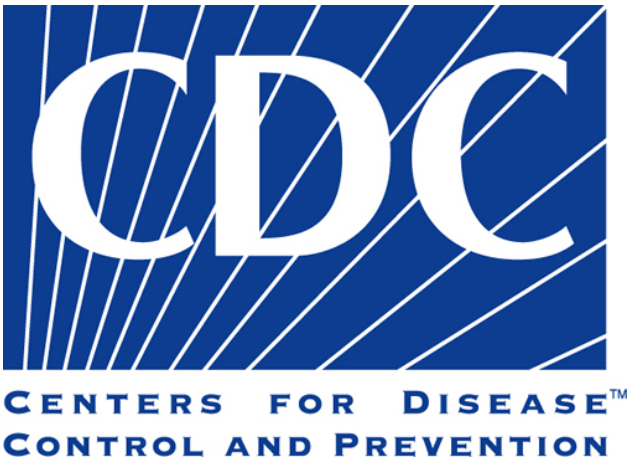

Centers for Disease Control and Prevention

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

Support and Scale Up of HIV Prevention Services in Sexual Health Clinics

CDC-RFA-PS-24-0003

01/15/2024

Table of Contents

Part I. Overview

Applicants must go to the synopsis page of this announcement at www.grants.gov and click on the "Subscribe" button link to ensure they receive notifications of any changes to CDC-RFA-PS-24-0003. Applicants also must provide an e-mail address to www.grants.gov to receive notifications of changes.

A. Federal Agency Name:

Centers for Disease Control and Prevention (CDC) / Agency for Toxic Substances and Disease Registry (ATSDR)

B. Notice of Funding Opportunity (NOFO) Title:

Support and Scale Up of HIV Prevention Services in Sexual Health Clinics

C. Announcement Type: New - Type 1:

This announcement is only for non-research activities supported by CDC. If research is proposed, the application will not be considered. For purposes of this NOFO, research is defined as set forth in 45 CFR 75.2 and, for further clarity, as set forth in 42 CFR 52.2 (see eCFR :: 45 CFR 75.2 -- Definitions and *https://www.gpo.gov/fdsys/pkg/CFR-2007-title42-vol1/pdf/CFR-2007-title42-vol1-sec52-2.pdf*. In addition, for purposes of research involving human subjects and available exceptions for public health activities, please see 45 CFR 46.102(l) (*https://www.ecfr.gov/current/title-45/subtitle-A/subchapter-A/part-46/subpart-A/section-46.102#p-46.102(l)*).

D. Agency Notice of Funding Opportunity Number:

CDC-RFA-PS-24-0003

E. Assistance Listings Number:

93.977

F. Dates:

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

11/29/2023

2. Due Date for Applications:
01/15/2024
11:59 p.m. U.S. Eastern Standard Time, at www.grants.gov.

3. Due Date for Informational Conference Call:
Monday, November 6, 2023 from 2:00-3:00 p.m. ET

Register in advance for this webinar:
https://www.zoomgov.com/webinar/register/WN_xlAeTKxtQqSWaePFxZsE5

G. Executive Summary:

1. Summary Paragraph
This NOFO supports the *Ending the HIV Epidemic in the U.S.* (EHE) initiative by scaling up HIV prevention and care services in sexual health clinics. Recipients funded years 1-5 under this NOFO will execute the following required strategies: A) strengthen clinic infrastructure and improve service delivery to address the syndemic of HIV and other sexually transmitted infections (STIs), and B) foster strategic partnerships in support of EHE. NOFO outcomes include enhanced adoption of optimal sexual health services and clinic models for provision of quality STI-related clinical care, increased understanding of and responsiveness to patients' needs, increased identification of new HIV and STI infections, increased persons eligible for HIV preexposure prophylaxis (PrEP) who are prescribed PrEP, increased collaboration and engagement with local partners and community members to inform sexual health service delivery, increased rapid linkage to HIV medical care for persons newly diagnosed with HIV, increased receipt of recommended, timely STI prevention & treatment, increased receipt of rapid antiretroviral therapy (ART) for individuals with newly diagnosed HIV, sustained community partnerships to inform strategic EHE planning and implementation, and increased clinic capacity to provide affirming, stigma- and discrimination-free HIV prevention and linkage to care services.

a. Eligible Applicants:
Open Competition

b. Funding Instrument Type:
CA (Cooperative Agreement)

c. Approximate Number of Awards
20

d. Total Period of Performance Funding:
$100,000,000

e. Average One Year Award Amount:
$1,000,000
The average one-year award will be $600,000 - $1,000,000 total for both strategies. The award amount is dependent on the amount of funding available. Applicants should prepare a budget towards the average one-year award amount.

f. Total Period of Performance Length:
5 year(s)

g. Estimated Award Date:
June 01, 2024

h. Cost Sharing and / or Matching Requirements:
No
Cost sharing or matching funds are not required for this program. Although no statutory matching requirement for this NOFO exists, leveraging other resources and related ongoing efforts to promote sustainability is strongly encouraged.

Part II. Full Text

A. Funding Opportunity Description

1. Background

a. Overview
An estimated 1.2 million people in the United States are living with HIV and approximately 1 in 7 (13%) are unaware they have HIV. The *Ending the HIV Epidemic in the U.S.* (EHE) initiative takes a whole-of-society approach that requires providing services to people with and at risk for HIV wherever they seek care. Common across HIV, STI, and viral hepatitis national strategic plans is the guiding principle of holistically addressing the syndemic of HIV, STIs, viral hepatitis, high-risk substance use, other related outcomes, and social determinants of health that impact related health disparities and inequities. A syndemic is population-level clustering of social and health problems. Despite signs of progress in HIV prevention, barriers to accessing prevention and care services are still contributing to racial, ethnic, sexual orientation, gender, and geographic disparities.

Having an STI is associated with a higher risk of acquiring HIV, both because the presence of another STI might enhance transmission of HIV and because of shared modes of transmission. Successful integration of HIV prevention and care services in sexual health clinics (i.e., STI clinics) is a crucial piece of a syndemic approach to addressing HIV and other STIs. Both the U.S. Preventive Services Task Force and CDC recommend routine HIV screening among all persons with diagnosed STIs. In 2021, an analysis of CDC-funded HIV tests found STI clinics provided nearly one-third of all HIV tests conducted among healthcare settings and had the highest percentage of tests resulting in new diagnoses among all healthcare settings. HIV/STI screening in sexual health clinics provides an opportunity to link patients to high-impact HIV prevention services and to facilitate linkage to, retention in, and re-engagement in HIV care among persons with HIV.

Scaling up HIV prevention services in sexual health clinics delivers key prevention strategies to populations hardest hit by HIV. A recent analysis of data from the STD Surveillance Network (SSuN) showed increases in the numbers of gay, bisexual, and other men who have sex with men (MSM) and transgender persons seeking care at STI clinics in this sentinel surveillance system. STI incidence among MSM who do not have HIV is a significant risk factor for HIV infection. In the U.S., syphilis and HIV are syndemic among MSM. Co-infection with syphilis in people with HIV has been associated with decreased CD4 cell counts and increased HIV viral load, which may lead to a greater risk of transmitting HIV. Additionally, during the 2022 mpox outbreak, the mpox virus was primarily spread by sexual contact among MSM. A recent CDC report showed that 41% of persons diagnosed with mpox reported an STI in the year prior, and 38% had HIV at the time of mpox diagnosis.

This NOFO builds on progress made scaling up HIV prevention services in STI clinics by Component C of CDC's PS20-2010. Component C awarded funds to nineteen jurisdictions and their participating clinics. Clinics integrated HIV prevention services and enhanced delivery of high-quality, affirming, and culturally and linguistically relevant sexual health services for racial, ethnic, sexual and gender minority populations. This NOFO supports EHE by further strengthening the infrastructure of sexual health clinics and improving service delivery to address the syndemic of HIV and other STIs and fostering additional strategic partnerships.

b. Statutory Authorities

This program is authorized under Sections 317 and 318 of the Public Health Service Act, as amended [42 U.S.C. Sections 247b and 247c].

c. Healthy People 2030

This NOFO supports the Healthy People 2030 focus area of Sexually Transmitted Infections: https://health.gov/healthypeople/objectives-and-data/browse-objectives/sexually-transmitted-infections

d. Other National Public Health Priorities and Strategies

This NOFO supports the following national strategies:

- Ending the HIV Epidemic in the U.S.
- Division of STD Prevention Strategic Plan 2022-2026
- National HIV/AIDS Strategy for the United States 2022–2025
- Sexually Transmitted Infections National Strategic Plan for the United States: 2021–2025
- NCHHSTP Strategic Plan 2022-2026
- Division of HIV Prevention Strategic Plan Supplement for 2022-2025
- Division of Viral Hepatitis 2025 Strategic Plan

e. Relevant Work

This NOFO builds on and supports the following cooperative agreements:

- PS19-1901: Strengthening STD Prevention and Control for Health Departments (STD PCHD)
- PS20-2004: National Network of Sexually Transmitted Diseases Clinical Prevention Training Centers (NNPTC), with a supplement supported by the Minority HIV/AIDS Fund
- PS20-2010: Integrated Programs for Health Departments to Support Ending the HIV Epidemic in the United States, Component C
- PS-23-0011: Enhancing STI and Sexual Health Clinic Infrastructure (ESSHCI)

2. CDC Project Description

a. Approach

Bold indicates period of performance outcome.

CDC-RFA-PS-24-0003 Logic Model: *Support and Scale Up of HIV Prevention Services in Sexual Health Clinics*

Strategies & Activities	Short-Term Outcomes	Intermediate Outcomes	Long-Term Outcomes
Strategy A: Strengthen clinic infrastructure and improve service delivery to address syndemic of HIV & other STIs (Required) - A1: Implement an action plan to address clinic infrastructure gaps - A2: Implement evidence-based or evidence-informed approaches - A3: Assess patient clinic experience and needs - A4: Adopt a whole-person approach to HIV prevention and care in clinic **Strategy B:Foster strategic partnerships in support of**	**Enhanced adoption of optimal sexual health services and clinic models for the provision of quality STI-related clinical care** (ST1) **Increased understanding of and responsiveness to patients' experiences, satisfaction, and needs** (ST2) **Increased identification of new HIV and STI infections and of persons with HIV who are out of care or not virally suppressed** (ST3) **Increased persons eligible for PrEP who were prescribed PrEP at the clinic** (ST4) **Increased collaboration and engagement with local partners and community members to inform sexual health service delivery, especially among priority populations affected by the HIV/STI syndemic** (ST5)	Improved patient flow, increased patient volume and ability to serve patients more efficiently, including timely testing and treatment **Increased rapid linkage to HIV medical care for persons newly diagnosed with HIV in a sexual health clinic** (IT1) **Increased receipt of recommended, timely STI prevention and treatment interventions for patients and their partners** (IT2) Increased PrEP adherence and persistence **Increased receipt of rapid ART in sexual health clinics for persons with newly diagnosed HIV** (IT3) Increased re-engagement to care for persons with HIV who are out of care or not virally suppressed **Sustained community partnerships to inform strategic**	Increased delivery and uptake of stigma-free, quality comprehensive sexual health services Increased viral suppression among persons with HIV Reduced new HIV and STI infections Reduced HIV and STI disparities, including racial, ethnic, gender, and sexual orientation disparities

the EHE Initiative (Required) - B1: Foster action-oriented, strategic partnerships with community providers, CBOs, health departments and other entities - B2: Participate in local HIV planning activities - B3: Build active and meaningful engagements with priority populations affected by HIV and STIs		**EHE planning and activity implementation** (IT4) **Increased clinic capacity to provide affirming, stigma- and discrimination-free HIV prevention and linkage to care services** (IT5)	

i. Purpose

The purpose of this NOFO is to support the *Ending the HIV Epidemic in the U.S.* (EHE) initiative by scaling up HIV prevention and care services in sexual health clinics. Recipients funded under this NOFO will: 1) strengthen clinic infrastructure and improve service delivery to address the syndemic of HIV and other STIs, and 2) foster strategic partnerships in support of EHE.

ii. Outcomes

Recipients must achieve the following outcomes by the end of the period of performance:

- Enhanced adoption of optimal sexual health services and clinic models for the provision of quality STI-related clinical care
- Increased understanding of and responsiveness to patients' experiences, satisfaction, and needs
- Increased identification of new HIV and STI infections and of persons with HIV who are out of care or not virally suppressed
- Increased persons eligible for PrEP who were prescribed PrEP at the clinic

- Increased collaboration and engagement with local partners and community members to inform sexual health service delivery, especially among priority populations affected by the HIV/STI syndemic
- Increased rapid linkage to HIV medical care for persons newly diagnosed with HIV in a sexual health clinic
- Increased receipt of recommended, timely STI prevention and treatment interventions for patients and their partners
- Increased receipt of rapid ART in sexual health clinics for persons with newly diagnosed HIV
- Sustained community partnerships to inform strategic EHE planning and activity implementation
- Increased clinic capacity to provide affirming, stigma- and discrimination-free HIV prevention and linkage to care services

iii. Strategies and Activities

This NOFO has two required strategies. Applicants must apply for Strategies A and B.

For EHE to reach its goal of reducing new HIV infections in the U.S. by 90% by 2030, HIV prevention and care services must reach the people and communities who need them. As part of the EHE initiative, this NOFO supports existing sexual health clinics that serve communities with high HIV and STI burden.

Applicants are also expected to identify priority population(s) disproportionately impacted by HIV and other STIs in the proposed clinics' catchment area (e.g., adolescents and young adults, racial, ethnic, sexual, and gender minority groups, women of reproductive age, persons who inject drugs, and/or persons experiencing incarceration and/or homelessness). Applicants must choose to focus on one or more of these populations based on the HIV/STI health disparities in their jurisdictions.

Recipients are expected to implement all Strategy A and B activities described below. Applicants can request to temporarily opt-out of selected required activities by providing a compelling justification which must be based on program priorities, resources, and/or policies, but are expected to provide a timeline for future implementation of required activities. Approval will be considered after review of the application.

If needed, programmatic changes should be made to maximize the impact of available resources in the applicant's jurisdiction. Applicants can consider proposing innovative strategies that better align with the needs of the priority populations. Any proposed new activity should include the rationale for the approach or a brief summary of the evidence that justifies its inclusion. Proposed strategies and activities should be consistent with and responsive to this NOFO's short, intermediate, and long-term outcomes as indicated in the logic model.

***Strategy A:* Strengthen clinic infrastructure and improve service delivery to address the syndemic of HIV & other STIs (Required Strategy – Years 1-5)**

This strategy strengthens clinic infrastructure and enhances the provision of comprehensive sexual health services in an existing clinic to address the syndemic of HIV and other STIs. Syndemics are epidemics that interact with each other and by that interaction increase their

adverse effects on the health of communities that face systemic, structural, and other inequities. Holistic, coordinated care is a hallmark of the syndemic approach. Activities under this NOFO will support a syndemic approach that is essential to providing patients comprehensive sexual health care in clinic settings where they routinely receive care.

Applicants must affirm that the proposed sexual health clinic has the following services available onsite or provide a detailed plan to have these services available onsite within six (6) months of award:

- HIV testing,
- STI testing at relevant anatomical sites,
- timely STI treatment, including onsite treatment for gonorrhea, chlamydia, and syphilis as recommended in CDC's STI Treatment Guidelines (e.g., penicillin G benzathine, ceftriaxone),
- recommended vaccinations (i.e., hepatitis A virus [HAV], hepatitis B virus [HBV], human papillomavirus [HPV], mpox), and
- comprehensive in-house PrEP and nPEP services, including follow-up care and required laboratory tests.

Activities must include:

Activity A1: Implement an action plan to address gaps identified by a clinic infrastructure assessment

Applicants will assess the clinic infrastructure of their proposed sexual health clinic to document the inventory of HIV and other sexual health services that are currently provided. They will then identify gaps to be addressed in the action plan that they will develop as part of Activity A1. For this NOFO, infrastructure includes the physical, technical, organizational, and systems-level components or assets that are necessary to deliver quality sexual health services. Clinic and laboratory components may include management, physical structure, supply systems, technical equipment, information technology (including electronic heath records), clinical services, staffing and organizational structure, and data.

While developing the application, applicants are expected to:

- Assess clinical service availability in their proposed sexual health clinic based on recommendations provided for STI specialty care settings in Recommendations for Providing Quality STD Clinical Services (STD QCS). Participating clinics are expected to offer all basic and specialty STI services, excluding any that are not authorized by state law. Applicants are expected to review the STD QCS recommendations, highlight gaps, and identify services to add or enhance during the NOFO period of performance.
- Review the documentation of clinic practices, including clinical protocols, pharmacy services, the referral/linkage to care plan for STI specialty services not provided onsite, patient scheduling options, and the continuous quality improvement (CQI) processes in place to improve quality of care.
- Review the clinic's billing practices and financial solvency.
    - Identify cost and barriers to adoption or upgrade of electronic health records (EHR) and/or a billing system, if not available.

- Review the clinic's organizational structure and staffing strategy. Sexual health service providers need to provide culturally appropriate care for populations that are medically underserved, including the lesbian, gay, bisexual, transgender, and queer (LGBTQ+) community, youth and young adults, and racial and ethnic minority groups disproportionately impacted by HIV and STIs.
    - Identify training needs to support the provision of culturally sensitive, trauma-informed, patient-centered care. Clinics must identify training opportunities for current and incoming providers, social workers, patient navigators, Disease Intervention Specialists (DIS) and other clinic staff through the National Network of STD Clinical Prevention Training Centers (NNPTC), the AIDS Education and Training Centers or other local academic partners.
- Assess existing ancillary and laboratory service capacity, including specimen self-collection, point-of-care (POC) testing services, and rapid turnaround time for results. Identify any agreements that need to be established for laboratory services.
- Invite clinic staff to share experiences delivering HIV/STI prevention and care services in the clinic, and perceived barriers to integrating HIV medical care into the sexual health clinic setting.

Recipients will be expected to:

- Develop an action plan to address gaps identified by the initial clinic infrastructure assessment outlined above. Consider the reason for each gap, the proper course of action to close it, the resources that will be required, and what barriers exist for closing the gap.
    - During plan development, collaborate with the NNPTC to identify training, technical assistance, and capacity-building opportunities to implement quality sexual health services at the participating clinic in accordance with the STD QCS.
    - Recipients must include all action plan steps/activities in their work plan.
- Monitor the implementation of the action plan, document updates in mid-year and end-of-year reports to CDC and continue to define next steps throughout the NOFO period of performance.

Applicants previously funded under Component C of PS20-2010 (as recipients or subrecipients) that are proposing activities in a Component C clinic must describe the clinic's current HIV-related service capacity, gaps identified during the Component C period of performance and whether they were addressed, the quality assurance/improvement process that was established during Component C and subsequent improvements, and how remaining gaps will be addressed through this NOFO.

<u>Activity A2:</u> Implement evidence-based or evidence-informed approaches to increase clinic efficiency

Applicants will identify and propose evidence-based or evidence-informed approaches or emerging strategies to implement at the participating clinic that will improve patient flow, increase patient volume, and allow clinic staff to serve patients more efficiently, including the provision of timely testing and treatment. This could also include approaches related to financial sustainability beyond the NOFO period of performance. Other possible approaches include, but

are not limited to: conducting client-initiated sexual risk assessments, offering specimen self-collection to increase capacity to test for STIs at all anatomic sites, developing provider job aids and patient education materials, optimizing the clinic's electronic medical record (EMR) system and templates, and expanding implementation of POC tests (e.g., HIV, syphilis, hepatitis C virus [HCV], gonorrhea/chlamydia, and other rapid tests). Some of the approaches may also include the use of tablets or other mobile technology. Applicants are advised to consider the NOFO's funding restrictions when identifying approaches to include in the application.

In addition, clinics are expected to implement or expand an express service model. Express services have the potential to play a key role in increasing access to HIV & STI testing and treatment, and adherence to recommended follow-up labs for individuals on PrEP, by optimizing clinic efficiency. In express services, asymptomatic patients are routed to a less intensive testing-only experience through standing orders and no physical examination. While express service models vary, there are several core elements seen across models:

- Triage to route patients to either an express visit or a traditional provider visit
- No physical examination during an express visit
- Patient self-collects specimens, including swabs and urine, while a nurse, DIS or phlebotomist collects blood
- Aided by technology/automation for triaging, faster lab turnaround times, and notification of results
- Reliance on diverse staffing to allow healthcare professionals to work at the top of their licenses (i.e., task-shifting)

Applicants previously funded under Component C of PS20-2010 (as recipients or subrecipients) that are proposing activities in a Component C clinic must describe any approaches implemented during the Component C period of performance and their resulting impact.

<u>Activity A3:</u> Assess patients' clinic experience and needs

Providing care that is patient-centered and meets an individual's specific sexual health needs can improve health outcomes and reduce health disparities. Participating clinics will assess the patient clinic experience and make improvements based on their findings.

Applicants must describe how they plan to:

- Gather patient experience data at baseline (and annually). Examples include but are not limited to:
    - A patient satisfaction survey looking at the cultural competency of providers, the acceptability of and interest in accessing services (such as PrEP and HIV medical care) at a sexual health clinic, etc.
    - Patient interviews or focus groups to gather in-depth feedback on the patient clinic experience in the patient's own words.
- Develop a plan to improve patient experience in the clinic and use a CQI approach to monitor improvement. The plan should be updated and refined as changes are implemented.

- Areas for improvement may include but are not limited to clinic systems (e.g., appointment scheduling, hours of operation, clinic flow), patient interactions (e.g., culturally and linguistically appropriate services, inclusive, trauma-informed), clinic environment (e.g., clinic's virtual and physical environment), and staff experience and engagement.

Activity A4: Adopt a whole-person approach to HIV prevention and care in the clinic

A whole-person approach to HIV prevention and care emphasizes high-quality care to engage and retain people in services regardless of whether the services are for HIV prevention or treatment. This approach prioritizes individual needs for services and support that are holistic, comprehensive, continuous, and culturally responsive.

Applicants must describe how they plan to adopt a whole-person approach to HIV prevention and care in their participating clinics, which includes the following:

1. Deliver culturally affirming, stigma-free care

- Recipients will develop and implement a training plan for clinic providers and support staff that includes training on recognizing and addressing implicit racial, ethnic, sexual orientation, drug use, and other biases.
- Participating clinics will identify and implement feasible recommendations listed in NCSH's Inclusive Sexual Health Services, such as ensuring patient questionnaires and/or EMR templates capture self-reported sexual orientation and gender identity (SOGI) data, pronouns, and lived name.

2. At time of HIV test, assess patient needs and facilitate linkage to appropriate services (including prevention and care services for co-occurring conditions and those that address social determinants of health) regardless of HIV test result

- Recipients will develop and maintain a linkage/referral roster for HIV treatment and PrEP/nPEP services, mental health and substance use disorder services, harm reduction services, family planning and reproductive health services, housing, transportation, and other services associated with improved sexual health outcomes. The roster should be organized by topic and populations served and should include providers in the area who provide culturally informed care for youth, the LGBTQ+ community, and racial and ethnic minority groups disproportionately impacted by HIV.

3. Expand clinic capacity to offer PrEP and nPEP, including recommended follow-up visits

- Applicants must describe how they plan to expand HIV testing and STI testing (including extragenital testing) per CDC and USPSTF recommendations to better identify patients who would benefit from PrEP. This should include taking a thorough sexual history to appropriately assess and screen for STIs in blood and at all anatomic sites of exposure.
  - Recipients should ensure HIV testing is offered when STI testing is requested and STI testing is offered when HIV testing is requested.
- Applicants must describe how the participating clinic will ensure that all persons who receive a negative HIV test result and are accessing STI testing services are educated about PrEP and nPEP.

- Recipients must ensure that whenever a patient is diagnosed with an STI, documentation of the clinical encounter identifies whether the patient is on PrEP.
- Clinics should strengthen the "nPEP to PrEP" referral process. If evaluation demonstrates nPEP is clinically indicated and that the patient is also eligible for PrEP (e.g., behavioral risk for repeated HIV exposure, recent bacterial STI diagnosis in a sexually active person), then the patient should both be provided a 28-day course of nPEP (or referred/linked to nPEP) and be evaluated for transition to PrEP at the conclusion of their nPEP course.

- Clinics are expected to offer comprehensive in-house PrEP services and follow-up care for patients on PrEP within 6 months of award, if not already offered. Clinics should also strengthen clinic and laboratory capacity for initial and follow-up PrEP care including recommended STI testing at relevant anatomical sites, as well as other preventive health services, including screening for HBV and HCV, and offering vaccination for HAV, HBV, HPV, and mpox.
    - Clinics are expected to initiate PrEP for willing and eligible patients on the same day of HIV screening unless: 1) acute HIV infection cannot be ruled out, and/or 2) PrEP is contraindicated due to medical reasons.
    - Clinics are encouraged to allow providers to schedule patient follow-up visits during the patient's current visit, if possible.
    - Clinics should consider disparities in PrEP persistence and implement interventions focused on increasing persistence, particularly among young adults.
    - Clinics should identify and possibly modify existing delivery approaches to expand PrEP and nPEP services and reduce structural and other perceived system barriers. Strategies may include but are not limited to: implementing telehealth services for ongoing monitoring of patients on PrEP; increasing awareness among racial and ethnic minority populations disproportionately impacted by HIV of the availability of services and financial assistance programs, and addressing PrEP-related stigma; to the extent permitted by law, allowing nurses to utilize standing orders for PrEP initiation, and allowing pharmacists to initiate PrEP and nPEP (e.g., within state license scope of practice, collaborative practice agreements); and reaching priority populations through new media and mobile technologies.
- Clinics are expected to facilitate access to condoms and linkage to harm reduction services for all patients.
- Applicants previously funded under Component C of PS20-2010 (as recipients or subrecipients) that are proposing activities in a Component C clinic must also provide a summary of clinic activities conducted during the Component C period of performance that focused on integrating PrEP and nPEP services, including key successes, challenges, and lessons learned.

4. Optimize linkage to, retention in, and re-engagement with HIV medical care

- Patients with newly diagnosed HIV and those not virally suppressed should be rapidly linked to HIV medical care (i.e., have attended their first HIV medical care appointment) either onsite or with an external provider within 7 days of HIV diagnosis. Participating clinics are expected to:

- Work with health department HIV/STD personnel and community providers to facilitate rapid linkage to care for patients who are newly diagnosed and facilitate re-engagement in care for patients with HIV who are out of care and not virally suppressed. This must be either a warm handoff from the clinic to an external provider that results in an appointment within 7 days (ideally same day) or rapid HIV antiretroviral therapy (ART) initiation onsite. Rapid ART refers to beginning HIV treatment as soon as possible after an HIV diagnosis, ideally on the same day the HIV diagnosis is made.
- Plan during the first budget year so that by the second year of award, clinics can offer rapid ART initiation onsite to patients newly diagnosed with HIV, if not already available. Clinics will need to ensure they have the capacity to implement laboratory testing for HIV evaluation and monitoring. While the strong preference is for clinics to offer rapid ART onsite, a warm handoff from the clinic to an external provider for a same-day appointment is acceptable. If providing a warm handoff, clinics are expected to have a signed agreement in place with the external provider within 6 months of award.
- Collaborate with the state and/or local health department to routinely review and engage persons who are not in care (NIC) to link or re-engage them in HIV medical care.
- Provide support to help patients remain in HIV medical care.

Participating clinics are encouraged to:

- Provide support for expanded partner services for all patients who are diagnosed with HIV, syphilis and rectal gonorrhea or chlamydia and their sex or needle-sharing partners, based on available resources. One approach is to have health department HIV/STD prevention staff available in the clinic to work with patients who could benefit from partner services, including confidentially notifying partners of a possible HIV and/or STI exposure, offering partners HIV and STI testing and treatment, and providing education and linkage to HIV PrEP/nPEP and doxycycline postexposure prophylaxis (doxy-PEP), when indicated. Expanded partner services could also include enhanced field-based services (e.g., field-based provision of HIV medications and telemedicine visits with sexual health clinic providers) and linkage to a range of medical, prevention, and psychosocial services for co-occurring conditions, as needed.

- Applicants previously funded under Component C of PS20-2010 (as recipients or subrecipients) that are proposing activities in a Component C clinic must also provide a summary of clinic activities conducted during the Component C period of performance that focused on linkage to HIV medical care, including key successes, challenges, and lessons learned.

Strategy B: ***Foster strategic partnerships in support of the EHE Initiative (Required Strategy – Years 1-5)***

Community partners are uniquely positioned to complement and extend the reach of HIV prevention efforts in sexual health clinics. Thus, it is critical that recipients consider the most productive means for reaching out and engaging the community and other partners. Action-

oriented and strategic partnerships are essential to meeting the goals of this NOFO and supporting the EHE initiative.

Applicants are expected to have an established staff point of contact for this strategy who is clearly identified in their application. As stated at the start of the Strategies & Activities section, applicants are also expected to identify priority population(s) disproportionately impacted by HIV and other STIs in their proposed clinics' catchment area (e.g., adolescents and young adults, racial, ethnic, sexual, and gender minority groups, women of reproductive age, persons who inject drugs, and/or persons experiencing incarceration and/or homelessness). Applicants must choose to focus on one or more of these populations based on the HIV/STI health disparities in their jurisdictions.

Activity B1: Foster action-oriented and strategic partnerships with community providers, community-based organizations, health departments and other entities

CDC expects recipients to foster strategic community partnerships with providers, community-based organizations, and health departments to maximize the impact of EHE implementation and improve equitable access to HIV and sexual health services. Applicants must describe how their community partners serve their priority population(s). Additional partners may include primary and HIV-specialty care providers, pharmacies, retail health clinics, urgent care clinics, tribal governments and/or tribally-designated organizations, faith-based organizations, community-based organizations (CBOs) that can help address patients' social determinants of health, and education agencies, among others.

This NOFO does not explicitly describe all relevant partnerships that relate to activity B1, as they can be specific to each participating clinic. The following are examples of partnership approaches that applicants should consider when developing their application:

- collaboration with local CBOs that serve priority populations not accessing care at the participating clinic to increase HIV/STI screening; the local CBO can conduct HIV/STI screening and facilitate easy linkage to STI treatment at the participating clinic, regardless of a person's ability to pay.
- collaboration with local Ryan White providers to improve routine comprehensive sexual history taking and STI screening among persons with HIV.
- collaboration with other local providers to improve comprehensive sexual history taking, HIV/STI screening, and PrEP uptake leveraging in-person and telemedicine visits.
- collaboration with a local pharmacy to increase sexual health services, including STI screening and linkage to care or, where allowed (e.g., by state license scope of practice, collaborative practice agreement), STI treatment at the pharmacy or expedited partner therapy.
- implementation of locally targeted communication strategies, such as: provider- and consumer-focused social marketing campaigns leveraging social media, mobile apps, and other communication channels to support PrEP and other sexual health services; development of, or participation in, websites with locators for PrEP and sexual health service providers; cross-promotion of existing clinics offering quality sexual health services.

- data sharing across jurisdictional sexual health service providers and HIV and STI surveillance systems, in accordance with NCHHSTP Data Security and Confidentiality Guidelines.
- development of a referral network with formal agreements among culturally competent and linguistically appropriate quality preventive, health care, psychosocial and support services in the community, including mental health and substance use disorder services, harm reduction services, housing, transportation, and other services associated with improved sexual health outcomes.
- implementation of patient support systems for patients on PrEP or receiving HIV medical care, including insurance and medication access assistance, health literacy education, medication adherence counseling services, and other supportive services.
- integration of community members that are representative of applicant's priority population(s) to provide peer navigation for PrEP and other preventive sexual health services in the community.

Applicants should identify the highest priority collaborations to focus on in Year 1. For each existing and new collaboration, applicants must describe 1) the extent of the current collaboration with the entity, 2) the specific objectives of the partnership for the purposes of implementing strategies and activities in this NOFO, 3) plans for strengthening or maintaining that collaboration in Year 1, and 4) any funding or sharing of resources that the clinic proposes to give the partner organization. Applicants are encouraged to provide letters of support or letters of commitment from partnering entities and have the option to provide existing memoranda of agreement (MOA) or memoranda of understanding (MOU), as appropriate. Files can be named "Letter of Support", "Letter of Commitment" or "MOA-MOU" and uploaded as PDF files in the application submitted through www.grants.gov.

Applicants previously funded under Component C of PS20-2010 (as recipients or subrecipients) that are proposing activities in a Component C clinic must also provide a summary of clinic activities conducted during the Component C period of performance that focused on the development of community partnerships in support of EHE, including key successes, challenges, and lessons learned.

Activity B2: Actively participate in existing local HIV planning activities

Recipients are expected to actively participate in existing local HIV planning activities including but not limited to engagement with existing EHE advisory groups or committees, HIV care continuum consortiums or Ryan White HIV/AIDS program planning councils/bodies, PrEP coalitions, and rapid start collaboratives (for PrEP and/or HIV care) in their jurisdiction.

Recipients are expected to use input obtained through participation in local HIV planning activities to improve the quality of clinical care and clinic experience in their participating clinic, and to focus on their priority population(s). Applicants must describe their current participation in local HIV planning activities and identify the new groups they plan to engage with after award.

Applicants should provide letters of support from the local EHE advisory group or committee and are also encouraged to provide letters of support from any other groups they will participate

in after award. Files can be named “Letter of Support” and uploaded as PDF files in the application submitted through www.grants.gov.

Activity B3: Build active and meaningful engagements with priority populations affected by HIV and other STIs

Recipients are expected to build active and meaningful engagements with the communities of priority populations affected by HIV and other STIs to inform clinic sexual health service delivery improvements and advance health equity. Clinics should tailor their community engagement (CE) activities to available resources, training, expertise, and the priority populations identified in their application. Applicants should consider how all priority populations identified can be represented in CE activities proposed in the application, and whether the clinic will need to take additional approaches to support any priority populations who are medically underserved by comprehensive sexual health services.

At a minimum, recipients must:

- identify the priority population(s) to participate in CE activities.
- design an equitable process to ensure meaningful community involvement (e.g., community advisory group, community liaisons, community partners).
- engage with community members that reflect the priority population(s) and obtain community voice 1-2 times per year through surveys, focus groups or discussions/town halls. Community advisory groups can be established by the recipient or leveraged through public health partners and other partnerships reflecting populations affected by HIV and other STI disparities.
- conduct an annual community needs assessment (or utilize an existing and recently conducted assessment) with input from community and advisory members to identify barriers preventing the recipient’s priority population(s) from accessing sexual health services at the clinic. Recipients are expected to disseminate findings through a community forum (e.g., community event, presentation, or health fair).
- implement structural changes to improve quality of clinical care and clinic experience based on community/patient feedback.
- conduct community outreach activities (including during events focused on wellness or general activities of cultural interest) to promote availability of comprehensive sexual health services. Outreach activities must be informed by community members of the identified priority population(s). Recipients are encouraged to consider innovative activities to engage communities.
    - Examples of engagement activities include health education events, community events, virtual engagements using social media or other digital tools, or informal community listening sessions.

Clinics with a higher capacity for community-driven engagement are encouraged to propose additional activities.

1. Collaborations

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

Recipients should establish strong working relationships with the National Network of STD Clinical Prevention Training Centers (NNPTC) for training and capacity building support. Recipients should collaborate with a regional Prevention Training Center (PTC) to implement and promote quality sexual health services in their clinics in accordance with the STD QCS.

Recipients are also expected to establish, build, and/or maintain working partnerships with other CDC-funded programs in their jurisdiction to ensure communication, collaboration, and coordination for the delivery of comprehensive sexual health services that is consistent with CDC standards and guidance. This includes collaboration with HIV and STD programs in health departments (e.g., state and local) in applicant jurisdictions, including recipients of PS19-1901 (Strengthening STD Prevention and Control for Health Departments) and, if appropriate, with a state or local public health laboratory. Depending on the applicant's project area and proposed activities, this may also include community-based organizations funded to implement high-impact HIV prevention programs, the STD Surveillance Network (SSuN), viral hepatitis and HPV vaccine programs, reproductive health organizations and adolescent sexual and reproductive health programs, opioid prevention programs, outbreak response teams, AIDS Education and Training Centers (AETC), and other programs funded by CDC.

Memoranda of agreement/memoranda of understanding (MOA/MOU) and/or data sharing agreements can be established. Applicants have the option to provide the MOU or MOA, as appropriate, naming the file "MOU-MOA", and uploading it as a PDF file in the application submitted through www.grants.gov.

Applicants are encouraged to provide letters of support or letters of commitment from partnering entities (including the local EHE advisory group or committee if funded by CDC). Files can be named "Letter of Support" or "Letter of Commitment" and uploaded as PDF files in the application submitted through www.grants.gov.

For each working partnership (not including DSTDP), applicants must clearly describe 1) the extent of their current collaboration with the organization or program, 2) the specific objectives of the partnership for purposes of implementing the strategies and activities in this NOFO, and 3) plans to maintain or strengthen the collaboration in Year 1 of the period of performance, including at least one concrete example of how they intend to collaborate to support a specific activity proposed in their Year 1 work plan.

b. With organizations not funded by CDC:

Recipients are expected to establish, build, and/or maintain collaborative relationships with organizations not funded by CDC that will support the implementation of proposed activities. Consideration should be given to fostering strategic collaborations with health care providers and organizations in their jurisdiction that serve populations disproportionately affected by HIV and other STIs, including partners that have demonstrated capacity to affect social determinants of health. Additional collaborations may include, but are not limited to, federally qualified health centers (FQHCs), LGBTQ+ health centers, community health centers, youth-serving organizations, clinics and hospitals, local education agencies, local colleges and universities (including Historically Black Colleges and Universities [HBCUs], Hispanic-Serving Institutions [HSIs], and other Minority-Serving Institutions [MSIs]), non-CDC funded community-based and faith-based institutions, and correctional facilities.

Memoranda of agreement/memoranda of understanding (MOA/MOU) and/or data sharing agreements can be established. Applicants have the option to provide the MOU or MOA, as appropriate, naming the file "MOU-MOA", and uploading it as a PDF file in the application submitted through www.grants.gov.

A letter of support from the local public health agency (i.e., city, county, territorial or state health department, as appropriate) is strongly encouraged unless the application is being submitted by the local public health agency. Applicants should title this document, "Public Health LOS" and upload it as a PDF file at www.grants.gov.

Applicants should identify the highest priority collaborations to focus on in Year 1 of their period of performance. For each of those collaborations, applicants should describe 1) the extent of the current collaboration with the entity, 2) the specific objectives of the partnership for the purposes of implementing strategies and activities in this NOFO (including activities contributing to health equity-related outcomes), 3) plans for strengthening or maintaining that collaboration in Year 1, and 4) any funding or sharing of resources that the clinic proposes to give the partner organization.

Applicants are encouraged to provide letters of support or letters of commitment from partnering entities (including the local EHE advisory group or committee if not funded by CDC). Files can be named "Letter of Support" or "Letter of Commitment" and uploaded as PDF files in the application submitted through www.grants.gov.

2. Population(s) of Focus

Applicants should describe the ability to reach the most affected subpopulations with high HIV and STI burden, and groups disproportionately impacted by HIV and STIs (e.g., racial, ethnic, sexual and gender minority groups), by providing the following information:

- Applicants should clearly state whether the proposed clinic is in one of the priority EHE jurisdictions.
- Applicants should include a table summarizing the following for 2022 or the most recent year of available data from the proposed clinic site, and describe the capacity to collect and report this data:

1. Total number of persons that received services at the clinic (denominator for persons served)
2. % of all persons served who tested positive for HIV
3. % of all persons served who tested positive for rectal gonorrhea and/or rectal chlamydia
4. % of all persons served who are non-Hispanic Black/African American
5. % of all persons served who are Hispanic/Latino
6. % of all persons served who are non-Hispanic White
7. % of all persons served who are MSM
8. % of all persons served who are transgender

Applicants should save the table as a file named "Clinic Data" and upload it as a PDF file in the application submitted through www.grants.gov.

Applicants are also expected to identify priority population(s) disproportionately impacted by HIV and other STIs in the proposed clinics' catchment area (e.g., adolescents and young adults,

racial, ethnic, sexual, and gender minority groups, women of reproductive age, persons who inject drugs, and/or persons experiencing incarceration and/or homelessness). Applicants should choose to focus on one or more of these populations based on the HIV/STI health disparities in their jurisdictions.

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

a. Health Disparities

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

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

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

There are significant disparities in rates of reported STIs. In 2021, half (50.5%) of reported cases of STIs were among adolescents and young adults aged 15–24 years. Disparities continue to persist in rates of reported STIs among some racial and ethnic groups when compared with rates among non-Hispanic White persons. In 2021, 31% of all cases of chlamydia, gonorrhea, and primary and secondary (P&S) syphilis were among non-Hispanic Black persons, even though they made up only approximately 12% of the US population. Men who have sex with men (MSM) are disproportionally impacted by STIs, including gonorrhea and P&S syphilis; further, almost 40% of MSM reported with P&S syphilis in 2021 had been diagnosed with HIV. Transgender persons often face stigma and socioeconomic and structural barriers to care that negatively affect health care usage and increase the likelihood that they may acquire HIV and other STIs.

MSM are the population most affected by HIV. In 2021, male-to-male sexual contact accounted for 67% (24,107) of all new HIV diagnoses in the United States and dependent areas. Racial and ethnic differences in HIV diagnoses persist. In 2021, Black/African American persons accounted for 40% (14,528) of all new HIV diagnoses. Additionally, Hispanic/Latino persons accounted for 29% (10,467) of all new HIV diagnoses. Nearly 1 million people identify as transgender in the United States. Transgender persons, particularly transgender women, are heavily affected by HIV and transgender women are among the groups most disproportionately affected by HIV in this country.

It is important to note that these disparities are unlikely explained by differences in sexual behavior and rather reflect differential access to quality sexual health care, as well as differences in sexual network characteristics. Acknowledging inequities in HIV and other STI rates is a critical first step toward empowering affected groups and the public health community to collaborate in addressing systemic inequities in the burden of disease. This NOFO supports efforts to improve the health of populations disproportionately impacted by HIV and other STIs by maximizing the health impact of public health services, reducing disease incidence, and advancing health equity.

Recipients should use reliable data, including social determinants of health data (e.g., CDC/ATSDR Social Vulnerability Index), to identify communities within their jurisdictions that are disproportionately affected by HIV/STIs and related diseases and conditions, and plan activities to help eliminate health disparities. In collaboration with partners and appropriate sectors of the community, recipients should consider social determinants of health when developing, implementing, and evaluating program-specific efforts, and should use culturally appropriate interventions and strategies that are tailored for the intended communities.

iv. Funding Strategy

The average one-year award amount is $600,000 - $1,000,000 and is dependent on the amount of funding available.

This NOFO has two required strategies. Applicants must apply for Strategies A and B. Applicants should prepare a budget towards the average one-year award amount.

b. Evaluation and Performance Measurement

i. CDC Evaluation and Performance Measurement Strategy

CDC will use a two-pronged evaluation and performance measurement approach for this NOFO: 1) PS-24-0003 recipient performance measurement and data management, and 2) CDC's evaluation of the collective impact of the NOFO across all PS-24-0003 recipients. This approach will be complementary and will help CDC determine the value, merit, and worth of the PS-24-0003 program at-large.

1. Recipient Performance Measurement and Data Management

All PS-24-0003 recipients will be expected to engage in performance measurement. Performance measurement is the ongoing monitoring of a set of indicators (performance measures) to determine program progress. Performance measurement interprets patterns in performance measures and answers the general line of questioning around "what occurred or what is occurring?" with the program. Performance measures are assessed with a set recurring frequency so that strategy and approach may be adjusted when needed. Program evaluation, on the other hand, takes performance measurement a step further by answering the question "why is the program performing poorly or well? Why were certain outcomes met, and others not? And how did this all happen?" (adapted from Performance Measurement & Program Evaluation: A Suite of Evaluative Insights).

To support performance measurement, all PS-24-0003 recipients will be expected to submit a performance and data management plan (PMDMP) for review within 60 days of award.

Please refer to the **Applicant Evaluation and Performance Measurement Plan** section of this NOFO for more detail on PMDMP expectations for all PS-24-0003 recipients.

Minimizing the burden was an active consideration throughout the process of identifying performance measures for this cooperative agreement. Where appropriate, aggregated data are reported stratified by the variables of age, gender, race and Hispanic origin, and population group. Although recipients will collect client-level data for these variables, they will report aggregate data to CDC to reduce the potential for small cell sizes that could identify an individual client.

Recipients will report required performance measurement quantitative and qualitative data using CDC-approved systems, according to an established schedule (biannually). These data will be used by CDC to generate Rapid Feedback Reports (RFRs) and other products that summarize and assess progress towards the goals of this NOFO and the EHE initiative. This data will be used to stimulate discussion of areas for program improvement, technical assistance delivery, and to share best practices across the network of EHE-funded clinics.

A list of required short- and intermediate-term outcomes and a partial list of associated performance measures/indicators is presented below. Measures will be disaggregated by age, gender, race/ethnicity, and population groups, where indicated. Recipients will receive a PMDMP template outlining all required outcomes, associated performance measures, and corresponding definitions to adequately equip recipients to complete the PMDMP.

Outcome: Enhanced adoption of optimal sexual health services and clinic models for the provision of quality STI-related clinical care (ST1)

- Measure: Number and type of clinic infrastructure services identified for enhancement or addition
- Measure: Number of clinic infrastructure action plan milestones planned, completed, in progress, and stopped/discontinued
- Measure: Number of training, technical assistance, and capacity-building events conducted to implement quality sexual health services at the participating clinic in accordance with the Recommendations for Providing Quality STD Clinical Services (or STD QCS).
- Measure: Number and type of evidence-based or informed clinic approaches identified for enhancement or addition
- Measure: Number of evidence-based or informed clinic approach milestones planned, completed, in progress, and stopped/discontinued

Outcome: Increased understanding of and responsiveness to patients' experiences, satisfaction, and needs (ST2)

- Measure (qualitative): Identified priority patient experience improvement opportunities within the participating clinic

Outcome: Increased identification of new HIV and STI infections and of persons living with HIV who are out of care or not virally suppressed (ST3)

- Measure: Number and proportion of persons tested for HIV at the sexual health clinic
- Measure: Number and proportion of persons who test positive for HIV

- Measure: Number and proportion of persons newly diagnosed with HIV

Outcome: Increased persons eligible for PrEP who were prescribed PrEP at the clinic (ST4)

- Measure: Number and proportion of persons eligible for PrEP who were offered PrEP but decline (and why)
- Measure: Number and proportion of persons eligible for PrEP who were prescribed PrEP at the clinic (newly prescribed)
- Measure: Number and proportion of persons eligible for PrEP who were prescribed refill PrEP prescriptions at the clinic (maintenance)

Outcome: Increased collaboration and engagements with local partners and community members to inform sexual health service delivery, especially among priority populations affected by the HIV/STI syndemic (ST5)

- Measure: Number (and type) of new partnerships established in the budget period
- Measure: Number and type of community engagement activities implemented in the budget period (e.g., health education events, community events, community health assessments, community advisory groups, virtual engagements using social media)

Outcome: Increased rapid linkage to HIV medical care for persons newly diagnosed with HIV in a sexual health clinic (IT1)

- Measure: Number and proportion of persons newly diagnosed with HIV who were linked to care within 7 days of diagnosis

Outcome: Increased receipt of recommended, timely STI prevention and treatment interventions for patients and their partners (IT2)

- Measure: Number and proportion of persons eligible for mpox vaccination receiving partial coverage
- Measure: Number and proportion of persons eligible for mpox vaccination receiving full coverage

Outcome: Increased receipt of rapid ART in sexual health clinics for persons with newly diagnosed HIV (IT3)

- Measure: Number and proportion of persons newly diagnosed with HIV who received rapid ART at the clinic

Outcome: Sustained community partnerships to inform strategic EHE planning and activity implementation (IT4)

- Measure: Number (and type) of existing/sustained partnerships represented during the budget period
- Measure (qualitative): Sustainment of community health assessments and/or community advisory groups

Outcome: Increased clinic capacity to provide affirming, stigma- and discrimination-free HIV prevention and linkage to care services (IT5)

- Measure: Number of participating clinics maintaining a linkage/referral roster for HIV treatment and PrEP/nPEP services, mental health and substance use disorder services, harm reduction services, family planning and reproductive health services, housing, transportation, and other services associated with improved sexual health outcomes

2. CDC Evaluation

CDC will use multiple evaluation sources and methods to assess the collective impact of this NOFO. To go beyond performance measurement and move in the direction of evaluation, CDC will conduct qualitative interviews or focus groups with recipients; review Annual Performance Reports, work plan updates, and success stories submitted by recipients (document review); assess common requests for technical assistance submitted by recipients; gather supplementary information at site visits or on conference calls with recipient; and explore the possibility of conducting cost-effectiveness and/or modeling studies using recipient data and input.

The aforementioned evaluation sources and methods will be utilized to answer evaluation questions, a sample of which may be found here below:

- To what extent have PS-24-0003 recipients accomplished the short and intermediate outcomes in the NOFO logic model? To what extent has clinic infrastructure/capacity changed over time, for individual clinics and across all clinics? What might explain changes observed (or not observed)?
- To what extent do observed clinic capacity changes align with clinics' performance measure data? Are some clinic capacity changes also realized in changes in patient outcomes? (e.g., if a clinic expands PrEP services, how do patient outcomes for PrEP for that clinic change?)
- To what extent have PS-24-0003 recipients built or enhanced partnerships to support NOFO activities and outreach to priority populations? How effective were these partnerships?

Use of Evaluation and Performance Measure Data

Taken together, performance measurement and evaluation findings will be systematically reviewed by CDC to (a) identify challenges encountered by recipients, (b) identify capacity-building assistance needs and actions needed to improve overall project performance, (c) compare methods and outcomes across recipients to identify promising or innovative practices for dissemination during the project period, (d) demonstrate the value of the NOFO (e.g., improved public health outcomes, effectiveness of key prevention strategies and activities), and (e) contribute to the evidence base for NOFO strategies and activities, taking into account which strategies are scalable and effective. CDC may report findings at national and regional conferences, online, in peer-reviewed journals, and in other public forums.

ii. Applicant Evaluation and Performance Measurement Plan

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

- How applicant will collect the performance measures, respond to the evaluation questions, and use evaluation findings for continuous program quality improvement,

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

- How key program partners will participate in the evaluation and performance measurement planning processes.
- Available data sources, feasibility of collecting appropriate evaluation and performance data, and other relevant data information (e.g., performance measures proposed by the applicant).
- How evaluation findings will be disseminated to communities and populations of interest in a manner that is suitable to their needs.
- Plans for updating the Data Management Plan (DMP) as new pertinent information becomes available. If applicable, throughout the lifecycle of the project. Updates to DMP should be provided in annual progress reports. The DMP should provide a description of the data that will be produced using these NOFO funds; access to data; data standards ensuring released data have documentation describing methods of collection, what the data represent, and data limitations; and archival and long-term data preservation plans. For more information about CDC's policy on the DMP, see https://www.cdc.gov/grants/additional-requirements/ar-25.html.

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

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

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

To support performance measurement, all PS-24-0003 recipients will be expected to submit a performance and data management plan (PMDMP) for review within 60 days of award. The PMDMP template will be provided upon award.

The PMDMP must:

- Identify staff person(s) responsible for collecting performance measure data and their ability and level of training;
- Identify the source(s) of data needed to calculate the performance measures;
- Clarify data standards ensuring released data have documentation describing methods of collection and archival and long-term data preservation plans;
- Describe how feasible it will be for the applicant to report on the measures, and to do so every 6 months;
- Describe any anticipated facilitators or barriers to obtaining and calculating the proposed measures;
- Describe how useful the measures would be to the applicant and how measures will support continuous program and quality improvement; and

- Highlight any areas for needed data-related technical assistance.

Applicants may also propose additional key outcome or performance measures that they plan to collect and track for themselves. Applicants are encouraged to list measures that they believe CDC should consider for inclusion in the final set of common performance measures for this cooperative agreement, either in addition to, or in lieu of, the ones proposed in this NOFO.

c. Organizational Capacity of Recipients to Implement the Approach

Applicants should provide a staffing plan, including an organizational chart, CVs, position descriptions and project management structure that demonstrates the capacity to meet the outcomes of the proposed project and defines staff roles and reporting structure. Any planned consultancies or subcontracts should be included in the project management structure. The staffing plan should name a current medical director or health officer overseeing clinical staff and provide their CV. Applicants should provide the CVs/resumes, organizational chart, and staffing plan, as appropriate, naming the file "CVs-Resumes", "Organizational Chart", or "Staffing Plan", and uploading it as a PDF file to the application submitted at www.grants.gov.

Applicants must be providers of clinical sexual health services in the proposed service area, or plan to provide the majority of funds to a provider of clinical sexual health services in the proposed area. Applicants should provide a letter (one page or less) stating that the applicant's proposed clinic site is a clinical sexual health service provider. The letter should be signed by the Chief Medical Officer or supervising physician. Title this document "Clinical Provider" and upload it as a PDF file in the application submitted at www.grants.gov.

Applicants should describe the proposed clinic's organizational capacity to achieve the outcomes of the award. The clinic organizational capacity statement should describe in detail:

- the nature and scope of the clinical services that are provided,
- hours of operations,
- electronic health record functionality and interoperability,
- the number and composition of staffing,
- the current state of services, and
- any known infrastructure and system-level barriers to expansion and full implementation (including any legal/compliance barriers associated with proposed activities, such as telemedicine).

Applicants should also:

- Describe expertise and experience in program and performance management, quality improvement methods, partnership development, evaluation, personnel management including the authority and ability to hire or contract in a timely fashion and maintain adequate personnel resources with applicable skills and expertise.
- Describe relevant experience and capacity (management, technical, and clinical) to implement each of the required strategies and associated activities and achieve the project outcomes.
- Describe experience and capacity to coordinate with internal and external entities, including local public health organization(s), to foster community partnerships.

- Describe experience and capacity to implement the evaluation plan, measure, and report on performance measures, and implement the data management plan.
- Describe the budget management and financial reporting capacity, including the management of travel requirements, the full capability, accountability and expertise to meet deadlines, track funds, submit reports, manage the required procurement efforts, and to write and award contracts in accordance with 45 CFR part 75 by a given due date.
- Describe plans to sustain this project through billing or partnering and leveraging resources with other sexual health service providers in the community.

Non-clinical applicants, including state, local, and territorial health departments, should describe the relationship to the proposed clinic and describe how funds will be directed to the clinic, including mechanisms and timelines to obligate funds. CDC anticipates that at least 90% of the funds will be directed to the proposed clinic to address the syndemic of HIV and other STIs through strengthened sexual health clinic infrastructure, strategic community partnerships, and specialized evaluation studies.

All applicants should describe their mission, organizational structure, overall organizational budget and funding sources, staff size and expertise, the nature and scope of their work and capabilities, long-term sustainability plan, and other information that would help CDC assess the organization's infrastructure and capacity to implement the proposed activities. Applicants should address the physical infrastructure as it relates to equipment, electronic information and data systems, ensuring data security and confidentiality, and communication systems to implement the award.

Applicants funded under Component C of PS20-2010 should provide the following information:

- A clinic self-evaluation identifying and reflecting on clinic assessment activities, PrEP and nPEP implementation activities, linkage to HIV medical care activities, and EHE partnership activities conducted during PS20-2010 Component C period of performance, as described in the Strategies and Activities section of this NOFO.
- A copy of the clinic’s most recent PS20-2010 Component C individualized rapid feedback report (IRFR).

d. Work Plan

Applicants must provide a work plan that includes a detailed description of the first year of the award, and a high-level overview of the entire five-year period of performance. The Year One detailed work plan should incorporate all required Strategy A and B activities. Applicants should propose specific, measurable, achievable, realistic, and time-based (SMART) process and/or outcome measures for each activity aligned with the related NOFO performance outcomes. The work plan should include training, capacity building, and TA activities to support the implementation of the proposed program. It should also include a concise description of how the recipient plans to implement and monitor each program activity.

The PS-24-0003 work plan template will be posted here: https://www.cdc.gov/std/funding/default.htm.

The applicant should address the following in the work plan:

Year One Detailed Work Plan

- Program strategies and activities
- Outcomes aligned with program strategies and activities
- Outcomes aligned with performance targets (including quantitative baselines and targets, based on the proposed program, that lead to an increase, decrease, or maintenance over time)
- Activities aligned with program outcomes and measures
- Timeline for implementation (including staffing of the proposed program, training, etc.)

Five-Year Overview of Project

- Intended outcomes for the entire period of performance

The work plan will not be counted toward the Project Narrative page limit if uploaded as an attachment. Applicants are strongly encouraged to use the CDC-provided work plan template. Applicants should name the file "Work Plan" and upload it as a PDF file to the application submitted at www.grants.gov.

Post-award, proposed work plan activities may be adjusted in collaboration with CDC to better address the overarching goals of the project.

e. CDC Monitoring and Accountability Approach

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

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

Monitoring may also include the following activities deemed necessary to monitor the award:

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

Monitoring and reporting activities that assist grants management staff (e.g., grants management officers and specialists, and project officers) in the identification, notification, and management of high-risk recipients.

CDC will monitor the cooperative agreement through ongoing communication between CDC and the recipient via virtual/in-person meetings, conference calls, site visits, and the recipient's reporting (including work plan, process and outcome performance measures, monthly/annual

summary reports, program success stories/promising practices, and financial reporting). CDC will assign at least one point of contact from DSTDP who will collaborate with the recipient through conference calls (at least monthly) and other routine communications. CDC will provide templates and guidance for monthly and annual summary reports. Post-award monitoring for cooperative agreements will include:

- Assessing the adequacy of the recipient's application in response to the NOFO description and requirements, working with the recipient to create a program implementation plan, and finalizing the evaluation plan,
- Monthly conference calls with the project primary investigator,
- Annual conference calls with the project business official, and
- Participation in webinars and recipient meetings.

After review of the first annual performance report, if the recipient is not conducting required recipient activities or not meeting process or outcome standards, CDC will provide or facilitate technical/capacity building assistance for program improvement. Recipients performing at a less-than-sufficient level to achieve program objectives within stated timeframes will be placed on a time-phased Programmatic Improvement Plan (PIP) developed by the CDC Project Officer in collaboration with the recipient. The PIP is a comprehensive tool used to assist recipients to improve program performance through identifying factors contributing to less-than-sufficient performance and developing specific action steps to address areas in need of improvement. If placed on a PIP, the recipient will have an opportunity to document a plan of action to improve the performance of program activities. During such periods, more intense engagement between the recipient and CDC is expected. In subsequent budget periods, funding may be affected based on performance.

Attendance at PS-24-0003 Recipient Meetings and CDC Conferences

- Participation in annual, in-person PS-24-0003 recipient meetings and the biennial national STD prevention conference is mandatory. All recipients are required to attend and are to include budget allocations consistent with this requirement. These allocations will be reviewed and approved annually as a part of the award continuation process. Failure of a recipient to send at least two representatives to the mandated meetings (regardless of state financial or administrative crisis) shall be cause for a determination of reduction in travel funding.
- Recipients are expected to adhere to CDC policies for securing prior approval for mandatory meetings and conferences.

f. CDC Program Support to Recipients

In a cooperative agreement, CDC and the recipients share responsibility for successfully implementing the award and achieving identified project outcomes. As a result, recipient collaboration is required with CDC's DSTDP. CDC will provide substantial involvement beyond regular performance and financial monitoring during the period of performance. Substantial involvement means that the recipient can expect federal programmatic partnership to accomplish the effort under the award.

CDC will partner with the recipient to ensure the success of the cooperative agreement by:

- Making subject matter experts available, including scientific leadership, program planning, evaluation, and senior leadership to foster strategic discussions on the best approaches to achieve program goals,
- Conducting an in-person or virtual kick-off meeting with DSTDP leadership and staff at the beginning of the five-year period of performance,
- Sharing scientific and policy reports, research publications, education media campaign updates, and other work,
- Providing data and expert opinion to inform project activities,
- Providing guidance and set standards on data collection, use, and submission requirements,
- Coordinating to improve the quality and effectiveness of the proposed program, including evaluation strategy, products and services, and other elements,
- Fostering ongoing opportunities for networking, communication, coordination, and collaboration,
- Providing guidance and expert opinion on the development and dissemination of program success stories/promising practices,
- Facilitating program collaboration with other CDC programs and HHS offices to enhance and improve integration of services, and
- Collecting and disseminating information, best practices, lessons learned, and evaluation results (e.g., through conferences, guidance, material development, webinars, data sharing publications, other social media, participation in meetings, committees, and working groups related to the cooperative agreement).

B. Award Information

1. Funding Instrument Type:
CA (Cooperative Agreement)
CDC's substantial involvement in this program appears in the CDC Program Support to Recipients Section.

2. Award Mechanism:
U62 Prevention/Surveillance Activities/Studies of AIDS

3. Fiscal Year:
2024

4. Approximate Total Fiscal Year Funding:
$20,000,000

5. Total Period of Performance Funding:
$100,000,000
This amount is subject to the availability of funds.

Estimated Total Funding:
$100,000,000

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

year(s)

7. Expected Number of Awards:
20

8. Approximate Average Award:

$1,000,000
Per Budget Period

The average one-year award will be $600,000 - $1,000,000 total for both strategies. The award amount is dependent on the amount of funding available. Applicants should prepare a budget towards the average one-year award amount.

9. Award Ceiling:
$0
Per Budget Period

This amount is subject to the availability of funds.

This NOFO does not have an award ceiling.

10. Award Floor:
$0
Per Budget Period

This NOFO does not have an award floor.

11. Estimated Award Date:
June 01, 2024

12. Budget Period Length:
12 month(s)

Throughout the period of performance, CDC will continue the award based on the availability of funds, the evidence of satisfactory progress by the recipient (as documented in required reports), and the determination that continued funding is in the best interest of the federal government. The total number of years for which federal support has been approved (period of performance) will be shown in the "Notice of Award." This information does not constitute a commitment by the federal government to fund the entire period. The total period of performance comprises the initial competitive segment and any subsequent non-competitive continuation award(s).

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

If you are successful and receive a Notice of Award, in accepting the award, you agree that the award and any activities thereunder are subject to all provisions of 45 CFR part 75, currently in

effect or implemented during the period of the award, other Department regulations and policies in effect at the time of the award, and applicable statutory provisions.

C. Eligibility Information

1. Eligible Applicants

Eligibility Category:
00 (State governments)

01 (County governments)

02 (City or township governments)

04 (Special district governments)

05 (Independent school districts)

06 (Public and State controlled institutions of higher education)

07 (Native American tribal governments (Federally recognized))

08 (Public housing authorities/Indian housing authorities)

11 (Native American tribal organizations (other than Federally recognized tribal governments))

12 (Nonprofits having a 501(c)(3) status with the IRS, other than institutions of higher education)

13 (Nonprofits without 501(c)(3) status with the IRS, other than institutions of higher education)

20 (Private institutions of higher education)

25 (Others (see text field entitled "Additional Information on Eligibility" for clarification))

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

Additional Eligibility Category:

Government Organizations:

State governments or their bona fide agents (includes the District of Columbia)

Local governments or their bona fide agents

Territorial governments or their bona fide agents in the Commonwealth of Puerto Rico, the Virgin Islands, the Commonwealth of the Northern Marianna Islands, American Samoa, Guam, the Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau

State controlled institutions of higher education

American Indian or Alaska Native tribal governments (federally recognized or state-recognized)

Non-government Organizations

American Indian or Alaska native tribally designated organizations

2. Additional Information on Eligibility

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

Applicants who do not include Strategies A and B in the application will be deemed non-responsive and the application will not be reviewed.

Applicants funded under Component C of PS20-2010 must clearly state that they are recipients or sub-recipients of Component C funding, and must clearly state whether they are proposing activities in a Component C-funded clinic.

For verification of eligibility requirements, applicants are expected to upload a document confirming that the application includes Strategies A and B, stating whether they are recipients or sub-recipients of PS20-2010 Component C funding, and stating whether they are proposing activities in a Component C clinic. Applicants should name the file "Eligibility Verification" and upload it as a PDF file to the application submitted at www.grants.gov.

3. Justification for Less than Maximum Competition

N/A

4. Cost Sharing or Matching

Cost Sharing / Matching Requirement:
No
Cost sharing or matching funds are not required for this program. Although no statutory matching requirement for this NOFO exists, leveraging other resources and related ongoing efforts to promote sustainability is strongly encouraged.

5. Maintenance of Effort

Maintenance of effort is not required for this program.

D. Application and Submission Information

1. Required Registrations

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

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

a. Unique Entity Identifier (UEI):

All applicant organizations must obtain a Unique Entity Identifier (UEI) number by registering in SAM.gov prior to submitting an application. A UEI number is a unique twelve-digit identification number assigned to the registering organization.

If funds are awarded to an applicant organization that includes sub-recipients, those sub-recipients must provide their UEI numbers before accepting any funds.

b. System for Award Management (SAM):

The SAM is the primary registrant database for the federal government and the repository into which an entity must submit information required to conduct business as a recipient. All applicant organizations must register with SAM, and will be assigned a SAM number and a Unique Entity Identifier (UEI). All information relevant to the SAM number must be current at all times during which the applicant has an application under consideration for funding by CDC. If an award is made, the SAM information must be maintained until a final financial report is submitted or the final payment is received, whichever is later. The SAM registration process can require 10 or more business days, and registration must be renewed annually. Additional information about registration procedures may be found at SAM.gov and the SAM.gov Knowledge Base.

c. Grants.gov:

The first step in submitting an application online is registering your organization at www.grants.gov, the official HHS E-grant Web site. Registration information is located at the "Applicant Registration" option at www.grants.gov.

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

Step	System	Requirements	Duration	Follow Up
1	System for Award Management (SAM)	1. Go to SAM.gov and create an Electronic Business Point of Contact (EBiz POC). You will need to have an active SAM account before you can register on grants.gov). The UEI is generated as part of your registration.	7-10 Business Days but may take longer and must be renewed once a year	For SAM Customer Service Contact https://fsd.gov/fsd-gov/home.do Calls: 866-606-8220
2	Grants.gov	1. Set up an account in Grants.gov, then add a profile by adding the organization's new UEI number. 2. The EBiz POC can designate user roles, including Authorized Organization Representative (AOR). 3. AOR is authorized to submit	Allow at least one business day (after you enter the EBiz POC name and EBiz POC email in SAM) to receive a UEI (SAM) which will allow you to register with Grants.gov and apply for federal funding.	Register early! Applicants can register within minutes.

		applications on behalf of the organization in their workspace.		

2. Request Application Package

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

3. Application Package

Applicants must download the SF-424, Application for Federal Assistance, package associated with this notice of funding opportunity at www.grants.gov.

4. Submission Dates and Times

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

a. Letter of Intent Deadline (must be emailed)

11/29/2023

b. Application Deadline

01/15/2024

11:59 pm U.S. Eastern Time, at www.grants.gov. If Grants.gov is inoperable and cannot receive applications, and circumstances preclude advance notification of an extension, then applications must be submitted by the first business day on which Grants.gov operations resume.

Due Date for Information Conference Call

Monday, November 6, 2023 from 2:00-3:00 p.m. ET

Register in advance for this webinar:
https://www.zoomgov.com/webinar/register/WN_xlAeTKxtQqSWaePFxZsE5

5. Pre-Award Assessments

Risk Assessment Questionnaire Requirement

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

CDC requires all applicants to complete the Risk Questionnaire, OMB Control Number 0920-1132 annually. This questionnaire, which is located at https://www.cdc.gov/grants/documents/PPMR-G-CDC-Risk-Questionnaire.pdf, along with supporting documentation must be submitted with your application by the closing date of the Notice of Funding Opportunity Announcement. If your organization has completed CDC's Risk Questionnaire within the past 12 months of the closing date of this NOFO, then you must submit a copy of that questionnaire, or submit a letter signed by the authorized organization representative to include the original submission date, organization's EIN and UEI.

When uploading supporting documentation for the Risk Questionnaire into this application package, clearly label the documents for easy identification of the type of documentation. For example, a copy of Procurement policy submitted in response to the questionnaire may be labeled using the following format: Risk Questionnaire Supporting Documents _ Procurement Policy.

Duplication of Efforts

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

Report Submission: The applicant must upload the report in Grants.gov under "Other Attachment Forms." The document should be labeled: "Report on Programmatic, Budgetary, and Commitment Overlap."

6. Content and Form of Application Submission

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

7. Letter of Intent

A letter of intent is requested but optional as part of the application for this NOFO. The purpose of an LOI is to allow CDC program staff to estimate the number of and plan for the review of submitted applications.

LOI must be sent via email to:

Diane Ballard

CDC, Division of STD Prevention

IQU0@cdc.gov

8. Table of Contents

(There is no page limit. The table of contents is not included in the project narrative page limit.): The applicant must provide, as a separate attachment, the “Table of Contents” for the entire submission package.

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

9. Project Abstract Summary

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

10. Project Narrative

(Unless specified in the "H. Other Information" section, maximum of 20 pages, single spaced, 12 point font, 1-inch margins, number all pages. This includes the work plan. Content beyond the specified page number will not be reviewed.)

Applicants must submit a Project Narrative with the application forms. Applicants must name this file “Project Narrative” and upload it at www.grants.gov. The Project Narrative must include **all** of the following headings (including subheadings): Background, Approach, Applicant Evaluation and Performance Measurement Plan, Organizational Capacity of Applicants to Implement the Approach, and Work Plan. The Project Narrative must be succinct, self-explanatory, and in the order outlined in this section. It must address outcomes and activities to be conducted over the entire period of performance as identified in the CDC Project Description section. Applicants should use the federal plain language guidelines and Clear Communication Index to respond to this Notice of Funding Opportunity. Note that recipients should also use these tools when creating public communication materials supported by this NOFO. Failure to follow the guidance and format may negatively impact scoring of the application.

a. Background

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

b. Approach

i. Purpose

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

ii. Outcomes

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

iii. Strategies and Activities

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

1. Collaborations

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

2. Population(s) of Focus and Health Disparities

Applicants must describe the specific population(s) of focus in their jurisdiction and explain how to achieve the goals of the award and/or alleviate health disparities. The applicants must also address how they will include specific populations that can benefit from the program that is described in the Approach section. Applicants must address the Population(s) of Focus and Health Disparities requirements as described in the CDC Project Description, including (as applicable to this award) how to address health disparities in the design and implementation of the proposed program activities.

c. Applicant Evaluation and Performance Measurement Plan

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

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

- Available data sources, feasibility of collecting appropriate evaluation and performance data, data management plan (DMP), and other relevant data information (e.g., performance measures proposed by the applicant).

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

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

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

d. Organizational Capacity of Applicants to Implement the Approach

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

11. Work Plan

(Included in the Project Narrative's page limit)

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

12. Budget Narrative

Applicants must submit an itemized budget narrative. When developing the budget narrative, applicants must consider whether the proposed budget is reasonable and consistent with the purpose, outcomes, and program strategy outlined in the project narrative. The budget must include:

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

Indirect costs could include the cost of collecting, managing, sharing and preserving data.

Indirect costs on grants awarded to foreign organizations and foreign public entities and performed fully outside of the territorial limits of the U.S. may be paid to support the costs of compliance with federal requirements at a fixed rate of eight percent of MTDC exclusive of tuition and related fees, direct expenditures for equipment, and subawards in excess of $25,000. Negotiated indirect costs may be paid to the American University, Beirut, and the World Health Organization.

If applicable and consistent with the cited statutory authority for this announcement, applicant entities may use funds for activities as they relate to the intent of this NOFO to meet national standards or seek health department accreditation or reaccreditation through the Public Health Accreditation Board (see: http://www.phaboard.org). Applicant entities to whom this provision applies include state, local, territorial governments (including the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, the Commonwealth of the Northern Marianna Islands, American Samoa, Guam, the Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau), or their bona fide agents, political subdivisions of states (in consultation with states), federally recognized or state-recognized American Indian or Alaska Native tribal governments, and American Indian or Alaska Native tribally designated organizations. Activities include those that enable a public health organization to deliver essential public health services and ensure foundational capabilities are in place, such as activities that ensure a capable and qualified workforce, strengthen information systems and organizational competencies, build attention to equity, and advance the capability to assess and respond to public health needs. Use of these funds must focus on achieving a minimum of one national standard that supports the intent of the NOFO. Proposed activities must be included in the budget narrative and must indicate which standards will be addressed.

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

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

The budget must follow the budget preparation guidance found here: https://www.cdc.gov/grants/documents/Budget-Preparation-Guidance.pdf

The budget must be broken out by each strategy so that it is clear which costs are associated with Strategy A and Strategy B.

Applicants are to budget for two representatives to attend the annual, in-person PS-24-0003 recipient meetings and the biennial national STD prevention conference. All recipients are

required to attend and are to include budget allocations consistent with this requirement. These allocations will be reviewed and approved annually as a part of the award continuation process. Failure of a recipient to send at least two representatives to the mandated meetings (regardless of state financial or administrative crisis) shall be cause for a determination of reduction in travel funding.

13. Funds Tracking

Proper fiscal oversight is critical to maintaining public trust in the stewardship of federal funds. Effective October 1, 2013, a new HHS policy on subaccounts requires the CDC to set up payment subaccounts within the Payment Management System (PMS) for all new grant awards. Funds awarded in support of approved activities and drawdown instructions will be identified on the Notice of Award in a newly established PMS subaccount (P subaccount). Recipients will be required to draw down funds from award-specific accounts in the PMS. Ultimately, the subaccounts will provide recipients and CDC a more detailed and precise understanding of financial transactions. The successful applicant will be required to track funds by P-accounts/sub accounts for each project/cooperative agreement awarded. Applicants are encouraged to demonstrate a record of fiscal responsibility and the ability to provide sufficient and effective oversight. Financial management systems must meet the requirements as described 45 CFR 75 which include, but are not limited to, the following:

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

14. Employee Whistleblower Rights and Protections

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

15. Copyright Interests Provisions

This provision is intended to ensure that the public has access to the results and accomplishments of public health activities funded by CDC. Pursuant to applicable grant regulations and CDC’s Public Access Policy, Recipient agrees to submit into the National Institutes of Health (NIH) Manuscript Submission (NIHMS) system an electronic version of the final, peer-reviewed manuscript of any such work developed under this award upon acceptance for publication, to be made publicly available no later than 12 months after the official date of publication. Also at the

time of submission, Recipient and/or the Recipient's submitting author must specify the date the final manuscript will be publicly accessible through PubMed Central (PMC). Recipient and/or Recipient's submitting author must also post the manuscript through PMC within twelve (12) months of the publisher's official date of final publication; however the author is strongly encouraged to make the subject manuscript available as soon as possible. The recipient must obtain prior approval from the CDC for any exception to this provision.

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

16. Funding Restrictions

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

- Recipients may not use funds for research.
- Recipients may not use funds for clinical care except as allowed by law.
- Recipients may use funds only for reasonable program purposes, including personnel, travel, supplies, and services.
- Generally, recipients may not use funds to purchase furniture or equipment. Any such proposed spending must be clearly identified in the budget.
- Reimbursement of pre-award costs generally is not allowed, unless the CDC provides written approval to the recipient.
- Other than for normal and recognized executive-legislative relationships, no funds may be used for:
    - publicity or propaganda purposes, for the preparation, distribution, or use of any material designed to support or defeat the enactment of legislation before any legislative body
    - the salary or expenses of any grant or contract recipient, or agent acting for such recipient, related to any activity designed to influence the enactment of legislation, appropriations, regulation, administrative action, or Executive order proposed or pending before any legislative body
- See Additional Requirement (AR) 12 for detailed guidance on this prohibition and additional guidance on anti-lobbying restrictions for CDC recipients.

- The direct and primary recipient in a cooperative agreement program must perform a substantial role in carrying out project outcomes and not merely serve as a conduit for an award to another party or provider who is ineligible.
- CDC funds may be used for laboratory costs to screen or monitor PrEP per CDC Guidelines for uninsured or underinsured people receiving PrEP in not-for-profit or governmental clinics.
- CDC funds may be used to screen, diagnose, or treat STIs in persons who are uninsured and underinsured.
- CDC funds may be used for mobile units and other novel engagement strategies.
- CDC funds used for the purchase of supplies or equipment related to injection drug use must comply with current federal law.
- CDC funds cannot be used to cover the costs of antiretroviral medication, including PrEP.
- CDC funds cannot be used to purchase family planning medications.
- CDC funds cannot be used to purchase medication for treatment of hepatitis C.

17. Data Management Plan

As identified in the Evaluation and Performance Measurement section, applications involving data collection or generation must include a Data Management Plan (DMP) as part of their evaluation and performance measurement plan unless CDC has stated that CDC will take on the responsibility of creating the DMP. The DMP describes plans for assurance of the quality of the public health data through the data's lifecycle and plans to deposit the data in a repository to preserve and to make the data accessible in a timely manner. See web link for additional information:
https://www.cdc.gov/grants/additional-requirements/ar-25.html.

18. Other Submission Requirements

a. Electronic Submission:

Applications must be submitted electronically by using the forms and instructions posted for this notice of funding opportunity at www.grants.gov. Applicants can complete the application package using Workspace, which allows forms to be filled out online or offline. Application attachments can be submitted using PDF, Word, or Excel file formats. Instructions and training for using Workspace can be found at www.grants.gov under the "Workspace Overview" option.

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

c. Validation Process: Application submission is not concluded until the validation process is completed successfully. After the application package is submitted, the applicant will receive a "submission receipt" e-mail generated by www.grants.gov. A second e-mail message to applicants will then be generated by www.grants.gov that will either validate or reject the submitted application package. This validation process may take as long as two business days.

Applicants are strongly encouraged to check the status of their application to ensure that submission of their package has been completed and no submission errors have occurred. Applicants also are strongly encouraged to allocate ample time for filing to guarantee that their application can be submitted and validated by the deadline published in the NOFO. Non-validated applications will not be accepted after the published application deadline date.

If you do not receive a "validation" e-mail within two business days of application submission, please contact www.grants.gov. For instructions on how to track your application, refer to the e-mail message generated at the time of application submission or review the Applicants section on www.grants.gov.

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

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

An applicant's request for permission to submit a paper application must:

1. Include the www.grants.gov case number assigned to the inquiry
2. Describe the difficulties that prevent electronic submission and the efforts taken with the www.grants.gov Contact Center to submit electronically; and
3. Be received via e-mail to the GMS/GMO listed below at least three calendar days before the application deadline. Paper applications submitted without prior approval will not be considered.

   If a paper application is authorized, OGS will advise the applicant of specific instructions for submitting the application via email.

E. Review and Selection Process

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

a. Phase 1 Review

All applications will be initially reviewed for eligibility and completeness by CDC Office of Grants Services. Complete applications will be reviewed for responsiveness by the Grants Management Officials and Program Officials. Non-responsive applications will not advance to Phase II review. Applicants will be notified that their applications did not meet eligibility and/or published submission requirements.

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

i. Approach

ii. Evaluation and Performance Measurement

iii. Applicant's Organizational Capacity to Implement the Approach

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

i. Approach **Maximum Points:** 35

Strategies A and B are required and will be scored together.

For Strategies A and B, evaluate the extent to which the applicant:

1. **(5 points)** Describes the ability to reach subpopulations with high HIV and STI burden, and groups disproportionately impacted by HIV and STIs in the proposed clinic's catchment area based on clinic data provided by applicant from 2022 or the most recent year of available data:

a. Percentage of all persons served who tested positive for HIV is greater than or equal to 0.69% (1 point)

b. Percentage of all persons served who tested positive for rectal gonorrhea/chlamydia is greater than or equal to 17% (1 point)

c. Percentage of all persons served who are Black/African American or Hispanic/Latino is greater than or equal to 70% (1 point)

d. Percentage of all persons served who are MSM is greater than or equal to 23% (1 point)

e. Percentage of all persons served who are transgender is greater than or equal to 0.82% (1 point)

2. **(5 points)** Describes an overall approach consistent with the NOFO Project Description and logic model.

3. **(10 points)** Describes strategies and associated activities that are achievable, appropriate to achieve the outcomes of the NOFO, and evidence-based or evidence-informed, including:

a. Strategy A: Strengthen clinic infrastructure to address syndemic of HIV & other STIs by implementing an action plan to address clinic infrastructure gaps; implementing evidence-based or evidence-informed approaches to increase clinic efficiency; assessing patient clinic experience and needs; and integrating a whole-person approach to HIV prevention and care in the clinic.

b. Strategy B: Foster strategic partnerships in support of the EHE Initiative by fostering action-oriented, strategic partnerships with community providers, CBOs, health departments and other entities; participating in local HIV planning activities; and

building active and meaningful engagements with priority populations affected by HIV and other STIs.

4. **(10 points)** Presents a work plan aligned with all required NOFO strategies, the associated activities, outcomes, and performance measures; and the extent to which the work plan is consistent with the content and format proposed by CDC.

5. **(5 points)** Presents outcomes that are consistent with the period of performance outcomes described in the NOFO and logic model.

ii. Evaluation and Performance Measurement **Maximum Points:** 30

Strategies A and B are required and will be scored together. For Strategies A and B, evaluate the extent to which the applicant:

1. **(10 points)** Shows/affirms the ability to collect performance measure data specified by CDC. The applicant has identified:

a. The staff person(s) responsible for collecting performance measure data and the ability to do so,

b. Available baseline measures (including definitions for numerators and denominators used and latest reporting year or time frame),

c. Source(s) of data to calculate the measures,

d. The ability to report on the measures every six months, and

e. Anticipated barriers to obtaining and calculating the proposed measures.

2. **(10 points)** Clearly articulates how performance measure data will be used for continuous program quality improvement of sexual health services offered in the participating clinic.

3. **(10 points)** Articulates how personally identifiable information (PII) will be appropriately collected, processed, stored, and protected to maintain compliance with public laws, federal regulations, and executive orders (DMP section of template).

iii. Applicant's Organizational Capacity to Implement the Approach **Maximum Points:** 35

Strategies A and B are required and will be scored together. For Strategies A and B, evaluate the extent to which the applicant:

1. **(5 points)** Provides an adequate staffing plan, including an organizational chart, CVs, position descriptions and project management structure that demonstrate sufficient capacity to meet the outcomes of the proposed project and defines staff roles and reporting structure. Any planned consultancies or subcontracts should be included in the project management structure.

a. Describes the authority and ability to hire or contract in a timely fashion for and maintain adequate personnel resources with applicable skills and expertise.

2. **(10 points)** Describes relevant experience and capacity (management, technical, and clinical) to implement each of the required strategies and associated activities and achieve the project outcomes.

a. Provides a letter stating that the applicant's proposed clinic site is a clinical sexual health service provider. The letter should be signed by the Chief Medical Officer or supervising physician.

b. Non-clinical applicants, including state, local, and territorial health departments, must describe the capacity for the proposed clinic. Applicants should describe the relationship to the proposed clinic and describe how funds will be directed to the clinic, including mechanisms and timelines to obligate funds.

c. (*If applicant is funded under Component C of PS20-2010 & is proposing activities in a Component C clinic*) The extent to which the PS20-2010 Component C clinic self-evaluation describes successful implementation of clinic assessment activities, PrEP and nPEP implementation activities, linkage to HIV medical care activities, and EHE partnership activities conducted during the PS20-2010 Component C period of performance, as described in the Strategies and Activities section of this NOFO.

d. (*If applicant is funded under Component C of PS20-2010 & is proposing activities in a Component C clinic*) The extent to which the data in the clinic's most recent PS20-2010 Component C individualized rapid feedback report (IRFR) supports the clinic's self-evaluation.

3. **(5 points)** Describes experience and capacity to coordinate with internal and external entities, including local public health organization(s), to foster community partnerships.

4. **(5 points)** Describes experience and capacity to implement the evaluation plan, measure and report on performance measures, and implement the data management plan.

5. **(5 points)** Describes plans to sustain this project through billing or partnering and leveraging resources with other sexual health service providers in the community.

6. **(5 points)** Describes the budget management and financial reporting capacity, including the management of travel requirements, the full capability, accountability and expertise to meet deadlines, track funds, submit reports, manage the required procurement efforts, and to write and award contracts in accordance with 45 CFR part 75 by a given due date.

Budget **Maximum Points:** 0

The budget will not be scored; however, the budget will be assessed to determine whether it aligns with the proposed work plan and is broken out by strategy.

c. Phase III Review

Phase III Review will be conducted after CDC's internal objective review process. The following factors may affect the funding decision:

- Preference for applicants located in priority EHE jurisdictions.
- Preference for organizations that are not currently receiving funding from any federal funding sources to provide similar sexual health services, as determined using the HHS' Tracking Accountability in Government Grants System (TAGGS) website.
- Preference for applicants proposing to serve underserved populations and priority populations that are not addressed in other applications.

Review of risk posed by applicants.
Prior to making a Federal award, CDC is required by 31 U.S.C. 3321 and 41 U.S.C. 2313 to review information available through any OMB-designated repositories of government-wide eligibility qualification or financial integrity information as appropriate. See also suspension and debarment requirements at 2 CFR parts 180 and 376.

In accordance 41 U.S.C. 2313, CDC is required to review the non-public segment of the OMB-designated integrity and performance system accessible through SAM (currently the Federal Recipient Performance and Integrity Information System (FAPIIS)) prior to making a Federal award where the Federal share is expected to exceed the simplified acquisition threshold, defined in 41 U.S.C. 134, over the period of performance. At a minimum, the information in the system for a prior Federal award recipient must demonstrate a satisfactory record of executing programs or activities under Federal grants, cooperative agreements, or procurement awards; and integrity and business ethics. CDC may make a Federal award to a recipient who does not fully meet these standards, if it is determined that the information is not relevant to the current Federal award under consideration or there are specific conditions that can appropriately mitigate the effects of the non-Federal entity's risk in accordance with 45 CFR §75.207.

CDC’s framework for evaluating the risks posed by an applicant may incorporate results of the evaluation of the applicant's eligibility or the quality of its application. If it is determined that a Federal award will be made, special conditions that correspond to the degree of risk assessed may be applied to the Federal award. The evaluation criteria is described in this Notice of Funding Opportunity.

In evaluating risks posed by applicants, CDC will use a risk-based approach and may consider any items such as the following:

(1) Financial stability;

(2) Quality of management systems and ability to meet the management standards prescribed in this part;

(3) History of performance. The applicant's record in managing Federal awards, if it is a prior recipient of Federal awards, including timeliness of compliance with applicable reporting requirements, conformance to the terms and conditions of previous Federal awards, and if applicable, the extent to which any previously awarded amounts will be expended prior to future awards;

(4) Reports and findings from audits performed under subpart F 45 CFR 75 or the reports and findings of any other available audits; and

(5) The applicant's ability to effectively implement statutory, regulatory, or other requirements imposed on non-Federal entities.

CDC must comply with the guidelines on government-wide suspension and debarment in 2 CFR part 180, and require non-Federal entities to comply with these provisions. These provisions restrict Federal awards, subawards and contracts with certain parties that are debarred, suspended or otherwise excluded from or ineligible for participation in Federal programs or activities.

2. Announcement and Anticipated Award Dates

Awards are projected for June 1, 2024.

F. Award Administration Information

1. Award Notices

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

Any applicant awarded funds in response to this Notice of Funding Opportunity will be subject to annual SAM Registration and Federal Funding Accountability And Transparency Act Of 2006 (FFATA) requirements.

Unsuccessful applicants will receive notification of these results by e-mail with delivery receipt.

2. Administrative and National Policy Requirements

Recipients must comply with the administrative and public policy requirements outlined in 45 CFR Part 75 and the HHS Grants Policy Statement, as appropriate.

Brief descriptions of relevant provisions are available at https://www.cdc.gov/grants/additional-requirements/index.html.

The HHS Grants Policy Statement is available at http://www.hhs.gov/sites/default/files/grants/grants/policies-regulations/hhsgps107.pdf.

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

- AR-4: HIV/AIDS Confidentiality Provisions
- AR-5: HIV Program Review Panel Requirements
- AR-6: Patient Care
- AR-8: Public Health System Reporting Requirements
- AR-9: Paperwork Reduction Act Requirements
- AR-10: Smoke-Free Workplace Requirements
- AR-11: Healthy People 2030
- AR-12: Lobbying Restrictions
- AR-14: Accounting System Requirements
- AR-15: Proof of Non-profit Status
- AR-23: Compliance with 45 CFR Part 87
- AR-24: Health Insurance Portability and Accountability Act Requirements
- AR-25: Data Management and Access
- AR-26: National Historic Preservation Act of 1966
- AR-29: Compliance with EO13513, “Federal Leadership on Reducing Text Messaging while Driving”, October 1, 2009
- AR-30: Information Letter 10-006, - Compliance with Section 508 of the Rehabilitation Act of 1973
- AR-31: Research Definition
- AR-32: Enacted General Provisions
- AR-34: Accessibility Provisions and Non-Discrimination Requirements

- AR-37: Prohibition on certain telecommunications and video surveillance services or equipment for all awards issued on or after August 13, 2020

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

3. Reporting

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

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

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

Report	When?	Required?
Recipient Performance Measurement Plan, including Data Management Plan (DMP)	60 days into award and updated annually as needed	Yes
Annual Performance Report (APR)	No later than 120 days before end of budget period. Serves as yearly continuation application.	Yes
Data on Performance Measures	Twice within the budget period. Biannual performance measure reporting will allow CDC and recipients to quickly adjust strategy or strengthen capacity as needed to allow for continuous quality improvement.	Yes

Federal Financial Reporting Forms	90 days after the end of the budget period	Yes
Final Performance and Financial Report	90 days after end of period of performance	Yes

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

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

Performance Measurement

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

Evaluation

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

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

b. Annual Performance Report (APR) (required)

The recipient must submit the APR via www.Grantsolutions.gov no later than 120 days prior to the end of the budget period. This report must not exceed 45 pages excluding administrative reporting. Attachments are not allowed, but web links are allowed.

This report must include the following:

- **Performance Measures:** Recipients must report on performance measures for each budget period and update measures, if needed.
- **Evaluation Results:** Recipients must report evaluation results for the work completed to date (including findings from process or outcome evaluations).
- **Work Plan:** Recipients must update work plan each budget period to reflect any changes in period of performance outcomes, activities, timeline, etc.
- **Successes**
    - Recipients must report progress on completing activities and progress towards achieving the period of performance outcomes described in the logic model and work plan.
    - Recipients must describe any additional successes (e.g. identified through evaluation results or lessons learned) achieved in the past year.
    - Recipients must describe success stories.
- **Challenges**
    - Recipients must describe any challenges that hindered or might hinder their ability to complete the work plan activities and achieve the period of performance outcomes.
    - Recipients must describe any additional challenges (e.g., identified through evaluation results or lessons learned) encountered in the past year.
- **CDC Program Support to Recipients**
    - Recipients must describe how CDC could help them overcome challenges to complete activities in the work plan and achieving period of performance outcomes.
- **Administrative Reporting** (No page limit)
    - SF-424A Budget Information-Non-Construction Programs.
    - Budget Narrative – Must use the format outlined in "Content and Form of Application Submission, Budget Narrative" section.
    - Indirect Cost Rate Agreement.

The recipients must submit the Annual Performance Report via www.Grantsolutions.gov no later than 120 days prior to the end of the budget period.

c. Performance Measure Reporting (optional)

CDC programs may require more frequent reporting of performance measures than annually in the APR. If this is the case, CDC programs must specify reporting frequency, data fields, and format for recipients at the beginning of the award period.

For each of the NOFO's program strategies, a partial list of performance measures is presented above. A full list of proposed outcomes and measures will be provided by DSTDP project staff 60 days from start of the period of performance. CDC will work with recipients to finalize the detailed PMDMP, including a Work Plan and Data Management Plan (DMP), in accordance with CDC program guidance. CDC will finalize these measures, their specific definitions, submission frequency, and submission templates in consultation with recipients.

Recipients will submit biannual performance measure reports to CDC using the templates provided by the DSTDP evaluation team. Biannual performance measure reporting will allow CDC and recipients to quickly adjust strategy or strengthen capacity as needed to allow for continuous quality improvement. In each report, recipients are also required to include a success story based on one of their NOFO activities. CDC will provide further guidance.

d. Federal Financial Reporting (FFR) (required)

The annual FFR form (SF-425) is required and must be submitted 90 days after the end of the budget period through the Payment Management System (PMS). The report must include only those funds authorized and disbursed during the timeframe covered by the report. The final FFR must indicate the exact balance of unobligated funds, and may not reflect any unliquidated obligations. There must be no discrepancies between the final FFR expenditure data and the Payment Management System's (PMS) cash transaction data. Failure to submit the required information by the due date may adversely affect the future funding of the project. If the information cannot be provided by the due date, recipients are required to submit a letter of explanation to OGS and include the date by which the Grants Officer will receive information.

e. Final Performance and Financial Report (required)

The Final Performance Report is due 90 days after the end of the period of performance. The Final FFR is due 90 days after the end of the period of performance and must be submitted through the Payment Management System (PMS). CDC programs must indicate that this report should not exceed 40 pages. This report covers the entire period of performance and can include information previously reported in APRs. At a minimum, this report must include the following:

- Performance Measures – Recipients must report final performance data for all process and outcome performance measures.
- Evaluation Results – Recipients must report final evaluation results for the period of performance for any evaluations conducted.
- Impact/Results/Success Stories – Recipients must use their performance measure results and their evaluation findings to describe the effects or results of the work completed over the period of performance, and can include some success stories.
- A final Data Management Plan that includes the location of the data collected during the funded period, for example, repository name and link data set(s)
- Additional forms as described in the Notice of Award (e.g., Equipment Inventory Report, Final Invention Statement).

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

Federal Funding Accountability and Transparency Act of 2006 (FFATA), P.L. 109–282, as amended by section 6202 of P.L. 110–252 requires full disclosure of all entities and organizations receiving Federal funds including awards, contracts, loans, other assistance, and payments through a single publicly accessible Web site, http://www.USASpending.gov.

Compliance with this law is primarily the responsibility of the Federal agency. However, two elements of the law require information to be collected and reported by applicants: 1) information on executive compensation when not already reported through the SAM, and 2) similar information on all sub-awards/subcontracts/consortiums over $30,000.

For the full text of the requirements under the FFATA and HHS guidelines, go to:

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

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

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

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

1) Annual Report: The recipient must submit a report on or before November 16 for each foreign country on the amount of foreign taxes charged, as of September 30 of the same year, by a foreign government on commodity purchase transactions valued at 500 USD or more financed with United States foreign assistance funds under this grant during the prior United States fiscal year (October 1 – September 30), and the amount reimbursed and unreimbursed by the foreign government. [Reports are required even if the recipient did not pay any taxes during the reporting period.]

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

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

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

5) Contents of Reports: The reports must contain:

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

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

6. Termination

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

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

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

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

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

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

G. Agency Contacts

CDC encourages inquiries concerning this notice of funding opportunity.

Program Office Contact

For programmatic technical assistance, contact:

First Name:
Diane

Last Name:
Ballard
Project Officer
Department of Health and Human Services
Centers for Disease Control and Prevention

Address:

Telephone:

Email:
IQU0@cdc.gov

Grants Staff Contact

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

First Name:
Chamarla

Last Name:
Brame
Grants Management Specialist
Department of Health and Human Services
Office of Grants Services

Address:
2920 Brandywine Rd

Atlanta, GA 30341

Telephone:

Email:
gpv3@cdc.gov

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

Hours of Operation: 24 hours a day, 7 days a week, except on federal holidays.

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

H. Other Information

Following is a list of acceptable application attachments that can be submitted using PDF, Word, or Excel file formats as part of their application at www.grants.gov. Applicants may not attach documents other than those listed; if other documents are attached, applications will not be reviewed.

- Project Abstract

- Project Narrative
- Budget Narrative
- Report on Programmatic, Budgetary and Commitment Overlap
- Table of Contents for Entire Submission

For international NOFOs:

- SF424
- SF424A
- Funding Preference Deliverables

Optional attachments, as determined by CDC programs:
Resumes / CVs

Position descriptions

Letters of Support

Organization Charts

Non-profit organization IRS status forms, if applicable

Indirect Cost Rate, if applicable

Memorandum of Agreement (MOA)

Memorandum of Understanding (MOU)

Bona Fide Agent status documentation, if applicable

- Work Plan (preferably using CDC-provided template)
- Letters of Commitment
- Table summarizing clinic census, demographic characteristics, and HIV/STI morbidity
- Letter stating that applicant's proposed clinic site is a clinical sexual health service provider
- Eligibility verification document, as described in the Eligibility Information section
- Letter of support from local public health agency, if applicable
- PS20-2010 Component C individualized rapid feedback report (IRFR), if applicable

Please note: The project narrative must not exceed a maximum of twenty (20) pages, single spaced, 12-point font, 1-inch margins. Number all pages. Content beyond the specified page number will not be reviewed. The work plan attachment <u>will not</u> count toward the page limit.

I. Glossary

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

Administrative and National Policy Requirements, Additional Requirements (ARs):
Administrative requirements found in 45 CFR Part 75 and other requirements mandated by

statute or CDC policy. All ARs are listed in the Template for CDC programs. CDC programs must indicate which ARs are relevant to the NOFO; recipients must comply with the ARs listed in the NOFO. To view brief descriptions of relevant provisions, see https://www.cdc.gov/grants/additional-requirements/index.html. Note that 2 CFR 200 supersedes the administrative requirements (A-110 & A-102), cost principles (A-21, A-87 & A-122) and audit requirements (A-50, A-89 & A-133).

Approved but Unfunded: Approved but unfunded refers to applications recommended for approval during the objective review process; however, they were not recommended for funding by the program office and/or the grants management office.

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

Assistance Listings Number: A unique number assigned to each program and NOFO throughout its lifecycle that enables data and funding tracking and transparency

Award: Financial assistance that provides support or stimulation to accomplish a public purpose. Awards include grants and other agreements (e.g., cooperative agreements) in the form of money, or property in lieu of money, by the federal government to an eligible applicant.

Budget Period or Budget Year: The duration of each individual funding period within the period of performance. Traditionally, budget periods are 12 months or 1 year.

Carryover: Unobligated federal funds remaining at the end of any budget period that, with the approval of the GMO or under an automatic authority, may be carried over to another budget period to cover allowable costs of that budget period either as an offset or additional authorization. Obligated but liquidated funds are not considered carryover.

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

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

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

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

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

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

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

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

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

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

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

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

Grant: A legal instrument used by the federal government to transfer anything of value to a recipient for public support or stimulation authorized by statute. Financial assistance may be money or property. The definition does not include a federal procurement subject to the Federal Acquisition Regulation; technical assistance (which provides services instead of money); or assistance in the form of revenue sharing, loans, loan guarantees, interest subsidies, insurance, or direct payments of any kind to a person or persons. The main difference between a grant and a cooperative agreement is that in a grant there is no anticipated substantial programmatic involvement by the federal government under the award.

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

Grants Management Officer (GMO): The individual designated to serve as the HHS official responsible for the business management aspects of a particular grant(s) or cooperative agreement(s). The GMO serves as the counterpart to the business officer of the recipient

organization. In this capacity, the GMO is responsible for all business management matters associated with the review, negotiation, award, and administration of grants and interprets grants administration policies and provisions. The GMO works closely with the program or project officer who is responsible for the scientific, technical, and programmatic aspects of the grant.

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

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

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

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

Healthy People 2030: National health objectives aimed at improving the health of all Americans by encouraging collaboration across sectors, guiding people toward making informed health decisions, and measuring the effects of prevention activities.

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

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

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

Lobbying: Direct lobbying includes any attempt to influence legislation, appropriations, regulations, administrative actions, executive orders (legislation or other orders), or other similar deliberations at any level of government through communication that directly expresses a view on proposed or pending legislation or other orders, and which is directed to staff members or other employees of a legislative body, government officials, or employees who participate in formulating legislation or other orders. Grass roots lobbying includes efforts directed at inducing or encouraging members of the public to contact their elected representatives at the federal, state, or local levels to urge support of, or opposition to, proposed or pending legislative proposals.

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

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

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

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

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

Objective Review: A process that involves the thorough and consistent examination of applications based on an unbiased evaluation of scientific or technical merit or other relevant aspects of the proposal. The review is intended to provide advice to the persons responsible for making award decisions.

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

Performance Measurement: The ongoing monitoring and reporting of program accomplishments, particularly progress toward pre-established goals, typically conducted by program or agency management. Performance measurement may address the type or level of program activities conducted (process), the direct products and services delivered by a program (outputs), or the results of those products and services (outcomes). A "program" may be any activity, project, function, or policy that has an identifiable purpose or set of objectives.

Period of performance –formerly known as the project period - : The time during which the recipient may incur obligations to carry out the work authorized under the Federal award. The start and end dates of the period of performance must be included in the Federal award.

Period of Performance Outcome: An outcome that will occur by the end of the NOFO's funding period

Plain Writing Act of 2010: The Plain Writing Act of 2010 requires that federal agencies use clear communication that the public can understand and use. NOFOs must be written in clear, consistent language so that any reader can understand expectations and intended outcomes of the funded program. CDC programs should use NOFO plain writing tips when writing NOFOs.

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

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

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

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

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

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

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

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

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

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

NOFO-specific Glossary and Acronyms

Sexual health services: Sexual health services cover broad preventive and treatment approaches related to sexual health including taking a sexual history and risk assessment; education and counseling; testing and treatment for HIV and other STIs; hepatitis B and C screening; PrEP/nPEP for HIV prevention; contraception; condoms; and recommended vaccinations.

Evidence-based interventions: Demonstrated effectiveness at improving the care and treatment of people with HIV, or at-risk of HIV. Published research evidence supporting these interventions meets CDC criteria for being evidence-based. (Adapted from Psihopaidas et al., 2020)

Evidence-informed interventions: Demonstrated effectiveness at improving the care and treatment of people with HIV, or at-risk of HIV. Published research evidence meets HRSA (and potentially CDC) evidence-informed criteria but does not meet CDC criteria for evidence-based interventions. (Adapted from Psihopaidas et al., 2020)

Emerging strategies: Demonstrated effectiveness at improving the care and treatment of people with HIV, or at-risk of HIV. Innovative strategies that address emerging priorities for improving the care and treatment of people with HIV or those at risk for HIV. Real world validity and effectiveness have been demonstrated, but emerging strategies do not yet have sufficient published research evidence. (Adapted from Psihopaidas et al., 2020)