NACCHO
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STDexpress
triage. test. treat.

STD Express Data Collaborative RFA Q&A

This document includes all questions that NACCHO has received regarding the STD Express Data Collaborative RFA. Note that some of these questions were also addressed on the informational webinar. This document will be updated periodically through the application period, which ends March 28, 2019, by 11:59 PT. It was most recently updated on March 19, 2019.

1. **Q: Our clinic has been operating express services for one month. Are we eligible?**
   A: Per the RFA, clinics are eligible if they have been operating express services for a minimum of 3 months. This requirement exists because the short project timeline focuses on data collection, rather than implementation support, and it is critical that clinics have the capacity to begin collecting data upon project kick-off in late April. It is possible that some clinics that have been operating express for fewer than 3 months might have strong enough protocols, experience, and data collection capacity to qualify for this project. However, clinics that meet the eligibility requirement have an advantage. We will not award a clinic that will be initiating express services as this project begins.

2. **Q: Our clinic is run by a nurse and counselors. Patients are all tested and do not receive physical examinations, whether or not they are symptomatic. If they receive a positive test result, they are treated according to standing orders. Are we eligible?**
   A: There are different definitions of express services. Per this RFA, express services refer to those that are triage-based and do not include a full physical examination. If patients are not triaged, the clinic is not eligible for this project.

3. **Q: Is this a one-time funding opportunity:**
   A: Yes.

4. **Q: What specific data will be required to share -- any individual level (protected health information)?**
   A: The level of data collected will be determined as part of the refinement of the evaluation plan, which is one of the first activities of the Data Collaborative sites. We do anticipate wanting to collect data related to testing outcomes, such as positives detected, time to treatment, and patient demographics.

5. **Q: Is data collection prospective, for example will start in May 2019, or will the time period be decided with each site?**
   A: The time period will be decided with each site depending on when services were implemented. We anticipate using a combination of historical and prospective data for sites, depending on what the clinic has available. It would be helpful to describe what type the clinic already has available in your application.

6. **Q: Do you have a timeframe for when the $30,000 would go out to each site?**

A: The awards will be divided up over the year-long project period according to a schedule of deliverables. Typically, we award a proportion upon contract signing.

7. **Q: If our clinic is currently funded through state dollars, but we provide express services, do we qualify?**
   A: Yes. Eligibility is open to STD clinics that have been operating express services for a minimum of 3 months.

8. **Q: How do you define triaging?**
   A: Triaging refers to a process in which patients complete an assessment for risks, which can include symptoms, behaviors, and health needs, among others, that results in their being routed to an appropriate level of service.

9. **Q: Are there restrictions on what funding can be used for?**
   A: Please refer to federal regulations regarding allowable and unallowable costs. NACCHO does not have specific budget requirements.

10. **Q: Would an IRB be involved? If so, a central and also a local IRB?**
    A. We are hoping to not have to involve IRB given the short timeframe for this project, and as such will take the need for IRB involvement into consideration when determining the final evaluation questions.

11. **Q: What data would be included in the cost-effectiveness analysis?**
    A: The data could include medication costs, provider salaries, equipment costs, number of cases detected, number of patients treated – any number of items related to STD services. We would like to note that conducting cost-effectiveness analyses are not routine, and sites should not be discouraged from applying if they have not done this. The CDC team will be doing a lot of this work on behalf of the sites and helping them identify what the data is and where it might be. CDC is also interested in providing training for cost-effectiveness analysis to increase the capacity of sites to do this work.

12. **Q: Do we have to be a NACCHO member to qualify?**
    A: No.

13. **Q: Patients do a risk assessment prior to testing over the phone. If they need other services they are referred. Does this mean we are ineligible?**
    A: The key element here is where those referred patients go for care, and whether the clinic has the capacity to collect that data. As this is an evaluation project, it's critical to have comparison data. If the clinic has access to data related to treatment, outcomes, cost, and cost-effectiveness for referred patients (e.g., they visit a different location that is part of the same system), then that clinic would be eligible. If the referral clinic is part of a different health system and such data is not shared, they are ineligible.

14. **Q: We operate a school-based clinic program and offer testing for everybody. We don't triage up front because we want everyone to come in, and then we triage afterwards for additional risks and testing needs. Would that be considered express?**
    A: Large-scale school-based screening programs that test all students are not eligible for this project. Any triage-based testing without a full physical examination that would occur within the school-based health center outside of that program would be eligible.

15. **Q: Are we required to test for specific STD tests as part of express services?**
    A: We are most interested in outcomes related to syphilis, gonorrhea, chlamydia, and HIV, but no, there are no specific test requirements.

16. **Q: Is there a background prevalence requirement?**
    A: No. We are interested in supporting clinics in high morbidity areas, but there is no threshold requirement.

17. **Q: We operate express visit hours on certain days and times of the week, and at that time we are a primarily express-only clinic. So we'll see people who are symptomatic or who report that they are a contact or brought in by a DIS at certain times, and then we also triage and make appointments for people who don't fit into the express visit availability. Does that model fit this RFA?**
    A: Yes, because there is a triage process and express patients do not receive full physical examinations.

18. **Q: We don't allow new patients to go to the express clinic. They have to see a provider first, and then someone returning for a screening can do express if they're symptomatic. Are there any issues with that in terms of eligibility?**
    A: No. Clinics can determine for themselves which patients are eligible for express services.

19. **Q: Is an EHR a necessity for the grant?**
    A: Capacity for data collection is a requirement for the grant. If you do not have an EHR but have all of the data accessible to share with us for analysis, that would likely suffice.

20. **Q: Are we supposed to submit an evaluation plan with the narrative?**
    A: No. The development of the evaluation plan will be one of the first activities of the Data Collaborative.

21. **Q: Can you clarify "Description of relevant experience and expertise conducting evaluations in the clinic setting"? Can you give examples of what a clinic could consider evaluations? What type of experience are you looking for?**
    A: We're trying to distinguish between typical project evaluations and evaluations that focus on outcomes associated with clinic-level activities and data. For example, a clinic might operate an HIV+ support group, and they might have evaluated that group for effects on adherence, risk behavior, etc. We're more interested in evaluations that looked at clinic operations or clinic-level outcomes, for example, a project that assessed and improved retention in care or

increased positives identified among a particular patient population. Many quality improvement (QI) projects would be relevant here. Ideally, experience would involve collecting and/or analyzing clinic- and client-level data.