
**Centers for Disease Control**

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

Integrated HIV Surveillance and Prevention Programs for Health Departments
CDC-RFA-PS18-1802
Application Due Date: 09/13/2017

Integrated HIV Surveillance and Prevention Programs for Health Departments
CDC-RFA-PS18-1802
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## Part I. Overview Information

Applicants must go to the synopsis page of this announcement at www.grants.gov and click on the "Send Me Change Notifications Emails" link to ensure they receive notifications of any changes to CDC-RFA-PS18-1802. Applicants also must provide an e-mail address to www.grants.gov to receive notifications of changes.

### A. Federal Agency Name:

Centers for Disease Control and Prevention (CDC)

### B. Funding Opportunity Title:

Integrated HIV Surveillance and Prevention Programs for Health Departments

### C. Announcement Type: New - Type 1

This announcement is only for non-research activities supported by CDC. If research is proposed, the application will not be considered. For this purpose, research is defined at https://www.gpo.gov/fdsys/pkg/CFR-2007-title42-vol1/pdf/CFR-2007-title42-vol1-sec52-2.pdf. Guidance on how CDC interprets the definition of research in the context of public health can be found at http://www.cdc.gov/od/science/integrity/docs/cdc-policy-distinguishing-public-health-research-nonresearch.pdf.

### D. Agency Funding Opportunity Number:

CDC-RFA-PS18-1802

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

93.940

### F. Dates:

**1. Due Date for Letter of Intent (LOI):** **07/11/2017**

**Is a LOI:** Recommended but not Required

*Recommended for Demonstration Projects only, but not required.*

**2. Due Date for Applications:** **09/13/2017**, 11:59 p.m. U.S. Eastern Standard Time, at www.grants.gov.

**3. Date for Informational Conference Call:** **07/12/2017**

Call #1: July 12, 2017 at 3:00 pm (Eastern Standard Time)

Call #2: August 9, 2017 at 3:00 pm (Eastern Standard Time)

Call #3: August 30, 2017 at 3:00 pm (Eastern Standard Time)

**Call Information will be posted on the PS18-1802 website: (https://www.cdc.gov/hiv/funding/announcements/ps18-1802/index.html)**

### G. Executive Summary:

**1. Summary Paragraph:**

CDC announces the availability of fiscal year 2018 funds for a cooperative agreement for health departments to implement an integrated HIV surveillance and prevention program. The purpose of this funding opportunity announcement (FOA) is to implement a comprehensive HIV surveillance and prevention program to prevent new HIV infections and achieve viral

suppression among persons living with HIV. In particular, the FOA promotes and supports improving health outcomes for persons living with HIV through achieving and sustaining viral suppression, and reducing health-related disparities by using quality, timely, and complete surveillance and program data to guide HIV prevention efforts. These goals are in accordance with the national prevention goals, HIV Care Continuum, and CDC's High-Impact HIV Prevention (HIP) approach.

The integration of these programs allows each jurisdiction to operate in unison and maximize the impact of federal HIV prevention funding. An integrated FOA strengthens implementation of HIP by further allowing health departments to align resources to better match the geographic burden of HIV infections within their jurisdictions and improve data collection and use for public health action.

The FOA priorities are to increase individual knowledge of HIV status, prevent new infections among HIV-negative persons, reduce transmission from persons living with HIV, and strengthen interventional surveillance to enhance response capacity and intensive data-to-care activities to support sustained viral suppression. Priority activities include (but are not limited to) HIV testing; linkage to, re-engagement in, and retention in care and support achieving viral suppression; pre-exposure prophylaxis (PrEP) related activities; community-level HIV prevention activities; HIV transmission cluster investigations and outbreak response efforts.

Strategies and activities include: systematically collect, analyze, interpret, and disseminate HIV data to characterize trends in HIV infection, detect active HIV transmission, implement public health interventions, and evaluate public health response; identify persons with HIV infection and uninfected persons at risk for HIV infection; develop, maintain, and implement plans to respond to HIV transmission clusters and outbreaks; provide comprehensive HIV-related prevention services for persons living with diagnosed HIV infection (PLWH); provide comprehensive HIV-related prevention services for HIV-negative persons at risk for HIV infection; conduct perinatal HIV prevention and surveillance activities; conduct community-level HIV prevention activities; develop partnerships to conduct integrated HIV prevention and care planning; implement structural strategies to support and facilitate HIV surveillance and prevention; conduct data-driven planning, monitoring, and evaluation to continuously improve HIV programs; and build capacity for conducting effective HIV program activities, epidemiological science, and geocoding.

**a. Eligible Applicants:** Open Competition
**b. FOA Type:** Cooperative Agreement
**c. Approximate Number of Awards:** 61

- Component A: Core program - 61 awards
- Component B: Demonstration Projects - 20 awards; the number of new awards are subject to the availability of funding and will be made based on program performance.

**d. Total Project Period Funding:** $2,000,000,000
**e. Average One Year Award Amount:** $0
Component B: Demonstration Projects (only) funding ranges

- $1,000,000 to $2,000,000 (approximately two (2) awards)
- $500,000 to $1,000,000 (approximately six (6) awards)
- up to $500,000 (approximately 12 awards)

Refer to Attachment B: Funding Tables on the PS18-1802 website for individual jurisdiction award information.

**f. Number of Years of Award:** 5
**g. Estimated Award Date:** 01/01/2018
**h. Cost Sharing and / or Matching Requirements:** N
Although no statutory matching requirement for this FOA exist, leveraging other resources and related ongoing efforts to promote sustainability is strongly advised.

## Part II. Full Text

## A. Funding Opportunity Description

### 1. Background

#### a. Overview

For over 30 years, the human immunodeficiency virus (HIV) has affected millions throughout the United States. In recent years, deaths among persons living with HIV have declined, while the number of people living with HIV has increased. [1] An estimated 1.1 million persons are living with HIV and approximately 166,000 (15%) are unaware of their infection. [2] Persons living with HIV who use antiretroviral therapy (ART) and achieve low levels of the virus (suppressed viral load) can have a nearly normal life expectancy and have very low risk for transmitting HIV to others. If untreated, HIV infection leads to illness, premature death, and potential transmission to others.

To reduce new HIV infections in the United States, it is critical to ensure that everyone with HIV is aware of their infection, linked to and retained in HIV medical care, and maintains viral suppression [3]. CDC's approach to reducing HIV infections in the United States, High Impact Prevention (HIP), supports the ultimate national HIV prevention goals to achieve and sustain viral suppression and reduce new infections. Viral suppression is the central tenet of these national HIV prevention efforts and is associated with improved health outcomes and longer lifespans for persons living with HIV and greatly reduces the likelihood of transmitting HIV to others. [4, 5] In 2014, 74.5% of persons living with diagnosed HIV were linked to care within one month, 56.5% were retained in care, and 54.7% had evidence of viral suppression. [2] While the nation has made progress overall, further efforts are necessary. Each step along the HIV care continuum (HIV diagnosis, prompt and sustained HIV medical care, and continuous use of ART) is essential for achieving a suppressed viral load. Behavioral strategies (e.g., use of condoms and reduction in number of partners) are effective in reducing risk of HIV infection. [6] Targeted HIV prevention efforts to HIV-negative persons at risk for infection are also important. These efforts supplement prevention efforts among persons living with HIV to help prevent new HIV infections as well as other sexually transmitted infections not protected by ART. This includes support for community-level HIV prevention activities, pre-exposure prophylaxis (PrEP), and

other targeted prevention strategies. PrEP is a highly effective intervention that can reduce the number of new HIV infections when supported by behavioral and structural strategies. [7] A high-impact prevention approach to achieving national HIV prevention goals requires a strategic combination of scientifically proven, cost-effective, and scalable structural, behavioral, and biomedical interventions. These interventions should target persons living with HIV and populations at risk for infection in geographic areas highly affected by HIV.

Since the late 1980s, CDC has formally partnered with state and local health departments to conduct HIV surveillance and expand the impact and reach of HIV prevention in affected communities. It is important that state and local health departments, tribal governments and/or tribally designated organizations, community-based organizations (CBOs), and health care providers focus on preventing new infections by reducing undiagnosed HIV infections and ensuring that comprehensive services promoting linkage to and engagement in HIV medical care are made available to all persons with diagnosed HIV. State and local health departments remain important partners in providing comprehensive high-impact HIV prevention services. Building individual competencies and technical expertise among health department staff, and improving organizational capacities and supportive structural environments, are key operational and foundational activities for HIV prevention programs and services. These operational and foundational activities are particularly important for comprehensive HIV prevention for people living with and at greatest risk of HIV infection, including blacks/African Americans; Hispanics/Latinos; all races/ethnicities of gay, bisexual, and other men who have sex with men (MSM); people who inject drugs (PWID); and transgender persons. Through this new funding cycle, CDC is seeking to improve the quality, completeness, and use of HIV surveillance and program data to monitor HIV trends, expand data-to-care capacity, and develop new and enhance existing strategies for HIV prevention programs that aim to achieve national prevention goals and CDC's HIP approach.

**b. Statutory Authorities**

Section 318(b-c) of the Public Health Service Act (42 USC § 247c(b-c)), as amended, and the Consolidated Appropriation Act of 2016 (Pub. L. 114-113).

**c. Healthy People 2020**

This FOA addresses the “Healthy People 2020” focus on HIV: http:// www.healthypeople.gov/ 2020/ topicsobjectives2020/ overview.aspx?topicid=22

d. Other National Public Health Priorities and Strategies

The national prevention goals: https://www.hiv.gov/federal-response/national-hiv-aids-strategy /overview

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

HIV Care Continuum: https:// www.aids.gov/ federal-resources/ policies/ care-continuum/

CDC Winnable Battles: http:// www.cdc.gov/ ;WinnableBattles/ index.html

Additional information about the goals and strategies of NCHHSTP is available:http:// www.cdc .gov/ nchhstp

**e. Relevant Work**

This FOA builds upon previous and current HIV surveillance and prevention programs for health departments and community-based partners, including:

CDC-RFA-PS12-1201: Comprehensive HIV Prevention Programs for Health Departments: http:// www.cdc.gov/ hiv/ funding/ announcements/ ps12-1201/ index.html

CDC-RFA-PS12-1210: The Care and Prevention in the United States (CAPUS) Demonstration Project: https:// www.cdc.gov/ hiv/ research/ demonstration/ ;capus/ index.html

CDC-RFA-PS13-1301: Accelerating the Prevention and Control of HIV/AIDS, Viral Hepatitis, STDs, and TB in the U.S. Affiliated Pacific Islands: http:// www.federalgrants.com/ Accelerating -the- Prevention-and- Control-of-HIV-AIDS-Viral-Hepatitis- ;STDs- and-TB-in-the-US-Affil iated- Pacific-Islands-36689.html

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

CDC-RFA-PS14-1403: Capacity Building Assistance (CBA) for High-Impact HIV Prevention: https:// www.cdc.gov/ hiv/ funding/ announcements/ ps14-1403/ index.html

CDC-RFA-PS14-1410: Partnerships for Care (P4C): Health Departments and Health Centers Collaborating to Improve HIV Health Outcomes: https:// www.cdc.gov/ hiv/ research/ demonstrat ion/ p4c/ index.html

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

CDC-RFA-PS15-1506: Health Department Demonstration Projects to Reduce HIV Infections and Improve Engagement in HIV Medical Care among Men Who Have Sex with Men (MSM) and Transgender Persons: http:// www.cdc.gov/ hiv/ funding/ announcements/ps15-1506/

CDC-RFA-PS15-1509: Health Department Demonstration Projects for Comprehensive Prevention, Care, Behavioral Health, and Social Services for Men Who Have Sex with Men (MSM) of Color at Risk for and Living with HIV Infection: http:// www.cdc.gov/ hiv/ funding/ announcements/ ps15-1509/

CDC-RFA-PS17-1704: Comprehensive High-Impact HIV Prevention Projects for Young Men of Color Who Have Sex with Men and Young Transgender Persons of Color: http:// www.cdc.gov/ hiv/ funding/ announcements/ ps17-1704/

FOA activities will support current and future CDC HIV surveillance and prevention programs and initiatives.

## 2. CDC Project Description

## a. Approach

**Bold** indicates project period outcome.

| Logic Model: PS18-1802 Integrated HIV Surveillance and Prevention Programs for Health Departments | | |
|---|---|---|
| **Strategies and Activities** | **Intended Short-Term and Intermediate Outcomes** | **Intended Long-Term Outcomes** |
| **Integrated HIV Surveillance and Prevention Activities (Core Activities) (to be conducted by the funded health department jurisdiction)** | | o Reduced new HIV infections among persons at risk for HIV infection<br>o Increased access to care for persons living with diagnosed HIV infection<br>o Improved health outcomes for persons living with diagnosed HIV infection, including maintaining viral suppression<br>o Reduced HIV-related health disparities<br>o Reduced death rate among persons living with diagnosed HIV infection |
| 1. Systematically collect, analyze, interpret, and disseminate HIV data to characterize trends in HIV infection, detect active HIV transmission, implement public health interventions, and evaluate public health response<br>• HIV surveillance<br>o Collect HIV case data, including (but not limited to) data on CD4, viral load, molecular laboratory test results, vital status, and geocoding<br>• HIV prevention program monitoring and evaluation<br>o Collect data to monitor and evaluate HIV prevention programs | *Short-term Outcomes:*<br>1.1. **Improved monitoring of trends in HIV infection**<br>1.2. **Improved completeness, timeliness, and quality of HIV surveillance and prevention program data**<br>1.3. **Increased ability to describe the geographic distribution of HIV and understand the social determinants of health in relation to HIV and HIV-related health disparities** | |
| 2. Identify persons with HIV infection and uninfected persons at risk for HIV infection<br>• HIV testing<br>• HIV Partner Services<br>• Data-to-Care activities | *Short-term Outcomes:*<br>2.1. **Increased number of persons who are aware of their HIV status**<br>2.2. **Increased participation in HIV partner services among persons with diagnosed HIV infection** | |
| 3. Develop, maintain, and implement plan to respond to HIV transmission clusters and outbreaks<br>• Identify and investigate HIV transmission clusters and outbreaks<br>• Rapidly respond to and intervene in HIV transmission clusters and outbreaks<br>• Maintain outbreak identification and response plan | *Short-term Outcomes:*<br>3.1. **Improved early identification and investigation of HIV transmission clusters and outbreaks**<br>3.2. **Improved response to HIV transmission clusters and outbreaks**<br>3.3. **Improved plan and policies to respond to and contain HIV outbreaks** | |
| 4. Provide comprehensive HIV-related prevention services for persons living with diagnosed HIV infection (PLWH)<br>• Provide linkage to, re-engagement in, and retention in HIV medical care services using Data-to-Care activities and other strategies<br>• Promote early ART initiation<br>• Support medication adherence<br>• Promote and monitor HIV viral suppression<br>• Monitor HIV drug resistance<br>• Conduct risk reduction interventions for PLWH<br>• Refer PLWH to other essential support services, to include screening and active referrals for healthcare benefits, behavioral health, and other medical and social services | *Short-term Outcomes:*<br>4.1. **Increased linkage to and retention in HIV medical care among PLWH**<br><br>*Intermediate Outcomes:*<br>4.2. Increased early initiation of ART among PLWH<br>4.3. Increased HIV viral load suppression among PLWH<br>4.4. Decreased risk behaviors among PLWH at risk of transmission | |

| Logic Model: PS18-1802 Integrated HIV Surveillance and Prevention Programs for Health Departments | | |
|---|---|---|
| **Strategies and Activities** | **Intended Short-Term and Intermediate Outcomes** | **Intended Long-Term Outcomes** |
| 5. Provide comprehensive HIV-related prevention services for HIV-negative persons at risk for HIV infection<br>• Periodic HIV testing and risk screening<br>• Screening for PrEP eligibility<br>• Linkage to and support for PrEP<br>• Risk reduction interventions for HIV-negative persons at risk for HIV infection<br>• Refer HIV-negative persons at risk for HIV infection to other essential support services, to include screening and active referrals for healthcare benefits, behavioral health, and other medical and social services | *Short-term Outcomes*<br>5.1. **Increased referral of persons eligible for PrEP**<br><br>*Intermediate Outcomes:*<br>5.2. Increased linkage of persons eligible for PrEP to PrEP providers<br>5.3. Increased prescription of PrEP to persons for whom PrEP is indicated<br>5.4. Decrea sed risk behaviors among HIV-negative persons at risk for HIV infection and other STDs | |
| 6. Conduct perinatal HIV prevention and surveillance activities<br>• Universal prenatal HIV testing<br>• Case surveillance for women with diagnosed HIV infection and their infants<br>• Perinatal HIV exposure reporting<br>• Perinatal HIV service coordination (e.g., fetal and infant mortality review) | *Short-term Outcomes:*<br>6.1. **Reduced perinatally acquired HIV infection**<br>6.2. **Increased number of pregnant women who are aware of their HIV status**<br>6.3. **Improved completeness, timeliness, and quality of perinatal HIV surveillance data (for case and exposure reporting)**<br><br>*Intermediate Outcome:*<br>6.4. Improved provision or coordination of perinatal HIV services | |
| 7. Conduct community-level HIV prevention activities<br>• Social marketing campaigns (e.g., support and promote education and information campaigns and messages focused on HIV prevention and awareness)<br>• Social media strategies (e.g., support and promote social media strategies targeted to relevant audiences, including digital media focused on HIV prevention and awareness)<br>• Community mobilization<br>• Syringe services programs<br>• Condom distribution programs | *Short term Outcomes*<br>7.1. **Increased availability of condoms among persons living with or at risk for HIV infection**<br><br>*Intermediate Outcomes:*<br>7.2. Increased awareness in affected communities at risk for transmitting or acquiring HIV infection and strategies for reducing these risks<br>7.3. Increased access to syringe service programs for persons who inject drugs<br>7.4. Reduced stigma and discrimination for persons with diagnosed HIV infection | |
| **Operational and Foundational Activities** | | |
| 8. Develop partnerships to conduct integrated HIV prevention and care planning<br>• Maintain HIV Planning Group<br>• Develop HIV prevention and care networks | *Intermediate Outcome:*<br>8.1. Increased coordination of, availability of, and access to comprehensive HIV prevention, treatment, and support services | |
| 9. Implement structural strategies to support and facilitate HIV surveillance and prevention<br>• Strengthen policies and protocols<br>• Strengthen health information systems infrastructure<br>• Promote expansion of technological advances<br>• Ensure data security, confidentiality, and sharing | *Short-term Outcome:*<br>9.1. **Increased data security, confidentiality, and sharing**<br><br>*Intermediate Outcome:*<br>9.2. Reduced systemic, legal, regulatory, policy, organizational, operational, social, or cultural barriers to HIV surveillance, prevention, and care | |

| Logic Model: PS18-1802 Integrated HIV Surveillance and Prevention Programs for Health Departments | | |
|---|---|---|
| **Strategies and Activities** | **Intended Short-Term and Intermediate Outcomes** | **Intended Long-Term Outcomes** |
| 10. Conduct data-driven planning, monitoring, and evaluation to continuously improve HIV surveillance, prevention, and care activities | *Intermediate Outcomes:*<br>10.1. Increased coordination and integration of comprehensive HIV prevention and care services<br>10.2. Improved targeting of HIV testing, prevention and care resources, funding, and services<br>10.3. Improved targeting, prioritization, and effectiveness of funded HIV prevention activities<br>10.4. Improved targeting of HIV programs to address HIV-related health disparities | |
| 11. Build capacity for conducting effective HIV program activities, epidemiologic science, and geocoding<br>• Assess capacity building assistance needs<br>• Develop and implement capacity building assistance plan, including technical assistance<br>• Enhance epidemiologic and analytic capacity (e.g., Data-to-Care, cluster detection and investigation, and other prevention activities)<br>• Enhance geocoding and data linkage capacity | *Intermediate Outcomes:*<br>11.1. Strengthened interventional surveillance and response capacity<br>11.2. Enhanced knowledge of the influence of social determinants on risk for disease and continuum of care outcomes | |

Note: Indicators in bold will be required to be measured and reported to CDC as part of the evaluation plan. A complete list of the outcomes will be included in the Evaluation and Performance Measurement Plan.

### i. Purpose

The purpose of this FOA is to implement a comprehensive and integrated HIV surveillance and prevention program to prevent new infections; improve health outcomes for persons living with HIV infection, including achieving and sustaining viral suppression; and reduce related health disparities in accordance with the national prevention goals, HIV Care Continuum and CDC's HIP approach by using quality, timely, and complete surveillance and program data to guide HIV prevention efforts.

### ii. Outcomes

The program is expected to demonstrate measurable progress toward addressing the short-term outcomes that appear in bold in the FOA logic model. Indicators that quantify these outcomes are described in the section entitled CDC Evaluation and Performance Measurement Strategy.

Expected short-term outcomes include the following:

1. Systematically collect, analyze, interpret, and disseminate HIV data to characterize trends in HIV infection, detect active HIV transmission, implement public health interventions, and evaluate public health response
    - **Outcome:** Improved monitoring of trends in HIV infection
    - **Outcome:** Improved completeness, timeliness, and quality of HIV surveillance and prevention program data
    - **Outcome:** Increased ability to describe the geographic distribution of HIV and understand the social determinants of health in relation to HIV and HIV-related health disparities
2. Identify persons with HIV infection and uninfected persons at risk for HIV infection
    - **Outcome:** Increased number of persons who are aware of their HIV status
    - **Outcome:** Increased participation in HIV partner services among persons with diagnosed HIV infection
3. Develop, maintain, and implement a plan to respond to HIV transmission clusters and outbreaks
    - **Outcome:** Improved early identification and investigation of HIV transmission clusters and outbreaks
    - **Outcome:** Improved response to HIV transmission clusters and outbreaks
    - **Outcome:** Improved plan and policies to respond to and contain HIV outbreaks
4. Provide comprehensive HIV-related prevention services for persons living with diagnosed HIV infection
    - **Outcome:** Increased linkage to and retention in HIV medical care among PLWH
    - **Outcome:** Increased HIV viral load suppression among PLWH
5. Provide comprehensive HIV-related prevention services for HIV-negative persons at risk for HIV infection
    - **Outcome:** Increased referral of persons eligible for PrEP
6. Conduct perinatal HIV prevention and surveillance activities
    - **Outcome**: Reduced perinatally acquired HIV infection
    - **Outcome:** Increased number of pregnant women aware of their HIV status
    - **Outcome:** Improved completeness, timeliness, and quality of perinatal HIV surveillance data (for case and exposure reporting)
7. Conduct community-level HIV prevention activities
    - **Outcome:** Increased availability of condoms among persons living with or at risk for HIV infection.
8. Develop partnerships to conduct integrated HIV prevention and care planning
9. Implement structural strategies to support and facilitate HIV surveillance and prevention
    - **Outcome:** Increased data security, confidentiality, and sharing
10. Conduct data-driven planning, monitoring, and evaluation to continuously improve HIV surveillance, prevention, and care activities
11. Build capacity for conducting effective HIV program activities, epidemiological science, and geocoding

**iii. Strategies and Activities**

Applicants are required to provide a comprehensive HIV surveillance and prevention program for

persons with HIV infection and HIV-negative persons at risk for HIV infection. The program consists of eleven strategies and related activities. Implementation of all strategies and activities is required. Applicants can request to opt out of selected required activities by providing a strong justification, which must be based on program need, resources and/or policies. Approval will be made after review of the application.

Priorities are to increase individual knowledge of HIV status; prevent new infections among HIV-negative persons; reduce transmission of HIV from persons living with HIV; and build interventional surveillance to enhance response capacity and intensive data-to-care activities to support sustained viral suppression. Priority activities include (but are not limited to) HIV testing; linkage to, re-engagement in and retention in care; pre-exposure prophylaxis (PrEP); community-level HIV prevention activities; intensive data-to-care activities to support sustained viral suppression; active HIV transmission cluster investigation; and outbreak detection and response to active HIV transmission clusters and outbreaks (as emphasized in strategies and activities 1 – 7). Strategies and activities described in 8 – 11 are operational and aim to support prioritized activities. At least 75% of funding should be used to support strategies 1 – 7. Adequate funding should be allocated to support the operational strategies and activities described in strategies 8 – 11.

Integrated HIV programs allow each jurisdiction to maximize the impact of federal HIV prevention funding, strengthen implementation of HIP, align resources to better match the geographic burden of HIV infections, and improve data collection for public health action. CDC encourages applicants to coordinate with partners such as Ryan White funded agencies, STD programs, viral hepatitis programs, other surveillance programs, laboratory units, other health agencies, tribal governments and/or tribally designated organizations, community-based organizations, community health centers, federally qualified health centers, lesbian, gay, bisexual and transgender (LGBT) health centers, STD and TB clinics, hospitals, specialty clinics, other non-governmental organizations, and criminal justice and correctional facilities to implement comprehensive HIV programs within the jurisdiction.

***Component A: Core Program***

Required Strategies and Activities

1. Systematically collect, analyze, interpret, and disseminate HIV data to characterize trends in HIV infection, detect active HIV transmission, implement public health interventions, and evaluate public health response
2. Identify persons with HIV infection and uninfected persons at risk for HIV infection
3. Develop, maintain, and implement a plan to respond to HIV transmission clusters and outbreaks
4. Provide comprehensive HIV-related prevention services for people living with diagnosed HIV infection
5. Provide comprehensive HIV-related prevention services for HIV-negative persons at risk for HIV infection
6. Conduct perinatal HIV prevention and surveillance activities
7. Conduct community-level HIV prevention activities
8. Develop partnerships to conduct integrated HIV prevention and care planning
9. Implement structural strategies to support and facilitate HIV surveillance and prevention
10. Conduct data-driven planning, monitoring, and evaluation to continuously improve HIV

surveillance, prevention, and care activities

11. Build capacity for conducting effective HIV program activities, epidemiologic science, and geocoding

1. ***Systematically collect, analyze, interpret, and disseminate HIV data to characterize trends in HIV infection, detect active HIV transmission, implement public health interventions, and evaluate public health response***
    - HIV Surveillance (*refer to "HIV Surveillance Technical Guidance for HIV Surveillance Programs")*
        - Identify and report all persons with diagnosed HIV infection using active and passive surveillance methods.
        - Conduct death ascertainment to identify deaths among all persons with HIV and identify persons with an HIV-related cause of death.
        - Conduct monthly intrastate de-duplication of HIV cases.
        - Complete routine interstate duplicate review (RIDR).
        - Conduct cumulative interstate duplicate review, per CDC guidance. If state, local, and tribal data sharing policies allow, interstate duplicate review may include participating in secure electronic privacy data sharing tools to expedite resolution of potential duplicates.
        - Conduct risk factor ascertainment for all cases of HIV infection, including prevalent cases.
        - In a timely manner, using a preferred electronic format, collect and report to CDC all HIV-related laboratory results, including all test results from a diagnostic algorithm for which the final result is positive; CD4 results regardless of value; all viral load results, whether detectable or undetectable; nucleotide sequence results; and recency results, if available from commercial assays.
        - Strengthen identification of early HIV infection, including investigating laboratory reports suggestive of incomplete reporting of the recommended laboratory-based testing algorithm and indicative of possible acute infection, and expanding methods of collecting documented negative HIV test results for persons with diagnosed HIV infection.
        - Collect treatment information/HIV antiretroviral use history information, per program guidance.
        - Investigate cases of public health importance (COPHI).
        - Routinely assess and improve data quality and conduct annual evaluation of the HIV surveillance system.
        - Report data to CDC in required format by required deadlines.
        - Analyze HIV surveillance data and disseminate findings, including an annual surveillance report and a Jurisdictional Epidemiologic Profile (refer to CDC/HRSA Integrated Epi Profile Guidance, https:// www.cdc.gov/ hiv / ;pdf/ guidelines_developing_epidemiologic_profiles.pdf).
        - Analyze HIV surveillance data to detect transmission clusters and monitor HIV drug resistance and HIV genetic diversity.
        - Integrate HIV data sources to enhance completeness and improve usability

of data to improve health outcomes.
        - Implement and maintain activities to support complete laboratory reporting.
        - Incorporate the use of analytic pipelines and data processing tools, where feasible and appropriate as recommended by CDC.
        - Collaborate with CDC funded programs such as the Epidemiology and Laboratory Capacity (ELC) Cooperative Agreement regarding electronic case reporting and electronic laboratory reporting initiatives.
    - HIV Prevention Program Monitoring and Evaluation *(refer to "National HIV Monitoring and Evaluation (NHM&E) Guidance" for HIV prevention program data variables)*
        - Collect and submit client and test-level data for HIV testing and other quantitative program data through a CDC approved reporting system and in accordance with CDC NHM&E requirements deadlines.
        - Report data to CDC in required format by required deadlines.
2. ***Identify persons with HIV infection and uninfected persons at risk for HIV infection***
    - Implement HIV Testing
        - Implement and/or coordinate opt out HIV testing of patients in healthcare settings (Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health-Care Settings, 2006, http:// www.cdc.gov/ mmwr/ preview/ ;mmwrhtml/ rr5514a1.htm?s_cid).
        - Implement and/or coordinate targeted HIV testing in non-healthcare settings to identify undiagnosed HIV infection using multiple strategies and the most current recommendations (Program guidance: Implementing HIV Testing in Nonclinical Settings: A Guide for HIV Testing Providers, https:// www.cdc.gov/ hiv/ ;pdf/ testing/ cdc_hiv_implementing_hiv_testing_in_nonclinical_settings.pdf).
        - Support and expand targeted HIV testing activities, including social network strategies (SNS) and couples-based testing, to reach persons with undiagnosed HIV infections.
        - Monitor and use the estimated number of individuals with new and undiagnosed HIV infection to focus HIV testing efforts.
        - Promote routine, early HIV screening for all pregnant women according to CDC recommendations.
        - Support voluntary testing for other STDs (e.g., syphilis, gonorrhea, chlamydial infection), HBV, HCV, and TB, in conjunction with HIV testing, including referral and linkage to appropriate services, where feasible and appropriate and in accordance with current CDC guidelines and recommendations. This activity may be implemented in collaboration with STD, viral hepatitis, and/or TB programs.
        - Ensure that laboratories provide tests of adequate quality, report findings promptly, and participate in a laboratory performance evaluation program for testing.
        - Incorporate approved new HIV testing technologies, where feasible and appropriate.
        - Encourage and support health department and non-health department

providers to increase the number of persons with HIV who are aware of their infection through strengthening current HIV testing efforts and/or creating new services.
        - Adopt sustainable, routine HIV testing programs in healthcare facilities. Use all available mechanisms to obtain reimbursement for HIV testing from third-party payers (e.g., Medicare, Medicaid, private insurance, health maintenance organization (HMO) programs) and develop the infrastructure to seek reimbursement for testing for HIV and related co-infections.
    - Provide Partner Services
        - Provide ongoing partner services for all persons with newly diagnosed infection, those with previously diagnosed infection, and their partners (Recommendations for Partner Services Programs for HIV Infection, Syphilis, Gonorrhea, and Chlamydial Infection, 2008. http:// www.cdc.gov/ mmwr/ preview/ ;mmwrhtml/ rr5709a1.htm):
        - Collaborate and coordinate with STD and HIV and/or STD surveillance programs to use data to maximize the number of persons identified as candidates for partner services.
        - Partner with non-health department providers, including CBOs and private medical treatment providers, to identify more opportunities to provide partner services.
        - Use partner services programs to facilitate cluster investigation and intervention (for persons with newly diagnosed infection and those with previously diagnosed infection) and support HIV care continuum activities.
        - Update the HIV surveillance system with data obtained from partner services investigations.
    - Conduct Data-to-Care (D2C) activities
        - Use HIV surveillance and other data to identify HIV-diagnosed individuals who are potentially not receiving HIV medical care or other prioritized groups such as persons not virally suppressed or experiencing viral failure to support the HIV care continuum (Operational steps for D2C, https:// effectiveinterventions.cdc.gov/ en/ ;HighImpactPrevention/ ;PublicHealthStrategies/ ;DatatoCare/ ;OperationalStepsandDataNeeds.aspx).
        - Identify and establish data sharing agreements when needed with partners (e.g., local health departments, tribal governments and/or tribally designated organizations, clinical and CBO partners) sharing client-level data for PLWH.
        - Use available data sources to identify persons with diagnosed HIV infection not reported to the surveillance system and update information needed for D2C activities.
        - Provide missing or updated data located during the investigative and/or programmatic activity to HIV surveillance for review, entry into the surveillance system, and quality assurance.
        - Provide timely lists of HIV-positive individuals potentially not in care or other prioritized groups, such as persons experiencing viral failure, those with early infection, and those in transmission clusters, to prevention and care services.

3. ***Develop, maintain, and implement plan to respond to HIV transmission clusters and outbreaks*** *(refer to Guidance for Detecting, Investigating, and Responding to HIV Transmission Clusters)*
    - Develop and maintain a jurisdiction-wide cluster and outbreak detection and response plan.
    - Develop program capacity for cluster detection and response.
    - Identify and investigate HIV transmission clusters and outbreaks.
        - Analyze data to identify HIV transmission clusters and outbreaks.
        - Review and prioritize transmission clusters for investigation and intervention.
        - Investigate transmission clusters, including collaboration with other jurisdictions when needed, to identify the entire transmission cluster and underlying risk network, identify factors associated with transmission, and determine potential interventions.
    - Rapidly respond to and intervene in HIV transmission clusters and outbreaks.
        - Implement prevention interventions to respond rapidly to identified HIV transmission clusters, including outbreak response if necessary.
        - Implement individual and population-level prevention interventions in networks with active transmission.
        - Communicate with CDC and other partners during investigation of and intervention in transmission clusters and outbreaks.
4. ***Provide comprehensive HIV-related prevention services for persons living with diagnosed HIV infection***
    - Provide linkage to medical care, treatment, and prevention services for PLWH (using D2C activities and other strategies).*
        - Link persons with newly diagnosed HIV infection to medical care within 30 days of diagnosis.
        - Re-engage PLWH who are currently not in care into medical care.
        - Support retention in medical care, treatment, and prevention services for PLWH.
        - Conduct annual continuum of care analysis to quantify the percent of HIV-positive individuals linked to care, retained in care, and virally suppressed.
        - Use HIV surveillance and other data to identify PLWH who are potentially not receiving HIV medical care or other prioritized groups, such as persons not virally suppressed or experiencing viral failure, to support the HIV care continuum (Operational Steps for D2C, https:// effectiveinterventions.cdc .gov/ en/ ;HighImpactPrevention/ ;PublicHealthStrategies/ ;DatatoCare/ ;OperationalStepsandDataNeeds.aspx).
    - Promote early ART and provide medication adherence strategies, if applicable (for medication adherence strategies refer to www.effectiveinterventions.cdc.gov). CDC funds may not be used to purchase antiretroviral therapy. *
    - Promote and monitor viral suppression.
    - Monitor HIV drug resistance (refer to case surveillance activities).
    - Conduct risk reduction interventions for PLWH.*
    - Refer PLWH to other essential support services, to include screening and active referrals for healthcare benefits, behavioral health, and other medical and social

services (e.g., housing, mental health services, substance use treatment services, employment, transportation, and other social services)
    - **For additional guidance on behavioral interventions to enhance biomedical interventions and reduce risk behaviors, refer to* www.effectiveinterventions.cdc.gov.
    - *Note: For additional information on expected collaborations, please refer to the Collaborations with Organizations Not Funded by CDC* section of the FOA.

5. ***Provide comprehensive HIV-related prevention services for HIV-negative persons at risk for HIV infection***
    - Provide periodic HIV testing and risk screening.
    - Increase awareness of and expand access to PrEP and medication adherence to PrEP.
        - Screening for PrEP eligibility.
        - Linkage to and support for PrEP.
        - Support adherence to PrEP.
        - Increase consumer knowledge, access, and use of PrEP.
        - Enhance provider knowledge and support for PrEP.
    - Identify communities/individuals for implementation of PrEP services using HIV surveillance, testing, and other data (refer to Preexposure Prophylaxis for the Prevention of HIV Infection in the United States – 2014 Clinical Practice Guideline: https:// www.cdc.gov/ hiv/ ;pdf/ guidelines/ PrEPguidelines2014.pdf). CDC funds may not be used for antiretroviral therapy (e.g., PrEP, PEP, ART).
    - Refer populations at greatest risk to Post-Exposure Prophylaxis (PEP) (refer to Updated Guidelines for Antiretroviral Post exposure Prophylaxis After Sexual, Injection Drug Use, or Other Nonoccupational Exposure to HIV—United States, 2016, https:// stacks.cdc.gov/ view/ cdc/ 38856/ cdc_38856_DS1.pdf?download-document-submit=Download).
    - Conduct risk reduction interventions for HIV-negative persons at risk for HIV infection.*
    - Refer HIV-negative persons at risk for HIV infection to other essential support services, to include screening and active referrals for healthcare benefits, behavioral health, and other medical and social services (e.g., housing, mental health services, substance use treatment services, employment, transportation, and other social services).
        - ** For additional guidance on behavioral interventions to enhance biomedical interventions and reduce risk behaviors, refer to www.effectiveinterventions.cdc.gov.*

6. ***Conduct Perinatal HIV Prevention and Surveillance Activities***
    - Promote routine, perinatal HIV testing of all pregnant women per CDC recommendations.
    - Conduct case surveillance activities for women with diagnosed HIV infection and their infants (refer to *"HIV Surveillance Technical Guidance for HIV Surveillance Programs"*).
    - Conduct annual matching of HIV-infected women reported to surveillance from the state birth registry and tribal birth registry, as applicable.

- Analyze and disseminate data on HIV-infected women of childbearing age, perinatal HIV exposures, and HIV-infected infants.
- For jurisdictions with perinatal cases or an increased number of HIV-infected women of child-bearing age (refer to the technical guidance for HIV surveillance and perinatal HIV program overview), conduct targeted activities such as:
    - Perinatal HIV Exposure Reporting (PHER), where laws/regulations allow*
        - Develop and implement standard operating procedures for identifying and conducting follow-up of perinatally HIV-exposed infants according to CDC guidance.
    - Perinatal HIV services coordination to address local issues that lead to missed perinatal HIV surveillance and prevention opportunities.*
    - Fetal Infant Mortality Review (FIMR)-HIV Prevention Methodology case-review (refer to http:// www.fimrhiv.org/).*
        - **Applicants that do not meet the morbidity threshold and/or have state regulations that prohibit exposure reporting may opt out of participating in one or more of these program components by providing a justification. Approval will be made after review of the application.*

7. ***Conduct community-level HIV prevention activities***
    - Social marketing campaigns*
        - Support and promote social marketing campaigns focused on HIV prevention, HIV awareness, or other related topics targeted to relevant audiences (e.g., providers, populations or communities at risk), including prioritizing the use of campaign materials developed and tested by CDC.
        - Support and promote educational and informational campaigns and messages focused on HIV prevention, HIV awareness or other related topics for the general population, based on local need, and link these efforts to other funded HIV prevention activities (e.g., pamphlets, hotlines, or social marketing campaigns).
    - Social media strategies*
        - Support and promote social media strategies targeted to relevant audiences, including digital media.
        - Support and promote the use of media technology (e.g., Internet, texting, and web applications) for HIV prevention messaging to targeted populations and communities.
    - Community mobilization*
        - Encourage community mobilization to create enabling environments that support HIV prevention by actively involving community members in efforts to raise HIV awareness, building support for and involvement in HIV prevention efforts, motivating individuals to work to end HIV stigma, discrimination, promote health equity, and encouraging HIV risk reduction among family, friends, and neighbors.
            - **For social marketing campaigns and media strategies, please adhere to the program guidance on the review of HIV-related educational and informational materials for CDC assistance programs (*https:// www.cdc.gov/ hiv/ ;pdf/ funding/ announceme

nts/ ps12-1201/ cdc-hiv-ps12-1201-content-review-guidance.pdf).

- Syringe Services Programs (SSP)*
  - CDC supports the implementation of comprehensive SSPs as an effective public health approach to reduce the spread of infectious diseases. SSPs have been associated with a reduced risk of infection with bloodborne diseases such as HIV and viral hepatitis. In addition to improving access to sterile injection equipment, SSPs often provide other services important in supporting persons who inject drugs (PWID). SSPs offer risk reduction counseling and are an important venue for HIV, viral hepatitis, STD, and TB testing; hepatitis A and hepatitis B vaccination; linkage to care and treatment; the provision of naloxone; and referrals to substance use treatment. More information for applicants is provided at the following link: http:// www.cdc.gov/ hiv/ risk/ ;ssps.html. Refer to the HHS Syringe Services Programs (SSP) Implementation Guidance at https:// www.aids .gov/ pdf/ ;hhs-ssp-guidance.pdf. The CDC Program Guidance for Implementing Certain Components of Syringe Services Programs, 2016, provides specific procedures for CDC-funded grantees: https:// www.cdc .gov/ hiv/ ;pdf/ risk/ cdc-hiv-syringe-exchange-services.pdf.
  - Determination of Need
    - Resources awarded as part of this FOA may be used to support efforts to build or expand SSPs, but only when certain conditions are met. In consultation with CDC, state and local health departments must first demonstrate that the jurisdiction or area they are serving is at risk for, or experiencing, a significant increase in hepatitis infections or an HIV outbreak due to injection drug use. Applicants can initiate the Determination of Need (DON) request at any time during the application process or during the project period once funding is awarded. If concurrence with the DON has not been received at the time the application for funding is submitted, applicants should include language stating the concurrence of DON is pending. However, funds cannot be allocated to support SSPs until concurrence with the DON has been received. More information can be found at https:// www.aids.gov/ pdf/ hhs-ssp-guidance.pdf.
    - CDC federal funds may be used to support certain components of SSPs, including—
      - Staff
      - Supplies (e.g., alcohol pads, sterile water, cotton)
      - Testing kits for viral hepatitis and HIV
      - Syringe disposal services
      - Navigation services to ensure linkage to services
      - Provision of naloxone to reverse drug overdoses (CDC funds may not be used to purchase naloxone)
      - Communication, outreach and educational materials
      - Condoms
      - Planning and evaluation activities

        - CDC federal funds cannot be used for—
            - Needles and syringes for illegal drug injection
            - Other devices solely used for illegal drug injection (e.g., cookers)
        - Applicants should describe the SSP activities they intend to support, associated staffing as part of the overall program, and provide an estimated budget (refer to the Application and Submission Information, Budget Narrative section). Programs are prohibited from using CDC funds to purchase sterile needles or syringes for the purposes of hypodermic injection of any drug used illicitly or for the preparation of drugs for injection (e.g., cookers). Applicants, therefore, should describe the funding source that will be used to support the procurement of sterile syringes.
            - **Applicants may opt out of conducting selected community-level HIV prevention activities by providing a justification as to why they cannot implement the activity, based on need, resources, and/or policy restrictions. Approval will be made after review of the application.*
    - Condom Distribution Programs
        - Conduct condom distribution efforts, including the promotion of and provision of condoms, within communities, venues, and other settings, to target HIV-positive persons and persons at highest risk of acquiring HIV infection.
        - For targeted condom distribution activities, CDC encourages applicants to partner and/or coordinate with entities such as CBOs, local health departments, tribal governments and/or tribally designated, community health centers, federally qualified health centers, LGBT health centers, STD clinics, hospitals, specialty clinics, bars, clubs, and local business partners.

8. ***Develop partnerships to conduct integrated HIV prevention and care planning***
    - Develop partnerships to conduct HIV prevention and care planning. Jurisdictions should establish and maintain an HIV planning group (HPG) and a process that entails engaging partners and stakeholders in prevention and care planning, improving the scientific basis of program decisions, and targeting resources to those communities at highest risk for HIV transmission and acquisition. For additional information on HIV planning processes, refer to the CDC HIV Planning Guidance at https:// www.cdc.gov/ hiv/ ;pdf/ funding/ announcements/ ps12-1201/ cdc-hiv-hiv_planning_guidance.pdf.
    - Develop, monitor, and update the jurisdiction's 2017 - 2021 CDC and HRSA Integrated HIV Prevention and Care Plan, including the Statewide Coordinated Statement part of the planning process. The plan is to assist with identifying ways to measure progress toward goals and objectives, selecting strategies, and analyzing information to inform decision-making and improve HIV prevention, care, and treatment efforts within the jurisdiction. For additional information on the CDC and HRSA Integrated HIV Prevention and Care Plan, refer to https:// www.cdc.gov/ hiv/ ;pdf/ funding/ announcements/ ps12-1201/ cdc-hiv-integrated-

hiv-prevention-care-plan-guidance.pdf.
        - All jurisdictions must have an active Integrated HIV Prevention and Care Plan prior to submission of this application.
        - Updates to the Integrated HIV Prevention and Care Plan will be submitted on an annual basis through the performance report.
    - Develop HIV prevention and care networks for increased coordination of, availability of, and access to comprehensive HIV prevention, treatment, and support services.
9. ***Implement structural strategies to support and facilitate HIV surveillance and prevention***
    - Strengthen policies and protocols to support HIV surveillance and prevention at the state and local level.
        - Support efforts to align existing structures, policies, and rules to create an enabling environment for optimal HIV surveillance, prevention, care, and treatment. Policy efforts should aim to improve efficiency of HIV surveillance and prevention efforts where applicable, and are subject to lobbying restrictions under federal law (see Administrative and National Policy Requirements, AR-12, Lobbying Restrictions, below). Examples include supporting policies for complete reporting of all HIV-related tests regardless of result, addressing barriers to HIV testing, and facilitating the use of data and sharing across health department programs, in accordance with state and local law.
    - Strengthen health information systems infrastructure.
        - Assess health information systems infrastructure to identify opportunities for improved efficiency.
        - Maintain and/or enhance integrated information systems.
        - Enhance the health information systems workforce.
        - Collaborate with programs supporting HIV or other related public and private sector systems (e.g., STD, CAREWare, Medicaid, pharmacies).
        - Support CDC approved software and hardware equipment necessary to strengthen health information systems infrastructure.
        - Ensure that all CDC provided software releases and upgrades are installed within required time frames.
    - Promote expansion of technological advances to enhance HIV surveillance, testing, data analysis, and sharing.
    - Ensure data security, confidentiality, and sharing.
        - Ensure that security and confidentiality procedures/policies are in place and all policies, procedures and data sharing agreements comply with standards described in the NCHHSTP Data Security and Confidentiality Guidelines for HIV, Viral Hepatitis, Sexually Transmitted Disease, and Tuberculosis Programs: Standards to Facilitate Sharing and Use of Surveillance Data for Public Health Action, 2011. https:// www.cdc.gov/ nchhstp/ ;programintegration/ docs/ ;PCSIDataSecurityGuidelines.pdf.
        - Provide a statement signed by an Overall Responsible Party (ORP) certifying program compliance with the NCHHSTP guidelines.
        - Apply the standards to all local/state/tribal staff and contractors funded

through NCHHSTP that have access to or maintain confidential public health data. Ensure that all sites where applicable public health data are maintained are informed about the standards.
        - Develop and implement secure procedures for data sharing, including D2C activities, within the context of existing laws. Data sharing agreements should be in place for all collaborative partnerships (see Collaboration section).
        - Support secure sharing and use of HIV Medical Monitoring Project (MMP) data across HIV programs. Applicants conducting MMP should coordinate with the cooperative agreement within the respective jurisdiction to enhance data quality and use.

10. ***Conduct data-driven planning, monitoring, and evaluation to continuously improve HIV surveillance, prevention, and care activities (e.g., FOA Work Plan, Evaluation and Performance Measurement Plan, Integrated HIV Prevention and Care Plan, and Jurisdictional Epidemiologic Profile)***
    - Develop an FOA-specific work plan, including program strategies and activities and outcomes aligned with program strategies and activities (refer to the work plan section of this FOA).
    - Develop a local evaluation and performance measurement plan.
        - Monitor and evaluate program processes and outcomes.
        - Conduct activities to ensure data quality.
    - Monitor the Integrated HIV Prevention and Care Plan, including outcomes along the HIV care continuum to continuously improve HIV programs (refer to Strategy 8).
    - Monitor the Jurisdictional Epidemiologic Profile to support continuous program implementation and improvement efforts (refer to Strategy 1).
    - Monitor HIV within the jurisdiction for program planning, resource allocation, and monitoring and evaluation purposes. Ensure that resources are provided across the jurisdiction based on the local epidemiology of HIV.
        - Use the most current epidemiological, surveillance, and other available data sources to inform local program efforts and assist in program planning, implementation, and evaluation.
        - To ensure that resources are reaching the areas of greatest need, funded jurisdictions will be required to report annually to CDC on the amount of funding allocated to the areas with 30% or greater of the HIV prevalence and how the funds were used. If no area represents at least 30% of the HIV prevalence, then funded jurisdictions will be required to identify each individual area (i.e., city, Metropolitan Statistical Area [MSA], county, or zip codes) within the jurisdiction that have the greatest burden of HIV disease and report accordingly.

11. ***Build capacity for conducting effective HIV program activities, epidemiological science, and geocoding***
    - Assess, identify, provide, and/or support capacity building and technical assistance (TA) within the jurisdiction.
    - Develop and implement a capacity building assistance plan, including TA.
        - Develop and implement standard operating procedures for local and tribal

authorities to request and receive HIV capacity building and TA**.**

- Build capacity of CBOs and community partners to effectively deliver HIV program strategies and interventions.
    - Provide or collaborate with partners within or external to the health department (e.g., capacity building assistance providers, TA providers for D2C, AIDS Education and Training Centers, STD/HIV Prevention Training Centers) to offer capacity building assistance to HIV prevention service providers and other prevention agencies and partners.
    - Ensure that all health department staff are appropriately trained for their respective job responsibilities under this program.
    - Provide or coordinate training and TA (e.g., interventions, organizational infrastructure, HIV testing efforts, policies for data security and confidentiality, data sharing across programs, and data reporting to surveillance) for providers and staff of participating healthcare facilities and CBOs or other service organizations.
    - Provide a mechanism to share relevant HIV data with community partners and planning groups (promote and support data sharing within the jurisdiction).
    - Document and track provision of training and TA to health department staff, staff of participating healthcare facilities, and CBOs or other service organizations.
    - Facilitate exchange of information and peer-to-peer consultation and TA among sites (e.g., convening jurisdiction-level workshops, development of collaborations, referral networks).
- Enhance analytic capacity to support epidemiological science and geocoding (e.g., D2C, cluster detection and investigation, and other prevention activities).
    - Enhance capacity to support D2C activities, including development and implementation of secure methods to electronically link internal health department and external partner data sets consistent with local laws and policies.
    - Develop and implement automated processes for tracking D2C results.
    - Enhance capacity for geocoding and data linkage to annually geocode to the census tract level residence at HIV disease diagnosis.
    - Collect and submit geocoded data to CDC annually, according to the Technical Guidance for HIV Surveillance Programs.
    - Conduct analysis of geocoded HIV surveillance data and produce maps that identify patterns between HIV morbidity and social determinants of heath for targeting testing and treatment activities.
    - Support analysis of HIV surveillance and other data to detect transmission clusters, according to CDC recommendations.

***Component B: Demonstration Projects (Optional)***

Applicants can enhance their programs by requesting funding to implement <u>one</u> demonstration project to expand high-impact HIV prevention and surveillance interventions and strategies. This funding will support implementation and structured evaluations of innovative programs or activities that are particularly novel or require additional resources for evaluation that would not

normally be a part of implementing the required strategies and activities of the FOA. Project proposals should describe activities that are primarily focused on improving program, surveillance, and policy outcomes. Projects that are primarily research will not be eligible. Collaborations with local partners are encouraged (e.g., universities, CBOs, hospitals, clinics). Proposed projects must address the goals of reducing new HIV infections, improving health outcomes of PLWH, or reducing HIV-related disparities and health inequities.

Applicants may submit one proposal. The proposal must address how the applicant will implement and evaluate activities over the project period (up to four years), with more detailed information for activities conducted during the first year of funding. Examples shown below represent possible focus areas and are used for descriptive purposes only. We welcome additional topics that are not listed. Examples may include, but are not limited to:

- Using pharmaceutical data to: 1) identify persons who have missed picking up their ART or PrEP; and 2) identify, implement, and evaluate strategies for encouraging persons to pick up their medication.
- Using reflex clinical decision tools to reduce undiagnosed HIV infection and identify comorbidities (e.g., reflex testing for HIV and viral hepatitis C, age-based screening, inpatient settings).
- Implementing and evaluating innovative interventions to improve PrEP uptake and adherence in specific populations (e.g., Black and/or Latino men) or geographic areas.
- Implementing and evaluating interventions that address social and structural factors (e.g., homelessness, mental health, poverty, unemployment, education, stigma, discrimination, patient-provider relationships, etc.) on HIV prevention and care outcomes, including HIV testing, linkage to, retention in, and re-engagement with care, treatment, and prevention among racial/ethnic and sexual minorities.
- Using a cohort review approach for systematically reviewing health outcomes of PLWH to increase retention in care and achieve and sustain viral load suppression.
- Using innovative methods (e.g., peer-recruitment) and molecular epidemiology to evaluate the implementation of a combination of high impact prevention interventions and strategies to limit HIV cluster growth in populations at elevated risk of infection.
- Expanding access to medical care services through the provision of telemedicine.

Provide a program description to include annual program goals and SMART objectives for the proposed project and activities that will be conducted to meet the objectives. Include process and outcome evaluation to measure performance, effectiveness and potential impact of the project (refer to the work plan section of the FOA).

- Include a timeline for implementation of the proposed project. The timeline should include planning, implementation and evaluation phases.
- Applicants shall provide the rationale for proposing the project (e.g., identified need, epidemiologic data, or other data), explain how this differs from required activities, and describe the methods, evaluation, and the data sources that were used to identify areas and/or facilities for project implementation. Collaborations with local partners (CBOs, hospitals, clinics, universities) should be described.
- If needed, applicants should describe collaboration with CDC or other TA providers to provide ongoing training, TA, and consultation to staff conducting the demonstration

project.
    - Provide evidence that the applicant has the experience and capacity to implement the demonstration project.
    - Provide any anticipated capacity building needs.
- If desired, applicants can request collaboration with CDC on the development and analysis of data collected in the demonstration project and use information from this analysis, as well as from ongoing use of program monitoring data, to assess and improve performance in delivering the intervention or strategy. This collaboration can also be initiated during the cooperative agreement.
- Develop and submit to CDC a detailed final report to include process, outcome, impact, cost and, if available, cost-effectiveness data, qualitative and quantitative findings, including successes, challenges, and lessons learned from the demonstration project.

**1. Collaborations**

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

Awardees are required to collaboratively partner with CDC. Awardees must also establish, build, and/or maintain working partnerships with other CDC awardees (e.g., directly funded CBOs, STD programs, Medical Monitoring Project) to ensure communication, collaboration, and coordination for the national delivery of a comprehensive and integrated HIV surveillance and prevention program that is consistent with CDC standards and guidance. For implementing activities, applicants should collaborate with local CBOs, tribal governments and/or tribally designated organizations, local health departments, medical institutions, federally qualified health centers (FQHCs), LGBT health centers, STD clinics, hospitals, specialty clinics, institutions of higher education, faith-based institutions, correctional institutions, etc. Awardees are expected to collaborate with other health departments (e.g., state and local) within the jurisdiction. If necessary, memoranda of agreements/memoranda of understandings (MOAs/MOUs), should be established.

**b. With organizations not funded by CDC:**

Awardees may establish, build, and/or maintain collaborative relationships with organizations not funded by CDC that will support the implementation of the proposed program. Consideration should be given to developing strategic partnerships with the following types of organizations: federal agencies (e.g., the Health Resources and Services Administration, the Centers for Medicaid and Medicare Services) and their awardees; public health departments; tribal governments and/or tribally designated organizations; local and state education agencies; colleges and universities; non-CDC funded CBOs; capacity building assistance organizations; faith-based organizations; for-profit organizations; clinics and hospitals; non-governmental organizations; state and local governments; community advocates; community members; and other stakeholders that may have a vested interest in promoting health through HIV prevention, care, and treatment. If necessary, memoranda of agreements/memoranda of understandings (MOAs/MOUs), should be established.

**2. Target Populations**

Target populations may vary. Applicants must provide HIV services to target population(s) among those identified within their local or state Integrated HIV Prevention and Care Plan, Needs Assessment, and/or Epidemiologic Profile as being people living with and at greatest risk of HIV infection. Applicants should also include social determinants data to identify communities that are disproportionately affected by HIV and plan activities to reduce or eliminate these disparities. Disparities by race, ethnicity, gender identity, sexual orientation, geography, socioeconomic status, disability status, primary language, health literacy, and other relevant dimensions such as tribal communities should be considered.

**a. Health Disparities**

Health disparities in HIV are inextricably linked to a complex blend of social determinants that influence populations most severely affected by this disease. Health equity is a desirable goal that entails special efforts to improve the health of those who have experienced social or economic disadvantage. Social determinants of health affect disparities in HIV, viral hepatitis, STD and TB. Environmental factors such as housing conditions, social networks, and social support are also key drivers for infection with HIV, viral hepatitis, STDs, and TB. This FOA supports efforts to improve the health of populations disproportionately affected by HIV by maximizing the health impact of public health services, reducing disease prevalence, and promoting health equity.

Applicants should use epidemiologic and social determinants data to identify communities within their jurisdictions disproportionately affected by HIV and related diseases and conditions. Likewise, applicants should use data describing the social determinants of diseases in their coverage areas to accurately focus activities for reducing health disparities and to identify strategies to promote health equity. In collaboration with partners and appropriate sectors of the community, applicants should consider social determinants of health in the development, implementation, and evaluation of program-specific efforts and use culturally appropriate prevention messages, strategies, and interventions that are tailored for the communities for which they are intended. For additional resources to identify disability social determinants of health, visit the Disability and Health Data System website (http://dhds.cdc.gov).

Details of the health equity strategy and approach are outlined in the NCHHSTP Social Determinants of Health White Paper (http:// www.cdc.gov/ socialdeterminants/ docs/ ;SDH-White-Paper-2010.pdf) and updates on the approach are described in Public Health Reports special supplement (Dean HD, Williams KM, Fenton KA. From Theory to Action: Applying Social Determinants of Health to Public Health Practice. Public Health Reports. 2013;128(Suppl 3):1-4.).

**iv. Funding Strategy (for multi-component NOFOs only)**

For Core Program: Awards will be allocated using a funding algorithm that is based on 2014 prevalence data (the relative share of the unadjusted number of people living with HIV through 2014 attributable to each eligible jurisdiction). The funding strategy includes a minimum funding base of $1,000,000 to support organizational infrastructure for the program. Applicants must direct at least 14% of the overall funds for surveillance activities. Refer to FOA funding tables for additional information.

For Demonstration Projects: In an effort to maximize the available funding, ensure a wide distribution in the size and scope of demonstration projects, and encourage maximum

participation from the eligible entities (thus achieving wider geographic diversity in the distribution of projects), awards for the demonstration projects will be distributed in the following manner. If an adequate number of applications, to make the estimated number of awards for any of the funding ranges it not received, the estimated number of awards for the other ranges may be adjusted. These amounts are applicable to the first 12-month budget period.

**b. Evaluation and Performance Measurement**

**i. CDC Evaluation and Performance Measurement Strategy**

CDC's approach to evaluation and performance measurement strategy involves assessing the performance of the overall project (i.e., all awardees combined) and each individual awardee (jurisdiction), to ensure quality of data, effective program implementation, and accountability of funds. This approach includes:

- Jurisdictions' contribution to overall project performance,
- How FOA funds are being allocated and spent, and
- Progress toward achieving the intended performance objectives of the FOA.

Program evaluation includes collection and analysis of program implementation and performance data submitted by awardees, tracking of key performance indicators and process and outcome standards, review of required reports, conference calls with awardees, and site visits. During the project period, CDC may partner with awardees on evaluation activities.

Data collected are used for program accountability, monitoring, evaluation, and improvement. These will include, but are not limited to, National HIV Surveillance System, Annual Performance Reports, and NHM&E data. Awardees will collect the required quantitative and qualitative data using CDC approved applications (software) and submit to CDC, according to an established schedule and via CDC approved systems. Guidance on data collecting, reporting, and analysis is provided in the HIV Surveillance Technical Guidance for HIV Surveillance Programs and the National HIV Prevention Program Monitoring and Evaluation Guidance for HIV Prevention Programs. Data collection for the HIV program has been approved by the Office of Management and Budget (OMB) under OMB Number 0920-0573, National HIV Surveillance System, Expiration Date: June 30, 2019, and OMB Number 0920-0696, National HIV Prevention Monitoring and Evaluation, Expiration Date: February 28, 2019. Changes to data collection requirements during the project period will be subject to review and approval by OMB.

Findings will be systematically reviewed by CDC to identify challenges encountered by awardees, identify capacity-building assistance needs and actions needed to improve overall project performance, compare methods and outcomes across awardees to identify promising practices for dissemination during the project period, demonstrate the value of the FOA (e.g., improved public health outcomes, effectiveness of key prevention strategies and activities), and contribute to the evidence base for FOA strategies and activities. Data will also be used to produce surveillance reports, reports on project accomplishments, project feedback reports, fact sheets, and other monitoring and evaluation reports. Approximately three months after the grantee has submitted data to CDC, CDC will provide all grantees with a report that summarizes each grantee's performance. This report will be reviewed and discussed with the grantee by the project officer. Findings may also be reported at national conferences, online, in peer-reviewed

journals, and in other public forums.

Awardees will be expected to demonstrate progress toward achieving the intended short, intermediate, and long-term outcomes that are bolded in the logic model. For each of the FOA's 11 program strategies, a partial list of outputs (i.e., program activities), outcomes, and indicators is presented below. A complete list of the outcomes is included in the Evaluation and Performance Measurement Plan (EPMP). CDC will work with awardees to finalize their detailed plan, including a Data Management Plan (DMP), in accordance with CDC program guidance. CDC will work with awardees that receive demonstration project funding to develop the project specific evaluation plans. Jurisdictions are required to establish a performance target for HIV testing based on most current diagnoses data available. Please reference the EPMP for additional guidance.

**Strategy 1: Systematically collect, analyze, interpret, and disseminate HIV data to characterize trends in HIV infection, detect active HIV transmission, implement public health interventions, and evaluate public health response**

**Outputs:**

- Increased use of surveillance and epidemiological data to guide prevention and care efforts, monitor HIV health outcomes, develop policy, allocate resources, and plan and implement services.
- Increased use of geocoded data linked to census and social determinants of health datasets to guide prevention and care efforts, monitor HIV health outcomes, develop policy, allocate resources, and plan and implement services.

**Outcomes:**

1.1. Improved monitoring of trends in HIV infection.

- Indicator: Include at least five years of trends or the years of complete data for measures based on laboratory and results, if not five years, in annual reports and the epidemiologic profile.

1.2. Improved completeness, timeliness, and quality of HIV surveillance and prevention program data.

- Indicator: Meet standards detailed in the *Technical Guidance for HIV Surveillance Programs* for case ascertainment, death ascertainment, risk factor reporting, duplicate review, geocoding, laboratory reporting, timeliness, data quality, completeness, and dissemination, assessed as required by CDC standards (Standards Evaluation Report (SER) Form approved OMB No: 0920-0573 Expiration Date: 06/30/2019).
- Indicator: Meet standards detailed in the *National HIV Prevention Program Monitoring and Evaluation Guidance* for key NHM&E program performance variables, timeliness, data quality, completeness, and dissemination, assessed as required by CDC standards.

1.3. Increased ability to describe the geographic distribution of HIV and understand the social

determinants of health in relation to HIV and HIV-related health disparities.

- Indicator: Disseminate maps and reports that display patterns between HIV morbidity and social determinants of health.

**Strategy 2: Identify persons with HIV infection and uninfected persons at risk for HIV infection**

**Outputs:**

- Increased HIV testing among persons at risk for HIV and in communities with high HIV prevalence.
  - Indicator: Of all CDC-funded HIV tests conducted, the percentage among persons at risk for HIV infection.
- Improve laboratory reporting to HIV surveillance.
  - Indicator: Meet criteria for complete reporting of all HIV-related test results as detailed in *Technical Guidance for HIV Surveillance Programs*.
- Increased identification of HIV-negative persons at risk for HIV infection.
  - Indicator: Of all CDC-funded tests conducted that had HIV-negative results, the percentage of tests that were among persons at risk for HIV infection.
- Increased notification and HIV testing of partners identified through HIV partner services.
  - Indicator: Of all named, notifiable partners identified through HIV partner services, the percentage notified for HIV partner services.
  - Indicator: Of all notified partners identified through HIV partner services, the percentage tested for HIV.

**Outcomes:**

2.1. Increased number of persons who are aware of their HIV status.

- Indicator: Number of CDC-funded HIV tests provided by awardees.
- Indicator: Of all CDC-funded HIV tests conducted, the percentage of tests among persons at risk for HIV infection.
- Indicator: Of all CDC-funded HIV tests conducted, the percentage of persons with newly diagnosed HIV infection.

2.2. Increased participation in HIV partner services among persons with diagnosed HIV infection.

- Indicator: Of all persons with newly diagnosed HIV infection, the percentage interviewed for partner services (FOA target: 85%).
- Indicator: Of all persons with previously diagnosed HIV infection, the percentage interviewed for partner services.

**Strategy 3: Develop, maintain, and implement a plan to respond to HIV transmission clusters and outbreaks**

**Outcomes:**

3.1. Improved early identification and investigation of HIV transmission clusters and outbreaks.

- Indicator: Meet standards detailed in the *Technical Guidance for HIV Surveillance Programs* for early identification and investigation of HIV transmission clusters and outbreaks, assessed as required by CDC standards.

3.2. Improved response to HIV transmission clusters and outbreaks.

- Indicator: Meet standards detailed in the *Technical Guidance for HIV Surveillance Programs* for response to selected HIV transmission clusters and outbreaks, assessed as required by CDC standards.

3.3. Improved plan and policies to respond to and contain HIV outbreaks.

- Indicator: Develop plan to maintain capacity for cluster and outbreak detection and response.

**Strategy 4: Provide comprehensive HIV-related prevention services for persons living with diagnosed HIV infection (PLWH)**

**Outputs:**

- Increased use of surveillance data to support PLWH throughout the HIV care continuum.
- Increased provision of ART medication adherence support among PLWH.
  - Indicator: Of all PLWH, who are in need of adherence support, the percentage referred to ART medication adherence support services.
- Increased screening and active referral for healthcare benefits, behavioral health, and prevention and essential support services.
  - Indicator: Of all PLWH, the percentage screened and referred for 1) healthcare benefits, 2) mental health and substance abuse treatment, 3) housing and transportation, and 4) employment assistance.
  - Indicator: Of all PLWH, the percentage screened and referred for HIV behavioral risk reduction services (FOA Target: 85%)

**Outcomes:**

4.1. Increased linkage and retention in HIV medical care among PLWH.

- Indicator: Of all persons with newly diagnosed HIV infection, the percentage linked to HIV medical care in ≤ 30 days after HIV diagnosis (FOA target: 85%).
- Indicator: Of all PLWH, the percentage retained in HIV medical care (FOA target: 90%).
- Indicator: Of all persons on the not-in-care (NIC) list identified through D2C activities, the percentage 1) confirmed to be not in care, 2) confirmed to be in care, and 3) confirmed to be deceased or out-of-jurisdiction
- Indicator: Of all persons on the not-in-care list identified through D2C activities confirmed as not-in-care, the percentage linked to or re-engaged in HIV medical care in ≤ 30 days after being contacted by program staff.

4.2. Increased early initiation of ART among PLWH.

4.3. Increased HIV viral load suppression among PLWH.

- Indicator: Of all PLWH, the percentage virally suppressed (FOA target: 80%).
- Indicator: Percentage of NIC PLWH linked to or re-engaged in HIV medical care through D2C activities who achieved viral suppression within a specified time frame after linkage or re-engagement to care.
- Indicator: Percentage of PLWH presumed to be in care but not virally suppressed who were confirmed through D2C activities to be in care but not virally suppressed.
- Indicator: Percentage of PLWH confirmed to be in care and not virally suppressed who achieved viral suppression within 12 months after the first contact with program staff through D2C activities.

4.4. Decreased risk behaviors among PLWH at risk of transmission.

**Strategy 5: Provide comprehensive HIV-related prevention services for HIV-negative persons at risk for HIV infection**

**Outputs:**

- Increased periodic HIV testing and risk screening among persons at risk for HIV infection.
- Increased screening of HIV-negative persons for PrEP eligibility.
  - Indicator: Of all HIV-negative persons not already on PrEP at the time of HIV testing, the percentages 1) screened for HIV risk and PrEP eligibility and 2) found eligible for PrEP.
- Increased screening and referral for healthcare benefits, behavioral health, and prevention and essential support services.
  - Indicator: Of all HIV-negative persons at risk for HIV infection, the percentage screened and referred for 1) healthcare benefits, 2) mental health and substance abuse treatment, 3) HIV prevention services, 4) housing and transportation, and 5) employment assistance.

**Outcomes:**

5.1. Increased referral of persons eligible for PrEP.

- Indicator: Of all HIV-negative persons screened and found eligible for PrEP, the percentage referred to PrEP.

5.2. Increased linkage of persons eligible for PrEP to PrEP providers.

5.3. Increased prescription of PrEP to persons for whom PrEP is indicated.

5.4. Decreased risk behaviors among HIV-negative persons at risk for HIV infection and other STDs.

**Strategy 6: Conduct perinatal HIV prevention and surveillance activities**

**Outputs:**

- Increased HIV screening among pregnant women.
- Increased provision of perinatal HIV services or service coordination among pregnant women living with diagnosed
- HIV and their infants.
    - Indicator: Of all pregnant women tested and with newly diagnosed HIV infection, the percentage screened for perinatal HIV care.
    - Indicator: Of all pregnant women with diagnosed HIV infection screened for perinatal HIV care, the percentage referred for perinatal HIV care.
- Increased use of surveillance and epidemiological data to guide perinatal prevention and care efforts, monitor HIV health outcomes, develop policy, allocate resources, and plan and implement services.

**Outcomes:**

6.1. Reduced perinatally acquired HIV infection

- Indicator: Number of perinatally acquired HIV infections among persons born in the jurisdiction, by year of birth.

6.2. Increased number of pregnant women who are aware of their HIV status.

- Indicator: Number of pregnant women aware of their HIV status.

6.3. Improved completeness, timeliness, and quality of perinatal HIV surveillance data (for case and exposure reporting).

- Indicator: Meet standards detailed in the *Technical Guidance for HIV Surveillance Programs* for perinatal surveillance and exposure reporting surveillance, assessed as required by CDC standards.

**Strategy 7: Conduct community-level HIV prevention activities**

**Outcomes:**

7.1. Increased availability of condoms among persons living with or at risk for HIV infection.

- Indicator: Number of condoms distributed to persons living with or at risk for HIV infection.

7.2. Increased awareness in affected communities at risk for transmitting or acquiring HIV infection and strategies for reducing these risks.

7.3. Increased access to syringe service programs for persons who inject drugs.

7.4. Reduced stigma and discrimination for persons with diagnosed HIV infection.

**Strategy 8: Develop partnerships to conduct integrated HIV prevention and care planning**

**Outcomes:**

8.1. Increased coordination of, availability of, and access to comprehensive HIV prevention,

treatment, and support services.

**Strategy 9: Implement structural strategies to support and facilitate HIV surveillance and prevention**

**Outcomes:**

9.1. Increased data security, confidentiality, and sharing.

- Indicator: Full compliance with NCHHSTP Data Security and Confidentiality Guidelines for HIV, Viral Hepatitis, Sexually Transmitted Disease, and Tuberculosis Programs (2011): http:// www.cdc.gov/ nchhstp/ ;programintegration / docs/ ;PCSIDataSecurityGuidelines.pdf.

9.2. Reduced systemic, legal, regulatory, policy, organizational, operational, social, or cultural barriers to HIV surveillance, prevention, and care**.**

**Strategy 10: Conduct data-driven planning, monitoring, and evaluation to continuously improve HIV surveillance, prevention, and care activities**

**Outputs:**

- Increased use of data to plan, monitor, evaluate, and improve HIV surveillance and prevention programs and monitor the impact of local HIV prevention efforts.
  - Indicator: Produce a continuum of care analysis using National HIV Surveillance System (NHSS) standards and publish in annual reports and epidemiologic profile.

**Outcomes:**

10.1. Increased coordination and integration of comprehensive HIV prevention and care services.

10.2. Improved targeting of HIV testing, prevention, and care resources, funding, and services.

- Indicator: Of all HIV tests conducted, the percentage of persons at risk for HIV infection.

10.3. Improved targeting, prioritization, and effectiveness of funded HIV prevention activities.

10.4. Improved targeting of HIV programs to address HIV-related health disparities.

**Strategy 11: Build capacity for conducting effective HIV program activities, epidemiological science, and geocoding**

**Outputs:**

- Increased capacity building support and TA provided within the jurisdiction (including CBOs and other partners).
- Increased jurisdictional capacity to conduct HIV surveillance activities (including D2C activities) and provide HIV prevention services.
- Enhanced capacity to geocode, manage, link, and integrate surveillance and other data for surveillance, prevention, and care.

**Outcomes:**

11.1. Strengthen interventional surveillance and response capacity.

11.2. Enhanced knowledge of the influence of social determinants on risk for disease and continuum of care outcomes.

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

- How applicant will collect the performance measures, respond to the evaluation questions, and use evaluation findings for continuous program quality improvement.
- How key program partners will participate in the evaluation and performance measurement planning processes.
- Available data sources, feasibility of collecting appropriate evaluation and performance data, and other relevant data information (e.g., performance measures proposed by the applicant)
- Plans for updating the Data Management Plan (DMP), if applicable, for accuracy throughout the lifecycle of the project. The DMP should provide a description of the data that will be produced using these NOFO funds; access to data; data standards ensuring released data have documentation describing methods of collection, what the data represent, and data limitations; and archival and long-term data preservation plans. For more information about CDC's policy on the DMP, see https://www.cdc.gov/grants/additionalrequirements/ar-25.html.

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

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

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

Jurisdiction evaluation and performance measurement involves use of data by awardees at the jurisdiction level to monitor, evaluate, and continuously improve program performance. This will be conducted by awardees, based on the jurisdictional EPMP they develop using a template provided by CDC. The jurisdictional EPMP will address all major program elements and include all indicators required by CDC, plus additional indicators useful to program managers. The jurisdictional EPMP findings should be reviewed by awardees at least quarterly and used to monitor, evaluate, and continuously improve program processes and performance. As part of their jurisdictional evaluation, awardees may conduct in-depth evaluation of selected program

activities to compare the effectiveness of different approaches used to accomplish project activities and identify the most effective methods for accomplishing project outcomes in their specific context and circumstances.

Applicants should plan for sufficient staffing and resources to accomplish all activities related to CDC and jurisdictional EPMPs, including planning, data collection, data entry, data management, reporting data to CDC, data analysis and interpretation, use of data for program improvement, development and dissemination of reports, and attendance at monitoring and evaluation meetings. Awardees must describe how funds will be allocated to support evaluation activities.

All awardees are expected to comply with the NCHHSTP Data Security and Confidentiality Guidelines for HIV, Viral Hepatitis, Sexually Transmitted Disease, and Tuberculosis Programs (2011). All standards included in the NCHHSTP Data Security and Confidentiality Guidelines should be implemented by awardees, unless otherwise justified. A Certification of Compliance statement signed by an overall responsible party or parties (ORP) will be submitted annually to the CDC Project Officer at the same time the Annual Performance Report (APR) is submitted. For information on the data security and confidentiality guidelines and example certification statement, please refer to: https:// www.cdc.gov/ nchhstp/ ;programintegration/ docs/ ;PCSIDataSecurityGuidelines.pdf.

**c. Organizational Capacity of Awardees to Implement the Approach**

All applicant organizations must demonstrate their existing or forthcoming capacity to successfully execute all proposed strategies and activities to meet the program requirements. Applicants must demonstrate expertise, experience, and/or capacity to develop, implement, and evaluate the required program strategies and activities. Working with state, tribal, local, and/or territorial health departments, community health centers, health care providers, laboratories, and other stakeholders within the jurisdiction is integral to program implementation. 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 program. 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.

Workforce Capacity

Applicants must provide details on their workforce capacity, competence, expertise and experience as they relate to all specific program strategies and activities. Applicants must have a strategy to ensure that the development, implementation, and delivery of HIV surveillance and prevention programs are appropriate to meet the needs of the population served within the jurisdiction. Details include experience and expertise related to the implementation of the required strategies and activities, recent examples of HIV surveillance and prevention program development and implementation, and demonstrated outcomes or benefits related to the HIV surveillance and prevention services provided. Applicants should provide a description of their current CDC funded HIV surveillance and prevention programs.

Staffing

Applicants must provide evidence of adequate program management/staffing plans, performance

measurement, evaluation, financial reporting, management of travel requirements, and workforce development and training. Applicants should identify key staff, including program management, with expertise in prevention and surveillance programs (Principal Investigator or Co-Principal Investigator) and must have a plan to ensure that program staff has adequate skills and relevant experience and capacity to implement the activities and achieve the project outcomes, including the evaluation plan. The staffing plan and project management structure should be sufficient to achieve the project outcomes (e.g., staff technical expertise, data management and data analysis capacity, and a plan for accessing capacity building assistance to support workforce development), inclusive of subcontractors and consultants if applicable, throughout the duration of the five-year project. Staff must have the breadth of subject matter expertise and experience required to conduct all proposed work. When feasible, applicants must hire direct service staff who have at least 12 months minimum experience working in related disease surveillance and prevention programs. Applicants should describe how they will assess staff competencies and develop a plan to address gaps through organizational and individual training and development opportunities. Additionally, a curriculum vitae or resume must be submitted for each existing key personnel who will be affiliated with this program. Applicant organizations are also required to provide an agency-wide organizational chart and an organizational chart for the proposed program.

**d. Work Plan**

Applicants are required to provide a work plan that provides both a high-level overview of the entire five-year project period and a detailed description of the first year of the award. The work plan should incorporate all FOA-related program strategies and activities. Applicants should propose specific, measurable, achievable, realistic, and time-based (SMART) process and/or outcome objectives for each activity aligned with the related FOA performance objectives, including FOA performance targets. The work plan should include training, capacity building, and TA needs to support the implementation of the proposed program. In addition, a concise description on how the grantee plans to implement and monitor each program activity should be included in the work plan.

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

The applicant should address the following outline in their work plan:

1. Five-Year Overview of Project (include narrative)
    - Intended outcomes for the entire five-year project period
2. Year 1 Detailed Work Plan
    - Program strategies and activities
    - Outcomes aligned with program strategies and activities
    - SMART objectives 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 objectives
    - Timeline for implementation (including staffing of the proposed program, training, etc.)

Below is a sample work plan format to show the alignment with the logic model and narrative. The table would be completed for each project period outcome. If a particular activity leads to multiple outcomes, it should be described under each outcome measure:

| Project Period Outcome: [from Outcomes section and/or logic model] | | Outcome Measure: [from Evaluation and Performance Measurement section] | |
|---|---|---|---|
| Strategies and Activities | Process Measures [from Evaluation and Performance Measurement section] | Responsible Position/Party | Completion Date |
| 1 | | | |
| 2 | | | |
| 3 | | | |
| 4 | | | |

**e. CDC Monitoring and Accountability Approach**

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

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

Monitoring may also include the following activities 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 awardees are performing at a sufficient level to achieve outcomes within stated timeframes.
- Working with awardees on adjusting the work plan based on achievement of outcomes, evaluation results and changing budgets.
- Monitoring performance measures (both programmatic and financial) to assure satisfactory performance levels.

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

Monitoring may also include other activities deemed necessary to monitor the award, if applicable.

After review of the first annual performance report, if the awardee 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. Awardees 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/Project Consultant/Epidemiologist in collaboration with the awardee. The PIP is a comprehensive tool used to assist awardees 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 awardee will have an opportunity to document a plan of action to improve the performance of program activities. In subsequent budget periods, funding may be affected based on performance.

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

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

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

1. Collaborate to ensure coordination and implementation of strategies to support the implementation of HIV surveillance and prevention activities.
2. Work with awardees to identify and address capacity building assistance (CBA) and TA needs that are essential to the success of the project. Awardees must work with the assigned Project Officer/Project Consultant/Epidemiologist to establish a mechanism to request direct CDC TA and establish a CBA Request Information System (CRIS) user account to facilitate receipt of CBA.
3. Provide access to training and TA that will strengthen staff capacity relevant to all required strategies and activities of the program.
4. Provide guidance to awardees and set standards on data collection, use, and submission requirements.
5. Facilitate coordination, collaboration, and, where feasible, service integration among federal agencies, other CDC funded programs, other health departments, community based organizations, local and state planning groups, other CDC directly funded programs, national capacity building assistance providers, medical care providers, laboratories, recipients of the Ryan White HIV/AIDS Treatment Extension Act of 2009, and other partners working with people living with and at greatest risk for HIV infection toward common goals of risk reduction, disease detection, and a continuum of HIV prevention, care, and treatment.
6. Monitor awardee program performance using multiple approaches, such as site visits, emails, conference calls, and standardized review of performance, grantee feedback and other data reports, to support program development, implementation, evaluation, and improvement.
7. Provide guidance and coordination to funded organizations to improve the quality and effectiveness of work plans, evaluation strategies, products and services, and collaborative activities with other organizations.
8. Collaborate to compile and publish accomplishments, best practices, performance criteria, and lessons learned during the project period.
9. Collaborate in assessing progress toward meeting strategic and operational goals/objectives and in establishing measurement and accountability systems for

documenting outcomes, such as increased performance improvements and best or promising practices.

10. Collaborate on strategies to ensure the provision of appropriate and effective HIV prevention services to target populations.
11. Provide requirements and expectations for standardized and other data reporting and support monitoring and evaluation activities.
12. Share information, best practices, lessons learned, and evaluation results between awardees (e.g., through conferences, guidance, material development, webinars, data sharing publications, other social media, participation in meetings, committees, conference calls, and working groups related to the cooperative agreement and its projects).

## B. Award Information

**1. Funding Instrument Type:** Cooperative Agreement

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

**2. Award Mechanism:** U62

**3. Fiscal Year:** 2018

**Estimated Total Funding:** $399,292,872

**4. Approximate Total Fiscal Year Funding:** $399,292,872

- Component A: Core Program - $380,292,872
- Component B: Demonstration Projects - $19,000,000

This includes direct and indirect costs.

This amount is subject to the availability of funds.

**5. Approximate Project Period Funding:** $2,000,000,000

**6. Total Project Period Length:** 5

Component B: Demonstration Projects- 4 year project period

**7. Expected Number of Awards:** 61

- Component A: Core program - 61 awards
- Component B: Demonstration Projects - 20 awards; the number of new awards are subject to the availability of funding and will be made based on program performance.

**8. Approximate Average Award:** $0 Per Budget Period

Component B: Demonstration Projects (only) funding ranges

- $1,000,000 to $2,000,000 (approximately two (2) awards)

- $500,000 to $1,000,000 (approximately six (6) awards)
- up to $500,000 (approximately 12 awards)

Refer to Attachment B: Funding Tables on the PS18-1802 website for individual jurisdiction award information.

This amount is subject to the availability of funds.

**9. Award Ceiling:** $0 Per Budget Period

Not applicable.

**10. Award Floor:** $0 Per Budget Period

**11. Estimated Award Date:** 01/01/2018

Component A: Core Program start date is January 1, 2018

Component B: Demonstration Project start date is March 1, 2018

- Awardees that compete successfully for the Demonstration Project funding will receive a revised Notice of Award to reflect the Demonstration Project funding.

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

**12. Budget Period Length:** 12 month(s)

**13. Direct Assistance**

Direct Assistance (DA) is available through this FOA.

Applicants may request federal personnel, equipment, or supplies, including SAS licenses, as Direct Assistance (DA) to support HIV surveillance and prevention activities, in lieu of a portion of financial assistance (FA). To address staffing and/or program expertise deficits, applicant may convert FA to DA to recruit staff with the requisite training, experience, expertise (e.g., Public Health Associate Program [PHAP]). For information on Direct Assistance for Assigning CDC Staff to State, Tribal, Local, and Territorial Health Agencies, refer to: https:// www.cdc.gov/ stltpublichealth/ ;GrantsFunding/ direct_assistance.html.

## C. Eligibility Information

### 1. Eligible Applicants

Eligibility Category: State governments
County governments

City or township governments

Additional Eligibility Category:

Government Organizations:

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

**2. Additional Information on Eligibility**

State, local, and/or territorial health departments currently funded under funding opportunity announcements PS12-1201: Comprehensive Human Immunodeficiency Virus (HIV) Prevention Programs for Health Departments and PS13-1302: National HIV Surveillance System (NHSS).

Eligible applicants include state, local and territorial health departments or their Bona Fide Agents currently funded under PS12-1201 or PS13-1302. This includes the 50 states, the District of Columbia, Puerto Rico, and the Virgin Islands. Also eligible are the local (county or city) health departments serving the following metropolitan areas: Baltimore City, Chicago, Fulton County (Atlanta), Houston, Los Angeles County, Philadelphia, New York City, and San Francisco.

- Jurisdictions with eligible state and local (city or county) health departments must discuss: (1) the proposed program approach being implemented by the local health department and (2) how the state and local area will collaborate during the project period to ensure appropriate provision of services within the metropolitan area and document any agreements reached in a letter of agreement/letter of concurrence (LOA/LOC), which must be submitted by both parties as part of their application.

The award ceiling for each component under Section B. Award Information is $0. CDC will not consider any application requesting an award higher than the specified amount. If a pre-application is required, then specify here and include it in the special eligibility requirements section. (https://www.hhs.gov/sites/default/files/grants/grants/policies-regulations/gpd2-04.pdf)

**3. Justification for Less than Maximum Competition**

Eligibility is limited to the organizations noted above.

### 4. Cost Sharing or Matching

Cost Sharing / Matching Requirement: No

Although no statutory matching requirement for this FOA exist, leveraging other resources and related ongoing efforts to promote sustainability is strongly advised.

### 5. Maintenance of Effort

Maintenance of effort is not required for this program.

## D. Required Registrations

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

### 1. Required Registrations

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

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

The applicant organization may request a DUNS number by telephone at 1-866-705-5711 (toll free) or internet at http:// fedgov.dnb. com/ webform/ displayHomePage.do. The DUNS number will be provided at no charge.

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

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

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

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

| Step | System | Requirements | Duration | Follow Up |
|---|---|---|---|---|
| 1 | Data | 1. Click | 1-2 Business Days | To confirm that you |

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

## 2. Request Application Package

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

## 3. Application Package

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

## 4. Submission Dates and Times

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

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

Due Date for Letter of Intent: **07/11/2017**

*Recommended for Demonstration Projects only, but not required.*

### b. Application Deadline

Due Date for Applications: **09/13/2017** , 11:59 p.m. U.S. Eastern Standard Time, at www.grants.gov. If Grants.gov is inoperable and cannot receive applications, and circumstances preclude advance notification of an extension, then applications must be submitted by the first business day on which grants.gov operations resume.

Date for Informational Conference Call: 07/12/2017

Call #1: July 12, 2017 at 3:00 pm (Eastern Standard Time)

Call #2: August 9, 2017 at 3:00 pm (Eastern Standard Time)

Call #3: August 30, 2017 at 3:00 pm (Eastern Standard Time)

**Call Information will be posted on the PS18-1802 website: (https://www.cdc.gov/hiv/funding/announcements/ps18-1802/index.html)**

## 5. CDC Assurances and Certifications

All applicants are required to sign and submit “Assurances and Certifications” documents indicated at http:// wwwn.cdc.gov/ grantassurances/ (S(mj444mxct51lnrv1hljjjmaa)) / Homepage.aspx.

Applicants may follow either of the following processes:

- Complete the applicable assurances and certifications with each application submission,

name the file “Assurances and Certifications” and upload it as a PDF file with at www.grants.gov

- Complete the applicable assurances and certifications and submit them directly to CDC on an annual basis at http:// wwwn.cdc.gov/ grantassurances/ (S(mj444mxct51lnrv1hljjjmaa)) / Homepage.aspx

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

**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

Is a LOI: Recommended but not Required

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

Completed LOI must be sent via email to HDFOA@CDC.gov.

Addressed to:

Constance Jarvis, Grants Management Specialist

Department of Health and Human Services

CDC Office of Grants Services

2920 Brandywine Road, MS E-15

Atlanta, GA 30341

Telephone: (770) 488-5859

Email: abq3@cdc.gov

## 8. Table of Contents

(There is no page limit. The table of contents is not included in the project narrative page limit.): The applicant must provide, as a separate attachment, the “Table of Contents” for the entire submission package.
Provide a detailed table of contents for the entire submission package that includes all of the documents in the application and headings in the "Project Narrative" section. Name the file "Table of Contents" and upload it as a PDF file under "Other Attachment Forms" at www.grants.gov.

## 9. Project Abstract Summary

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

Multi-component NOFOs may have a maximum of 15 pages for the “base” (subsections of the Project Description that the components share with each other, which may include target population, inclusion, collaboration, etc.); and up to 4 additional pages per component for Project Narrative subsections that are specific to each component.

Text should be single spaced, 12 point font, 1-inch margins, and number all pages.

Page limits include work plan; content beyond specified limits may not be reviewed. Applicants should use the federal plain language guidelines and Clear Communication Index to respond to this Notice of Funding Opportunity Announcement. Note that awardees 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.

Applicants must submit a project narrative with the application forms. 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 project period as identified in the CDC Project Description section.

## a. Background

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

## b. Approach

### i. Purpose

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

### ii. Outcomes

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

### iii. Strategies and Activities

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

### 1. Collaborations

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

Applicants must describe how they will collaborate with other health departments (e.g., state and local) within the jurisdiction.

Applicants must file the MOA or MOU, as appropriate, name the file "MOAs/MOUs," and upload it as a PDF file at www.grants.gov.

Applicants must file letters of support, as appropriate, name the file "Letters of Support," and upload it as a PDF file at www.grants.gov.

### 2. Target Populations and Health Disparities

Applicants must describe the specific target population(s) in their jurisdiction and explain how such a target will achieve the goals of the award and/or alleviate health disparities. The applicants must also address how they will include specific populations that can benefit from the program that is described in the Approach section. Applicants must address the Target Populations and Health Disparities requirements as described in the CDC Project Description.

## c. Applicant Evaluation and Performance Measurement Plan

Applicants must provide an evaluation and performance measurement plan that demonstrates how the awardee will fulfill the requirements described in the CDC Evaluation and Performance

Measurement and Project Description sections of this NOFO. At a minimum, the plan must describe:

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

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

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

Awardees 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 awardee plans to carry out achieving the project period 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 will not be reimbursed under grants to foreign organizations, international organizations, and foreign components of grants to domestic organizations (does not affect indirect cost reimbursement to the domestic entity for domestic activities). For guidance on completing a detailed budget, see Budget Preparation Guidelines at: http:// www.cdc.gov /grants /interested in applying /application resources.html.
If applicable and consistent with the cited statutory authority for this announcement, applicant entities may use funds for activities as they relate to the intent of this NOFO to meet national standards or seek health department accreditation through the Public Health Accreditation Board (see: http://www.phaboard.org). Applicant entities to whom this provision applies include state, local, territorial governments (including the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, the Commonwealth of the Northern Marianna Islands, American Samoa, Guam, the Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau), or their bona fide agents, political subdivisions of states (in consultation with states), federally recognized or state-recognized American Indian or Alaska Native tribal governments, and American Indian or Alaska Native tribally designated organizations. Activities include those that enable a public health organization to deliver public health services such as activities that ensure a capable and qualified workforce, up-to-date information systems, and the capability to assess and respond to public health needs. Use of these funds must focus on achieving a minimum of one national standard that supports the intent of the NOFO. Proposed activities must be included in the budget narrative and must indicate which standards will be addressed.
Applicants must name this file “Budget Narrative” and upload it as a PDF file at www.grants.gov. If requesting indirect costs in the budget, a copy of the indirect cost-rate agreement is required. If the indirect costs are requested, include a copy of the current negotiated federal indirect cost rate agreement or a cost allocation plan approval letter for those Grantees under such a plan. Applicants must name this file “Indirect Cost Rate” and upload it at www.grants.gov.

Note: Applicants with the capacity to implement integrated screening activities (e.g., screening

for STDs, viral hepatitis, and/or TB) should continue implementing service integration activities and are eligible to utilize up to 5% of the requested total funding amount to enhance these efforts.

Note: Provide a separate itemized budget if applying for DA. In addition, provide a separate 424A form.

Note: Provide a separate itemized budget if applying for Component B: Demonstration Projects.

## 13. Intergovernmental Review

Executive Order 12372 does not apply to this program.

## 14. Pilot Program for Enhancement of Employee Whistleblower Protections

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

### 14a. 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). Grantees will be required to draw down funds from award-specific accounts in the PMS. Ultimately, the subaccounts will provide grantees and CDC a more detailed and precise understanding of financial transactions. The successful applicant will be required to track funds by P-accounts/sub accounts for each project/cooperative agreement awarded. Applicants are encouraged to demonstrate a record of fiscal responsibility and the ability to provide sufficient and effective oversight. Financial management systems must meet the requirements as described 2 CFR 200 which include, but are not limited to, the following:

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

### 14b. 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.

**14c. 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 grantee 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 grantee did not pay any taxes during the reporting period.]

2) Quarterly Report: The grantee 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. grantee 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 grantee must include this reporting requirement in all applicable subgrants and other subagreements.

**14d. Data Management Plan**
As identified in the Evaluation and Performance Measurement section, applications involving data collection must include a Data Management Plan (DMP) as part of their evaluation and performance measurement plan. The DMP is the applicant’s assurance of the quality of the public health data through the data’s lifecycle and plans to deposit data in a repository to preserve and to make the data accessible in a timely manner. See web link for additional information: https://www.cdc.gov/grants/additionalrequirements/ar-25.html

## 15. Funding Restrictions

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

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

- 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.

- Awardees may not use funds to purchase antiretroviral therapy.
- Awardees may not use funds to purchase sterile needles or syringes for drug injection.
- Funding should not be used for construction purposes.

## 16. Other Submission Requirements

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

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

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

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

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

If you do not receive a "validation" e-mail within two business days of application submission, please contact www.grants.gov. For instructions on how to track your application, refer to the e-mail message generated at the time of application submission or the Grants.gov Online User Guide.
https://www.grants.gov/ help/html/help/ index.htm? callingApp=custom#t=
Get_Started%2FGet_Started. htm

**d. Technical Difficulties:** If technical difficulties are encountered at www.grants.gov, applicants should contact Customer Service at www.grants.gov. The www.grants.gov Contact Center is available 24 hours a day, 7 days a week, except federal holidays. The Contact Center is available by phone at 1-800-518-4726 or by e-mail at support@grants.gov. Application submissions sent by e-mail or fax, or on CDs or thumb drives will not be accepted. Please note that www.grants.gov is managed by HHS.
**e. Paper Submission:** If technical difficulties are encountered at www.grants.gov, applicants should call the www.grants.gov Contact Center at 1-800-518-4726 or e-mail them at support@grants.gov for assistance. After consulting with the Contact Center, if the technical difficulties remain unresolved and electronic submission is not possible, applicants may e-mail CDC GMO/GMS, before the deadline, and request permission to submit a paper application. Such requests are handled on a case-by-case basis.
An applicant's request for permission to submit a paper application must:

1. Include the www.grants.gov case number assigned to the inquiry
2. Describe the difficulties that prevent electronic submission and the efforts taken with the www.grants.gov Contact Center to submit electronically; and
3. Be received via e-mail to the GMS/GMO listed below at least three calendar days before the application deadline. Paper applications submitted without prior approval will not be considered.
   If a paper application is authorized, OGS will advise the applicant of specific instructions for submitting the application (e.g., original and two hard copies of the application by U.S. mail or express delivery service).

## E. Review and Selection Process

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

**a. Phase I Review**
All applications will be initially reviewed for eligibility and completeness by the Office of Grants Services. Complete applications will be reviewed for responsiveness by 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.

| Component A: Core Program | Maximum Points: 100 |
|---|---|

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.

Applicants should respond to the criteria below for the core integrated HIV program (Strategies 1 – 11).

**i. Approach (45 points)**

Evaluate the extent to which the applicant:

1. Presents outcomes that are consistent with the project period outcomes described in the Integrated HIV Surveillance and Prevention Programs Project Description and logic model.
2. Describes an overall strategy and activities consistent with the Integrated HIV Surveillance and Prevention Programs Project Description and logic model.
3. Describes each strategy and the associated activities that are achievable, appropriate to achieve the outcomes of the project, and evidence-based (to the degree practicable).
4. Shows that the proposed use of funds is an efficient and effective way to implement each of the required strategies and associated activities and attain the project period outcomes.
5. Presents a work plan that is aligned with each of the required strategies and associated activities, outcomes, and performance measures in the approach and is consistent with the content and format proposed by CDC.

**ii. Evaluation and Performance Measurement (30 points)**

Evaluate the extent to which the applicant:

1. Shows/affirms the ability to collect data on the process and outcome performance measures specified by CDC in the project description and presented by the applicant in their approach.
2. Describes clear monitoring and evaluation procedures and how evaluation and performance measurement will be incorporated into planning, implementation, and reporting of project activities.
3. Describes how performance measurement and evaluation findings will be reported, and used to demonstrate the outcomes of the FOA and for continuous program quality improvement.
4. Describes how evaluation and performance measurement will contribute to developing an evidence base for programs that lack a strong effectiveness evidence base.
5. Describes any evaluation activities they are to undertake. Describe in sufficient detail to identify the key evaluation questions, and data sources and analysis methods.

6. Includes a preliminary Data Management Plan (DMP), if applicable.

**iii. Applicant's Organizational Capacity to Implement the Approach (25 points)**

Evaluate the extent to which the applicant addresses the items below.

1. Demonstrates relevant experience and capacity (management, administrative, and technical) to implement each of the required strategies and associated activities and achieve the project outcomes.
2. Demonstrates experience and capacity to implement the evaluation plan.
3. Provides capacity building needs.
4. Provides a staffing plan and project management structure that will be sufficient to achieve the project outcomes and which clearly defines staff roles. Provides an organizational chart.
5. Demonstrates experience and capacity to coordinate with tribal governments and/or tribally designated organizations in their jurisdiction, if applicable.

**iv. Budget and Budget Justification (Not scored)**

Evaluate the extent to which the budget appears reasonable and consistent with the proposed activity and purpose of the program.

- When reviewing or scoring budgets, CDC programs must assess whether the budget aligns with the proposed work plan. For additional guidance, check with the CIO extramural program office, GMO, or GMS.

Component B: Demonstration Projects Maximum Points: 100

Applicants should respond to the criteria below if applying to implement a demonstration project.

**i. Approach (45 points)**

Evaluate the extent to which the applicant:

1. Provides a rationale for proposing the project within the specified focus area (e.g., identified need, epidemiologic data or other data), including background and need, as it relates to addressing the public health problem. Describes how the demonstration project addresses the national HIV prevention goals of reducing new HIV infections, increasing access to care or reducing HIV-related disparities and health inequities and expected outcomes for the jurisdiction.
2. Provides a detailed description of the proposed demonstration project and related activities to include:
    - Scope of program
    - Target population
    - Strategies to be used
    - Collaborators and partners
    - Reach and impact
    - Training and technical assistanc
    - Dissemination of findings throughout the jurisdiction

3. The adequacy of the methods and the data sources used to identify the areas and facilities to implement the project.
4. Quality of the health department's experience and capacity to implement the demonstration project.
5. Anticipated impact of proposed demonstration project on burden of disease in the jurisdiction.

**ii. Evaluation and Performance Measurement (30 points)**

Evaluate the extent to which the applicant:

1. Provides information on the project description and approach.
    - Annual program goals and SMART objectives for the proposed activity, to include program performance targets.
    - Activities that will be conducted to meet the objectives.
    - Capacity building needs.
    - Timeline for the project period that shows the implementation of the proposed project related activities. Timeline includes planning, implementation and evaluation phases.
2. Provides information for the monitoring and evaluation description.
    - Describes a plan for evaluating progress and outcomes of the project and for identifying lessons learned. Includes a logic model addressing program objectives and expected outcomes
    - Proposed demonstration projects should have a separate EPMP, including data management plan. Refer to EPMP and DMP sections
        - Data collection and management, entry, submission, and data analysis
        - Data usage: how, by whom, and when data will be used to support program planning, resource allocation, and evaluation; measure progress toward meeting objectives; and to improve program performance, quality, and accountability
        - Local monitoring and evaluation activities.
        - A description of procedures in place for data security and confidentiality. These procedures must be in accordance with CDC's Data Security and Confidentiality Guidelines for HIV, Viral Hepatitis, STD, and TB Programs: Standards to Facilitate Sharing and Use of Surveillance Data for Public Health Action.
    - Describes how the results will be used and shared, including data dissemination and sharing with participating healthcare/non-healthcare facilities, CBOs or other service organizations, and key stakeholders.

**iii. Applicant's Organizational Capacity to Implement the Approach (25 points)**

Evaluate the extent to which the applicant:

1. Describes the health department's experience and capacity to implement the demonstration project.
2. Submits a staffing and management description for the proposed demonstration project that includes staff experience and background to support and carry out the activities of

the program including evaluation.
3. Describes how applicant will manage, monitor, and maintain collaborations with other programs, service providers and/or stakeholders.
4. Plans to collaborate with CDC or other technical assistance providers to provide ongoing training, technical assistance, and consultation to all staff conducting the demonstration project.

**iv. Budget and Budget Justification (Not scored)**

Evaluate the extent to which the budget appears reasonable and consistent with the proposed activity and purpose of the program.

- When reviewing or scoring budgets, CDC programs must assess whether the budget aligns with the proposed work plan. For additional guidance, check with the CIO extramural program office, GMO, or GMS.

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.

**c. Phase III Review**

A technical review process will be conducted by CDC to provide feedback to all applicants on the proposed program. All eligible and technically acceptable applications submitted in response to Component A: Core Program will be funded.

Component B: Demonstration Project applications deemed eligible and technically acceptable by the review panel will be funded in order of score and rank within their funding tier. Additonally, the following factors may affect the funding decision: availability of funds, geographic diversity, ability to reach the target population, and relevance to DHAP program priorities.

**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 Awardee 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

Component A: January 1, 2018

Component B: March 1, 2018

## F. Award Administration Information

### 1. Award Notices

***Awardees 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 awardee and CDC.*** The NOA will be signed by an authorized GMO and emailed to the Awardee Business Officer listed in application and the Program Director.
Any applicant awarded funds in response to this NOFO will be subject to the DUNS, SAM Registration, and Federal Funding Accountability And Transparency Act Of 2006 (FFATA) requirements.
Unsuccessful applicants will receive notification of these results by e-mail with delivery receipt or by U.S. mail.

## 2. Administrative and National Policy Requirements

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

- 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 2020
- AR-12: Lobbying Restrictions (June 2012)
- AR-13: Prohibition on Use of CDC Funds for Certain Gun Control Activities
- AR-14: Accounting System Requirements
- AR-15: Proof of Non-profit Status
- AR-16: Security Clearance Requirement
- AR-21: Small, Minority, And Women-owned Business
- AR 23: Compliance with 45 CFR Part 87 (faith-based organizations)
- AR-24: Health Insurance Portability and Accountability Act Requirements
- AR-25: Release and Sharing of Data
- AR-26: National Historic Preservation Act of 1966
- AR-27: Conference Disclaimer and Use of Logos
- AR-29: Compliance with EO13513, “Federal Leadership on Reducing Text Messaging while Driving,” October 1, 2009
- AR-30: Compliance with Section 508 of the Rehabilitation Act of 1973
- AR-34: Language Access for Persons with Limited English Proficiency

**Attendance at CDC-Sponsored Conferences and Workshops**

- Participation in CDC sponsored grantee meetings and workshops is mandatory. All grantees are required to attend and are to include budget allocations consistent with this

requirement. These allocations will be reviewed and approved annually as a part of the award continuation process. Failure to attend the mandated meetings and workshops (regardless of state financial or administrative crisis) shall be cause for a determination of reduction in travel funding.
- Adhere to CDC policies for securing prior approval for CDC sponsored conferences and meetings.

**Other Required Activities**

- Submit any newly developed public information resources and materials to the CDC National Prevention Information Network (NPIN) to be added to the database and accessed by other organizations and agencies.
- If using materials that include the name or logo of either CDC or the Department of Health and Human Services, submit a copy of the proposed material to CDC for approval.
- Comply with 508 compliance requirements for information posted to websites.
- Comply with the requirements set forth in the HIV Content Review Guidelines.
- In addition to funding under this announcement, demonstrate effort to sustain HIV prevention efforts throughout the jurisdiction.
- Develop and maintain strategic partnerships within and external to the health department for shared planning, implementation, and sustainability of program efforts.
- Ensure ongoing communication and information sharing between the state and local health departments and other providers.
- Collect and submit additional information as required for performance reports.
- Collect and submit additional data requirements as required by CDC.

For more information on the CFR visit http://www. access.gpo.gov/ nara/cfr/cfr-table-search.html.

## 3. Reporting

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

- Helps target support to awardees;
- Provides CDC with periodic data to monitor awardee progress toward meeting the NOFO outcomes and overall performance;
- Allows CDC to track performance measures and evaluation findings for continuous quality and program improvement throughout the project period and to determine applicability of evidence-based approaches to different populations, settings, and contexts; and
- Enables CDC to assess the overall effectiveness and influence of the 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? |
|---|---|---|
| Awardee Evaluation and Performance Measurement Plan | 6 months into award | 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 | At least twice within the budget period | Yes |
| Federal Financial Reporting Forms | 90 days after end of calendar quarter in which budget period ends | Yes |
| Final Performance and Financial Report | 90 days after end of project period | Yes |
| Payment Management System (PMS) Reporting | As determined by OGS | Yes |

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

Awardee Evaluation and Performance Measurement Plan (required): This plan should provide additional detail on the following:
Performance Measurement
• Performance measures and targets
• The frequency that performance data are to be collected.
• How performance data will be reported.
• How quality of performance data will be assured.
• How performance measurement will yield findings to demonstrate progress towards achieving NOFO goals (e.g., reaching target populations or achieving expected outcomes).
• Dissemination channels and audiences.
• Other information requested as determined by the CDC program.

Evaluation

• The types of evaluations to be conducted (e.g. process or outcome evaluations).
• The frequency that evaluations will be conducted.
• How evaluation reports will be published on a publically available website.
• How evaluation findings will be used to ensure continuous quality and program improvement.
• How evaluation will yield findings to demonstrate the value of the NOFO (e.g., effect on improving public health outcomes, effectiveness of NOFO, cost-effectiveness or cost-benefit).
• Dissemination channels and audiences.
HHS/CDC or its designee will also undertake monitoring and evaluation of the defined activities within the agreement. The recipient must ensure reasonable access by HHS/CDC or its designee to all necessary sites, documentation, individuals and information to monitor, evaluate and verify the appropriate implementation the activities and use of HHS/CDC funding under this Agreement.

**b. Annual Performance Report (APR) (required)**
The awardee must submit the APR via www.Grantsolutions.gov 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 weblinks are allowed.
This report must include the following:

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

- Indirect Cost Rate Agreement.

The awardee must submit the Annual Performance Report via www.Grantsolutions.gov 120 days prior to the end of the budget period.

Guidance on the requirements of the Annual Performance Report and submission instructions will be transmitted to the awardee by the GMS. The contact information for the GMS is listed in the "Agency Contacts" section of the FOA.

For year 2 and beyond of the award, awardees may request that as much as 75% of their estimated unobligated funds be carried over into the next budget period.

The carryover request must:

- Express a bona fide need for permission to use an unobligated balance;
- Include a signature, dated, and accurate Federal Financial Report (FFR) for the budget period from which funds will be transferred (as much as 75% of unobligated balances); and
- Include a list of proposed activities, an itemized budget, and a narrative justification for those activities.

**c. Performance Measure Reporting (optional)**
CDC programs may require more frequent reporting of performance measures than annually in the APR. If this is the case, CDC programs must specify reporting frequency, data fields, and format for awardees at the beginning of the award period.

In addition to the Annual Performance Report, awardees are required to submit data at the end of each budget year. Awardees will be required to complete an End of Year (EOY) Performance Report that captures the quantitative data from the last six months of the previous budget period and qualitative data for the entire 12 month budget period. The EOY Performance Report is due 90 days after the end of the budget period. Awardees will also be required to submit a Standard Evaluation Report (SER) Form approved OMB No: 0920-0573, Expiration Date: 06/30/2019.

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

**e. Final Performance and Financial Report (required)**
This report is due 90 days after the end of the project period. CDC programs must indicate that

this report should not exceed 40 pages. This report covers the entire project period and can include information previously reported in APRs. At a minimum, this report must include the following:

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

Awardees will be required to complete a Program Closeout Report that captures the quantitative data from the last six months of the previous budget period and qualitative data for the entire project period. The Program Closeout Report is due 90 days after the end of the project period.

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

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

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

## G. Agency Contacts

CDC encourages inquiries concerning this NOFO.

### Program Office Contact

**For programmatic technical assistance,** contact:

Renata D. Ellington, Project Officer
Department of Health and Human Services

Centers for Disease Control and Prevention
1600 Clifton Road, NE, MS D-21
Atlanta, GA 30333
Telephone: (404) 639-6030
Email: HDFOA@cdc.gov

### Grants Management Office Information

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

Constance Jarvis, Grants Management Specialist
Department of Health and Human Services
Office of Grants Services
2920 Brandywine Road, MS E-15
Atlanta, GA 30341
Telephone: (770) 488-5859
Email: ABQ3@cdc.gov

For assistance with **submission difficulties related to** www.grants.gov, contact the Contact Center by phone at 1-800-518-4726.
Hours of Operation: 24 hours a day, 7 days a week, except on federal holidays.

For all other **submission** questions, contact:
Technical Information Management Section
Department of Health and Human Services
CDC Office of Financial Resources
Office of Grants Services
2920 Brandywine Road, MS E-14
Atlanta, GA 30341
Telephone: 770-488-2700
E-mail: ogstims@cdc.gov

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

## H. Other Information

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

- Project Abstract
- Project Narrative
- Budget Narrative
- CDC Assurances and Certifications

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

For international NOFOs:

- SF424
- SF424A
- Funding Preference Deliverables

Optional attachments, as determined by CDC programs:

- Resumes / CVs
- Organization Charts
- Indirect Cost Rate, if applicable

All attachments are located at https://www.cdc.gov/hiv/funding/announcements/ps18-1802/attachments.html

- Attachment A: Sample Table of Contents
- Attachment B: Funding Tables
- Attachment C: PS18-1802 CDC Evaluation Plan Guide, Local Evaluation Plan Guide and Demonstration Projects Evaluation Plan Guide  PS18-1802 Work Plan Guide
- Attachment D: HIV Testing Reporting Requirements
- Attachment E: Detecting, Investigating, and Responding to HIV Transmission Clusters
- Attachment F: Letter of Intent (LOI) to Apply for Demonstration Project Funding
- Attachment G: Sample Letter of Agreement (LOA) for City/State pairs, if applicable
- Attachment H: Official Responsible Party (ORP) Certification Sample Template
- Attachment I: HIV Perinatal Program Guidance
- Attachment J: HIV Data-to-Care Program Guidance
- Attachment K: CDC PrEP Program Guidance for HIV Prevention Health Department Grantees
- Attachment L: CDC Assurance of Compliance (must be downloaded from www.grants.gov)

***PS18-1802 application package and CDC Assurance of Compliance must be downloaded from www.grants.gov

**Important Resources**

Additional resources include the *Surveillance Technical Guidance for HIV Surveillance Programs* (for access to this technical guidance, please send a request email to HDFOA@cdc.gov) and the Data-to-Care technical reports (refer to www.effectiveinterventions.cdc.gov.gov/en/HighImpactPrevention/Public

HealthStrategies/DatatoCare.aspx).

**References**

1. Satcher Johnson A, Song R, Hall IH. State-level estimates of HIV incidence, prevalence, and undiagnosed infection. 2017. Presented at: The Conference on Retroviruses and Opportunistic Infections. February 2017. Seattle, WA

2. National HIV/AIDS Strategy for the United States: Updated to 2020. Published July 2015. https://www.aids.gov/federal-resources/national-hiv-aids-strategy/nhas-update.pdf

3. CDC. HIV Testing at CDC-Funded Sites, United States, Puerto Rico, and the U.S. Virgin Islands, 2014. Published April 2016. https://www.cdc.gov/hiv/resources/reports/pdf/PEB_2010_H IV_Testing Report .pdf

4. CDC. Trends in U.S. HIV Diagnoses, 2005-2015. Published February 2016. http://www.cdc.gov/nchhstp/newsr oom/docs/factsheets/hiv-data-trends-fact-sheet-508.pdf

5. CDC. Antiretroviral Therapy (ART) for Treating HIV. https://wwwn.cdc.gov/hivrisk/decreased_risk/medicines/art.html

6. US Public Health Service. Preexposure prophylaxis for the prevention of HIV infection in the United States – 2014. https://www.cdc.gov/hiv/pdf/prepguidelines2014.pdf

7. CDC. Effective Interventions, behavioral interventions. https://effectiveinterventions.cdc.gov

Please see the PS18-1802 website for additional resources: https://www.cdc.gov/hiv/funding/announcements/ps18-1802/index.html

## 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; awardees must comply with the ARs listed in the NOFO. To view brief descriptions of relevant provisions, see http:// www.cdc.gov/ grants/ additional requirements/ index.html. Note that 2 CFR 200 supersedes the administrative requirements (A-110 & A-102), cost principles (A-21, A-87 & A-122) and audit requirements (A-50, A-89 & A-133).
**Approved but Unfunded:** Approved but unfunded refers to applications recommended for approval during the objective review process; however, they were not recommended for funding by the program office and/or the grants management office.
**Award:** Financial assistance that provides support or stimulation to accomplish a public purpose. Awards include grants and other agreements (e.g., cooperative agreements) in the form of money, or property in lieu of money, by the federal government to an eligible applicant.
**Budget Period or Budget Year:** The duration of each individual funding period within the project period. Traditionally, budget periods are 12 months or 1 year.
**Carryover:** Unobligated federal funds remaining at the end of any budget period that, with the approval of the GMO or under an automatic authority, may be carried over to another budget period to cover allowable costs of that budget period either as an offset or additional

authorization. Obligated but liquidated funds are not considered carryover.
**Catalog of Federal Domestic Assistance (CFDA):** A government-wide compendium published by the General Services Administration (available on-line in searchable format as well as in printable format as a .pdf file) that describes domestic assistance programs administered by the Federal Government.
**CFDA Number:** A unique number assigned to each program and NOFO throughout its lifecycle that enables data and funding tracking and transparency.
**CDC Assurances and Certifications:** Standard government-wide grant application forms.
**Competing Continuation Award:** A financial assistance mechanism that adds funds to a grant and adds one or more budget periods to the previously established project period (i.e., extends the "life" of the award).
**Continuous Quality Improvement:** A system that seeks to improve the provision of services with an emphasis on future results.
**Contracts:** An award instrument used to acquire (by purchase, lease, or barter) property or services for the direct benefit or use of the Federal Government.
**Cooperative Agreement:** A financial assistance award with the same kind of interagency relationship as a grant except that it provides for substantial involvement by the federal agency funding the award. Substantial involvement means that the recipient can expect federal programmatic collaboration or participation in carrying out the effort under the award.
**Cost Sharing or Matching:** Refers to program costs not borne by the Federal Government but by the awardees. It may include the value of allowable third-party, in-kind contributions, as well as expenditures by the awardee.
**Direct Assistance:** A financial assistance mechanism, which must be specifically authorized by statute, whereby goods or services are provided to recipients in lieu of cash. DA generally involves the assignment of federal personnel or the provision of equipment or supplies, such as vaccines. DA is primarily used to support payroll and travel expenses of CDC employees assigned to state, tribal, local, and territorial (STLT) health agencies that are recipients of grants and cooperative agreements. Most legislative authorities that provide financial assistance to STLT health agencies allow for the use of DA. http:// www.cdc.gov /grants /additionalrequirements /index.html.
**DUNS:** The Dun and Bradstreet (D&B) Data Universal Numbering System (DUNS) number is a nine-digit number assigned by Dun and Bradstreet Information Services. When applying for Federal awards or cooperative agreements, all applicant organizations must obtain a DUNS number as the Universal Identifier. DUNS number assignment is free. If requested by telephone, a DUNS number will be provided immediately at no charge. If requested via the Internet, obtaining a DUNS number may take one to two days at no charge. If an organization does not know its DUNS number or needs to register for one, visit Dun & Bradstreet at http://fedgov.dnb.com/ webform/displayHomePage.do.
**Evaluation (program evaluation):** The systematic collection of information about the activities, characteristics, and outcomes of programs (which may include interventions, policies, and specific projects) to make judgments about that program, improve program effectiveness, and/or inform decisions about future program development.
**Evaluation Plan:** A written document describing the overall approach that will be used to guide an evaluation, including why the evaluation is being conducted, how the findings will likely be used, and the design and data collection sources and methods. The plan specifies what will be done, how it will be done, who will do it, and when it will be done. The NOFO evaluation plan

is used to describe how the awardee and/or CDC will determine whether activities are implemented appropriately and outcomes are achieved.
**Federal Funding Accountability and Transparency Act of 2006 (FFATA):** Requires that information about federal awards, including awards, contracts, loans, and other assistance and payments, be available to the public on a single website at www.USAspending.gov.
**Fiscal Year:** The year for which budget dollars are allocated annually. The federal fiscal year starts October 1 and ends September 30.
**Grant:** A legal instrument used by the federal government to transfer anything of value to a recipient for public support or stimulation authorized by statute. Financial assistance may be money or property. The definition does not include a federal procurement subject to the Federal Acquisition Regulation; technical assistance (which provides services instead of money); or assistance in the form of revenue sharing, loans, loan guarantees, interest subsidies, insurance, or direct payments of any kind to a person or persons. The main difference between a grant and a cooperative agreement is that in a grant there is no anticipated substantial programmatic involvement by the federal government under the award.
**Grants.gov:** A "storefront" web portal for electronic data collection (forms and reports) for federal grant-making agencies at www.grants.gov.
**Grants Management Officer (GMO):** The individual designated to serve as the HHS official responsible for the business management aspects of a particular grant(s) or cooperative agreement(s). The GMO serves as the counterpart to the business officer of the recipient organization. In this capacity, the GMO is responsible for all business management matters associated with the review, negotiation, award, and administration of grants and interprets grants administration policies and provisions. The GMO works closely with the program or project officer who is responsible for the scientific, technical, and programmatic aspects of the grant.
**Grants Management Specialist (GMS):** A federal staff member who oversees the business and other non-programmatic aspects of one or more grants and/or cooperative agreements. These activities include, but are not limited to, evaluating grant applications for administrative content and compliance with regulations and guidelines, negotiating grants, providing consultation and technical assistance to recipients, post-award administration and closing out grants.
**Health Disparities:** Differences in health outcomes and their determinants among segments of the population as defined by social, demographic, environmental, or geographic category.
**Health Equity:** Striving for the highest possible standard of health for all people and giving special attention to the needs of those at greatest risk of poor health, based on social conditions.
**Health Inequities:** Systematic, unfair, and avoidable differences in health outcomes and their determinants between segments of the population, such as by socioeconomic status (SES), demographics, or geography.
**Healthy People 2020:** National health objectives aimed at improving the health of all Americans by encouraging collaboration across sectors, guiding people toward making informed health decisions, and measuring the effects of prevention activities.
**Inclusion:** Both the meaningful involvement of a community's members in all stages of the program process and the maximum involvement of the target population that the intervention will benefit. Inclusion ensures that the views, perspectives, and needs of affected communities, care providers, and key partners are considered.
**Indirect Costs:** Costs that are incurred for common or joint objectives and not readily and

specifically identifiable with a particular sponsored project, program, or activity; nevertheless, these costs are necessary to the operations of the organization. For example, the costs of operating and maintaining facilities, depreciation, and administrative salaries generally are considered indirect costs.

**Intergovernmental Review:** Executive Order 12372 governs applications subject to Intergovernmental Review of Federal Programs. This order sets up a system for state and local governmental review of proposed federal assistance applications. Contact the state single point of contact (SPOC) to alert the SPOC to prospective applications and to receive instructions on the State's process. Visit the following web address to get the current SPOC list: http://www.whitehouse.gov/omb/ grants_spoc/.

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

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

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

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

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

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

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

**Objective Review:** A process that involves the thorough and consistent examination of applications based on an unbiased evaluation of scientific or technical merit or other relevant

aspects of the proposal. The review is intended to provide advice to the persons responsible for making award decisions.
**Outcome:** The results of program operations or 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.
**Plain Writing Act of 2010:** The Plain Writing Act of 2010 requires that federal agencies use clear communication that the public can understand and use. NOFOs must be written in clear, consistent language so that any reader can understand expectations and intended outcomes of the funded program. CDC programs should use NOFO plain writing tips when writing NOFOs.
**Program Strategies:** Strategies are groupings of related activities, usually expressed as general headers (e.g., Partnerships, Assessment, Policy) or as brief statements (e.g., Form partnerships, Conduct assessments, Formulate policies).
**Program Official:** Person responsible for developing the NOFO; can be either a project officer, program manager, branch chief, division leader, policy official, center leader, or similar staff member.
**Project Period Outcome:** An outcome that will occur by the end of the NOFO's funding period.
**Public Health Accreditation Board (PHAB)**: A nonprofit organization that works to promote and protect the health of the public by advancing the quality and performance of public health departments in the U.S. through national public health department accreditation http://www.phaboard.org.
**Social Determinants of Health:** Conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.
**Statute:** An act of the legislature; a particular law enacted and established by the will of the legislative department of government, expressed with the requisite formalities. In foreign or civil law any particular municipal law or usage, though resting for its authority on judicial decisions, or the practice of nations.
**Statutory Authority:** Authority provided by legal statute that establishes a federal financial assistance program or award.
**System for Award Management (SAM):** The primary vendor database for the U.S. federal government. SAM validates applicant information and electronically shares secure and encrypted data with federal agencies' finance offices to facilitate paperless payments through Electronic Funds Transfer (EFT). SAM stores organizational information, allowing www.grants.gov to verify identity and pre-fill organizational information on grant applications.
**Technical Assistance:** Advice, assistance, or training pertaining to program development, implementation, maintenance, or evaluation that is provided by the funding agency.
**Work Plan:** The summary of project period outcomes, strategies and activities, personnel and/or partners who will complete the activities, and the timeline for completion. The work plan

will outline the details of all necessary activities that will be supported through the approved budget.

**Active referral:** This involves efforts beyond passive referral, in which the individual is only given contact information for the service(s) and is left to make their own contact. There are varying types of *active* referral. Active referral may include but is not limited to activities for the client such as: making appointments, providing transportation, using a case manager or peer navigator to help with access to services, providing the organization to which the client is referred with information collected about the client (including the professional assessment of the client's needs), a "warm hand-off" – such as a 'live' three way conversation (individual/organization making the referral, individual/organization receiving the referral, and the client) – in person or by telephone – in which the client is introduced, and providing explanations about what has already been done to assist the client and reason for referral.

**Application:** A formal request to CDC for HIV prevention funding. The application contains a written narrative and budget that reflects the priorities described in the program announcement and the jurisdiction's comprehensive HIV prevention plan.

**Behavioral Health:** A mental/emotional state of being and/or choices and actions that affect wellness, productivity, and the ability to function in major life activities and cope with normal stresses of life. Services to support behavioral health include mental health and substance use treatment.

**Behavioral Interventions:** The use of behavioral approaches designed to moderate intra- and interpersonal factors to prevent acquisition and transmission of HIV infection.

**Biomedical Interventions:** The use of medical, clinical, and public health approaches designed to moderate biological and physiological factors to prevent HIV infection, reduce susceptibility to HIV, and/or decrease HIV infectiousness.

**Capacity Building:** Activities that strengthen the core competencies of an organization and contribute to its ability to develop and implement an effective HIV prevention intervention and sustain the infrastructure and resource base necessary to support and maintain the intervention.

**Capacity Building Assistance (CBA):** Activities that strengthen and maintain the organizational infrastructure and resources necessary to support HIV prevention services. Capacity building enhances the abilities of key personnel to plan and implement intervention activities. It may also focus on community development to support the delivery of effective HIV prevention services.

**Capacity Building Assistance Consumers:** Community-based organizations, health departments, HIV planning groups, and other community stakeholders serving populations at high risk and/or racial ethnic minority populations are the prioritized audience for HIV prevention CBA services.

**CBA Providers:** National and regional organizations funded by the CDC to provide expert programmatic, scientific, and technical support to health departments, community-based organizations, and communities in the design, implementation, and evaluation of HIV prevention interventions and programs.

**Centers for Disease Control and Prevention (CDC):** The lead federal agency for protecting the health and safety of people, providing credible information to enhance health decisions, and

promoting health through strong partnerships. Based in Atlanta, Georgia, this agency of the U.S. Department of Health and Human Services serves as the national focus for developing and applying disease prevention and control, environmental health, and health promotion and education activities designed to improve the health of the people of the United States.

**Clinical Laboratory Improvement Amendment Program (CLIA):** U.S. federal regulatory standards for the accuracy, reliability, and timelines of all clinical laboratory testing performed on humans, except as a part of research. CLIA requires that any facility examining human specimens for diagnosis, prevention, and treatment of a disease or for assessment of health must register with the federal Centers for Medicare and Medicaid Services (CMS) and obtain CLIA certification.

**CLIA Certificate of Waiver:** One of four types of certificates issued under CLIA, it is issued when tests have been approved by the FDA and are simple to use, require very little training to perform, and are highly accurate. Non-clinical testing sites that plan to offer waived rapid HIV tests must either apply for their own CLIA certificate of waiver or establish an agreement to work under the CLIA certificate of an existing laboratory.

**Collaboration:** Working with another person, organization, or group for mutual benefit by exchanging information, sharing resources, or enhancing the other's capacity, often to achieve a common goal or purpose.

**Condom Distribution:** The means by which condoms are transferred, disseminated, or delivered from a community resource (e.g., health department, community-based organization, or health care organization).

**Confidentiality:** Ensuring that information is accessible only to those authorized to have access.

**Confirmatory Testing:** Additional testing performed to verify the results of an earlier (screening) test. For HIV diagnosis, a Western blot or, less commonly, an immunofluorescence assay (IFA) are typically used, although additional more sensitive tests may also be considered.

**Coordination:** Aligning processes, services, or systems to achieve increased efficiencies, benefits, or improved outcomes. Examples of coordination may include sharing information, such as progress reports, with state and local health departments or structuring prevention delivery systems to reduce duplication of effort.

**Counseling and Testing:** A process through which an individual receives information about HIV transmission and prevention, HIV tests, and the meaning of tests results; is provided HIV prevention counseling to reduce their risk for transmitting or acquiring HIV; and is provided testing to detect the presence of HIV antibodies.

**Culturally Appropriate:** Conforming to a culture's acceptable expressions and standards of behavior and thought. Interventions and educational materials are more likely to be culturally appropriate when representatives of the intended target audience are involved in planning, developing, and pilot testing them.

**Effective:** Demonstrating the desired effect when widely used in practice or under real-world conditions that are considerably less rigorous and controlled, rather than in environments that test efficacy but are still designed to ensure that the desired effect can be attributed to the intervention in question.

**ELR:** Enhanced Laboratory Reporting.

**Epidemic:** The occurrence of cases of an illness, specific health-related behavior, or other health-related events in a community or region in excess of normal expectancy.

**Ethnicity:** The cultural characteristics that connect a particular group or groups of people to each other, such as people of Hispanic/Latino origin.

**Evidence-based Interventions:** Behavioral, social, and structural interventions relevant to HIV risk reduction that have been tested using a methodologically rigorous design and have been shown to be effective in a research setting. These evidence- or science-based interventions have been evaluated using behavioral or health outcomes; have been compared to a control/comparison group(s) (or pre-post data without a comparison group if a policy study); had no apparent bias when assigning persons to interventions or control groups or were adjusted for any apparent assignment bias; and produced significantly greater positive results when compared to the control/comparison group(s), while not producing adverse consequences.

**Faith-based Organization:** A faith-based organization is a non-governmental agency owned by religiously affiliated entities such as (1) individual churches, mosques, synagogues, temples, or other places of worship or (2) a network or coalition of churches, mosques, synagogues, temples, or other places of worship.

**Funding Opportunity Announcement (FOA):** A CDC announcement informing the public of the availability of funds to develop and implement programs that meet a public health goal, including a solicitation of applications for funding. The FOA describes required activities and asks the applicants to describe how they will carry out the required activities.

**Health Equity:** A desirable goal that entails special efforts to improve the health of those who have experienced social or economic disadvantage. It requires continuous efforts focused on elimination of health disparities, including disparities in the living and working conditions that influence health, and continuous efforts to maintain a desired state of equity after particular health disparities are eliminated.

**HIV Planning Group (HPG):** A group of local health officials, community stakeholders, representatives from HIV-affected communities, and technical experts who share responsibility for developing an integrated HIV prevention and care plan for their community (refer to Integrated Prevention and Care Plan definition).

**HIV Medical Care/Evaluation/Treatment:** Medical services that address HIV infection, including evaluation of immune system function and screening, treatment, and prevention of opportunistic infection.

**HIV Prevention Counseling:** An interactive process between client and counselor aimed at reducing risky sex and drug-injection behaviors related to HIV acquisition or transmission.

**HIV Screening:** HIV testing strategy of all persons in a defined population.

**HIV Testing Strategy:** The approach an agency or a person uses when conducting HIV testing in order to decide who will be tested. Testing strategies include HIV screening that is population-based and targeted testing of subpopulations of persons at higher risk.

**Incentive:** A type of reward (e.g., voucher for transportation, food, money, or other small reward) given as compensation for a person’s time and participation in a particular activity.

**Incidence:** The number of new cases in a defined population within a certain time period (often a year). It is important to understand the difference between HIV incidence, which refers to new HIV infections, and new HIV diagnosis. New HIV diagnosis is a person who is newly diagnosed as HIV-infected, usually through HIV testing. These persons may have been infected recently or at some time in the past.

**Integrated Guidelines for Developing Epidemiologic Profiles:** Guidelines developed by CDC and HRSA to: (1) assist persons who compile and interpret HIV prevention and care data for state, territorial, or local HIV/AIDS epidemiologic profiles; (2) provide one set of guidelines to help profile writers produce an integrated epidemiologic profile; and (3) interpret the data in ways that are consistent and useful in planning needs for both HIV prevention and care planning bodies.

**Integrated Prevention and Care Plan (The Plan):** The Plan is based on the Integrated HIV Prevention and Care Plan Guidance that requires a collaborative process between CDC and HRSA to identify and addresses: statewide goals for HIV prevention and care; emphasize the populations and communities most affected by the epidemic; highlight areas of need, service gaps, and barriers; identify health disparities and social and structural determinants of HIV-related health; outline activities for implementing goals; and, identify factors for measuring success in achieving goals.

**Intervention:** A specific activity (or set of related activities) intended to reduce the risk of HIV transmission or acquisition. Interventions may be either biomedical or behavioral and have distinct process and outcome objectives and protocols outlining the steps for implementation.

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

**Linkage:** Actively assisting clients with accessing needed services through a time-limited professional relationship. The active assistance typically lasts a few days to a few weeks and includes a follow-up component to assess whether linkage has occurred. Linkage services can include assessment, supportive counseling, education, advocacy, and accompanying clients to initial appointments.

**Linkage to Medical Care:** This occurs when a patient is seen by a health care provider (e.g., physician, a physician's assistant, or nurse practitioner) to receive medical care for his/her HIV infection, usually within a specified time. Linkage to medical care can include specific referral to care service immediately after diagnosis and follow-up until the person is linked to long-term case management.

**Local Health Department:** A health department and/or health department facility responsible for providing and/or supporting the provision of direct client services in a county or city.

**Medication Adherence:** The extent to which patients take their medication as prescribed by their doctors.

**Men Who Have Sex with Men (MSM):** Men who report sexual contact with other men (i.e., homosexual contact) and men who report sexual contact with both men and women (i.e., bisexual contact), whether or not they identify as "gay."

**MSM/PWID:** Men who report both sexual contacts with other men and using a needle to inject drugs.

**National HIV/AIDS Strategy for the United States: Updated to 2020 (NHAS):** A comprehensive plan focused on reducing HIV incidence, increasing access to care and optimizing health outcomes, and reducing HIV-related health disparities.

**National HIV Monitoring and Evaluation (NHM&E) Data Set:** The official database containing the full set of National HIV Prevention Program Monitoring and Evaluation data variables.

**Navigation Services:** Patient navigation assistance is the process of helping a person obtain timely and appropriate medical or social services, taking into account provider preferences, insurance status, scheduling issues, and other factors that may complicate access or utilization of services.

**Navigator:** Patient navigators are peers, volunteers, and staff members of clinics, health departments, and community-based organizations. Patient navigators may be lay persons, paraprofessionals, or medical professionals (e.g., RNs, LPNs).

**New FOA:** Any FOA that is not a continuation or supplemental award.

**Not-in-Care (NIC):** Used when clinic and health department data (after being reconciled) indicate that the patient has not received HIV care within a specified time frame.

**Outcome Evaluation:** Collection of data about outcomes before and after the intervention for clients as well as a similar group that did not participate in the intervention being evaluated (i.e., control group); determines if the intervention resulted in the expected outcomes.

**Outcome Monitoring:** Involves the routine documentation and review of program-associated outcomes (e.g., individual-level knowledge, attitudes, and behaviors or access to services; service delivery; community or structural factors) in order to determine whether the anticipated outcomes have occurred and thus define the extent to which program goals and objectives are being met.

**Outreach:** A process of engaging face-to-face with persons at risk in their own neighborhoods or venues where they typically congregate to provide HIV testing or referrals for testing. Outreach is often conducted by peers or paraprofessional educators.

**Partner Services (PS):** A systematic approach to notifying sex and needle-sharing partners of HIV-infected persons of their possible exposure to HIV so they can be offered HIV testing and learn their status or, if already infected, prevent transmission to others. PS helps partners gain earlier access to individualized counseling, HIV testing, medical evaluation, treatment, and other prevention services.

**Persons at High Risk**: Groups or populations can be described as “vulnerable” or “key” or “groups [populations] at risk” if they are subject to societal pressures or social circumstances that make them vulnerable to contracting or transmitting HIV.

**Persons who Inject Drugs (PWID):** Someone who uses a needle to inject drugs into his or her body.

**Prevalence:** The total number of cases of a disease in a given population at a particular point in time. HIV/AIDS prevalence refers to persons living with HIV, regardless of time of infection or diagnosis date. Prevalence does not give an indication of how long a person has had a disease and cannot be used to calculate rates of disease. It can provide an estimate of risk that an

individual will have a disease at a point in time.

**Prevention Services:** Any service or intervention directly aimed at reducing risk for transmitting or acquiring HIV infection (e.g., prevention counseling, behavioral interventions, risk reduction counseling, substance abuse and mental health services, and other services focused on social determinants of health). The goal is to provide a comprehensive health service to clients to reduce their risk of transmitting or acquiring HIV infection.

**Previously Diagnosed HIV infection:** HIV infection in a person who meets either of the following criteria: (1) self-reports having previously tested HIV-positive or (2) has been previously reported to the health department's surveillance registry as being infected with HIV.

**Primary Medical Care (for HIV-negative persons at high risk of acquiring HIV):** Routine outpatient care that a patient receives at first contact with a health care provider**.**

**Protected Sex:** Sex with a condom; oral sex with a condom or dental dam; vaginal or anal sex with a condom and/or medicines to prevent or treat HIV (e.g., PrEP or ART).

**Qualitative Data:** Non-numeric data, including information from sources such as narrative behavior studies, focus group interviews, open-ended interviews, direct observations, ethnographic studies, and documents. Findings from these sources are usually described in terms of underlying meanings, common themes, and patterns of relationships, rather than numeric or statistical analysis. Qualitative data often complement and help explain quantitative data.

**Quantitative Data:** Numeric information, such as numbers, rates, and percentages, representing counts or measurements suitable for statistical analysis.

**Race:** A client's self-reported classification of the biological heritage with which they most closely identify. Standard OMB race codes are applied.

**Recruitment:** The process by which persons are identified and invited to become participants in an intervention or other HIV prevention service, such as counseling, testing, and referral (CTR).

**Referral:** Directing clients to a service in person or through telephone, written, or other form of communication. Generally, a one-time event. Referral may be made formally from one clinical provider to another, within a case management system by professional case managers, informally through support staff, or as part of an outreach service program.

**Risk Behaviors:** Behaviors that can directly expose persons to HIV or transmit HIV, if the virus is present (e.g., sex without a condom, sharing unclean needles). Risk behaviors are actual behaviors by which HIV can be transmitted, and a single instance of the behavior can result in transmission.

**Risk Factors:** Factors based on observations of behaviors and contexts in which HIV is likely to be transmitted (e.g., lifetime number of sex partners, crack use, environmental factors like membership in a demographic group highly impacted by HIV, using expired-date condoms, Internet use). Influencing factors of behavioral risk refer to associations with risk (risk correlates and risk contexts), not behavioral determinants.

**Risk Reduction Activities (RRA) (formerly known as Health Education/Risk Reduction [HE/RR]):** Organized efforts to reach people at increased risk of becoming HIV-infected or, if

already infected, transmitting the virus to others. The goal is to reduce the spread of infection. Activities range from individual HIV prevention counseling to broad, community-based interventions.

**Risk Reduction Education:** Providing brief HIV facts on how HIV is transmitted, explanation of the HIV test procedure, information about the window period, and the meaning of the potential test results.

**Ryan White Treatment Modernization Act:** The name given to the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act when it was reauthorized in 2006. This is the primary federal legislation that addresses the needs of persons in the United States living with HIV/AIDS and their families. The original CARE Act was enacted in 1990.

**Social Determinants:** The economic and social conditions that influence the health of persons, communities, and jurisdictions and include conditions for early childhood development; education, employment, and work; food security; health services; housing; income; and social exclusion.

**Social Network:** A map of the relationships between persons, indicating the ways in which they are connected through various social familiarities, ranging from casual acquaintance to close familial bonds.

**Social Networking:** A recruitment strategy in which a chain of referrals is based on persons at high risk using their personal influence to enlist their peers they believe to be at high risk.

**Substance Abuse Services:** Services for the treatment and prevention of drug or alcohol use.

**Surveillance:** The ongoing and systematic collection, analysis, and interpretation of data about occurrences of a disease or health condition.

**Target Populations:** The primary groups of people or organizations that a program, strategy, or intervention is designed to affect.

**Technical Assistance (TA):** Advice, assistance, or training provided by the funding agency to address program development, implementation, maintenance, or evaluation.

**Transgender Female to Male (FTM):** An individual whose physical or birth sex is female but whose gender expression and/or gender identity is male.

**Transgender Male to Female (MTF):** An individual whose physical or birth sex is male but whose gender expression and/or gender identity is female.

**Transmission Risk:** A behavior that places the priority population at potential risk for HIV infection or transmission.