AMENDMENT I (as of 11/10/2010):

Pg 2: Deleted targeted countries

Pg 15: See Appendix G for an overview of the POG criteria for STD

Pg 20: Determined by individual audience needs (see Appendix E for course descriptions)

Pg 21: Reporting form (see Appendix F) documenting the consultation or training assistance request

Pg 28: And Observation (see Appendix E for course descriptions)

Pg 33: Strategies (SNS) and STD Program Management (STD PM) (see Appendix E for course

Pg 34: Level V activities, the PTC must complete a reporting form (see Appendix F)

Pg 43: Letter of support and collaboration from state or local health department on the

Pg 45: See Appendix D for an example table of contents.

Pg 48: Bio-sketches (2 page maximum, per staff and other key persons)

Pg 49: 501(c)(3) status for non-profits (if applicable) [Appendix G], Supporting Documentation (including model STD clinic records and floor plans) [Appendix H].

Pg 58: (1,2,3,or 4) as determined by individual audience needs. See Appendix E

Pg 70: Appendix E for course descriptions

Pg 86: Observation of clinical care at a PTC model STD clinic (see Appendix G for an

Pg 87: For this level of training, the PTC will complete a reporting form (see Appendix F) documenting

Pg 87: PTC will complete a reporting form (see Appendix F) documenting the training

Pg 89: Added Budget Narrative to Part IV of Table of Contents

Pg 89: Added to Appendix C: Biosketches of staff and other key persons of Table of Contents

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U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention (CDC)

Sexually Transmitted Diseases/Human Immunodeficiency Virus Prevention Training Centers

I. AUTHORIZATION AND INTENT

Announcement Type: New – Type 1

Funding Opportunity Number: CDC-RFA-PS11-1103

Catalog of Federal Domestic Assistance Number: 93.941

Key Dates:

Letter of Intent Deadline Date: November 1, 2010

Application Deadline Date: December 1, 2010, 5:00pm Eastern Standard Time

Authority:

This program is authorized under Sections 301 (a) and 318 of the Public Health Service Act [42 U.S.C. Sections 247b(k)(2)(d) and 247c(b)(4)], as amended

Purpose:

The purpose of this program is to create a National Network of Sexually Transmitted Disease (STD)/Human Immunodeficiency Virus (HIV) Prevention Training Centers (NNPTC). The Prevention Training Centers (PTCs) will provide high-quality curriculum development, training and training assistance for the diagnosis, treatment and prevention of Sexually Transmitted Diseases (STDs) and Human Immunodeficiency Virus (HIV) for health care professionals and prevention specialists across the United States. This program addresses the "Healthy People 2010" focus areas of Sexually Transmitted Diseases, HIV, and Public Health Infrastructure.

Executive Summary: Under this announcement, high-quality STD/HIV training translates state-of-the-art research findings into a range of training activities, resources, and materials with specific application to STD/HIV prevention programs and to health professionals who provide services to individuals affected by or at risk for STDs and HIV. To achieve this high-quality training, each PTC must be structured and function as a partnership between:

An organization that can bring state-of the-art research findings to the development of STD/HIV prevention education and training activities, resources, and materials for health care professionals, prevention specialists, and STD/HIV prevention programs, such as an academic institution; and an organization that can deliver the resulting STD/HIV prevention education and training activities, resources, and materials to health professionals, prevention specialists, and STD/HIV prevention programs, such as a state or local public health department.

Additionally, each PTC must be staffed by health professionals with demonstrated STD/HIV training and subject matter expertise. The PTCs must have the capacity and flexibility to provide STD/HIV prevention education and training activities, resources, and materials to a dynamic number and range of health care professionals, prevention specialists, and STD/HIV prevention programs that provide services to individuals affected by or at risk for STDs and HIV. The PTCs must have the capacity and flexibility to provide training to their U.S. coverage area as well as to contribute to the development, implementation, and evaluation of the national training plan. They are expected to work with one another individually and through the NNPTC, with the Centers for Disease Control and Prevention (CDC), with state and local STD/HIV programs, and with other STD/HIV training programs and stakeholders to be responsive to: changes in STD/HIV morbidity; advances in STD/HIV prevention, detection, and treatment; changes in the health care system that affect the delivery of STD/HIV care; and changes in the STD/HIV training needs of health care professionals and prevention specialists. PTCs will work in

collaboration with CDC to modify proposed program plans and budgets to ensure that PTCs are responsive to the changes of the areas listed above.

PTC training will target health care professionals and prevention specialists who serve populations that are disproportionately at risk for or affected by STDs and HIV and associated complications. Those population groups include African Americans, Hispanics, American Indian/Alaskan Natives, Asian and Pacific Islanders, women, adolescents, and young adults as noted in Healthy People 2010. Also included are groups considered at risk because of high-risk sexual behaviors, including men who have sex with men and persons with multiple sex partners.

Additionally, training activities should target health care professionals and prevention specialists working in settings accessed by population groups at disproportionate risk for STD/HIV. These settings include, community-based service organizations (CBOs), state and local health departments, schools and universities, hospitals or hospital-affiliated clinics, HMOs and managed care organizations, correctional facilities, military, Tribal/Indian Health Service agencies, community or non-profit health centers or clinics, Capacity-Building Assistance (CBA) providers and private group and solo practice medical care facilities. Training should facilitate integrated STD/HIV prevention efforts, including viral hepatitis prevention, and enhance STD/HIV prevention services that ultimately contribute to decreased STD/HIV morbidity and mortality in the United States.

Training and training assistance developed and delivered as part of this funding opportunity announcement should support and be congruent with the STD/HIV Essential Functions and Areas of Special Emphasis and relevant HHS/CDC policy, guidelines, programs, and initiatives, including:
The National Center for HIV, Viral Hepatitis, STD, and TB Prevention (NCHHSTP) Program Collaboration and Service Integration (PCSI) initiative:
http://www.cdc.gov/nchhstp/programintegration/Default.htm

The NCHHSTP Health Disparities and Health Equity initiative: http://www.cdc.gov/nchhstp/healthdisparities/

Program Operations Guidelines for STD Prevention (POG): http://www.cdc.gov/std/program/

STD Treatment Guidelines: http://www.cdc.gov/STD/treatment/

STD Laboratory Guidelines: http://www.cdc.gov/STD/LabGuidelines/default.htm

Diffusion of Effective Behavioral Interventions (DEBI) program: http://effectiveinterventions.org/

The CDC Recommendations for Partner Services Programs for HIV Infection, Syphilis, Gonorrhea, and Chlamydial Infection: http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5709a1.htm

Division of Human Immunodeficiency/Acquired Immunodeficiency Diseases Prevention (DHAP) initiative, Act Against AIDS (AAA), and the African American Leadership Initiative: http://www.cdc.gov/hiv/aaa

The CDC Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health Care Settings: http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5514a1.htm

The CDC, the Health Resources and Services Administration (HRSA), the National Institutes of Health (NIH), and the HIV Medicine Association of the Infectious Disease Society of American (IDSA) Guidelines for Incorporating HIV Prevention into the Medical Care of Persons Living with HIV http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5212a1.htm

The PTCs will be structured as four distinct but related Parts:

Part I: Between four and eight centers will be funded to provide training in STD clinical and laboratory services, HIV prevention in care, and HIV biomedical prevention interventions.

Part II: Between two to four centers will be funded to provide training in behavioral interventions and STD/HIV program support.

Part III: Between two and four centers will be funded to provide training in STD/HIV partner services and STD/HIV program support.

Part I, II, and III PTCs will be geographically located to ensure the provision of adequate training in all areas of the United States (U.S.). Each of the U.S. geographic quadrants defined in Appendix A will be served by at least one Part I PTC, one Part II PTC, and one Part III PTC.

Part IV: One center will be funded in conjunction with a Part I, II, or III PTC to provide coordination and support for the NNPTC and nationally focused training activities, initiatives and projects. Applicants for Part I, II, or III may apply for additional funds to serve as the NNPTC National Resource and Coordinating Center. The Part IV Center will be selected from among the applicants funded for Part I, II, and/or III that applied for Part IV.

The Part I PTCs will provide high-quality training on STD clinical and laboratory services and HIV prevention in care. Part I training must be responsive to changes in STD/HIV morbidity, advances in STD/HIV prevention, detection, and treatment (including HIV biomedical prevention interventions); changes in the health care system that affect the delivery of STD/HIV care; changes in the STD/HIV training needs of health care professionals and prevention specialists. The target audience for Part I training is practicing health care providers in the public and private sectors, especially those working with the populations disproportionately at risk for or affected by STD/HIV as noted previously. The specific methods of training should be based on the U.S. coverage area needs and could include didactic, skills-building, clinic-based experiential, educational clinical consultation, and training assistance at the organization and individual provider level. The geographic U.S. coverage area for each Part I PTC will be determined by the location and the number of centers funded (See Appendix A for map showing HHS regions and quadrant configurations.) The Part I PTCs will be expected to collaborate with each other and CDC to develop, implement, and evaluate a national

clinical training plan that may require training outside of their U.S. coverage areas. Each Part I PTC will be expected to collaborate with the Part II and Part III PTCs serving their assigned U.S. coverage area to assess and address the STD/HIV training needs of their U.S. coverage area; as well as with the Centers comprising the NNPTC to assess and address national-level STD/HIV training needs.

Part II PTCs will provide high-quality development of training curricula, other development of training, delivery of training, other training assistance and training assessment on social and behavioral interventions that have shown evidence of reducing risky behaviors associated with the transmission of HIV infection. These trainings may also include an overview of structural interventions, biomedical interventions and evidence based approaches to the integration of social, behavioral, and biomedical prevention services. The Part II PTCs also will provide program support training that strengthens public and private HIV prevention programs. The specific type(s) of training provided should be based on need and could include training in such areas as program management, cultural competency, and program evaluation.

The target audience for Part II training is professionals, including health educators, counselors, community-based providers, clinicians, HIV prevention program managers, and others responsible for designing or implementing HIV behavioral prevention interventions, especially to staff in agencies that reach populations disproportionately affected by HIV. The geographic U.S. coverage area is to be one of the NNPTC quadrants. The Part II PTCs will be expected to collaborate with each other and CDC to develop a national training plan that could require training across quadrants.

Each Part II PTC will be expected to collaborate with the Part I and Part III PTCs, serving their assigned U.S. coverage area to assess and address regional and national level STD/HIV training needs. PTCs also will be expected to work with partners who include a training coordination contractor, an agency which provides training coordination for the Diffusion of Effective Behavioral Interventions (DEBI) project, and

CBA provider(s) designated by CDC to provide technical assistance (TA) and other capacity building services to agencies implementing the designated interventions.

The Part III PTCs will provide high-quality training that focuses on STD/HIV partner elicitation, notification, and referral and on STD/HIV counseling and case management in accordance with the CDC Recommendations for Partner Services Programs for HIV Infection, Syphilis, Gonorrhea, and Chlamydial Infection. Additionally, the Part III PTCs will provide program support training that strengthens state and local health department STD and HIV prevention programs and should include training in such areas as program management, surveillance and data management, outbreak response planning, and field safety. The training provided by each Part III PTC should be based on the training needs of their U.S. coverage area. The target audience for Part III training is professionals who work with STD/HIV- infected individuals and their partners. These professionals work in settings such as state and local health department STD/HIV programs, community-based organizations, clinics, and substance-abuse treatment and prevention programs. The geographic U.S. coverage area for each Part III PTC will be determined by the location and the number of centers funded (See Appendix A for map showing HHS regions and quadrant configurations.) The Part III PTCs will be expected to collaborate with the other Part III PTCs and CDC to develop, implement, and evaluate a plan for meeting national partner services and program support training needs that may require training outside of their geographic U.S. coverage area. Each Part III PTC will be expected to collaborate with the Part I and Part II PTCs serving their U.S. coverage area to assess and address STD/HIV training needs for the U.S. coverage area; as well as with the Centers comprising the NNPTC to assess and address national-level STD/HIV training needs. They will also be expected to collaborate with the other Part III PTCs and CDC to develop partner services and program support training activities and resources.

The Part IV (NNPTC National Resource and Coordinating Center) will provide coordination and support for NNPTC and national-level activities, initiatives, and projects, including, the NNPTC website, marketing, continuing education accreditation, NNPTC resource clearinghouse, NNPTC committees and workgroups, NNPTC meetings,

and national collaborative activities. The Part IV will be expected to coordinate and support NNPTC activities on behalf of the Part I, Part II, and Part III PTCs. The Part IV PTC will be expected to coordinate and support the activities of the Part I, Part II, and Part III PTCs from a national and not a regional, perspective.

This program addresses the "Healthy People 2010" focus areas of Sexually Transmitted Diseases, HIV, and Public Health Infrastructure.

Program Collaboration and Service Integration: This program also supports the NCHHSTP strategy calling for Program Collaboration and Service Integration (PCSI). PCSI promotes improved comprehensive services at the client level though enhanced collaboration at the health department jurisdiction level and at the organization program level, thereby offering opportunities to (1) increase efficiency, reduce redundancy, and eliminate missed opportunities; (2) increase flexibility and better adapt to overlapping epidemics and risk behaviors; and (3) improve operations by sharing data.

Elimination of Health Disparities: This program supports efforts to improve the health of populations disproportionately affected by HIV/AIDS, viral hepatitis, STDs and TB by maximizing the health impact of public health services, reducing disease prevalence, and promoting health equity consistent with the National HIV/AIDS Strategy.

Health disparities in HIV, viral Hepatitis, STDs, and TB are inextricably linked to a complex blend of social determinants that influence which populations are most severely affected by these diseases. Health equity is a desirable goal that entails special efforts to improve the health of those who have experienced social or economic disadvantage. See Appendix C for definitions of health disparity, social determinants of health and health equity.

Programs should use data, including social determinants data, to identify communities within their jurisdictions that are disproportionately affected by HIV, viral hepatitis, STDs and TB and related diseases and conditions, and plan activities to help eliminate

health disparities. In collaboration with partners and appropriate sectors of the community, programs should consider social determinants of health in the development, implementation, and evaluation of program specific efforts and use culturally appropriate interventions that are tailored for the communities for which they are intended.

Performance Goals: Measurable outcomes of the program will be in alignment with one (or more) of the following performance goal(s) for the CDC National Center for HIV, STD, Viral Hepatitis and TB Prevention (NCHHSTP):

- Strengthen the capacity nationwide to monitor the HIV epidemic, develop and implement effective HIV prevention interventions, and evaluate prevention programs.
- Decrease the number of persons at high risk for acquiring or transmitting HIV infection.
- Increase the proportion of HIV-infected persons who know they are infected.
- Increase the proportion of HIV-infected persons who are linked to appropriate prevention, care, and treatment services.
- Strengthen the capacity nationwide to monitor the epidemic, and develop and implement effective HIV prevention interventions
- Reduce STD rates by providing Chlamydia and gonorrhea screening, treatment, and partner treatment to 50 percent of women in publicly funded family planning and STD clinics nationally.
- Reduce the incidence of primary and secondary (P&S) syphilis.
- Reduce the incidence of congenital syphilis.
- By 2010, increase by 13% the proportion of HIV-infected people who know they are infected, as measured by the proportion diagnosed before progression to AIDS (Baseline: 76 % in 2000; target for 2010: 85 percent).
- By 2010, increase the proportion of HIV infected people who are linked to appropriate prevention, care, and treatment services to at least 80%, as measured

by those who report having received some form of medical care within three months of their HIV diagnosis (2001 Baseline: 79%).

- By 2010, reduce the number of new HIV infections in the US by 25%, as measured by a reduction in the number of HIV infections diagnosed each year among people under 25 years of age; from 2,100 in 2000 to approximately 1,600 in 2010.

Measurable outcomes of the program will focus on the education and training activities that increase STD and HIV knowledge, skills, and practices of health professionals in areas that support the attainment of one or more of the NCHHSTP performance goals listed previously.

Measurable outcomes of the program could be amended during the project period if necessary to respond to changes in STD/HIV morbidity; advances in STD/HIV prevention, detection, and treatment; changes in the health care system that affect the delivery of STD/HIV care; changes in the STD/HIV training needs of health care professionals and prevention specialists; or changes in NCHHSTP performance goals.

This announcement is only for non-research activities supported by CDC. If research is proposed, the application will not be reviewed. For the definition of research, please see the CDC Web site at the following Internet address:

http://www.cdc.gov/od/science/regs/hrpp/researchDefinition.htm

II. PROGRAM IMPLEMENTATION

Recipient Activities:

General Awardee Activities

All applicants are required to implement activities and develop Specific, Measurable, Achievable, Realistic, and Time-Phased (SMART) objectives and timelines.

A Administration/Managerial Capacity **(Parts I, II, III, IV)**

Provide the following key personnel for the program: one coordinator to serve as a single point of contact for this award , and who will be responsible for the planning, day-to-day operations, and administrative duties related to all training activities (if applying for Parts I, II, III and/or IV); a Medical/Clinical Director (if applying for Part I); a Behavioral Interventions Training Director (if applying for Part II); a Partner Services Training Director (if applying for Part III); a National Resource Director (if applying for Part IV) a data coordinator who will be responsible for transmitting training data from all Parts to CDC (if applying for Part I, II, III and/or IV).

Centers that are funded for more than one training Part are expected to coordinate administrative and training duties and responsibilities, as appropriate, to function as one entity and, avoid duplication of labor, services, or materials. The PTCs are required to attend national meetings and conferences as directed by CDC (e.g. HIV Prevention Leadership Conference (HPLS), National STD Conference, and NNPTC meeting) and other meetings deemed appropriate by CDC to assist with meeting goals of this FOA.

B NNPTC Participation **(Part I, II, III)**

Work with CDC and the PTC Part IV to support and maintain the NNPTC. Delegate one representative from Parts I, II, and/or III, as applicable, to serve on the NNPTC Steering Committee. Participate in NNPTC standing committee (e.g., marketing, evaluation, curriculum, enduring materials) and ad-hoc workgroup activities, including membership in at least one of the standing committees during each budget period of the project period. The grantee is required to participate in NNPTC national-, quadrant-, and Part-specific meetings, conferences, and conference calls. NNPTC meetings that travel is required will include, at minimum, a PTC grantee orientation meeting, organized and led by CDC, to be held within six weeks of the award date and NNPTC annual meetings in the second and third project years. Support and participate in NNPTC collaboration with national stakeholders, including the Federal Training Center Collaboration (FTCC), National

Coalition of STD Directors (NCSD) and the National Alliance of State and Territorial AIDS Directors (NASTAD). Participate in other activities that support the NNPTC such as assisting with marketing events and initiatives, enlisting faculty to participate in the clinician symposium initiative (a clinician speakers' bureau on STD/HIV topics for selected professional meetings and conferences), participating in establishing standards for developing and evaluating eLearning and other technology-based training activities to ensure that activities are complementary and non-duplicative, and serving as chair of the NNPTC steering committee, other standing committees, or ad-hoc workgroups. Collaborate with CDC and the PTC Part IV: to plan and host NNPTC annual meetings; to obtain and maintain CE accreditation for training events and resources when applicable; to develop and conduct national-level training activities, projects, and initiatives; and to maintain the NNPTC Website with up-to-date information on course offerings, course schedules, training resources, and other information deemed appropriate by CDC and the NNPTC steering committee.

C Key Organizational Collaborations **(Part I, II, III)**

Develop and maintain collaborations and linkages with other PTCs, CDC, STD/HIV training and service delivery programs, and other training stakeholders to determine and respond to ongoing and emerging national and U.S. coverage area training needs; and to ensure that STD/HIV prevention training provided by the PTC is available, well-coordinated, and addresses the training needs of the entire U.S. coverage area. The following STD/HIV prevention training programs and stakeholders should be included when appropriate in collaborative efforts: PTCs, other federal training center programs {e.g., the Health Resources and Services and Administration (HRSA), AIDS Education Training Centers (AETCs); the Office of Population Affairs (OPA), Regional Training Centers (RTCs); the Substance Abuse Mental Health Services Administration (SAMHSA), Addiction Technology Transfer Centers (ATTCs); CDC's, Viral Hepatitis Networking, Education and Training (VHNET) grantees; CDC's, TB Regional Training and Medical Consultation Centers (RTMCCs); state and local health department STD and HIV programs, State Primary Health Care Associations, Federally Qualified Community Health Centers, Rural Health Centers, correctional facilities, university and college

student health services, health care provider professional associations, local community based organizations, local primary care providers and HMO/managed care organizations, local academic institutions and those stakeholders that emerge as a result of health reform. Applicants should document the existence of these stakeholders in their U.S. coverage area and demonstrate how they plan to collaborate to ensure maximum effective use of resources. Collaborative activities might include, but are not limited to, sharing needs assessment data, curricula, resources and materials, conducting joint training needs assessments, co-sponsoring training events and activities, and co-developing educational offerings and materials.

Develop and maintain liaisons with national, regional, state, or local STD/HIV prevention programs and professional organizations to identify ongoing and emerging training needs and to design and deliver training programs that avoid redundancy and provide training that is most relevant to the greatest needs of STD/HIV prevention programs.
Collaborate with experts in the community and in graduate schools, as necessary, to design or develop state-of-the-art training needs assessments, educational objectives, curriculum content, delivery methods, and course evaluations.

Establish innovative arrangements with universities for student academic involvement in PTC activities (e.g., graduate assistantships or internships).
Collaborate with health departments, managed care organizations, professional organizations, community-based organizations (CBOs), and non-governmental organizations (NGOs) in the U.S. coverage area to serve as a resource for dissemination of STD/HIV information to health care providers or prevention specialists in public and private settings.

D Training Program **(Part I, II, III)**
Develop and deliver innovative, high-quality STD/HIV training and educational courses, materials, and other activities that: meet the STD/HIV training needs of public and private sector health professionals relevant to the Part for which you are applying; are evidence- and science-based and congruent with CDC guidelines, programs, and

initiatives listed previously; are likely to result in the improved practice of health professionals caring for persons at risk for or infected with STD/HIV; and employ interactive training modalities designed for the adult learner.

Utilize a range of training methods, approaches, and modalities appropriate for the training content and the training audience. The PTC must have the capacity to develop and deliver training that utilizes: training methods (See Appendix B for detailed definitions of training methods.) including didactic training (Level I), such as grand rounds, lectures, presentations, skills-building training (Level II), such as case studies, role play, simulated patients, microscopy skills), hands-on preceptor training (Level III) when applicable, educational consultation (Level IV) when applicable, and training assistance at the organization and individual provider level (Level V) when applicable; training approaches that include instructor-led and self-study training; and training modalities that include in-person, distance-based, internet-based and other technology-based learning.

Employ faculty, trainers, and preceptors that have appropriate credentials and demonstrated expertise in STD/HIV prevention training.

Utilize instructional designers and curriculum developers that have appropriate credentials and demonstrated expertise in designing and developing training curricula, courses and other activities for adult learners and professional audiences, including designing and developing technology-based training.

Utilize evaluation specialists that have appropriate credentials and demonstrated expertise in developing and implementing evaluation of training activities. Funded applicants will be required to collaborate on instructional design, curriculum development and evaluations activities as appropriate to avoid duplication of labor, services, and materials.

Utilize adequate training facilities and equipment; and, if applying for Parts I or III, access to a model STD clinic. A model STD clinic is one that meets the criteria for clinic

operations described in the CDC Program Operations Guidelines for STD Prevention (POG). See **Appendix G** for an overview of the POG criteria for STD clinic operations.

Develop and produce all print handouts and job aid materials in a coordinated manner to avoid duplication of labor, services, and materials.
Develop and implement a training plan designed to meet the STD/HIV training needs of health professionals relevant to the Part for which you are applying in all states of the U.S. coverage area. An initial training plan will be required as part of the application for this funding opportunity. Specific Training Program activities for each Part are described in greater detail in the Part-specific activities.

The PTC in collaboration with CDC will update and revise the initial training plan to reflect ongoing and emerging training needs in the U.S. coverage area. The PTC will review its training plan at least annually with its key stakeholders or advisory committee (identified in the application) to ensure that the plan will meet the training needs of the U.S. coverage area. The updated plan will be required for each subsequent continuation application for this funding opportunity. The PTC will be required to provide quarterly training program status reports for CDC review and technical monitoring.

E Continuing Education and Course Management **(Part I, II, III)**

Work with CDC and the other PTCs to establish and maintain a centralized continuing education system coordinated through the PTC Part IV. The purpose of the system is to accredit PTC training activities and resources and to provide continuing medical education (CME), continuing nursing education (CNE), and continuing education unit (CEU) credits that meet the needs of most course participants.

The PTC will be expected to utilize the centralized continuing education system coordinated through the PTC Part IV to accredit relevant courses and other training activities and to award CME, CNE, and other CEU for participants. If necessary, the

PTC will be expected to use an alternative continuing education system until the centralized system is established.

Maintain a course registration database, including required CME, CNE, and CEU documentation. Report, on time, the training events and student demographic data for inclusion in the NNPTC database per CDC reporting protocol. Maintain a current 6-12 month schedule of course offerings. The course schedule should be posted on the NNPTC and the PTC websites and should be available in brochure or flyer format for distribution and marketing purposes.
When appropriate, submit planned group training to the Capacity Building Branch Training Events Calendar (TEC) or other designated mechanism for dissemination to training participants and partners.

Develop and use a quality assurance strategy that ensures the delivery and tracking of high-quality training and curriculum design.

F Evaluation Plan **(Part I, II, III)**

Conduct on-going process monitoring, process evaluation, and outcome monitoring of all courses, both independently and in conjunction with CDC, the NNPTC, or both. Determine appropriate process indicators (e.g., trainee demographics, ratings of course quality, relevance to practice); short-term training outcome indicators (e.g., changes in knowledge and skills); and medium-term training outcome indicators (e.g., application of knowledge and skills to practice or delivery of services) in collaboration with CDC and the NNPTC.

Measure process and outcome indicators for courses either independently or together with other PTCs, CDC, and/or the NNPTC. Develop a plan to utilize course evaluation data to provide continuous quality improvement of trainings. It is expected that the PTC will work with CDC and the other PTCs to coordinate and standardized evaluation

activities when appropriate to avoid duplication of labor, services, or materials; and to avoid inconsistencies or gaps in evaluation activities.

PTCs will work in collaboration with CDC - to modify activities and budgets during the project period, if necessary, to respond to: changes in STD/HIV morbidity; advances in STD/HIV prevention, detection, and treatment; changes in the health care system that affect the delivery of STD/HIV care; changes in the STD/HIV training needs of health care professionals and prevention specialists; or changes in CDC, NCHHSTP, DSTDP, or DHAP performance goals or initiatives.

Training Program Plan

The training program plan recipient activities are described separately for each part. Please refer to the application section for the part(s) for which you are applying.

Part I

The Part I PTC will provide training in STD clinical and laboratory services and HIV prevention in care.

a. Training Program

The PTC will be expected to devote approximately 70% of its effort and resources to the provision of clinical training for its designated U.S. coverage area (regional training activities) and 30% of its effort and resources to national training activities undertaken in collaboration with the other Part I PTCs, the Part IV PTC, and CDC (such as curriculum development or other national training initiatives).

The PTC will be expected to provide training in STD clinical care and HIV prevention in care to a geographic U.S. coverage area assigned by CDC. The PTC will be expected to develop and deliver training that is responsive to changes in STD/HIV morbidity, advances in STD/HIV prevention, detection, and treatment (including HIV biomedical prevention interventions); changes in the health care system that affect the delivery of STD/HIV care; changes in the STD/HIV training needs of health care professionals and

prevention specialists. The geographic U.S. coverage area for each Part I PTC will depend on the number of centers funded, the location of funded centers, and criteria that include, current STD/HIV morbidity, population size and demographics, and the costs associated with traveling to states/territories that are not located within the contiguous United States (e.g., Alaska, Hawaii, Pacific Islands, Puerto Rico, and U.S. Virgin Islands).

Specific U.S. coverage areas for each Part I PTC will be determined by CDC in consultation with the funded centers prior to the award date. It is expected that each funded center will be responsible for a geographic U.S. coverage area comprised of between four and twelve states/territories. The composition of each Part I PTC geographic U.S. coverage area will be based on the final awardee selection, location of awardees, and criteria as referenced above. CDC will work with the PTC to assign specific U.S. coverage areas before the start of the project period to ensure equitable distribution of the regional training workload across the Part I PTC grantees.

The PTC will be required to develop a sample training plan, describing regional training activities for a nine-month period, as part of the application for this funding opportunity. For the purposes of the application only, the applicant should develop a plan to provide STD clinical training, including the STD Intensive (includes Part-Time STD Intensive, Flex STD Intensive, Advanced STD Intensive, Adolescent STD Intensive, and STD Practicum), STD Laboratory and Microscopy Methods, STD Updates for Clinicians, and Ask-Screen-Intervene (ASI) HIV prevention in care training during the period of July 1, 2011 to March 31, 2012 for the HHS region in which the applicant is located. The sample plan should include a minimum of five STD Intensive courses, two STD Laboratory and Microscopy Methods courses, three STD Update for Clinicians courses, and three presentations of the ASI curriculum in its entirety (modules 1-4) to the same participants (using flexible approaches over time or in single long presentations), one ASI TOT, one overview ASI, four presentations of single ASI module (1,2,3,or 4) as determined by individual audience needs. (see Appendix E for course descriptions).

Each PTC will be expected to devote approximately 70% of its effort and resources to the provision of training respective to its final designated U.S. coverage area, so the sample regional training plan should reflect an equivalent level of effort and resources for illustrative purposes. The sample training plan should be based on an assessment of the training needs of the HHS region in which the applicant is located (see evaluation criteria for complete description of needs assessment elements). Key stakeholders, including clinicians, organizations, and institutions that provide care for populations in the region disproportionately at risk for or affected by STD and HIV, should be consulted, interviewed, or surveyed to identify training needs.

Each PTC will be required to use a variety of training methods (see Appendix B for training method definitions) in the design and delivery of its courses and curricula. During the first project year, overall, approximately 10-20% of PTC training activities should use didactic methods (Level I), approximately 30-40% should use interactive skills-building methods (Level II), approximately 30-40% should use hands-on clinical methods (Level III); 10% or less should use educational clinical consultation (Level IV); and 10% or less should use training assistance methods (Level V). Most courses and curricula will use multiple training methods. For example ASI is trained using approximately 60% Level I methods and 40% Level II methods; while a typical STD Intensive course is trained using approximately 30% Level I methods, 20% Level II methods, and 50% Level III methods.

The PTC must report CDC-required event and participant data for Level I, II, and/or III training activities. For some Level I training events, participant registration might be waived (e.g., grand rounds, STD/HIV educational presentations for community groups). The PTC must receive approval from CDC in order to waive participant registration for a given Level I training event.

The PTC must work in consultation with CDC prior to conducting any Level IV or V training activities. For Level IV and V activities, the PTC must complete a reporting form

(see Appendix F) documenting the consultation or training assistance request, the consultation or assistance provided and the outcomes of the activity.

Percentages for use of each training method are estimated ranges for the first project year. The percentage of each course or curriculum that is taught using a particular training method will be contingent on the content, the skills to be learned and applied, and the needs of the audience for that specific course or curriculum. In the second and third project year the training method proportions could be revised to optimize the ability of the PTC to meet training needs in its coverage area.

The sample regional training plan should describe training courses and other educational resources and activities to be developed and delivered during this nine-month period of the project. The sample plan should include: number and type of the regional training events and activities to be developed and/or delivered; the training need (s) addressed by each event or activity; target audiences for the events and activities; the number and type of health professionals expected to participate in the events or activities; partners collaborating in the events and activities; strategies for reaching priority clinicians (those serving populations disproportionately at risk for or affected by STD/HIV in the U.S. coverage area); and strategies for reaching clinicians throughout the entire U.S. coverage area. The sample training plan should indicate the overall proportion of training activities that will be delivered using each of the five levels of training methods. The sample training plan should include a sample regional marketing plan.
The PTC must indicate how the components of the sample training plan address the training needs identified in the needs assessment.

Regional training strategies may include, but are not limited to, providing instructor-led and self-study training activities; establishing training sites in different states within the designated U.S. coverage area; establishing scholarship programs, preceptorship programs, and clinician consultation services and training assistance services; using in-person, distance-based, Internet-based and other technology-based learning approaches;

disseminating print- or Internet-based materials; conducting joint training activities with other stakeholders; and conducting on-site training and training assistance activities. The PTC must attend the PTC orientation meeting to be held within six weeks of the start of the project period. The orientation meeting will be organized and led by CDC. The Part I-specific session of the PTC orientation meeting will have two main objectives: reviewing regional U.S. coverage areas and initiating development of the collaborative national clinical training plan. The first three months of the first project year (April – June 2011) will be devoted to revising regional training plans (including regional marketing plans), updating national curricula, developing the national clinical training plan, and preparing to implement it.

The assigned regional U.S. coverage area for some grantees may differ from the HHS region for which the grantee developed their sample training plan. In such cases, grantees will share regional training needs assessment findings to ensure that each grantee has the requisite information to revise their sample plan to address the training needs of their assigned area. The PTC will work in collaboration with CDC to revise their sample training plan to describe both the regional and national level activities they will be engaged in during the first project year. ,A date for the revised training plan submissions will be finalized during the orientation meeting. Grantees will be expected to begin implementing their regional training activities no later than July 1, 2011.

In collaboration with CDC the PTC will update and revise the regional training plan to reflect on-going regional training needs in regard to STD clinical care, HIV prevention in care, and HIV biomedical prevention interventions. The PTC should review its regional training plan at least annually with its advisory committee to ensure that the plan will meet the training needs of the U.S. coverage area. The PTC will be required to submit the updated plan for CDC review and approval as part of each subsequent continuation application for this funding opportunity.

The PTC will be required to collaborate with the CDC, the other Part I PTCs, and the Part IV PTC to evaluate, revise and update the national clinical training plan and curricula to

respond to ongoing national training needs in regard to STD clinical care, HIV prevention in care, and HIV biomedical prevention interventions. Revisions and adaptations should be culturally appropriate and should address the transmission dynamics specific to the relevant target communities and networks. The PTC will be required to submit a narrative describing their roles, duties, and responsibilities in carrying out national training activities for CDC review and approval as part of each subsequent continuation application for this funding opportunity. The PTC will be required to provide quarterly training program status reports for CDC review and technical monitoring.

The PTC will be expected to develop and deliver training that is responsive to changes in the delivery of primary health care that may occur as a result of the passage of federal health reform legislation or other health reform measures. In particular, the PTC will be expected to respond to changes in STD clinical care, HIV prevention in care, and HIV biomedical prevention interventions. The PTC will be expected to have the flexibility and capacity to effectively respond to needs of specific audiences and training needs brought about by the aforementioned changes. The PTC will be expected to work with CDC to reassess U.S. coverage area training needs and revise their regional training program (i.e., training audiences, activities, resources, types, methods, modalities, collaborative partners, etc) to ensure that, in a changing health care environment, training in STD clinical care, HIV prevention in care, and HIV biomedical prevention interventions is relevant, current, and accessible to clinicians serving populations disproportionately at risk for or affected by STD/HIV. The PTC will be expected to work together with CDC, the other Part I PTCs, and the Part IV PTC to evaluate and update the national clinical training plan to ensure that it is responsive to new or emerging training needs in a changing health care environment.

The PTC will be required to work with CDC, the other Part I PTCs and the Part IV PTC throughout the project period to reassess their regional training program and the national clinical training plan to ensure that PTC training activities are in support of and congruent

with the findings, conclusions and recommendations of t consultations on STD Prevention Training for the 21st Century and on STD Prevention and Health Reform.

In the event of changes in behavioral and biomedical science related to HIV prevention, the PTC will be required to work with CDC, the other Part Is, Part IIs, Part IIIs and the Part IV to develop and deliver training that promotes the use and supports the interplay of behavioral interventions with biomedical prevention modalities.

The PTC will be required to participate in conference calls and meetings (i.e., PTC Orientation meeting, NNPTC annual meetings, Part I PTC training program planning meetings, standing and ad hoc Part I PTC calls) with CDC and the other Part I PTCs during the project period to ensure that the U.S. coverage area and national training programs are coordinated and responsive to changes in the health care system and to the consultation reports. During the first and second project years, the PTC might be expected to participate in up to two meetings per project year to develop, monitor, and evaluate the national clinical training plan, one of which would be scheduled in conjunction with the PTC Orientation meeting (Year 1) or NNPTC annual meeting (Year 2).

The PTC will be required to document all training efforts; including, training activities, logistical support, development, revision, and implementation of curricula, collaborative functions and other related activities. This will be considered when determining the deliverables and according to the amount of funding and assessments of regional and national training and training assistance needs.

The PTC will be required to establish and maintain an advisory committee to ensure that the PTC regional training activities are responsive to the training needs of the U.S. coverage area. The PTC advisory committee should provide key input to the U.S. coverage area training needs assessments, review each annual training plan, and review training activity content and proposed new training activities. The advisory committee should be representative of the entire U.S. coverage area. The advisory committee should

be representative of the providers, organizations, and facilities that provide clinical care for populations in the U.S. coverage area most at risk for or affected by HIV/STDs and that provide STD and HIV care on a routine and regular basis in the U.S. coverage area. The advisory committee should include representation from a variety of stakeholders such as state and local STD programs, HIV care providers, regional/state/local chapters of professional organizations (i.e., physician groups, mid-level provider groups, nurses groups) and facilities that provide clinical care for populations most at risk for or affected by STDs and HIV (Federally qualified community health centers, private practice offices, HMOs/managed care organizations, hospitals, correctional facilities, family planning clinics, Indian Health Services facilities, etc) in the U.S. coverage area.

The PTC must provide a letter of agreement to participate in the PTC advisory committee from each committee member. The PTC must provide a plan for regularly soliciting input from their Advisory Committee on the training needs of the U.S. coverage area and the PTC training program. The PTC will be expected to revise the composition of its Advisory Committee when revising its training plan if needed.

b. Collaborations

Collaborate with other Part I, II, and III PTCs to ensure that national Part I curricula (e.g. the NNPTC Core Curriculum for Clinical Training Courses, the NNPTC STD Case Studies, *Ask, Screen, Intervene: Incorporating HIV Prevention Into the Medical Care of Persons Living with HIV* curriculum) incorporate evidence-based content, are congruent with the most recent CDC guidelines, support CDC policies, programs, and initiatives, and that all revisions incorporate lessons learned from previous training cycles.

Collaborate with other Part I, II, and III PTCs, FTCC partners, and other training stakeholders as appropriate to develop innovative national training activities utilizing new and emerging training technologies, methods and modalities (e.g., eLearning, webinars, podcasts, social networking sites).

Collaborate with the Part II and Part III PTCs, FTCC partners, and other training stakeholders in the designated U.S. coverage area to assess and meet the clinical training needs of health professionals in the U.S. coverage area.

Collaborate with other Part I, II, and III PTCs, the Part IV PTC, and CDC to ensure that NNPTC website maintenance, marketing and continuing education activities are performed in an efficient and effective manner.

Collaborate with the other Part I PTCs, the Part IV PTC, and CDC in the development and implementation of a national STD clinical training plan.

Collaborate with the other Part I PTCs, the Part IV PTC, and CDC to develop and implement a national Part I marketing plan. The national Part I marketing plan should include strategies to reach organizations and professional associations with access to clinicians working with populations disproportionately affected by or at risk for STDs and HIV. If needed, the PTC may consult with marketing experts to determine the most cost-effective marketing strategies.

Collaborate with other Part I, Part II, and Part III PTCs, the Part IV PTC, and CDC to establish standards for the development and evaluation of eLearning activities and other technology-based training activities.

Part II

The Part II PTC will provide training, training assistance, evaluate trainings, and collaborate with others in the provision of trainings on behavioral HIV prevention interventions following the protocol below:

a. Training Program

Develop and implement a U.S. national training plan, particularly to support the CDCs Diffusion of Effective Behavioral Interventions (DEBI) Program. National-level courses that support the DEBI Program include, but are not limited to: Healthy Relationships;

Many Men, Many Voices; CLEAR; Project START; Partnership for Health; Personalized Cognitive Counseling; Sister-to-Sister; Community PROMISE; Comprehensive Risk Counseling Services (CRCS); Selecting Evidence-Based Interventions; Bridging Theory and Practice; Adapting EBIs using Focus Groups; and Adapting EBIs using Interviews and Observation (see Appendix E for course descriptions). An initial training plan should be based on an assessment of U.S. coverage area training needs, as identified by state or local health department STD/HIV programs and other key stakeholders. About eighty percent of courses to be taught should be devoted to national-level standardized behavioral intervention courses that support CDC's DEBI program. About twenty percent of courses to be taught should be devoted to program support training tailored to the needs of health professionals and STD/HIV program staff including, introduction and application of theories and models to effective individual, group, and community-level STD/HIV prevention interventions; and recruiting and maintaining prevention partnerships with affected communities. Additionally, of all courses and events taught, 20% should use Level I Didactic, 70% Level II Interactive training methods, and 10% Level V training assistance methods (see Appendix B for detailed definitions of training methods).

This training plan should describe training courses and other educational resources and activities to be delivered during the first year of the project. The plan should include the description of any new training courses and training activities that will be developed; the target audience for the training; partners collaborating in the development of the training; and the training need that the new training will address.

The plan should include strategies for reaching potential trainees in all of the U.S. coverage area. These strategies could include, but are not limited to, developing satellite training sites in different states within the U.S. coverage area; initiating scholarship programs; providing distance-learning courses; developing print- or Internet-based self-study materials; conducting joint training activities with other stakeholders; or sending trainers to conduct on-site training activities. The plan should include strategies for reaching potential trainees serving populations disproportionately affected by HIV. The

initial training plan should include the number and type of training courses and other educational activities (distance learning events, lectures to health professional organizations and community groups, conference presentations, etc.) to be delivered; partners collaborating in those events; and the number and type of health professionals expected to attend those events.

Post-award each award recipient will collaborate with CDC and other Part II PTCs to develop a national training plan that will determine the number, type, and delivery of national- and quadrant-specific behavioral intervention and program support courses needed to meet national training needs and be responsive to substantive input from an advisory committee of training stakeholders. Advisory committee members and stakeholders should include quadrant representatives from city, county, state and territorial health departments, Capacity Building Associations funded by the DHAP's Capacity Building Branch as well as behavioral scientists who have developed evidence-based interventions diffused by CDC. The national training plan will require review and approval from CDC prior to implementation.

Provide trainings as will be determined, making use of the initial and national training plans, in the post-award cooperative agreement process in collaboration between the grantee and CDC based on defined training need and final award amount.

Announce the availability of trainings on respective Web sites, effectiveinterventions.org, and Training Events Calendar (TEC). The PTCs will ensure that marketing of training is directed to providers and funders of providers relevant to each intervention model selected for training.

Screen the readiness of organizations interested in implementing selected behavioral HIV prevention interventions. In order to appropriately manage the diffusion of the interventions, it is important to screen prospective participants. PTC staff will use a clinic readiness assessment tool, available at www.effectiveinterventions.org. Contact and agency information on organizations requesting training from Training Coordination Contractor will be forwarded by Training Coordination Contractor to PTC grantees so

they can start screening and building training plans tailored to each organization for those screened as eligible.

Conduct registration of participants for each training event.

Create intervention resources and support materials as needed for the behavioral HIV prevention interventions trainings to be placed on www.effectiveinterventions.org as requested by CDC.

Provide support for each PTC staff person designated to train selected behavioral HIV prevention intervention to complete a training of facilitators and a training of trainers as needed to develop competency to provide the training.

b. Assessment

Ensure that participants complete registration forms, participant information and course evaluation data that include CDC-required data elements for trainings. Submit and analyze course evaluation data on behavioral interventions, three support courses (such as Bridging Behavioral Theory and Practice, Group Facilitation, and Selection of Evidence-based Interventions), and CRCS to CDC on a quarterly basis. Revise training evaluation forms in collaboration with CDC if necessary and submit other course evaluation data to CDC as requested by CDC.

c. Other training assistance

Provide other training assistance like point of contact training on those behavioral interventions and capacity building courses for which they provide training to support diffusion and implementation of evidence-based interventions and public health strategies. Other training assistance will be provided on a case-by-case basis, as approved by the CDC Technical Monitor, and only by telephone, email or other mechanism to be determined by CDC.

d. Collaboration

The Part II—PTCs will be expected to collaborate with each other, CDC, and other training and capacity-building assistance (CBA) providers in order to provide training and evaluation, and other training assistance for behavioral HIV prevention interventions (www.effectiveinterventions.com) and other interventions as determined by needs assessment.

PTCs also will be expected to work with partners who include a Training Coordination Contractor, an agency that provides training coordination for the Diffusion of Effective Behavioral Interventions (DEBI) project, and CBA provider(s) designated by CDC to provide other training assistance services to agencies implementing the designated interventions.

Collaborate with other Part II PTCs and CDC to ensure the national training U.S. coverage of DEBI curricula, including working with a contractor to develop and maintain a national training calendar for those courses.

Collaborate with the Part I and Part III PTCs in the assigned quadrant to assess and meet the program support training needs of health professionals in the quadrant.

Develop each training event in collaboration with intervention site points of contacts who are interested in the training, CDC, designated CBA staff, and Training Coordination Contractor staff. PTCs, CBA provider(s), and the site "points of contact" will communicate, via phone, e-mail, fax, or Web conferencing, to discuss the training plan, negotiate training dates and logistics. The training plan will be tailored to meet the specific needs of each organization requesting training. PTC staff will work with the Training Coordination Contractor to develop a timeframe to schedule the different elements of the training based on the training plan. PTC training staff will follow up with the site "points of contact" to finalize training logistics and needs. PTC staff will submit "closed" training events to the CDC CBB Training Events Calendar and communicate scheduled dates to Training Coordination Contractor. PTC trainers will collect and send

participant lists to Training Coordination Contractor within one week prior to training dates.

Collaborate with Training Coordination Contractor and CBA provider(s) to develop a detailed plan to manage the production, distribution, and shipping of kits and other intervention training materials. The plan will include assigned roles and responsibilities for reproducing, distributing, and shipping materials by Training Coordination Contractor, PTC trainers, and site coordinators. In addition, staff attending the training will be able to view and download all materials from the Training Coordination Contractor Web site.

Collaborate with the PTC Parts I and III to support the interplay of behavioral interventions with biomedical prevention modalities.

Collaborate with national partners: other federal training center programs [e.g. Health Resources and Services and Administration (HRSA), AIDS Education Training Centers (AETCs); the Office of Population Affairs (OPA), Regional Training Centers (RTCs); the Substance Abuse Mental Health Services Administration (SAMHSA), Addiction Technology Transfer Centers (ATTCs); CDC's, Viral Hepatitis Networking, Education and Training (VHNET) grantees; CDC's, TB Regional Training and Medical Consultation Centers (RTMCCs)]; state and local health department STD and HIV programs, State Primary Health Care Associations, Federally Qualified Community Health Centers, Rural Health Centers, correctional facilities, university/college student health services, health care provider professional associations, local community based organizations, local primary care providers and HMO/managed care organizations, local academic institutions and those stakeholders that emerge as a result of health reform.

Part III

The Part III PTC will provide training in STD/HIV partner services and program support.

a. Training Program

The PTC will be expected to provide training in STD/HIV partner services and program support to a U.S. coverage area assigned by CDC. The U.S. coverage area for each Part III PTC will depend on the number of centers funded, the location of funded centers, and criteria that include, current STD/HIV morbidity, population size and demographics, and the costs associated with traveling to states and territories that are not located within the contiguous United States (e.g., Alaska, Hawaii, Pacific Islands, Puerto Rico, and U.S. Virgin Islands).

Specific U.S. coverage areas for each Part III PTC will be determined by CDC in consultation with the funded centers prior to the award date. It is expected that each funded center will be responsible for a U.S. coverage area comprised of between ten and thirty-five states or territories. The composition of each Part III PTC U.S. coverage area will be based on the final awardee selection, location of awardees, and criteria as referenced above. CDC will work collaboratively with the PTC to assign specific U.S. coverage areas before the start of the project period to ensure equitable distribution of the regional training workload across the Part III PTC grantees.

The PTC will be required to develop a sample training plan, describing training activities for a nine-month period, as part of the application for this funding opportunity. For the purposes of the application only, the applicant should develop a plan to provide STD/HIV partner services and program support during the period of July 1, 2011 to March 31, 2012 for the geographic quadrant in which the applicant is located. (See Appendix A for map showing HHS regions and quadrant configurations.)

The sample training plan should be based on an assessment of the training needs of the geographic quadrant in which the applicant is located (See evaluation criteria for complete description of needs assessment elements). Key stakeholders, including state or local health department STD/HIV programs, community-based organizations, and other organizations and providers that provide STD/HIV partner services should be consulted, interviewed, or surveyed to identify training needs.

Each PTC will be required to use a variety of training methods (see Appendix B for training method definitions) in the design and delivery of its courses and curricula. During the first project year, overall, approximately 40-50% of PTC training activities should use didactic methods (Level I), approximately 40-50% should use interactive skills-building methods (Level II), and 10-20% should use training assistance methods (Level V). It is anticipated that little to no Part III PTC training activities will use hands-on clinical methods (Level III) or educational clinical consultation (Level IV); Most courses and curricula will use multiple training methods. For example ISTDI is trained using approximately 50% Level I methods and 50% Level II methods.

The PTC must report CDC-required event and participant data for Level I and/or II training activities.
The PTC must consult with CDC prior to providing any Level V training activities. For Level V activities, the PTC must complete a reporting form (see Appendix F) documenting the training assistance request, the assistance provided and the outcomes of the activity.

Percentages for use of each training method are estimated ranges for the first project year. The percentage of each course or curriculum that is taught using a particular training method will be contingent on the content, the skills to be learned and applied, and the needs of the audience for that specific course or curriculum. In the second and third project year the training method proportions may be revised to optimize the ability of the PTC to meet training needs in its coverage area.

The sample training plan should describe training courses and other educational resources and activities to be developed or delivered between July 1, 2011 and March 31, 2012. The training plan must include the provision of training on the standardized partner services courses and program support courses, {i.e., Introduction to STD Intervention (ISTDI), HIV Partner Counseling and Referral Services (HIV PCRS) Social Network Strategies (SNS) and STD Program Management (STD PM)} (see **Appendix E** for course descriptions). The plan should include the number and type of training courses and

other educational activities to be delivered; partners collaborating in those events; and the number and type of health professionals expected to attend those events. The sample training plan should describe any plans to develop new training courses and other education resources and activities to meet the training needs in the U.S. coverage area. The plan should include the description of any new training courses and training activities that will be developed; the target audience for the training; partners collaborating in the development of the training; and the training need that the new training will address. The plan should include strategies for reaching potential trainees in all of the U.S. coverage area and potential trainees serving populations disproportionately affected by disease and health disparities. These strategies could include, but are not limited to, developing satellite training sites in different states within the U.S. coverage area; initiating scholarship programs; developing and conducting training courses and activities using a range of training approaches (e.g., in-person, distance-, Internet-, and other technology-based learning approaches); developing print-, Internet- or other technology-based self-study materials; conducting joint training activities with other stakeholders; or sending trainers to conduct on-site training activities.

This training plan could require modification contingent upon assignment of training regions prior to award date. If modifications are necessary, the PTC will be given 60 days from the time of the orientation meeting to complete and submit a revised training plan to CDC. During the time that the training plan is being revised, the PTC will be expected to ensure adequate provision of CDC standardized trainings to their assigned U.S. coverage area.

Devote approximately 80% of resources and effort (e.g., staff time, course hours) to the development, delivery, evaluation, and revision of the standardized partner services and program support courses (e.g., ISTDI, HIV PCRS, SNS, STD PM). This includes collaboration with CDC and the other Part III PTCs to develop and implement a national training plan.

Devote approximately 20% of resources and effort (e.g., staff time, course hours) to the provision of other partner services and program support courses.

The PTC is required to submit instructor assessment of courses, pre/post test scores, and copies of course evaluations on a monthly bases.

The PTC will be required to conduct Post-course follow-up assessment on standardized partner services and program support courses (e.g., ISTDI, HIV PCRS, SNS, STD PM).

The PTC will be required to establish and maintain an advisory committee to ensure that the PTC regional training activities are responsive to the training needs of the U.S. coverage area. The PTC advisory committee should provide key input to the U.S. coverage area training needs assessments, review each annual training plan, and review training activity content and proposed new training activities. The advisory committee should be representative of the entire U.S. coverage area. The advisory committee should be representative of the providers and organizations that provide partner services. The advisory committee should include representation from a variety of stakeholders such as state/local STD programs, HIV programs, community based-organizations, etc in the U.S. coverage area.

The PTC must provide a letter of agreement to participate in the PTC advisory committee from each committee member. The PTC must provide a plan for regularly soliciting input from their Advisory Committee on the training needs of the U.S. coverage area and the PTC training program. The PTC will be expected to revise the composition of its Advisory Committee when revising its training plan if needed.

Collaborate with CDC and other Part III PTCs to develop and implement a national training plan that describes the number, type, and delivery of national- and U.S. coverage area-specific partner services and program support training courses and other training activities needed to meet national, state, and local STD/HIV program training needs.

Attend the PTC orientation meeting to be held within six weeks of the award date. The orientation meeting will be organized and led by CDC. The main objective of the Part

III-specific session of the meeting will be to develop a national partner services and program support training plan in collaboration with CDC and the other Part III PTC awardees. The PTC will be expected to revise their sample training plan, if needed, so that it is aligned with the objectives and activities of the national training plan and to ensure adequate U.S. coverage for all four quadrants. CDC anticipates that the sample training plan will require revision to replace standardized STD- and HIV-specific partner services training courses (i.e., ISTDI and PCRS) with standardized STD/HIV integrated partner services training activities when this course becomes available.

Complete development of the Integrated Partner Services curriculum. The PTC will be expected to work with CDC and the other Part III PTCs to continue the development, design, and assessment of the Integrated Partner Services Curriculum. This curriculum will replace the existing STD- and HIV-specific partner services courses, ISTDI and HIV PCRS. The PTC will be expected to collaborate with CDC and the other Part III PTCs to conduct training activities related to finalizing, piloting and field testing the training materials for this curriculum. It is anticipated that development of the curriculum will be completed in the first project year. The PTCs will be expected to provide hosting and Learning Management System (LMS) during the piloting phase of the curriculum. Establishing hosting and LMS should be done in a coordinated effort to minimize duplication of services. Curriculum development activities should include but not limited to the following activities:

Establish and develop process and outcome monitoring tools to evaluate Integrated Partner Services curriculum (face-to-face and online) and curriculum job aids, materials, and training; develop accompanying job aides for Integrated Partner Service Curriculum; conduct usability testing; conduct training pilots of Integrated Partner Services curriculum; design pilot strategy for face to face and on-line curriculum; identify Modules for pilot; identify agencies and individuals to participate in pilot; develop a process for incorporating changes and appropriate feedback from the pilot into the curriculum; establish timeline with roles and activities for the pilot; and provide LMS and hosting for the curriculum during the piloting phase.

Collaborative Activities

Collaborate with other Part III PTCs and CDC to ensure national training U.S. coverage of standardized partner services training courses.

Collaborate with the other Part III PTCs, the Part IV PTC, and CDC to develop and implement a national Part III marketing plan. The national Part III marketing plan should include strategies to reach organizations that serve target populations. If needed, the PTC could consult with marketing experts to determine the most cost-effective marketing strategies.

Collaborate with the Part I and Part II PTCs in the assigned quadrant to assess and meet the program support training needs of health professionals in the quadrant.

Collaborate with Part I, II, and other III PTCs, the Part IV PTC, and CDC to establish standards for the development and evaluation of eLearning activities and other technology-based training activities.

Develop standardized evaluation criteria for 3 months and 6 months post course training follow-up.

Part IV Activities:
The Part IV (NNPTC National Resource and Coordinating Center) will provide coordination and support for NNPTC and national-level activities, initiatives, and projects.

National Resource and Coordinating Center

The Part IV PTC will be expected to: maintain the NNPTC website with up-to-date information on course offerings, course schedules (calendars), training resources, and other information deemed appropriate by CDC and the NNPTC steering committee; coordinate marketing activities that promote NNPTC training opportunities to health professionals; coordinate the continuing education accreditation process, develop and maintain a NNPTC resource clearinghouse as a component of the NNPTC website; facilitate and coordinate NNPTC committees and workgroups; coordinate, implement, and evaluate the NNPTC annual and other nationally-focused meetings; and facilitate and coordinate nationally-focused collaborative activities with FTCC partners and other training stakeholders.

The Part IV PTC will be expected to engage staff with the expertise and experience to carry out the activities associated with coordination and support of the NNPTC; and to work closely with the Part I, II, and III PTCs and CDC to maintain and enhance the NNPTC.

The Part IV PTC will be expected to work closely with the CDC Office of Continuing Education, the CDC project officer and technical monitors, and the Part I, II, and III PTCs to establish and maintain a centralized continuing education accreditation process for all relevant PTC training activities, resources and products.

In a cooperative agreement, CDC staff is substantially involved in the program activities, above and beyond routine grant monitoring.

CDC Activities:

Ensure that all PTC training programs, evaluation plans, and budgets accommodate the needs and resources of CDC in addressing its national STD/HIV prevention goals and priorities.

Provide STD/HIV subject matter and education/training experts to advise and assist in curriculum development; to advise on course objectives, instructional design, and

delivery; to ensure that evaluation is consistent with desired training outcomes; to be a source of up-to-date information on STD/HIV epidemiology and national STD/HIV prevention programs and priorities; and to advise on budget issues.

Provide technical assistance in the development and implementation of evaluation plans.

Provide technical assistance in reviewing/approving training plans before implementation and monitoring training plans during implementation to ensure adequate training throughout the regional U.S. coverage areas and nationally.

Provide technical assistance and quality assurance through site visits, conference calls, and provision of resource materials.

Provide technical assistance and quality assurance through review and approval of training curricula and materials and by coordinating CDC clearance of training products when appropriate.

Convene an orientation meeting of all PTCs within six weeks of the notice of grant award. Activities during this meeting will include outlining expectations for the project and clarifying reporting, administrative, and evaluation requirements. During the PTC orientation meeting, specific U.S. coverage areas for each Part I PTC and for each Part III PTC will be determined by CDC in consultation with the funded centers.

Provide training assistance and advice in the development, implementation, and evaluation of the national clinical training plan, prevention in care training plan, and biomedical prevention modalities training and implementation support.

Support the NNPTC through assistance in planning the annual NNPTC meetings and through assistance in planning NNPTC collaborative meetings with other federal training programs.

Support the NNPTC through assistance in developing and maintaining the NNPTC website and other NNPTC marketing and educational activities, such as exhibits and educational presentations at professional meetings and conferences.
Support the NNPTC through assistance in establishing and maintaining the NNPTC continuing education accreditation process.

Monitor and evaluate program activities by maintaining and supporting national participant and training course event databases, and analyzing and presenting cumulative data on NNPTC training activities.

III. AWARD INFORMATION AND REQUIREMENTS

Type of Award: Cooperative Agreement. CDC substantial involvement in this program appears in the activities section above.

Award Mechanism: U62

Fiscal Year Funds: 2011

Approximate Current Fiscal Year Funding: Part I $4,257,508

Part II $3,213,196

Part III $1,843,525

Part IV $70,000

Approximate Total Project Period Funding: Part I $12,772,524; Part II $9,639,588; Part III $5,530,575; Part IV $210,000 (This amount is an estimate and is subject to availability of funds.)

Approximate Number of Awards: Part I Four to Eight Awards

Part II Two to Four Awards

Part III Two to Four Awards

Part IV One Award

Approximate Average Award: Part I $709,584; Part II $1,071,065; Part III $614,508; Part IV $70,000 (This amount is for the first 12-month budget period, and includes both direct and indirect costs.)

Floor of Individual Award Range: Part I $532,188; Part II 803,299; Part III $460,881; Part IV $70,000

Ceiling of Individual Award Range: Part I $ 1,064,377; Part II $1,606,598; Part III $921,762; Part IV $70,000 (This ceiling is for the first 12-month budget period.) This includes both direct and indirect costs) If a funding amount greater than the ceiling of the award range is requested, the application will be considered non-responsive and will not be entered into the review process.

Anticipated Award Date: April 1, 2011

Budget Period Length: 12 months

Project Period Length: 3 years

Throughout the project period, CDC's commitment to continuation of awards will be conditioned on the availability of funds, evidence of satisfactory progress by the recipient (as documented in required reports), and the determination that continued funding is in the best interest of the Federal government.

IV. ELIGIBILITY

Eligible applicants that can apply for this funding opportunity are listed below:

- Nonprofit with 501C3 IRS status (other than institution of higher education)
- Nonprofit without 501C3 IRS status (other than institution of higher education)

- For-profit organizations (other than small business)
- Small, minority, and women-owned businesses
- Universities
- Colleges
- Research institutions
- Hospitals
- Community-based organizations
- Faith-based organizations
- Federally recognized or state-recognized American Indian/Alaska Native tribal governments
- American Indian/Alaska native tribally designated organizations
- Alaska Native health corporations
- Urban Indian health organizations
- Tribal epidemiology centers
- State and local governments or their Bona Fide Agents (this includes 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)
- Political subdivisions of States (in consultation with States)

A Bona Fide Agent is an agency/organization identified by the state as eligible to submit an application under the state eligibility in lieu of a state application. If applying as a bona fide agent of a state or local government, a letter from the state or local government as documentation of the status is required. Attach with "Other Attachment Forms" when submitting via www.grants.gov.

SPECIAL ELIGIBILITY CRITERIA: Licensing/Credential/Permits

Cost Sharing or Matching

Cost sharing or matching funds are not required for this program.

Maintenance of Effort is not required for this program.

Other

If a funding amount greater than the ceiling of the award range is requested, the application will be considered non-responsive and will not be entered into the review process. The applicant will be notified that the application did not meet the eligibility requirements.

Special Requirements:

- Proof of 501(c)(3) status for non-profits
- Letter of support and collaboration from state **or** local health department on the health department's letterhead and be signed by the state STD/AIDS Director or director coordinator of STD and HIV/AIDS prevention program.(If applicant is a health departments, they will need letter of support and collaboration from the university, all other applicants will need to have both letters included in application).
- Letter of support and collaboration from a university on the university's letterhead and signed by the designated official. (If applicant is a university, they will need the letter of support and collaboration from state **or** local health department, all other applicants will need to have both letters included in application).

If the documents required in this section are not submitted with the application in Grants.gov under "Other Attachment Forms" the application will non-responsive and will not entered into the review process.

Upload all additional documentation in Grants.gov under "Other Attachment Forms," review Section V. (Application Content) below, regarding how documents should be labeled.

Note: Title 2 of the United States Code Section 1611 states that an organization described in Section 501(c)(4) of the Internal Revenue Code that engages in lobbying activities is not eligible to receive Federal funds constituting a grant, loan, or an award.

Intergovernmental Review of Applications

Executive Order 12372 does not apply to this program.

V. Application Content

Prospective applicants are asked to submit a letter of intent (LOI).

Submit the LOI by express mail, delivery service, fax or e-mail to:

Ms. Jocelyn Dudley
CDC, NCHHSTP/OD/ERPO
1600 Clifton Road, Mailstop E-60
Atlanta, GA 30329
Telephone: 404-498-2277
Fax: 404-498-2626
Email: enrt@cdc.gov

Although a letter of intent is not required, is not binding and does not enter into the review of a subsequent application, the information that it contains allows CDC Program staff to estimate and plan the review of submitted applications.

LOIs should be provided no later than by the date indicated in Section I entitled "Authorization and Intent."

This announcement requires submission of the following information: 1) table of contents 2) a cover letter 3) an abstract, 4) a project narrative, 5) a budget with staffing breakdown and justification

Table of Contents

A table of contents listing all application sections and appendices must be included with the application. See **Appendix D** for an example table of contents. The table of contents **will not count** toward the page limit of the project narrative.

Cover Letter

A cover letter is required with the application. The cover letter must contain the following information:

- The applicant's name, address, and the name of the business official.
- A statement about which Parts the applicant is applying for (e.g., Part I, Part II, Part III, or Part IV).

The cover letter must be written in the following format:

- Maximum number of pages: two.
- Font size: 12 point unreduced, Times New Roman.
- Single-spaced.
- Paper size: 8.5 by 11 inches.
- Page margin size: One inch.
- Print only on one side of the page.

A Project Abstract must be completed in the Grants.gov application forms. The Project Abstract must contain a summary of the proposed activity suitable for dissemination to the public. It should be a self-contained description of the project and should contain a statement of objectives and methods to be employed. It should be informative to other persons working in the same or related fields and insofar as possible understandable to a technically literate lay reader. This abstract must not include any proprietary/confidential information.

A Project Narrative must be submitted with the application forms. A separate project narrative must be submitted for each part for which the applicant is seeking funding; The project narrative must be uploaded in a PDF file format when submitting via Grants.gov. The narrative must be submitted in the following format:

- Maximum number of pages: 30 pages for each part applying (e.g. if applying for two parts your maximum is 60 pages etc). All pages must be numbered. If your narrative exceeds the page limit, only the first pages which are within the page limit will be reviewed.

- Font size: 12 point unreduced, Times New Roman
- Double spaced
- Paper size: 8.5 by 11 inches
- Page margin size: One inch
- Number all narrative pages; not to exceed the maximum number of pages.

The narrative should address activities to be conducted over the entire project period and must include the following items in the order listed: Organizational and Training Capacity, Training Program Plan, Collaboration Plan, Evaluation Plan and budget and budget justification.

Organizational and Training Capacity

a. Describe the applicant's experience and expertise as it relates to the design, development, delivery and evaluation of training and training assistance activities and materials.
b. Describe the applicant's experience in collaborating with health departments, training stakeholders, and other training organizations.
c. Describe how the applicant's fiscal and human resource management systems will function and support the proposed program plan.

Training Program

a. Provide a detailed training needs assessment for the U.S. coverage area appropriate and specific to the part for which application is being made.
b. Provide a detailed description of the planned and anticipated training activities including development and design of curricula and training materials, delivery of training and training assistance, and evaluation of training (appropriate and specific to the part for which application is being made).
c. Describe strategies to market to, recruit, and train providers that serve racial and ethnic minorities and other populations disproportionately at risk for or affected

by STD/HIV as reflected in the most current available STD/HIV surveillance data.

d. Describe objectives, strategies for delivery, activities, timelines, and staff members responsible for implementing activities must be included. Proposed objectives should be specific, measurable, achievable, realistic, and time-phased (SMART).

Collaboration Plan

a. Describe plans to collaborate with other PTCs. Describe plans to collaborate with other training partners, professional associations, and organizations with access to racial and ethnic minorities and other populations disproportionately at risk for or affected by STD/HIV.

Evaluation Plan

a. Describe the applicant's process for setting program goals and objectives and measuring their achievement.
b. Describe the applicant's process of evaluating training, training assistance and product development activities.
c. Describe the applicant's plan for using evaluation findings to monitor and improve its program (Quality Assurance).

Budget and Justification, and Staffing Breakdown

Submit a budget and justification and staffing breakdown for each Part the applicant seeks funding. The information will not be counted toward the page number limit of the application.

a. Provide a detailed budget by cost categories (e.g., salaries and wages, fringes, travel) for all proposed program activities for the budget period. Justify all operating expenses in relation to the planned activities and stated objectives. CDC might not approve or fund all proposed activities. Be precise about the program purpose of each budget item, and itemize calculations wherever appropriate.

b. For each contract and consultant mentioned in the application budget, describe the type(s) of organizations or parties to be selected and the method(s) of selections; identify the specific contractor(s), if known; describe the services to be performed and justify the use of a third party to perform these services; provide a breakdown of and justification for the estimated costs of the contracts and consultants; specify the period of performance; and describe the methods to be used for contract monitoring.
c. Provide a job description for each position—specifying job title, function, and general duties and activities. Provide a salary range or rate of pay and the level of effort and percentage of time to be spent on activities that would be funded through this funding opportunity. If the identity of any key person filling a position is known, his or her name and a bio-sketch (2 page maximum, per **staff and other key persons**) should be attached. Experience and training related to proposed project should be noted. If the identity of staff members is unknown, describe the recruitment plan. If volunteers are to be involved in the project, provide job descriptions.

The budget and budget justification will be included as a separate attachment, not to be counted in the narrative page limit.

Additional information may be included in the application appendices. The appendices will not be counted toward the narrative page limit. This additional information includes:

- (Letters of Support and memorandum of agreements [Appendix A], Organizational Charts [Appendix B], Bio-sketches (2 page maximum, per staff) [Appendix C], Bibliographies of Curriculum (where primary author) [Appendix D], examples of curriculum products developed (not full curriculum, key excerpts) [Appendix E], indirect cost rate agreements.) [Appendix F], Proof of 501(c)(3) status for non-profits (if applicable) [Appendix G], **Supporting Documentation(including model STD clinic records and floor plans)[Appendix H]**

- Additional information submitted via Grants.gov should be uploaded in a PDF file format, and should be named:
- "Other Attachments Forms" should be titled/named(as indicated above) when uploaded under Mandatory Documents into Grants.gov.
- Any other submitted appendices should be labeled as "non-mandatory" in a PDF file.
- **In the appendices, no more than 50 pages maximum for each part for a total page limit of 200 if applying for all four parts. Appendices cannot exceed 200 pages of allowable electronic attachments should be uploaded per application.**

Additional requirements for additional documentation with the application are listed in Section VII. Award Administration Information, subsection entitled "Administrative and National Policy Requirements."

APPLICATION SUBMISSION

Registering your organization through www.Grants.gov, the official agency-wide E-grant website, is the first step in submitting an application online. Registration information is located on the "Get Registered" screen of www.Grants.gov. Please visit www.Grants.gov at least 30 days prior to submitting your application to familiarize yourself with the registration and submission processes. The "one-time" registration process will take three to five days to complete. However, the Grants.gov registration process also requires that you register your organization with the Central Contractor Registry (CCR) annually. The CCR registration can require an additional one to two days to complete.

Submit the application electronically by using the forms and instructions posted for this funding opportunity on www.Grants.gov. If access to the Internet is not available or if the applicant encounters difficulty in accessing the forms on-line, contact the HHS/CDC Procurement and Grant Office Technical Information Management Section (PGO TIMS) staff at (770) 488-2700 for further instruction.

Note: Application submission is not concluded until successful completion of the validation process.

After submission of your application package, applicants will receive a "submission receipt" email generated by Grants.gov. Grants.gov will then generate a second e-mail message to applicants which will either validate or reject their submitted application package. This validation process may take as long as two (2) business days. Applicants are strongly encouraged check the status of their application to ensure submission of their application package is complete and no submission errors exists. To guarantee that you comply with the application deadline published in the Funding Opportunity Announcement, applicants are also strongly encouraged to allocate additional days prior to the published deadline to file their application. Non-validated applications will not be accepted after the published application deadline date.

In the event that you do not receive a "validation" email within two (2) business days of application submission, please contact Grants.gov. Refer to the email message generated at the time of application submission for instructions on how to track your application or the Application User Guide, Version 3.0 page 57.

Other Submission Requirements

Letter of Intent (LOI):

A letter of intent is due November 1, 2010.

Dun and Bradstreet Universal Number (DUNS)

The applicant is required to have a Dun and Bradstreet Data Universal Numbering System (DUNS) identifier to apply for grants or cooperative agreements from the Federal government. The DUNS is a nine-digit number which uniquely identifies business entities. There is no charge associated with obtaining a DUNS number. Applicants may obtain a DUNS number by accessing the Dun and Bradstreet website or by calling 1-866-705-5711.

Electronic Submission of Application:

Applications must be submitted electronically at www.Grants.gov. The application package can be downloaded from www.Grants.gov. Applicants can complete the application package off-line, and then upload and submit the application via the Grants.gov Web site. The applicant must submit all application attachments using a PDF file format when submitting via Grants.gov. Directions for creating PDF files can be

found on the Grants.gov Web site. Use of file formats other than PDF may result in the file being unreadable by staff.

Applications submitted through Grants.gov (http://www.grants.gov) are electronically time/date stamped and assigned a tracking number. The AOR will receive an e-mail notice of receipt when HHS/CDC retrieves the application. The tracking number serves to identify the submission.

If the applicant encounters technical difficulties with Grants.gov, the applicant should contact Grants.gov Customer Service. The Grants.gov Contact Center is available 24 hours a day, 7 days a week. The Contact Center provides customer service to the applicant community. The extended hours will provide applicants support around the clock, ensuring the best possible customer service is received any time it's needed. You can reach the Grants.gov Support Center at 1-800-518-4726 or by email at support@grants.gov. Submissions sent by e-mail, fax, CD's or thumb drives of applications will not be accepted.

Organizations that encounter technical difficulties in using www.Grants.gov to submit their application must attempt to overcome those difficulties by contacting the Grants.gov Support Center (1-800-518-4726, support@grants.gov). After consulting with the Grants.gov Support Center, if the technical difficulties remain unresolved and electronic submission is not possible to meet the established deadline, organizations may submit a request prior to the application deadline by email to PGO TIMS for permission to submit a paper application. An organization's request for permission must: (a) include the Grants.gov case number assigned to the inquiry, (b) describe the difficulties that prevent electronic submission and the efforts taken with the Grants.gov Support Center (c) be submitted to PGO TIMS at least 3 calendar days prior to the application deadline. Paper applications submitted without prior approval will not be considered.

If a paper application is authorized, the applicant will receive instructions from PGO TIMS to submit the original and two hard copies of the application by mail or express delivery service.

Submission Dates and Times

This announcement is the definitive guide on the LOI, application content, submission and deadline. It supersedes information provided in the application instructions. If the application submission does not meet the deadline published herein, it will not be eligible for review and the applicant will be notified the application did not meet the submission requirements.

Letter of Intent (LOI) Deadline Date: November 1, 2010

Application Deadline Date: December 1, 2010, 5:00pm Eastern Standard Time.

Explanation of Deadlines: Applications must be successfully submitted to Grants.gov by 5:00pm U.S. Eastern Standard Time on the deadline date.

VI. Application Review Information

Eligible applicants are required to provide measures of effectiveness that will demonstrate the accomplishment of the various identified objectives of the PS11-1103 (Sexually Transmitted Diseases/Human Immunodeficiency Virus Prevention Training Center). Measures of effectiveness must relate to the performance goals stated in the "Purpose" section of this announcement. Measures of effectiveness must be objective, quantitative and measure the intended outcome of the proposed program. The measures of effectiveness must be included in the application and will be an element of the evaluation of the submitted application.

All applicants are reviewed for eligibility according to the criteria listed in section IV. Once deemed eligible, applications undergo an evaluation process against the evaluation criteria listed below. Applications will be evaluated by an objective review panel

assigned by CDC. The panel will assign each application a score using the scored evaluation criteria.

PART I Evaluation Criteria

Eligible Part I applications will be evaluated against the following criteria for a total of 100 points. Those areas are as follows:

1. Abstract (Not Scored)

Does the applicant provide a two-page summary of the program, indicating the Part(s) for which funding is requested, the name of the person with authority over the PTC, the academic and public health collaborators, other key collaborators, the program objectives, a plan for achieving the objectives, and the training evaluation plan? "Do not copy & past text into the Project Abstract Form provided in the Grants.gov application package, as it may cause electronic submission errors due to converted, unacceptable characters."

2. Organizational and Training Capacity (25 points)

a. **Organizational Description and General Training Capacity**

Does the Part I applicant provide the following information?

i. Descriptions of proposed PTC administrative and training staff positions, including duties, responsibilities, requisite credentials, and relevant STD/HIV training and program experience.

ii. A letter from each partner organization describing its partnership with the PTC, specifying the training-related activities that will be provided. This includes partner organizations that will be serving as STD clinical training sites.

iii. An organizational chart showing linkages between the applicant and partner organizations and related PTC positions, indicating lines of authority.

iv. A description of experience with collaborative STD/HIV training activities for health professionals as described in the Key Organizational Collaborations section of this program announcement. Include collaborative

relationships and linkages with STD/HIV training and service delivery programs and stakeholders in the U.S. coverage area and collaborative activities and projects undertaken during the last five years.

v. A description of the proposed training site(s), including location, accessibility of site location to health professionals throughout the U.S. coverage area, number of students that can be accommodated, and approximate costs to students for attending training at the proposed site(s).

vi. A plan for keeping training faculty, trainers, and preceptors (as applicable) current on content area(s) and educational methodologies.

vii. A plan, with anticipated costs, for acquiring CME, CNE, and CEU as appropriate for trainees. (The PTC will be responsible for acquiring continuing education (CE) accreditation for its courses until or unless a centralized CE process is established)

viii. A list of available equipment used in classroom-based training, clinic and laboratory-based training and technology-based training.

ix. A plan to capture student registration and event information in database format for local use and for submission to CDC, including a description of data management capabilities.

x. A plan for providing resources to trainees, including a process to reproduce course materials quickly, economically and in collaboration with other PTCs when appropriate.

b. **Part I Training Experience and Capability**

Does the Part I applicant provide the following information about its experience and capabilities to develop and deliver training on STD clinical and laboratory skills and HIV prevention in care strategies:

i. Description of the traditional and technology-based courses delivered during the past five years, including:

a. Number of courses trained, topic(s) of each course trained, the length of each course trained, the training methods (see appendix B for

detailed definitions of training methods), approaches and modalities used for each course.

b. Number and characteristics of trainees, including discipline, practice settings and states in which trainees practiced.

c. Number and experience of faculty qualified to train, including their discipline, area(s) of expertise, number of years training.

ii. Description of courses developed during the past five years, including:

a. Number of courses developed, topic(s) of each course developed, the length of each course developed, the training methods (see appendix B for detailed definitions of training methods), approaches and modalities used for each course.

b. Experience and credentials for developer(s) of each course and their relationship to the applicant (e.g. staff, consultant, contractor, etc).

iii. A description of experience in collaborating with other training programs to plan, develop or provide national-level STD/HIV training activities and resources (e.g., Clinician Symposia project; Ask, Screen, Intervene course; STD Core Curriculum outlines, STD On-line Case Studies, etc) . Include specific roles and responsibilities, collaborative partners, and outcome or product of the collaboration.

3. Part I STD Clinical Training Sites (10 points)

Does the Part I applicant provide the following information about each model STD clinic that will serve as a clinical training site:

a. Current STD morbidity statistical tables (for most recent year available) that demonstrate a client volume and profile that reflects regional disease trends and allows for diverse clinical training opportunities.

b. A current list of the type and number of the state laboratory tests performed over the past year and those sent to reference laboratories.

c. A clinic and fee schedule that demonstrates accessibility for communities at risk (e.g., daily, evening, and weekend hours; continual services; and free or low-cost services).

d. An STD clinic floor plan indicating a traffic pattern that minimizes movement for clients and preserves confidentiality.
e. An outline of clinic management protocols, such as elements of the registration procedure and appointment, triage, and priority systems.
f. The numbers and types of clinic staff members and the time devoted to their main client responsibilities, including which staff members will serve as preceptors for training courses.
g. A copy of a blank clinic medical record.
h. A description of the quality assurance plan and committee, and of the clinic's management structure.

4. Training Program (40 points)

a. **Part I Training Needs Assessment**

Does the Part I applicant provide the following training needs assessment information:

i. A description of the STD/HIV clinical training needs, HIV prevention in care training needs, and knowledge gaps and barriers to training for various types of clinicians that deliver STD and HIV clinical care in the HHS region?
ii. A comprehensive description of the STD/HIV morbidity and STD/HIV clinical service delivery system in the HHS region?
iii. A description of the methodology used to identify education and training needs and preferences
iv. A description of the roles of various types of clinicians and clinical care settings in the delivery of STD/HIV clinical care in the HHS region? This description should include the extent to which various types of clinicians provide care to populations disproportionately at risk for or affected by STDs and HIV.
v. A description of the STD clinical expertise, HIV prevention in care expertise, and training resources available through other training programs in the HHS region? The description should include how the activities of other programs affect the training needs to be addressed by the applicant.

vi. A description of proposed plans and mechanisms for updating needs assessment throughout the project period? The description should include the processes the applicant will use to periodically solicit and review input from their advisory committee and other key stakeholders.

b. **Part I Training Program Plan**

i. Does the Part I applicant provide a sample nine-month training plan, describing regional training activities for the HHS region in which it is located? For the purposes of the application only, the applicant should develop a plan to provide STD clinical training and HIV prevention in care training during the period of July 1, 2011 to March 31, 2012 for the HHS region in which the applicant is located. The PTC will be expected to devote approximately 70% of its effort and resources to the provision of training respective to its final designated U.S. coverage area, so the sample regional training plan should reflect an equivalent level of effort and resources for illustrative purposes.

ii. Does the Part I applicant's sample nine-month training plan include the following information:

a. A description of the training audiences to be targeted, including the projected numbers and types of clinicians to be trained, their clinical practice settings and their patient populations? Does the applicant describe how the needs assessment findings were used to determine target training audiences, as related to the content of the courses or curricula to be offered?

b. A description of the training courses and other training activities the applicant will provide, including the training topics, methods (See appendix B for detailed definitions of training methods.), and modalities to be used? Does the applicant describe the planned number of trainings by topic, training level and length of training, and their relationship to the knowledge and skills gaps identified in the needs assessment?

c. A description of planned training courses to be delivered? Does the applicant include the delivery of a minimum of five STD Intensive courses

(e.g., STD Intensive, Part-time STD Intensive, Three-day STD Intensive, Flex STD Intensive, Adolescent STD Intensive, Advanced STD Intensive, STD Practicum), two STD Laboratory and Microscopy Methods courses, three STD Update for Clinicians courses, and three presentations of the ASI curriculum in its entirety (modules 1-4) to the same participants (using flexible approaches over time or in single long presentations), one ASI TOT, one overview of ASI, four presentations of single ASI module (1,2,3,or 4) as determined by individual audience needs. See Appendix E for course descriptions.

d. A description of how the planned training courses and other training activities are coordinated with existing training resources available in the HHS region for training for clinicians in STD care and HIV prevention strategies

iii. Does the Part I applicant describe a sample regional training plan that is based on their existing training capabilities; that adequately addresses the training needs identified in the needs assessment; and that reflects an adequate level of effort and resources?

iv. Does the Part I applicant provide the following information about its proposed training program:

a. A description of the process to develop (and/or revise) training curriculum, courses and other training activities? This should include: how needs assessment findings are used; how training topics are identified and prioritized; how training methods and modalities are determined; and how lessons learned from previous course evaluations are applied?

b. A description of the criteria and processes that will be used to identify faculty, trainers, and preceptors, and the process for tracking, monitoring, and evaluating their performance?

c. A description of the methods it will use to establish, maintain and utilize an advisory committee to ensure that the PTC regional training activities are responsive to the training needs of the U.S. coverage area? This should include a letter of agreement to participate in the PTC advisory

committee from each committee member with a description of the member's agreed-upon duties and responsibilities?

d. A description of a process to work with CDC and other Part I PTC grantees to develop and implement a national training plan? Part I grantees will be expected to devote approximately 30% of their effort and resources national training efforts.

c. **General Program Objectives**

Does the applicant provide specific, measurable, achievable, time-phased, realistic (SMART) objectives that reflect the STD/HIV prevention training needs in their U.S. coverage area for each Part for which it is applying?

d. **General Training Marketing Plan**

Does the applicant provide a plan to market training courses to target audiences in all states of the U.S. coverage area, including types of marketing (e.g., printed materials, websites, conference exhibits, symposia for health professional meetings and organizations) that are appropriate to reach the target audiences for each Part for which it is applying? Are organizations and professional associations with access to health professionals working with populations disproportionately at risk for or affected by STDs and HIV addressed in the plan?

5. Collaboration Plan (10 points)

Does the Part I applicant provide the following information:

a. Description of a plan to collaborate with CDC and the other PTCs to support and maintain the NNPTC. Does it include contact persons and proposed roles and activities.

b. Description of a plan for collaborating with other PTCs and other STD/HIV training and service delivery programs and stakeholders (see the Key Organizational Collaborations section of this program announcement) in the U.S. coverage area.

6. Evaluation Plan (15 points)

Does the Part I applicant provide a description of its ability to participate in and conduct ad hoc and on-going evaluation of all courses, both independently and in conjunction with the CDC, NNPTC, or both for each part for which it is applying? This includes a plan for conducting evaluation activities that determine and measure short-term and medium-term outcomes of training; a plan for utilizing program evaluation data to provide continuous quality improvement of the PTC; and access to an evaluation specialist with appropriate experience and credentials.

7. Budget (SF 424A) and Budget Narrative (Reviewed, but not scored)

Although the budget is not scored applicants should consider the following in development of their budget. Is the itemized budget for conducting the project, and justification reasonable and consistent with stated objectives and planned program activities?

If the applicants requests indirect costs in the budget, a copy of the indirect cost rate agreement is required. If the indirect cost rate is a provisional rate, the agreement should be less than 12 months of age. The indirect cost rate agreement should be uploaded as a PDF file with "Other Attachment Forms" when submitting via Grants.gov

Indirect costs under training grants to organizations other than State, local or Indian tribal governments will be budgeted and reimbursed at 8% of modified total direct costs rather than on the basis of a negotiated rate agreement, and are not subject to upward or downward adjustment. Direct cost amounts for equipment (capital expenditures), tuition and fees, and subgrants and subcontracts in excess of $25,000 are excluded from the actual direct cost base for purposes of this calculation. Indirect costs under grants to local government agencies (other than those designated as "major" pursuant to OMB Circular A-87) shall be budgeted and reimbursed on the basis of the rates computed and proposed by the local government in its grant application unless the awarding office requests Division of Cost Allocation, HHS (DCA) involvement.

Include only one SF-424A for the application and specify each Part for which you are applying on the one SF-424A form.

PART II Evaluation Criteria

Eligible Part II applications will be evaluated against the following criteria for a total of 100 points: Those areas are as follows:

1. Abstract (Not Scored)

Does the applicant provide a two-page summary of the program, indicating the Part(s) for which funding is requested, the name of the person with authority over the PTC, the academic and public health collaborators, other key collaborators, the program objectives, a plan for achieving the objectives, and the training evaluation plan? "Do not copy & past text into the Project Abstract Form provided in the Grants.gov application package, as it may cause electronic submission errors due to converted, unacceptable characters."

2. Organizational and Training Capacity (30 points)

a. **Organizational Description and General Training Capacity**

Does the Part II applicant provide the following information?

i. Descriptions of proposed PTC administrative and training staff positions, including duties, responsibilities, requisite credentials, and relevant STD/HIV training and program experience.

ii. A letter from each partner organization describing its partnership with the PTC, specifying the training-related activities that will be provided. This includes partner organizations that will be serving as STD clinical training sites.

iii. An organizational chart showing linkages between the applicant and partner organizations and related PTC positions, indicating lines of authority.

iv. A description of experience with collaborative STD/HIV training activities for health professionals as described in the Key Organizational Collaborations section of this program announcement. Include collaborative relationships and linkages with STD/HIV training and service delivery

programs and stakeholders in the U.S. coverage area and collaborative activities and projects undertaken during the last five years.

v. A description of the proposed training site(s), including location, accessibility of site location to health professionals throughout the U.S. coverage area, number of students that can be accommodated, and approximate costs to students for attending training at the proposed site(s).

vi. A plan for keeping training faculty, trainers, and preceptors (as applicable) current on content area(s) and educational methodologies.

vii. A plan, with anticipated costs, for acquiring CME, CNE, and CEU as appropriate for trainees. (The PTC will be responsible for acquiring continuing education (CE) accreditation for its courses until or unless a centralized CE process is established)

viii. A list of available equipment used in classroom-based training, clinic and laboratory-based training and technology-based training.

ix. A plan to capture student registration and event information in database format for local use and for submission to CDC, including a description of data management capabilities.

x. A plan for providing resources to trainees, including a process to reproduce course materials quickly, economically and in collaboration with other PTCs when appropriate.

b. **Part II Training Experience and Capability**

Does the description of behavioral interventions training experience and capability include the following?

i. Number of years teaching program support courses, including Comprehensive Risk Counseling Services (CRCS).

ii. Number of program support courses developed, piloted, and diffused.

iii. Number of years teaching DEBI courses, including types of courses taught; number of times and locations in which each course has been taught during the past year; number of trainers qualified to teach each course; and number of years each trainer has taught each course.

iv. Number of courses and curricula developed, piloted, and diffused for the DEBI program, including types of courses taught; number of times and locations in which each course has been taught during the past year; number of trainers qualified to teach each course; and number of years each trainer has taught each course.

3. Training Program (45 points)

a. **Part II Training Needs Assessment**

Does the Part II applicant provide the following training needs assessment information:

i. A description of relevant, current activities conducted to determine the training needs of health professionals in each state of the quadrant in which the applicant is located, including an adequate rationale for inclusion and exclusion of specific assessment activities.

ii. Main findings and conclusions of the needs assessment, including:

a. Description of the target audiences, locations for training courses and educational activities, educational content, and training methods and modalities.

b. Description of the relationship of the training needs identified in the U.S. coverage area to the CDC programs, initiatives, and guidelines previously listed.

c. Description of STD/HIV prevention training provided by other programs (e.g., state and local health department STD and HIV programs, AETCs, RTCs, ATTCs, TB RTMCCs, and VHNET grantees) in each state in the U.S. coverage area, and how the activities of other programs affect the training needs to be addressed by the applicant.

d. Description of a process to annually reassess the target audience training needs for each state in their U.S. coverage area during the project period. This would include methods to periodically solicit and review input from key stakeholders in the U.S. coverage area and national partners, such as

the National Coalition of STD Directors (NCSD) and the National Alliance of State and Territorial AIDS Directors (NASTAD).

b. **Part II Training Program Plan:**

Does the Part II applicant provide the following information about its training program?

i. A complete and comprehensive training plan for the first 12 months of the project that adequately addresses the needs identified in the needs assessment, and is based on existing training capabilities.

ii. Course information for training courses in the training plan, including course names; length; 20% (Level I), 70% (Level II), and 10% (Level V) training methods (see appendix B for detailed definitions of training methods); dates; locations (facility, city, and state); training audiences; training faculty; training modalities; course objectives; brief content outlines; and method(s) to evaluate course quality.

iii. Information for all other educational activities in the training plan, such as grand rounds presentations, conference hosting, etc., including activity names; length of activities; activity dates; locations (facility, city, and state); audiences; faculty; modality; objectives; brief content outlines or agendas; and method(s) to evaluate course quality.

iv. A plan to continuously provide quality assurance of faculty, trainers, and preceptors.

v. A description of how the planned training courses and other training activities support the STD/HIV Essential Functions and Areas of Special Emphasis and relevant HHS/CDC policy, guidelines, programs, and initiatives (listed in the Executive Summary), as appropriate.

vi. Does the behavioral interventions training plan for the first 12 months of the project include the following:

a. Eighty percent of course hours devoted to national-level standardized behavioral intervention courses that support CDC's DEBI program. National-level courses that support the DEBI Program include, but are not

limited to: Healthy Relationships; Many Men, Many Voices; CLEAR; Project START; Partnership for Health; Personalized Cognitive Counseling; Sister-to-Sister; Community PROMISE; Comprehensive Risk Counseling Services (CRCS); Selecting Evidence-Based Interventions; Bridging Theory and Practice; Adapting EBIs using Focus Groups; and Adapting EBIs using Interviews and Observation.

b. Twenty percent of course hours devoted to program support training tailored to the needs of health professionals and STD/HIV program staff working in the quadrant, including, introduction and application of theories and models to effective individual, group, and community-level STD/HIV prevention interventions; and recruiting and maintaining prevention partnerships with affected communities.
c. Description of a plan to train prevention providers to implement DEBI interventions, including a plan to provide training to clinics and CBOs that have received direct or indirect CDC funding to implement DEBI interventions.
d. Description of how training on DEBI interventions supports the Capacity Building Assistance (CBA) program targeting high risk racial/ethnic minority subpopulations and description of the mechanism to refer training participants to these technical assistance providers.
e. Outline of a plan to conduct Train-the-Trainer events on selected DEBIs and support courses and a description of how the Train-the-Trainer events will prepare CBA staff and other stakeholders to train prevention providers to implement, adapt, monitor and evaluate DEBI interventions.
f. Outline of a plan to develop curricula on future interventions, current DEBI interventions and program support courses and a description of processes for collaboration and sharing of curricula with the other Part II PTCs.
g. Description of a plan to collaborate with contractors and other partners on a national training calendar.

h. Description of how training addresses cultural norms, values, and traditions; is sensitive to issues of sexual identity; is developmentally appropriate; and is linguistically specific and educationally appropriate.
i. Description of a plan to translate, pilot, revise, and train one course each year in Spanish in order to meet the needs for trainings conducted in Spanish.
j. Description of how the training plan addresses the program support training needs of the quadrant, including a plan to collaborate with the Part I and Part III PTCs in the quadrant to identify and meet quadrant program support training needs.

c. **General Program Objectives**

Does the applicant provide specific, measurable, achievable, time-phased, realistic (SMART) objectives that reflect the STD/HIV prevention training needs in their U.S. coverage area for each Part for which it is applying?

d. **General Training Marketing Plan**

Does the applicant provide a plan to market training courses to target audiences in all states of the U.S. coverage area, including types of marketing (e.g., printed materials, websites, conference exhibits, symposia for health professional meetings and organizations) that are appropriate to reach the target audiences for each Part for which it is applying? Are organizations and professional associations with access to health professionals working with populations disproportionately at risk for or affected by STDs and HIV addressed in the plan?

4. Collaboration Plan (10 points)

Does the Part II applicant provide the following information for each Part for which it is applying?

a. Description of a plan to collaborate with CDC and the other PTCs to support and maintain the NNPTC. Does it include contact persons and proposed roles and activities.
b. Description of a plan for collaborating with other PTCs and other STD/HIV training and service delivery programs and stakeholders (see the Key Organizational Collaborations section of this program announcement) in the U.S. coverage area.

5. Evaluation Plan (15 points)

Does the Part II applicant provide a description of its ability to participate in and conduct ad hoc and on-going evaluation of all courses, both independently and in conjunction with the CDC, NNPTC, or both for each part for which it is applying? This includes a plan for conducting evaluation activities that determine and measure short-term and medium-term outcomes of training; a plan for utilizing program evaluation data to provide continuous quality improvement of the PTC; and access to an evaluation specialist with appropriate experience and credentials?

6. Budget (SF 424A) and Budget Narrative (Reviewed, but not scored)

Although the budget is not scored applicants should consider the following in development of their budget. Is the itemized budget for conducting the project, and justification reasonable and consistent with stated objectives and planned program activities?

If the applicants requests indirect costs in the budget, a copy of the indirect cost rate agreement is required. If the indirect cost rate is a provisional rate, the agreement should be less than 12 months of age. The indirect cost rate agreement should be uploaded as a PDF file with "Other Attachment Forms" when submitting via Grants.gov
Indirect costs under training grants to organizations other than State, local or Indian tribal governments will be budgeted and reimbursed at 8% of modified total direct costs rather than on the basis of a negotiated rate agreement, and are not subject to upward or downward adjustment. Direct cost amounts for equipment (capital expenditures), tuition and fees, and subgrants and subcontracts in excess of $25,000 are excluded from the

actual direct cost base for purposes of this calculation. Indirect costs under grants to local government agencies (other than those designated as "major" pursuant to OMB Circular A-87) shall be budgeted and reimbursed on the basis of the rates computed and proposed by the local government in its grant application unless the awarding office requests Division of Cost Allocation, HHS (DCA) involvement.
Include only one SF-424A for the application and specify each Part for which you are applying on the one SF-424A form.

PART III Evaluation Criteria

Eligible Part III applications will be evaluated against the following criteria for a total of 100 points. Those areas are as follows:

1. Abstract (Not Scored)

Does the applicant provide a two-page summary of the program, indicating the Part(s) for which funding is requested, the name of the person with authority over the PTC, the academic and public health collaborators, other key collaborators, the program objectives, a plan for achieving the objectives, and the training evaluation plan? "Do not copy & past text into the Project Abstract Form provided in the Grants.gov application package, as it may cause electronic submission errors due to converted, unacceptable characters."

2. Organizational and Training Capacity (30 points)

a. Organizational Description and General Training Capacity

Does the Part III applicant provide the following information?

i. Descriptions of proposed PTC administrative and training staff positions, including duties, responsibilities, requisite credentials, and relevant STD/HIV training and program experience.

ii. A letter from each partner organization describing its partnership with the PTC, specifying the training-related activities that will be provided. This includes partner organizations that will be serving as STD clinical training sites.

iii. An organizational chart showing linkages between the applicant and partner organizations and related PTC positions, indicating lines of authority.

iv. A description of experience with collaborative STD/HIV training activities for health professionals as described in the Key Organizational Collaborations section of this program announcement. Include collaborative relationships and linkages with STD/HIV training and service delivery programs and stakeholders in the U.S. coverage area and collaborative activities and projects undertaken during the last five years.

v. A description of the proposed training site(s), including location, accessibility of site location to health professionals throughout the U.S. coverage area, number of students that can be accommodated, and approximate costs to students for attending training at the proposed site(s).

vi. A plan for keeping training faculty, trainers, and preceptors (as applicable) current on content area(s) and educational methodologies.

vii. A plan, with anticipated costs, for acquiring CME, CNE, and CEU as appropriate for trainees. (The PTC will be responsible for acquiring continuing education (CE) accreditation for its courses until or unless a centralized CE process is established)

viii. A list of available equipment used in classroom-based training, clinic and laboratory-based training and technology-based training.

ix. A plan to capture student registration and event information in database format for local use and for submission to CDC, including a description of data management capabilities.

x. A plan for providing resources to trainees, including a process to reproduce course materials quickly, economically and in collaboration with other PTCs when appropriate.

b. **Part III Training Experience and Capability**

Does the Part III applicant provide the following information about its experience and capabilities to develop and deliver STD/HIV partner services and program support:

i. Description of experience in the past five years teaching partner services and program support courses for health professionals that are consistent with relevant CDC guidelines and policy. Description of experience in the past five years teaching the following courses: Introduction to STD Intervention (ISTDI); Fundamentals of STD Intervention; HIV Partner Counseling and Referral Services (PCRS), and STD Program Management (STD PM). (See **Appendix E** for course descriptions.)

ii. Number and experience of faculty qualified to train, including their discipline, area(s) of expertise, and number of years training.

iii. Description of experience in the past five years developing STD/HIV partner services and program support courses, including the types of courses developed; and the experience and credentials for developer(s) of each course and their relationship to the applicant (e.g. staff, consultant, contractor, etc).

iv. A description of each STD and HIV program that will serve as a partner services training site, including current statistics (one year) for client and partner services intervention outcomes.

3. Training Program (45 points)

a. **Part III Training Needs Assessment**

Does the Part III applicant provide the following training needs assessment information?

i. A comprehensive description of the STD/HIV morbidity, STD/HIV partner services, and the state/local STD/HIV programs in the geographic quadrant?

ii. A description of the STD/HIV partner services and program support training needs, knowledge gaps and barriers to training for various types of STD/HIV partner services providers and program staff in the geographic quadrant?

iii. A description of the methodology used to identify training needs and preferences

iv. A description of the STD/HIV partner services and program support expertise and training resources available through other training programs in

the geographic quadrant? The description should include how the activities of other programs affect the training needs to be addressed by the applicant.

v. A description of proposed plans and mechanisms for updating needs assessment throughout the project period? The description should include the processes the applicant will use to periodically solicit and review input from their advisory committee and other key stakeholders.

b. **Part III Training Program Plan**

Does the Part III applicant provide a sample nine-month training plan describing training activities for the geographic quadrant in which it is located? For the purposes of the application only, the applicant should develop a plan to provide STD/HIV partner services and program support training during the period of July 1, 2011 to March 31, 2012 for the geographic quadrant in which it is located (see Appendix A for map showing HHS regions and quadrant configurations).

Does the Part III applicant's sample nine-month training plan include the following information:

i. A description of the training audiences to be targeted, including the projected numbers of health professionals to be trained, the settings in which they practice, and their patient or client populations?

ii. A description of the training courses and other training activities the applicant will provide, including planned number of trainings by topic, training level (see appendix B for detailed definitions of training methods), and length of training, and their relationship to the knowledge and skills gaps identified in the needs assessment?

iii. A description of planned training courses to be delivered? Does the applicant include the delivery of at least two ISTDI courses, two HIV/PCRS or SNS courses, and one STD Program Management course that meet the needs of the quadrant?

iv. A description of planned activities indicating that approximately 80% of effort and resources will be devoted to development and delivery of partner

services training and approximately 20% of effort and resources will be devoted to the development and delivery of program support courses?

v. Does the Part III applicant describe a sample regional training plan that is based on their existing training capabilities; that adequately addresses the training needs identified in the needs assessment; and that reflects an adequate level of effort and resources?

Does the Part III applicant provide the following information about its proposed training program:

i. A description of the process to develop (and/or revise) training curriculum, courses and other training activities? This should include: how needs assessment findings are used; how training topics are identified and prioritized; how training methods and modalities are determined; and how lessons learned from previous course evaluations are applied?

ii. A description of the criteria and processes that will be used to identify faculty, trainers, and preceptors, and the process for tracking, monitoring, and evaluating their performance?

iii. A description of the methods it will use to establish, maintain and utilize an advisory committee to ensure that the PTC regional training activities are responsive to the training needs of the U.S. coverage area? This should include a letter of agreement to participate in the PTC advisory committee from each committee member with a description of the member's agreed-upon duties and responsibilities?

iv. An outline of a plan to collaborate with the other Part III PTCs and the CDC to meet the nationwide needs of health professionals for the standardized partner services and program support courses?

v. An outline of a plan to collaborate with the Part I and Part II PTCs in the quadrant to identify and meet the quadrant needs for partner services and program support training?

c. **General Program Objectives**

Does the applicant provide specific, measurable, achievable, time-phased, realistic (SMART) objectives that reflect the STD/HIV prevention training needs in their U.S. coverage area for each Part for which it is applying?

d. **General Training Marketing Plan**

Does the applicant provide a plan to market training courses to target audiences in all states of the U.S. coverage area, including types of marketing (e.g., printed materials, websites, conference exhibits, symposia for health professional meetings and organizations) that are appropriate to reach the target audiences for each Part for which it is applying? Are organizations and professional associations with access to health professionals working with populations disproportionately at risk for or affected by STDs and HIV addressed in the plan?

4. Collaboration Plan (10 points)

Does the Part III applicant provide the following information:

a. Description of a plan to collaborate with CDC and the other PTCs to support and maintain the NNPTC. Does it include contact persons and proposed roles and activities.
b. Description of a plan for collaborating with other PTCs and other STD/HIV training and service delivery programs and stakeholders (see the Key Organizational Collaborations section of this program announcement) in the U.S. coverage area.

5. Evaluation Plan (15 points)

Does the Part III applicant provide a description of its ability to participate in and conduct ad hoc and on-going evaluation of all courses, both independently and in conjunction with the CDC, NNPTC, or both for each part for which it is applying? This includes a plan for conducting evaluation activities that determine and measure short-term and medium-term outcomes of training; a plan for utilizing program evaluation data to provide continuous quality improvement of the PTC; and access to an evaluation specialist with appropriate experience and credentials.

6. Budget (SF 424A) and Budget Narrative (Reviewed, but not scored)

Although the budget is not scored applicants should consider the following in development of their budget. Is the itemized budget for conducting the project, and justification reasonable and consistent with stated objectives and planned program activities?

If the applicants requests indirect costs in the budget, a copy of the indirect cost rate agreement is required. If the indirect cost rate is a provisional rate, the agreement should be less than 12 months of age. The indirect cost rate agreement should be uploaded as a PDF file with "Other Attachment Forms" when submitting via Grants.gov

Indirect costs under training grants to organizations other than State, local or Indian tribal governments will be budgeted and reimbursed at 8% of modified total direct costs rather than on the basis of a negotiated rate agreement, and are not subject to upward or downward adjustment. Direct cost amounts for equipment (capital expenditures), tuition and fees, and subgrants and subcontracts in excess of $25,000 are excluded from the actual direct cost base for purposes of this calculation. Indirect costs under grants to local government agencies (other than those designated as "major" pursuant to OMB Circular A-87) shall be budgeted and reimbursed on the basis of the rates computed and proposed by the local government in its grant application unless the awarding office requests Division of Cost Allocation, HHS (DCA) involvement.

Include only one SF-424A for the application and specify each Part for which you are applying on the one SF-424A form.

PART IV Evaluation Criteria

For applicants applying for additional funds to serve as the NNPTC National Resource and Coordinating Center (Part IV). Eligible applications will be evaluated against the following criteria for a total of 100 points. The areas are as follows:

1. Organizational and Personnel Capacity (50 points)

Does the applicant provide the following information?

a. Descriptions of proposed PTC administrative and resource coordination and support staff positions, including duties, responsibilities, requisite credentials, and relevant experience, staffing to perform the following functions: planning, day-to-day operations, and administrative duties required to provide coordination and support for NNPTC and national-level activities, initiatives, and projects; NNPTC website development and maintenance; coordination of NNPTC marketing activities; coordination of the continuing education accreditation process; NNPTC resource clearinghouse development and maintenance; meeting, committee, and collaboration facilitation and coordination.
b. An organizational chart showing relationships and/or linkages between the applicant and staffing for Part IV functions, indicating lines of authority. The PTC funded to serve as the NNPTC National Resource and Coordinating Center is expected to coordinate those duties and responsibilities, as appropriate, with its Part I, II, and/or III duties and responsibilities to function as one entity and, thus, avoid duplication of labor, services, or materials.

2. Program Plan (50 points)

Does the applicant provide the following information?

a. Descriptions of plans to establish and maintain the functions of the NNPTC National Resource and Coordination Center (Part IV). Provide information about the activities the applicant will engage in to provide NNPTC resource coordination and support services, including: develop and maintain the NNPTC website with up-to-date information on course offerings, course schedules (calendars), training resources, and other information deemed appropriate by CDC and the NNPTC steering committee; coordinate marketing activities that promote NNPTC training opportunities to health professionals; coordinate the continuing education accreditation process; develop and maintain a NNPTC resource clearinghouse as a component of the NNPTC website, facilitate and coordinate NNPTC committees and workgroups; coordinate, implement, and evaluate the NNPTC annual and other nationally-focused meetings; and facilitate and coordinate nationally-focused collaborative activities with FTCC partners and other training stakeholders.

b. Descriptions of plans to provide coordination and support for NNPTC and national-level activities, initiatives and projects, including information on how the Part IV plans to communicate with the Centers comprising the NNPTC .
c. Description of how activities will be evaluated and plan for quality assurance

3. Budget (SF 424A) and Budget Narrative (Reviewed, but not scored)

Although the budget is not scored applicants should consider the following in development of their budget. Is the itemized budget for conducting the project, and justification reasonable and consistent with stated objectives and planned program activities?

If the applicants requests indirect costs in the budget, a copy of the indirect cost rate agreement is required. If the indirect cost rate is a provisional rate, the agreement should be less than 12 months of age. The indirect cost rate agreement should be uploaded as a PDF file with "Other Attachment Forms" when submitting via Grants.gov
Indirect costs under training grants to organizations other than State, local or Indian tribal governments will be budgeted and reimbursed at 8% of modified total direct costs rather than on the basis of a negotiated rate agreement, and are not subject to upward or downward adjustment. Direct cost amounts for equipment (capital expenditures), tuition and fees, and subgrants and subcontracts in excess of $25,000 are excluded from the actual direct cost base for purposes of this calculation. Indirect costs under grants to local government agencies (other than those designated as "major" pursuant to OMB Circular A-87) shall be budgeted and reimbursed on the basis of the rates computed and proposed by the local government in its grant application unless the awarding office requests Division of Cost Allocation, HHS (DCA) involvement.

Include only one SF-424A for the application and specify each Part for which you are applying on the one SF-424A form.

Funding Restrictions

Restrictions, which must be taken into account while writing the budget, are as follows:

- Recipients may not use funds for research.
- Recipients may not use funds for clinical care.
- Recipients may only expend funds for reasonable program purposes, including personnel, travel, supplies, and services, such as contractual.
- Awardees may not generally use HHS/CDC/ATSDR funding for the purchase of furniture or equipment. Any such proposed spending must be identified in the budget.
- The direct and primary recipient in a cooperative agreement program must perform a substantial role in carrying out project objectives and not merely serve as a conduit for an award to another party or provider who is ineligible.
- Reimbursement of pre-award costs is not allowed.
- This is a training grant with an 8% indirect cost cap.
- The government retains unlimited usage of all products and may authorize others to reproduce and distribute these products.

The applicant can obtain guidance for completing a detailed justified budget on the CDC website, at the following Internet address: http://www.cdc.gov/od/pgo/funding/budgetguide.htm.

Pre-application technical assistance conference call will be scheduled during the period between the FOA published date and the application deadline.

Application Review Process

All eligible applications will be initially reviewed for completeness by the Procurement and Grants Office (PGO) staff. In addition, eligible applications will be jointly reviewed for responsiveness by NCHHSTP and PGO. Incomplete applications and applications that are non-responsive to the eligibility criteria will not advance through the review process. Applicants will be notified the application did not meet eligibility and/or published submission requirements.

An objective review panel will evaluate complete and responsive applications according to the criteria listed in Section VI. Application Review Information, subsection entitled

"Evaluation Criteria". The objective review process will follow the policy requirements as stated in the GPD 2.04 at http://198.102.218.46/doc/gpd204.doc.

Applications Selection Process

Applications will be funded in order by score and rank determined by the review panel. In addition, the following factors may affect the funding decision:

Preferences for funding will be given to ensure that funded applicants are balanced in terms of targeted racial/ethnic minority groups. The funded applicants serving each racial/ethnic minority group may be adjusted based on burden of infection in that group as measured by HIV/AIDS/STD reporting.

Maintaining geographic diversity: Funding applicants are balanced in terms of geographic distribution. The funded applicants may be adjusted based in the burden of infection in the jurisdiction measures by HIV/AIDS/STD reporting.

CDC will provide justification for any decision to fund out of rank order.

VII. Award Administration Information

Award Notices

Successful applicants will receive a Notice of Award (NoA) from the CDC Procurement and Grants Office. The NoA shall be the only binding, authorizing document between the recipient and CDC. The NoA will be signed by an authorized Grants Management Officer and e-mailed to the program director. A hard copy of the NoA will be mailed to the recipient fiscal officer identified in the application.

Unsuccessful applicants will receive notification of the results of the application review by mail.

Administrative and National Policy Requirements

Successful applicants must comply with the administrative requirements outlined in 45 Code of Federal Regulations (CFR) Part 74 or Part 92, as appropriate. The following additional requirements apply to this project:

- AR-4 HIV/AIDS Confidentiality Provisions
- AR-5 HIV Program Review Panel Requirements

- AR-8 Public Health System Reporting Requirements
- AR-9 Paperwork Reduction Act Requirements
- AR-10 Smoke-Free Workplace Requirements
- AR-11 Healthy People 2010
- AR-12 Lobbying Restrictions
- AR-14 Accounting System Requirements
- AR-15 Proof of Non-Profit Status
- AR-25 Release and Sharing of Data
- AR-27 Conference Disclaimer and Use of Logos
- AR-29 Compliance with E.O. 13513 Federal Leadership on Reducing Text Messaging while driving

Additional information on the requirements can be found on the CDC Web site at the following Internet address: http://www.cdc.gov/od/pgo/funding/Addtl_Reqmnts.htm.

For more information on the Code of Federal Regulations, see the National Archives and Records Administration at the following Internet address: http://www.access.gpo.gov/nara/cfr/cfr-table-search.html

CDC Assurances and Certifications can be found on the CDC Web site at the following Internet address: http://www.cdc.gov/od/pgo/funding/grants/foamain.shtm

TERMS AND CONDITIONS

Reporting Requirements

Additionally, funded applicants must provide CDC with an original, plus two hard copies of the following reports

Each funded applicant must provide CDC with an annual Interim Progress Report submitted via www.grants.gov:

1. The interim progress report is due no less than 90 days before the end of the budget period. The Interim Progress Report will serve as the non-competing

continuation application, and must contain the following elements:

a. Standard Form ("SF") 424S Form.
b. SF-424A Budget Information-Non-Construction Programs.
c. Budget Narrative.
d. Indirect Cost Rate Agreement.
e. Current budget period activities and objectives
f. Narrative toward progress on achieving objectives for current budget period
g. Detailed line item budget and justification
h. Proposed budget narrative for upcoming budget period
i. Proposed project narrative for upcoming budget period

Detailed guidance will be sent to grantees prior to the start of the next budget period.

2. Annual progress report, due 90 days after the end of the budget period. Required content: Narrative summarizing completion of objectives for the entire budget and a description of challenges (if applicable, for objectives not met), rationale for unmet objectives, strategies for meeting objectives; data for entire budget period.
3. Financial Status Report (SF 269) and annual progress report, no more than 90 days after the end of the budget period.
4. Final performance and Financial Status Reports, no more than 90 days after the end of the project period.

These reports must be submitted to the attention of the Grants Management Specialist listed in the Section VIII below entitled "Agency Contacts".

VIII. Agency Contacts

CDC encourages inquiries concerning this announcement.

For **programmatic technical assistance**, contact:

LaShaun Polk, Project Officer

Department of Health and Human Services
Centers for Disease Control and Prevention
1600 Clifton Road, MS E-40
Atlanta, GA 30329
Telephone: 404-639-5204
E-mail: STDHIVPTCs@cdc.gov

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

Louvern Asante, Grants Management Specialist
Department of Health and Human Services
CDC Procurement and Grants Office
2920 Brandywine Road, MS E-15
Atlanta, GA 30341
Telephone: 770-488-2835
E-mail: lha5@cdc.gov

For **assistance with submission difficulties** (see page 50) contact:

Grants.gov Contact Center
Phone: 1-800-518-4726
Email: support@grants.gov
Hours of Operation: 24hrs a day, 7 days a week, closed on federal holidays

For **application submission** questions, contact:

Technical Information Management Section
Department of Health and Human Services
CDC Procurement and Grants Office

2920 Brandywine Road, MS E-14
Atlanta, GA 30341
Telephone: 770-488-2700
Email: pgotim@cdc.gov

CDC Telecommunications for the hearing impaired or disabled is available at:
TTY (888) 232-6348

Other Information

Appendix A: Map Showing HHS Regions and Quadrant

Appendix B: Definition of Training Methods

Appendix C: Health Equity Definitions

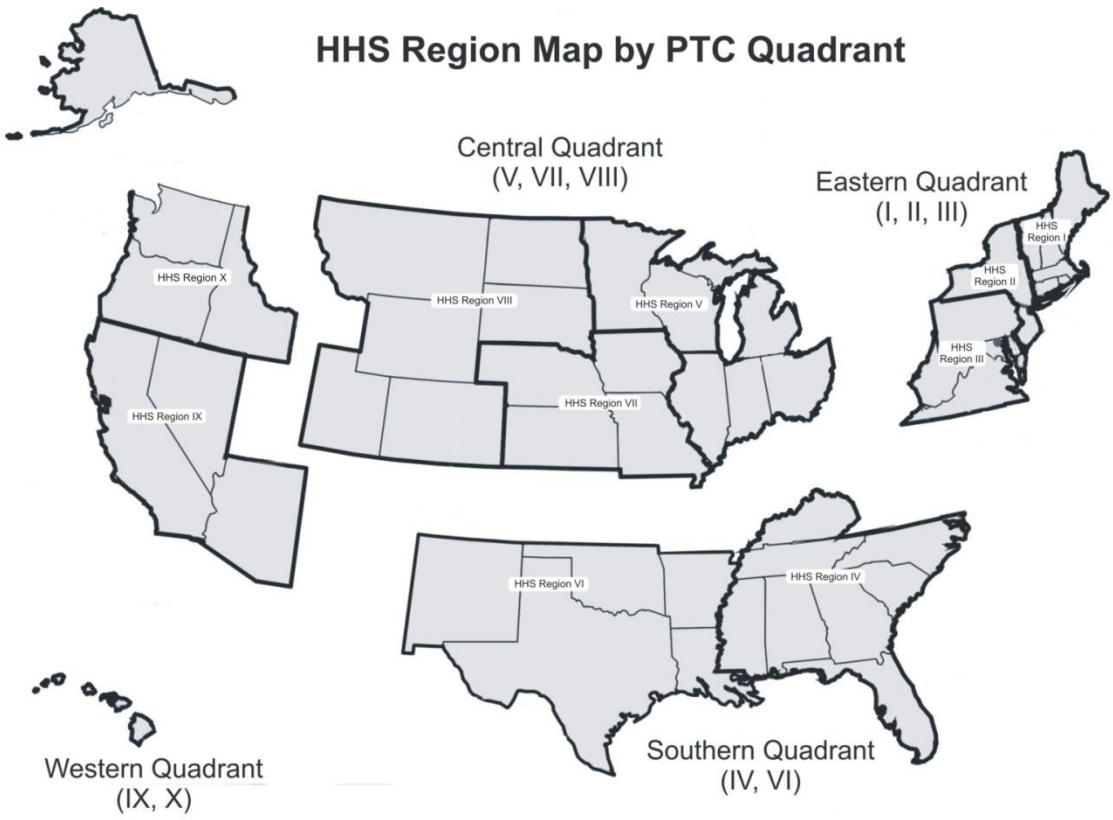
Appendix D: Table of Contents for Application Example

Appendix E: PTC Course Descriptions

Appendix F: PTC Level IV/V Training Request

Appendix G: Overview of CDC Program Operations Guidelines for STD Prevention (POG) criteria for STD clinic operations

Appendix A


HHS Region Map by PTC Quadrant
Central Quadrant
(V, VII, VIII)
Eastern Quadrant
(I, II, III)
HHS Region X
HHS Region VIII
HHS Region V
HHS Region I
HHS Region II
HHS Region III
HHS Region IX
HHS Region VII
HHS Region VI
HHS Region IV
Western Quadrant
(IX, X)
Southern Quadrant
(IV, VI)

Appendix B – Training Method Definitions

Level I: Didactic presentations, introductory courses, and updates

Primarily didactic presentations, panel discussions, self-instructional materials, journal clubs, teleconferences, webinars, etc., to meet the needs of providers in the coverage area as described in the training plan (e.g., didactic component of STD Intensive Courses, STD Updates, Clinician Updates, STD- and HIV-related grand rounds presentations, presentations to health professional organizations and community groups, conference presentations). Trainees are often passive learners and activities may vary in length from brief lectures to multi-day courses.

For most Level I training events, participants will complete registration forms that include CDC-required data elements and the PTC will complete reporting forms documenting the training provided and the participants attending the event.

For some Level I training events, participant registration may be waived (e.g., grand rounds, STD/HIV educational presentations for community groups). The PTC must receive approval from CDC in order to waive participant registration for a given Level I training event.

PTC Part I:

- There is no limit to the number of health professions students who are close to practice who may attend didactic courses or the didactic component of courses with both didactic and experiential components.

Level II: Interactive, skills-building training

Primarily interactive and skills-building activities including case studies, role play, polling using audience response systems, simulated patients, microscopy and laboratory skills (e.g., training in an STD laboratory), and other skill building activities. Trainees actively participate in Level II training activities and activities may vary in form from interactive sessions that are part of a larger training event (e.g., ISTDI role-play activities) to stand-alone interactive courses (e.g., a microscopy skills course).

For these training events, participants will complete registration forms that include CDC-required data elements and the PTC will complete reporting forms documenting the training provided and the participants attending the event.
PTC Part I:

- Health professions students should not account for more that 30 percent of the total number of participants receiving hands-on training.

Level III: Hands-on clinical training

Primarily experiential clinical care activities including preceptorships, practica, or observation of clinical care at a PTC model STD clinic (see Appendix F for an overview of the POG criteria for STD clinic operations) training site, a clinical training site that meets "model STD clinic" criteria, or the trainee's worksite. Trainees are actively involved with actual clinical care experiences involving patients.

For these training events, participants will complete registration forms that include CDC-required data elements and the PTC will complete reporting forms documenting the training provided and the participants attending the event.
PTC Part I:

- Health professions students should not account for more that 30 percent of the total number of participants receiving hands-on training.

Level IV Educational clinical consultation

Patient-specific clinical consultation provided to individual or groups of health care professionals. Level IV training activities are characterized as: an interaction occurs between two clinicians; training is initiated through chart review, clinical quality assessment process, or by a trainee based on a patient-specific clinical question; information is provided on state of the art clinical care; communication occurs via telephone, electronic media, or in person; an interaction with no direct contact between patient and trainer; and an interaction supported financially or

administratively by PTC funds. The PTC must receive approval from CDC in order to conduct a Level IV training activity.
For this level of training, the PTC will complete a reporting form (see **Appendix F**) documenting the consultation request, the consultation provided and the outcomes of the consultation.

Level V Training assistance

Level V training assistance provides information resources and guidance to improve STD/HIV service delivery and performance at the organizational and individual provider levels. Training assistance utilizes a consultation style approach, which is either organizational or PTC-driven. The focus is on organizational or program structure issues. The PTC must receive approval from CDC in order to conduct a Level V training activity. For this level of training, the PTC will complete a reporting form (see **Appendix F**) documenting the training request, the assistance provided and the outcomes of the training assistance.

CDC reporting requirements for participant registration and training event information and recommended reporting form templates will be described in greater detail at the CDC orientation meeting.
It is expected that most training activities will be comprised of multiple training levels (for example ASI consists of approximately 60% Level I and 40% Level II). Percentages of programmatic effort directed to each level of training activity are estimate ranges for the first project year. The estimated ranges for individual courses and curricula will be contingent on the content, the skills to be learned and applied, and the needs of the audience for each specific course or curriculum. In the second and third project year the proportion of effort may be revised to optimize the ability of the PTC to meet training needs in its coverage area.

Appendix C - Health Equity Definitions

Health disparity is a particular type of health difference that is closely linked with social or economic disadvantage based on their racial or ethnic group, religion, socioeconomic status, gender, mental health, cognitive, sensory, or physical disability, sexual orientation, geographic location, or other characteristics historically linked to discrimination or exclusion. [HP 2020-http://www.healthypeople.gov/hp2020/advisory/PhaseI/glossary.htm]

Social determinants are the economic and social conditions that influence the health of individuals, communities and jurisdictions and include conditions for early childhood development; education, employment, and work; food security, health services, housing, income, and social exclusion.

Health equity is 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 health and 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.

Appendix D - Table of Contents for Application EXAMPLE

Application Content

Appendix E - PTC Course Descriptions

Clinical and Laboratory – Part I - courses

STD Intensive

This is a comprehensive introductory clinical training course for clinicians (i.e.,

physicians, advanced practice nurses, physician assistants, nurses) who manage patients/clients at risk for or infected with STDs. The course is targeted to clinicians working in public or private health care settings (e.g., family planning, adolescent health, women's health, primary care, urgent care, community health centers, STD clinics) who examine and treat individuals at risk for STDs.

The course provides comprehensive and in-depth information on STD clinical care. The course is based on the most current CDC STD Treatment Guidelines and the NNPTC Core Curricular Outlines for Clinical Training Courses. The course includes diagnosis, treatment, and management of STDs; clinic protocols and medical record format; clinic how-to; performance standards for clinician-patient interactions; sexual history-taking and male and female physical examinations; universal precautions; STAT testing procedures for point-of-service laboratories; clinical quality assurance; and an overview of disease intervention techniques. The course includes didactic lectures, interactive case studies, and experiential STD clinical training. A minimum of 50 percent of course time is devoted to experiential STD clinical training. Experiential STD clinical training is a hands-on, precepted clinical and laboratory work experience (sometimes called a preceptorship or practicum). In an experiential STD clinical training, the course participant works alongside an experienced clinician in an STD clinic setting, usually for a period of one to three days (six to eighteen hours).

The length of the course is usually five days, but a shorter, three-day version, the *Part-time STD Intensive* or *Three-day STD Intensive*, may be offered. The lecture, case studies and experiential training/practicum are usually offered together, however, a version, the *Flex STD Intensive* or the *STD Practicum*, may be offered in which the experiential training/practicum is scheduled separately for participants unable to schedule three-five consecutive days for training. A version of the STD Intensive targeted to more experienced clinicians, the *Advanced STD Intensive* or a version targeted to clinicians working with adolescents, the *Adolescent STD Intensive* may be offered. Continuing Education credit (Continuing Medical Education (CME) and/or Continuing Nursing Education (CNE) credits must be offered for the *STD Intensive* course.

STD Laboratory and Microscopy Methods

This course is targeted to personnel who perform STAT testing procedures in a point-of-service laboratory that supports STD clinical services. The course of study depends on current disease prevalence, and it may include procedures for bright-field and dark-field microscopy; endocervical and urethral specimen slide preparation; presumptive culture identification; rapid tests and an overview of current testing developments; laboratory records and protocols; and laboratory quality assurance. The course is based on a lecture format, but it devotes a minimum of 50 percent of class time to laboratory experience. The course length varies from one-half day to three days. Continuing Education credit (Continuing Medical Education (CME) and/or Continuing Nursing Education (CNE) credits must be offered for the *STD Laboratory and Microscopy Methods* course.

STD Update for Clinicians

This is a 1 to 2 day overview of current STD medical practices. The course may be tailored to meet specific needs relative to current disease prevalence and medical developments. To accommodate large audiences, a lecture format is utilized, along with limited case study presentations. In some locations, the *STD Update* may also be paired with an optional 2-day STD clinical practicum. Continuing Education credit (Continuing Medical Education (CME) and/or Continuing Nursing Education (CNE) credits must be offered for the *STD Update for Clinicians* course.

Ask, Screen, Intervene: Incorporating HIV Prevention Into the Medical Care of Persons Living with HIV

In concert with the recommendations of the Centers for Disease Control and Prevention, the Health Resources and Services Administration, the National Institutes of Health, and the HIV Medicine Association of the Infectious Disease Society of America, this modular course is designed for care providers of persons with HIV and promotes the use of the clinical encounter for the prevention of HIV transmission. The full course can be provided as a single half-day session or as four discrete sessions, each lasting approximately one hour. Continuing Education credit (Continuing Medical Education (CME) and/or Continuing Nursing Education (CNE) credits must be offered for the *Ask, Screen, Intervene* course.

Behavioral Interventions- Part II courses

Bridging Theory and Practice: Applying Behavioral Theory to STD/HIV Prevention

Learn practical applications of behavior science theory. Explore "theoretical domains," a newly developed learning model that examines the dynamics of personal, interpersonal, emotional, and structural influences on STD/HIV risk-taking behavior. Create a framework to design more effective interventions and better evaluate them. Especially suited for practitioners with limited exposure to behavior science theory. This is a 2 day course.

CLEAR: Choosing Life! Empowerment! Action! Results!

CLEAR: is an evidence-based, health promotion intervention for males and females ages 16 and older living with HIV/AIDS or at high risk for HIV. CLEAR uses one-on-one cognitive-behavioral techniques to assist clients in changing their behaviors around issues like sexual risk, substance abuse, treatment adherence, stigma, disclosure and health/self-care. CLEAR enables prevention counselors to individually tailor the intervention to address the unique needs of each client. CLEAR consists of 5 core skill sessions, 21 menu sessions, and a wrap-up session. The core skill sessions teach the essential cognitive and behavioral skills of the program. Within these core skill sessions, clients develop a personal life goal and an individual prevention plan which directs the focus and selection of subsequent menu sessions. The Centers for Disease Control and Prevention's (CDC's) guidelines on Comprehensive Risk Counseling and Services (CRCS), formerly known as Prevention Case Management (PCM), identify CLEAR as a structured intervention that may be integrated into CRCS programs. This is a four day course.

Foundations of Comprehensive Risk Counseling and Services: An Intensive Individual-Level Intervention (CRCS)

This intensive three-day workshop provides trainees the knowledge, skills, and practice to successfully implement a Comprehensive Risk Counseling and Services (CRCS) program in their community. Using interactive group exercises, role plays, games, and case studies, trainees will explore the relationship between Ryan White Case

Management and CRCS, conduct risk assessments, practice applying core counseling skills, and use implementation tools to develop risk reduction plans. This course is not intended to teach counseling skills, but to provide a framework for implementing CRCS.

Using Focus Groups for Adapting Effective Behavioral Interventions .

This two-day course is designed to provide participants with the skills to use focus group results to adapt Effective Behavioral Interventions (EBIs) that best fit their community's HIV prevention needs and organizations capacity. This focus group research process will consequently provide the foundation for successful adaptation and implementation of the intervention(s).

Using Interviewing and Observation Methods for Adapting Effective Behavioral Interventions

This two-day course is designed to provide participants with the skills to use interview and observational methods results to adapt Effective Behavioral Interventions (EBIs) that best fit their community's HIV prevention needs and organizations capacity. Data collected using these methods will consequently provide the foundation for successful adaptation and implementation of the intervention(s).

Community PROMISE Part 1: Overview and Community Identification

The training for this intervention is conducted over two 3-day courses. These courses are designed for STD/HIV health and prevention professionals, who plan, design and implement STD/HIV community level interventions. This first 3-day course includes a 1-day overview of the Community PROMISE intervention model and a 2-day in-depth training on Community Identification. This course includes a comprehensive overview of the intervention, including the core elements necessary for Community PROMISE, as well as the methods used to effectively identify at risk populations within a community and the factors that influence their behaviors. Participants will learn the steps in conducting community identification and have ample time to practice interviewing, observation, and ways to analyze data.

Community PROMISE Part 2: Role Model Stories & Peer Advocates

The training for this intervention is conducted over two 3-day courses. This Part 2 3-day course teaches the two remaining core elements, Role Model Stories and Peer Advocates. Participants will learn how to interview for role model stories, as well as how to effectively write and produce these stories. Additionally, participants learn how to recruit, train and maintain peer advocate networks used to disseminate the role model stories.

Healthy Relationships

Health Relationships is a four-day, five session, small-group intervention for men and women living with HIV/AIDS. It is based on Social Cognitive Theory and focuses on developing skills and building self-efficacy and positive expectations about new behaviors through modeling behaviors and practicing new skills. Audience: Skilled counselors/mental health providers, peer facilitators (or others) who will facilitate the Healthy Relationships sessions.

Many Men, Many Voices - Level One

Many Men, Many Voices (3MV) is a three-day, seven-session, group level STD/HIV prevention intervention for men who have sex with men (MSM) of color. In Level One, participants will experience the intervention as a client; the seven sessions will be conducted over the 3 days by group facilitators. Sessions are highly interactive, incorporating group exercises, behavioral skills practice, group discussions, and role play. Audience: Prevention staff from CBOs, NGOs and public health departments, outreach workers, case managers and anyone who wants to learn how to facilitate an evidence-based, group intervention for MSM of color.

Many Men, Many Voices - Level Two

Many Men, Many Voices Level 2 is a four-day training where participants will learn to facilitate the Many Men, Many Voices Group intervention for men who have sex with men (MSM) of color. Audience: Prevention staff from CBOs, NGOs and public health departments, outreach workers, case managers and anyone who wants to learn how to facilitate an evidence-based, group intervention for MSM of color.

Partnership for Health

This training consists of three events, an orientation, half day clinic training and a booster training for the clinic to provide clinic staff with the knowledge and skills needed to implement the Partnership for Health intervention. Training is provided for staff of an HIV treatment clinic, implementing the Partnership for Health intervention, on a clinic by clinic basis.

Personalized Cognitive Counseling

This three day training provides training on basic knowledge and skills needed to implement the brief Personalized Cognitive Counseling intervention.

RESPECT

This two-day training will teach participants the RESPECT model, which is an individual level, client focused, HIV prevention intervention, consisting of two brief interactive counseling sessions. Audience: STD/HIV test counselors, outreach workers, case managers, health care professionals, clinicians and other front-line prevention service providers

Project START

The goal of this 5-day training is to prepare facilitators from community-based agencies, AIDS service agencies and health departments to implement Project START successfully with individual clients transitioning from a correctional facility back into the community. The training will provide key information, skills, and resources necessary to fully implement the program.

Sister to Sister

This 1-day training teaches female health care providers the skills to implement a brief (20 minute), individual-level, skill-based HIV/STD behavioral intervention for sexually active, heterosexual African American women; ages 18-45, for use in primary health care clinics. The intervention is based on the Social Cognitive Theory and consists of two sets of core elements. The content core elements are those believed to change risk behaviors,

such as teach, demonstrate and practice negotiation skills, refusal skills, and using condoms, bolster 3 outcome expectancies (sexual pleasure, presentation, and partner reaction), and to build self-efficacy to empower the women to want to be safe sexually. The implementation core elements are essential characteristics of the intervention that relate to the logistics that result in a positive learning environment which consist of the facilitator's ability to demonstrate a caring attitude; and ability to integrate and use all core intervention materials.

Partner Services and Program Support – Part III courses

Introduction to Sexually Transmitted Disease Intervention (ISTDI)

This 9-day course is designed for full-time disease intervention specialists (DIS). It emphasizes the development of skills and techniques for interviewing STD patients in order to identify sex partners for referral to medical evaluation. It also focuses on how to help patients manage current infection and prevent future ones. Participants practice communication, problem solving, and motivation skills in role-plays, and receive feedback from the instructor. The course includes an introduction to visual case analysis for syphilis, case management, and the Lot System. Prior to attending this course, participants will need to successfully complete the CDC Employee Development Guide (EDG).

Fundamentals of Sexually Transmitted Disease Intervention (Fund of ISTDI)

This 5-day course designed for counselors, managers of staff who conduct partner services, public health nurses, or other prevention workers who need comprehensive partner service skills. Focusing on gonorrhea and chlamydia, this class will cover interview periods, communication, assertiveness, problem solving, the STD interview format, field investigations, partner notification and referral, and a brief overview of case management. This course does not provide in-depth syphilis case management or visual case analysis. Prior to attending this course, participants will need to successfully complete selected portions of the CDC Employee Development Guide.

HIV Partner Counseling and Referral Services (PCRS)

This 3-day course is a skills-based training designed for staff in both prevention and care programs working with people living with HIV. This course provides participants with the knowledge and skills to conduct partner counseling, elicitation, and field-oriented HIV partner notification. Participants also role-play situations likely to be encountered during an HIV field investigation. Additionally, the course will provide a perspective on local PCRS considerations. A prerequisite for this course is the successful completion of the course Fundamentals of Prevention Counseling.

STD Program Management Training

This course is designed to provide new STD program managers working in state or local health department STD programs with a solid foundation in the components of disease prevention and the essential competencies needed to manage more effective and comprehensive STD prevention and control programs. The course consists of nine modules, including, Overview of STD Prevention and Control, Cultural Competency in STD Programs, STD Surveillance and Epidemiology, STD Forms, Reporting and Data Management, STD Disease Intervention Services, Health Education, Health Communication and Behavioral Interventions in STD programs, STD Outbreak Response, STD Clinical and Laboratory Services, and Program Collaboration and Service Integration. Each module is taught by experts in the topic and the course includes authentic case studies that incorporate decision-making and problem-solving skills critical to STD program management. The course has been delivered as a three-day in-person course and is currently being revised so that it can be offered as an e-Learning or blended learning course.

Using Social Networks: A Recruitment Strategy for Counseling, Testing and Referral (SNS)

The goals of this 2 to 3-day training are to provide participants with a comprehensive understanding of how to utilize social networks as a recruitment strategy for Counseling, Testing and Referral (CTR) and to develop knowledge and skills needed to successfully implement SNS for CTR in HIV/STD prevention agencies. SNS allows agencies to reach highest-risk persons; hard-to-reach communities and HIV infected individuals who are

unaware of their status by building on existing relationships of trust, in turn creating positive responses to HIV testing messages. At the end of the training, participants will be able to differentiate SNS from other activities, explain the four phases of the SNS, describe the benefits of SNS to reach people at high risk for infection, and develop a plan for implementation.

Chlamydia Partner Management for Family Planning Providers

This 1-day course assists family planning staff to facilitate a client-centered discussion of Chlamydia infection and appropriately answer client concerns around partners. Discussion of key client motivators in explaining the benefits of partner referral to clients is addressed and also features information about all sex partner notification options, with an emphasis on client self-referral of partners for examination and treatment.

Partner Services and Referral for Health Care Professionals

The 1 to 3-day course is designed to enable health care professionals, especially in rural health care settings, to develop the skills, knowledge and techniques to better elicit, notify and refer sex partners of clients infected with STDs or HIV infection. This course is also available as training-of-trainers for STD/HIV prevention program staff interested in obtaining the skills and materials needed to present this course independently in their local site. This course can be accomplished through distance learning methods using self-paced modules, or presented on-site as classroom training. Students' skills are evaluated through videotaped role plays scenarios, and through pre- and post-course testing. Feedback is provided for both training settings. The 16-hour course on STD partner elicitation/notification can be expanded to 24 hours to include instruction on partner elicitation/notification for patients infected with HIV infection.

Training/Operations for Safety Around Field Encounters (TOPSAFE)

This 2-day interactive skill-building course is for public health professionals who are involved in fieldwork, such as full-time Disease Intervention Specialists or community outreach workers. Participants experience situations associated with basic safety principles, interpersonal communications, and problem solving.

Appendix F - PTC Level IV/V Training Request Form

Date: _____

PTC: _____

PTC staff and/or faculty involved: _____

Estimated time, effort and resources needed: _____

Collaborating training partners (if applicable): _____

Clinician, organization, or agency targeted for training: _____

Description of training issue and analysis of training need:

Training plan:

Expected outcomes:

Expected timeline:

Appendix G - Overview of CDC Program Operations Guidelines for STD Prevention (POG) criteria for STD clinic operations

ACCESSIBILITY

Clinics should be located so that they are readily accessible through public and private transportation from residential areas. Clinic hours and staffing should be sufficient to accommodate patients, with minimal patients turned away. No patient should be denied care for lack of money. Medical services should be at no charge, minimal, or based on a sliding scale.

RANGE OF SERVICES

At a minimum, clinics should have the capability to accurately diagnose and treat bacterial STDs. Clinics should have the capacity to distribute medications for diseases diagnosed in the clinic. At a minimum, medications must be available for locally prevalent STDs, with prescriptions available for diagnosed diseases not prevalent in the community. Confidential counseling and testing for STDs, including HIV, should not be denied because a patient refuses other STD services.

CLINIC ENVIRONMENT

The building in which a STD clinic is located should have signs making it easy to locate. Signs at the building entrance should be easy to read and should clearly list STD among the services. Examination rooms should be clean and private and should have adequate equipment and supplies for physical examinations and specimen collection for both male and female patients. The number of examination rooms should be adequate to accommodate the number of clinicians (at least one room per clinician) and to serve patients promptly during the normal working day.

Patient Considerations

Patient confidentiality must be maintained. Confidentiality should be promoted by using a system other than names when calling patients from waiting areas. Patients should be told what to expect during the clinic visit, including being told STDs for which they are being tested and the common ones for which they are not being tested.

All clinic staff should develop and maintain cross-cultural awareness and display cultural sensitivity.

REGISTRATION PROCESS

Confidentiality

Registration information should be obtained in a confidential manner.

Procedure

Clinics should have systems in place to assess and modify patient visits to assure minimal waiting.

CLINIC FLOW

Walk-in patients with genital ulcers, discharges, and women with abdominal pain or who are pregnant should be examined that day. Patient stops should be kept to a minimum (ideally, not more than three—registration, clinical care, and an STD/HIV interviewing/counseling session, if needed).

MEDICAL RECORDS

All procedures concerning content and filing of medical records should be in accordance with state and local laws and statutes.

CLINIC MANAGEMENT STRUCTURE

The clinic manager should have adequate specialized training in STD, clinic and personnel management, and public health. The medical director should have specialized training in STD, be available for consultation during clinic hours and ensure the overall quality of clinical services.

CLINIC MANUALS

An STD clinic manual should contain the goals and the objectives of the clinic, including fully integrated STD/HIV services. Clinic protocols or standard medical instructions for specific patient management should include:

1. Patient evaluation

2. Management of STDs (See CDC STD Treatment Guidelines http://www.cdc.gov/std/treatment/2006/toc.htm)
3. Medical consultation and referral
4. Follow-up after therapy
5. Counseling/education
6. Management of sex partners

Protocols should include current recommended treatments for STDs.

CLINICIAN ROLES AND PERFORMANCE STANDARDS

Nurses, nurse practitioners, and physician assistants should work in full compliance with established clinic protocols as clinicians responsible for the entire clinical care process, including history taking, physical examination, laboratory specimen collection, diagnosis, treatment, plan for follow-up, and counseling/education. All clinicians should have a specific STD training course and AIDS update course.

STANDARD PRECAUTIONS

Gloves should not be worn outside the examination room or the laboratory. Skin on hands or other parts of the body should be immediately and thoroughly washed if contaminated with blood or other body fluids. Hands should always be washed before and after the examination and before leaving the examination room.

EMERGENCY PROCEDURES

STD prevention programs should develop and implement policies and procedures to manage occupational exposures of health care workers.

STAT LABORATORY MANAGEMENT STRUCTURE

Laboratory Services

Each clinic that provides STD services should have an on-site stat laboratory or capacity to perform stat tests. The laboratory must have a current CLIA certificate and be in compliance with CLIA-88. Point-of-care tests should only be used to provide immediate results and treatment to patients. If testing does not occur immediately, tests with greater

sensitivity and specificity should be used. STD clinics should use routine and reference laboratory services which further facilitate the diagnosis of STDs.

LABORATORY BIOSAFETY LEVEL CRITERIA

Thorough hand washing should be performed after handling infectious materials and before leaving the laboratory. Laboratory personnel should receive appropriate training on the potential hazards associated with the work involved, the necessary precautions to prevent exposures, and exposure evaluation procedures. Personnel should receive periodic updates, or as necessary. Laboratory equipment and work surfaces should be decontaminated with an appropriate disinfectant on a routine basis after work with infectious materials is finished, and especially after spills. Protective laboratory coats, gowns, smocks, or uniforms designated for lab use should be removed and left in the laboratory before leaving for non-laboratory areas.

Examination gloves should be worn when handling infectious materials, contaminated surfaces or equipment. Gloves should be disposed of when contaminated, or when work with infectious materials is completed. Disposable gloves should not be washed or reused. Each laboratory should contain a sink for washing hands. An eyewash facility should be readily available.

LABORATORY PRACTICE AND TECHNIQUES

All procedures should be consistent with recognized standard and specialized microbiologic practices. Safety equipment should include items for personal protection such as gloves, coats, face shields, and safety glasses.

Biosafety Manual

The biosafety manual should be regularly updated.

DISEASE INTERVENTION SPECIALIST SERVICES IN MEDICAL FACILITIES

DIS should be on site or on call to provide disease intervention services during clinic hours. Where resources are lacking for specialized disease intervention staff, or work is reassigned based on disease priorities, clinicians and counselors can perform intervention

services. DIS should have a thorough understanding of STD clinical care and STD diagnostic test results. DIS should be provided with an adequate number of private rooms to ensure that confidential STD interviews and HIV prevention counseling sessions can be conducted without interruption.

QUALITY ASSURANCE PROCEDURES

Staff interactions with patients should be observed regularly. Medical records should be audited regularly (checked against clinic protocols) to determine the appropriateness of diagnoses and treatment and the completeness of documentation.

REPORTING

Clinics should promptly submit morbidity reports following the diagnosis of a case in the format determined by the state or local prevention program.