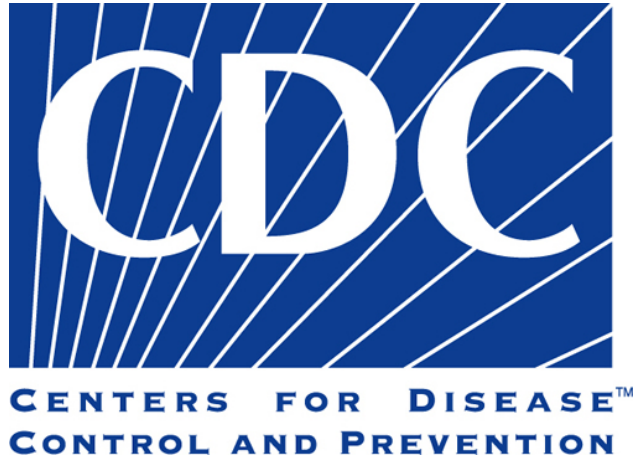




Centers for Disease Control and Prevention

NATIONAL CENTER FOR HIV, VIRAL HEPATITIS, STD AND TB PREVENTION

Sexually Transmitted Infection Surveillance Network (SSuN) Cycle 5

CDC-RFA-PS-24-0082

05/15/2024

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Part I. Overview

Applicants must go to the synopsis page of this announcement at www.grants.gov and click on the "Subscribe" button link to ensure they receive notifications of any changes to CDC-RFA-PS-24-0082. 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:

Sexually Transmitted Infection Surveillance Network (SSuN) Cycle 5

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 purposes of this NOFO, research is defined as set forth in 45 CFR 75.2 and, for further clarity, as set forth in 42 CFR 52.2 (see eCFR :: 45 CFR 75.2 -- Definitions and <https://www.gpo.gov/fdsys/pkg/CFR-2007-title42-vol1/pdf/CFR-2007-title42-vol1-sec52-2.pdf>). In addition, for purposes of research involving human subjects and available exceptions for public health activities, please see 45 CFR 46.102(l) ([https://www.ecfr.gov/current/title-45/subtitle-A/subchapter-A/part-46/subpart-A/section-46.102#p-46.102\(l\)](https://www.ecfr.gov/current/title-45/subtitle-A/subchapter-A/part-46/subpart-A/section-46.102#p-46.102(l))).

D. Agency Notice of Funding Opportunity Number:

CDC-RFA-PS-24-0082

E. Assistance Listings Number:

93.977

F. Dates:

1. Due Date for Letter of Intent (LOI):

04/01/2024

2. Due Date for Applications:

05/15/2024

11:59 p.m. U.S. Eastern Standard Time, at www.grants.gov.

3. Due Date for Informational Conference Call:

Two identical informational webinars will be hosted:

1. March 12, 2024, 9:00-10:00am, EST: <https://cdc.zoomgov.com/meeting/register/vJltf-6hrDwoHPMDngA1rUSVYdedNzG0FHI>
2. March 14, 2024, 3:30-4:30pm, EST: https://cdc.zoomgov.com/meeting/register/vJltceGorD8jEqm0uYInyVM9n_y3HT3Ikac

G. Executive Summary:

1. Summary Paragraph

CDC announces availability of fiscal year 2024 funding for cooperative agreements for Cycle 5 of the STI Surveillance Network (SSuN). Continuing resurgence of STIs, along with the imperative to implement syndemic approaches to surveillance addressing related epidemics such as HIV and mpox inform this competitive Notice of Funding Opportunity (NOFO), which will support sentinel and enhanced surveillance at the local, state, and national level. Emergent issues of concern such as mpox add urgency to the maintenance of robust surveillance at the community level and in sexual health clinical settings. This NOFO supports two core and one supplemental strategy. Strategy A supports sentinel surveillance in sexual health clinical facilities, Strategy B implements enhanced surveillance for STIs reported to health departments and Strategy C supports limited supplemental projects. Both core strategies (A & B) integrate a syndemic approach to monitoring STIs, HIV, behavioral data, and preventive services accessed by persons presenting for care in sexual health settings, and persons diagnosed and reported with selected STIs from all provider settings in defined geographic areas. The goal of this NOFO is to monitor trends in patient characteristics, screening, and diagnoses to identify opportunities and gaps across the STI/HIV prevention continuum. Protocols address information gaps in routine case reporting and incorporate local flexibility to respond to emergent health issues.

a. Eligible Applicants:

Open Competition

b. Funding Instrument Type:

CA (Cooperative Agreement)

c. Approximate Number of Awards

30

d. Total Period of Performance Funding:

\$40,000,000

Up to \$40,000,000; contingent on the availability of federal funding.

e. Average One Year Award Amount:

\$266,666

Range of individual awards: \$130,000 to \$720,000 per award depending on patient census, morbidity levels, specific strategies proposed and number of STI/Sexual Health clinics included.

f. Total Period of Performance Length:

5 year(s)

g. Estimated Award Date:

August 15, 2024

h. Cost Sharing and / or Matching Requirements:

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.

Part II. Full Text

A. Funding Opportunity Description

1. Background

a. Overview

In 2022, more than 2.5 million cases of syphilis, gonorrhea and chlamydia were reported to CDC representing an increase of 1.9% since 2018. Considering interruptions to sexual health care services related to the COVID-19 pandemic, this increase in reported cases may underestimate the true burden of disease as many infections are asymptomatic and may never be diagnosed and reported to public health authorities. Sexually transmitted infections (STIs) can have long-term health consequences, especially regarding reproductive health. Rates of congenital syphilis continue to surge with over 3,700 cases reported in 2022, an increase of over 900% in the last decade (1-3). STIs represent a significant economic drain on the U.S. healthcare system, with annual costs estimated to be nearly \$16 billion in 2018 (4).

Moreover, persons at risk for or diagnosed with bacterial STIs are at increased risk for acquisition or transmission of HIV, representing overlapping populations essential to national efforts to end the HIV epidemic (5). Successful STI surveillance programs must also recognize the syndemics that affect the people and places disproportionately affected by these infections. Recent emergence and global spread of mpox (6) through overlapping, global sexual networks highlight the importance of improving the surveillance infrastructure for monitoring population-level incidence of STIs, ascertainment of demographic and behavioral characteristics of persons being diagnosed with STIs, and the prevalence of co-infections. It is especially important to systematically measure the uptake of important biomedical interventions such as Pre-Exposure Prophylaxis (PrEP) for HIV, preventive vaccinations for mpox and other viral infections such as Human Papilloma Virus (HPV) and the viral hepatitis, antimicrobial treatments, and the use of post-exposure antibiotic prophylaxis to prevent bacterial STIs.

Significant inequities in the burden of STIs in the U.S., including differential access to and utilization of preventive services by racial, ethnic and gender/sexual minority populations (GSM), have also been documented (7). Additional demographic, socioeconomic, and behavioral information on patients presenting for care and for persons diagnosed and reported with STIs is needed to better characterize the extent of these disparities and to inform timely efforts to ensure equitable sexual health outcomes across all U.S. populations.

This new, competitive NOFO builds upon and expands, participation in a geographically diverse network of clinical and public health partners implementing syndemic approaches to enhanced and sentinel STI surveillance. This approach recognizes that disease risks cross-cut multiple diseases and conditions, as well as the social contexts in which they occur, often resulting in worse outcomes such as increased transmission, morbidity, and exacerbation of existing health inequities. Data obtained through this surveillance initiative are critical to understanding changing risk patterns, detecting emergent, re-emergent or novel infections and sequelae, and informing both local and national STI/HIV control and prevention efforts. This NOFO also seeks to maximize the synergies offered through Ending the HIV Epidemic in the US (EHE) and to provide substantial integration with respect to surveillance activities in sexual health clinical settings to better characterize patient-level co-factors that may facilitate, or present barriers to, the uptake of HIV prevention interventions such as HIV PrEP.

b. Statutory Authorities

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

c. Healthy People 2030

This project addresses the “Healthy People 2030” topic area of Sexually Transmitted Diseases: <https://health.gov/healthypeople/objectives-and-data/browse-objectives/sexually-transmitted-infections>, <https://health.gov/healthypeople>, also addresses the priority areas of Health Equity and the Social Determinants of Health and objectives related to LGBTQ+ (<https://health.gov/healthypeople/objectives-and-data/browse-objectives/lgbt>) population health, improving health care (<https://health.gov/healthypeople/objectives-and-data/browse-objectives/health-care>), and Public Health Infrastructure (<https://health.gov/healthypeople/objectives-and-data/browse-objectives/public-health-infrastructure>).

d. Other National Public Health Priorities and Strategies

This project is responsive to the following priorities:

STI National Strategic Plan (<https://www.hhs.gov/programs/topic-sites/sexually-transmitted-infections/plan-overview/index.html>),

NCHHSTP Strategic Plan (<https://www.cdc.gov/nchhstp/strategicpriorities/default.htm>)

Division of STD Prevention 2022 – 2026 Strategic Plan: ([Division of STD Prevention Strategic Plan 2022-2026](#))

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

National HIV/AIDS Strategy (<https://www.hiv.gov/federal-response/national-hiv-aids-strategy/national-hiv-aids-strategy-2022-2025/>),

Ending the HIV Epidemic in the U.S. (<https://www.cdc.gov/endinghiv/index.html>).

e. Relevant Work

This NOFO expands and builds on the foundation of sentinel and enhanced surveillance currently funded under CDC-RFA-PS19-1907 (STD Surveillance Network), programmatic activities funded under CDC-RFA-PS20-2010 (Ending the HIV Epidemic, EHE), PS18-1802 (Integrating HIV Surveillance and Prevention Programs for Health Departments) and CDC-RFA-PS19-1901 (STD Prevention and Control for Health Departments). Additional work under CDC-RFA-TP22-2201 Public Health Crisis Response Cooperative Agreement for mpox also informs this current funding opportunity.

2. CDC Project Description

a. Approach

Bold indicates period of performance outcome.

Strategies and Activities	Short-Term Outcomes	Intermediate Outcomes	Long-Term Outcomes
(A) Protocol-based sentinel surveillance in STI/Sexual Health Clinics: 1. Systematic abstraction of patient and visit-level data from electronic health records (EHRs) 2. Systematic abstraction of diagnoses, treatments, vaccinations, prophylaxis, and laboratory data from EHRs 3. Periodic patient surveys 4. Routine, frequent	(1.1) Improved ascertainment of patient characteristics, STI/HIV-risk and repeat infections (1.2) Improved ascertainment of patient-level eligibility for and uptake of STI/HIV/mpox preventive services (1.3) Improved timeliness, data completeness and data quality (1.4) Timely availability of findings informing	(2.1) Increased data-driven, evidence-based public health action (2.2) Timely, comprehensive ascertainment of HIV/STI/mpox specific clinical and preventive services in STI/Sexual Health clinical settings (2.3) Improved understanding of barriers to preventive STI services, sexual health clinical care and provider-based HIV and STI prevention interventions (2.4) Improved ascertainment of adverse outcomes and negative	(3.1) Improved quality of care in STI/Sexual Health clinical care settings (3.2) Improved provider compliance with STI/HIV/mpox screening, preventive services, and CDC treatment guidelines (3.3) Improved patient access to preventive STI services, sexual health clinical care and provider-based HIV and STI prevention interventions

patient-based matching with state HIV surveillance records	STI/HIV/mpox control and prevention policy	sequela of STIs by STI Programs and Clinics	(3.4) Improved evidence for developing recommendations, guidelines, and best practices for STI surveillance
(B) Protocol-based enhanced case-based STI surveillance: 1. Systematic collection of enhanced data elements for a full census of reported cases 2. Enhanced case investigations 3. Routine case-based matching with state HIV surveillance records. 4. Provision of technical assistance to state and local STI surveillance and program staff in monitoring and improving STI surveillance data quality	(1.5) Quarterly data quality reporting (1.6) Increased understanding of STI surveillance data by provider, health department and community stakeholders through dissemination of findings in relevant journals, reports, publications, and conferences	(2.5) Improved ascertainment of prescribed/administered treatment(s) (2.6) Improved awareness of disease burden by relevant patient characteristics in community settings (2.7) Improved availability of information on trends in HIV status, HIV care, PrEP, doxy PEP, MenB & mpox vaccination among STI cases diagnosed in community settings (2.8) Improved STI surveillance systems and methods	(3.5) Decreased disease incidence and morbidity associated with STI/HIV/mpox

(C) Surveillance Focus Activities: Short-term activities to evaluate methods, monitor STI/HIV testing, diagnosis, treatment, sequelae, and eligibility/uptake of HIV-prevention interventions				i.
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Purpose

The purpose of this NOFO is to support sentinel and enhanced surveillance for STIs providing complete demographics, behavioral risk, clinical and preventive services data missing in routine case reporting or not available from other sources. Surveillance activities funded by this NOFO provide epidemiologic and preventive services information filling gaps in knowledge regarding STI/HIV prevention priorities. These data improve the ability of public health agencies to address STI/HIV health equity outcomes, emergent threats and syndemic interactions in populations with shared risks.

ii. Outcomes

Recipients of funding under CDC-RFA-PS-24-0082 are expected to demonstrate full implementation of data collection, data cleaning, data transmission and related output activities in compliance with project protocols in order to address the outcomes appearing in **bold** in the logic model. Datasets constitute the primary outputs supporting achievement of these outcomes and must be routinely and securely transmitted to CDC at specified intervals and in specified formats in compliance with data submission schedules.

Expected outcomes by component Strategy include:

Strategy A: (Protocol-based sentinel surveillance in collaborating STI/Sexual Health Clinics)

- Improved, timely ascertainment of patient characteristics, clinical services, diagnoses, laboratory testing, treatments prescribed/provided to patients.
- Improved, timely ascertainment of HIV, STI and mpox preventive services delivered to patients (e.g., HIV PrEP/ PEP, Doxycycline Post Exposure Prophylaxis[doxy PEP], mpox, Meningococcal B (MenB) and other relevant vaccinations such as HPV and the viral hepatitis).
- Improved provider compliance with screening, treatment, and preventive service recommendations through timely ascertainment and reporting of patient outcomes.
- Improved timeliness, data completeness and data quality through continuous quality assurance activities.
- Improved ability to understand health equity outcomes across multiple demographic and behavioral groups through timely ascertainment and analyses of patient characteristics and outcomes.

Strategy B: (Protocol-based enhanced STI case surveillance in defined geographic areas)

- Improved, timely ascertainment of reported cases of gonorrhea and syphilis.
- Improved ability to estimate patient demographic characteristics, behavioral risk, treatment, and access to (and use of) preventive services through enhanced investigations on a representative sample of reported cases.
- Improved, timely information on HIV co-infection and trends among diagnosed and reported gonorrhea and syphilis cases.
- Improved, timely information on HIV and mpox-related preventive services delivered to persons diagnosed and reported with gonorrhea and/or syphilis.
- Improved provider and community-level compliance with gonorrhea and syphilis treatment recommendations.
- Improved ability to understand community-wide health equity issues across multiple demographic and behavioral groups through timely ascertainment and analyses of patient characteristics and outcomes.
- Improved timeliness, data completeness and data quality through continuous quality assurance activities

Strategy (C): Surveillance Focus Activities

These shorter-duration, limited-scope activities are designed to improve quality and utility of surveillance data and to pilot methods for monitoring the burden of disease, cost, and adverse health outcomes across a range of STIs and laboratory and provider settings. Eligible applicants should also apply for one or more Strategy C activities relevant to the core activities they are proposing in their application (Strategy A or B separately, or both strategies in combination). Strategy C activities may be awarded if funds are available for the initial budget period.

Examples of anticipated/potential outcome and outputs include:

- Improved ability to ascertain and respond to emergent issues of concern in STI surveillance.
- Improved ability to ascertain co-factors affecting access to (and use of) preventive services.
- Enhanced ability to assess, visualize and report on community-level trends in gonorrhea and syphilis diagnosis and treatment using data obtained from enhanced investigations on a representative sample of reported cases.
- Improved ability to integrate, manage, de-duplicate, visualize, interpret and rapidly report on trends in STI-related laboratory and case data using local surveillance data management systems.
- Improved programmatic outcomes through comprehensive evaluation efforts.
- Documented EHR/EMR system requirements and implementation plan.
- Documented EHR/EMR system modifications, datasets, data entry screens, and/or reports.
- Quarterly reporting/monitoring of proportion of eligible patients referred to, initiating, and maintaining HIV PrEP (or dPEP).
- Quarterly reporting/monitoring of proportion of HIV PrEP/doxy PEP users screened for STIs in compliance with guidelines.
- Quarterly reporting/monitoring of proportion of HIV PrEP/doxy PEP users diagnosed with STI(s).

- Quarterly reporting/monitoring of proportion of HIV PrEP/doxy PEP users maintaining HIV PrEP/doxy PEP at quarterly intervals.
- Quarterly reporting/monitoring of proportion of HIV PrEP/doxy PEP users lost to follow-up at quarterly intervals.
- Documented system requirements for adherence support platform and implementation plan.
- Proportion of HIV PrEP patients enrolling and actively using adherence support platform.
- Evaluation of the adherence support platform's user (patient) acceptability and effectiveness.
- Comprehensive analysis of co-factors facilitating HIV PrEP uptake and maintenance.
- Comprehensive analysis of co-factors inhibiting HIV PrEP uptake and maintenance.
- Programmatic recommendations for enhancing HIV PrEP uptake and maintenance among sex and gender minorities and women of color.
- Implementation and evaluation of CDC-provided syphilis automated record search and review algorithm.
- Evaluation of surveillance case definitions for neonatal HSV.
- Peer-reviewed publication(s) or conference presentation(s) based substantially on multi-site SSuN data.

iii. Strategies and Activities

Strategy A – Protocol-based sentinel surveillance in STI/Sexual Health Clinics

All recipients funded for Strategy A of the STI Surveillance Network are required to fully implement sentinel surveillance data abstraction, data collection, data cleaning/formatting, and transmission of data to CDC from one or more specialty STI/Sexual Health clinics in compliance with project protocols (<https://www.cdc.gov/std/ssun/default.htm>) as described below.

For the purposes of this NOFO, STI/Sexual Health clinics are defined as any clinical facility providing timely, comprehensive, confidential, and culturally sensitive STI care as the facility's advertised and usual function, including HIV testing, STI testing at relevant anatomical sites, timely STI treatment (benzathine penicillin LA, and ceftriaxone) and provision of, or referral to, recommended vaccinations (i.e., Hepatitis A and B, Human Papilloma Virus[HPV], mpox). Clinics need not be stand-alone and may be integrated into broader practice settings or may be part of a network with multiple facilities. However, the selected facility must have a specifically identifiable STI/Sexual Health clinic with an annual patient census greater than 2,000 unique patients per facility and have the capacity to identify and extract visit, laboratory, diagnosis, and treatment records from their electronic health records system(s) just for those patients specifically seeking STI/Sexual Health clinical services distinct from their broader patient population.

All Strategy A recipients will be required to prepare and securely transmit to CDC four (4) related datasets six (6) times annually (every two months) as described in Table 1 below in compliance with project protocols. Additionally, all Strategy A recipients are required to collaborate with the appropriate HIV surveillance authority to conduct periodic matches of all individual patients presenting for care in their proposed clinic against their jurisdiction's official HIV surveillance registry to assist in determining the clinic's HIV coinfection rate and the disease status of patients as described in 3.a-b below. Clinics do not necessarily need to have an

administrative relationship with health departments for HIV registry matching collaboration; they may be independent entities but must be willing to provide name-identified patient information to the appropriate HIV surveillance authority for registry matching purposes and document this intention with an MOU/MOA with the HIV surveillance unit. Registry matching must be fully implemented within the initial budget period.

1. Systematic abstraction of patient and visit-level data from electronic health records (EHRs)
 - a. Recipients must identify one or more STI/Sexual Health clinic(s) in their jurisdiction as collaborating partners in sentinel surveillance activities and provide metadata for each clinic documenting policies and current practices for STI screening, STI treatment, doxy PEP, HIV testing, HIV PrEP/PEP initiation, monitoring and/or referral. Where multiple facilities, either in a network or stand-alone, are contributing data to Strategy A, a unique metadata record will be submitted for each separate facility/clinic in specified formats. Metadata for all clinics will be updated annually.
 - b. Recipients must abstract visit-level clinical records for all persons receiving STI/HIV or sexual health services in the collaborating STI/Sexual Health clinics, including all data elements specified in project protocols. Static patient IDs are required and must be preserved throughout the project period. If the applicant is a current (SSuN Cycle 4) recipient, static patient IDs must be maintained between cycles. Recipients will abstract all data elements specified in project protocols including clinical information, data on patient demographics (age, sex, race/ethnicity, sexual orientation, gender identity, etc.), behaviors (gender and number of sex partners, etc.) and preventive services received (provision of dPEP, HIV PrEP/PEP, mpox vaccinations, etc.).
2. Systematic abstraction of diagnoses, treatments, vaccinations, prophylaxis, and laboratory data from EHRs
 - a. Recipients must abstract in a separate, relational file all STI-related laboratory records associated with each unique clinic visit record, including relevant test types, condition tested, specimen type, anatomic site, collection date, and results (qualitative and quantitative) in formats specified in project protocols.
 - b. Recipients must abstract in a separate, relational file all diagnoses associated with each unique visit, including all diagnosis-related data elements, diseases and conditions in formats specified in project protocols.
 - c. Recipients must abstract in a separate, relational file all treatment records associated with each unique visit, including relevant medications/vaccines administered or prescribed, date medication was prescribed/administered method of administration, and dosing schedule (e.g., dosage(s), frequency, and duration) in formats specified in project protocols.
3. Periodic patient surveys
 - a. Recipients must establish an infrastructure to implement periodic patient surveys at the time of service (e.g., in the waiting room or upon registration)
4. Routine, frequent patient-based matching with state HIV surveillance records

- a. Recipients must collaborate with the appropriate local or state HIV surveillance authority to routinely match all patients (regardless of presence or lack of STI or other diagnoses) seen in the clinic against the jurisdiction's HIV case registry (such as the HIV/AIDS Reporting System [eHARS] or similar local, comprehensive HIV case registry). Where person-based matches are established, relevant HIV-related diagnostic and laboratory data (HIV viral loads and CD4+ lymphocyte counts/percents) will be abstracted from HIV surveillance registries and integrated into required visit (A.2) and laboratory datasets (A.3) in formats specified in project protocols. Laboratory records for HIV-specific tests (obtained from the HIV registry) for matching patients are requested for all tests with a specimen collection date for a period of one year prior to the patient's most recent date of visit to the STI clinic.
- b. In collaboration with the relevant health department's HIV Overall Responsible Party (ORP), recipients must ensure that patient name-based identifiers are replaced in all archived datasets with non-name-based unique identifiers; personally identifiable information (PII) must be redacted from datasets prior to transmission to CDC.

Required Activities Supporting Strategy A Implementation:

- a. Recipients must ensure timely and prompt data quality assurance, including recoding source data into required formats, application of CDC-provided edit and data validity checks to datasets and must address all identified data quality issues prior to secure transmission of all required datasets to CDC following protocols and data transmission schedules.
- b. Recipients must be responsive to CDC-provided quality assurance feedback and attempt to correct local records or recoding processes when errors, missing data and/or data validity issues are identified, either through routine reporting or in response to specific analytic priorities.
- c. Recipients must ensure that measures, methods, and processes are developed and implemented within the first budget period to provide for timely local analysis, visualization, reporting and dissemination of findings to relevant clinical, health department and community stakeholders.
- d. STI/Sexual Health Clinical facilities receiving SSuN Strategy A funding that are also funded under CDC-RFA-PS-24-0003 (Support and Scale Up of HIV Prevention Services in Sexual Health Clinics) are required to continue to submit aggregate performance measures required under CDC-RFA-PS-24-0003 until such time as their Strategy A data have been formally validated by CDC. Once Strategy A data have been validated for a participating facility, CDC will notify the recipient and assume responsibility for producing and submitting aggregate reports (for overlapping SSuN data elements) for CDC-RFA-PS-24-0003 as part of an effort to reduce the reporting burden on clinics funded under both initiatives.
- e. Proposals for multi-site analyses, especially those focusing on health equity in HIV/STI preventive services relating to HIV PrEP/PEP, HIV testing and doxy PEP, will be periodically solicited and sent to Strategy A principal investigators for their consideration. Dissemination of findings is a key component of successful surveillance activities. Recipients of Strategy A funding are required to promptly review analytic

proposals and indicate their preference for inclusion of their clinic's data as well as indicate willingness to participate as a co-author in SSuN multi-site analytic projects. Local clearance of resulting manuscripts will be concurrent with submission to CDC clearance. These analyses generally lead to publication in an STI-related academic and/or professional journal or as reviewed abstracts for oral or poster presentations at relevant public health conferences.

- f. Recipients of Strategy A funding (Principal Investigators and key staff) are required to participate in routine, monthly project conference calls with CDC project staff and to support travel for 2-3 project representatives (Principal Investigators and key staff) to attend annual SSuN Principal Investigator's meetings in Atlanta.

Table 1: Datasets required to be abstracted from clinic sources, re-coded, and securely transmitted routinely to CDC by recipients of funding under SSuN Strategy A

Strategy A Dataset(s)	Record Contents	Frequency of Submission
1 - Clinic Visit Records	Line-listed, visit-level data that includes demographics, behavioral, and clinical information consistent with protocol, cumulative from the beginning of the calendar year	Every 2 months
2 - Clinic Laboratory Records	Line-listed STI-related laboratory tests associated with each patient visit in a separate record, consistent with protocol and cumulative from the beginning of the calendar year	Every 2 months
3 - Clinic Diagnosis Records	Line-listed STI-related diagnoses associated with each visit in a separate record, consistent with protocol and cumulative from the beginning of the calendar year	Every 2 months
4 - Clinic Treatment Records	Line-listed medications, vaccines, treatments prescribed, dispensed or administered at each visit in a separate record, consistent with protocol and cumulative from the beginning of the calendar year	Every 2 months
5 - Clinic metadata file	Descripting/services/policy information for each clinic consistent with protocol for that calendar year in separate record	Initial submission, updated annually thereafter
Year-End Datasets (1-5)	Final, cleaned and validated annual cumulative datasets consistent with protocol and containing all records for the previous calendar year. These serve as the primary analytic data.	Due March 15th of each year of the cooperative agreement

Strategy B – Protocol-based enhanced case-based STI surveillance:

All recipients funded for Strategy B of the STI Surveillance Network are required to fully implement enhanced case-based surveillance, case sampling, provider and patient enhanced investigations, HIV registry matching, data cleaning/formatting, and transmission activities in compliance with project protocols (<https://www.cdc.gov/std/ssun/default.htm>) for reported cases of gonorrhea and syphilis (all stages) as described below.

All Strategy B recipients are required to prepare and securely transmit to CDC three (3) related datasets six (6) times annually (every two months) as described in Table 2 below in compliance with project protocols. Additionally, all Strategy B recipients are required to collaborate with the appropriate local or state HIV surveillance authority to match individual patients reported with gonorrhea and syphilis (all stages) against their jurisdiction's official HIV surveillance registry to assist in determining HIV prevalence among reported cases and the disease status of individual cases as described below.

1. Systematic collection of enhanced data elements for a full census of reported cases
 - a. Recipients must implement processes to rapidly identify a random, probability sample of STI cases (gonorrhea and early syphilis cases [primary, secondary, and non-primary/non-secondary cases) reported among residents of their jurisdiction. These processes must allow the flexibility to periodically vary the sampling fraction independently between diseases and geographic sub-units (i.e., counties, if applicable) in their jurisdiction.
 - b. Recipients will collaborate with CDC to conduct routine assessments of their probability sampling method by disease and by geography to ensure that there are no systematic sampling biases and to ensure 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, this should be documented in data submitted in compliance with protocols.
 - c. Recipients must extract, recode, format, and transmit all reported case records from their STI surveillance data management system for all cases of gonorrhea and 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 selection assignment, and all other required data elements per CDC protocols and in appropriate formats and file structures as specified in project protocols. Cumulative case datasets will be extracted and transmitted to CDC at 2-month intervals (6x annually).
 - d. Recipients must extract, recode, format, and transmit all available treatment information associated with each reported gonorrhea or syphilis cases in a dataset related to the case record dataset through event IDs. Cumulative treatment datasets will be extracted and transmitted to CDC at 2-month intervals (6x annually).
 - e. The minimum sample size for gonorrhea and syphilis cases should be determined based on overall morbidity reported in the jurisdiction and adjusted by anticipated interview completion rates to result in fully completed case investigations for no less than 2% of the overall total of all cases reported. For example, if there are 10,000 reported gonorrhea cases, the minimum target for cases with fully completed investigations would be 200. Assuming an investigation completion

rate of 65% of all cases initiated, the total number of gonorrhea cases that need to be sampled would be 308 (a sample fraction of 3.08%). Investigation completion rates can vary substantially over time and across the project area. Recipients should begin with an initially higher sample fraction and adjust over time to reflect local disease trends, investigative capacity, and other relevant factors.

2. Enhanced case investigations

- a. Recipients must conduct internal, look-back investigations using existing health department records (surveillance registries, electronic laboratory records, etc.) for all gonorrhea and early syphilis cases (primary, secondary, and non-primary/non-secondary early syphilis cases) in compliance with CDC protocols; these investigations ensure de-duplication of persons and cases, obtain history of previous STI/HIV diagnoses and obtain additional information that may be present in existing surveillance records to assist in patient and/or provider investigations.
- b. For gonorrhea and early syphilis cases (primary, secondary, and non-primary/non-secondary early syphilis cases) identified in the random sample, recipients must conduct provider investigations in compliance with SSuN protocols. Provider investigations with the diagnosing/reporting provider or facility will include verification and ascertainment of gonorrhea and/or syphilis treatment (drugs & doses), signs/symptoms, clinical manifestations of infection such as Disseminated Gonococcal Infection (DGI), indications of otic, ocular and neurosyphilis, all anatomic site(s) of infection for gonorrhea, screening by anatomic site, insurance status, preventive services, HIV status, HIV testing, pregnancy status, provision of doxy PEP, and to obtain additional contact information from the provider to assist in contacting patients for interview. Methods for provider investigations 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 to achieve a provider investigation completion rate of 65% or greater of all cases identified in the random sample.
- c. Recipients must attempt to interview all gonorrhea and early syphilis cases (primary, secondary, and non-primary/non-secondary early syphilis cases) reported throughout their jurisdiction that are in the random sample in compliance with project protocols. At least 4 attempts at patient contact are required and may be comprised of different methods (SMS, voice call, field visit, US mail, etc.). Methods and outcomes of each contact attempt must be fully documented before closing the case record as 'unable to contact'. If local partner services (PS) investigations are initiated for syphilis cases, every attempt should be made to incorporate SSuN data elements into the PS case investigations and to de-conflict processes to prevent multiple patient contacts.
- d. Recipients must ensure that adequate, trained staff resources are available to conduct enhanced case investigations for the anticipated volume of cases sampled throughout the geographic extent of their proposed project area.
- e. Recipients must ensure that interview attempts can be initiated and/or patient call-backs can occur during some 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 and emergency contact information, and other available methods. Patient interviews for SSuN enhanced case investigations may be conducted by telephone or in-person following local health department procedures for contacting and confirming the identity of patients during routine partner services investigations.

3. Routine case-based matching with state HIV surveillance records.
 - a. Recipients must collaborate with the appropriate local or state HIV surveillance authority to routinely match all reported gonorrhea and syphilis cases against the jurisdiction's HIV case registry (such as eHARS or similar local, comprehensive HIV case registry). Where person-based matches are established, relevant HIV-related diagnostic and laboratory data (HIV viral load, CD4+) will be abstracted from HIV surveillance registries and integrated into required case (B.3) and laboratory datasets (B.5) in formats specified in project protocols. Laboratory records for HIV-specific tests (obtained from the HIV registry) for matching patients are requested for all tests with a specimen collection date for a period of one year prior to the diagnosis (or report) date of the case.
 - b. In collaboration with the relevant health department's HIV Overall Responsible Party (ORP), recipients must ensure that patient name-based identifiers are replaced in all archived datasets with non-name-based unique identifiers; personally identifiable information (PII) must be redacted from all datasets prior to transmission to CDC.
4. Provision of technical assistance to state and local STI surveillance and program staff in monitoring and improving STI surveillance data quality
 - a. Dissemination of findings is a key component of successful surveillance activities. Recipients of Strategy B funding are required to review, analyze, visualize, interpret, and report locally on Strategy B findings to enhance and improve STI surveillance capacity and enhance local STI prevention and control activities.

Required Activities Supporting Strategy B Implementation:

- a. Recipients must be responsive to CDC-provided quality assurance feedback and attempt to correct local records or recoding processes when errors, missing data and/or data validity issues are identified, either through routine reporting or in response to specific analytic priorities.
- b. Proposals for multi-site analyses, especially those focusing on health equity in HIV/STI preventive services relating to HIV PrEP/PEP, HIV testing and doxy PEP, as well as demographic, clinical and behavioral trends in reported cases will be periodically solicited and sent to Strategy B principal investigators for their consideration. Dissemination of findings is a key component of successful surveillance activities. Recipients of Strategy B funding are required to promptly review analytic proposals and indicate their preference for inclusion of their jurisdiction's data as well as indicate willingness to participate as a co-author in SSuN multi-site analytic projects. Local clearance of resulting manuscripts will be concurrent with submission to CDC clearance. These analyses generally lead to publication in an STI-related academic and/or

professional journal or as reviewed abstracts for oral or poster presentations at relevant public health conferences.

- c. Recipients of Strategy B funding are required to participate in routine, monthly project conference calls with CDC project staff and to support travel for local project representative(s) to attend annual SSuN Principal Investigators' meetings in Atlanta.

Table 2: Datasets required to be abstracted from health department surveillance, electronic laboratory, or other record systems, recoded, and securely transmitted to CDC by recipients of funding under SSuN Strategy B

Strategy B Dataset(s)	Record Contents	Frequency of Submission
1 - Case Records	Line-listing of all diagnosed and reported gonorrhea and syphilis cases, consistent with protocol and cumulative from the beginning of the calendar year	Every 2 months
2 - Case Laboratory Records	Line listing of all STI-related laboratory tests (from all sources, including ELR) associated with reported case, consistent with protocol and cumulative from the beginning of the calendar year	Every 2 months
3 - Case Treatment Records	Line listing of all STI-related treatments/medications for reported cases, consistent with protocol and cumulative from the beginning of the calendar year	Every 2 months
4 - Provider Reference file	Each unique reporting facility/provider documented in separate record that reported one or more cases in the previous calendar year	Initial submission, updated annually thereafter
Year-End Datasets (1-4)	Final, cleaned and validated annual cumulative datasets containing all records consistent with protocol for the previous calendar year. These serve as the primary analytic data	Due March 15th of each year of the cooperative agreement

Strategy C – Surveillance Focus Activities: Short-term activities to evaluate methods, monitor STI/HIV testing, diagnosis, treatment, sequelae, and eligibility/uptake of HIV-prevention interventions.

Strategy C activities are shorter-term (1-year) single or multi-site projects intended to improve quality and use of surveillance data, explore new methods for monitoring the burden of reportable and/or non-reportable STIs, investigate sequelae of STIs, monitor uptake of biomedical interventions and monitor adverse health outcomes across the full range of community and provider settings. Funding for Strategy C activities is discretionary and dependent on availability of Federal funds; not all proposed Strategy C activities will necessarily be funded, and no Strategy C activities at all may be funded in some budget periods. Not all

applicants for a given activity will necessarily receive funding in any given budget period either, based on availability of Federal funds. Strategy C activities may change, be revised, or be retired in subsequent budget periods, reflecting CDC priorities. Priority funding for Strategy C activities will be based on technical review of proposed projects separate from review criteria for Strategy A and Strategy B proposals. If Federal funds are not available for Strategy C activities, no technical reviews will be conducted, but proposals will be archived.

All applicants are required to propose at least one (1) but no more than two (2) Strategy C activities from the list of those relating to their proposed core surveillance strategies (see activities C.1- C.7) or those recommended for any applicant (see activities C.8 & C.9). Applicants must include a one-page, separable, narrative for their proposed Strategy C activity identifying the activity by number as listed below and include a project plan for their local implementation. A separate 1-page budget justification for each proposed Strategy C activity should also be included and applicants should also address any proposed Strategy C activity in their work plan. Recipients should prepare reasonable budget requests of no more than \$100,000 for any individual Strategy C activity.

Strategy C Activities for Strategy A Recipients:

C.1: Improvements to medical record systems – enhancements to clinic-based electronic medical record (EMR) or electronic health record (EHR) systems supporting collection of SSuN data for Strategy A during patient visits. Recipients are invited to propose innovative approaches to automate, increase efficiency, and lower burden data collection from clinic patients and to initiate design/requirements collection or to implement ‘off-the-shelf’ solutions achievable with available resources to enhance and facilitate Strategy A visit-level data management, data cleaning, automated reporting, or enhanced analysis and visualization to support SSuN activities and to monitor patient care.

Expected outputs:

- i. Documented system requirements and implementation plan.
- ii. Documented system modifications, datasets, data entry screens, and/or reports.

C.2: (a) HIV-PrEP Patient Monitoring (b) doxy PEP Monitoring – develop clinic-based panel of PrEP (or doxy PEP) users and provide for quarterly monitoring of STI screening, STI behavioral risks, incident diagnoses of STIs and PrEP (or doxy PEP) use, and maintenance as documented through prescriptions or dispensing.

Expected outputs:

- i. Quarterly reporting/monitoring of:
 - a. Proportion of eligible patients referred to, initiating, and maintaining HIV PrEP (or dPEP).
 - b. Proportion of HIV PrEP/doxy PEP users screened for STIs in compliance with guidelines.
 - c. Proportion of HIV PrEP/doxy PEP users diagnosed with STI(s).
 - d. Proportion of HIV PrEP/doxy PEP users maintaining HIV PrEP/doxy PEP at quarterly intervals.
 - e. Proportion of HIV PrEP/doxy PEP users lost to follow-up at quarterly intervals.

C.3: Technology to Enhance HIV PrEP Monitoring – implementation of clinic-based technologies for PrEP adherence support, recall/scheduling management and monitoring (SeraAlert, SMS, etc.)

Expected outputs:

- i. Documented system requirements and implementation plan.
- ii. Proportion of HIV PrEP patients enrolling and actively using platform.
- iii. Evaluation of the platform’s user (patient) acceptability and effectiveness.

C.4: Evaluating HIV PrEP uptake and retention – comprehensive analysis of co-factors of HIV PrEP initiation and maintenance, with focus on transgender persons and women of color. May include records-based analyses supplemented with qualitative methods such as surveys, focus groups and/or interviews. Compliance with local IRB requirements will be required.

Expected outputs:

- i. Comprehensive analysis of co-factors facilitating HIV PrEP uptake and maintenance.
- ii. Comprehensive analysis of co-factors inhibiting HIV PrEP uptake and maintenance.
- iii. Programmatic recommendations for enhancing HIV PrEP uptake and maintenance among sex and gender minorities and women of color.

Strategy C Activities for Strategy B Recipients:

C.5: Enhancements to local surveillance data systems supporting collection of SSuN data for Strategy B: Recipients are invited to propose innovative approaches to automated, efficient, and lower burden data collection for patient interview data and to initiate design/requirements collection or to implement ‘off-the-shelf’ solutions achievable with available resources. These can include SMS, REDCap or other secure web or mobile device-enabled data collection tools or enhancements to data systems used to manage and facilitate Strategy B data management, data cleaning, automated reporting, or enhanced analysis and visualization of SSuN data.

Expected outputs:

- i. Documentation of system requirements
- ii. Evaluation of system enhancements with respect to
 - a. Patient response rates
 - b. Completeness of key data elements
- iii. Recommendations for future modifications/enhancements.

C.6: Implementing syphilis automated record search and review algorithm– reactive syphilis serologies are routinely reported to health departments in the United States and are investigated to determine if they represent a new infection, reinfection, treatment failure, or are biological false positives. This determination is based on the results of treponemal and nontreponemal serologic testing. Although the treponemal test is specific to syphilis, it usually remains positive for life. By contrast, nontreponemal tests provide qualitative and semi-quantitative results with the titer level corresponding to the activity level of the infection. In patients with a history of syphilis, nontreponemal titers are useful for following response to treatment, and for determining treatment failure and reinfection. Historical test results are routinely maintained on file to aid with the interpretation of any subsequent tests. Automation of this process eliminates the need

for any manual intervention, freeing-up valuable human resources that were previously allocated for manual record search and review to conduct prioritized investigations to identify syphilis cases, offer partner services, and break the chain of transmission within sexual networks.

Expected outputs:

- i. Implementation of CDC-provided syphilis automated record search and review algorithm
- ii. Evaluation of algorithm performance
 - a. Quantify time from report to prioritization of case follow-up
 - b. Estimated saving versus manual review effort using traditional reactor grids
 - c. Additional evaluation in collaboration with CDC SMEs
- iii. Recommendations for future modifications/enhancements.

C.7: Neonatal HSV case investigations and medical record abstraction - collaborate with CDC subject-matter experts to identify key clinical, laboratory and maternal characteristics useful for developing useful, reliable, specific and sensitive case criteria for surveillance purposes.

Expected outputs:

- i. In collaboration with CDC, deploy a medical record abstraction tool to collect vital infant and maternal data elements.
- ii. Identify cases of Neonatal HSV infection and abstract required clinical, demographic, laboratory and treatment data.
- iii. Evaluate potential, candidate case definitions against formal criteria:
 - a. Timeliness for case reporting purposes
 - b. Specificity of definition to rule out non-cases
 - c. Sensitivity to detect neonatal infections
- iv. Recommendations for future surveillance of Neonatal HSV.

Strategy C Activities for Strategy A and/or Strategy B Recipients

C.8: Innovative Analyses of Multi-Site Data from SSuN Cycles 3&4: All SSuN recipients (regardless of participation in previous cycles) may propose to support innovative analysis of multi-site data from Strategy A or Strategy B surveillance activities leading to dissemination of findings to relevant stakeholders through peer-reviewed publications or abstract-driven conferences. Applicants for this activity must describe the specific analytic question, proposed analytic methods and potential impact of findings. All multi-site analyses and manuscript preparation will be proposed, approved, and completed in collaboration with SSuN Science Officers at CDC and with the consent and participation of Principal Investigators from former or current SSuN sites providing data. Funds may be used to support existing SSuN staff, or to support fellows, interns or collaborating academic partners through appropriate local contractual mechanisms (however, tuition reimbursement is NOT an allowable budget item).

Expected outputs:

- i. One or more peer-reviewed publication(s) or conference presentation(s) based substantially on multi-site SSuN data. Other data sources may be incorporated as needed (e.g., American Community Survey or other US Census data for ecologic analyses).

C.9: Surveillance Focus Activity of local interest: Recipients may propose to collaborate with CDC to implement a locally relevant focus activity designed to implement activities that address issues pertinent to improving/enhancing local STI surveillance capacity, efficiency, timeliness, completeness, representativeness of surveillance data, and/or to analyze, interpret and disseminate local STI surveillance data to relevant stakeholders in innovative and meaningful ways. In collaboration with CDC, recipients will evaluate, document, and disseminate findings of the activity.

Expected outputs:

- i. One (or more) analytic products or project reports comprehensively describing goals, objectives, methods, findings, and recommendations.

Applicants funded for Strategy C activities will be required to collaborate post-award with CDC subject-matter experts in developing specific project protocols and in monitoring implementation of any funded projects.

Required Activities (relevant to all recipients and that must be implemented by all SSuN recipients regardless of Strategies funded)

- a. Recipients are required to participate in regularly scheduled conference calls (Principal Investigator and key staff), virtual meetings, interviewer training, requests from CDC for technical assistance to other SSuN recipients and annual in-person Principal Investigators meetings 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.
- b. Recipients are required to address data quality, completeness and validity issues identified through routine quality assurance reporting. While not all underlying data errors in local systems of record can be changed to reflect correct values, CDC expects recipients to maintain an 'exception' log to recode erroneous values and apply these changes prior to routine data transmissions.
- c. Recipients are required to ensure that local information systems (either clinic EHR/EMRs or jurisdiction surveillance data management systems) are adequate for required collection, management, integration, analysis, and transmission of all project data. All data system modifications needed to ensure complete data collection for SSuN activities must be completed within the first budget period.
- d. Recipients should ensure that adequate documentation of local data management processes is created and maintained to ensure uninterrupted transmission of required data to CDC per project protocols in the event of staffing disruptions. CDC encourages recipients to invest the resources necessary for automation of SSuN processes wherever possible in the initial budget period to ensure sustainability of SSuN surveillance activities.
- e. Recipients must develop processes to use findings from their clinic and case-based surveillance activities locally to improve and enhance the availability of STI/HIV preventive services in their jurisdictions and communities.
- f. Recipients are required to conduct surveillance evaluation projects to fulfill the Applicant Evaluation and Performance Measurement Plan; these should be conducted in collaboration with CDC and state/local STI/HIV program staff; findings must be formally

documented and applied to improving overall surveillance capacity in the recipient's jurisdiction.

- g. Recipients are required to establish and maintain robust collaborations with STI and HIV programs in their state, county, jurisdiction, or community to ensure minimal duplication of effort in patient or case contact, create efficiencies of scale with respect to data collection and to maximize beneficial public health outcomes from sentinel and enhanced surveillance activities implemented under this NOFO.
- h. Recipients are required to adhere to all local and state regulations regarding the maintenance of patient confidentiality and the principles outlined in NCHHSTP's "Data Security and Confidentiality Guidelines for HIV, Viral Hepatitis, Sexually Transmitted Disease, and Tuberculosis Programs: Standards to Facilitate Sharing and Use of Surveillance Data for Public Health Action" (available at: <https://www.cdc.gov/nchhstp/programintegration/docs/pcsidatasecurityguidelines.pdf>).

1. Collaborations

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

Recipients should demonstrate ongoing collaboration with relevant public health authorities within their jurisdiction (specifically, health departments who are funded recipients of PS20-2010, PS19-1901, PS-20-2004 and/or PS-23-0011), in data sharing, dissemination of findings and active participation in the jurisdiction's STI/HIV prevention planning and policy efforts.

Applicants must provide a letter of support, memorandum of agreement or memorandum of understanding from the appropriate state/city or county health department official(s) responsible for oversight of their state or jurisdiction's STI and HIV surveillance programs (the Overall Responsible Person [ORP]) demonstrating intent to routinely collaborate with required name-based STI/HIV record-matching processes. Applicant must file the letters of support, MOUs or MOAs, as appropriate, name the file "MOUs/MOAs", and upload as a PDF, Word, or Excel file format at www.grants.gov.

Applicants for Strategy C activities requiring collaborations with clinical or other external partners should provide letters of support, MOUs or MOAs, as appropriate, documenting proposed collaborations.

b. With organizations not funded by CDC:

Applicants should consider creating and cultivating external partnerships, as necessary, to ensure that data needed for Strategy B provider investigations can be completed; such partnerships could include negotiating public health access to electronic health records with high-volume diagnosing health care organizations, negotiating memorandum of understanding for faxing or otherwise providing required treatment, clinical and relevant patient contact information, etc. for gonorrhea and syphilis cases randomly selected for enhanced case investigations.

2. Population(s) of Focus

Applicants are expected to use available local data to identify and reach populations disproportionately affected by STIs in their surveillance or clinical service areas to achieve the greatest health impact, including developing locally relevant key insights on health equity leading to programmatic recommendations.

This NOFO, including funding and eligibility, is not limited based on, and does not discriminate on the basis of race, color, national origin, disability, age, sex (including gender identity, sexual orientation, and pregnancy) or other constitutionally protected statuses.

a. Health Disparities

The goal of health equity is for everyone to have a fair and just opportunity to attain their highest level of health. Achieving this requires focused and ongoing societal efforts to address historical and contemporary injustices; overcome economic, social, and other obstacles to health and healthcare; and eliminate preventable health disparities.

Broadly defined, social determinants of health are non-medical factors that influence health outcomes. They are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. These forces (e.g., racism, climate) and systems include economic policies and systems, development agendas, social norms, social policies, and political systems. See content below and in other sections (e.g., Approach, Collaborations, Populations of Focus) for information on how this specific NOFO affects social determinants of health.

A health disparity is a preventable difference in the burden of disease, injury, violence, or opportunities to achieve optimal health that are experienced by populations that have been socially, economically, geographically, and environmentally disadvantaged. Health disparities are inextricably linked to a complex blend of social determinants that influence which populations are most disproportionately affected by these diseases and conditions.

The burden of STIs (including HIV) is disproportionately distributed among several specific population subgroups, including race and ethnic minorities, gender/sexual minorities (GSM, including Lesbian, Gay, Bisexual, Transsexual, Queer, Intersex, Asexual and others[LGBTQI+]), people of lower socio-economic status and those who have experienced historical trauma and marginalization such as American Indian and Alaska Native persons. It is a goal of this NOFO to specifically include data collection that helps to better characterize and raise the visibility of these STI-related health inequities. This NOFO will provide information to improve STI and HIV prevention, testing, and treatment services and ultimately aid in reducing the incidence among populations that have historically been disproportionately impacted by STIs.

Surveillance data collected under this NOFO will be used to monitor disparities in receipt of important preventive services such as HIV testing, HIV PrEP, mpox vaccination and emergent biomedical interventions such as doxy PEP and administration of Meningococcal B vaccine (which may be efficacious in preventing gonorrhea) in sexual health clinical and other community settings. These surveillance data will be used to inform local STI prevention program efforts as well as to address national STI prevention strategies addressing the social and epidemiologic determinants of sexual health.

Recipients of funding should make every effort to ensure that processes do not inadvertently or purposely exclude any sub-population(s) of interest. Strategy A specifically intends to extend the reach of sentinel surveillance activities funded through the STI Surveillance Network to additional sexual health clinics in underserved and priority geographic areas identified through the EHE initiative as bearing a disproportionate burden of new HIV infections.

iv. Funding Strategy

There are two core surveillance strategies for this funding opportunity and one supplemental strategy. Applicants may apply for either Strategy A or Strategy B, or applicants may apply for both Strategy A and Strategy B, if fiscal integration and collaboration between health departments and proposed clinical facilities is sufficiently robust to provide greater efficiency with CDC supporting a single recipient for both strategies. Moreover, all applicants are requested to submit proposals for one or more supplemental Strategy C activities relevant to the core strategies for which they are applying.

Applicants should prepare budget requests within the following patient census and morbidity guidelines, with an understanding that sufficient resources will need to be funded for data abstraction and data management for Strategy A and/or for case investigations and data management reflecting appropriate anticipated sampling targets for Strategy B:

Strategy A funding is anticipated in the range of \$130,000 - \$160,000 per recipient with an annual patient census in 2023 of 2,000 or more unique patients served with STI/HIV-related services per clinic (or 4,000 or more for a network of clinics sharing health records). Applicants with a patient census of 2,000 – 4,000 should propose budgets near the lower end of this range, applicants with a patient census of between 4,000 and 6,000 should propose budgets in the middle of this range and those with a patient census greater than 6,000 should propose budgets near the higher end of this range.

Strategy B funding is anticipated in the range of \$130,000 - \$360,000 per recipient reporting more than 2,500 gonorrhea and syphilis cases (combined) in 2023 within the geographic boundaries of the proposed jurisdiction. Applicants with reported case counts between 2,500 – 10,000 should propose budgets near the lower end of this range, applicants with case counts between 10,000 and 50,000 should propose reasonable budgets in the middle of this range and applicants with reported case counts greater than 50,000 may propose budgets reflecting the higher end of this range.

Strategy C activities are intended to be time-limited, single-year activities. Budgets up to \$100,000 per activity may be proposed; funding is subject to the availability of federal funding. Strategy C activities may be revised in subsequent budget periods and may not be funded for any (or all) recipients in each specific budget period; not every activity proposed will necessarily be funded, depending on CDC priorities and available federal resources. Applicants should carefully consider the time-limited nature of funding for these Strategy C activities with respect to personnel and related categories of expenses.

Funding priorities for Strategy A and Strategy B are described in greater detail in Section E. Review and Selection Process.

b. Evaluation and Performance Measurement

i. CDC Evaluation and Performance Measurement Strategy

CDC will require 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 PS-24-0082, STI Surveillance Network, is two-fold: involving routinely and frequently assessing the performance of the overall project with respect to strategies A-C (i.e., across all recipients) as well as the performance of individual recipients as outlined below.

CDC will frequently assess recipients' contribution to overall project performance quantitatively using quality assurance reports generated using data submitted and qualitatively using assessments derived from conference calls (with Principal Investigators and key recipient staff members), site visits and other routine and regularly scheduled communications with recipients (Principal Investigators and key recipient staff). CDC will monitor how NOFO funds are allocated and expended at the recipient level through annual fiscal tracking tools. Progress toward achieving specific objectives with respect to project outputs and outcomes will also be assessed through annual progress reporting.

CDC will monitor transmission of required datasets (Tables 1 and 2 in “Strategies and Activities” section above) to CDC as required by project protocols and according to data submission schedules. 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 finalize evaluation and performance measures in collaboration with recipients within six months of the project start date. Recipients should expect that at a minimum, CDC will collaboratively monitor the following key process metrics:

Strategy A – Sentinel Surveillance in STI/Sexual Health Clinics

**Short-term Outcome 1.3: Improved timeliness, data completeness and data quality;
Short-term Outcome 1.5: Quarterly data quality reporting**

- Proportion of required Strategy A datasets transmitted to CDC on or before the scheduled due date (Target: 100%).
- Proportion of datasets received that pass all data quality and structural validation edit checks (Target: 100%).
- Proportion of records received with key data elements completed, particularly those data elements relating to sexual behaviors, HIV testing, HIV-related laboratory results, HIV PrEP/PEP, doxy PEP and mpox vaccination (consistent with ACIP 2023 recommendations) (Target: 100%).
- Annual submission of required information on STI/HIV screening, HIV PrEP/PEP and related care standards and policies (Target: 100%).
- Participation in regularly scheduled site-specific calls, All-Site calls, and annual Principal Investigators meetings (Target: 100%).

Strategy B – Enhanced Surveillance (gonorrhea and syphilis)

**Short-term Outcome 1.3: Improved timeliness, data completeness and data quality;
Short-term Outcome 1.5: Quarterly data quality reporting**

- Proportion of required Strategy B datasets transmitted to CDC on or before the scheduled due date (Target: 100%).
- Proportion of reported cases (gonorrhea, all stages of syphilis) randomly sampled for enhanced investigations (Target: >5%).
- Proportion of sampled cases with completed look-back, provider and patient investigations (Target: >70%).

- Proportion of datasets received that pass all data quality and structural validation edit checks (Target: 100%).
- Proportion of enhanced investigations received with CDC-defined key data elements completed, particularly those data elements relating to number and gender of sex partners, HIV testing, HIV-related laboratory results, HIV PrEP/PEP, doxy PEP and mpox vaccination (Target: 100%).
- Participation in regularly scheduled site-specific SSuN calls, All-Site SSuN calls, and annual SSuN Principal Investigators meetings (Target: 100%).

Specific outcome metrics will be determined post-award and may include:

Strategy A – Sentinel Surveillance in STI/Sexual Health Clinics

Short-term Outcome 1.1: Improved ascertainment of patient characteristics, STI/HIV-risk and repeat infections; Short-term Outcome 1.2: Improved ascertainment of patient-level eligibility for and uptake of STI/HIV/mpox preventive services; Short-term Outcome 1.6: Increased understanding of STI surveillance data by provider, health department and community stakeholders through dissemination of findings in relevant journals, reports, publications, and conferences; Intermediate Outcome 2.2: Timely, comprehensive ascertainment of HIV/STI/mpox specific clinical and preventive services in Sexual Health clinical settings; Intermediate Outcome 2.5: Improved ascertainment of prescribed/administered treatment(s)

- Proportion of clinic patients presenting for care by gender, age, race, Hispanic ethnicity, and sex-of-sex partners (Target: TBD post-award).
- Proportion of eligible clinic patients tested for HIV (Target: TBD post-award).
- Proportion of eligible clinic patients referred for or prescribed HIV and other preventive services (HIV PrEP/PEP, mpox vaccination, doxy PEP, etc.) (Target: TBD post-award).
- Proportion of eligible clinic patients on HIV PrEP (Target: TBD post-award).
- Proportion of clinic patients diagnosed with STIs who are treated with recommended regimens. (Target: 100%)
- Documentation of local data summaries, publications, presentations to stakeholders. (Target: TBD post-award)
- Documentation of collaboration in multi-site analyses, manuscripts, and publications. (Target: TBD post-award)

Strategy B – Enhanced Surveillance (gonorrhea and syphilis)

Short-term Outcome 1.1: Improved ascertainment of patient characteristics, STI/HIV-risk and repeat infections; Short-term Outcome 1.2: Improved ascertainment of patient-level eligibility for and uptake of STI/HIV/mpox preventive services; Short-term Outcome 1.6: Increased understanding of STI surveillance data by provider, health department and community stakeholders through dissemination of findings in relevant journals, reports, publications, and conferences; Intermediate Outcome 2.6: Improved awareness of disease burden by relevant patient characteristics in community settings; Intermediate Outcome 2.7: Improved availability of information on trends in HIV status, HIV care, PrEP, doxy PEP, MenB & mpox vaccination among STI cases diagnosed in community settings

- Distribution of reported gonorrhea and syphilis cases by gender, age, race, Hispanic ethnicity, and sex-of-sex partners.(Target: TBD post-award)
- Proportion of reported gonorrhea and syphilis cases that are determined to be repeat infections. (Target: TBD post-award)
- Proportion of reported gonorrhea and syphilis cases with documentation of testing for HIV and by HIV status (Target: TBD post-award).
- Proportion of reported gonorrhea and syphilis cases treated with recommended regimens by case characteristics and provider settings (Target: TBD post-award).
- Documentation of local STI analyses, including enhanced surveillance data, publications, and presentations to stakeholders.(Target: TBD post-award)
- Documentation of collaboration in multi-site analyses, manuscripts, presentations, and publications.(Target: TBD post-award)

All applicants should submit a **Data Management Plan (DMP)** as part of their evaluation and performance management plan. See <https://www.cdc.gov/grants/additionalrequirements/ar-25.html> for additional information on preparing a DMP. At a minimum, the DMP should include the following:

- A description of the data to be collected or generated in the proposed project consistent with the specific strategies proposed;
- The standards to be used for the collection, abstraction or generation of the data;
- Description of proposed process to create static, unique person-identifiers for persons diagnosed and reported with STIs and/or those presenting for care in sexual health clinical settings;
- Mechanisms for, and limitations to, providing access to the data, including a description of provisions for recipient-level protection of privacy, confidentiality and security of the data consistent with NCHHSTP guidelines (<https://www.cdc.gov/nchhstp/programintegration/data-security.htm>);
- Statement of standards to be used to ensure complete documentation describing data collection, data sources, data management and retention of data, and;
- Plans for archiving data, or rationale for why long-term preservation and access are not justified.

Applicants should include a DMP that is as complete as possible. The DMP may be submitted as a checklist, paragraph, or other format. DMPs may be required to be revised and re-submitted post-award based on CDC review.

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, including, as applicable to the award, how findings will contribute to reducing or eliminating health disparities and inequities.

- 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).
- How evaluation findings will be disseminated to communities and populations of interest in a manner that is suitable to their needs.
- Plans for updating the Data Management Plan (DMP) as new pertinent information becomes available. If applicable, throughout the lifecycle of the project. Updates to DMP should be provided in annual progress reports. 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/additional-requirements/ar-25.html>.

Where the applicant chooses to, or is expected to, take on specific evaluation studies, the applicant 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 successful applicants post-award to develop and implement a more detailed evaluation plan.

c. Organizational Capacity of Recipients to Implement the Approach

Successful applicants will have (and should comprehensively describe/demonstrate in their application materials) the organizational capacity to fully implement the strategies and activities described in this NOFO. Implementation and long-term maintenance of sentinel and enhanced surveillance activities requires a stable, well-balanced mix of information technology skills, dedicated data management, well-trained public health interviewers, epidemiologists with STI subject-matter expertise and existing fiscal and administrative support sufficient to manage staffing and fiscal resources appropriately. Prior participation is not required for applicants to the current NOFO; however, prior experience with SSuN or similar sentinel and enhanced surveillance projects is helpful and should be described in detail, including documenting successes, barriers, and outcomes in previous sentinel and enhanced STI surveillance activities.

For Strategy A, a functional and stable electronic health or electronic medical record system is essential for successful implementation of the activities described in this NOFO. Additionally, data management expertise at the clinic level, with experience using SQL, SAS, R or similar data management/analytic tools, is also required to query or extract required data from electronic health or electronic medical record (EHR/EMR) systems and to recode, re-format and perform

extensive quality assurance on visit, laboratory, diagnosis and treatment data prior to transmission to CDC. Many EHR/EMR systems do not provide user-side data table access by default; contractors may be needed to build data exports or provide appropriate table access. This capacity should be anticipated and appropriate record-level access either currently available to data managers at the clinic level or planned to be procured during the initial project period.

Where required data are either not collected, or not stored as structured data elements within the patient record for any reason, it may still be possible to retrieve, recode or infer valid proxy data using other information in the patient health record. Applicants should discuss any current limitations, especially concerning patient sexual orientation, gender identity and risk behaviors and indicate how proxy data will be used for supplying required data elements.

Applicants for Strategy A (alone, or in combination with Strategy B proposals) should demonstrate in their application that they meet the following organizational capacity parameters to successfully implement Strategy A activities:

- Documented annual patient census in calendar year 2023 of at least 2,000 unique persons served with STI/HIV-related clinical services per stand-alone clinical facility proposed. If a network of 2 or more associated clinics/facilities meeting the criteria defined above qualifying as a STI/Sexual Health clinic, the combined patient census must exceed 4,000 unique persons served with STI/HIV-related clinical services in 2023.
- Documented current use of an electronic health record (EHR) or electronic medical record (EMR) system that meets the facility's clinical needs, stores the required information as structured data and that can provide line-listed exports necessary to support SSuN data needs.
- Documented local capacity to electronically abstract, manipulate and manage record-level visit, patient, clinical, laboratory, diagnoses and treatment data from existing EHR/EMR systems in their clinic(s).
- Documented collection and capacity to abstract and analyze key demographic and behavioral metrics at clinic encounters, including such measures as patient sex at birth, race/Hispanic ethnicity, sexual orientation/gender identity, gender and number of recent sex partners. Such documentation should include description of current patient census data stratified by these characteristics.
- Documented past collaboration, or demonstration of intent to collaborate, with their jurisdiction's state/local HIV surveillance unit for matching clinic patients against the jurisdiction's HIV case registry (eHARS or comprehensive local proxy); applicants must obtain and include a Letter of Support from their state or jurisdiction's HIV surveillance unit stating intent to provide HIV registry matching and relevant laboratory data for clinic patients. Such documentation could include description of current patient census data stratified by self-report and supplemented with HIV-registry match information.

For Strategy B, applicant agencies or organizations that currently maintain fully functioning case surveillance data management systems, integrated electronic laboratory reporting, as well as a robust disease investigation specialist (DIS) or experienced case investigator workforce currently providing partner services (with an established infrastructure to record results/outcomes) to diagnosed and reported STI cases are well-positioned to implement SSuN activities. Applicants are encouraged to be as comprehensive as possible in describing their capacity for name-based STI surveillance, ability to provide support for enhanced case investigations by trained staff and

should document their ability to successfully collaborate with HIV surveillance staff in accomplishing required HIV registry matching.

Experience in previous cycles of SSuN has demonstrated that non-business hours, such as limited weekend and evening hours, maximize the opportunity for successfully contacting and interviewing patients. Applicants should also address mechanisms and staff capacity to ensure that sufficient resources are available for the anticipated volume of sampled cases. Applicants are encouraged to integrate enhanced case investigations wherever possible into existing partner management activities to avoid duplication of effort between SSuN and routine disease control activities and to describe this in their applications.

Personnel resources with strong skills for analysis and presentation of STI surveillance data to steer programmatic responses in their jurisdiction are also useful to achieving maximal local impact of SSuN. However, the need for higher-level staff may differ across the life-cycle of both Strategy A and B; applicants are encouraged to be strategic in balancing the need for scientific staff against the need for staff resources performing outcome-related activities at different stages in project implementation and to budget accordingly.

Applicants for Strategy B (Enhanced Case-based Surveillance, either alone or in combination with Strategy A proposal) for this NOFO should demonstrate in their application that they meet the following organizational capacity parameters to successfully implement Strategy B activities:

- Documented assurance that the applicant entity has clear statutory authority (clearly identifiable through citation of relevant public health laws, statutes, regulations, etc.) for name-based reporting of notifiable diseases within a clearly defined proposed geographic area (i.e., state, county, or city).
- Documented assurance that the applicant entity has clear statutory authority to conduct case and provider-level disease investigations, including providing partner services for persons diagnosed and reporting with STI/HIV in their proposed jurisdiction.
- Documented current use of a stable, National Electronic Disease Surveillance System (NEDSS)-complaint surveillance data management system for nationally reportable STIs (gonorrhea, chlamydia, syphilis, chancroid [if locally reported]).
- Documented access to record-level laboratory reporting records including (electronic lab reporting [ELR] if available locally) within their proposed jurisdiction. Ability to electronically receive and consume laboratory records, although not required, is strongly recommended.
- Documented capacity to work with local providers to obtain access to additional clinical and diagnostic information on reported cases, staff capacity to contact reported cases, successfully conduct enhanced case investigation interviews and capacity to conduct these enhanced investigations throughout the full geographic area proposed.
- Documented capacity to electronically abstract, manipulate and manage record-level case, patient interview, laboratory, and retrospective person-based data from existing surveillance and ELR systems.
- Documented access to HIV case registry (eHARS or comprehensive local proxy) for matching reported STI cases; applicants must include a Letter of Support from their state or jurisdiction's HIV surveillance unit stating intent to provide HIV registry matching and relevant laboratory data.

All applicants for Strategy B should document existing statutory authority for their agency or organization to conduct name-based disease surveillance and active case investigations for STIs/HIV at the population level throughout the full extent of their state/county/city or other legally recognized jurisdiction. Include such documentation through citation of regulations, statutes or local public health codes and clearly label with an identifiable sub-heading in the Strategy B project narrative. All applicants for Strategy B should also document in their application narrative the number and characteristics of gonorrhea cases and syphilis cases (stratified by stage) reported in 2023, or the most recent year for which complete case data are available.

For each Strategy C activity proposed, applicants should prepare a narrative description of no more than one page in length clearly labeled with the activity number and an accompanying one-page budget narrative justification. In each Strategy C proposal, applicants should describe their local methods for achieving the desired outcomes, resources needed to complete the activity and a proposed timeline for completing the activity within the initial budget period.

Skills and experience for all proposed personnel must be documented through inclusion of resumes/C.V.s showing relevant education, certifications and/or training; 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 or to-be-hired, the applicants should describe the required skill set and present a reasonable hiring plan and timeline. Budget requests for these currently vacant positions/contracts should be pro-rated to adjust for anticipated delays during the hiring/contracting process.

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 applicable federal statutes, regulations, and terms and conditions of the federal award.

d. Work Plan

Applicants must provide a detailed work plan for the first year of this award and a high-level work plan for the entire five-year period of performance. For Strategy A & B, the first period of performance work plan should also include any Strategy C activities proposed.

The work plan for the first period of performance should include a table with the following columns and headings:

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

<i>Strategy B</i>					
<i>Activity Description</i>	<i>Related Output(s) from Logic Model</i>	<i>Performance Measure (from Evaluation and Performance Measurement section)</i>	<i>Person(s) Responsible</i>	<i>Start Date</i>	<i>Completion or Implementation Date</i>
<i>Strategy C</i>					
<i>Activity Description</i>	<i>Related Output(s) from Logic Model</i>	<i>Performance Measure (from Evaluation and Performance Measurement section)</i>	<i>Person(s) Responsible</i>	<i>Start Date</i>	<i>Completion or Implementation Date</i>

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

- A. How they plan to maintain key partnerships with clinics, agencies, organizations and/or health department units that are essential for the successful implementation of SSuN activities.
- B. How they plan to sustain successfully initiated project activities through enhanced automation and ongoing process documentation.
- C. How they plan to ensure continuing data quality and to monitor project performance.
- D. Plans for additional evaluation and analysis of the data collected.
- E. Plan for how they will anticipate and minimize the impact of significant changes in staffing or locally available resources.

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 SSuN project-wide and individual recipient conference calls on a routine schedule, to be negotiated post-award.

Performance measures and quality assurance reports will be reviewed with recipients routinely during regularly scheduled site calls. Based on review of performance measures and recipient reporting during project implementation, if a recipient is not conducting required activities, or failing to adhere to required protocols in the conduct of funded activities, CDC will initiate technical and/or capacity-building assistance for program improvement; CDC may require additional monitoring or recipient reporting during a defined probationary 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 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. Repeated failure to meet the minimum standards with respect to timeliness and completeness for scheduled data transmissions to CDC may have implications for funding in subsequent budget periods.

Monitoring and reporting activities are outlined in Chapter 2.01.101 of the HHS Grants Policy Administration Manual (GPAM) that assists grants management staff (e.g., grants management officers (GMOs) and specialists (GMS), and project officers) in the identification, notification, and management of high-risk recipients.

f. CDC Program Support to Recipients

In a cooperative agreement, CDC staff are substantially involved in all aspects of project activities in addition to routine progress monitoring. CDC project staff will work in partnership with recipients to ensure successful implementation of the cooperative agreement, ensure appropriate outputs (datasets) are produced and transmitted to CDC in a complete and timely manner and to ensure that overall project outcomes are achieved. CDC supportive activities for SSuN are as follows:

- Facilitate development and implementation of standardized, multi-site protocol documents and data collection standards.
- CDC will work with recipients as necessary post-award to identify capacity building and TA needs essential for the success of the project.
- CDC will schedule and convene routine recipient conference calls and annual Principal Investigators meetings.
- Participating and/or leading analysis and dissemination of SSuN data including conducting or coordinating analyses and disseminating findings to support STI/HIV and related prevention efforts.
- Assisting in the evaluation of overall effectiveness of program operations.
- Providing timely feedback to recipients on reported data for quality assurance purposes.
- Maintaining secure and confidential databases at CDC for the archiving of SSuN data submitted by recipients.
- CDC will also provide ongoing guidance and coordination to recipients to improve data quality and effectiveness of activities, develop specific evaluation strategies, improve data products, and build and maintain strategic partnerships internal and external to CDC.

B. Award Information

1. Funding Instrument Type:

CA (Cooperative Agreement)

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

2. Award Mechanism:

H25-Community Services Program - Venereal Disease Control

3. Fiscal Year:

2024

4. Approximate Total Fiscal Year Funding:

\$8,000,000

5. Total Period of Performance Funding:

\$40,000,000

This amount is subject to the availability of funds.

Up to \$40,000,000; contingent on the availability of federal funding.

Estimated Total Funding:

\$40,000,000

6. Total Period of Performance Length:

5 year(s)

year(s)

7. Expected Number of Awards:

8. Approximate Average Award:

\$266,666

Per Budget Period

Range of individual awards: \$130,000 to \$720,000 per award depending on patient census, morbidity levels, specific strategies proposed and number of STI/Sexual Health clinics included.

9. Award Ceiling:

\$0

Per Budget Period

This amount is subject to the availability of funds.

Awardees may, or may not, receive additional funds above core awards for Strategy A and/or Strategy B for proposed Strategy C projects in the initial or subsequent budget periods, depending on Division of STD Prevention priorities and the availability of federal funding.

10. Award Floor:

\$0

Per Budget Period

11. Estimated Award Date:

August 15, 2024

12. Budget Period Length:

12 month(s)

Throughout the period of performance, 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 (period of performance) 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.

If you are successful and receive a Notice of Award, in accepting the award, you agree that the award and any activities thereunder are subject to all provisions of 45 CFR part 75, currently in effect or implemented during the period of the award, other Department regulations and policies in effect at the time of the award, and applicable statutory provisions.

C. Eligibility Information

1. Eligible Applicants

Eligibility Category:

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

2. Additional Information on Eligibility

1. Applicants must apply for at least one of the two core strategies of this NOFO. Applicants proposing one or more Strategy C Activity but not proposing either or both of the core strategies (Strategy A and/or Strategy B) will be considered non-responsive and will not receive further review.
2. Applicants must provide documentary evidence of their ability match their STI Clinic patient census and/or reported STI cases with the official HIV case registry. Access to the jurisdiction's official HIV case registry (eHARS or similar proxy) is critical to successfully implementing the required program strategies, either through the applicant agency's internal systems or through agreements with relevant health department entities. Applicants must include a letter of support/memorandum of agreement with the designated Overall Responsible Party (ORP) for HIV surveillance in their jurisdiction documenting collaboration for the purposes of name-based HIV surveillance registry matching. This requirement applies to Strategy A and/or Strategy B applications. Name this signed letter "HIV_ORP_MOA" and upload as an attachment with the application package at www.grants.gov. Applicants failing to provide a clearly labeled MOU/MOA from the jurisdiction's ORP for HIV surveillance will be considered non-responsive and will not receive further review.

Please note: Sections 317 and 318 of the Public Health Service Act authorize funding to States, political subdivisions of States, and any other public and nonprofit private entities, but do not authorize awards to for-profit entities.

Please note: Sections 317 and 318 of the Public Health Service Act authorize funding to States, political subdivisions of States, and any other public and nonprofit private entities, but do not authorize awards to for-profit entities.

3. Justification for Less than Maximum Competition

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.

PLEASE NOTE: Effective April 4, 2022, applicants must have a Unique Entity Identifier (UEI) at the time of application submission (SF-424, field 8c). The UEI is generated as part of SAM.gov registration. Current SAM.gov registrants have already been assigned their UEI and can view it in SAM.gov and Grants.gov. Additional information is available on the [GSA website](https://www.gsa.gov), [SAM.gov](https://sam.gov), and [Grants.gov- Finding the UEI](https://www.grants.gov).

a. Unique Entity Identifier (UEI):

All applicant organizations must obtain a Unique Entity Identifier (UEI) number associated with your organization's physical location prior to submitting an application. A UEI number is a unique twelve-digit identification number assigned through SAM.gov registration. Some organizations may have multiple UEI numbers. Use the UEI number associated with the location of the organization receiving the federal 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 and a Unique Entity Identifier (UEI). 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 [SAM.gov](https://sam.gov) and the [SAM.gov Knowledge Base](https://sam.gov).

c. [Grants.gov](https://www.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	System for Award	1. Go to SAM.gov and create an Electronic Business Point of Contact (EBiz POC). You will	7-10 Business Days but may take longer and must be renewed once a year	For SAM Customer Service

	Management (SAM)	need to have an active SAM account before you can register on grants.gov). The UEI is generated as part of your registration.		Contact https://fsd.gov/fsd-gov/home.do Calls: 866-606-8220
2	Grants.gov	1. Set up an account in Grants.gov, then add a profile by adding the organization's new UEI number. 2. The EBiz POC can designate user roles, including Authorized Organization Representative (AOR). 3. AOR is authorized to submit applications on behalf of the organization in their workspace.	Allow at least one business day (after you enter the EBiz POC name and EBiz POC email in SAM) to receive a UEI (SAM) which will allow you to register with Grants.gov and apply for federal funding.	Register early! Applicants can register within minutes.

2. Request Application Package

Applicants may access the application package at www.grants.gov. Additional information about applying for CDC grants and cooperative agreements can be found here: <https://www.cdc.gov/grants/applying/pre-award.html>

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.

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)

Due Date for Letter Of Intent 04/01/2024

04/01/2024

b. Application Deadline

Due Date for Applications 05/15/2024

05/15/2024

11:59 pm U.S. Eastern 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.

Due Date for Information Conference Call

Two identical informational webinars will be hosted:

1. March 12, 2024, 9:00-10:00am, EST: <https://cdc.zoomgov.com/meeting/register/vJltf-6hrDwoHPMDngA1rUSVYdedNzG0FHI>
2. March 14, 2024, 3:30-4:30pm, EST: https://cdc.zoomgov.com/meeting/register/vJltceGorD8jEqm0uYInyVM9n_y3HT3Ikac

5. Pre-Award Assessments

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

The purpose of an LOI is to allow CDC program staff to estimate the number of applicants and plan for the review of submitted applications.

Please clearly identify the potential applicants, clinics and or agency and indicate which core strategies (Strategy A, Strategy B, or both Strategy A and Strategy B) the applicants intend to apply for.

LOI must be sent via email to:

Marvin Fleming, Project Officer

CDC, NCHHSTP, DSTDP

Email address: mfleming@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, Word, or Excel file format under "Other Attachment Forms" at www.grants.gov.

9. Project Abstract Summary

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 period of performance, 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 period of performance. 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. Population(s) of Focus and Health Disparities

Applicants must describe the specific population(s) of focus in their jurisdiction and explain how to 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 Population(s) of Focus and Health Disparities requirements as described in the CDC Project Description, including (as applicable to this award) how to address health disparities in the design and implementation of the proposed program activities.

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 <https://www.cdc.gov/os/integrity/reducepublicburden/index.htm>.

- 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 or reaccreditation 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 Mariana 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 essential public health services and ensure foundational capabilities are in place, such as activities that ensure a capable and qualified workforce, strengthen information systems and organizational competencies, build attention to equity, and advance 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. These goals may include supporting vital records offices participating in the Vital Records and Health Statistics Accreditation Program, certifying vital records offices to meet industry standards. 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; provide financial assistance to support accreditation related fees and/or support staff time to coordinate accreditation activities; or support vital records improvement efforts, as approved by CDC.

Applicants must name this file "Budget Narrative" and can upload it as a PDF, Word, or Excel file format 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.

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 45 CFR 75 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. Employee Whistleblower Rights and Protections

Employee Whistleblower Rights and Protections: All recipients of an award under this NOFO will be subject to a term and condition that applies the requirements set out in 41 U.S.C. § 4712, “Enhancement of contractor protection from reprisal for disclosure of certain information” and 48 Code of Federal Regulations (CFR) section 3.9 to the award, which includes a requirement that recipients and subrecipients inform employees in writing (in the predominant native language of the workforce) of employee whistleblower rights and protections under 41 U.S.C. § 4712. For more information see: <https://oig.hhs.gov/fraud/whistleblower/>.

15. 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.

16. 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 anti-lobbying restrictions 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.

17. Data Management Plan

As identified in the Evaluation and Performance Measurement section, applications involving data collection or generation must include a Data Management Plan (DMP) as part of their evaluation and performance measurement plan unless CDC has stated that CDC will take on the responsibility of creating the DMP. The DMP describes plans for assurance of the quality of the public health data through the data's lifecycle and plans to deposit the 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/additional-requirements/ar-25.html>.

18. Intergovernmental Review

This NOFO is not subject to executive order 12372, Intergovernmental Review of Federal Programs. No action is needed.

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. Application attachments can be submitted using PDF, Word, or Excel file formats. Instructions and training for using Workspace can be found at www.grants.gov under the "Workspace Overview" option.

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 review the Applicants section on www.grants.gov.

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 via email.

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

NOFO reviewers will follow CDC’s merit review process by evaluating eligible and responsive applications in accordance with the criteria below. Reviewers may be external to the federal

government (non-federal personnel), federal personnel, or a mix of federal and non-federal personnel.

- 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

Strategy A

Extent to which the application:

- a. Presents outcomes and outputs that are consistent with the project period outcomes described in the STI Surveillance Network (SSuN) Project Description for Strategy A and logic model. (5 points)
- b. Describes an overall strategy and specific surveillance-related activities consistent with the STI Surveillance Network (SSuN) Project Description and logic model. (5 points)
- c. Describes specific activities for Strategy A that are achievable and appropriate to producing each of the required datasets and desired outcomes of the project. (5 points)
- d. Demonstrates that the proposed use of funds is an efficient and effective way to implement activities required for Strategy A and can reasonably be expected to achieve the project period outcomes. (5 points)
- e. Presents a work plan that is aligned with and reasonable with respect to the required activities, outcomes, and performance measures for Strategy A in the approach. (5 points)

Strategy B

Extent to which the application:

- a. Presents outcomes and outputs that are consistent with the project period outcomes described in the STI Surveillance Network (SSuN) Project Description for Strategy B and logic model. (5 points)
- b. Describes an overall strategy and specific surveillance-related activities consistent with the STI Surveillance Network (SSuN) Project Description and logic model. (5 points)
- c. Describes specific activities for Strategy B that are achievable and appropriate to producing the required datasets and desired outcomes of the project. (5 points)
- d. Demonstrates that the proposed use of funds is an efficient and effective way to implement activities required for Strategy B and can reasonably be expected to achieve the project period outcomes. (5 points)
- e. Presents a work plan that is reasonable and aligned with the required activities, outcomes, and performance measures for Strategy B in the approach. (5 points)

Strategy C

Extent to which the application:

Identifies at least one specific Strategy C activity and presents narrative proposal aligned with the project description for the selected activity.

ii. Evaluation and Performance Measurement

Maximum Points: 25

Strategy A, B and C

Extent to which the application:

- a. Describes clear monitoring and evaluation procedures and how evaluation and performance measurement will be incorporated into planning, implementation, and reporting of project activities. (10 points)
- b. Includes a clear, comprehensive preliminary Data Management Plan. (5 points)
- c. Includes a clear narrative proposal and separable budget justification for at least one Strategy C activity. (10 points)

iii. Applicant's Organizational Capacity to Implement the Approach

Maximum Points: 50

Strategy A

Extent to which the application:

- a. Demonstrates that the proposed STI/Sexual Health clinic(s) meet the patient census inclusion thresholds and provide the required sexual health clinical services outlined in section iii. (Strategies and Activities) and includes a demographic and behavioral description (by sex, age, race/Hispanic ethnicity, gender of sex partners and HIV status) of the 2022 patient population. (10 Points).
- b. Demonstrates that the proposed STI/Sexual Health clinic(s) has a fully functioning EHR/EMR and that the applicants can extract and manipulate required data elements in record-level datasets for patient visits, laboratory observations, diagnoses, and treatments consistent with the requirements in section iii. (Strategies and Activities). (12 Points)
- c. Demonstrates that the applicants have staff with the skills (SQL, SAS, R or equivalent) and capacity to work with extracted data to recode, format and transmit data to CDC. (8 Points)
- d. Demonstrates that the applicants can create unique non-name-based patient IDs for patients in their clinic(s) and maintain these unique IDs for the duration of the project. (6 points)
- e. Demonstrates that the applicants have outlined a realistic plan, including proposed collaborations, for conducting routine, periodic person-based matching of clinic patients to the jurisdiction's HIV surveillance registry in collaboration with their jurisdiction's CDC-funded HIV Surveillance Program; demonstrates prior experience conducting person-based matching of clinic patients to an external disease registry. (8 Points)
- f. Demonstrates compliance with Data Security and Confidentiality Guidelines for HIV, Viral Hepatitis, Sexually Transmitted Disease, and Tuberculosis Programs: Standards to Facilitate Sharing and Use of Surveillance Data for Public Health Action" (available at: <https://www.cdc.gov/nchhstp/programintegration/docs/pcsidatasecurityguidelines.pdf>). (4 points)
- g. Includes a clear, comprehensive preliminary Data Management Plan. (2 points)

Strategy B

Extent to which the application:

- a. Clearly defines the full geographic extent of the proposed case-based enhanced surveillance activities and includes a full demographic profile of gonorrhea and syphilis cases reported in the proposed geographic area in 2022. (10 Points).
- b. Demonstrates that the applicant agency/health department has the statutory/regulatory authority to carry out all proposed case-based surveillance activities outlined in section iii. (Strategies and Activities) (10 points).
- c. Demonstrates that the applicant agency/health department has the necessary expertise and collaborations with the jurisdiction's HIV surveillance unit to conduct HIV-registry matching activities for STI cases reported in their jurisdiction as outlined in section iii. (Strategies and Activities) (10 points).
- d. Demonstrates that the applicant agency/health department have staff with the necessary skills and expertise (SQL, SAS, R or equivalent) to extract data from their surveillance data management systems, to recode, appropriately format, and transmit these data to CDC. (6 points)
- e. Demonstrates that the applicants can create unique non-name-based patient IDs for persons reported with STIs and to maintain these unique IDs for the duration of the project. (6 points)
- f. Demonstrates compliance with Data Security and Confidentiality Guidelines for HIV, Viral Hepatitis, Sexually Transmitted Disease, and Tuberculosis Programs: Standards to Facilitate Sharing and Use of Surveillance Data for Public Health Action” (available at: <https://www.cdc.gov/nchhstp/programintegration/docs/pcsidatasecurityguidelines.pdf>). (6 points)
- g. Includes a clear, comprehensive preliminary Data Management Plan. (2 points)

Strategy C

Extent to which the application:

Identifies at least one specific Strategy C activity and demonstrates that the applicant agency/health department has the necessary expertise and capacity to conduct the proposed activity within the budget period.

Budget

Maximum Points: 0

Reviewed but not scored: Assess the extent to which the applicant's budget aligns with the proposed work plan and appears sufficient to achieve the desired outcomes of the project.

c. Phase III Review

The following factors may affect the funding decisions:

- Applications proposing both Strategy A and Strategy B activities offer significant efficiencies and provide more comprehensive surveillance coverage of overall community STI burden. CDC will provide justification if such efficiencies affect funding decisions.

- The importance of including higher volume STI/Sexual Health clinics. CDC will provide justification if clinic volume affects Strategy A funding decisions.
- The importance of including racial, ethnic and gender/sexual minority (LGBTQI+) populations disproportionately affected by STIs. CDC will provide justification if population composition affects either Strategy A or Strategy B funding decisions.
- The importance of including STI/Sexual Health clinics serving populations in priority EHE jurisdictions for Strategy A, (<https://www.cdc.gov/endhiv/about-ehe/index.html>). CDC will provide justification if inclusion of clinics in priority EHE jurisdictions affects Strategy A funding decisions.
- The need for geographic diversity for SSuN Strategy B. CDC will provide justification if geographic diversity affects Strategy B funding decisions.

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 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 review of risk may impact reward eligibility.

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.

Additionally, we may ask for additional information prior to the award based on the results of the CDC's risk review.

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 by return-receipt e-mail: Between August 1, 2024 and August 31, 2024

Anticipated award date: August 15th, 2024

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 annual 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.

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 <https://www.cdc.gov/grants/additional-requirements/index.html>.

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-25: Data Management and Access](#)
- [AR-34: Language Access for Persons with Limited English Proficiency](#)
- [AR-37: Prohibition on certain telecommunications and video surveillance services or equipment for all awards issued on or after August 13, 2020](#)

Participation in CDC-sponsored SSuN recipient meetings is mandatory. All recipients are required to attend 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.

Participation in all required, conference calls, webinars, etc. as determined by CDC staff is also required.

If you receive an award, you must follow all applicable nondiscrimination laws. You agree to this when you register in [SAM.gov](#). You must also submit an Assurance of Compliance ([HHS-690](#)). To learn more, see the [HHS Office for Civil Rights website](#).

3. Reporting

Reporting provides continuous program monitoring and identifies successes and challenges that recipients encounter throughout the period of performance. 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.

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 specific 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 publicly 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 than 120 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.

This report is due no later than 120 days before the end of the budget period and serves as the continuation application each year. CDC staff may also review specific deadline dates identified in Fiscal Year Planning Memo. This report must not exceed 20 pages excluding administrative reporting. Attachments are not permitted when submitting this report.

This report should include the information specified in the solicitation from the GMS/GMO via <https://www.grantsolutions.gov>. The contact information for the GMS is listed in the “Agency Contacts” section of the NOFO.

Programs may request that recipients submit carryover requests as part of this report. If requested, CDC should provide instructions on the percentage of estimated unobligated amounts that recipients may request be carried forward to the next budget period.

The carryover request must:

- Express a bona fide need for permission to use an unobligated balance; and
- 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.

Required submission of surveillance datasets every two months in compliance with data submission schedules constitutes, in part, performance measure reporting.

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 through the Payment Management System (PMS). 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)

The Final Performance Report is due 120 days after the end of the period of performance. The Final FFR is due 120 days after the end of the period of performance and must be submitted through the Payment Management System (PMS). 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 period of performance, 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 \$30,000.

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.frs.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.

6. Termination

CDC may impose other enforcement actions in accordance with 45 CFR 75.371- Remedies for Noncompliance, as appropriate.

The Federal award may be terminated in whole or in part as follows:

(1) By the HHS awarding agency or pass-through entity, if the non-Federal entity fails to comply with the terms and conditions of the award;

(2) By the HHS awarding agency or pass-through entity for cause;

(3) By the HHS awarding agency or pass-through entity with the consent of the non-Federal entity, in which case the two parties must agree upon the termination conditions, including the effective date and, in the case of partial termination, the portion to be terminated; or

(4) By the non-Federal entity upon sending to the HHS awarding agency or pass-through entity written notification setting forth the reasons for such termination, the effective date, and, in the case of partial termination, the portion to be terminated. However, if the HHS awarding agency or pass-through entity determines in the case of partial termination that the reduced or modified portion of the Federal award or subaward will not accomplish the purposes for which the Federal

award was made, the HHS awarding agency or pass-through entity may terminate the Federal award in its entirety.

G. Agency Contacts

CDC encourages inquiries concerning this notice of funding opportunity.

Program Office Contact

For programmatic technical assistance, contact:

First Name:

Marvin

Last Name:

Fleming

Project Officer

Department of Health and Human Services

Centers for Disease Control and Prevention

Address:

Department of Health and Human Services

Centers for Disease Control and Prevention

Surveillance and Data Science Branch

Division of STD Prevention

1600 Clifton Road NE, Mailstop H24-4

Atlanta, GA 30329-4027

Telephone:

404.639.8352

Email:

mfleming@cdc.gov

Grants Staff Contact

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

First Name:

Christy

Last Name:

Wipperfurth

Grants Management Specialist

Department of Health and Human Services

Office of Grants Services

Address:

Grants Management Officer

Office of Grants Services (OGS)

Office of Financial Resources (OFR)

Centers for Disease Control and Prevention (CDC)

Mail Stop TCU3

2920 Brandywine Rd

Atlanta, GA 30341

Telephone:

770.488.3946

Email:

lmh4@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.

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

H. Other Information

Following is a list of acceptable application attachments that can be submitted using PDF, Word, or Excel file formats 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
- 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

Non-profit organization IRS status forms, if applicable

Memorandum of Agreement (MOA)

Memorandum of Understanding (MOU)

Bona Fide Agent status documentation, if applicable

Project narrative section (including work plans) may include up to, but must not exceed, 25 pages. Content beyond 25 pages will not be reviewed.

If applicants are unable to attend either of the two scheduled pre-application webinars, materials presented and other supplemental documentation may be requested by emailing SSUN_TA@cdc.gov.

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 <https://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.

Assistance Listings: A government-wide collection of federal programs, projects, services, and activities that provide assistance or benefits to the American public.

Assistance Listings 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 period of performance. 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.

Community engagement: The process of working collaboratively with and through groups of people to improve the health of the community and its members. Community engagement often involves partnerships and coalitions that help mobilize resources and influence systems, improve relationships among partners, and serve as catalysts for changing policies, programs, and practices.

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. <https://www.cdc.gov/grants/additional-requirements/index.html>.

Equity: The consistent and systematic fair, just, and impartial treatment of all individuals, including individuals who belong to underserved communities that have been denied such treatment (from Executive Order 13985).

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: Preventable differences in the burden of disease, injury, violence, or opportunities to achieve optimal health that are experienced by populations that have been socially, economically, geographically, and environmentally disadvantaged.

Health Equity: The state in which everyone has a fair and just opportunity to attain their highest level of health. Achieving this requires focused and ongoing societal efforts to address historical and contemporary injustices; overcome economic, social, and other obstacles to health and healthcare; and eliminate preventable health disparities.

Health Inequities: Particular types of health disparities that stem from unfair and unjust systems, policies, and practices and limit access to the opportunities and resources needed to live the healthiest life possible.

Healthy People 2030: 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: The act of creating environments in which any individual or group can be and feel welcomed, respected, supported, and valued to fully participate. An inclusive and welcoming climate embraces differences and offers respect in words and actions for all people.

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.

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 education, 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 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.

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).

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: The non-medical factors that influence health outcomes. The conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. These forces (e.g., racism, climate) and systems include economic policies and systems, development agendas, social norms, social policies, and political systems. <https://www.cdc.gov/about/sdoh/index.html>

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.

UEI: The Unique Entity Identifier (UEI) number is a twelve-digit number assigned by SAM.gov. When applying for Federal awards or cooperative agreements, all applicant organizations must obtain a UEI number as the Universal Identifier. UEI number assignment is free. If an organization does not know its UEI number or needs to register for one, visit www.sam.gov.

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

EMR: electronic medical record

doxy PEP: Post-exposure prophylaxis with doxycycline to prevent bacterial STIs

GC: Neisseria gonorrhoeae (gonorrhea)

HIV: Human immunodeficiency virus

Mpox: (monkeypox) an illness caused by a virus of the genus Orthopoxvirus

PEP: Post-exposure prophylaxis for HIV

PrEP: Pre-exposure prophylaxis for HIV

SDH/SDOH: social determinants of health

STD: Sexually Transmitted Disease

STI: Sexually Transmitted Infection (used interchangeably with STD)

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

TA: Technical assistance