-occurring epidemics, to identify populations at risk for adverse health impacts, or to identify opportunities and gaps in sexual health and preventive services. This NOFO addresses these information needs, and incorporates flexibility to respond to emergent health issues related to STDs by supporting a network of geographically diverse health departments and STD-related clinical partners to implement protocol-based surveillance activities. These activities complement existing surveillance strategies. They also expand the capacity of health departments to collect high-quality, timely data to inform disease prevention and control activities.

a. Eligible Applicants:	Open Competition
b. NOFO Type:	Cooperative Agreement
c. Approximate Number of Awards:	10
d. Total Period of Performance Funding:	$24,000,000
e. Average One Year Award Amount:	$480,000
f. Total Period of Performance Length:	5
g. Estimated Award Date:	08/15/2019
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 NOFO exists, leveraging other resources and related ongoing efforts to promote sustainability is strongly encouraged.

Part II. Full Text

A. Funding Opportunity Description

Part II. Full Text

1. Background

a. Overview

Three curable bacterial sexually transmitted diseases (STDs): chlamydia (CT), gonorrhea (GC), and syphilis are nationally notifiable and have historically been the focus of federally funded STD prevention programs throughout the U.S. In 2017, 2.3 million cases of these STDs were reported to CDC, reflecting an increase of 35% since 2013[1]. However, these cases do not fully reflect the burden of STDs as many infections are asymptomatic and never diagnosed and reported - and this does not include other STDs that are not nationally notifiable. STDs can have long-term health consequences in addition to the immediate impact on an individual's health. STDs are also an economic burden on the U.S. healthcare system costing billions annually[2]. Persons with STDs are at risk for acquisition or transmission of HIV and represent

a population essential to national efforts to end the HIV epidemic and reduce the spread of STDs.

Monitoring populations seeking care in STD clinics, along with documenting the eligibility and receipt of STD-related HIV preventive interventions, will directly contribute to the development of local, state and national STD/HIV interventions to reduce the burden of disease. Specialty STD clinical facilities and other sexual health clinics, provide safety net services to populations at risk for acquiring STDs and HIV. STD clinics are ideal settings to link HIV-negative patients to preventive services (e.g., Pre and post exposure prophylaxis, PrEP/PEP). They are also positioned to re-engage or link persons living with HIV to treatment. Monitoring these services at the patient level can help identify gaps and missed opportunities for STD and HIV preventative care. A robust network of high-quality specialty STD clinical facilities provides the capacity for CDC and collaborators to investigate additional STD issues related to health care seeking behaviors, social determinants of health, and health disparities in these STD-specific clinical contexts.

However, a large proportion STDs are diagnosed outside of STD clinics. As the burden of STDs increases nationally, surveillance systems at the state and local level struggle to ascertain complete information on the characteristics of individual cases reported as well as the potential for co-occurring conditions among persons diagnosed and reported with STDs. This information is essential for understanding why STDs are increasing, for determining population-level differences in health equity and for monitoring adverse health outcomes of STDs. Conducting enhanced surveillance activities among a representative sample of individuals diagnosed with STDs *across all provider settings* is imperative for monitoring the uptake of prevention interventions known to reduce STDs and HIV transmission at the population level. These data are also critically needed to describe trends in co-incidence of STDs and HIV among at-risk and vulnerable populations and identify factors associated with STD transmission, information essential to steering prevention and control efforts in both the public and private health care sectors.

A comprehensive approach to sentinel and enhanced surveillance, supporting core strategies focused on persons with, or at demonstrable risk for STDs and other co-occurring conditions across the full range of community settings is the primary public health objective of this NOFO. This program builds upon a foundation of previous STD Surveillance Network (SSuN) collaborations providing strong evidence of the efficacy and utility of these core surveillance strategies[3,4].

b. Statutory Authorities

Section 318(c) of the Public Health Service Act [42 U.S.C. Section 247c(c)], as amended.

c. Healthy People 2020

This project addresses the Healthy People 2020 focus area(s) of Sexually Transmitted Diseases: https://www.healthypeople.gov/2020/topics-objectives/topic/sexually-transmitted-diseases.

Healthy People 2020 (http://www.healthypeople.gov) contains national objectives to improve the health of all Americans by encouraging collaborations across sectors, guiding people toward making informed health decisions, and measuring the impact of prevention activities.

This NOFO also addresses: Access to Quality Health Services; HIV Infection; Immunization

and Access to Quality Health Services, Immunization and Infectious Diseases, Maternal, Infant, and Child Health, and Public Health Infrastructure

d. Other National Public Health Priorities and Strategies

This NOFO supports the goals of NCHHSTP to decrease incidence of infection, decrease morbidity and mortality, and decrease health disparities associated with HIV, viral hepatitis, STDs and TB by implementing programs, policies and research that are guided by the principle of high impact prevention (HIP). In addition, this NOFO supports a holistic framework that enables NCHHSTP to more comprehensively address the broader, cross-cutting issues of health and wellness by addressing Health Equity and Program Collaboration and Service Integration (PCSI). Health equity entails special efforts to improve the health of those disproportionately affected by disease. PCSI supports programmatic efforts to integrate and improve efficiency when addressing syndemics among populations with or at risk for at least two or more infections in the following areas: HIV, Viral Hepatitis, STD, and TB. Additional information about the goals and strategies of NCHHSTP, Health Equity, and PCSI is available: http://www.cdc.gov/nchhstp

CDC's Call to Action: Let's Work Together to Stem the Tide of Rising Syphilis in the United States https://www.cdc.gov/std/syphilis/syphiliscalltoactionapril2017.pdf

National Strategy for Combating Antibiotic-Resistant Bacteria https://www.cdc.gov/drugresistance/pdf/carb_national_strategy.pdf

CDC National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP) Strategic Plan https://www.cdc.gov/nchhstp/docs/NCHHSTP-Strategic-Plan-through-2020-508.pdf

National HIV/AIDS Strategy https://www.hiv.gov/federal-response/national-hiv-aids-strategy/overview

e. Relevant Work

This NOFO builds upon previous and existing STD and HIV surveillance programs:

PS13-1306: STD Surveillance Network (SSuN)

https://www.cdc.gov/std/ssun/default.htm

PS18-1802: Integrating HIV Surveillance and Prevention Programs for Health Departments

https://www.cdc.gov/hiv/funding/announcements/ps18-1802/index.html

PS19-1901: Strengthening STD Prevention and Control for Health Departments (STD PCHD)

https://www.cdc.gov/std/funding/pchd/default.htm

Gonococcal Isolate Surveillance Project (GISP)

https://www.cdc.gov/std/gisp/default.htm

Strengthening the United States Response to Resistant Gonorrhea (SURRG):

https://www.cdc.gov/std/gonorrhea/arg/carb.htm

2. CDC Project Description

a. Approach

Bold indicates period of performance outcome.

CDC-RFA-PS19-1907 Logic Model: *STD Surveillance Network (SSuN)*

Strategies	Outputs	Short-Term Outcomes	Intermediate Outcomes	Long-Term Outcomes
(A) Protocol-based sentinel surveillance in STD Clinics: 1. Systematic abstraction of data in electronic health records. 2. Periodic patient surveys. 3. Routine patient-based matching with state HIV surveillance records.	Datasets containing: a. Visit-level patient demographic, behavioral and clinical information for all patient visits. b. STD/HIV-related laboratory records for all patient visits. c. STD-related diagnoses for all patient visits. d. Treatment(s) administered or prescribed for each patient visit. e. Periodic patient behavioral and health services survey data.	**(1.1) Improved monitoring of patient characteristics, STD/HIV-risk and repeat infections (Strategies A-C)** **(1.2) Improved monitoring of patient-level eligibility for and uptake of STD-related HIV preventive services. (Strategies A & B)** **(1.3) Improved timeliness, data completeness and data quality. (Strategies B & C)** **(1.4) More timely dissemination of findings informing STD/HIV control and prevention policy. (Strategies A-C)** **(1.5) Annual data quality reporting. (Strategies A-C)** **(1.6) Dissemination of surveillance data products to provider, health department and community stakeholders. (Strategies A,B,C)** **(1.7) Dissemination of findings in STD/HIV-related journals and publications. (Strategies A-C)**	(2.1) Data-driven public health action. (Strategies A-C) **(2.2) Improved, timely monitoring of HIV and STD-specific clinical and preventive services in STD-specific clinical settings. (Strategies A & C)** (2.3) Improved understanding of barriers to preventive STD services, sexual health clinical care and provider-based HIV and STD prevention interventions. (Strategies A-C) (2.4) Improved monitoring of adverse outcomes and negative sequela of STDs. (Strategy B & C) **(2.5) Improved monitoring of patient treatment in STD clinics. (Strategy A)** **(2.6) Improved monitoring of disease burden by relevant patient characteristics in community settings. (Strategies B & C)** **(2.7) Monitoring of trends in HIV status, PrEP referral and use, HIV care among STD cases diagnosed in community settings. (Strategies B & C)** (2.8) Improved STD surveillance systems and methods. (Strategies A-C)	(3.1) Improved quality of care in STD clinical care settings (Strategy A) **(3.2) Improved provider compliance with STD/HIV screening, preventive services and treatment guidelines. (Strategies A-C)** (3.3) Improved patient access to preventive STD services, sexual health clinical care and provider-based HIV and STD prevention interventions. (Strategies A-C) (3.4) Improved evidence for developing recommendations, guidelines and best practices for STD surveillance. (Strategies A-C) (3.5) Decreased disease incidence and morbidity associated with STDs. (Strategies A-C)
(B) Protocol-based enhanced case-based STD surveillance: 1. Systematic collection of enhanced data elements for reported cases of STD. 2. Ascertainment of patient demographics, behavioral risk, STD treatment, clinical characteristics and HIV/STD preventive services for a probability sample of selected cases reported in the jurisdiction. 3. Provision of technical assistance to state and local STD surveillance and program staff in monitoring and improving the quality of STD surveillance data.	Datasets containing: f. Case records for a complete census of reported gonorrhea and syphilis cases. g. Laboratory records associated with all reported cases h. Documented provider investigations for sampled cases.			
(C) Surveillance Focus Strategy: short-term activities to evaluate methods, monitor STD/HIV testing, diagnosis, treatment, sequelae and eligibility/uptake of HIV-prevention interventions.	a. Datasets and aggregate analyses. b. Analytic products.			

i. Purpose

The purpose of this NOFO is to enhance capacity for STD surveillance and better meet CDC's disease surveillance mandate. Recipients funded under this NOFO will: 1) implement protocol-based sentinel surveillance in STD clinics, including periodic patient surveys and routine matches with HIV surveillance records; 2) implement protocol-based enhanced case

surveillance, including HIV registry matching; 3) conduct short-term activities to monitor consequences of STDs to further strengthen overall surveillance efforts; and, 4) provide technical assistance to state and local STD surveillance staff.

ii. Outcomes

Expected program outcomes for the performance period include:

Short-Term Outcomes

- 1.1 Improved monitoring of patient characteristics, STD/HIV-risk and repeat infections (Strategies A-C)
- 1.2 Improved monitoring of patient-level eligibility for and uptake of STD-related HIV preventive services. (Strategies A & B)
- 1.3 Improved timeliness, data completeness and data quality. (Strategies B & C)
- 1.4 More timely dissemination of findings informing STD/HIV control and prevention policy. (Strategies A-C)
- 1.5 Annual data quality reporting. (Strategies A-C)
- 1.6 Dissemination of surveillance data products to providers, health department and community stakeholders. (Strategies A-C)
- 1.7 Dissemination of findings in STD/HIV-related journals and publications. (Strategies A-C)

Intermediate Outcomes

- 2.2 Improved, timely monitoring of HIV and STD-specific clinical and preventive services in STD-specific clinical settings. (Strategies A & C)
- 2.5 Improved monitoring of patient treatment in STD clinics. (Strategy A)
- 2.6 Improved monitoring of disease burden by relevant patient characteristics in community settings. (Strategies B & C)
- 2.7 Monitoring of trends in HIV status, PrEP referral and use, HIV care among STD cases diagnosed in community settings. (Strategies B & C)

Long-Term Outcomes

- 3.2 Improved provider compliance with STD/HIV screening, preventive services and treatment guidelines. (Strategies A-C)

Recipients will collaborate with CDC in demonstrating measurable progress toward achieving these short, medium and long term outcomes (those appearing in **bold** in the logic model).

iii. Strategies and Activities

Recipients funded under CDC-RFA-PS19-1907 are expected to fully implement project protocols for sentinel and enhanced STD surveillance activities for Strategies A & B. Recipients will routinely transmit relevant, uniquely identified case, investigation and clinic visit records, including required HIV-related information (HIV exposure, earliest documented HIV-positive test, viral load and CD4+ tests within one year of patient STD clinic visit or STD diagnosis) obtained through HIV surveillance registry matches routinely to CDC in specified

formats and at specified intervals. Implementation of **all** activities described below for Strategies A & B must be fully addressed by all applicants in their work plan. Protocols for Strategy A and Strategy B activities are available at https://www.cdc.gov/std/funding/ssun/default.htm.

Recipients are also expected to propose to participate in at least one Strategy C (Surveillance Focus Activities) activity each project year, depending on the availability of funding. Applicants should develop proposals for at least one but not more than five focus activities of local interest. Proposals for each Strategy C activity should be separate from Strategies A & B activities; with each proposed Strategy C activity having a separate narrative (no more than 1 page single spaced, 12-point font) and separate budget justification. Any proposed Strategy C activities should also be addressed in the applicant's work plan.

Strategy A - Protocol-based sentinel surveillance in STD Clinics

For the purposes of this NOFO, STD clinics are defined as any clinical facility providing timely, comprehensive, confidential, and culturally sensitive STD care as the facility's primary function. Clinics need not be 'stand-alone' and may be integrated into broader practice settings. However, the selected facility must have a specifically identifiable STD clinic and have the ability to identify and extract records from their electronic health records system(s) for patients *specifically seeking STD clinical services* separately from any broader patient population.

At least one STD clinic proposed for inclusion in Strategy A activities must have a volume of at least 5,000 documented patient visits annually for STD-related clinical services, provide active management of (or documented referral to) PrEP/PEP, collect and be able to transmit key variables (demographics, gender of sex partners, symptoms, anatomic site(s) of testing, HIV testing and HIV status, PrEP referral/use) and agree to submit patient names to the recipient agency for HIV registry matching. These requirements must be explicitly documented in a separate MOU/MOA or Letter of Collaboration (LOC) for each collaborating STD clinic (or network of administratively associated STD clinics if appropriate). Where multiple STD clinics in a jurisdiction are proposed, at least one (1) individual STD clinic site must meet the minimum volume requirement of at least 5,000 visits per year and provide active management of (or documented referral to) PrEP/PEP for eligible patients.

1.1 Recipients will identify one or more STD clinic(s) in their jurisdiction as collaborating partners in sentinel surveillance activities. Where multiple facilities are potential candidates for inclusion, criteria for selection should be described and applied including provision of PrEP/PEP (or documented referrals for PrEP/PEP), patient volume, geographic representativeness within jurisdiction, and patient characteristics (i.e. higher risk for HIV, socioeconomic characteristics, etc.).

1.2 Recipients will collaborate with selected STD specialty clinical facilities to routinely obtain visit-level clinical records for all patients receiving STD or sexual health services in the collaborating STD clinics, *including all data elements specified in project protocols*, and at intervals sufficiently timely to fulfill project protocols.

1.3 Recipients will collaborate with selected STD specialty clinical facilities to routinely obtain patient demographics (age, sex, race, sexual orientation, gender identity, etc.), behavioral data (e.g. gender of sex partners) and STD-related HIV preventive services received (e.g. PrEP/PEP, etc.) with all visits. Visit records must include all data elements

specified in project protocols, and be extracted and transmitted to the recipient at intervals sufficiently timely to fulfill project protocols.

1.4 Recipients will collaborate with selected clinical facilities to routinely obtain laboratory records associated with tests performed at the STD clinic visit, including all laboratory data elements specified in project protocols and at intervals sufficiently timely to fulfill project protocols.

1.5 Recipients will collaborate with selected STD specialty clinical facilities to routinely obtain diagnosis data associated with all visits, including all diagnosis-related data elements, diseases and conditions specified in project protocols, and at intervals sufficiently timely to fulfill project protocols.

1.6 Recipients will collaborate with selected STD specialty clinical facilities to routinely obtain treatment data associated with all visits, including all treatment-related data elements specified in project protocols, and at intervals sufficiently timely to fulfill project protocols.

1.7 Recipients will collaborate with selected STD specialty clinical facilities to obtain patient identifiers associated with clinic visit records to routinely match patients against the jurisdiction's HIV case registry (such as eHARS or similar local, comprehensive HIV case registry) and STD registry at intervals sufficiently timely to fulfill project protocols. This may be accomplished through separate patient index files maintained at the recipient health department (a master patient index) or using other methods deemed appropriate by health department and HIV surveillance program collaborators. Recipients will obtain available HIV diagnostic and HIV laboratory data for matching patients (limited to earliest recorded initial HIV-positive diagnostic test and date, HIV viral load tests/dates within one year of patient STD clinic visit date, CD4+ tests/dates within one year of patient STD clinic visit date). Recipients will collaborate with HIV surveillance programs to address reciprocal information sharing to assure that desired patient demographics, sexual orientation, gender identity, HIV testing and/or treatment, HIV-related risks and preventive services are available to HIV surveillance staff for related evaluations and to enhance the completeness of HIV case surveillance data. There is no requirement for HIV match data to be shared back to clinical facilities for the purpose of patient-level interventions or public health actions. However, in consultation with CDC and the jurisdiction's HIV surveillance and prevention programs, recipients may use these data for assessing and addressing gaps in HIV preventive services as locally determined. Applicants must document any and all data sharing activities in their Data Management Plan (DMP, see section b. Evaluation and Performance Measurement, below).

1.8 In collaboration with health department Overall Responsibility Party (ORP), recipients will assure that patient name-based identifiers are redacted in all archived datasets and replaced with non-name-based unique identifiers; name-based identifiers must be removed from all datasets prior to transmission to CDC.

1.9 Recipients will collaborate with CDC and with selected STD specialty clinical facilities to implement periodic, brief patient surveys. At least one (1) survey administration period must occur in the first funding year with a minimum of 350 patient/respondents in each data collection cycle (CDC survey protocols may be varied in subsequent project years). Survey methods must be designed to allow capture of self-reported voluntary responses from all patients seen consecutively during the survey administration interval. Patients

should respond to the survey prior to receipt of their clinical services (e.g., in the registration area/waiting room). Patient duplication during the survey period is allowed, but only a single survey should be administered/collected per visit. Survey data may be linkable to the associated clinic visit record for patients through appropriate identifiers where feasible (unique visit ID, medical record number, patient name, etc.; jurisdictions may pilot various methods to link with clinical records in the first or subsequent years). Jurisdictions may propose paper-based or technology-assisted data collection methods, as appropriate for their STD specialty clinical settings to obtain these self-administered survey data. Recipients with multiple STD specialty clinic sites should consider survey administration in higher-volume clinics (>5,000 visits per year) and may propose rotating between participating clinics with this volume annually as needed to fully represent the jurisdictions STD specialty clinic population. Data entry of survey data (if needed based on methods proposed) may be accomplished at the clinic site, or surveys aggregated at a central location for data entry based on recipient needs.

1.10 Recipients will collaborate with STD specialty clinical facilities to collect data in the first year describing the individual clinic site's STD & HIV screening, testing, treatment policies, inventory of services (including linkage to HIV care) and service types provided (e.g. express versus clinician visit), PrEP and PEP referral/provision policies and other information necessary for interpretation of patient-visit data. These data must be collected, updated and reported to CDC for all STD specialty clinics contributing data in the first year and updated throughout the project period.

1.11 Recipients will assure timely and prompt data quality assurance, including recoding source data into required formats, application of CDC-provided edit and completeness checks to datasets prior to transmission, address all identified data issues prior to transmission and securely transmit all required datasets to CDC following protocols and data transmission schedules.

1.12 Recipients will assure that measures, methods and processes are developed and implemented to provide timely data quality feedback to collaborating facilities and to assure remedial actions and processes are implemented to improve data collection and quality in the event challenges are identified locally or by CDC.

Expected outputs associated with Strategy A activities:

a) Dataset of uniquely identified STD speciality clinic visits - transmitted per protocol to CDC every 2 months

b) Dataset of laboratory data associated with each STD speciality clinic visit - transmitted per protocol to CDC every 2 months

c) Dataset of diagnoses associated with each STD speciality clinic visit - transmitted per protocol to CDC every 2 months

d) Dataset of treatment data associated with each STD speciality clinic visit - transmitted per protocol to CDC every 2 months

e) Dataset with STD clinic survey records - transmitted per protocol to CDC annually

f) Dataset with STD clinic metadata relating to clinic policies - transmitted per protocol to CDC annually

Strategy B - Enhanced Case-Based Population Surveillance

2.1. Recipients will implement processes to identify a random, probability sample of all STD cases (chlamydia, gonorrhea, syphilis, chancroid) reported in their jurisdiction. These processes must allow the flexibility to vary a sampling fraction independently between diseases and geographic sub-units (if applicable) in their jurisdiction. The most appropriate way to implement case sampling is within the surveillance data management system by assigning and appending a system-generated random number to each 'case record' entered into their system, regardless of source of report (laboratory, provider, facility, etc.). This random number will then be used to select a probability sample of cases, either externally to the system or with a logic stored within the data management system, for additional investigation as needed for surveillance, evaluation or quality assurance purposes.

2.2. Recipients will collaborate with CDC to conduct routine assessments of the recipient's probability sampling method by disease and by geography to assure that there are no systematic sampling biases and to assure that all reported cases have an equal probability of being sampled within the recipient jurisdiction and/or geographic subunit. There will be no replacement sampling; if a case is found to be a duplicate, out of jurisdiction, or false-positive test through investigation, this should be documented in data submitted in compliance with protocols.

2.3. Recipients will extract records from the recipient's STD surveillance data management system for all cases of gonorrhea diagnosed and reported among residents of the recipient's jurisdiction, regardless of source of report. Case records must include a unique, static patient identifier, unique case identifier, random sample indicator, and all other required data elements per CDC protocols and recoded in appropriate formats and structures as specified in project protocols for submission to CDC. Syphilis and gonorrhea treatment information, in addition to core demographic, behavioral, clinical and partner services data, are required data elements for core surveillance for PS19-1901, STD-PCHD; project staff at CDC will coordinate with STD-PCHD to assure streamlined reporting.

2.4. Recipients will extract records from the recipient's STD surveillance data management system for all cases of adult (non-congenital) syphilis diagnosed and reported among residents of their jurisdiction, regardless of source of report. Case records must include a unique, static patient identifier, unique case identifier, random sample indicator, and all other required data elements per CDC protocols and recoded in appropriate formats and structures as specified in project protocols for submission to CDC. Syphilis and gonorrhea treatment information, in addition to core demographic, behavioral, clinical and partner services data, are required data elements for core surveillance for PS19-1901, STD-PCHD; project staff at CDC will coordinate with STD-PCHD to assure streamlined reporting.

2.5. Recipients will conduct look-back investigations using disease surveillance registries for all gonorrhea and adult syphilis cases in compliance with CDC protocols; the purpose of these investigations is to assure de-duplication of persons and cases, obtain history of previous STD/HIV diagnoses and to obtain additional information that may be present in existing surveillance records to assist in patient follow-up. Data from these investigations will be embedded in case records and transmitted to CDC in compliance with SSuN

protocols.

2.6. Recipients will routinely match **all** reported gonorrhea and adult syphilis case records with their local HIV surveillance registry (eHARS or similar official, comprehensive HIV case registry) to obtain and retain local HIV case number, earliest documented date of HIV infection, transmission category (as captured in the HIV case record), most recent viral load testing (date and result), and most recent CD4+ testing (date and result). Date of initial and most recent registry matching/searches must be documented for all cases. For matched cases, recipients must provide relevant patient-level information back to HIV surveillance/prevention units to help resolve cases reported to HIV surveillance with no reported risk (NRR), to better monitor HIV care status, to refer and/or re-link patients to HIV care, to monitor prevalence patterns by current residence and to better understand gaps in, and opportunities for, promotion and uptake of HIV prevention interventions. Recipients will collaborate with HIV surveillance programs to address reciprocal information sharing to assure that desired patient demographics, sexual orientation, gender identity, HIV testing and/or treatment, HIV-related risks and preventive services are available to HIV surveillance staff for related evaluations and to enhance the completeness of HIV case surveillance data. Applicants must document any and all data sharing activities in their Data Management Plan (DMP, see section b. Evaluation and Performance Measurement, below).

2.7. Recipients will conduct provider investigations for a random sample of all gonorrhea cases in the entire jurisdiction in compliance with SSuN protocols. Provider investigations with the diagnosing/reporting provider or facility will include verification and ascertainment of gonorrhea treatment (drugs & doses), signs/symptoms, anatomic site(s) of infection, gonorrhea screening by anatomic site, insurance status, preventive services, HIV status, HIV testing and to obtain additional contact information from the provider to assist in obtaining patient interviews. Methods proposed may include fax-based forms, enhanced case reports, telephone follow-up, electronic access to clinical records or a mixture of such methods as locally appropriate. Data from these investigations will be embedded in case records transmitted to CDC in compliance with SSuN protocols.

2.8. Recipients will attempt to obtain patient interviews with a random sample of gonorrhea cases reported throughout their jurisdiction in compliance with protocols to ascertain required behavioral and demographic information. At least 4 attempts at patient contact are required and outcomes of each contact attempt must be fully documented before abandoning attempts and closing the record as 'unable to contact'. Recipients are required to implement measures to maximize interview completion rates such as assuring interview attempts can be initiated and/or patient call-backs can occur during limited evening hours and on Saturdays. Interview completion rates among sampled cases will be a primary performance measure. Jurisdictions should implement expansive measures to obtain patient contact information and should include social media searches, the provider's patient or emergency contact information, ancillary state administrative databases and any other available methods. Patient interviews may be conducted by telephone as the primary interview method. All local procedures for confirming the identity of the patient prior to discussing confidential information must be followed for SSuN enhanced case investigations. Data from these investigations will be embedded in case records transmitted to CDC in compliance with SSuN protocols.

2.9. The target sample size for enhanced gonorrhea case investigations should be determined by overall morbidity reported in the jurisdiction. For jurisdictions with >50,000 cases reported in 2017, the minimum acceptable target for **completed** case investigations is 2.5% of all reported cases; for jurisdictions with 30,000 - 50,000 cases reported in 2017, the minimum acceptable target for **completed** case investigations is 3.0% of all reported cases for jurisdictions with 10,000 - 30,000 cases reported in 2017, the minimum acceptable target for **completed** case investigations is 3.5% of all reported cases, for jurisdictions with <10,000 cases reported in 2017, the minimum acceptable target for **completed** case investigations is 4% of all reported cases. Complete case investigations in this context refers to complete patient interviews. CDC expects interview success rates (defined as completed interviews divided by cases randomly sampled) to meet or exceed 65% and to result in a minimum of completed interviews in each budget period as defined by the percentages specified above.

2.10. Recipients will collaborate with CDC to identify, plan, conduct, document and disseminate project findings for STD surveillance technical assistance and evaluation activities related to STD-PCHD-funded surveillance components. The objective of these activities is to improve core surveillance capacity and provide technical assistance to non-SSuN funded, STD-PCHD jurisdictions. Examples of such surveillance evaluation activities may include but are not limited to: (A) assessments of data completeness for laboratory reporting and recommendations for improving ascertainment of key data elements, (B) assessment of the population-level coverage of electronic laboratory reporting (ELR) and/or electronic health records (EHR) and recommendations for enhancing ELR and/or EHR coverage to include all laboratories or providers in the jurisdiction, (C) enhancing the completeness of provider type variables in routine case surveillance and recommendations for more useful taxonomies for provider types, (D) assessing robustness of person-identifier to longitudinally monitor unique persons with recommendations for best practices, (E) assessing specificity/sensitivity of registry matching methods and recommendations for fully integrating automated registry matching, and/or, (F) other surveillance evaluation activity of local interest investigating quality/completeness of STD-specific surveillance data. Recipients should conduct data improvement activities to identify best practices and develop tool kits for dissemination.

2.11. Recipients will collaborate with CDC to assure timely and prompt data quality assurance on all required datasets, including recoding into required structures and formats, application of CDC-provided edit and completeness checks, remedial action to address deficiencies prior to data transmission and secure transmission of all required datasets to CDC following project protocols and schedules.

Expected outputs associated with Strategy B activities:

a) Dataset of all reported gonorrhea and adult syphilis cases with unique patient, case and provider IDs, HIV match results, provider and case investigations for randomly sampled cases - transmitted per protocol to CDC every 2 months

b) Dataset of all STD/HIV related laboratory data associated with each case record - transmitted per protocol to CDC every 2 months

c) Dataset of unique providers reporting STD cases - transmitted per protocol to CDC at

least once annually

Strategy C - Surveillance Focus Activities

These activities are intended to improve quality and use of surveillance data, explore new methods for monitoring the burden of reportable and/or non-reportable STDs, investigate incidence of sequelae and monitor adverse health outcomes of STDs across the full range of laboratory and provider settings. Applicants are required to apply for at least one (1) but no more than five (5) surveillance focus activities. Applicants must include separate budgets and address the activity in the applicant's work plan for each proposed activity. Applicants should base their budget request on current morbidity levels or anticipated volume; maximum budget request estimates are provided in the budget narrative section (Section 12 below) for each activity.

Activity 3: Lymphogranuloma venereum (LGV) surveillance among persons seeking care in STD clinics

3.1 Applicants are invited to propose methods, staffing and infrastructure in collaborating STD clinics to collect remnant CT-positive (by NAAT testing) rectal swabs/specimens from both symptomatic and asymptomatic male and female patients for shipment to the CDC laboratory for testing to determine the prevalence of LGV serovars.

3.2 Recipients may collect specimens continuously for a specified period of time, or sequentially until 200 specimens are obtained per participating clinic.

3.3 Recipients must be able to link specimens to SSuN clinic visit record through unique SSuN patient ID and visit date.

Expected outputs:

a) Dataset of all specimens collected and shipped with event IDs linking specimens to Strategy A datasets - transmitted per protocol to CDC

Activity 4: Enhanced cases investigations among a sample of reported chlamydia cases in a high morbidity area

4.1 Following protocols specifying a limited set of pre-defined demographic, clinical and behavioral data elements, recipients will conduct enhanced provider and brief patient follow-up investigations on a random probability sample of reported chlamydia cases in a well-defined high morbidity county, neighborhood planning area or health planning region within the recipient's jurisdiction for two (2) discrete time periods per project year.

4.2 Recipients will use the same methods to select a random sample of CT cases that they employ for the selection of cases in Strategy B (2.1 above). Similarly, applicants should describe methods for assuring that the random sample is free from selection bias.

4.3 Recipients will collaborate with CDC to propose and employ separate patient interview methodologies for each of the two (2) investigation periods (examples include traditional DIS follow-up, SMS text messaging, secure on-line survey with unique ID code, phone-based survey app, etc.). The purpose of this requirement is to evaluate the relative merits

and costs of different methods of patient contact; process information on contact methods and outcomes will be evaluated locally, documented and reported with aggregate results to CDC. Additional guidance will be provided to successful applicants for this focus activity post-award.

Expected outputs:

a) Dataset of all reported chlamydia cases in the specified area with unique patient, case and provider IDs, HIV match results, and investigations for randomly sampled cases - transmitted per protocol to CDC at the conclusion of each investigation period

Activity 5: Enhanced cases investigations among early syphilis cases reporting neuro, ocular and otic symptoms

5.1 Following revised SSuN protocols (https://www.cdc.gov/std/funding/ssun/default.htm), recipients will conduct enhanced provider and patient follow-up on early syphilis cases to identify signs and symptoms of neuro, otic, or ocular syphilis as well as treatment provided and results of any clinical evaluations.

Expected outputs:

a) Dataset of adult syphilis cases with unique patient, case and provider IDs, HIV match results, provider and patient investigations - transmitted per protocol to CDC

Activity 6: Syndromic surveillance for neuro, ocular and otic signs/symptoms to detect undiagnosed syphilis

6.1 Recipients will collaborate with CDC to propose and conduct active surveillance projects in a high volume ED, ophthalmology, neurology or other appropriate clinical facility in their jurisdiction designed to apply a syndromic surveillance case definition to potentially identify patients with neuro, ocular or otic symptoms not otherwise explained by other underlying causes for follow-up testing and evaluation for syphilis. This activity must involve the active participation of an appropriate clinical partner. This partner, and rationale for the choice of this facility must be fully described in the proposal. Recipients of funding for this focus activity will collaborate with CDC in the creation of the surveillance case definition, monitor project implementation in the clinical setting and to design and conduct evaluation of the project.

Expected outputs:

a) Documentation of case definition and unique patient records queried - aggregate results summarized and transmitted per protocol to CDC

Activity 7: Implementation of HL7 case reporting through NNDSS

7.1 Recipients will collaborate with CDC to implement STD and congenital syphilis (CS) message mapping guides (MMGs) and complete the transition to HL7-based case reporting to CDC though the National Notifiable Diseases Surveillance System (NNDSS) Modernization Initiative (NMI). Additional information on NMI and the STD and CS

MMG requirements can be found at https://www.cdc.gov/nmi/index.html.

7.2 Recipients funded for this focus activity will work with the Center for Surveillance, Epidemiology and Laboratory Science (CSELS) at CDC to begin the on-boarding process and agree to implement STD and CS message mapping guides for routine reporting of STD cases to CDC through NNDSS.

Expected outputs:

a) Implementation package showing NNDSS data cross-walk and HL7 mappings - transmitted per protocol to CDC/CSELS

b) HL7 test records transmitted per protocol to CDC/CSELS

c) Limited production HL7 messages transmitted per protocol to CDC/CSELS

d) Year-to-date matching datasets in both NETSS and HL7 formats transmitted per protocol to CDC/CSELS

e) Cut-over to HL7 production for reporting of STDs to CDC through NNDSS

Activity 8: Technical assistance to STD-PCHD recipients implementing enhanced gonorrhea investigations

8.1 Recipients funded for this focus activity will work with CDC SSuN and Program Development and Quality Improvement Branch (PDQIB) staff to identify technical assistance needs in neighboring jurisdictions, design curricula and provide direct peer-to-peer assistance (facilitated through webinar, conference call, materials sharing and [infrequently] through site visit) to health departments implementing limited enhanced gonorrhea activities funded under STD-PCHD.

Expected outputs:

a) Documentation of technical assistance needs, gaps identified, communications and technical assistance plans, summary results.

Activity 9: Surveillance Focus activities of local interest

9.1 Recipients will propose and collaborate with CDC to implement a locally relevant focus activity designed to implement activities that address issues pertinent to improving/enhancing local STD surveillance capacity, efficiency, timeliness, completeness, representativeness of surveillance data and/or to analyze, interpret and disseminate STD surveillance data to relevant stakeholders in innovative, impactful ways. In collaboration with CDC, recipients will evaluate, document and disseminate findings of the activity.

Overarching Activities Relevant to All Strategies

10.1 Recipients are required to participate in regularly scheduled conference calls, virtual meetings, interviewer trainings, requests from CDC for technical assistance for STD-PCHD (PS19-1901) recipients and annual face-to-face recipient meetings (a minimum of 2 key staff should attend from each funded area) as required by CDC to review protocols, refine best practices, report progress toward meeting SSuN objectives, present preliminary data and describe status of all ongoing activities.

10.2 Recipients are assumed to have sufficiently robust local information systems necessary for the collection, management, integration, analysis, and transmission of all project data. Any minor local data system modifications necessary for data management of case investigation data, clinic visit and related data, and processes/systems for collection and data entry of clinic survey data must be completed and data collection activities initiated in a timely manner in the first year of funding.

10.3 Recipients will assure that data management methods and information systems supporting these activities provide efficient, sustainable, routine, automated and well-documented processes in order to limit staff burden and minimize the effect of unanticipated staff turnover.

10.4 Recipients will demonstrate willingness and capacity to provide meaningful resources and technical assistance to STD clinics providing data to assure ongoing extraction, appropriate transformation, transmission, validation/quality assurance, and data management of all required data. Meaningful resources may include direct assistance through staff time or financial support to the data-providing entity through subcontracts or other local mechanisms.

10.5 Recipients must be willing to work collaboratively with CDC and other funded project areas to assure protocols and data elements for SSuN activities are fully implemented and maintained across all funded strategies and activities. Recipient inability to initiate or to maintain data collection activities in full compliance with protocols, and with appropriate data quality assurance, may affect future support.

10.6 'Jurisdiction' for the purposes of this NOFO is defined as the entire geographic extent of the funded agency's administrative boundaries. For state governments, this includes all counties and cities in that state regardless of independent funding status. For city or county health departments independently funded by CDC under PS19-1901, this includes whole or partial counties within that health department's entire administrative catchment area. For city or county health department applicants not independently funded by CDC under PS19-1901 (STD-PCHD), formal proxy authority for access to HIV/STD surveillance data must be obtained from the appropriate state health agency funded through PS19-1901 (STD-PCHD) and clearly documented through attachment(s). City or county health department applicants (regardless of independent funding status under PS19-1901), in consultation with state health department STD programs, may propose to conduct activities in broader geographic areas. The geographic extent must be specified and formal proxy authority for access to HIV/STD surveillance data throughout the entire geographic area proposed must be documented. Name the file 'Proxy' and upload it as a PDF file at www.grants.gov. All recipients must implement Strategy B activities within their entire jurisdiction or proposed geographic area, and may choose to include STD-specific clinical facilities for Strategy A activities from any location within their jurisdiction or proposed geographic area. Preference should be given to those facilities that are considered most representative of at-risk populations in the jurisdiction. Geographic extent of all proposed activities must be fully documented in the application.

10.7 Recipients must use findings and methods from their SSuN activities to improve and enhance existing STD (or STD/HIV, if integrated) surveillance capacity in their jurisdictions and assure that SSuN activities are fully integrated into surveillance activities

funded under PS19-1901 (STD-PCHD). Recipients are required to conduct surveillance evaluation activities as a requirement of Strategy B (see above) and to fulfill the Applicant Evaluation and Performance Measurement Plan; these should be conducted in collaboration with CDC and with state/local STD program staff; findings must be formally documented and applied to improving overall STD surveillance capacity in the recipient's jurisdiction.

10.8 Recipients will develop methods to incorporate efficiencies achieved in the course of SSuN efforts, with respect to data systems and electronic lab/case data, into routine surveillance practice. Applicants are strongly encouraged to integrate resources and activities within STD (or STD/HIV, if integrated) surveillance and program units.

10.9 Recipients are required to create formal, ongoing collaborative processes (workgroups, committees, etc.) with STD programs in their jurisdiction implementing PS19-1901 (STD-PCHD) to assure minimal duplication/interruption of effort, create efficiencies of scale and to maximize beneficial public health outcomes from sentinel and enhanced surveillance activities implemented under STD-PCHD and this NOFO.

1. Collaborations

a. With other CDC programs and CDC-funded organizations:

Recipients are required to implement project activities in collaboration with their jurisdiction's STD or relevant infectious disease prevention and surveillance programs funded under PS19-1901, Strengthening STD Prevention and Control for Health Departments (STD-PCHD) as well as the HIV surveillance units funded under PS18-1802: Integrated Human Immunodeficiency Virus (HIV) Surveillance and Prevention Programs for Health Departments.

Applicants are expected to implement Strategy B (enhanced case-based surveillance) in collaboration with surveillance activities funded under PS19-1901 (STD-PCHD). Strategy B is intended to expand enhanced surveillance activities (such as sampling of gonorrhea cases) conducted under PS19-1901 to include all of the recipient's jurisdiction and to standardize these activities by implementing SSuN protocols for data collection and reporting.

Applicants must describe and document existing enhanced surveillance activities (such as those planned or implemented under PS19-1901), specify geographic areas in which those activities are being conducted, and clearly identify how staff and other fiscal resources used to fulfil requirements of PS19-1901 are being enhanced through geographic expansion and protocol standardization with SSuN funding. Applicants must assure that resources for SSuN Strategy B do not supplant or replace resources funded under PS19-1901. Activities and funds from SSuN are required to be additive rather than subtractive of STD-PCHD funding. For jurisdictions funded under SSuN, performance measure reporting to CDC (for the enhanced gonorrhea surveillance activity funded under STD-PCHD) will be streamlined to reduce duplication of effort.

Applicants must provide an MOA/MOU verifying collaborations with the STD program within their health department and a separate MOA/MOU with authorities responsible for management of relevant HIV surveillance program (if applicant agency is not an integrated HIV/STD program) verifying appropriate access to name-based HIV surveillance registries and laboratory data for the purposes of regular, routine data matching. Applicants must further document explicit concurrence of the HIV surveillance unit with sharing relevant HIV-related data with

CDC in de-identified records for clinic patients and reported STD cases. Applicants must submit this/these MOUs or MOAs, as appropriate, name the files 'STDProgramMOU' and RegistryMatching, respectively, and upload as PDF files at www.grants.gov.

Applicants must provide a separate MOU/MOA/Certification of Compliance documenting that the jurisdiction's Overall Responsible Party (ORP) for HIV/STD has reviewed the applicant's Data Management Plan and proposed project activities for compliance with NCHHSTP Data Security and Confidentiality standards (https://www.cdc.gov/nchhstp/programintegration/docs/pcsidatasecurityguidelines.pdf). Note: Name this file ORPCert and upload as a PDF in grants.gov.

b. With organizations not funded by CDC:

Recipients are required to implement Strategy A activities in collaboration with one or more STD specialty clinics in their jurisdiction providing categorical STD clinical services (i.e. 'STD Clinics'). An MOA/MOU or Letter of Collaboration (LOC) must be submitted for each participating STD clinic specifying number of visits in 2017, explicit agreement to provide name-identified clinical visit records for HIV registry matching, associated diagnoses, associated laboratory observations and treatment records for all patients seeking STD clinical services to the recipient state/county/city health department implementing SSuN. A single MOA, MOU or LOC may be submitted if multiple STD clinics are proposed, and these share a central medical record system and joint administration; all included clinics must be specifically identified and listed separately. Patient identifiers are required at the recipient level for the sole purpose of matching against the recipient jurisdiction's HIV surveillance registry and will not to be transmitted to CDC. At least one STD specialty clinic site among those proposed for collaboration must have a volume of 5,000 or more visits annually documented in the attached MOA/MOU/LOC, which must also clearly state that the applicant will not share patient names with CDC or any other third party as well as specify compliance with appropriate local data security and confidentiality requirements. Multiple documents should be aggregated into a single PDF, name the file STDClinics.pdf and upload to grants.gov.

If decisions on inclusion of specific STD clinics for activities under Strategy A are based on local target populations of interest, this must be documented and described in the project narrative.

2. Target Populations

Health equity is a desirable goal that entails special efforts to improve the health of those who have experienced social or economic disadvantage. Applicants should use epidemiologic and social determinant data to identify communities disproportionately affected by STDs, including HIV, within their jurisdictions and should ensure that surveillance activities proposed under this NOFO appropriately include these populations. (definitions of 'health' and 'health equity' are available at http://www.healthypeople.gov/hp2020/advisory/phaseI/glossary.htm).

Populations of specific interest to this NOFO include:

1. Persons diagnosed and reported with gonorrhea, chlamydia, syphilis, HIV, other STDs and STD-related health outcomes.
2. Persons presenting for care in facilities providing STD clinical services.
3. Men who have sex with men (MSM).

4. Other vulnerable populations such as racial minorities and persons of Hispanic ethnicity.

a. Health Disparities

Health disparities in STDs and HIV are inextricably linked to a complex blend of underlying social determinants that influence which populations are most severely affected by these diseases. In collaboration with partners and appropriate sectors of their community, recipients of funding under this NOFO will address information gaps in their current STD case surveillance, providing a more comprehensive portrait of the social determinants of STDs and a more complete epidemiologic profile of populations with acute inequities in the burden of disease and related adverse outcomes.

iv. Funding Strategy

Approximately $340,000 will be awarded annually per recipient to support core Strategies A & B;

Approximately $140,000 may be awarded annually per recipient to support one or more focus activities under Strategy C.

Not all Strategy C activities will be funded in any given budget period, or for all applicants proposing to participate in a given activity. Funding for Strategy C activities is contingent on available federal funding and on CDC/DSTDP programmatic priorities.

b. Evaluation and Performance Measurement

i. CDC Evaluation and Performance Measurement Strategy

CDC requires ongoing evaluation and performance measurement under this NOFO and expects recipients to maintain sufficient staffing and analytic capacity to meet these requirements. CDC's approach to evaluation and performance measurement for PS19-1907, STD Surveillance Network, is two-fold and involves assessing the performance of the overall project with respect to strategies A-C (i.e., across all recipients) and the performance of individual recipients in each component.

With respect to individual recipients, CDC will annually assess the recipient's contribution to overall project performance quantitatively using submitted data and qualitatively using assessments derived from conference calls, site visits and other communications with recipients. CDC will also actively monitor recipient compliance with Data Security and Confidentiality Guidelines, especially as these relate to HIV matching and data sharing activities, through annual audits and formal assessments - which may include collaboration with HIV surveillance SMEs and the recipient jurisdiction's Project Officer for PS18-1802.

CDC will monitor how PS19-1907 funds are allocated and expended at the recipient level through fiscal tracking tools and annual budget reviews. Progress toward achieving specific objectives with respect to project outputs and outcomes will also be assessed through annual progress reports.

CDC expects recipients to transmit data products (See Outputs under Strategies and Activities above) to CDC as required by project protocols on a routine, regular basis, as primary outputs of supported activities. These datasets lead directly to overall desired outcomes. CDC will use

these data to track process measures indicating acceptable progress in achieving certain key data quality and performance measures, essential to the outcomes of the NOFO.

CDC will provide all recipients with semi-annual reports that summarize each recipient's performance as well as the performance of other recipients. This report will routinely be reviewed and discussed with the recipient and the project officer, and among CDC staff.

These data outputs will also be used to produce summary surveillance reports, reports on project accomplishments, data quality reports, fact sheets, and other monitoring and evaluation reports. Findings may be reported at national conferences, online, in peer-reviewed journals, and in other public forums independently by CDC (for aggregate data), or in collaboration with recipients where site-specific data are to be presented. CDC will finalize evaluation and performance measures in collaboration with recipients within six months of the project start date.

*Proposed **process** measures that CDC and recipients will collaboratively monitor may include:*

Strategy A: Sentinel Surveillance in STD Clinics

Proportion of required facility component datasets (Strategy A, outputs a-f, listed above) transmitted to CDC on or by the scheduled due date.

Proportion of datasets that pass all data structural validation and edit checks (Strategy A, outputs a-f, listed above).

Proportion of records in datasets received with key data elements completed (Strategy A, outputs a-f, listed above).

Proportion of clinics submitting required information on STD/HIV screening, PrEP/PEP and related care standards and policies. (Strategy A output f, listed above)

Strategy B: Enhanced Case-based Surveillance (gonorrhea and syphilis)

Proportion of gonorrhea cases randomly sampled for enhanced investigation as documented in datasets received (Strategy B, output a, listed above).

Proportion of gonorrhea cases in the sample with completed look-back, provider and patient investigations as documented in datasets received (Strategy B, outputs a-c, listed above).

Proportion of adult syphilis cases with completed look-back investigations as documented in datasets received (Strategy B, outputs a-c, listed above).

Proportion of datasets received that pass all data structural validation and edit checks (Strategy B, outputs a-c, listed above).

Proportion of records received with key data elements completed as documented in datasets received (Strategy B, outputs a-c, listed above).

Strategy C: Surveillance Focus Activities

Progress on implementing activities demonstrated through monthly reporting.

Proportion of records/specimens/cases/investigations/datasets received with key data

elements completed.

*Proposed **outcome** measures that CDC and recipients will collaboratively monitor may include:*

Strategy A: Sentinel Surveillance in STD Clinics

Proportion of STD clinic patients by gender, age, race, Hispanic ethnicity and sex-of-sex partners (Outcome 1.1, listed above).

Proportion of STD clinic patients with repeat visits (Outcomes 1.1, 2.2, 3.2, listed above).

Proportion of eligible STD clinic patients tested for HIV (Outcomes 1.1, 2.2, 3.2, listed above).

Proportion of eligible STD clinic patients referred for HIV-preventive services (Outcomes 1.1, 2.2, 3.2, listed above).

Documentation of local data summaries, publications, presentations to stakeholders (Outcomes 1.4, 1.6, listed above).

Documentation of collaboration in multi-site analyses, manuscripts and publications (Outcomes 1.4, 1.6, listed above).

Documentation of time from initial visit to referral for HIV-preventive services among eligible STD clinic patients (Outcomes 1.2, 2.2, listed above).

Proportion of STD clinic patients diagnosed with STDs treated with recommended regimens (Outcomes 2.5, 3.2, listed above).

Strategy B: Enhanced Case-based Surveillance (gonorrhea and syphilis)

Distribution of reported gonorrhea and syphilis cases by gender, age, race, Hispanic ethnicity and sex-of-sex partners (Outcome 2.6, listed above).

Proportion of reported gonorrhea and syphilis cases that are repeat infections (Outcome 2.6, listed above).

Proportion of reported gonorrhea and syphilis cases tested for HIV and by HIV status (Outcomes 2.7, 3.2, listed above).

Proportion of eligible reported gonorrhea cases referred for and actively participating in HIV-preventive services (Outcomes 2.7, 3.2, listed above).

Documentation of local STD epidemiology summaries including enhanced surveillance data, publications, presentations to stakeholders (Outcomes 1.4, 1.6, listed above).

Documentation of collaboration in multi-site analyses, manuscripts and publications (Outcomes 1.4, 1.6, listed above).

Proportion of reported gonorrhea and syphilis cases treated with recommended regimens by case characteristics and provider settings (Outcomes 2.5, 3.2, listed above).

Data Management Plan (DMP)

A DMP is a living, evolving document that captures data processes throughout the life-cycle of

the project and must be submitted with the application. All recipients will routinely transmit de-identified record-level datasets to CDC, which will also provide long-term archiving and assure appropriate access limitations to data submitted by recipients. However, local data management processes should be described in the DMP, with particular focus on data quality assurance, limiting access to identifiable data or to potentially re-identifiable data (e.g. aggregate data with small cell counts) and local data re-release policies.

Applicant's DMP should appear as a separate section in the applicant's project narrative, be referenced in the table of contents and must include the following information:

- A general description of the data to be collected or generated in the proposed project (see SSuN project protocols and data dictionaries, https://www.cdc.gov/std/funding/ssun/default.htm.)
- Mechanisms for, and limitations to, providing access to and sharing of data (include a description of provisions for the protection of privacy, confidentiality, security, intellectual property, or other rights). This section should address access to identifiable as well as de-identified data.
- Description of proposed process to create unique, static person-identifiers for persons diagnosed and reported with STDs and for patients seeking care in collaborating STD specialty clinics (either jointly across strategies or separately for reported cases and for clinic patients, as determined by local practices and policies) to allow for monitoring incidence of STDs over time among unique persons and for dynamic, person-based linkages with HIV and other relevant surveillance registries.
- Description of agreements with HIV surveillance program/unit in their jurisdiction to share relevant record-level information for STD clinic patients or reported cases that are matched with the HIV registry. These data should include patient demographics, STD diagnoses, behavioral information pertinent to HIV risk, HIV testing and treatment history that may be captured in clinic records and other information as mutually agreed.
- Statement of the use of data standards that ensure all locally released de-identified data have appropriate documentation that describes the method of data collection, what the data represent, potential limitations for use and explicit acknowledgement of CDC support for data collection through this cooperative agreement.
- DMP should also include local plans for archiving and long-term preservation of the data, or narrative explaining why long-term preservation and access are not justified.

ii. Applicant Evaluation and Performance Measurement Plan

Applicants must provide an evaluation and performance measurement plan that demonstrates how the recipient will fulfill the requirements described in the CDC Evaluation and Performance Measurement and Project Description sections of this NOFO. At a minimum, the plan must describe:

- How applicant will collect the performance measures, respond to the evaluation questions, and use evaluation findings for continuous program quality improvement.
- How key program partners will participate in the evaluation and performance measurement planning processes.
- Available data sources, feasibility of collecting appropriate evaluation and performance

data, and other relevant data information (e.g., performance measures proposed by the applicant)
- Plans for updating the Data Management Plan (DMP), if applicable, for accuracy throughout the lifecycle of the project. The DMP should provide a description of the data that will be produced using these NOFO funds; access to data; data standards ensuring released data have documentation describing methods of collection, what the data represent, and data limitations; and archival and long-term data preservation plans. For more information about CDC's policy on the DMP, see https://www.cdc.gov/grants/additionalrequirements/ar-25.html.

Where the applicant chooses to, or is expected to, take on specific evaluation studies, they should be directed to:

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

Recipients will be required to submit a more detailed Evaluation and Performance Measurement plan, including a DMP, if applicable, within the first 6 months of award, as described in the Reporting Section of this NOFO.

CDC will collaborate with recipients post-award to develop a detailed evaluation plan.

c. Organizational Capacity of Recipients to Implement the Approach

The organizational capacity to successfully implement the strategies and activities described in this NOFO requires a well-balanced mix of data management staff, trained public health interviewers, epidemiologists with STD subject matter expertise and adequate fiscal and administrative support to manage fiscal resources appropriately. Recipients are pressumed to have sufficiently robust local information systems necessary for the collection, management, integration, analysis, and transmission of all project data. Any minor local data system modifications necessary for data management of case investigation data, clinic visit and related data, and processes/systems for collection and data entry of clinic survey data must be identified in the application and plans to complete these fully articulated to allow for initiation of all data collection activities in the first year of funding.

For strategies A & B, high-functioning data management expertise and stable surveillance data management systems are required to extract, recode, re-format and to perform extensive quality assurance on case and clinic visit data. Moreover, HIV and other registry matching tasks are sophisticated public health information management activities that require extensive programming, skilled manual data review capacity and skills to build data-sharing collaborations across organizational units and between public health agencies. Applicants should describe data management methods and information systems supporting proposed activities and assure efficient, sustainable, routine, automated and well-documented processes in order to limit staff burden; applicants should describe plans to minimize the effect of unanticipated staff turnover.

All applicant agencies or organizations must fully demonstrate sufficient existing or planned

staff capacity to manage large, complex surveillance data management projects including the ability to extract, match, merge, recode, format and archive datasets for transmission to CDC. Advanced SAS skills are strongly encouraged for the successful implementation of the surveillance strategies in this NOFO. Agencies anticipating migrations to, or implementation of, new/integrated STD surveillance data management systems within the applicant's jurisdiction should carefully consider the impact of these changes on planned/ongoing activities and fully describe plans to mitigate any potential interruptions in SSuN data management.

All applicants must demonstrate willingness and capacity to provide meaningful resources and technical assistance to STD clinics providing data to assure ongoing extraction, appropriate transformation, transmission, validation/quality assurance, and data management of all required data. Meaningful resources may include direct assistance through staff time or financial support to the data-providing entity through subcontracts or other local mechanisms. Applicants must demonstrate willingness to work collaboratively with CDC and other funded project areas to assure protocols and data elements for SSuN activities are fully implemented and maintained across all funded strategies and activities. Recipient inability to initiate or to maintain data collection activities in full compliance with protocols, or to comply with appropriate data quality standards, may affect future support.

Successful enhanced case investigations require well-trained disease intervention specialists or other dedicated public health staff with patient contact experience and demonstrated persistence in locating often hard-to-reach patients and for routine follow-up with a broad range of reporting providers. Applicants should address the staff/capacity needs based on the anticipated number of case investigations to be completed and fully justify personnel requests in the budget narrative and align these with proposed work plans.

Experience in previous cycles of SSuN has demonstrated that non-business hours, such as limited weekend and evening hours, are needed to maximize the opportunities for patient interview success. Applicants should address mechanisms and funded staff capacity to assure that sufficient resources are available for the anticipated volume of cases to be investigated and with appropriate scheduling to maximize interview success rates. Recipients are encouraged to integrate enhanced case investigations into existing partner management activities where feasible and appropriate to avoid duplication of effort between SSuN and routine disease control activities. Applicants should describe plans for integration fully and should address previous or current experience assessing, surveying, interviewing or enrolling patients in studies or investigations (without financial compensation to the patient) with a success rate of 65% or greater.

Personnel resources with strong epidemiology skills for analysis and presentation of STD surveillance data to steer programmatic responses in the recipient's jurisdiction are also required for overall project leadership and to direct successful implementation of SSuN strategies. Needs for higher-level staff may differ across the life-cycle of these strategies; applicants are encouraged to balance the need for scientific staff against the need for operational and data management staff resources at different stages in project implementation, and to adjust their budget request accordingly.

Relevant skills and experience for all proposed personnel must be documented through inclusion of resumes/CVs showing relevant education, certifications and/or trainings; name the file 'CVsResumes' and upload to www.grants.gov. For any proposed FTE or contractual

resources not yet hired/identified or otherwise listed as TBD, the applicants must describe the required skill set and present a reasonable hiring plan and time line. Budget requests for these vacant or TBD positions/contracts must be pro-rated to adjust for anticipated salary savings during hiring/contracting process.

All applicants must describe and fully document routine, regular access to relevant STD/HIV surveillance data and other ancillary databases to facilitate extraction and sampling of case records for enhanced investigations, extraction of name-based visit records from collaborating clinics and for matching records across existing surveillance registries.

All applicant agencies/organizations must describe relevant experience conducting routine case surveillance activities for STD, including components of provider, facility and laboratory reporting as well as matching surveillance data across HIV and STD case registries. If the jurisdiction currently integrates HIV and STD surveillance registries in a single data management system, this must be fully described. Organizational charts describing the applicant's work unit and relationship to the applicant agency must be included; name the file 'OrganizationalChart' and upload to www.grants.gov.

Applicants must fully describe proposed registry matching methods and processes to assure maximum sensitivity/specificity of record matching, criteria for manual review of partially-matching records and processes to assure that match data are refreshed and updated longitudinally for unique persons reported with gonorrhea and syphilis and persons presenting for care in collaborating STD clinics. Implementing best practices, such as the creation and maintenance of a 'master person index', thorough de-duplication of case registries prior to matching and strong, multi-component matching algorithms are strongly encouraged for implementing SSuN strategies. If commercial software is employed or proposed for registry matching, these tools must be described in the application.

Successful implementation of SSuN Strategy A requires building and maintaining collaborative partnerships with STD clinics in the applicant's jurisdiction. Applicants should describe previous or ongoing partnerships, including contractual arrangements, with STD clinical partners and describe how these partnerships will be enhanced and strengthened to include SSuN activities.

Applicants are required to demonstrate that they have a financial management system that will allow proper funds management and meet the requirements as stated in the Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards: https://www.ecfr.gov/cgi-bin/text-idx?node=pt45.1.75#se45.1.75_1302_45_CFR_75.302 . The financial system should permit the preparation of reports required by general and program-specific terms and conditions; and the tracing of funds to a level of expenditure adequate to establish that such funds have been used according to the federal statutes, regulations, and terms and conditions of the federal award.

d. Work Plan

Applicants are required to provide a work plan that provides both a high-level overview of the entire five-year period of performance (for Strategies A & B) and a detailed description of the first year of the award.

The work plan for the first period of performance should include a table for each strategy (or

individual activity under Strategy C) with the following columns and headings:

Strategy A					
Activity Description	*Related Output(s) from Logic Model*	*Performance Measure (from Evaluation and Performance Measurement section)*	*Person(s) Responsible*	*Start Date*	*Completion or Implementation Date*

CDC strongly encourages applicants to use the suggested work plan template at the NOFO website: https://www.cdc.gov/std/funding/SSuN/default.htm.

For the five-year overview, applicants should describe in narrative format the following for Strategy A and Strategy B:

1. How the applicants plan to maintain key partnerships with agencies, organizations and/or health department units that are essential to successful implementation of SSuN activities.
2. How the applicants plan to sustain successfully initiated project activities.
3. How the applicants plan to assure ongoing data quality and monitor local project performance.
4. Plans for additional evaluation and analysis of the data collected.
5. Anticipated changes to ongoing activities or planned changes in staffing or resources allocation to reflect changing needs.

e. CDC Monitoring and Accountability Approach

Monitoring activities include routine and ongoing communication between CDC and recipients, site visits, and recipient 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 recipient progress in achieving the desired outcomes.
- Ensuring the adequacy of recipient 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 deemed necessary to monitor the award:

- Ensuring that work plans are feasible based on the budget and consistent with the intent of the award.
- Ensuring that recipients are performing at a sufficient level to achieve outcomes within stated timeframes.
- Working with recipients 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.

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 recipients.

CDC will require recipients to actively participate in routine SSuN project-wide as well as individual recipient conference calls.

Based on review of process measures and recipient reporting during project implementation, if a recipient is not conducting required activities, or failing to adhere to required protocols, CDC will initiate technical and/or capacity building assistance for program improvement; CDC may require additional monitoring or recipient reporting during a defined time frame (up to six months).

Recipients performing at a less than acceptable level beyond the agreed-upon time frame will be required to work with CDC to identify factors negatively affecting performance, develop a formal action plan for program improvement and to use that plan to guide the work until the recipient is meeting performance standards.

During such periods, more extensive and frequent engagement between the recipient and CDC is to be expected. In subsequent budget periods, funding may be contingent on meeting performance expectations.

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

In a cooperative agreement, CDC staff are substantially and substantively involved in the project activities beyond routine progress monitoring. SSuN Project and Scientific Officers will work in partnership with recipients to ensure successful implementation of the cooperative agreement, ensure appropriate outputs are produced assure datasets are transmitted to CDC in a complete and timely manner and assure that short and medium-term overall outcomes are achieved. CDC supportive activities for SSuN are as follows:

Technical assistance and capacity building

Existing initial recipient capacity to implement required strategies is assumed for all successful applicants. However, CDC will work with recipients as necessary post-award to identify capacity building and TA needs essential for the overall success of the project. CDC will provide for the use of project funds as appropriate and reasonable for access to training and TA collaboratively identified as essential for successful implementation of SSuN activities.

Award guidance and monitoring

CDC will support recipients in implementing the requirements of the cooperative agreement, prioritizing activities to produce required outputs and to achieve identified outcomes.

CDC will monitor recipients' performance using multiple approaches (described in the CDC Evaluation and Performance Measurement Strategy section above), such as routine calls, site visits, emails, standardized reporting of process indicators, recipient feedback and

other CDC-generated data reports.

CDC will provide guidance and coordination to recipients to improve data quality and effectiveness of activities, develop specific evaluation strategies, improve data products and build and maintain partnerships.

CDC will provide protocols, data content and structure requirements and explicit expectations for reporting and evaluation.

B. Award Information

1. Funding Instrument Type: Cooperative Agreement

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

2. Award Mechanism: H25

H25 - Venereal Disease Control

3. Fiscal Year: 2019

4. Approximate Total Fiscal Year Funding: $4,800,000

5. Approximate Period of Performance Funding: $24,000,000

This amount is subject to the availability of funds.

Estimated Total Funding: $24,000,000

6. Approximate Period of Performance Length: 5 year(s)

7. Expected Number of Awards: 10

8. Approximate Average Award: $480,000 Per Budget Period

9. Award Ceiling: $600,000 Per Budget Period

This amount is subject to the availability of funds.

10. Award Floor: $200,000 Per Budget Period

11. Estimated Award Date: 08/15/2019

12. Budget Period Length: 12 month(s)

Throughout the project period, CDC will continue the award based on the availability of funds, the evidence of satisfactory progress by the recipient (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 period of performance comprises the initial competitive segment and any subsequent non-competitive continuation award(s).

13. Direct Assistance

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

C. Eligibility Information

1. Eligible Applicants

Eligibility Category:	Unrestricted (i.e., open to any type of entity above), subject to any clarification in text field entitled "Additional Information on Eligibility"

Additional Eligibility Category:

2. Additional Information on Eligibility

Eligibility is limited to the following types of entities, per the program's authorizing statute: States and, in consultation with the State health authority, the political subdivisions of States.

The following documents are required for the application to be deemed responsive:

1) Documentation of the applicant agency's statutory or regulatory authority to conduct name-based surveillance and case investigations for sexually transmitted diseases and/or HIV within a clearly defined geographic area (city, county, state, or other political unit). Authority must be demonstrated by attachment of appropriate documentation such as state statute, regulation, or other authorizing legislation specifically identifying the applicant agency's authority to conduct surveillance for notifiable conditions in the applicant's jurisdiction). Proxy assignment of authority for STD surveillance activities may be an acceptable basis for eligibility if documented with a duly executed MOU/MOA from an appropriate authority citing authorizing statutes or regulatory authority.

Note: Aggregate appropriate documents into single file named SurvillanceAuthority and upload as a PDF in grants.gov. Proxy assignment of authority, if needed, should be named Proxy.pdf and upload as a PDF in grants.gov.

2) MOU/MOA from the HIV Surveillance Program at the Health Department responsible for maintenance of the jurisdiction's HIV surveillance registry providing documentation of collaboration with the applicant for the purposes of HIV surveillance registry matching of a) reported cases of gonorrhea and adult syphilis, and, b) patient records submitted from the collaborating STD speciality clinic(s) and transmission of de-identified, record-level match results to CDC as data elements in required datasets.

Note: Name the file RegistryMatching and upload as a PDF in grants.gov.

3) MOU/MOA/Certification of Compliance documenting that the jurisdiction's Overall Responsible Party (ORP) for HIV/STD has reviewed the applicant's proposed activities and Data Management Plan for compliance with NCHHSTP Data Security and Confidentiality standards

(https://www.cdc.gov/nchhstp/programintegration/docs/pcsidatasecurityguidelines.pdf).

Note: Name the file ORPCert and upload as a PDF in grants.gov.

If any of these required documents are missing, the application will be deemed non-responsive and not be passed along for further review.

3. Justification for Less than Maximum Competition

N/A

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 NOFO 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. Application and Submission Information

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 at http:// 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-recipients, those sub-recipients 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 a recipient. 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 can require 10 or more 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 at www.grants.gov, the official HHS E-grant Web site. Registration information is located at the "Applicant Registration" option at www.grants.gov.
All applicant organizations must register at www.grants.gov. The one-time registration process usually takes not more than five days to complete. Applicants should start the registration process as early as possible.

Step	System	Requirements	Duration	Follow Up
1	Data Universal Number System (DUNS)	1. Click on http://fedgov.dnb.com/ webform 2. Select Begin DUNS search/request process 3. Select your country or territory and follow the instructions to obtain your DUNS 9-digit # 4. Request appropriate staff member(s) to obtain DUNS number, verify & update information under DUNS number	1-2 Business Days	To confirm that you have been issued a new DUNS number check online at (http://fedgov.dnb.com/webform) or call 1-866-705-5711
2	System for Award Management (SAM) formerly Central Contractor Registration (CCR)	1. Retrieve organizations DUNS number 2. Go to www.sam.gov and designate an E-Biz POC (note CCR username will not work in SAM and you will need to have an active SAM account before you can register on grants.gov)	3-5 Business Days but up to 2 weeks and must be renewed once a year	For SAM Customer Service Contact https://fsd.gov/fsd-gov/home.do Calls: 866-606-8220
3	Grants.gov	1. Set up an individual account in Grants.gov using organization new DUNS number to become an authorized organization representative (AOR) 2. Once the account is set up the E-BIZ POC will be notified via email 3. Log into grants.gov using the password the E-	Same day but can take 8 weeks to be fully registered and approved in the system (note, applicants MUST obtain a	Register early! Log into grants.gov and check AOR status until it shows you have been approved

		BIZ POC received and create new password 4. This authorizes the AOR to submit applications on behalf of the organization	DUNS number and SAM account before applying on grants.gov)	

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 notice of 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 OGS staff at 770-488-2700 or e-mail OGS ogstims@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 NOFO, it will not be processed. Office of Grants Services (OGS) 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 OGS.

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

Due Date for Letter of Intent: **04/15/2019**

b. Application Deadline

Due Date for Applications: **05/15/2019** , 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.

Date for Information Conference Call

Two identical webinars will be held to provide information about this NOFO. Dates, times, and registration links are as follows:

(1) Tuesday, March 12, 1 - 2 PM Eastern Standard Time (https://cc.readytalk.com/r/r7myqz6hdrfp&;eom), and,

(2) Tuesday March 19, 3:30 - 4:30 PM Eastern Standard Time (https://cc.readytalk.com/r/mi2qiecr329i&;eom).

5. CDC Assurances and Certifications

All applicants are required to sign and submit "Assurances and Certifications" documents indicated at http://wwwn.cdc.gov/ grantassurances/ (S(mj444mxct51lnrv1hljjjmaa)) /Homepage.aspx.
Applicants may follow either of the following processes:

- Complete the applicable assurances and certifications with each application submission, name the file "Assurances and Certifications" and upload it as a PDF file with 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.

Risk Assessment Questionnaire Requirement
CDC is required to conduct pre-award risk assessments to determine the risk an applicant poses to meeting federal programmatic and administrative requirements by taking into account issues such as financial instability, insufficient management systems, non-compliance with award conditions, the charging of unallowable costs, and inexperience. The risk assessment will include an evaluation of the applicant's CDC Risk Questionnaire, located at https://www.cdc.gov/grants/documents/PPMR-G-CDC-Risk-Questionnaire.pdf, as well as a review of the applicant's history in all available systems; including OMB-designated repositories of government-wide eligibility and financial integrity systems (see 45 CFR 75.205(a)), and other sources of historical information. These systems include, but are not limited to: FAPIIS (https://www.fapiis.gov/), including past performance on federal contracts as per Duncan Hunter National Defense Authorization Act of 2009; Do Not Pay list; and System for Award Management (SAM) exclusions.

CDC requires all applicants to complete the Risk Questionnaire, OMB Control Number 0920-1132 annually. This questionnaire, which is located at https://www.cdc.gov/grants/documents/PPMR-G-CDC-Risk-Questionnaire.pdf, along with supporting documentation must be submitted with your application by the closing date of the Notice of Funding Opportunity Announcement. If your organization has completed CDC's Risk Questionnaire within the past 12 months of the closing date of this NOFO, then you must submit a copy of that questionnaire, or submit a letter signed by the authorized organization representative to include the original submission date, organization's EIN and DUNS.
When uploading supporting documentation for the Risk Questionnaire into this application package, clearly label the documents for easy identification of the type of documentation. For example, a copy of Procurement policy submitted in response to the questionnaire may be labeled using the following format: Risk Questionnaire Supporting Documents _ Procurement Policy.

Duplication of Efforts

Applicants are responsible for reporting if this application will result in programmatic, budgetary, or commitment overlap with another application or award (i.e. grant, cooperative agreement, or contract) submitted to another funding source in the same fiscal year. Programmatic overlap occurs when (1) substantially the same project is proposed in more than one application or is submitted to two or more funding sources for review and funding consideration or (2) a specific objective and the project design for accomplishing the objective are the same or closely related in two or more applications or awards, regardless of the funding source. Budgetary overlap occurs when duplicate or equivalent budgetary items (e.g., equipment, salaries) are requested in an application but already are provided by another source. Commitment overlap occurs when an individual's time commitment exceeds 100 percent, whether or not salary support is requested in the application. Overlap, whether programmatic, budgetary, or commitment of an individual's effort greater than 100 percent, is not permitted. Any overlap will be resolved by the CDC with the applicant and the PD/PI prior to award. Report Submission: The applicant must upload the report in Grants.gov under "Other Attachment Forms." The document should be labeled: "Report on Programmatic, Budgetary, and Commitment Overlap."

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

Letter of Intent (LOI) is requested but is optional. 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 sent via U.S. express mail, delivery service, fax, or email to:

Mark R. Stenger, MA, Science Officer

Department of Health and Human Services

Centers for Disease Control and Prevention

Surveillance and Data Management Branch

Division of STD Prevention

1600 Clifton Road NE, Mail stop US12-2

Atlanta, GA 30329-4027

Telephone: (404) 639-8260

e-mail: mstenger@cdc.gov

8. Table of Contents

(There is no page limit. The table of contents is not included in the project narrative page 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

(Unless specified in the "H. Other Information" section, maximum of 20 pages, single spaced, 12 point font, 1-inch margins, number all pages. This includes the work plan. Content beyond the specified page number will not be reviewed.)
Applicants must submit a Project Narrative with the application forms. Applicants must name this file “Project Narrative” and upload it at www.grants.gov. The Project Narrative must include **all** of the following headings (including subheadings): Background, Approach, Applicant Evaluation and Performance Measurement Plan, Organizational Capacity of Applicants to Implement the Approach, and Work Plan. 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 period of performance as identified in the CDC Project Description section. Applicants should use the federal plain language guidelines and Clear Communication Index to respond to this Notice of Funding Opportunity. Note that recipients should also use these tools when creating public communication materials supported by this NOFO. Failure to follow the guidance and format may negatively impact scoring of the application.

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 public health 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, as identified in the logic model in the Approach section of the CDC Project Description. Outcomes are the results that the program intends to achieve and usually indicate the intended direction of change (e.g., increase, decrease).

iii. Strategies and Activities
Applicants must provide a clear and concise description of the strategies and activities they will use to achieve the period of performance 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 the Strategies and Activities section of the CDC Project Description.

1. Collaborations
Applicants must describe how they will collaborate with programs and organizations either internal or external to CDC. Applicants must address the Collaboration requirements as described in the CDC Project Description.

2. Target Populations and Health Disparities
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. The applicants must also address how they will include specific populations that can benefit from the program that is described in the Approach section. Applicants must address the Target Populations and Health Disparities requirements as described in the CDC Project Description.

c. Applicant Evaluation and Performance Measurement Plan

Applicants must provide an evaluation and performance measurement plan that demonstrates how the recipient will fulfill the requirements described in the CDC Evaluation and Performance Measurement and Project Description sections of this NOFO. At a minimum, the plan must describe:

- How applicant will collect the performance measures, respond to the evaluation questions, and use evaluation findings for continuous program quality improvement. The Paperwork Reduction Act of 1995 (PRA): Applicants are advised that any activities involving information collections (e.g., surveys, questionnaires, applications, audits, data requests, reporting, recordkeeping and disclosure requirements) from 10 or more individuals or non-Federal entities, including State and local governmental agencies, and funded or sponsored by the Federal Government are subject to review and approval by the Office of Management and Budget. For further information about CDC's requirements under PRA see http://www.hhs.gov/ ocio/policy/collection/.
- How key program partners will participate in the evaluation and performance measurement planning processes.
- Available data sources, feasibility of collecting appropriate evaluation and performance data, data management plan (DMP), and other relevant data information (e.g.,

performance measures proposed by the applicant).

Where the applicant chooses to, or is expected to, take on specific evaluation studies, they should be directed to:

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

Recipients will be required to submit a more detailed Evaluation and Performance Measurement plan (including the DMP elements) within the first 6 months of award, as described in the Reporting Section of this NOFO.

d. Organizational Capacity of Applicants to Implement the Approach

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

11. Work Plan

(Included in the Project Narrative's 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 recipient plans to carry out achieving the period of performance outcomes, strategies and activities, evaluation and performance measurement.

12. Budget Narrative

Applicants must submit an itemized budget narrative. 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 could include the cost of collecting, managing, sharing and preserving data. Indirect costs on grants awarded to foreign organizations and foreign public entities and performed fully outside of the territorial limits of the U.S. may be paid to support the costs of compliance with federal requirements at a fixed rate of eight percent of MTDC exclusive of tuition and related fees, direct expenditures for equipment, and subawards in excess of $25,000. Negotiated indirect costs may be paid to the American University, Beirut, and the World Health Organization.

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 NOFO 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 NOFO. Proposed activities must be included in the budget narrative and must indicate which standards will be addressed.

Vital records data, including births and deaths, are used to inform public health program and policy decisions. If applicable and consistent with the cited statutory authority for this NOFO, applicant entities are encouraged to collaborate with and support their jurisdiction's vital records office (VRO) to improve vital records data timeliness, quality and access, and to advance public health goals. Recipients may, for example, use funds to support efforts to build VRO capacity through partnerships; provide technical and/or financial assistance to improve vital records timeliness, quality or access; or support vital records improvement efforts, as approved by CDC.

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 Recipients under such a plan. Applicants must name this file "Indirect Cost Rate" and upload it at www.grants.gov.

Additional Guidance for Preparing Budget Requests

Strategy A:

Applicants proposing a single STD clinic in this activity may propose a budget not to exceed $120,000 including indirect costs; applicants proposing multiple STD clinics for this activity may propose a budget not to exceed $150,000 including indirect costs.

Strategy B:

Applicants with >50,000 gonorrhea cases reported in their jurisdiction in 2017 may propose a

budget not to exceed $220,000 including indirect costs; applicants with 30,000 – 50,000 gonorrhea cases reported in their jurisdiction in 2017 may propose a budget not to exceed $200,000 including indirect costs; applicants with 10,000 – 30,000 gonorrhea cases reported in their jurisdiction in 2017 may propose a budget not to exceed $160,000 including indirect costs; Applicants with fewer than 10,000 gonorrhea cases reported in their jurisdiction in 2017 may propose a budget not to exceed $130,000 including indirect costs for Strategy B activities.

Applicants must explicitly describe how funds requested for Strategy B activities are supplemental to (rather than replacing) funding received under STD-PCHD (PS19-1901) for enhanced gonorrhea and syphilis surveillance.

Strategy C, focus activities (included as separate budget justifications):

Activity 3: Applicants may propose a budget not to exceed $20,000 including indirect costs.

Activity 4: Applicants may propose a budget not to exceed $100,000 including indirect costs.

Activity 5: Applicants may propose a budget not to exceed $75,000 including indirect costs in jurisdictions with more than 1,000 early syphilis cases reported in their jurisdictions in 2017; jurisdictions with fewer than 1,000 reported early syphilis cases may propose a budget not to exceed $60,000 including indirect costs.

Activity 6: Applicants may propose a budget of up to $75,000, including indirect costs, for this activity.

Activity 7: Applicants may budget for STD surveillance staff time, contractual support and/or relevant training up to a maximum budget of $50,000, including indirect costs for this activity.

Activity 8: Applicants may budget for appropriate staff time and limited travel up to a maximum budget of $10,000 including indirect costs for technical assistance activities.

Activity 9: Applicants may propose a budget not to exceed $75,000 for this activity, including indirect costs.

Applicants must prepare a separate project narrative (1 page, single-spaced, 12-point font) and a separate budget justification for each Strategy C focus activity they are proposing.

13. Funds Tracking

Proper fiscal oversight is critical to maintaining public trust in the stewardship of federal funds. Effective October 1, 2013, a new HHS policy on subaccounts requires the CDC to set up payment subaccounts within the Payment Management System (PMS) for all new grant awards. Funds awarded in support of approved activities and drawdown instructions will be identified on the Notice of Award in a newly established PMS subaccount (P subaccount). Recipients will be required to draw down funds from award-specific accounts in the PMS. Ultimately, the subaccounts will provide recipients and CDC a more detailed and precise understanding of financial transactions. The successful applicant will be required to track funds by P-accounts/sub accounts for each project/cooperative agreement awarded. Applicants are encouraged to demonstrate a record of fiscal responsibility and the ability to provide sufficient and effective oversight. Financial management systems must meet the requirements as described 2 CFR 200 which include, but are not limited to, the following:

- Records that identify adequately the source and application of funds for federally-funded activities.
- Effective control over, and accountability for, all funds, property, and other assets.
- Comparison of expenditures with budget amounts for each Federal award.
- Written procedures to implement payment requirements.
- Written procedures for determining cost allowability.
- Written procedures for financial reporting and monitoring.

14. Intergovernmental Review

Executive Order 12372 does not apply to this program.

15. 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 Code of Federal Regulations (CFR) section 3.908 to the award and requires that recipients 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.

16. Copyright Interests Provisions

This provision is intended to ensure that the public has access to the results and accomplishments of public health activities funded by CDC. Pursuant to applicable grant regulations and CDC's Public Access Policy, Recipient agrees to submit into the National Institutes of Health (NIH) Manuscript Submission (NIHMS) system an electronic version of the final, peer-reviewed manuscript of any such work developed under this award upon acceptance for publication, to be made publicly available no later than 12 months after the official date of publication. Also at the time of submission, Recipient and/or the Recipient's submitting author must specify the date the final manuscript will be publicly accessible through PubMed Central (PMC). Recipient and/or Recipient's submitting author must also post the manuscript through PMC within twelve (12) months of the publisher's official date of final publication; however the author is strongly encouraged to make the subject manuscript available as soon as possible. The recipient must obtain prior approval from the CDC for any exception to this provision.

The author's final, peer-reviewed manuscript is defined as the final version accepted for journal publication, and includes all modifications from the publishing peer review process, and all graphics and supplemental material associated with the article. Recipient and its submitting authors working under this award are responsible for ensuring that any publishing or copyright agreements concerning submitted articles reserve adequate right to fully comply with this provision and the license reserved by CDC. The manuscript will be hosted in both PMC and the CDC Stacks institutional repository system. In progress reports for this award, recipient must identify publications subject to the CDC Public Access Policy by using the applicable NIHMS identification number for up to three (3) months after the publication date and the PubMed

Central identification number (PMCID) thereafter.

17. Funding Restrictions

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

- Recipients may not use funds for research.
- Recipients may not use funds for clinical care except as allowed by law.
- Recipients may use funds only for reasonable program purposes, including personnel, travel, supplies, and services.
- Generally, recipients 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 generally is not allowed, unless the CDC provides written approval to the recipient.
- 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 Additional Requirement (AR) 12 for detailed guidance on this prohibition and additional guidance on lobbying for CDC recipients.
- 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.
- In accordance with the United States Protecting Life in Global Health Assistance policy, all non-governmental organization (NGO) applicants acknowledge that foreign NGOs that receive funds provided through this award, either as a prime recipient or subrecipient, are strictly prohibited, regardless of the source of funds, from performing abortions as a method of family planning or engaging in any activity that promotes abortion as a method of family planning, or to provide financial support to any other foreign non-governmental organization that conducts such activities. See Additional Requirement (AR) 35 for applicability (https://www.cdc.gov/grants/additionalrequirements/ar-35.html).

Recipients may not use funds to purchase HIV Pre-exposure Prophylaxis (PrEP) medications or medications for expedited partner therapy (EPT) for STDs.

Recipients may not use funds to purchase STD medications or to support STD clinical services.

18. Data Management Plan

As identified in the Evaluation and Performance Measurement section, applications involving data collection must include a Data Management Plan (DMP) as part of their evaluation and performance measurement plan. The DMP is the applicant's assurance of the quality of the public health data through the data's lifecycle and plans to deposit data in a repository to preserve and to make the data accessible in a timely manner. See web link for additional information:
https://www.cdc.gov/grants/additionalrequirements/ar-25.html

19. Other Submission Requirements

a. Electronic Submission:

Applications must be submitted electronically by using the forms and instructions posted for this notice of funding opportunity at www.grants.gov. Applicants can complete the application package using Workspace, which allows forms to be filled out online or offline. All application attachments must be submitted using a PDF file format. Instructions and training for using Workspace can be found at www.grants.gov under the "Workspace Overview" option.
If Internet access is not available or if the forms cannot be accessed online, applicants may contact the OGS TIMS staff at 770- 488-2700 or by e-mail at ogstims@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 OGS 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 NOFO. 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 Grants.gov Online User Guide.

https:// www.grants.gov/help/html/help/index.htm? callingApp=custom#t=
Get_Started%2FGet_Started. htm

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@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@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 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 received via e-mail to the GMS/GMO listed below 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, OGS 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 1 Review
All applications will be initially reviewed for eligibility and completeness by CDC Office of Grants Services. Complete applications will be reviewed for responsiveness by the Grants Management Officials and Program Officials. Non-responsive applications will not advance to Phase II review. Applicants will be notified that their applications did not meet eligibility and/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
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.

i. Approach	Maximum Points:25

Evaluate the extent to which the applicant:

a. Presents outcomes that are consistent with the project period outcomes described in the STD Surveillance Network (SSuN) Project Description and logic model. (**Maximum 5 Points**)
b. Describes an overall strategy and activities consistent with the STD Surveillance Network (SSuN) Project Description and logic model. (**Maximum 5 Points**)
c. Shows that the proposed use of funds is an efficient and effective way to implement activities required for Strategies A & B and achieve the project period outcomes. (**Maximum 5 Points**)
d. Presents a work plan that is aligned with the required activities, outcomes, and performance measures for Strategies A & B in the approach, describes activities proposed for at least one, and not more than five surveillance focus activities under Strategy C and is consistent with the content and format proposed by CDC. (**Maximum 10 Points**)

ii. Evaluation and Performance Measurement	Maximum Points:25

Evaluate the extent to which the applicant:

a. Describes clear monitoring and evaluation procedures and how evaluation and performance measurement will be incorporated into planning, implementation, and reporting of project activities. (**Maximum 15 Points**)
b. Describes any evaluation studies they are to undertake. Describe in sufficient detail to identify the key evaluation questions, and data sources and analysis methods.(**Maximum 10 Points**)

iii. Applicant's Organizational Capacity to Implement the Approach	Maximum Points:50

Evaluate the extent to which the applicant:

1. Demonstrates that collaborating STD clinics will provide a census of patients with sufficient identifying information to accomplish HIV surveillance registry matching:
    a. **Maximum 15 points** if applicants clearly document STD clinic willingness provide information on a census of all patients for HIV registry matching and document at least one clinic site with >5,000 visits annually with included MOA(s)/MOU(s) or Letter(s) of Collaboration;
    b. **Maximum 10 points** if proposed clinics will only provide information on a subset of patients for HIV registry matching and document at least one clinic site with >5,000 visits annually through MOA(s)/MOU(s) or Letter(s) of

Collaboration;

c. **No (0) points** if documentation on clinic intention to share information for matching to HIV surveillance registry is not clearly present, or applicants fail to document at least one clinic site with >5,000 visits annually, and/or MOA(s)/MOU(s) or Letter(s) of Collaboration from proposed STD clinics are not included with the application.

2. Demonstrates sufficient expert-level data management and informatics capacity to successfully implement all proposed strategies and activities. Do they specifically identify advanced SAS programming and other relevant database and data management skills? Are sufficient FTE allocated for the described level of effort? Do CVs/Resumes included for data management staff match described capacity? (**Maximum 6 Points**)
3. Demonstrates sufficient capacity to successfully conduct enhanced investigations on all randomly sampled gonorrhea cases in the first year, either through centrally hired staff or through contract with counties or other collaborating partners. Do they specifically identify interviewer training, background and/or prior experience relevant to conducting confidential patient investigations? Are sufficient FTE allocated for the described level of effort with sufficient flexibility to allow for interview capacity outside of normal business hours? (**Maximum 6 Points**)
4. Demonstrates the ability to assess, survey, interview or enroll patients in studies or investigations without financial compensation with a success rate of 65% or greater. (**Maximum 7 Points**)
5. Includes CVs/Resumes or position descriptions for patient interviewer staff matching the desired experience. (**Maximum 2 Points**)
6. Demonstrates leadership and analytic support by scientific staff at the master's or higher degree level (epidemiologists, clinicians, etc.; documented in CVs/Resumes). Are sufficient FTE allocated for supervising, monitoring and evaluating proposed activities? Are sufficient analytic resources available for local analysis, interpretation and dissemination of findings? Are sufficient analytic resources available for collaboration with CDC in analysis and dissemination of findings at the national level? (**Maximum 3 Points**)
7. Organizational chart(s) clearly situate the proposed project within the larger organization/agency and demonstrates realistic collaborations between STD programs and HIV surveillance units. (**Maximum 1 Point**)

Budget

Reviewed but not scored: Assess the extent to which the applicant's budget aligns with the proposed work plan.

c. Phase III Review

An Objective Review will be performed on eligible applications; applications will be ranked based on application scores and funding awarded in rank order. The following factors also may affect the final funding decision:

- The need for geographic diversity.

- The importance of including high STD morbidity areas and higher-volume STD clinics.
- The importance of including populations disproportionately affected by STDs.

These factors will not affect scoring or placement on the ranking list. CDC will provide justification for any decision to fund out of rank order.

Review of risk posed by applicants.
Prior to making a Federal award, CDC is required by 31 U.S.C. 3321 and 41 U.S.C. 2313 to review information available through any OMB-designated repositories of government-wide eligibility qualification or financial integrity information as appropriate. See also suspension and debarment requirements at 2 CFR parts 180 and 376.
In accordance 41 U.S.C. 2313, CDC is required to review the non-public segment of the OMB-designated integrity and performance system accessible through SAM (currently the Federal Recipient Performance and Integrity Information System (FAPIIS)) prior to making a Federal award where the Federal share is expected to exceed the simplified acquisition threshold, defined in 41 U.S.C. 134, over the period of performance. At a minimum, the information in the system for a prior Federal award recipient must demonstrate a satisfactory record of executing programs or activities under Federal grants, cooperative agreements, or procurement awards; and integrity and business ethics. CDC may make a Federal award to a recipient who does not fully meet these standards, if it is determined that the information is not relevant to the current Federal award under consideration or there are specific conditions that can appropriately mitigate the effects of the non-Federal entity's risk in accordance with 45 CFR §75.207.
CDC's framework for evaluating the risks posed by an applicant may incorporate results of the evaluation of the applicant's eligibility or the quality of its application. If it is determined that a Federal award will be made, special conditions that correspond to the degree of risk assessed may be applied to the Federal award. The evaluation criteria is described in this Notice of Funding Opportunity.
In evaluating risks posed by applicants, CDC will use a risk-based approach and may consider any items such as the following:
(1) Financial stability;
(2) Quality of management systems and ability to meet the management standards prescribed in this part;
(3) History of performance. The applicant's record in managing Federal awards, if it is a prior recipient of Federal awards, including timeliness of compliance with applicable reporting requirements, conformance to the terms and conditions of previous Federal awards, and if applicable, the extent to which any previously awarded amounts will be expended prior to future awards;
(4) Reports and findings from audits performed under subpart F 45 CFR 75 or the reports and findings of any other available audits; and
(5) The applicant's ability to effectively implement statutory, regulatory, or other requirements imposed on non-Federal entities.
CDC must comply with the guidelines on government-wide suspension and debarment in 2 CFR part 180, and require non-Federal entities to comply with these provisions. These provisions restrict Federal awards, subawards and contracts with certain parties that are

debarred, suspended or otherwise excluded from or ineligible for participation in Federal programs or activities.

2. Announcement and Anticipated Award Dates

Anticipated award notification: Between August 1, 2019 and September 1, 2019

Anticipated award date: August 15, 2019

F. Award Administration Information

1. Award Notices

Recipients will receive an electronic copy of the Notice of Award (NOA) from CDC OGS. The NOA shall be the only binding, authorizing document between the recipient and CDC. The NOA will be signed by an authorized GMO and emailed to the Recipient Business Officer listed in application and the Program Director.

Any applicant awarded funds in response to this Notice of Funding Opportunity 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

Recipients must comply with the administrative and public policy requirements outlined in 45 CFR Part 75 and the HHS Grants Policy Statement, as appropriate.
Brief descriptions of relevant provisions are available at http://www.cdc.gov/grants/additionalrequirements/index.html#ui-id-17.
The HHS Grants Policy Statement is available at http://www.hhs.gov/sites/default/files/grants/grants/policies-regulations/hhsgps107.pdf.

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

AR-4: HIV/AIDS Confidentiality Provisions

AR-9: Paperwork Reduction Act Requirements

AR-10: Smoke-Free Workplace Requirements

AR-12: Lobbying Restrictions

AR-14: Accounting System Requirements

AR-24: Health Insurance Portability and Accountability Act Requirements

AR-25: Data Management and Access

AR-34: Language Access for Persons with Limited English Proficiency

Participation in CDC-sponsored recipient meetings, conference calls and webinars, as

determined by CDC staff is mandatory. All recipients are required to attend an annual, in-person project meeting and are to include budget allocations consistent with this requirement. These allocations will be reviewed and approved annually as a part of the award continuation process. Failure to attend the mandated meetings (regardless of financial or administrative crisis at the recipient agency) shall be cause for a determination of reduction in travel funding.

The full text of the Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards, 45 CFR 75, can be found at: https://www.ecfr.gov/cgi-bin/text-idx?node=pt45.1.75

3. Reporting

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

- Helps target support to recipients;
- Provides CDC with periodic data to monitor recipient progress toward meeting the Notice of Funding Opportunity outcomes and overall performance;
- Allows CDC to track performance measures and evaluation findings for continuous quality and program improvement throughout the period of performance 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 NOFO.

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 NOFO copying the CDC Project Officer.

The recipient evaluation and performance measurement plan, including data management plan, guide evaluation-related technical assistance and guidance for performance measures.

Annual progress reports will provide critical information on successes, challenges, progress, and changes experienced by individual recipients as well as for the program as a whole. Information from those reports will be synthesized to identify crosscutting challenges and success, guide technical support, and inform reports that CDC produces for stakeholders. CDC will also produce summaries of progress reports to share with recipients, in order to stimulate information-sharing among recipients.

The financial forms are essential to tracking how the funds obligated through this program are spent and for planning future allocations.

Report	When?	Required?
Recipient Evaluation and Performance Measurement	6 months into award	Yes

Plan		
Annual Performance Report (APR)	No later than 120 days before end of budget period. Serves as yearly continuation application.	Yes
Federal Financial Reporting Forms	90 days after the end of the budget period.	Yes
Final Performance and Financial Report	90 days after end of project period.	Yes
Payment Management System (PMS) Reporting	Quarterly reports due January 30; April 30; July 30; and October 30.	Yes

a. Recipient Evaluation and Performance Measurement Plan (required)
With support from CDC, recipients must elaborate on their initial applicant evaluation and performance measurement plan. This plan must be no more than 20 pages; recipients must submit the plan 6 months into the award. HHS/CDC will review and approve the recipient's monitoring and evaluation plan to ensure that it is appropriate for the activities to be undertaken as part of the agreement, for compliance with the monitoring and evaluation guidance established by HHS/CDC, or other guidance otherwise applicable to this Agreement.

Recipient Evaluation and Performance Measurement Plan (required): This plan should provide additional detail on the following:

Performance Measurement

• Performance measures and targets
• The frequency that performance data are to be collected.
• How performance data will be reported.
• How quality of performance data will be assured.
• How performance measurement will yield findings to demonstrate progress towards achieving NOFO goals (e.g., reaching target populations or achieving expected outcomes).
• Dissemination channels and audiences.
• Other information requested as determined by the CDC program.

Evaluation

• The types of evaluations to be conducted (e.g. process or outcome evaluations).
• The frequency that evaluations will be conducted.
• How evaluation reports will be published on a publically available website.
• How evaluation findings will be used to ensure continuous quality and program improvement.
• How evaluation will yield findings to demonstrate the value of the NOFO (e.g., effect on improving public health outcomes, effectiveness of NOFO, cost-effectiveness or cost-benefit).
• Dissemination channels and audiences.

HHS/CDC or its designee will also undertake monitoring and evaluation of the defined activities within the agreement. The recipient must ensure reasonable access by HHS/CDC or its designee to all necessary sites, documentation, individuals and information to monitor, evaluate and verify the appropriate implementation the activities and use of HHS/CDC funding under this Agreement.

b. Annual Performance Report (APR) (required)

The recipient must submit the APR via www.Grantsolutions.gov no later than120 days prior to the end of the budget period. This report must not exceed 45 pages excluding administrative reporting. Attachments are not allowed, but web links are allowed.
This report must include the following:

- **Performance Measures:** Recipients must report on performance measures for each budget period and update measures, if needed.
- **Evaluation Results:** Recipients must report evaluation results for the work completed to date (including findings from process or outcome evaluations).
- **Work Plan:** Recipients must update work plan each budget period to reflect any changes in period of performance outcomes, activities, timeline, etc.
- **Successes**
    - Recipients must report progress on completing activities and progress towards achieving the period of performance outcomes described in the logic model and work plan.
    - Recipients must describe any additional successes (e.g. identified through evaluation results or lessons learned) achieved in the past year.
    - Recipients must describe success stories.
- **Challenges**
    - Recipients must describe any challenges that hindered or might hinder their ability to complete the work plan activities and achieve the period of performance outcomes.
    - Recipients must describe any additional challenges (e.g., identified through evaluation results or lessons learned) encountered in the past year.
- **CDC Program Support to Recipients**
    - Recipients must describe how CDC could help them overcome challenges to complete activities in the work plan and achieving period of performance 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.

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 recipients must submit the Annual Performance Report via www.Grantsolutions.gov no later than 120 days prior to 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 recipients 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 90 days after the end of the budget period. 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, recipients are required to submit a letter of explanation to OGS 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 period of performance. CDC programs must indicate that this report should not exceed 40 pages. This report covers the entire period of performance and can include information previously reported in APRs. At a minimum, this report must include the following:

- Performance Measures – Recipients must report final performance data for all process and outcome performance measures.
- Evaluation Results – Recipients must report final evaluation results for the period of performance for any evaluations conducted.

- Impact/Results/Success Stories – Recipients 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.
- A final Data Management Plan that includes the location of the data collected during the funded period, for example, repository name and link data set(s)
- Additional forms as described in the Notice of Award (e.g., Equipment Inventory Report, Final Invention Statement).

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

Federal Funding Accountability and Transparency Act of 2006 (FFATA), P.L. 109–282, as amended by section 6202 of P.L. 110–252 requires full disclosure of all entities and organizations receiving Federal funds including awards, contracts, loans, other assistance, and payments through a single publicly accessible Web site, http://www.USASpending.gov. Compliance with this law is primarily the responsibility of the Federal agency. However, two elements of the law require information to be collected and reported by applicants: 1) information on executive compensation when not already reported through the SAM, and 2) similar information on all sub-awards/subcontracts/consortiums over $25,000.
For the full text of the requirements under the FFATA and HHS guidelines, go to:

- https://www.gpo.gov/fdsys/pkg/PLAW-109publ282/pdf/PLAW-109publ282.pdf,
- https://www. fsrs.gov/documents /ffata_legislation_ 110_252.pdf
- http://www.hhs.gov/grants/grants/grants-policies-regulations/index.html#FFATA.

5. Reporting of Foreign Taxes (International/Foreign projects only)

A. Valued Added Tax (VAT) and Customs Duties – Customs and import duties, consular fees, customs surtax, valued added taxes, and other related charges are hereby authorized as an allowable cost for costs incurred for non-host governmental entities operating where no applicable tax exemption exists. This waiver does not apply to countries where a bilateral agreement (or similar legal document) is already in place providing applicable tax exemptions and it is not applicable to Ministries of Health. Successful applicants will receive information on VAT requirements via their Notice of Award.

B. The U.S. Department of State requires that agencies collect and report information on the amount of taxes assessed, reimbursed and not reimbursed by a foreign government against commodities financed with funds appropriated by the U.S. Department of State, Foreign Operations and Related Programs Appropriations Act (SFOAA) (“United States foreign assistance funds”). Outlined below are the specifics of this requirement:

1) Annual Report: The recipient must submit a report on or before November 16 for each foreign country on the amount of foreign taxes charged, as of September 30 of the same year, by a foreign government on commodity purchase transactions valued at 500 USD or more financed with United States foreign assistance funds under this grant during the prior United States fiscal year (October 1 – September 30), and the amount reimbursed and unreimbursed by

the foreign government. [Reports are required even if the recipient did not pay any taxes during the reporting period.]

2) Quarterly Report: The recipient must quarterly submit a report on the amount of foreign taxes charged by a foreign government on commodity purchase transactions valued at 500 USD or more financed with United States foreign assistance funds under this grant. This report shall be submitted no later than two weeks following the end of each quarter: April 15, July 15, October 15 and January 15.

3) Terms: For purposes of this clause:
"Commodity" means any material, article, supplies, goods, or equipment;
"Foreign government" includes any foreign government entity;
"Foreign taxes" means value-added taxes and custom duties assessed by a foreign government on a commodity. It does not include foreign sales taxes.

4) Where: Submit the reports to the Director and Deputy Director of the CDC office in the country(ies) in which you are carrying out the activities associated with this cooperative agreement. In countries where there is no CDC office, send reports to VATreporting@cdc.gov.

5) Contents of Reports: The reports must contain:
a. recipient name;
b. contact name with phone, fax, and e-mail;
c. agreement number(s) if reporting by agreement(s);
d. reporting period;
e. amount of foreign taxes assessed by each foreign government;
f. amount of any foreign taxes reimbursed by each foreign government;
g. amount of foreign taxes unreimbursed by each foreign government.

6) Subagreements. The recipient must include this reporting requirement in all applicable subgrants and other subagreements.

G. Agency Contacts

CDC encourages inquiries concerning this notice of funding opportunity.

Program Office Contact

For programmatic technical assistance, contact:

Mark Stenger, Project Officer
Department of Health and Human Services
Centers for Disease Control and Prevention
Division of STD Prevention

1600 Clifton Road NE, Mailstop US12-2

Atlanta, GA 30329-4027

Telephone: 404.639.8260
Email: mstenger@cdc.gov

Grants Staff Contact

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

Constance Jarvis, Grants Management Specialist
Department of Health and Human Services
Office of Grants Services
2920 Brandywine Rd

Atlanta, GA 30341

Telephone: (770) 488-5859
Email: abq3@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 Office of Financial Resources
Office of Grants Services
2920 Brandywine Road, MS E-14
Atlanta, GA 30341
Telephone: 770-488-2700
Email: ogstims@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
- Report on Programmatic, Budgetary and Commitment Overlap

- Table of Contents for Entire Submission

For international NOFOs:

- SF424
- SF424A
- Funding Preference Deliverables

Optional attachments, as determined by CDC programs:

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

The following attachments are required:

1) Documentation of STD/HIV surveillance authority (named as SurveillanceAuthority.pdf)

2) MOU/MOA from STD Program (named as STDProgramMOU.pdf)

3) MOU/MOA from HIV surveillance program concurring with HIV registry matching activities (named as RegistryMatching.pdf)

4) MOU/MOA/LOC for collaborating STD clinics (aggregated, named as STDclinic.pdf)

5) MOU/MOA/Certification from the Overall Responsible Party specifying that all activities and data management plans comply with NCHHSTP Data Security and Confidentiality Guidelines (named as ORPCert.pdf)

6) Resumes or Curriculum Vitaes for key staff, including Principal Investigator, project epidemiologist(s), data manager(s) (named as CVsResumes.pdf)

7) Organizational charts (named as OrganizationalChart.pdf)

The following attachments may be included, as needed:

8) Documentation of proxy authority from state/county/city health department for STD surveillance (named as Proxy.pdf)

For this NOFO, the Project Narrative should not exceed 20 pages (single-spaced, 12-point font), including the work plan (table and/or narrative format). Any application content beyond this

maximum will not be reviewed.

Additional resources for completing this application can be found at: https://www.cdc.gov/std/funding/SSuN/default.htm

References cited in the Background Section:

[1] Centers for Disease Control and Prevention. Sexually Transmitted Diseases Surveillance, 2017. Atlanta, GA: Department of Health and Human Services, 2018. (https://www.cdc.gov/std/stats17/default.htm)

[2] Owusu-Edusei K, Jr., Chesson HW, Gift TL, Tao G, Mahajan R, Ocfemia MC, Kent CK. The estimated direct medical cost of selected sexually transmitted infections in the United States, 2008. Sex Transm Dis 2013;40(3):197-201.

[3] Rietmeijer, C. A., J. Donnelly, K. T. Bernstein, J. M. Bissette, S. Martins, P. Pathela, J. A. Schillinger, M. Stenger, H. S. Weinstock, and L. M. Newman. "Here Comes the SSuN: Early Experiences with the STD Surveillance Network." Public Health Reports. Association of Schools of Public Health, 2009. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2775403/ .

[4] CDC-RFA-PS13-1306: STD Surveillance Network (SSuN) https://www.cdc.gov/std/ssun/default.htm

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 75 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 NOFO; recipients must comply with the ARs listed in the NOFO. To view brief descriptions of relevant provisions, see http:// www.cdc.gov/ grants/ additional requirements/ index.html. Note that 2 CFR 200 supersedes the administrative requirements (A-110 & A-102), cost principles (A-21, A-87 & A-122) and audit requirements (A-50, A-89 & A-133).
Approved but Unfunded: Approved but unfunded refers to applications recommended for approval during the objective review process; however, they were not recommended for funding by the program office and/or the grants management office.
Assitance Listings (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.
Assistance Listings (CFDA) Number: A unique number assigned to each program and NOFO throughout its lifecycle that enables data and funding tracking and transparency
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.
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 period of performance (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 recipients. It may include the value of allowable third-party, in-kind contributions, as well as expenditures by the recipient.
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 NOFO evaluation plan is used to describe how the recipient 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.
Health Equity: Striving for the highest possible standard of health for all people and giving special attention to the needs of those at greatest risk of poor health, based on social conditions.
Health Inequities: Systematic, unfair, and avoidable differences in health outcomes and their determinants between segments of the population, such as by socioeconomic status (SES), demographics, or geography.
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: https://www.whitehouse.gov/wp-content/uploads/2017/11/Intergovernmental_-Review-_SPOC_01_2018_OFFM.pdf.

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 activitIes; 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.
Period of performance –formerly known as the project period - : The time during which the recipient may incur obligations to carry out the work authorized under the Federal award. The start and end dates of the period of performance must be included in the Federal award.
Period of Performance Outcome: An outcome that will occur by the end of the NOFO's funding period
Plain Writing Act of 2010: The Plain Writing Act of 2010 requires that federal agencies use clear communication that the public can understand and use. NOFOs must be written in clear, consistent language so that any reader can understand expectations and intended outcomes of the funded program. CDC programs should use NOFO plain writing tips when writing NOFOs.
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 NOFO; can be either a project officer, program manager, branch chief, division leader, policy official, center leader, or similar staff member.
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.
Social Determinants of Health: Conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.
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 period of performance 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.

NOFO-specific Glossary and Acronyms

CT: Chlamydia trachomatis (chlamydia)

EHR: electronic health record

GC: Neisseria gonorrhoeae (gonorrhea)

HIV: Human immunodeficiency virus

HL7: Health Level Seven International standards for the exchange, integration, sharing and retrieval of electronic health information.

LGV: Lymphogranuloma venereum

LOC: Letter of collaboration

PEP: Post-exposure prophylaxis

PrEP: Pre-exposure prophylaxis

STD: Sexually Transmitted Disease

STD-PCHD: Strengthening STD Prevention and Control for Health Departments (STD PCHD, CDC-RFA-PS19-1901)

TA: Technical assistance