FOA PS06 606 Pre-Application Questions and Answers

These are the questions received by email by December 1, 2005 and answered on the December 1, 2005 Pre-application conference call. Additional questions emailed to PTC-FOA@cdc.gov before the December 12, 2005 repeat of the pre-application conference call will be answered on that call and posted to the website after the call.

General Questions

1. For administrative staff positions, are we limited to 3 FTEs in the roles of coordinator, medical director and data manager or is the announcement requesting that individuals simply be identified for these functions (since each function may not require 1.0 FTE and other program administrative requirements are not covered under these functions)?
   No FTE requirements or limitations are specified in the Announcement. At the minimum, awardees are expected to provide the following administrative support for the program: one coordinator to serve as a single point of contact for this award, and who will be responsible for the administrative duties related to all training activities; a Medical 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); faculty, trainers, and/or preceptors; and a data coordinator who will be responsible for transmitting data from all Parts to CDC. (See Activities Section A. Administration.) Applicants should provide descriptions of proposed PTC administrative and training staff positions, including duties, responsibilities, requisite credentials, and relevant experience (See Section V.1.2.a.i.)

2. Under the Administration section, it is stated that a data coordinator should be responsible for transmitting data from all parts to CDC. We would like to confirm that if we are applying for just Part 1, then one data coordinator would be from our part and submit only data from our Part 1 to the CDC?
   Yes. Your data coordinator would be responsible only for submission of data from the Parts that your PTC has. A PTC that has more than one Part is expected to have one data coordinator who is responsible for data submission for all Parts, not a separate data coordinator for each Part.

3. On the HHS region map by PTC Quadrant, Puerto Rico & the US Virgin Islands [USVI] are not depicted on this map. They have historically been part of Region II and we would like to confirm that they remain in this region, with New York & New Jersey.
   Yes, Puerto Rico and the USVI will remain in HHS Region II.

4. There is a section called "Special Requirements Section", It comes under III - Eligibility information. It says that you have to indicate that documentation be part of the appendix - how this should be handled? Some parts of the "Special Requirements" will be narrated in the application part, but do we need to respond to each of the points separately in the appendix?
   The section in question states "Place documentation of all special requirements in an Appendix." If some of the special requirements are included in the narrative, then you may choose not to duplicate the information in the Appendix. However, if you choose not to duplicate this information, then you must specify in the Appendix exactly where the requested information may be found in the narrative; this should include the narrative's page number(s) and paragraph(s) as relevant.

5. The other question is under V - Application Review information - Criteria. It ask for applicants to provide measures of effectiveness that will demonstrate the accomplishment of the various identified objectives of the cooperative agreement. And it says that these measures of effectiveness must be submitted with the application and will

be an element of evaluation. What is being referred to here - are this the objectives we list in our semi-annual plan and should be part of an appendix here? Or is this something different?

The measures of effectiveness addressed in Section V.1 must relate to the performance goals stated in the "Purpose" section of this announcement Measures must be objective and quantitative, and must measure the intended outcome. These measures of effectiveness must be submitted with the application and will be an element of evaluation. The "Purpose" section states that: 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, and are in alignment with, one or more of the following performance goal(s) for the CDC National Center for HIV, STD, and TB Prevention (NCHSTP):

- **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;**
- **Decrease the numbers of persons at high risk for acquiring or transmitting HIV infection;**
- **By 2010, increase by 13 percent the proportion of HIV-infected people who know they are infected, as measured by the proportion diagnosed before progression to AIDS (Baseline: 76 percent in 2000; target for 2010: 85 percent);**
- **By 2010, increase to at least 80 percent the proportion of HIV-infected people who are linked to appropriate prevention, care, and treatment services, as measured by those who report having received some form of medical care within three months of their HIV diagnosis (2001 Baseline: 79 percent);**
- **Strengthen the capacity nationwide to monitor the HIV epidemic, develop and implement effective HIV prevention interventions, and evaluate prevention programs.**

The PTC program has not previously been required to submit performance measures that address the NCHSTP performance goals requirement, so this does not refer to objectives listed as part of the semi-annual or annual plan (progress report) of any currently funded PTC.

6. Are there funds from DHAP [CDC Division of HIV/AIDS Prevention] included in the Announcement for training on the curriculum based on the MMWR Guidelines for Incorporating HIV Prevention into the Medical Care of People living with HIV?
   No DHAP funds for training on this curriculum are included in this FOA.

7. Is it CDC's plan to maintain the NNPTC website or are funds included in the announcement for a PTC to do this?
   Although we understand there are questions and concerns surrounding funding for specific NNPTC joint activities, we feel it is important that the questions addressed during these calls remain restricted to the technical issues of the FOA and the application process. Issues regarding the particulars of funding will be addressed after final award notices have been made.

Part I Specific Questions

8. Can the 130 hours of didactic training be delivered through distance learning methods such as webcasts, teleconferences, online case-based training or must it be delivered through "in-person" courses?
   As long as students complete registration forms that include CDC-required data elements, any modality (in-person or distance learning modalities) may be used to

deliver the 130 hours of STD/HIV didactic educational offerings. (see application section V.1.5.a.i – Part I Part-Specific Training Plan)

9. Under hours of training that the Part 1 PTC is to fulfill, if CME activities are done in terms of online training modules which category of training does this fall under - the 130 hours of training or 30 hours of training?
   As long as the student completes a registration form that include CDC-required data elements, this type of training activity would fall under the 130 hours of training. (See application section V.1.5.a.i – Part I Part-Specific Training Plan)

10. For the Part 1 clinical training hours, there is a 70 hours experiential training to a minimum of 75 students that is to be provided. For the laboratory/microscopy skills-building activities - what falls under this definition? Is a didactic lecture on lab/microscopy with skills-building components qualified to fulfill this requirement? In addition, does this have to be one-on-one training?
    Laboratory/microscopy skills-building activities qualify as experiential training; Laboratory/microscopy lectures qualify as didactic training. (See application section V.1.2.b –Part I Part Specific Training Capability) Example: a 4-hour microscopy course with one instructor with 2 hours of lecture and 2 hours of microscopy skills-building experience would qualify as 2 hours of didactic training and 2 hours of experiential training. This is not required to be one-on-one training.

11. Regarding the experiential requirement of a minimum of 70 hours for a minimum of 75 participants, can CDC clarify if these hours refer to actual training time per student trained? For example, if 3 students attend an 8 hour clinical practicum, we currently count that as 24 hours of training time to 3 students. How should these hours be counted? It appears that the expectation is that participants will complete clinical practicums of less than 1 hour each?
    The 70-hour requirement refers to the amount of time trainers/preceptors spend providing experiential training. The 75-participant requirement refers to the number of participants attending the experiential activity. The previous announcement stipulated only an experiential hour requirement and it was not clearly defined whether the requirement referred to the number of trainer hours or the number of participant hours. (See section V.I.5.a.ii – Part I Part-Specific Training Plan) Examples: An 8 hour clinical practicum attended by 3 students, each with a preceptor for the 8 hour period qualifies as 24 experiential training hours (3 preceptors x 8 hours) and 3 participants. An 8 hour clinical practicum attended by 3 students, all 3 precepted at the same time by the same preceptor qualifies as 8 experiential training hours (1 preceptor x 8 hours) and 3 participants.

12. Under "Part-Specific Training Plan", it states to have a plan to deliver a minimum of 70 experiential training hours to 75 students. Can you clarify this statement? Does this mean that if we had 75 students go through experiential training, each student could have one hour of experiential training?
    These are two separate measures. The 70-hour requirement refers to the amount of time trainers/preceptors spend providing experiential training. The 75-participant requirement refers to the number of participants attending the experiential activity. (See section V.I.5.a.ii – Part I Part-Specific Training Plan). Seventy-five students attending a one-hour experiential training activity taught by one trainer qualifies as one experiential training hour (1 trainer x 1 hour) and 75 participants. Seventy-five students attending a one-hour experiential training activity taught by three trainers qualifies as three experiential training hour (3 trainers x 1 hour) and 75 participants.

13. In terms of clinic tables for the application part "Part 1 - Training Capability - STD morbidity and model clinics" - it is requested for data to be stratified by disease, sex,

race, age. Can these be done in separate tables per clinic and are all of these data components expected?
Yes, these may be submitted in separate tables. However, the application narrative is limited to 60 pages. These components are expected and your application will be scored based on the completeness of information provided. (Also see next question.)

14. In regards to this funding announcement, the data tables requested for each model STD clinic - can these data tables be a part of the appendices or do they need to be part of the main narrative part of the application (which has a 60 page limit)?
The data tables may be part of the appendices or they may be part of the main narrative. If the data tables are placed in an appendix, you must specify in the narrative where the tables are located including the appendix name and page number.

15. Under application criteria for Part-Specific Training Capability, it is asked for part a4 for a STD clinic floor plan. How formalized is this plan expected to be - can it be hand drawn as long as it lists the required routes, etc.? And if the clinic plans are the same for several clinics that are our model clinics does a plan need to be submitted for each clinic or can one plan represent all clinics?
The floor plan may be hand-drawn, but it must be neat and legible. If the clinic plan is the same for several clinics, one floor plan representing those clinics may be submitted; however, you must clearly specify which clinics the floor plan represents.

16. In regards to the grant announcement, are resumes required for clinic preceptors?
A bio-sketch, resume or curriculum vita should be submitted for all proposed PTC administrative and training staff positions. These may be placed in the appendix.

17. Can courses on Venipuncture Techniques for RNs, DIS & community health outreach workers to conduct STD testing be counted toward didactic/practicum hours & participants in Part 1 applications?
Courses on Venipuncture Techniques should not be a major focus of Part I training. Part I PTCs are expected to provide didactic and experiential training on STD clinical and laboratory services for practicing health care professionals. Specific course content will be discussed in greater depth after the awards are made.

18. Can "On Site Monitoring Reports" conducted by State Health Department STD Programs at proposed Model STD Clinics be submitted as documentation of clinic management protocols since they address all issues of interest (registration, procedures, appointments, triage, priority systems, confidentiality, standing orders, etc)?
The application should include an outline of clinic management protocols, such as elements of the registration procedure and appointment, triage, and priority systems. You may submit monitoring reports in addition to, but not in lieu of, documentation of these clinic procedures and systems.

Part II Specific Questions:

19. 2.b Part Specific Training Capability, ii) Part II a) refers to Prevention Case Management as a Program Support course. Is that how we are to list it?
Yes, list Prevention Case Management as a support course.

20. 5 Part Specific Training Plan, b Part II, vii) says Description of a plan to translate and train three courses each year in Spanish. Does this mean that we are to translate three

new courses each year of the five years and also teach three courses in Spanish each year?
The applicant should plan to train 3 courses in Spanish each year for five years. Existing Spanish curricula may be used for these trainings.

21. The RFP says clearly that the application needs to be a partnership between an organization that can bring state-of-the-art research findings as well as an organization that can deliver the training. You give examples of these being an academic institution and a health department. We are a part of a medical school and have provided the PTC Behavioral Intervention courses for eleven years. So we have the capability to deliver courses. Can we partner with another academic institution that can increase our ability to bring state-of-the-art research findings to our work?
The quality of the partnerships will be determined by the breadth of experience of those partners in bringing state-of-the-art research findings to training development and delivery. Therefore, if the applicant is an academic institution, they can partner with another academic institution or health department.

22. You ask for documentation that we have developed certain courses. What will suffice as documentation - agenda, sections of curricula?
Course agendas are considered sufficient documentation.

23. You ask for documentation that we have taught courses - what will suffice as documentation - a letter from AED [Academy for Educational Development] stating that they arranged these courses with us as trainers, flyers and registration sheets, letters from host agencies?
Yes, a letter from AED confirming the number of courses taught will suffice.

24. How would we document our work on the Adapting course since it is not final yet?
Provide an agenda for the training or a Table of Contents for the curriculum and dates and locations of planning meetings attended.

25. The RFP asks us to do intermediate outcome evaluation on ALL courses? Are the Part IIs to do this for all 440 hours we teach on every type of course or some subsampling? Are we to do it for all the DEBI courses and so are to do it as a collaborative effort?
No requirements or limitations have been placed on this. Your application will be reviewed based on the criteria as described in Section V.1. The specific criteria for Evaluation are listed in Section V.1.7.

26. Section V.1.b.Part II c) and d) seem to be the same thing - number of times and locations DEBI [Diffusion of Effective Behavioral Interventions] courses are taught, etc. please clarify.
c) refers to packaged DEBIs such as VOICES/VOCES that are trained by the applicant, and d) refers to DEBIs developed and diffused by the applicant, such as Healthy Relationships.

27. The RFA does not specify the definition of organizational partners. Is it permissible to have the organizational partners be under the same umbrella. For example, within Duke University the following entities, representing different areas of expertise and experience, Department of Medicine, Infectious Diseases Clinic; Pastoral Services, Partners In Caring; Terry Sanford School of Public Policy, Health Inequalities Program are potential partners for this RFA. If these organizations meet all experience and expertise requirements in the RFA, would it be permissible for these entities to be the collaborative entities?

The applicant may choose internal or external partners. However, the quality of the partnership will be determined by the breadth of the experience of linking state-of-the-art research findings with delivery of trainings informed by this research.

28. Would training programs that meet the RFA criterion, but are not among those programs listed in the RFA, acceptable for training under Part II?
    The CDC wishes to diffuse specific evidence-based interventions and fund agencies with expertise in delivering trainings on these interventions that comprise the DEBI program.

29. As a portion of Part II, is it acceptable under Part II to develop and implement an innovative training program?
    The CDC wishes to support training programs that support the diffusion of specific evidence-based interventions that comprise the DEBI program.

30. May "Prevention with Positives" be a focus of the Part II trainings? A secondary focus?
    Prevention with Positives is currently a focus of the trainings on interventions specified in the FOA, such as Healthy Relationships.

Part III Specific Questions

31. The program announcement mentions access to a Model STD Clinic and while announcement is pretty clear for the Part I applicants it's less so for the Part III applicants. Would you please clarify how the Part III applicants would reference (access to a Model STD Clinics) the information in the application?
    Part III applicants may submit 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. Intervention outcomes include number and type of clients eligible for interview, percentage interviewed, numbers of sex and needle-sharing partners per client interviewed, percentage of partners located, and percentage tested or treated for syphilis, HIV infection, and other STDs addressed with partner services. (See section V.1.2.b.iii - Part Specific Training Capability: Part III)