Questions and Answers for Applicants to PS19-1901 STD PCHD

Version Date: July 23, 2018 (Week 12 since NOFO publication)

Additions since last posting on 7/11/2018 are highlighted

Contents

Formal NOFO Amendments

These are copied from the document on grants.gov that amends the NOFO posted there. These are intended to clarify two issues that DSTDP PDQIB received many questions about. (6/13/2018)

NOFO amendment

PS19-1901 STD PCHD

6/6/2018

Q: Can recipients purchase STD medication apart from Benzathine penicillin G under STD PCHD?

Yes, recipients can purchase medications for syphilis, gonorrhea, chlamydia for underinsured and uninsured people at risk of STDs as part of the (no more than) 10% funding that recipients may allocate for assistance to safety net providers that serve those populations. Medication purchases beyond that may be allowed but will need prior approval from CDC.

Q: For applicants that opt to use the OMB-approved work plan templates, what is the page limit for the application? The stated limit on page 58 is difficult to stay within, when using those templates.

For This NOFO, the Project Narrative should not exceed 15 pages (single-spaced), not including the work plans. Applicants who opt to use the OMB-approved work plan templates should submit those templates with their application, regardless of page length when printed. Work plans from applicants who do not opt to use the OMB-approved work plan templates should not exceed 25 pages.

Eligibility

A. I wonder if the XXXXXXX Department of Public Health is eligible to apply for funding through "NOFO: PS19-1901 Strengthening STD Prevention and Control for Health Departments (STD PCHD)"? If the answer is no, are you able to provide a rationale as to why not? (5/14/2018)

a. Answer: Eligibility is limited to those programs funded under PS14-1402 (STD AAPPS). In order to provide a coordinated and complete public health approach to STD prevention, the funded entity must already have in place the necessary public health infrastructure, including the legal (statutory) authority to: conduct disease surveillance; report surveillance data to the CDC; respond to outbreaks; contain emerging disease threats; and conduct disease investigation, intervention and follow-up. The infrastructure must be focused on STD-specific prevention approaches. PS19-1901 eligibility will be limited to the fifty states, two territories (Puerto Rico and the United States Virgin Islands), and seven cities (Washington, DC; Baltimore, MD; Philadelphia, PA; New York City, NY; Chicago, IL; Los Angeles, CA; and San Francisco, CA) based upon consultation in accordance with Section 318(c) of the PHS Act (42 USC § 247c(c)).

Funding amounts and funding restrictions

A. How do I know what percent reduction I should have from 2018? (5/7/2018)

a. Answer: Because the third award for STD AAPPS has not been issued yet, no applicants have the information they need to calculate or see their percent change from 2018 to the estimated 2019 amount listed in the year 1 funding table for STD PCHD. When the final funding numbers for 2018 are released, each area will be able to determine that. We will also add this information to the Funding Table and share this information with applicants as soon as we are able.

B. According to the funding table, [a project area] is eligible for $X amount of money. However, the budget or cost to do all 17 of the activities outlined in this NOFO will far exceed [that amount]. May we submit a budget for an amount greater than the [amount listed]? For an example, would our application still be accepted if we submitted a budget of [twice that amount]? Is the amount listed in the NOFO funding table a hard set ceiling amount? (5/21/2018)

a. Answer: Applicants may submit a budget for higher than the amount listed, but they should know that it is unlikely that their funding in year 1 will be significantly higher than that listed in the funding table. DSTDP PDQIB does not intend to deviate from the funding formula, and large increase in the total budget for PS19-1901 in year 1 is unlikely. An applicant may submit a proposal for more funding, but they would then need to revise the submitted budget to fit the amount available to the program from DSTDP. A better strategy may be to propose a scope of work that the applicant feels can be completed with the listed funding amount, and provide justification for that (presumably more limited) scope. Note that DSTDP PDQIB expects project areas to try to leverage other funding from state, local, and other sources to supplement the dedicated federal funding from PS19-1901.

C. Can technology be purchased? If so, are there any restrictions on technology? (5/21/2018)

a. Answer: "Technology" is a broad term, applicable to phones, tablets, laptops, desktops, software, surveillance packages, etc. In order to assess whether technology purchases are appropriate with STD PCHD funding, CDC must receive a budget request with all items properly justified, and their relationship to NOFO elements made clear. A simple guide to preparing your budget and including such items is found at this web site: https://www.cdc.gov/grants/documents/Budget-Preparation-Guidance.pdf.

D. Can NOFO funds be used to pay for the DIS certification fee? (5/21/2018)

a. Answer: NOFO funds can be used to pay for DIS certification fees, but DSTDP PDQIB reserves the right to review such requests to ensure costs are reasonable and proportionate, given all the strategies and activities to be implemented under STD PCHD.

E. [The NOFO] speaks to not including direct assistance as part of your budget (ex. If grant assistance is 200,000.00 your budget should be 800,000 and not 1,000,000.00). We currently have a CDC Assignee, should we consider them as direct assistance and deduct their salary from our budget? (5/22/18)

a. Applicants should write their applications to the amounts listed on the funding table on the STD PCDH website. Two applicants have asterisks next to them (New York City and Puerto Rico), indicating that for them, the listed amount needs to be adjusted accordingly. The remaining areas that have one or more CDC assignees in their project areas do NOT need to further adjust

their estimated year one budgets.

F. Does STD PCDH restrict funding for integrated surveillance systems? (6/13/2018)

a. Answer: STD PCHD can be used to invest in integrated surveillance systems. Under the Cross-Cutting Strategies section (p. 8) and under Strategy Area I Surveillance (p. 10), the NOFO includes statements that support integrated systems, particularly as related to integration with HIV-related data and systems. For example, it states "[Applicants] should work with their health departments' communicable disease programs to build interoperable or integrated disease reporting and surveillance systems." However, because surveillance is just one of five Strategy Areas in the NOFO, the funding that can be devoted to integrated systems is limited. STD PCHD suggests that approximately 25-35% of NOFO funding be allocated to Surveillance (p. 10), but as noted elsewhere in the NOFO, DSTDP PDQIB understands the need for flexibility and will consider well-justified proposals to allocate more than 35% of the total award to surveillance.

G. The NOFO suggests the percentage of the budget that we should allocate to different Strategy Areas. We have organized our budget accordingly. When we submit the budget, should it be organized according to the CDC budget preparation guidelines where all staff are listed together, then supplies, travel, etc.? Or, as an alternative, should the budget be organized according to Strategy Area (Staff, supplies, travel for Strategy 1, staff, supplies, travel for Strategy 2) to coordinate with the NOFO recommendations? If the CDC budget preparation guidelines are preferred (where all staff are listed together), how should we indicate the percentage that we will allocate to each Strategy Area? (7/2/2018)

a. Answer: Applicants should submit the budget information according to posted CDC guidelines using the standard categories (personnel, etc.). However, it would be helpful if applicants included information on the Strategy Area effort allocation somewhere else, for example within the budget narrative where costs and roles are explained. Alternatively, applicants could send a Strategy Area-based budget breakdown directly to their prevention specialist, at the time of application.

Application process generally

A. On pg 38 of 65, the Project Narrative states, "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." . . . .Can you please clarify whether we need to use the CDC Clear Communication Index when writing the grant narrative itself, or if we only need to use the plain language guidelines (such as using Everyday Words for Public Health Communication and sticking to clear organization) when completing the grant narrative? (5/21/18)

a. Answer: Applicants do not need to use the CDC Clear Communication Index when writing the grant narrative itself. Applicants should apply general plain language guidelines when completing the grant narrative.

B. Typically with grant applications comes an update on the previous year and a mid-term report for the current year. I do not see any mention of this in the PCHD application requirements. Will there be a 2nd announcement for the updates for AAPPS? (5/21/2018)

a. Answer: Because STD PCHD is a new cooperative agreement, and not a continuation, the NOFO does not include any requests for information related to STD AAPPS, such as progress reports or

updated work plans. A progress report for this final year of STD AAPPS will be due later in 2018, and the guidance for that will be issued separately, soon.

C. **Why are we submitting via grants.gov and not grantsoltions.gov? I thought all grants were supposed to go through grantsolutions now…. (5/21/2018)**
   a. Answer: Grantsolutions is the interface being used for managing grants, but not all grant-related functions have migrated to that interface at this time. The application process still goes through grants.gov. So after award, most of the formal award/communication with recipients will be through grantsolutions.

D. **Can you please provide guidance on the mandatory forms available on www.grants.gov? The package forms available (SF-424, etc.) are not editable PDF documents. How can we access the editable version of these forms? (5/21/2018)**
   a. Answer: Fillable forms are found within the Workspace on Grants.gov. The Workspace is the part of Grants.gov in which the applicants develop and store parts of their applications until the package is ready to be submitted. We would like to provide you with a link to fillable forms within the Workspace, but CDC staff do not have Workspaces, so we can only provide the link to the Workspace landing page: https://www.grants.gov/web/grants/applicants/workspace-overview.html

E. **What's the difference between Grants.Gov and GrantSolutions? (6/20/2018)**

   a. Answer: Grants.gov is the Federal government web site that houses all funding announcements. Your application for STD PCHD funding must be submitted to Grants.gov, using the instructions shown here. GrantSolutions, on the other hand, is the program that both the recipients and CDC will use to manage the cooperative agreement, starting with the first Notice of Award.

F. **In the past, a cover letter was one of the requirements for all grant applications, which I do not see a request for a cover letter in the CDC=RFA-PS19-1901 announcement. Please let me know if a cover letter is needed as one of the acceptable attachments. (7/2/2018)**
   a. Answer: The cover letter is not listed as a required document for this Notice of Funding Opportunity, however it is recommended.

Questions about Strategies in general

A. **Do we have to conduct all 17 activities? If we can provide an explanation why we cannot do one of the activities will that be acceptable? (i.e., Implement a Benzathine penicillin G forecasting inventory-management system to monitor supply, and have a plan to address shortages in the applicant's project area) (5/21/2018)**
   a. Answer: As stated in the NOFO, applicants can opt out of specific strategies with justification and approval from CDC. In such cases, applicants should highlight this in the narrative and in their work plans and provide a strong and clear justification for this. DSTDP PDQIB will review the request, and a recommendation of approval or disapproval will be sent back to such applicants prior to the start of the period of performance.

      Note also that some strategies are not applicable to some areas (e.g. local project areas do not need to do 16C, and many areas with < 10 congenital syphilis cases do not have to do some strategies under 4).

B. In the PCHD NOFO, on page 39 under the Strategies and Activities section it says, "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…." By "existing evidence based strategies," is it referring to the strategies that are the grey text boxes on each tab of the 1-year work plan? Moreover, is the "OR" supposed to be AND? (7/23/2018)

a. Answer: That sentence is not specific to this NOFO but rather affirms CDC's general interest in funding evidence-based interventions and strategies in its NOFOs to the degree possible. When evidence-based strategies are not available, and applicants to a NOFO propose something new or unevaluated, CDC expects applicants to propose to also evaluate those strategies, to build the evidence base further.

Questions about Strategy Area I: Surveillance

A. Do areas funded with SSuN have to do strategy 2b, i.e. the enhanced GC surveillance follow up? (5/7/2018) [Correction 5/14/2018]

a. Previous Answer: No, applicants that are recipients of SSuN do not need to propose objectives and activities related to the enhanced GC surveillance. Such applicants should clearly denote in the narrative application and work plan that they are a SSuN site, and therefore are covering this activity through other means. ~~In such cases, if using the recommended work plan template, the applicant should write "N/A- SSuN site" in the associated SMART objectives text box. Please do not leave that strategy section completely blank.~~

b. Correction [5/14/2018]: Current recipients of the SSuN Cycle 3 cooperative agreement cannot assume that they will be funded for Cycle 4 of SSuN, scheduled to be awarded in the fall of 2019 following a competitive application process. Therefore, current SSuN recipients should propose in their year one STD PCHD work plan those activities related to continuing enhanced GC surveillance activities in the final quarter of 2019, with the assumption that during that quarter, they may not have SSuN funding to support the activity. Once the 4th Cycle SSuN cooperative agreement is awarded in the fall of 2019, all affected STD PCHD recipients would need to modify their work plans and re-direct budgeted resources accordingly. DSTDP will provide more guidance closer to that time.

Follow-up: The updated 5/14/18 answer to the SSuN – 2B strategy question is still a bit confusing. Are you saying that current recipients of SSuN should only propose an objective and activities that cover (or will take place) in the 4th quarter of 2019? This seems to contradict what was said on the webinar on Friday, which seemed to imply that SSuN recipients had to BOTH propose different objectives for 2b in PCHD AND do their required activities under SSuN. (5/21/18)

c. Answer: We apologize for the confusion. SSuN will be re-competed through a new NOFO in 2019. Therefore, in the PCHD application, project areas who are current recipients of SSuN should briefly describe current gonorrhea sampling activities funded under SSuN through September, 2019 and propose similar or modified objectives/activities under Strategy 2B of STD PCHD for the final quarter of 2019.

B. Regarding GC epidemiology: [Our project area] is a SSuN participant and we select a random sample of GC records for client interviews. For this NOFO, should we re-adjust to select an additional amount

of GC clients for interviews and provider follow-up or is the current 10% selection sufficient for this activity? (5/29/2018)

a. Answer: Please see the other responses related to SSuN recipients. In general, a project area funded by SSuN that is doing the enhanced GC interviewing under that project does not need to change their strategy because of STD PCHD, at this time. What is done under SSuN is generally more than adequate to meet the intent of Strategy 2B.

C. Regarding Strategy 2B: If programs are already contacting clients to assure treatment for gonorrhea, can we simply add a smaller random sample to this existing practice? (5/29/2018)

a. Answer.
Yes, as long as your random sample is drawn initially from all reported GC cases in your chosen high morbidity jurisdiction and not just the cases that you currently contact for treatment verification. In addition to treatment information, the enhanced investigations must collect additional core epidemiologic variables, including, but not limited to demographics (e.g., race/ethnicity), clinical information (e.g., gonorrhea-related sequelae), and behavioral information (e.g., gender of sex partners).

D. Regarding Strategy 2B: How large of a problem is it if we are not able to achieve a generalizable sample size of GC interviews due to resource constraints? (5/29/2018)

a. Answer:
We realize that not every program will be able to acquire and analyze a fully generalizable set of data, especially during the first year. However, it is important to make progress toward this goal. For this objective, programs may choose to identify a well-defined high morbidity area and select a random sample representative of all cases in that area. In the initial budget period it is critical that jurisdictions ensure they have the infrastructure in place to select a representative random sample in the well-defined geographic area; this should be done before implementing patient and provider investigations in a phased approach. To assure that the sample is a true probability sample, cases selected for enhanced investigation should be compared to all reported cases by sex, age and area (if multiple counties/regions are included); distribution of cases by these characteristics should match and be periodically reassessed to assure ongoing validity of their sample. Programs should write objectives and plan activities in a phased manner consistent with resources of their project areas.

E. Regarding Strategy 2B: Is CDC going to consider using multisite data to create at least a regional picture of GC risk? (5/29/2018)

a. Answer: Programs should use data collected through enhanced investigations to inform local prevention and control efforts. In addition, enhanced data can inform national surveillance efforts and programs should report these data to CDC. Many of these data elements are reportable to CDC through NETSS (e.g., gender of sex partners, pregnancy status, etc.) and through implementation of the STD HL7 Message Mapping Guide (MMG). Variables not currently included in the NETSS record layout or in the STD MMG (e.g., co-infection with other STDs, treatment received, etc.) should be used locally.

The STD MMG and current NETSS Record Layout include a variable to indicate if a case was randomly sampled for enhanced investigation within a jurisdiction. This should be marked as "Yes" if the case was selected for this activity even if not able to complete the patient interview . In addition, it is possible that some cases that are not in the random sample will be prioritized for partner services or other activity such as treatment assurance. In this situation, the

information gathered during partner services or treatment assurance should be included in the case report and the variable indicating if the case was randomly sampled should be marked as "No."

F. Can current enhanced surveillance investigations for gonorrhea be used in place of random enhanced gonorrhea interviews? (5/21/2018)

a. Answer: Some jurisdictions currently conduct follow-up on select gonorrhea cases of programmatic interest (e.g., pregnant women). As these cases are not representative of all cases of gonorrhea, these investigations cannot stand alone to fulfill objective 2B.

Additionally, some project areas participate in other CDC-funded projects that include enhanced investigations. In the case of the SURRG project, cases are not chosen randomly (i.e., they are selected based on antimicrobial susceptibility test results or if they are in a subpopulation of particular interest), so cannot be used as to fill the STD PCHD requirement for random sampling. If a case falls into the random sample and is also a SURRG case, then the enhanced surveillance information can be used for both SURRG and STD PCHD purposes. If the project area is a SSuN grantee, that program should already be implementing random sampling on a larger scale. The STD PCHD requirement is more specific and local than the SSuN protocol in most areas.

G. Are SURRG recipients exempt from the 2B requirement for enhanced GC surveillance and interviews since we already do this? (This question was answered on the Fri. webinar yet I am still confused and would like to know what exactly is our purpose in doing these random audits of GC interviews? What are we to be looking for/assessing? Are we to send results of this to CDC in a report? What variables do they want us to collect, etc?) (5/21/2018)

a. Answer: The PCHD strategy on enhanced gonorrhea surveillance is designed to address gaps in information on reported cases such as treatment, race and Hispanic ethnicity, anatomic site of infection, gender of sex partners and other epidemiologically meaningful information generally missing through routine laboratory-based reporting. Please see the NOFO and the Technical Assistance Notes [https://www.cdc.gov/std/funding/pchd/technical-notes.htm] for this strategy for specific variables of interest.

Programs should use data collected through enhanced investigations to inform local prevention and control efforts. In addition, enhanced data can inform national surveillance efforts and programs should report these data to CDC. Many of these data elements are reportable to CDC through NETSS (e.g., gender of sex partners, pregnancy status, etc.) and through implementation of the STD HL7 Message Mapping Guide (MMG). Variables not currently included in the NETSS record layout or in the STD MMG (e.g., co-infection with other STDs, treatment received, etc.) should be used locally.

If the project area is a current SURRG awardee, cases selected for enhanced investigation are not chosen randomly (i.e., they are selected based on antimicrobial susceptibility test results or if they are in a subpopulation of particular interest). Therefore, activities in SURRG cannot be used to fulfill the STD PCHD requirement for enhanced gonorrhea surveillance, which requires a random sample of all cases in a well-defined, high morbidity area. If a case falls into the random sample and is also selected for follow-up through SURRG, then the enhanced information

gathered can be used for both SURRG and STD PCHD purposes.

H. For Strategy Area 1: Conduct GC surveillance, can sites expect to receive a more detailed/standardized description of the core variable and additional variable fields, similar to what was provided by SSuN? (5/29/2018)

a. Answer: This strategy has two components. The first strategy (2A) pertains to the routine, comprehensive case-based surveillance for gonorrhea. All state health departments have regulations specifying the minimum requirements for disease surveillance, including specifying core person- and disease-based information. Jurisdictions funded under PCHD should assure the maintenance of a person-based case registry that is comprehensive of all cases of gonorrhea diagnosed in their jurisdictions, and that their case registry is de-duplicated by case (https://www.cdc.gov/std/laboratory/de-duplication-guidance-june2016.pdf) and by person.

The core epidemiological variables that should accompany each case meeting the CSTE Surveillance Case Definition (https://wwwn.cdc.gov/nndss/conditions/gonorrhea/case-definition/2014/) are specified in the NOFO and include variables available on laboratory reports: age, sex, county, diagnosing facility type, specimen collection date, and anatomic site(s) of infection. Value sets/formats for these variables are provided in DSTDP's NETSS Implementation Guide (Jan 2018, https://www.cdc.gov/std/program/STD-NETSSIMPLN-V5_2018Jan.pdf) for jurisdictions reporting cases to CDC through NETSS, and the HL7 Message Mapping Guide (https://wwwn.cdc.gov/nndss/document/STD_V1.0_MMG_F_R1_20180123.xlsx) for jurisdictions reporting to CDC through HL7.

The second strategy (2B) pertains to enhanced investigation of a random sample of cases from the entire jurisdiction or in a well-defined, high morbidity area. The enhanced investigation involves collection of additional epidemiologic variables to help programs better under the GC epidemiology in their jurisdiction. Some of these variables are included in the NETSS Record Layout and in the MMGs (e.g., race, ethnicity, gender of sex partner) and programs should consider using the value sets/formats provided in these documents. For variables not defined in the NETSS Record Layout and MMGs, jurisdictions could consider using value sets defined in the SSuN protocol (https://www.cdc.gov/std/ssun/protocol_v8.2_508.pdf).

I. How are we supposed to do surveillance for adverse outcomes such as neurosyphilis, otic and ocular when these are not reported through NETSS transmission and there is no case report form, etc.? Is this just for local use? Are we expected to send this to CDC somehow? How/why would we do surveillance for other adverse outcomes such as PID? (5/21/2018)

a. Answer: Revisions to the syphilis surveillance case definition and case report variables related to clinical manifestations of syphilis were made and took effect January 1, 2018. These revisions were made to ensure consistent and accurate reporting of cases and the appropriate capture of clinical manifestations, especially neurologic and ocular manifestations and late clinical manifestations. To enable jurisdictions to report these data to CDC, the STD NETSS record layout was revised to include these variables (https://www.cdc.gov/std/program/std-netssimpln-v5_2018jan.pdf) and the STD HL7 Message Mapping Guide includes these variables. For more information on how to conduct surveillance of these adverse outcomes, including strategies on how to collect data on clinical manifestations, please see the Technical Assistance Notes

[https://www.cdc.gov/std/funding/pchd/technical-notes.htm] for this strategy. At this time, the activities for this strategy should focus on surveillance of specific adverse outcomes of adult syphilis. In future years, CDC and programs may consider expanding to additional outcomes, such as PID.

J. Strategy 3B and work plan objective 3B-1, says "if needed, brief patient interviews of all cases of P and S syphilis". My question is related to the wording "if needed". Shouldn't all P&S cases should be interviewed? (7/2/2018)

a. Answer: The "if needed" statement is there to reinforce the fact that interviews of all cases may not need to be conducted for surveillance purposes. Discussions with providers could be sufficient in some areas, in order to obtain the core surveillance information on P&S syphilis. For disease investigation and intervention purposes, interviews with cases would be needed and are expected, as described under Strategy Area II.

Questions about Strategy Area II: Disease investigation and intervention

A. For Strategy Area II, HIV DIS activities are not really highlighted. Are HIV DIS prioritized in the CDC HIV grant? Can you speak to this? (5/21/2018)

a. Answer: note that the STD PCHD language includes a cross-cutting strategy, STD-related HIV prevention, on which programs may spend up to 10% of STD PCHD resources (NOFO page 8). STD-related HIV prevention efforts are expected as part of the work defined in all Strategy Areas. The CDC HIV cooperative agreement can be found at this site: https://www.cdc.gov/hiv/pdf/funding/announcements/ps18-1802/cdc-hiv-ps18-1802-nofo.pdf. To discuss the HIV cooperative agreement's support for HIV DIS, we recommend that you contact your CDC DHAP HIV prevention project officer.

B. Does CDC have a definition of outbreak which will be used for the grant? (5/21/2018)

a. Answer: While there is no standard definition of "outbreak," the document found at this link was developed to give STD programs a framework for understanding their epidemiology, determining if and when an outbreak might be occurring, and determining when additional resources and activities could be needed to prevent further transmission of disease: http://c.ymcdn.com/sites/www.cste.org/resource/resmgr/STD/SyphilisOutbreakDetectionGui.pdf. Also, the relevant Technical Assistance Notes on Strategy 6 may be helpful: https://www.cdc.gov/std/funding/pchd/technical-notes.htm]

C. The NOFO uses the phrase: "Conduct health department syphilis disease investigation . . ." Does this mean the disease investigation that is done only for health department clients infected with syphilis? (7/23/2018)

a. Answer: No, that phrase refers to syphilis investigation that is done by health department staff (usually DIS), as opposed to investigation and intervention done by the health care sector (e.g. via EPT). It does not refer to where people were diagnosed or who is prioritized for disease investigation.

Questions about Strategy Area III: Promotion of CDC-recommended screening, diagnosis, and treatment

A. In the new NOFO on page 15 under the "Assistance for STD clinical prevention services" section, it mentions that applicants may not provide more than 10 percent of the overall award amount without prior approval from CDC. What is the prior approval process for requesting to use more than 10 percent in that area? (5/7/2018)

a. Answer: Applicants who intend to exceed the 10% limit on this assistance should propose what they want to do in their application/budget, and provide strong justification for their proposal in their project narrative. DSTDP PDQIB will review the application and will communicate a recommendation to relevant applicants before the start of the period of performance if the information is proved in the initial application. Please note, this request can also be made throughout the period of performance and is not limited to the application submission.

B. We are hoping to have the option to use some of our STD PCHD funding to support innovative applications from county health departments for CT/GC/syphilis screening and treatment pilot projects in correctional settings, and we know that some of these may want to subcontract funds out from their health departments to their for-profit correctional medical services contractors. Is this allowed? (5/7/2018)

a. Answer: DSTDP PDQIB will need more information to approve or disapprove this proposal at this time. We suggest that the applicant 1) proposes what they would like to do in their application/budget, 2) provides additional justification for working with those particular correctional settings, and 3) provides draft MOU/ contract language that would ensure that the for-profit institutions would NOT profit from the safety net assistance provided by the state and local health departments. DSTDP PDQIB will make a recommendation after the application is received, and our recommendation to OGS (Office of Grant Services) will be communicated before the start of the period of performance.

C. Question: Is the requirement to "maintain a Bic forecasting inventory management system to monitor supply" specific to the drug supply purchased and maintained by the applicant as described on p15 under "assistance for STD clinical prevention services," OR is the expectation that the applicant maintain a tracking system for all Bic purchased by all providers within the applicant jurisdiction? I understand the need to have a plan in place to address shortages within the project area; my question is about how comprehensive the noted "inventory-management system" needs to be. (5/14/2018)

a. Answer: Applicants are not expected to create a comprehensive inventory management system for all Benzathine Penicillin G procurement and use across their project area. The forecasting inventory management system should focus on the Bic supply that the project area manages. For monitoring project area-wide syphilis treatment, it is important that project areas use surveillance data to monitor overall need (e.g., by regularly assessing syphilis treatment among reported cases to identify potential treatment supply issues (Strategy 11b)) and encouraging providers who are facing shortages or barriers to procuring treatment to inform the health department. Forecasting supply needs based on syphilis trends could also be helpful. Applicants that create a public health program for Benzathine Penicillin G provision for patients at risk of not being treated (under Strategy 11c) should closely track use of those particular treatments (as described in the NOFO), but that is separate from monitoring and forecasting

supply in general. NCSD, in collaboration with DSTDP PDQIB, is planning a webinar focused on Benzathine Penicillin G monitoring for June 20th from 3:00 to 4:00 PM ET, which may be helpful – the registration information will be shared soon. Discussion of how best to operationalize Benzathine Penicillin G monitoring, forecasting, and provision under STD PCHD will continue after award.

D. Define STD Specialty Clinics and provide examples by type of site or provider. (5/29/2018)

a. Answer: STD Specialty Clinics are provider settings whose services focus on the delivery of comprehensive, confidential STD clinical services, including same day diagnostic and treatment services. STD Specialty Clinics provide expert specialty care for STDs; they may be referral sites for STD care, or places that the populations served think of as an "STD clinic." They may be run by health departments in some areas, located in community health centers in others, be a CBO in some, or other variations.

E. Question: The NOFO assumes all states have STD Specialty Clinics. How should states that do not have STD Specialty Clinics respond, specifically to objectives around STD Specialty Clinics? Is this an area where the state would be able to "opt out" due to inability to perform the work? (5/14/2018)

a. Answer: In program areas without specialty care clinics, programs should focus these efforts on the clinics or care settings where a high proportion of the program area's STDs are diagnosed, or where a high proportion of the at-risk population seeks care. The goal is to improve adherence to CDC recommendations regarding screening, diagnosis, treatment and follow-up of STDs. If most STDs are diagnosed in non-specialty clinics, then project areas should focus on those facilities providing STD services. Specifically, for Strategy 10 (A and B) (NOFO page 15), programs without specialty clinics should write "N/A – no specialty care clinics" in the relevant parts of the Work Plan Template. For Strategies 11A-C and 12A-C (NOFO page 16), programs should conduct this work with clinics/settings who diagnose a high proportion of STDs and clinics/settings where at-risk populations seek health care. Please note that specialty STD clinics refer to public STD clinics whether on the state, city or county level that provide confidential and comprehensive STD services. State project areas should consider working with local counties who oversee STD specialty care clinics. Please see the related Technical Assistance Notes for this Strategy as well [https://www.cdc.gov/std/funding/pchd/technical-notes.htm]

F. Can we interpret "providers" more broadly to include not just clinical, but other stakeholders (health educators/teachers) that provide services to target populations? (5/21/2018)

a. Answer: The question does not specify which part of the NOFO might be expanded to include other, non-medical providers. However, if the budget request is properly justified with data showing the benefit of such spending, the request may be approved, subject to limitations. A proper justification for expanding the interpretation of "providers" would include a demonstrated lack of "providers" who meet the existing interpretation, and a justification for how the other stakeholders add value to the work being proposed.

G. Is the 10% funding [for safety net assistance] required? Can it be lower, say 5%? (5/21/2018)

a. Answer: Applicants are allowed to spend up to 10% of their funding on safety net assistance to governmental or non-profit clinics. They can spend less than 10%, whether 5% or even 0% (i.e. no funding used in this way).

H. On page 15, information about the allowance to purchase Benzathine penicillin G for the treatment of syphilis references some rules that overlap with 340B requirements. Can we use 340B to purchase this medication? (6/7/2018)

a. Answer: The 340B program is administered by HRSA's Office of Pharmacy Affairs. All 340B-related questions should be discussed with HRSA. For more information, see: https://www.hrsa.gov/opa/index.html. Please refer to the NOFO regarding the use of funds for clinical STD preventive services.

I. How do we get permission to purchase chlamydia and gonorrhea medications with CDC funds? Is purchasing azithromycin still allowed? Can we use PCHD funds to purchase meds for PDPT distribution efforts (through subcontract with partner organization)? Can azithromycin and lab supplies to cover chlamydia and gonorrhea testing for the priority populations who are under-insured be covered under Strategy III? Can only syphilis treatment be purchased under this grant? (6/7/2018)

a. Answer: STD medication purchases are allowed. Programs can use up to 10% of the overall award amount without prior approval from CDC, to support not-for-profit or governmental clinics that can document their ability to provide safety-net STD clinical preventive services as per CDC guidance. As part of this, recipients can opt to purchase STD medications for CT, GC, or syphilis, if such medications are a high priority to support safety net services for uninsured and underinsured patients.

This guidance supersedes the statement on page 45, under Funding Restrictions, which states "Recipients may not use funds to purchase medications other than those noted in the NOFO, without prior approval from CDC."

J. Is the 10% what would be given to state public health laboratories for testing the safety net population? Is this the only funding that state public health labs would receive for performing CT/GC and syphilis testing? Is there anything in the NOFO that restricts the amount of funding that can be used towards STD testing in the public health laboratory? (6/7/2018)

a. Answer: If a public health laboratory is doing CT/GC screening for under/uninsured patients as part of the safety net assistance, then funding for that activity would fall within the 10% and doesn't require approval from DSTDP unless it will exceed that percentage. Work that a public health laboratory does to support screening or testing in the course of other strategies under STD PCHD – such as disease investigation and intervention, outbreak situations, or enhanced surveillance -- would not necessarily fall under that 10% limit. DSTDP expects that state, local, other federal funding, as well as health insurance reimbursement, should be leveraged whenever possible to complement public health laboratory support under STD PCHD.

K. I was reading the new PCHD NOFO and under the funding restrictions section, page 44 of 65, it states, "Applicants may provide assistance, no more than 10% of the overall amount, without prior approval from CDC, to not-for-profit or government clinics that can document their ability to provide safety-net STD clinical preventive services as per CDC's guidance." I was wondering if our Chlamydia and Gonorrhea Screening program would fall into this category? If it does, this would significantly impact STD Screening in the state and if we were not able to financially support this program, it would be a huge loss for the entire state. (6/7/2018)

a. Answer: The chlamydia and gonorrhea screening program, when implemented using test kits, laboratory services, and/or clinical support provided by funding from this NOFO, will count as part of the 10%. In order to obtain approval to exceed the 10% limit on this assistance, the

applicant should show strong justification for their proposal in the project narrative. Strong justifications include data showing the need for such screening program in the proposed geographic area, the population impact of this activity and the need for NOFO funds to support it. DSTDP PDQIB will review the application and will communicate a recommendation to relevant applicants before the start of the period of performance if the information is provided in the initial application. Please note, this request can also be made throughout the period of performance and is not limited to the application submission.

L. This CT/GC Screening program for Local Health Departments, Title X Clinics and other community based organizations DOES qualify as "STD Clinical Prevention Services" and will be capped at 10% funding of the total award? The word that is throwing me off is "clinical" because this is just a testing program where we purchase test kits and provide them to local agencies, so I don't believe that truly qualifies as a clinical prevention service. (6/7/18)

a. Answer: For DSTDP, funding for test kits is considered assistance for clinical preventive services and <u>does</u> fall within the 10% safety net assistance. While the STD program may not be providing clinical services directly, the test kits are used in the context of STD clinical preventive services.

M. We would like a little more clarification around what types of funded efforts/services/supplies are considered to be part of "safety-net STD clinical preventive services" funding that is allowable via PCHD and specifically categorized as part of the <u>≤</u>10% clinical assistance amount. The guidance document on p. 15 states that these funds may be provided to "not-for-profit or governmental <u>clinics</u> that can document their ability to provide safety-net STD clinical preventive services…" and "at minimum, clinics receiving assistance should have the capacity to rapidly diagnose and treat bacterial STDs." I see that any purchase of Bic with these funds would count towards these dollars. What about any funding for program oversight of a Bic dispensing <u>infrastructure</u> – does that funding get counted? (6/7/18)

a. Answer: The assistance for safety net services must support STD clinical preventive services, but it can do so directly or indirectly. Applicants could fund service providers through direct contracts, fund laboratory testing at a public health laboratory, purchase test kits or fund other supportive services that help assure the provision of clinical preventive services for under/un-insured patients at risk of STDs. Funding for a Bic *dispensing* infrastructure could be included in that, so long as it was clear that the infrastructure assistance was clearly supporting or assuring STD clinical preventive services for such patients (in this case, access to Bic). Funding related to infrastructure for *monitoring* Bic (first part of strategy 11c) would be considered separate and not subject to the 10% assistance limit. These situations may require case-by-case review in collaboration with DSTDP and the Office of Financial Resources (OFR).

N. On p. 44, it is stated that "recipients may not use funds to purchase STD medications, other than noted in this NOFO…" It is not stated directly that we can use PCHD funds to buy PDPT meds – is this allowed? If so, would our purchase of CT/GC medications for our contracted PDPT Distribution Project fit in this category? And if yes, would we also need to count the funds we spend to pay a subcontractor to package the meds into partner dose packets need to be included? What about our contract to a CBO to manage and implement this online dispensing project? Separately, most of these PDPT packets are distributed to FQHCs, county, and Title X clinics, however some also go to counties for field-delivered therapy disseminated not via a clinic but by DIS. Is this allowable? (6/7/18)

a. Answer: STD medications aside from Benzathine penicillin G can be purchased under STD PCHD as part of the 10% safety net assistance, provided that the purpose is for uninsured or

underinsured patients. PDPT medications are also allowed. This guidance supersedes the statement on page 45, under Funding Restrictions, which states "Recipients may not use funds to purchase medications other than those noted in the NOFO, without prior approval from CDC." Costs related to assuring PDPT in particular (i.e. the contractor costs mentioned in the question) could be a part of the 10%, but it could also be considered a part of the work for Strategy 8 under Strategy Area II, Disease Investigation and Intervention. Without a better understanding of the program, it is difficult for DSTDP PDQIB to make a firm determination at this time. The applicant should categorize the work as they see fit. EPT/PDPT provided outside of clinical settings (i.e., by DIS in the field) is allowed under STD PCHD.

O. What about purchase of condoms and our condom distribution project – are those costs (condoms, postage, online website costs, project management and implementation costs) included in this category of safety-net services? (6/7/18)

a. Answer: No, condom distribution is not considered part of the clinical preventive services that the STD PS19-1901 safety-net assistance is intended to support. Applicants are encouraged to collaborate with HIV prevention programs that may have dedicated funding to support condom distribution.

P. On page 42 of the NOFO it speaks to implementing integrated screening activities for HIV, viral hepatitis, and/or TB. Does this also include being able to purchase vaccination for Hepatitis A and B? (7/2/2018)

a. Answer: The note on page 42 is NCHHSTP language to encourage Program Collaboration and Service Integration (PSCI) for the prevention and control programs supported by the Center (HIV, VH, STD and TB). The priority is to encourage integration of screening activities, not vaccination programs. An example of this type of service integration could be comprehensive HIV, STD, VH and TB screening in the field as part of partner services programs offered by DIS.

Q. Can DSTDP please summarize all the guidance related to the 10% safety net assistance? It is still a bit confusing to me. (7/2/2018)

a. Answer: A new STD PCHD TA Note has been posted that summarizes information related to the 10% safety net assistance. Please go here: https://www.cdc.gov/std/funding/pchd/technical-notes.htm to access that new document.

R. We would like to request an exception to the 10% safety net assistance cap for year one of STD PCHD and spend more than that. [*justification provided; omitted here*]. Will CDC approve this proposal? (7/2/2018)

a. Answer: Applicants who seek to spend more than 10% of the total funding on the safety net assistance for STD clinical preventive services should include such proposals, with justification, in their application for STD PCHD. DSTDP PDQIB will review such requests as part of the application review process and in the context of the entire prevention and control program outlined in the application. DSTDP recognizes that each STD program is unique. Thus, STD PCHD provides flexibility so that jurisdictions can tailor their STD prevention and control programs to the local context based on STD epidemiology and available resources to achieve highest impact.

There have been no predetermined decisions made at DSTDP as to how a program should implement the strategies outlined in the NOFO, however we have outlined possible approaches

and provided suggestions in the Technical Notes. The new STD PCHD TA Note about the 10% assistance provides additional suggestions on preparing proposals to spend more than 10% of the total funding.

S. For areas that currently devote more than 10% of their budget to safety net assistance, does this 10% cap have to be implemented in the first year of PCHD, or will CDC provide flexibility for this requirement to be phased in over the 5 year PCHD project period (7/2/2018)

a. Answer: The 10% assistance for safety net services does not have to be implemented in the first year of STD PCHD. As noted above, DSTDP will offer some flexibility to implement this funding limit over time and will work with recipients who request to spend more than 10% based on their program context and rationale. For the application period, DSTDP recommends that applicants submit what they would like to do for their safety net assistance, with justification, and DSTDP will review and assess these proposals within the context of the larger application and program context. The new STD PCHD TA Note about the 10% assistance provides additional suggestions for preparing such proposals: https://www.cdc.gov/std/funding/pchd/technical-notes.htm.

T. A 10% cap to all jurisdictions does not seem like parity given wide variation in funding levels -- i.e. you can do a lot more with 10% of a million than $300,000. How does CDC think about this issue? (7/2/2018)

a. Answer: The program awards are based on a formula that takes into account the size of the at-risk population and STD morbidity and thus helps address previous parity issues. The higher award project areas have bigger safety net populations to serve. Additionally, it is also important to bear in mind that the award floor for STD PCDH was increased by 100% compared to STD AAPPS, to better support comprehensive STD prevention and control programs in smaller project areas.

U. I was reading through the STD PCHD Technical Assistance Notes and on the last page of 11B near the flag it states to refer to 11C for notes regarding the Bicillin L-A Monitoring. On the website I do not see a 11C Link. Is it available? (7/2/2018)

a. Answer: That particular STD PCHD TA Notes document was taken down from the website to be revised. It will be posted again when it is ready. DSTDP PDQIB hopes it will be within the next week or two.

V. Does CDC have a list of medications that we are allowed to purchase under the grant for STD prevention? (7/23/2018)

a. Answer: No, DSTDP does not have a list to offer at this time. Budget narratives should include lists of specific medications that applicants propose to purchase with STD PCHD funds. After the application period, DSTDP PDQIB will discuss with applicants any questions about medications proposed for purchase, as needed.

W. Would direct assistance provided to STD Specialty Care clinics in the form of test kits and laboratory services fall within the 10% safety net assistance? (7/23/2018)

a. Answer: Yes, such assistance would fall within the 10% safety net assistance, assuming the assistance was for STD screening, diagnosis, and treatment for under/uninsured patients.

Applicant should refer to the STD PCHD TA Note on the 10% assistance for additional information about that assistance.

Questions about Strategy Area IV: Prevention and policy

A. It doesn't look like the work plan template is created to allow us to add a new (e.g., 13B, 13C) sub-strategies that align more with the previous AAPPS strategies that fell under Assurance: Health Promotion and Prevention Education . . . Does this mean that we should leave out of our work plan all of our efforts focused on health promotion and prevention education for at-risk populations and non-clinical safety-net providers who serve them that do not align with 13A? Or can we add these efforts in somewhere? (5/7/2018)

a. Answer: If the work on health promotion and prevention education is strategically important for an applicant, that work should definitely be represented in the work plan. Such activities for at-risk populations does fit best under Strategy 13A under Strategy Area IV. In such cases, applicants should add an objective under 13A to relay their objectives and activities related to community education, and applicants should be sure to include relevant contextual information about the health promotion activities in the work plan sections related to partnerships and other context (if the applicant is using the recommended templates.)

In general, if an applicant plans to continue activities implemented under STD AAPPS or other funding mechanisms that are not clearly required by STD PCHD, they are encouraged to share their successes and challenges in the narrative section of the application as well as subsequent IPRs/APRs (interim and annual progress reports). In no way should the set of 17 STD PCHD strategies been seen as the only ones that a health department may focus on for STD prevention and control. Rather, the NOFO outlines the strategies that DSTDP is prioritizing and providing funding to accomplish. However, applicants cannot substitute STD AAPPS activities in lieu of those strategies that are required in STD PCHD.

B. Can smaller jurisdictions, such as separately funded cities, not spend as much on the Prevention and Policy Strategy (15-20%) as state jurisdictions with many counties and potentially disparate programs with a greater breadth of policy responsibilities? (5/29/2018)

a. Answer: Yes, as stated in the NOFO, the suggested allocation of effort provided in the document is a recommendation. Applicants should justify any major deviations from the recommended allocation range in their applications.

Questions about Strategy Area V: Data use for program improvement

A. Are directly funded cities required to complete strategy 16.C since there are no other local jurisdictions that we work with? Are there any other strategies that might not apply to us? (5/7/2018)

a. Answer: No, directly funded cities are not required to complete strategy 16.C., i.e. to work with local jurisdictions to help analyze and use their data. This is the only strategy that does not apply to directly funded cities. If using the recommended work plan template, these applicant should write "N/A- local jurisdiction" in the associated SMART objectives text box for 16C. Please do not leave that strategy section completely blank.

Evaluation and performance measurement

A. Page 24: The "analyze and use data" section is confusing. "% of recipients" refers to who? Is this a larger CDC measure re jurisdictions? (5/7/2018)

a. Answer: These proposed measures have not yet been defined in detail. As noted in the NOFO (p. 22), DSTDP PDQIB plans to work with recipients to further define all measures after award. The specific measure referenced in the question is one that CDC would measure across its funded recipients, not something that recipients would be expected to track themselves over time. DSTDP PDQIB would ask each recipient to report whether in some determined time period, they had conducted a data-driven review, etc.; and CDC would aggregate and track that over the period of performance. This will be vetted and discussed together at a later date.

B. Are the outcome objectives outlined in the "CDC Evaluation and Performance Measurement Strategy" section of the NOFO what we can expect for POMS this cycle, or are those examples of objectives that would fit in the work plan under each strategy? (5/21/18)

a. Answer: The measures proposed in the CDC Evaluation and Performance Measurement Strategy section of the NOFO reflect the set of POM (program outcome measures) that we plan to discuss with recipients after the application period. It is likely that some of those will change through those discussions, and we will issue final guidance with definitions and reporting/ report-out plans after that. So the outcomes described in the NOFO are what applicants can expect to discuss with DSTDP PDQIB as potential POM, but they are not the final POM. They are also examples of objectives that could fit into the work plan under each strategy. Some project areas may adopt a DSTDP POM as their own objective, while other project areas may not (e.g., if they are doing very well on a POM or have another high priority measure they want to use to direct their work). So the answer is mixed. They could be examples of objectives that could fit into the work plan under each strategy, but applicants should not just rely on those for objectives. Each project area should develop objectives that make sense for their program, priorities, and emphasis in a particular year.

C. Can you give more information about the Data Management Plan requirement? (5/21/2018)

a. Answer: The Data Management Plan (DMP) mentioned on pages 25 and 26 of the NOFO is a new CDC-wide requirement. Applicants to PS19-1901 do not need to provide a DMP with their application. Rather, DSTDP PDQIB will provide more guidance on this requirement after the application period is over, and a DMP will be a part of the larger Evaluation Plan that all recipients will be asked to provide within 6 months of award.

D. On page 24, a process measure related to "% of federally and state funded DIS who are certified" is listed as a Prevention and Policy Area measure. Can we put a related objective for this in the DII Strategy Area (II), or must it fall under Prevention and Policy Area IV? (5/21/2018)

a. Answer: Applicants can include an objective around that proposed process measure under Strategy Area II (Disease Investigation and Intervention). They do not have to apply that objective to the Prevention and Policy Strategy Area. Activities related to DIS training in general can be included under Strategy Area II. That measure's placement under Strategy Area IV in the NOFO reflects how DSTDP PDQIB conceptualized the measure, namely as a policy issue; but that should not dictate where/how applicants use the proposed process measures in their work plans at this time.

E. Is the applicant evaluation and performance measurement plan included as part of the 15 page narrative, or is this something we will be submitting within the first 6 months of the grant? (5/22/2018)

a. The applicant evaluation and performance measurement plan should be part of the 15 page narrative, and guidance for what to cover in that section appears on pages 26-27 of the NOFO, starting under "Performance Measures" and then under "Evaluation." Responding to those sets of bullet points should take only a few pages. A full Evaluation and Performance Measurement plan will be due within 6 months of award, after DSTDP PDQIB and recipients finalize the performance measures together and after recipients have more time to develop a full targeted evaluation plan. DSTDP PDQIB will provide guidance on the TEP and what to include in the 6-month evaluation plan at a later date.

F. Page 12 of the NOFO indicates, "Therefore, the highest priority populations for health department STD services are: pregnant women with syphilis and other women of reproductive age with early syphilis, followed by men with primary and secondary syphilis whose partners are pregnant or are other women of reproductive age." This **is followed with letter B on page 13 with, "Provider timely and comprehensive partner services to men with primary and secondary syphilis who report pregnant or other female partners of reproductive age." How is performance addressed for this population in the Evaluation and Performance Measurement potion of the NOFO? (5/29/2018)**

a. Answer: As described on page 40 of the NOFO, applicants will be required to submit a more detailed Evaluation and Performance measure plan (including data management plan elements) within the first 6 months of the award, as described in the Reporting Section of the NOFO. CDC DSTDP PDQIB will work with recipients on evaluation and performance plans. Please follow the NOFO's application guidance for the evaluation and performance measure requirements in the applicant. This does not have to include a performance measure for each activity.

G. In order to respond to the required outcome measures piece of the Evaluation and Performance Measurement Section, we would like to create a grid to track all of the measurement details. Must this grid be included within the body of the narrative, or might we submit the grid as an appendix as an option to save space? (6/7/18)

a. Answer: DSTDP prefers applicants to include their responses to the proposed outcome measures as part of the Evaluation and Performance Measurement section of the narrative body. Using a grid or table would be an efficient way to relay information about the proposed measures and could be pasted into the narrative. If space remains an issue, applicants could find other ways to summarize their initial reactions to the outcome measures (e.g., focus only on the outcome measures that they find most problematic or questionable).

H. This question relates to the Evaluation and Performance Measurement potion of "Promote STD prevention and policy." For the outcome of improved health department policies for STD prevention, % of *recipients* reporting positive policy changes within the health department, are recipients our health department patients/clients? (6/7/2018)

a. Answer: No, in this proposed measure, the "recipients" are recipients of STD PCHD. It is a global measure that DSTDP PDQIB would track across the 59 recipients of STD PCHD. Each recipient would only report for itself, whether they (not their subcontractors) had experienced a positive policy change within their health department in a particular time period.

I. Can we use performance measures in the NOFO as Output Indicators in the work plan? For example, if our objective is to improve the timeliness of CT reporting to PDPH to better understand and react to

potential CT outbreaks, and one of our activities is to increase the % of CT laboratory reports received and process via electronic laboratory reporting (ELR) into the surveillance system by 3%. Output indicator: % of CT Labs coming via ELR. (6/7/2018)

a. Answer: Yes, applicants can use performance measures in the NOFO as Objective Indicators in their work plans, but they should not feel limited to using only those measures that appear in the NOFO. If the process or outcome measures proposed are appropriate for the work planned, then please feel free to use them.

J. **Would a CT QI project for our new database be an acceptable TEP idea? (6/20/2018)**
   a. Answer: Yes, Quality Improvement (QI) projects usually make excellent TEPs. For further information, please see the Technical Assistance Note on TEPS (https://www.cdc.gov/std/funding/docs/STD-PCHD-TA-Notes-17b-Targeted-Evaluation-Projects.pdf). Please note that the topic of the TEP is all that is needed for the proposal; once awards are made, the Evaluation Team will be in contact to further discuss the TEP topics with you.

K. **On page 23 of 65 of the NOFO, under the outcome: increased use of recommended, timely treatment the following is listed: 1) # of patients or partners provided one shot of Benzathine penicillin G through the public health program for untreated cases, and 2) # of patients or partners provided three shots of Benzathine penicillin G through the public health program for untreated cases. Can you please clarify what "through the public health program" means? Our health department does not have a clinic and we are not anticipating using any of this funding to purchase Benzathine penicillin G. (6/20/2018)**
   a. Answer: By "the public health program," DSTDP PDQIB is referring to a program set up by an applicant to assure appropriate syphilis treatment to under/uninsured patients, as described in the Strategies section of the NOFO (under Strategy Area III, p. 15 paragraph starting with "This funding can be used to . . . "). If an applicant is not establishing and running a program to facilitate the availability of Benzathine penicillin G to such patients in their project area, they do not need to track those two measures referenced.

L. **In reference to proposed outcome measures for Disease Investigation and Intervention: When you say "% of other women of reproductive age with syphilis…." Are you referring to 1) All female syphilis cases of reproductive age (15-44) or 2). Non-pregnant female syphilis cases of reproductive age (15-44)? (7/2/2018)**
   a. Answer: At this time, DSTDP PDQIB is referring to #2. These and other proposed measures will be discussed with recipients of STD PCHD, and more detailed definitions and reporting guidelines will be provided after award, as mentioned on Page 22 of the NOFO ("CDC will finalize these measures, their specific definitions, benchmarks, submission frequency, and submission templates in consultation with recipients within 6 months of award.")

M. **On Page 23/65 under the section "Promote CDC-recommended screening, diagnosis, and treatment the following is asked: Promote timely and recommended treatment: 1) # of patients or partners provided one shot of Benzathine penicillin G through the public health program for untreated cases, and 2) # of patients or partners provided three shots of Benzathine penicillin G through the public health program for untreated cases. I am confused with what you mean by the last part "untreated cases". Are you asking about Preventatively treated patients or partners who are not cases or are you considering "untreated cases" to be defined as patients or partners who are infected and meet case definition but have not yet been treated? (7/2/2018)**

a. Answer: Those measures refer to people served through any special Benzathine pencillin G program that a project area decides to set up under STD PCHD (and who, in turn, receive 1 or 3 shots). Under Strategy Area III, there is permission to set up a public health program to make Benzathine pencillin G more available to under/uninsured persons who are at risk of not receiving appropriate, timely treatment. The "untreated cases" in the proposed measures refers to those patients, in a short-hand way.

Note that the measures in the Performance Measurement section are proposed, not final. As mentioned on Page 22 of the NOFO, "CDC will finalize these measures, their specific definitions, benchmarks, submission frequency, and submission templates in consultation with recipients within 6 months of award."

N. **On page 26 of the NOFO it states, "For the proposed outcome measures listed above, applicants should describe: Any available baseline measures..." Does any available baseline measures include only baseline measures we've already reported to CDC (i.e. via POMs), or does this refer to our ability to obtain a baseline measure for each of the proposed outcome measures listed? (7/11/2018)**

a. Answer: That phrase refers to applicants' ability to obtain baseline measures for the proposed outcome measures listed. DSTDP PDQIB does not expect applicants to submit baseline data in their applications. That said, applicants are welcome to do so (e.g., as objectives in their work plans, or as part of rationale given for certain priorities or approaches outlined in the application). The measures will be finalized after award in consultation with recipients, and formal data submission guidance will be provided to recipients after the measures are finalized.

O. **Is there any additional guidance or template for the Evaluation and Performance Measurement Plan other than what is in the NOFO? We are struggling with the level of detail to include in the narrative for the evaluation and performance measurement plan. The NOFO lists quite a lot of required information, but, also makes me believe it can be very general, with the detail coming 6 months into the funding year. (7/11/2018)**

a. Answer: DSTDP PDQIB did not provide a template for the Evaluation and Performance Measurement part of the application. That should be a section of the 15-page project narrative. That section should cover the following topics: 1) feedback on proposed outcome (not process) measures, 2) Suggestions for other measures, 3) Proposed topic for first TEP (not a full plan), and 4) Other evaluation work you plan to pursue (from slide 54, orientation webinar).

The review criteria for Evaluation and Performance Measurement (page 47 of the NOFO), also summarizes what to cover in that section, in a slightly more detailed way: "Evaluate the extent to which the applicant:

Provides a detailed response to proposed common outcome (not process) measures described in the CDC Evaluation and Performance Measurement Strategy section, including:
Any baseline data and definitions used for those measures,
Their perceived ability to report on proposed, required measures,
The perceived utility of the proposed, required measures;
Other measures they believe would be strong common measures

Describes the topic for their proposed first targeted evaluation project (TEP) and provides a strong justification for that topic, &
Demonstrates capacity and interest in conducting more in-depth evaluation of high priority or innovative strategies or activities"

As described in other Q&A, applicants may opt to insert a table in their applications that summarizes their reactions to the outcome measures or find other ways to streamline that part of the response (e.g. focus only on measures they find particularly problematic).

P. Are we allowed to present detailed information for our "Evaluation and Performance Measurement Plan" as an attachment, vs. in the narrative? (7/23/2018)

a. Answer: DSTDP PDQIB prefers that each applicant's response to the Evaluation and Performance Measurement section of the Project Narrative be included within the Project Narrative, rather than an attachment, if possible. Inserting a table into the narrative section to efficiently summarize general reactions to proposed outcome measures is encouraged, to save space on that part of the EPMP. Applicants are also encouraged to review closely the guidance provided by DSTDP about what to include in that section (see other Q&A above).

Q. On page 26 of the NOFO it states, "For the proposed outcome measures listed above, applicants should describe: Any available baseline measures..." Does any available baseline measures include only baseline measures we've already reported to CDC (i.e. via POMs), or does this refer to our ability to obtain a baseline measure for each of the proposed outcome measures listed? (7/23/2018)

a. Answer: This refers to applicants' ability to obtain baseline measures. DSTDP PDQIB does not expect all applicants to submit baseline measures for the proposed measures at this time, since the measures are still under development.

Organizational capacity & Collaborations

A. Do the point people for each strategy area of PCHD have to be city/state employees (as opposed to CDC)? [In reference to Organizational Capacity to Implement the Approach, p. 28 of NOFO, in which CDC requests information in the application on key personnel that will be responsible for implementing each of the 5 Strategy Areas] (5/21/18)

a. Answer: No, they do not have to be city/state employees. They can be federal staff (if applicable), contractors, or other employee/staff types.

B. Do the point people have to be listed in the budget for PCHD (i.e. on the grant) or can they contribute to the grant in-kind? (5/21/18)

a. Answer: Point people can be in-kind. If an individual is playing a key role in program implementation, even in an in-kind way, we recommend that they and their time still be listed in the budget (albeit with 0$ next to them). That way, the budget document presents a fuller picture of the key staffing for the project. However, every person who contributes any in-kind support to implementation of STD PCHD does not need to be included in the budget. This suggestion is for key personnel contributing in-kind (or as funded staff) to the project.

C. In small states, the HIV and STD PIs might be the same person. Is it necessary to answer all the questions regarding collaboration in that case? (5/21/2018)

a. Answer: Yes. In that section, DSTDP PDQIB seeks to understand some of the most important ways in which the CDC-funded HIV prevention work supports the CDC-funded STD program work, and vice versa. Regardless of program structure, staffing, or size, applicants should highlight the more important ways the two programs collaborate to meet the goals of STD PCHD.

D. The guidance specifically states a required partnership with regional PTCs. Are recipients also encouraged to partner with the National Centers of the NNPTC network? (5/21/2018)

a. Answer: Yes, applicants certainly are encouraged to partner with the National Centers of the NNPTC network as well. However, we expect that for most applicants, the regional centers will be the more important source of collaboration over the course of the project. Moreover, applicants do not need to outline their highest priority planned collaborations with the National Centers in their application under "Collaborations," as they are asked to do for their respective regional center.

E. Do you have guidance on what information should be addressed within the city-state pair letters? (5/21/2018)

a. Answer: Cooperative agreement PS18-1802 that came out from CDC's Division of HIV/AIDS Prevention (DHAP) also required this kind of letter. On that NOFO's website, there is an outline of what that letter could cover: https://www.cdc.gov/hiv/pdf/funding/announcements/ps18-1802/CDC-HIV-PS18-1802-AttachmentG-City-State-Sample-Letter-of-Agreement.pdf Applicants also may want to reach out to their health department colleagues who applied to PS18-1802, to see what they ended up submitting for that, and use that as a model.

F. For the management and staffing plan component of the Organizational Capacity section, it asks for relevant expertise of staff that will be working in each of the strategies. How much detail are we expected to go into here? Would it be sufficient to simply list their title since we will be submitting CVs with the application? (7/2/2018)

a. Answer: In this section, applicants should briefly describe the relevant expertise for staff that will be the primary points of program oversight or implementation for each of the 5 strategy areas. Applicants should provide CVs or resumes for key personnel as attachments, and they should also provide a short summary of the key personnel's qualifications (beyond their title) in the project narrative. The summary may be brief, such as a few sentences or a short paragraph, per strategy area or per key personnel.

G. Are we required to work with NCSD on policy development? (7/11/2018)

a. Answer: Collaboration with the NNECS recipient is required as described on pages 17 & 19; however as with all required strategies and activities, an applicant can request to opt out of an activity (page 8-9). See below for language from the NOFO:

Page 17: Strategy Area IV: Promote STD Prevention and Policy: "15. Monitor STD-related policies and policy development a) Work with the CDC, the NNECS recipient, and other partners to identify STD-related policies of interest. Monitor proposed and actual changes in policies that may affect STD prevention programs, b) Work with local policy liaisons and with partner organizations on the development of policies that enhance the work of the STD prevention program"

Page 19: Collaborations: a. With Other CDC programs and CDC-funded organizations: "Second, recipients are required to collaborate with the National Network to Enhance Capacity of State and Local Sexually Transmitted Disease Prevention Program (NNECS) (currently PS13- 1309; to be PS18-1808), for which the National Coalition of STD Directors (NCSD) is the current recipient (as of April 2018). Recipients must collaborate with the NNECS recipient to strengthen policy

development, communication and collaboration with other recipients to conduct program improvement, and to address other STD program technical issues."

Page 8-9: Required strategies and activities: "Implementation of all strategies and activities described below is required by all applicants. Applicants can request to opt out of selected required activities by providing a strong justification, which must be based on program priorities, resources, and/or policies. Approval will be considered after review of the application."

H. Can we just list collaborators in the table format? (7/23/2018)

a. Answer: Yes, that is acceptable, though it should be included within the 15 pages of project narrative.

Work plan

A. Set of questions about the page limits for the application, as related to the work plans: Is the project narrative limited to 20 pages (p 38) or 15 pages (p58)? Please clarify the discrepant information presented on pages 38, 40, and 58, in terms of whether work plans count towards the narrative page limit, or whether they can be separate attachments and not count towards the narrative page limit. Are there separate page limits for the one year and five year workplans? If so, please say what they are and explain whether they count towards the project narrative page limit. (5/7/2018) and (5/14/2018)

a. Answer: We are aware that the NOFO document includes inconsistent information about the page limits for the narrative and work plan.

1. The correct information can be found on page 58, which indicates that "*For this NOFO, the Project Narrative should not exceed 15 pages (single-spaced), and the work plan should not exceed 25 pages (table format)*." So, applicants have a recommended combined limit of 40 pages for the total Project Narrative (work plans + narrative).
2. The work plans can be submitted as separate PDF files with your application and are not included in the maximum 15 pages of narrative. In other words, while not technically part of the "attachments," the work plan documents can be submitted separately.
3. The "work plan" mentioned in the NOFO includes both the 5 year and 1-year work plans. There are not separate page limits for the two parts.
4. If an applicant opts to use the recommended Excel templates, and the applicant discovers that 25 pages in printed PDF form is insufficient to capture the information they want to provide, please inform DSTDP PDQIB and please go ahead and submit a complete work plan (5-year + 1-year), even if that ends up exceeding 25 pages when printed to PDF format at the time of submission. For this NOFO, complete work plans are more important to DSTDP PDQIB than the suggested page limit, which was an estimate. Applicants should attempt to keep their work plans streamlined, but those who exceed the 25 pages for the work plan as part of the application process will not be penalized.

B. Question: In looking at how the work plan is organized, I am wondering if we could use the same language/format to ask this of our counties so all jurisdictions are focused on the same strategies. Could we borrow from the NOFO when planning our own renewal process and documents for our counties? (5/14/2018)

a. Answer: The NOFO is public information, and as such, you are free to use it in your efforts in states, counties, and cities. If the format of the work plan is useful in your program area, then

we encourage the use of it at multiple levels. To be clear, the only work plan that should be submitted to CDC is the work plan for the entire project area. Local work plans should be used only within your program, and do not need to be sent to CDC. In addition, programs are reminded that this NOFO covers the core activities of STD prevention and control, but recipients are strongly encouraged to review their local data, alongside other local and national priorities, to tailor STD prevention and control strategies in their region.

C. Would CDC be willing (or are you planning to) share some best practice/good examples of SMART objectives for each Strategy area? In the past, we've gotten conflicting information from our project officer about the scope of the objectives (broad – disease-based outcomes or can the objectives be more short-term process objectives)? (5/21/18)

a. Answer: The work plan orientation sessions scheduled for Friday, 5/18 and 5/22, should help address this question. DSTDP PDQIB is working actively to harmonize TA and advice to project areas around issues like this, to ensure consistent guidance is given to all project areas around work plan expectations. Specific to the question raised about best practices for writing SMART objectives, in general, DSTDP is interested in short-term objectives that relate to each applicant's plans for year one, rather than SMART objectives covering the 5-year period.

D. Does the 25 page limit for the work plan include the 5 year work plan as well as the 1 year work plan? (5/29/2018)

a. Answer: Yes, but if your files add up to more than 25 pages, DSTDP PDQIB still encourages applicants to submit all relevant work plan documents. DSTDP PDQIB recognizes that the formatting and white space in the templates may increase the page limit, but applicants should submit both templates filled out to the best of their ability. If an applicant anticipates going significantly over the 25 page combined limit, they should contact std_pchd@cdc.gov.

E. Some sample work plan objectives appear to be process-oriented, rather than outcome-oriented. Are we able to contribute process-oriented objectives for STD PCHD? (5/29/2018)

a. Answer: Yes. DSTDP PDQIB encourages outcome-oriented, quantitative, SMART objectives wherever possible. However, some applicants may have important process-oriented objectives that are a priority for Year 1, particularly among new or revised strategies. Programs are encouraged to consider their stage of implementation across each strategy, and develop relevant objectives, be they process or outcome-oriented. When proposing process-oriented objectives, applicants may feel that their objectives do not fit the "SMART" formula perfectly. In such cases, objectives should be designed to be as "SMART" as possible, while still in line with what is being proposed. Specific process and outcome measures will be required as part of STD PCHD Program Outcome Measures (POM) reporting; but work plans can, and should, have a mix of both process and outcome measures.

F. Is there a requirement surrounding the number of activities per objective? (5/29/2018)

a. Answer: The current work plan template allow a maximum of four listed activities per objective. Applicants are not required to submit exactly four activities for each objective, but must submit at least one activity per listed objective.

G. Can we repeat objectives that apply to multiple strategies, or between strategy areas (e.g., improving surveillance quality in a number of disease areas)? (5/29/2018)

a. Answer: Applicants should not repeat *identical* objectives across different strategies, but they can submit similar objectives around a priority area, such as improving surveillance data quality or promoting CDC-recommended screening/DX/TX practices. Applicants are encouraged to review their data and develop relevant disease/population/sector-specific objectives, with baseline/target measures for each strategy. For example, data quality objectives might be "Increase the completeness of site of infection on gonorrhea lab reports from 30% to 55%," and "Increase the completeness of race on chlamydia lab reports from 47% to 65%".

H. Related questions: Should the work plan be submitted in a .pdf or .xlsx format? (May 18 webinar) To confirm, we can submit an Excel file to grants.gov? On page 57 of the NOFO, it states that attachments should be uploaded as PDF files. (May 24 webinar) (5/29/2018)

a. Answer: Grants.gov does accept multiple file formats, including .xlsx. Applicants are encouraged to upload a finalized copy of their work plan template documents in .xlsx (Excel) format to grants.gov, with a courtesy copy sent to std_pchd@cdc.gov. If local programmatic regulations restrict your ability to upload documents in non-PDF formats, a PDF upload of the document is also accepted, but applicants are requested to send the courtesy copy in .xlsx format.

I. How do you make changes after you click "Save to Submit"? (5/29/2018)

a. Answer: Clicking "Save to Submit" will create a ***new*** template file that is protected from further editing. If an applicant needs to edit the document, they should open the most recent saved .xlsm version of the work plan template, and re-select the "Save to Submit" button to create a new non-editable .xlsx file

J. Given that text fields expand to fit what we enter, and there is a page limit for work plan submission, will the "Save to Submit" button automatically adjust page breaks to minimize page length, or do project areas have to adjust these by hand? (5/29/2018)

a. Answer: Applicants are not expected to manually adjust the page breaks to prepare the template for submission; template print areas are pre-set. The Excel formatting will result in additional white space that may increase the page length of these documents. Applicants should fill out their work plans to the best of their ability, and reach out to std_pchd@cdc.gov if the cumulative page length is significantly over the 25 page limit.

K. What shall we do if we do not have specific baseline data yet for our objectives? The SMART objective builder tool and the Year 1 Work Plan require these very specific data. Similarly with other brand new intervention efforts outside of the clinical areas, we may not have baseline data until we start or even finish the work in year 1. How would you like us to indicate that baseline data is not available yet? Also, if we propose to increase outcome measures by at least 10% over baseline, without knowing the baseline number exactly, how would you like us to indicate that goal? (5/29/2018)

a. Answer: CDC encourages the use of SMART objectives wherever possible, and has included the SMART Objective Builder as an ***optional*** tool to help programs develop objectives in situations where quantifiable data is currently available. However, we recognize that programs may be in varying stages of implementation across different STD PCHD strategies, and may not have specific measures to include in their Year One work plan. This is entirely acceptable, and expected. If your program's priority in the first year is an objective that does not currently have baseline measures, you can enter "*N/A*" or "*TBD*" in the Baseline or Target fields in the work plan template. Or, in a situation where the Year One objective is specifically to develop baseline

measures for a strategy, it is acceptable to list, in the Target field, "*Establish baseline measures for Year 2*." It is expected that non-quantifiable baselines/targets will be replaced with SMART objectives as implementation of STD PCHD strategies unfolds over the five-year project period.

L. In the Baseline and Target sections on the Year 1 Workplan, would you prefer a number (75%) or a number and an explanation (DIS completed 75% of assigned P&S interviews in 2017)? (5/29/2018)

a. Answer: In the Baseline and Target sections, you can simply place the quantitative value without an explanation. The explanation for that number should be included as part of your annual objective statement. For the example above, you might write "*By December 2019, increase the percent of P&S index patients interviewed by DIS from 75% to 90%"* in the Objective field, and then include the values "75%" and "90%" in the respective baseline and target fields to the right on the template.

M. If we don't have baseline data, can we make gathering baseline data part of the year one activities? (5/29/2018)

a. Answer: Yes. We recognize that programs may be in varying stages of implementation across different STD PCHD strategies, and may not have specific baseline measures to include in their Year One work plan. If your program's priority in the first year is an objective that does not currently have baseline measures, you can enter "*N/A*" or "*TBD*" in the Baseline or Target fields in the work plan template. Or, in a situation where the Year One objective is specifically to develop baseline measures for a strategy, it is acceptable to list, in the Target field, "*Establish baseline measures for Year 2*." It is expected that non-quantifiable baselines/targets will be replaced with SMART objectives as implementation of STD PCHD strategies unfolds over the five-year project period.

N. Can we use activities outlined in the Technical Assistance (TA) Notes in our work plan? Examples: Create and automate standardized weekly report of CT trends; and conduct regular data cleaning SAS programs to detect any errors / illogical dates in laboratory reports (specimen collection dates in the future or preceding birthdates) (6/7/2018)

a. Answer: Applicants may use the examples outlined in the STD PCHD TA Notes in their work plans. However, the TA Notes are not intended to limit the activities proposed. If the activities outlined in the TA Notes are in line with the needs of an applicant's program, then they should feel free to use them.

O. Currently you can only enter text into yellow cells and you are unable to insert comments into any cells either. It would be extremely helpful to have a notes/comments field to the right of the existing fields/form to help with assigning sections to staff and generating ideas/questions while working on completing the work plan/applications. Is this something you could add to the file for everyone's benefit? (6/13/2018)

a. Answer: In order to protect and maintain template functionality and navigation features, certain functions - such as adding columns, comments, or modifying workbook structure – are disabled. We recognize that this does present limitations in collaboratively editing or commenting on in-progress Excel files. For draft versions of the work plan, applicants can copy and paste template sheets into Word, which maintains template formatting and allows for Review ribbon functions such as Comments and Track Changes to be enabled. (To maintain layout and readability in Word, users would want to "Keep Source Formatting" when pasting, and then click into the pasted table, navigate to the Table Tools – Layout ribbon, and select

Auto-Fit Window to adjust table borders.) When finalized, Work Plan fields would then have to be copied/pasted back into the .xlsx template for submission. Please note: when copying from Word to Excel, users should click to move the cursor to the Excel formula bar before pressing the paste button or Ctrl-V. Pasting into the Excel file without clicking in the formula bar first may result in text being strangely formatted, and may prevent the user from making any future edits. If your program is experiencing significant difficulty working within the template structure, we encourage you to email STD_PCHD@cdc.gov for individualized troubleshooting. We also encourage applicants to submit suggestions & recommendations to improve template functionality, which DSTDP can take into consideration for future template iterations.

P. We are a large program and have many people working on different sections. How can we best create multiple copies of the templates that are folded into one master? (6/13/2018)

a. Answer: In order to protect and maintain template functionality and navigation features, the ability to copy or move individual sheets has been disabled. We recognize that this does present limitations in collaboratively editing or commenting on in-progress Excel files. Due to the variety of Microsoft Office versions and unique IT configurations among applicants, we cannot recommend one particular solution, but potential workarounds include:

- Co-authoring template files through Microsoft OneDrive or SharePoint (To avoid compatibility issues in the web app, DSTDP recommends opening and editing these files in the Excel application)
- Having co-authors complete their portion of the template work plan in separate files, and copying & pasting content into a final merged file. Instructions on how to efficiently consolidate work plan templates have been added to the Excel Work Plan Template User Guide on the STD PCHD website.
- Creating a shared workbook for collaboratively editing template files. However, due to many limitations of this function, this is not encouraged by DSTDP or Microsoft, and may result in the loss of some template functionality.

We encourage applicants to consult with their IT programs to determine the best solution available. Additionally, we recommend that applicants who chose to use co-authorizing or shared workbook functionality save backup copies of their workbooks frequently. If your program is experiencing significant difficulty merging or combining template content, we encourage you to email STD_PCHD@cdc.gov for individualized troubleshooting

Q. Do the text boxes have a word limit? (6/13/2018)

a. Answer: In order to ensure work plan information is collected in similar locations across applications, some fields have character limits. In the 5 Year Workplan Template, the '*Comments (Optional)*' box in the Program Priorities section has a 255-character limit. In the 1 Year Workplan Template, the following fields have character limits:

- Program Context & Partners: *Strategy Area Point of Contact* (255 char), *Brief Partner Details* (255 char)
- Strategy Pages: *Annual Objective* (500 char), *Baseline, Target, Activity Description, Activitiy Timeframe, Output Indicator, Assigned To* (255 char)

R. Currently when you are entering an additional objective, Excel does not let any other users know if there is content in that area and the item has been minimized. Are there ways to deal with this? (6/13/2018)

a. Answer: If text data are entered in secondary or tertiary objective fields on the individual strategy pages and subsequently minimized, this data will still be retained in the template, but may not be visible to other users. We recommend that when data is entered in additional objective fields, users keep those fields expanded. Before finalizing the Work Plan for submission, applicants should review any collapsed data fields to ensure all content is appropriately entered.

S. In the "Assigned To" column it says to list the name and title of the staff person the activity is assigned to. Can we stop listing the person's title after the first activity they are assigned? (6/20/2018)

a. Answer: Yes, you can stop listing the person's title after it has been listed the first time.

T. In the "Assigned To" column, can we list DIS instead of each DIS name individually to reflect the fact that all DIS will be responsible for completing the activity? (6/20/2018)

a. Answer: Yes, when an activity will be the responsibility of a group of people, you can use the name of the group (e.g., "DIS") as the "person responsible."

U. Sometimes when you copy and paste information from a cell in another document into the PCHD Work Plan Y1 template, it will lock the cell in the template so that it is now "protected" and there is nothing you can do to edit the cell after. To unprotect that cell, you need a password, which we don't have. (6/20/2018)

a. Answer**:** You should be able to copy/paste from other documents as long as you double click in the yellow cell to trigger the blinking cursor, or if you paste directly into the function bar, at the top. However, this error will come up if you just click the cell once and then hit Ctrl+V or paste. Instructions for copy/paste are on the template home pages, and in the User Guide.

V. In the PCHD 5 Year Work Plan we are asked to rate certain program priorities by importance (*how would you rate the relevant importance of this strategy?*) and by strength of implementation (*how strong or weak would you say your STD program is in implementing the following strategies?*). Do we create our own rating system and explain it or is there a rating approach CDC would like us to use? (6/20/2018)

a. Answer: Those data fields in the 5 year work plan template were designed to have drop-down menus in them. By clicking in the text boxes in those columns, a drop-down menu should appear, as an arrow on the far right. A standardized menu of responses should appear. If not, please contact DSTDP PDQIB again for additional help and trouble-shooting.

W. How can we unprotect the view for the Year 1 Work Plan Excel Document? I am getting prompted for a password. (6/20/2018)

a. Answer: In order to protect and maintain template structure, certain functions - such as modifying, adding, or entering data in non-indicated fields – are disabled. When this occurs, users will encounter a pop-up that says "*The cell or chart you're trying to change is on a protected sheet. To make a change, unprotect the sheet. You might be requested to enter a password*." Users should **not** need to enter a password to enter data and navigate the work

plan templates. If users are encountering this error when entering data, be sure that your cursor is blinking in on one of the yellow-shaded data entry cells, or on the top function bar. If this pop-up is occurring in a yellow-shaded cell, please contact DSTDP PDQIB for additional troubleshooting.

X. When adding an objective to the work plan, I encountered an error message that "the cell or chart you're trying to change is on a protected sheet." Why? (6/20/2018)

a. Answer: By double-clicking on the "create objective" link in the work plan templates, applicants may receive this error. Applicants should try to click once on the "create objective" link, and hopefully the templates should function smoothly as intended. If you still receive an error message, try saving your template progress, closing the workbook, and re-opening again. If this still does not resolve the issue, please contact DSTDP PDQIB again for additional help and trouble-shooting.

Y. What's the best way to cut and paste into the work plan template from Word? (6/20/2018)

a. Answer: When cutting and pasting into the Excel templates, applicants should first select the (yellow) cell they want to paste into and either 1) paste text into the formula bar at the top of the worksheet, or 2) click in the cell so that a cursor appears and then press Ctrl-V (paste). Applicants will encounter an error message if they try to "Ctrl-V" into a cell without ensuring first that the cursor is flashing in the cell. Instructions for copying and pasting are reiterated on the Home Page tab of both work plan templates, and in the Template User Guide.

Z. Are we really allowed only up to 3 objectives per strategy? (7/11/2018)

a. Answer: Yes, the year 1 work plan template limits objectives to 3 per strategy. The work plans should focus on the highest priority investments for that year, for each strategy. The work plan templates include other space for applicants to provide information on other routine activities or relevant contextual information (e.g. "Context and Partnerships" section). This limitation is not intended to stifle innovation or comprehensive approaches to the strategies, however. Applicants are still encouraged to innovate and do more than what is just listed in the work plan objectives.

AA. Can the work plan be used for tracking staff performance? (7/11/2018)

a. Answer: These work plans were designed to relay to DSTDP PDQIB what an applicant as a whole wants to focus on and do under STD PCHD; they are intended to support communication between applicants and PDQIB. They were not designed to meet the personnel management needs of applicants.

Application Components

A. Is a cover letter required? (5/14/2018)

a. Answer: A cover letter is recommended, but not required.

B. Can we include a list of references as an attachment? If yes, will this count against the narrative page limit? (5/21/2018)

a. Answer: You can provide a list of references as an attachment. It will not count against the narrative page limit.

C. Is a template for the ORP Certification going to be created for PS19-1901? If we use the version provided for PS18-1802 on that NOFO's website, is it a problem? (7/11/2018)

a. Answer: Appendix D, page 57, of the PCIS Data Security Guidelines provides a sample certification statement that can be adapted for STD PCHD. DSTDP PDQIB added a Word version of that sample statement to the STD PCHD webpage. The template provided on the PS19-1901 website is acceptable (even if it is labeled with PS19-1901) so long as the date is updated.

D. Do the 1-year and 5-year work plans suffice as a project narrative? (7/23/2018)

a. Answer: No, they do not. As described on page 38: "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." The Project Narrative should complement – not repeat – information in the work plans; it should include additional information on the each applicant's epidemiologic and programmatic context, Approach, Evaluation and Performance Measurement, and Organizational Capacity, within 15 single-spaced pages. For additional guidance on what to cover in each section, applicants should review the slides from the General Orientation Webinar to the STD PCHD, available on the STD PCHD website (PDF pages 52-55 in particular), as well as relevant sections of the NOFO, including pages 19 and 20 (collaborations), pages 26-27 (evaluation and performance measurement), and page 28-29 (organizational capacity).

E. LOA/LOC: Is that only for states like NY and CA that have NYC and LA county that they apply with? (7/23/2018)

a. Answer: Yes. The LOA/LOC is only for city-state pairs within eligible applicants. Most eligible applicants do not need to provide this as part of the application.

Other CDC requirements (e.g. travel) and support

A. Can you please provide a bit more detail on attendance at CDC-sponsored conferences & workshops? Will there be a required grantee meeting? How many people will be required to attend? Will there be a number of people required to attend NCSD? (5/21/2018)

a. Answer: Recipient (grantee) meetings and Special Interest Group (SIG) meetings are required, but there is no required number of attendants. In previous years, we have *recommended* 1-2 staff from small program areas (under $500K funding), 2-3 staff from medium areas (under $1M funding), and 3-5 staff from larger areas. In general, we recommend that you send as many people as needed to cover any relevant, concurrent sessions, and that these attendees be required to share the meeting information with their colleagues upon their return to the program area. NCSD's annual meeting is not a CDC-sponsored meeting, but in years without a CDC recipient meeting, SIG meeting, or other CDC-sponsored meeting, those travel funds may be used to attend NCSD.

B. On page 50 of the NOFO in the Attendance and CDC-Sponsored Conferences and Workshops section, it says "All recipients are required to attend and are to include budget allocations consistent with this requirement." Can you please provide guidance on the required language necessary in the budget narrative for mission critical travel to these events? (5/21/2018)

a. Answer: CDC's Budget Preparation Guidance (https://www.cdc.gov/grants/documents/Budget-Preparation-Guidance.pdf) contains an example of travel budget justification for CDC meetings.

C. Have project officers been assigned? (5/21/2018)

a. Answer: The Program Development and Quality Improvement Branch is in the process of staffing the Program Support Team with project officers (prevention specialists). Prevention specialists have been assigned to program areas, and each prevention specialist has been in contact with assigned programs. If you have not been contacted by your prevention specialist, then your area has not been assigned to a prevention specialist yet. You can continue to receive help and support from PDQIB by emailing STD_PCHD@cdc.gov, an email address that is monitored by PDQIB staff.

D. Will there be a grantee meeting for STD PCHD in 2019 and if so how many days should we plan to budget for travel? (6/20/2018)

a. Answer: DSTDP PDQIB has not decided whether to hold a separate meeting for STD PCHD recipients in 2019. Applicants should include in their year 1 budget, some funding for travel for two persons to a 4-day meeting outside the project area during 2019. This travel could be used to attend the annual meeting of the National Coalition of STD Directors, if DSTDP PDQIB opted not to hold a separate all-recipient meeting.