DC | HEALTH

GOVERNMENT OF THE DISTRICT OF COLUMBIA

DEPARTMENT OF HEALTH

HIV/AIDS, Hepatitis, STD and TB Administration

HAHSTA_RWA_10.11.24

REQUEST FOR APPLICATIONS

SUBMISSION DEADLINE:

TUESDAY, DECEMBER 03, 2024, BY 3:00 PM

The Department of Health (DC Health) reserves the right without prior notice, to reduce or cancel one or more programs listed in this Request for Applications (RFA). DC Health reserves the right to reject all applications, adjust the total available funds or cancel the RFA in part or whole. Funding levels for the total program and budget amounts of individual awards shall be contingent upon continued receipt of funding by DC Health, as well as any reduction, elimination or reallocation of funds by a federal grantor, the Executive Office of the Mayor (EOM) and/or DC Health. Any adjustments shall be in accordance with authorizing legislation for the use of funds, all DC municipal regulations for grant-making and the applicable federal and DC Health terms of agreement.

DC DEPARTMENT OF HEALTH

HIV/AIDS, Hepatitis, STD and TB Administration

NOTICE OF FUNDING AVAILABILITY (NOFA)

FY 2025 Ryan White Part A HIV/AIDS Program

FO# HAHSTA_RWA_10.11.24

The District of Columbia, Department of Health (DC Health) is requesting proposals from qualified applicants to provide services in the program and service areas described in this Notice of Funding Availability (NOFA). This announcement is to provide public notice of DC Health's intent to make funds available for the purpose described herein. The applicable Request for Applications (RFA) will be released under a separate announcement with guidelines for submitting the application, review criteria and DC Health terms and conditions for applying for and receiving funding.

Funding Opportunity Title:	FY 2025 Ryan White Part A HIV/AIDS Program
Funding Opportunity Number:	HAHSTA_RWA_10.11.24
DC Health Administrative Unit:	HIV/AIDS, Hepatitis, STD, & Tuberculosis Administration
DC Health Program Bureau	Care and Treatment Division
Funding Opportunity Contact:	Ebony Fortune, Ryan White Program Manager, Email: HAHSTARFAs@dc.gov
Funding Opportunity Description:	The Government of the District of Columbia, DC Health, HIV/AIDS, Hepatitis, STD and Tuberculosis Administration (HAHSTA) is requesting proposals from qualified applicants to provide a variety of clinical and medical support services to indigent, uninsured, and under-insured persons living with HIV/AIDS in the Washington, DC Eligible Metropolitan Area (EMA).
Eligible Applicants	Not-for-profit organizations, including healthcare entities and institutions of higher education; government-operated health facilities; for-profit health and support service providers demonstrated to be the only entity able to provide the service. All applicants must have service locations within and provide services in the DC EMA.
Anticipated # of Awards:	32

Anticipated Amount Available:	$26,000,000
Annual Floor Award Amount:	$75,000
Annual Ceiling Award Amount:	$3,000,000
Legislative Authorization	Ryan White HIV/AIDS Treatment Extension Act of 2009
Associated CFDA#	93.914
Associated Federal Award ID#	H89HA00012
Cost Sharing/Match Required?	No
RFA Release Date:	October 11, 2024
Letter of Intent Due date:	Strongly Recommended by October 22, 2024
Application Deadline Date:	December 3, 2024
Application Deadline Time:	3:00 p.m.
Links to Additional Information about this Funding Opportunity	DC Grants Clearinghouse https://communityaffairs.dc.gov/content/community-grant-program#4 DC Health EGMS https://egrantsdchealth.my.site.com/sitesigninpage

Notes:

1. DC Health reserves the right to issue addenda and/or amendments subsequent to the issuance of the NOFA or RFA, or to rescind the NOFA or RFA.
2. Awards are contingent upon the availability of funds.
3. Individuals are not eligible for DC Health grant funding.
4. Applicants must have a Tax ID# and be registered in the federal Systems for Award Management (SAM) with an active UEI# to be registered in DC Health's Enterprise Grants Management System.

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RFA TERMS AND CONDITIONS

The following terms and conditions are applicable to this, and all Requests for Applications issued by the District of Columbia Department of Health (DC Health) and to all awards, if funded under this RFA:

A. Funding for a DC Health subaward is contingent on DC Health's receipt of funding (local, federal, or private) to support the services and activities to be provided under this RFA.

B. DC Health may suspend or terminate an RFA pursuant to its own grant making rule(s) or any applicable federal regulation or requirement.

C. The RFA does not commit DC Health to make any award.

D. Individual persons are not eligible to apply or receive funding under any DC Health RFA.

E. DC Health reserves the right to accept or deny any or all applications if the DC Health determines it is in the best interest of DC Health to do so. An application will be rejected if it does not comply with eligibility requirements, formatting or submission requirements outlined in the RFA. DC Health shall notify the applicant if it rejects that applicant's proposal for review.

F. DC Health reserves the right to issue addenda and/or amendments subsequent to the issuance of the RFA, or to rescind the RFA. The prospective applicant is responsible for retrieving this information via sources outlined in the RFA (e.g. DC Grants Clearinghouse).

G. DC Health shall not be liable for any costs incurred in the preparation of applications in response to the RFA. The applicant agrees that all costs incurred in developing the application are the applicant's sole responsibility. No funds already awarded the applicant under other instruments or agreements shall be used by the applicant to fund the preparation of the application.

H. DC Health may conduct pre-award site visits (either in-person or virtually) to verify information submitted in the application and to determine if the applicant's facilities are appropriate for the services intended.

I. DC Health shall determine an applicant's eligibility by way of local and federal registries for excluded parties searches and documents and certifications submitted by the applicant.

J. The Applicant Organization must obtain a Unique Entity Identifier (UEI) to apply for funding and register for the federal System for Award Management (SAM) at www.sam.gov prior to award.

K. DC Health reserves the right to require registry into local and federal systems for award management at any point prior to or during the Project Period (i.e., the total number of years for which funding has been approved). This includes DC Health Electronic Grants Management System (EGMS), for which the awardee will be required to register and maintain registration of the organization and all users.

L. DC Health may enter into negotiations with an applicant and adopt a firm funding amount or other revision of the applicant's proposal that may result from negotiations.

M. DC Health shall establish terms of agreement for an award funded under this RFA. If funded, the applicant will receive a Notice of Grant Award (NOGA). The NOGA will establish the Project Period and define any segments of the Project Period (e.g. initial partial year, or a 12-month budget period). The NOGA shall outline conditions of award or restrictions.

N. Continuation of funding, if awarded shall be based on availability of funds, documented satisfactory progress in interim and annual reports, continued eligibility and determination that the continued funding and activities is in the best interest of the District of Columbia.

O. DC Health shall provide the citations to the local or federal statute/s and implementing regulations that authorize the award; all applicable District of Columbia and Federal regulations, including 2 CFR 200 and Department of Health and Services (HHS) published 45 CFR Part 75, payment provisions identifying how the awardee will be paid for performing under the award; reporting requirements, including programmatic, financial and any special reports required by the funding agency; and compliance conditions that must be met by the awardee.

P. If there are any conflicts between the terms and conditions of the RFA and any applicable federal or local law or regulation, or any ambiguity related thereto, then the provisions of the applicable law or regulation shall control, and it shall be the responsibility of the applicant to ensure compliance.

Additional information about grants management policy and procedures may be obtained at the following site: https://oca.dc.gov/page/division-grants-management or click here: Citywide Grants Manual and Sourcebook.

If your organization would like to obtain a copy of the **DC Health RFA Dispute Resolution Policy,** please visit the DC Health Office of Grants Management webpage, here.

Any additional questions regarding the RFA Dispute Resolution Policy may be directed to the Office of Grants Management (OGM) at doh.grants@dc.gov. Your request for this document will not be shared with DC Health program staff or reviewers.

CHECKLIST FOR APPLICATIONS

- ☐ Applicants must be registered in the federal Systems for Award Management (SAM) and the DC Health Enterprise Grants Management System (EGMS).
- ☐ Complete your EGMS registration at least **two weeks** prior to the application deadline.
- ☐ Start constructing and uploading your application components into EGMS at least a week prior to the application deadline.

  The complete **Application Package** should include the following:

  - ☐ Certificate of Clean Hands dated within 60 days of the application deadline or attestation of operations outside of the District of Columbia
  - ☐ Current business license or certificate of licensure or proof to transact business in local jurisdiction
  - ☐ Current certificate of insurance
  - ☐ Copy of cyber liability policy
  - ☐ IRS tax-exempt determination letter (for nonprofits only)
  - ☐ IRS 990 form from most recent tax year (for nonprofits only)
  - ☐ Current list of Board of Directors, on letterhead, signed and dated by a certified official from the Board (this cannot be the executive director)
  - ☐ Assurances, certifications and disclosures (refer to assurances checklist)
  - ☐ Project Abstract
  - ☐ Project Narrative
  - ☐ Workplan
  - ☐ Organizational Chart
  - ☐ Staffing Plan
  - ☐ Budget Table
  - ☐ Budget Justification
  - ☐ Capacity to Provide Culturally Competent Services
  - ☐ Other Sources of Funding
  - ☐ Medicaid Certification
  - ☐ Scope of Services
  - ☐ Organizational Risk Self-assessment

- ☐ Documents requiring signature have been signed by an organization head or authorized representative of the applicant organization.
- ☐ The applicant needs a Unique Entity Identifier number (UEI#) and an active registration in the System for Award Management to be awarded funds.
- ☐ The project narrative is written on 8½ by 11-inch paper, 1.0 spaced, Times New Roman font using 12-point type *(11–point font for tables and figures)* with a one-inch margins.

- ☐ The application proposal format conforms to the “Proposal Components” (See section 5.2) listed in the RFA.
- ☐ The proposed budget is complete and complies with the budget forms provided in the RFA. The budget narrative is complete and describes the categories of items proposed.
- ☐ The proposed work plan and other attachments are complete and comply with the forms and format provided in the RFA.
- ☐ Submit your application via EGMS by the application due date and time**. Late applications will not be accepted.**

1. GENERAL INFORMATION

1.1 KEY DATES

- Notice of Funding Announcement Date: **September 27, 2024**
- Request for Application Release Date: **October 11, 2024**
- Pre-Application Meeting **Visit** **https://OGMDCHealth.eventbrite.com**
- Deadline to register in EGMS for new applicants: **November 19, 2024**
- Application Submission Deadline: **December 03, 2024**
- Anticipated Award Start Date: **March 01, 2025**

1.2 OVERVIEW

The District of Columbia Department of Health (DC Health) HIV/AIDS, Hepatitis, STD and Tuberculosis Administration (HAHSTA) serves as the primary local agency responsible for protecting the public against tuberculosis, human immunodeficiency virus (HIV) and its disease progression, acquired immunodeficiency syndrome (AIDS), as well as other sexually transmitted diseases (STDs). HAHSTA administers federal funds for HIV prevention in Washington, DC and HIV/AIDS care and treatment services across the Washington, DC Eligible Metropolitan Area (DC EMA) through partnerships with healthcare facilities and community-based organizations. The strong community-focused system maximizes regional-level prevention, surveillance, and disease control response, ensuring the effective delivery of medical care, health service planning, and policy responsiveness. Our collective efforts highlight our approach to patient-centricity by focusing on equitable outcomes.

The established community-focused system of care for people living with HIV/AIDS includes a compendium of prevention, core medical, and supportive services designed to provide tailored, high-quality care to eligible individuals. Its primary goals are to reduce new HIV transmissions, engage people living with HIV in continuous care, and increase viral suppression rates.

By 2030, DC Health aims to achieve the triple 95 targets for HIV/AIDS: ensuring 95% of individuals know their HIV status, 95% of those diagnosed receive treatment, and 95% of those on treatment achieve viral suppression. Additionally, DC Health targets a 50% uptake of pre-exposure prophylaxis (PrEP) among eligible individuals, with a goal to reduce new HIV diagnoses to 21 cases per year by 2030. To meet these goals, HAHSTA will support innovative programs that contribute to ending the HIV epidemic using the following key pillars:

- **Diagnose**: Improve and expand access points for HIV testing among undiagnosed individuals living with HIV within their communities.

- **Treat**: Ensure people living with HIV, newly diagnosed or not-in-care, are linked to essential HIV care, treatment, and support services to help them stay in care and adhere to medication where they will reach and maintain an undetectable viral load.
- **Prevent**: Provide HIV prevention services, including outreach, partnerships, and workforce expansion to increase access to and uptake of PrEP for individuals experiencing a disproportionate impact of HIV.
- **Respond**: Support transmission-ending strategies by providing HIV care and treatment and PrEP to those identified through cluster detection activities.
- **Engage**: Address resident-expressed stress barriers to prioritize HIV health, including stigma reduction, stable housing, economic opportunity, and ensuring cultural humility in service delivery.

While there may be overlap between the pillars, HAHSTA's Care and Treatment Division focuses on the Treat, Respond and Engage pillars.

1.3 Purpose

The purpose of this funding announcement is to create new and/or expanded access points for Ryan White eligible customers seeking core medical and supportive services within the DC EMA.

This funding announcement supports a comprehensive range of services for individuals living with HIV and those disproportionately affected by the virus, aiming to:

- Advance health equity across HIV treatment strategies.
- Reduce health disparities in HIV-related outcomes.
- Enhance timely access to HIV-related care and treatment.
- Improve effective communication between customers and healthcare providers.
- Provide a supportive environment for patient care.
- Promote engagement and retention in HIV care.
- Improve viral suppression among individuals living with HIV.

1.4 Source of Grant Funding

Approximately $26 million dollars are available for this funding opportunity. The availability of funding is contingent upon the availability of funds to DC Health by the Health Resources and Services Administration (HRSA) under the RWHAP Part A program for the Washington, DC EMA.

The services funded under this RFA represent a subset of the total Ryan White service categories that will be supported in the EMA for GY35. *Please note, this competitive process is the only opportunity to enter the subrecipient network for the compendium of services funded under the Washington DC Eligible Metropolitan Area Ryan White Part A Grant.*

DC Health is the primary recipient of federal funds awarding these funds. As a primary recipient,

DC Health has the responsibility to pass through requirements and objectives agreed to in our federal notices of award (42 U.S.C. § 300ff-11-20 and § 300ff-121, HRSA-25-054, HIV EMERGENCY RELIEF PROJECT GRANTS, H89HA00012).

1.5 Award Information

1.5.1 Amount of Funding Available

The chart below outlines the approximate funds available for service categories and bundles offered under this funding announcement.

1. EMA-Wide Ryan White Core Medical and Support Services Service Categories		
1a) Fee- For- Value- Program	**Maximum # Available Awards**	
i. Medical Care Coordination	10 Awards	$ 7,184,834
ii. Non-Medical Care Coordination	6 Awards	$ 3,665,732
iii. Medical Nutrition Therapy	5 Awards	$ 293,259
iv. Food Bank and Home-Delivered Meals	5 Awards	$ 2,052,810
1b) Other EMA-Wide Services	**Maximum # Available Awards**	
i. Oral Health Services	5 Awards	$ 1,759,551
ii. Early Intervention Services	10 Awards	$ 4,692,137
iii. Medical Transportation	8 Awards	$ 293,259
2. Jurisdictional Ryan White Core and Support Services		
2a) Washington, DC	**Maximum # Available Awards**	
i. Substance Abuse Outpatient Care	4 Awards	$ 293,259
ii. Mental Health Services	4 Awards	$ 513,202
iii. Home and Community Based	2 Awards	$ 146,629
iv. Psychosocial Support Services	5 Awards	$ 1,016,293
v. Other Professional Services	1 Awards	$ 293,259
2b) Suburban, MD	**Maximum # Available Awards**	
i. Health Insurance Prem & Cost-Sharing Asst. (HIPCSA)	3 Awards	$ 87,978
ii. Outreach Services	3 Awards	$ 205,281
iii. Psychosocial Support Services	3 Awards	$ 102,640
2c) Northern, VA	**Maximum # Available Awards**	
i. Substance Abuse Outpatient Care	2 Award	$ 43,989
ii. Mental Health Services	2 Award	$ 43,989
iii. Psychosocial Support Services	2 Awards	$ 293,259

2d) West Virginia (Jefferson and Berkley Counties)	2 Awards	$ 450,000
3. Emergency Financial Assistance (Washington, DC and Suburban, MD)	2 Awards	$ 3,225,844
4. Minority AIDS Initiative (MAI)- Youth Reach (EMA-Wide)	5 Awards	$ 2,496,054

1.5.2 Period of Performance and Funding Availability

The first budget period of this award is anticipated to begin on March 1, 2025, and continue through February 28, 2026. After the first budget period, there will be up to two additional 12-month budget periods for a total project period, March 1, 2025 – February 29, 2028.

Continuations will be determined based upon satisfactory program performance and grant compliance, the availability of continued funding, and the compatibility with HAHSTA's business model. HAHSTA reserves the right to change the mechanism by which it supports Ryan White programming at any time.

1.5.3 Eligible Organizations/Entities

The following are eligible organizations/entities that can apply for grant funds under this RFA:

- Not-for-profit health and support service providers, including universities.
- Government-operated health facilities, which are located within and provide service within the Washington, DC EMA.
- For-profit entities are eligible for funding ***only in the event*** there are no non-profit organizations that are willing and able to deliver the proposed services.

1.5.4 Non-Supplantation

Recipients may supplement, but not supplant, funds from other sources for initiatives that are the same or similar to the initiatives being proposed in this award.

2. BACKGROUND

2.1 DEMOGRAPHIC OVERVIEW

The Washington, DC EMA spans a wide metropolitan region of 6,922 square miles, comprising the District of Columbia, five counties in suburban Maryland, 11 counties and six independent cities in Northern Virginia, and two counties in West Virginia. The DC EMA is home to 6,224,799 people, according to 2022 US Census Bureau estimates.

As of December 31, 2022, 39,725 persons were diagnosed and living with HIV in the DC EMA. The overall prevalence of people living with HIV (PLWH) for the DC EMA at the end of 2022 was 0.6%, above the national estimated prevalence rate of 0.4% for diagnoses of HIV. Despite accounting for 10.8% of the DC EMA general population, the District of Columbia is the region's epicenter of HIV with 45% of all diagnosed HIV cases. Whereas, diagnosed HIV cases in Maryland accounted for 34.1%, Virginia at 21%, and West Virginia at less than 1%. In 2022, Washington, DC had the highest number of living diagnosed cases (17,829), followed by Maryland (13,536), Virginia (8,360) and West Virginia (247; based on 2019 data).

In the DC EMA, racial and ethnic minorities are disproportionately affected by HIV. People of color account for approximately half of the general DC EMA population, but over 78% of the estimated number of PLWH in the EMA. Blacks account for most cases at 65.7%; Whites, 16.1%; Hispanic/Latino/a/x, 11.5%; Asian/Pacific Islanders, 1.3%; and "other/ unknown," 5.2%. Most people living with HIV in the DC EMA are over 40 years of age (77.0%), with those over 50 years of age representing 56.4%. This demographic trend underscores the transformation of HIV/AIDS from a terminal illness into a chronic condition where individuals who receive treatment are living long and productive lives. Approximately 5.7% are 29 years of age or younger. Males account for the majority of people living with HIV in the DC EMA (70.4%). Maryland has the highest proportion of cases among females (35.1%). The landscape for DC is similar to the regional level data with the majority of PLWH being Black (67.5%), male (73.3%), and over 40 years of age (81%).

In terms of race and ethnicity, the District's population is highly diverse—approximately 41% Black, 38% White, and 5% Asian, with Hispanic/Latino/a/x residents of any race making up 11% of the population.[1] However, the population is also highly segregated, with significant economic disparities observed by ward and race. For example, Wards 2 and 3 have the highest

percentage of white residents and the lowest percentage of Black residents, whereas Wards 7 and 8 have the highest percentage of Black residents and the lowest percentage of white residents. While 2021 District-wide median household income was more than $91,000, median household income in Ward 3 was more than 3.6 times higher than in Ward 8; median household income among white District residents was approximately 1.7 times higher than among Hispanic/Latino/a/x residents and 3.1 times higher than among Black residents.[2] In December 2021, the District's overall unemployment rate was 5.8%. However, in Ward 8, which had the highest rate, unemployment was more than four times higher than in Ward 3, where the rate was the lowest.

2.2 Program Information

The Ryan White Program model promotes the core values of the Ryan White HIV/AIDS Program: quality service delivery, improved health outcomes for customers with HIV, and a strong partnership between HAHSTA and its Ryan White service providers. It employs a thoughtful and strategic approach that will support parity across the network of Ryan White providers, support network providers through capacity building efforts, and reward providers for quality service delivery.

The Ryan White Program Model features several program components that will be outlined in this funding announcement:

- Service Provider Tracks
- Organizational Capacity Assessments
- Fee-for-Value Program
- Care Coordination Service Bundles
- Capacity Building Assistance and Targeted Trainings; and
- Centralized Eligibility System

2.3 Additional Program Information

Ryan White services support the HIV-related medical and support service needs of eligible individuals. Subrecipients must be able to make an explicit connection between any service supported by RWHAP funds and the intended customer’s HIV status, or care-giving relationship to a person living with HIV.

3. PURPOSE

The DC Health HIV/AIDS, Hepatitis, STD, and TB Administration (HAHSTA) is requesting proposals from qualified applicants to deliver a selection of Ryan White Part A defined services to eligible customers residing in the Washington, DC EMA. The intended purpose of these services is to: advance health equity across HIV treatment strategies, reduce health disparities in HIV-related outcomes, enhance timely access to HIV care and treatment, promote engagement and retention in HIV care, and improve viral suppression rates among EMA residents living with HIV.

3.1 APPROACH

Integrated Assessment Tool

HAHSTA remains committed to enhancing the quality of services offered by its Ryan White-funded subrecipients. To support this goal, it utilizes the Integrated Assessment Tool (IAT) to evaluate the capacity and operational processes of these subrecipients within DC Health's provider network. subrecipient. The key functions of the IAT are:

- To objectively assess strengths and areas for improvement of Ryan White funded subrecipients.
- To provide tailored solution guidance for areas in need of capacity growth development and sustainability.
- To serve as a baseline to monitor and track performance progress in identified areas over time.
- To support informed decisions on interventions, resources, and funding eligibility.
- To determine applicant's eligibility for participation in the fee-for-value (FFV) program.
- To determine applicant's funding track for this funding announcement.

Typically, the IAT gauges an organization's capacity and administrative processes across various aspects to provide a holistic view of its performance. However, for the sole purpose of this funding opportunity, the assessment will only focus on applicant's capacity.

Results of the assessment help standardize how HAHSTA views the performance and capabilities of its subrecipients, highlights best practices, and pinpoints technical assistance and training needs.

Design and Utilization

The tool assesses applicants across five major categories: organizational infrastructure; fiscal management; program management; data collection, reporting, and use; and quality management. Each of these categories includes a series of questions that are answered based on a Likert scale. Utilizing a Likert scale allows HAHSTA to more accurately assess the range of

capacity levels among all applicants. Additionally, the Likert scale uses a point system that helps identify an applicant's capacity level as low, moderate, or high.

In subsequent continuation grant years, the IAT will be used annually to evaluate the capacity and processes of successful applicants who have become subrecipients within HAHSTA's Ryan White network. Each assessment is conducted by a cross-departmental team of HAHSTA staff, identified as subject matter experts, who assign scores for their respective categories.

Rating

Applicants receive scores in each category based on responses to a series of questions that have assigned point values. The scores of each category are combined to obtain the total points. The total points are then divided by the maximum points possible. This calculation will determine an applicant's capacity level as *Low Capacity, Moderate Capacity*, or High *Capacity.*

The IAT will be used during the pre-award compliance site visit to evaluate applicants' capacity in response to RFA #HAHSTA_RWA_10.11.24. There are no documents to upload in EGMS. HAHSTA staff will utilize prescribed responses from applicants' submissions as verification sources to assign scores for each criterion within the IAT. The outcomes of the IAT will determine which applicants demonstrate sufficient capacity to meet HAHSTA's standards and regulations, directly influencing the final award decisions.

Capacity Levels

The IAT identifies and categorizes three levels of capacity in its efforts to strengthen the capabilities and effectiveness of providers in HAHSTA's Ryan White network. The parameters of each level of capacity (low, moderate, and high) are different and affect the services for which a subrecipient may be funded and the capacity building requirements to which a subrecipient must adhere as a condition of funding.

<u>Low Capacity</u>

Low Capacity subrecipients work closely with HAHSTA and its designated contractor to receive customized technical assistance. Technical assistance on this level is focused on growth and development and supports building sustainable programs. Low Capacity subrecipients are expected to attend all trainings and to complete all quarterly modules as prescribed. It is anticipated that subrecipients with this level of capacity complete all required technical assistance offerings will score a minimum of Moderate Capacity during the IAT assessment in the following grant year.

Subrecipients identified as Low Capacity are ineligible to participate in HAHSTA's fee-for-value (FFV) program model during the initial award period. Applicants that are recommended for FFV funding but are rated as Low Capacity may become eligible to receive FFV funding in the subsequent grant year (GY36) if they complete the customized technical assistance plan

successfully and receive at least a Moderate Capacity rating in the IAT assessment *at the end of the initial award period.*

Moderate Capacity

Subrecipients identified as Moderate Capacity work with HAHSTA and its designated contractor to receive targeted technical assistance. Targeted areas of technical assistance include any criteria with a response that did not receive the highest score. Moderate Capacity subrecipients are expected to attend all trainings and to complete all modules as prescribed. Focus is given to process and practice enhancements. Moderate Capacity subrecipients receive support to become more strategic, agile, data-informed, and outcome driven. It is anticipated that subrecipients with this level of capacity will, at a minimum, maintain their status as Moderate Capacity during the IAT assessment in the following grant year.

High Capacity

Subrecipients identified as High Capacity participate in HAHSTA-guided technical assistance opportunities to maintain high-level outcomes, as needed. They are expected to participate in sharing evidence-informed best practices and are encouraged to participate in trainings that support onboarding and refresher opportunities. It is anticipated that subrecipients with this level of capacity will, at a minimum, maintain their status during the IAT assessment in the following grant year. High Capacity subrecipient s that maintain their status for two (2) consecutive years will receive an abbreviated IAT assessment in the following grant continuation year.

Technical Assistance and Trainings

Technical assistance and training are prescribed based on IAT ratings.

HAHSTA and/or its affiliates provide technical assistance and training in the following broad categories:

- Data Collection, Reporting, and Use
- Clinical Quality Management Programs
- Program Management
- Organizational Infrastructure
- Fiscal and Billing Systems

For successful applicants, their identified capacity building requirements will be detailed in the "Conditions of Award" section of their new grant award.

4. PERFORMANCE REQUIREMENTS

Successful applicants shall employ strategies and implement activities for the service areas outlined in this section. Applicants shall demonstrate how the proposed project plan will impact each of these areas and demonstrate their organizational capacity to do so.

4.1 TARGET POPULATION

All Ryan White services are intended to support indigent, uninsured, and under-insured persons living with HIV in the Washington, DC EMA. Based upon surveillance data, the following populations are disproportionately impacted by HIV in the Washington, DC EMA:

1. Transgender Women
2. Black and Latino Same Gender Loving (Male to Male Sexual Contact)
3. Black Cisgender Heterosexual Women
4. Black Cisgender Heterosexual Men

4.2 LOCATION OF SERVICES

Awards are for services to residents of the Washington, DC EMA. Service delivery sites must be located within the Washington, DC EMA, which is comprised of the District of Columbia, five counties in Maryland, 11 counties and six independent cities in northern Virginia, and two counties in West Virginia.

- Washington, DC
- Maryland Counties
  - Prince George's
  - Montgomery
  - Frederick
  - Calvert
  - Charles
- Virginia Cities
  - Alexandria
  - Fairfax
  - Falls Church
  - Fredericksburg
  - Manassas
  - Manassas Park
- Virginia Counties
  - Arlington
  - Clarke
  - Culpeper
  - Fairfax
  - Fauquier
  - King George
  - Loudoun
  - Prince William
  - Spotsylvania
  - Stafford
  - Warren
- West Virginia Counties
  - Berkely
  - Jefferson

Applicants are responsible for documenting the availability of locations proposed and securing/maintaining all applicable assurances and certifications necessary to transact business in the jurisdiction where services will be offered.

Service Areas

1. EMA-Wide Ryan White Core Medical and Support Services Service Categories
1a) Fee- For- Value Program
1b) Other EMA-Wide Services
1. Jurisdictional Ryan White Core and Support Services
2a) Washington, DC
2b) Suburban, MD
2c) Northern Virginia
2d) West Virginia (Jefferson and Berkley Counties)
3. Emergency Financial Assistance
4. Minority AIDS Initiative (MAI)- Youth Reach**

**** Virginia providers are only eligible to apply for funding under Service Area 1: EMA-Wide Services, Service Area 2: Jurisdictional Ryan White Core and Support Services, and Service Area 4: Minority AIDS Initiative Youth Reach.**

The Ryan White Compendium of Services *(Section 14)* contains the definition, key activities and program requirements for each service category funded by this funding opportunity. The service category descriptions comprised in the compendium provide applicants with the program requirements to which they must respond in the project description section of their applications.

4.3 Program Strategies

HAHSTA's Ryan White Program uses sub-grants exclusively as the mechanism for supporting Ryan White services across the Washington, DC EMA. Grants will be used to award funds based on provider capacity, service category and Fee-for-Value designation, as applicable. Fee-for-Value (FFV) grants are limited to five service categories and consist of two primary components: a base award for capacity and a value enhancement award for performance against FFV benchmarks. All other service categories outside of the FFV designation will be funded through the traditional grant structure and will not include any enhancement awards.

Service Provider Tracks

Service providers will be awarded under two program tracks through this funding opportunity: Track I (immediate implementation) and Track II (capacity building to deliver services). Applicants are required to self-select a track; however, HAHSTA reserves the decision to assign a track at the conclusion of the review process as a condition of award. Regardless of

the applicant's experience in service delivery, it is expected that all the selected programs will achieve full implementation and be fully scaled Ryan White Part A service providers by March 2026. Additional guidance for how to select a track can be found in section 5.2.

Track I. Immediate Implementation

This track is for providers that have an established system of care, are experienced in the delivery of Ryan White services and can implement all services with minimal assistance. For this cadre of providers, technical assistance outside of the capacity assessment will be offered, upon request and/or as needed.

Track II. Capacity Building to Deliver Services

This track is for providers that have an established system of care and a demonstrated ability to deliver services to the focus population but are limited in their ability to deliver all components of the Ryan White Part A service categories at the time of application. Capacity building assistance will be provided to this group of successful applicants.

4.4 Allowable Activities

Items 1-7 below describe requirements that all applicants must meet regardless of which services they propose to provide. Applicants should reference how they will accomplish these requirements in the Program Description section of each service category application.

1. **Program Goal**
   Applicants applying to provide services must demonstrate the provision of services that will advance health equity across HIV treatment strategies, reduce health disparities in HIV-related outcomes and leverage partnerships and resources to improve customer health outcomes.

2. **Data Management**
   Applicants applying to provide services must demonstrate the following: a) how the proposed provision of service delivery will impact process and outcome measures specific to the proposed service category and b) how the program's data management practices will track process and outcome data, including reporting data in CAREWare.

3. **Referral Sources**
   The applicant is responsible for accepting referrals from hospitals, HIV counseling and testing centers, physicians, community-based organizations and HIV service providers.

4. **Coordination Among Agencies**
   The applicant is responsible for developing linkage agreements with shelters, congregate living facilities, community residential facilities (CRFs), day treatment

facilities including, primary care sites, skilled nursing facilities, personal care services, and other potential referral sources for persons living with HIV seeking care.

5. **Staff Cultural Competency**

The applicant is responsible for employing culturally competent staff that reflect the racial, ethnic, sexual orientation, gender, and linguistic background of the customer population(s) the applicant expects to serve.

6. **RWHAP as Payer of Last Resort**

RWHAP funds are always the payer of last resort. RWHAP funds cannot be used to pay for services reimbursable by private insurance, Medicaid, Medicare, or any other federal, state, or local services/programs.

7. **Preparation of Project Work Plan, Scope of Services, Budget, and Budget Narrative Justification**

Applicants are required to prepare a work plan for each proposed service category, a scope of services table for each proposed service category, a budget table for each proposed service category, and a budget justification for each proposed service category and applicable budget line items.

The service category specific scopes of services are tools used by the Ryan White HIV/AIDS Program (RHAWP) to highlight and report how subrecipient grant awards contribute to strategic goals and the comprehensive system of care. The scope of services serves as the basis for tracking the Ryan White Program's progress and performance against stated goals and objectives. It is used to evaluate program impact, improved health status, and ensure accountability. The ability to set meaningful and reasonable targets is critical as is a standardized process for target setting and monitoring. For the purposes of this funding opportunity, applicants are required to complete a scope of services table for each service category. Note applicants proposing to leverage resources for a required service category, must include a scope of services and workplan for those leveraged services. The scope of services submitted should be accurate, competitive and contain realistic targets that are in alignment with the applicant's proposed workplan, linkage summary table and overall program proposal.

In the section below is a summary list of the service categories available under this core service area. To respond to this core service area, applicant organizations must use the Ryan White Compendium of Services in Section 14 to obtain information on specific program requirements.

CORE SERVICE AREA 1:
EMA-Wide Ryan White Core Medical and Support Services Service Categories

Care coordination involves deliberately organizing patient care activities and sharing information among all participants concerned with a patient's care, to achieve safer and more effective care. This means that the patient's needs and preferences are known ahead of time and communicated at the right time to the right people, and that this information is used to provide safe, appropriate, and effective care to the customer.

Broad care coordination approaches include:

- Teamwork
- Care management
- Medication management
- Health information technology
- Patient-centered medical home

Specific care coordination activities include:

- Establishing accountability and agreeing on responsibility
- Communicating/sharing knowledge
- Helping with transitions of care
- Assessing patient needs and goals
- Creating a proactive care plan
- Monitoring and follow-up, including responding to changes in customers' needs
- Supporting patients' self-management goals
- Linking to community resources
- Working to align resources with patient and population needs.

1a. Fee- For-Value Program

HAHSTA's Ryan White HIV/AIDS Program is committed to supporting the delivery of high quality medical and support services to people living with HIV, and to the community partners providing that care. The RWHAP's Fee-For-Value Program rewards subrecipients for their provision of services and achievement of quality health outcomes.

FFV Services Categories

HAHSTA has designated five service categories that will be funded exclusively through Fee-For-Value grants.

(1) Outpatient/Ambulatory Health Services
(2) Non-medical Case Management
(3) Medical Case Management
(4) Medical Nutrition Therapy
(5) Food Bank and Home-Delivered Meals

In this RFA, the FFV services available are the two care coordination bundles. The bundles require the same level of care coordination outlined under Service Area 1a. Applicants proposing services under a care coordination bundle must submit one project description that outlines how they will deliver all services within the bundle. Applicants can choose to apply to **no more than one care coordination bundle**.

1. **Medical Care Coordination:** This Fee-For-Value service bundle requires a comprehensive multi-disciplinary approach to the delivery of Outpatient/Ambulatory Health Services; Medical Case Management Services; and Non-Medical Case Management Services.

2. **Non-Medical Care Coordination**: This Fee-For-Value service bundle requires a collaborative effort to provide both Medical and Non-Medical Case Management Services. ***Applicants for this bundle cannot be medical providers.***

Fee-for-Value Reimbursement Structure

The Fee-for-Value (FFV) funding model is a subset of the grant-funding model, but with enhanced inputs used to determine final award amounts. For each service category in the FFV model, there will be two components for each award. The two components are 1) Capacity and 2) Value Enhancements.

Capacity Award:

1. **Capacity Award:** In year one, successful applicants will receive a capacity award under the FFV funding model. HAHSTA will reserve 60% of the overall award per service category for this purpose. Funded subrecipients will be awarded commensurate with the size of their proposed program. The process to determine the award is algorithmic considering the number of customers proposed for Outpatient/Ambulatory Health Services, Medical Case Management, Non-Medical Case Management and Medical

Nutrition Therapy; and the number of service units provided for Food Bank and Home-Delivered Meals. Funding for new subrecipient will be calculated from applicants' self-report of performance based on the scope of services submissions (applicant overestimation of proposed performance is highly discouraged as it will negatively impact provider ability to receive value enhancements under FFV). Funding for subsequent years will be calculated from service data submitted in CAREWare.

Value Enhancement: Successful applicants will receive process assessment funds as a portion of their award in the first year of grant funding. Value enhancements in the first year of grant funding are based on process assessment scores only. This portion of the award is algorithmically calculated based on the integrated assessment conducted during the application review process.

2. **Process Assessment:** Successful applicants will be awarded value enhancements based on their performance as a Ryan White subrecipient as well as their demonstrated ability to provide funded services commensurate with the size and scope of their program. The process to determine the award is algorithmic – considering:

   The assessment of organizational processes is measured with an objective tool, the Integrated Assessment Tool (IAT), to evaluate current practices at each organization. The process criteria are based on Ryan White Program deliverables and assessed by HAHSTA staff. Process assessment criteria in the IAT evaluate the subrecipients' processes in the following areas: fiscal management; program management; data collection, reporting, and use; and data management.

   Every funded subrecipient will receive an award for process assessment. Subrecipients will be grouped with like-sized subrecipients. The process assessment award will be distributed proportionately within like-sized groups, based on subrecipients' process assessment scores.

   HAHSTA reserves the right to amend or revise the process assessment process, as needed.

For successful applicants, the Fee-for-Value awards will vary year to year, based on the program's capacity, performance and the quality of the services provided by the program. In addition to compensating subrecipients for service delivery, this model rewards subrecipients with a reimbursement enhancement for their performance as a Ryan White subrecipient and the quality of services provided to RWHAP customers in the network.

For GY35, the total grant award structure for the FFV program will be comprised of the following portions: sixty percent (60%) for capacity and forty percent (40%) for performance. Since the goal of FFV is to incentivize subrecipients to focus on the quality of services rendered and improve health outcomes, HAHSTA plans to adjust these proportions to favor performance outcomes over capacity in the coming years. HAHSTA reserves the right to change the award proportions of FFV

programs from year to year, as the RWHAP and subrecipient network adjusts to the FFV structure. Subrecipients will be notified of any changes to the proportional distribution of the FFV award at the beginning of the budget period.

****DC Health reserves the right to make final determinations of subrecipient awards from other inputs, including but not limited to, subrecipient budget, previous spending, and program performance.**

1b. Other EMA-Wide Services

CORE SERVICE AREAS

ORAL HEALTH

Definition

Oral health care includes diagnostic, preventive, and therapeutic services provided by general dental practitioners, dental specialists, dental hygienists and auxiliaries and other trained primary care providers. Dentures deemed essential for the maintenance of health will be included.

EARLY INTERVENTION SERVICES

Definition

Early Intervention Services (EIS) is the bridge in the continuum of care that joins HIV prevention to care services. The goal is to identify persons with HIV that are unaware of their status and link them to medical care and treatment. For this funding opportunity, the only Early Intervention Services programs available for funding will be status neutral, Early Intervention Services programs that employ the use of the Hi-V model.

EIS does not include general awareness or education efforts or broad-based testing.

The following criteria must be used by service providers to determine customer eligibility for early intervention services:

- Status neutral customers (those testing negative for HIV but having high risk behaviors) are not required to have Ryan White eligibility documents in CAREWare. (Unless there are customers who are affected by HIV, which may require assessing eligibility for the provision of additional services).
- Ryan White customers are required to have eligibility documents that include the following: proof of HIV positive status, proof of residence in the EMA, proof of income, and proof of insurance.

SUPPORT SERVICE AREAS

MEDICAL TRANSPORTATION

Definition

Medical Transportation is to provide non-emergency transportation services to eligible customers in the Washington, DC Eligible Metropolitan Area (EMA) that enables them to access or be retained in core medical and support services.

In the section below is a summary list of the service categories available under this core service area. To respond to this core service area, applicant organizations must use the Ryan White Compendium of Services in Section 14 to obtain information on specific program requirements.

CORE SERVICE AREA 2:
Jurisdictional Ryan White Core and Support Services

The Washington EMA includes portions of three states and the District of Columbia. The availability of services, customer HIV-related needs and number of Ryan White service providers varies for each jurisdiction. HAHSTA's RWHAP is committed to supporting a broad Ryan White Provider Network that meets the needs of the EMA's constituents. This service area details the service categories that are available for application in the Washington, DC, West Virginia, Northern Virginia, and Suburban Maryland jurisdictions of the Washington EMA.

The Washington DC Regional Planning Commission on Health and HIV (COHAH) allocates Ryan White Part A funding based on the disease burden in each of the jurisdictions that comprises the Washington EMA. That body also uses epidemiological and Ryan White Program data to determine the service categories that will be supported in each jurisdiction. Additionally, HAHSTA participates in a regional collaboration with the State Health Departments in Virginia and Maryland to maximize the availability of Ryan White services in the overlapping jurisdictions in the Washington EMA, given the limitations in funding. Through the Regional Health Department collaboration, Virginia utilizes funds from their Ryan White Part B grant awards to support some or all of the COHAH allocated service categories. As such, not all service categories supported across the EMA are included in this funding opportunity. Virginia providers are only eligible to apply for funding under Service Area 1: EMA-Wide Services, Service Area 2: Jurisdictional Ryan White Core and Support Services, and Service Area 4: Minority AIDS Initiative Youth Reach.

This service area is separated into four sub-sections that speak to the availability of service categories for Washington, DC, Suburban Maryland, Northern Virginia and West Virginia.

See funding chart on page #13 for detailed information on the amount of funds available for this service category and expected number of awards.

2a. Ryan White Core and Support Services Washington, DC

This service area details the service categories that are available only for applicants located in the Washington, DC jurisdiction of the Washington EMA.

CORE SERVICE AREAS

SUBSTANCE ABUSE OUTPATIENT CARE

Definition
Substance abuse outpatient care is the provision of outpatient services for the treatment of drug or alcohol use disorders (i.e., alcohol, and or legal and illegal drugs, injection drugs and non-injection drugs) provided in an outpatient setting, rendered by a physician or under the direct supervisor of a physician, or by other identified qualified personnel. Acupuncture therapy may be allowable under this service category only when it is included in a documented plan, as part of a substance use disorder treatment program funded under the RWHAP.

MENTAL HEALTH SERVICES

Definition
Mental health services are the provision of outpatient psychological and psychiatric screening, assessment, diagnosis, treatment, and counseling services offered to customers living with HIV. Services are based on a treatment plan, conducted in an outpatient group or individual session, and provided by a mental health professional licensed or authorized within the state/jurisdiction to render such services. Such professionals typically include psychiatrists, psychologists, and licensed clinical social workers.

HOME AND COMMUNITY-BASED HEALTH SERVICES (HCBS)

Definition
Home and community-based health services include skilled health services furnished to an individual in the individual's home, based on a written plan of care established by a case management team that includes appropriate health care professionals.

SUPPORT SERVICE AREAS

LINGUISTIC SERVICES (LS)

Definition
Linguistic services include the provision of interpretation and translation services.

Services include:

- American Sign Language and other language interpreters
- Voice relay
- Tactile or oral assistance

PSYCHOSOCIAL SUPPORT SERVICES

Definition
Psychosocial support services provide group or individual support and counseling services to assist eligible people living with HIV to address behavioral and physical health concerns. Psychosocial support services are the provision of support and counseling activities, child abuse and neglect counseling, HIV support groups, pastoral care, caregiver support, and bereavement counseling. It includes nutrition counseling provided by a non-registered dietician but excludes the provision of nutritional supplements.

OTHER PROFESSIONAL SERVICES (OPS)

Definition
Other Professional Services allow for the provision of professional and consultant services rendered by members of professions licensed and/or qualified to offer such services by local governing authorities.

Key activities include:

- Legal services provided to and/or on behalf of the individual living with HIV and involving legal matters related to or arising from their HIV disease.
- Income tax preparation services to assist customers in filing Federal tax returns that are required by the Affordable Care Act for all individuals receiving premium tax credits.
- Preparation of:
    - Healthcare power of attorney
    - Durable powers of attorney
    - Living wills

2b. Ryan White Core and Support Services Suburban Maryland

This service area details the service categories that are available only for applicants located in the Suburban Maryland jurisdiction of the Washington EMA.

CORE SERVICE AREAS

HEALTH INSURANCE PREMIUM AND COST SHARING PROGRAM (HIPCSA)

Definition

Health Insurance Premium and Cost Sharing Assistance (HIPCSA) provides financial assistance for eligible customers living with HIV to maintain continuity of health insurance or to receive medical and pharmacy benefits under a health care coverage program. For purposes of this service category, health insurance also includes standalone dental insurance.

SUPPORT SERVICE AREAS

OUTREACH SERVICES (OS)

Definition

Outreach Services includes the identification of individuals at points of entry and access to services and provision of HIV testing (with prior approval) and targeted counseling, referral services, linkage to care, and health education and literacy training that enable customers to navigate the HIV system of care.

PSYCHOSOCIAL SUPPORT SERVICES

Definition

Psychosocial support services provide group or individual support and counseling services to assist eligible people living with HIV to address behavioral and physical health concerns. Psychosocial support services are the provision of support and counseling activities, child abuse and neglect counseling, HIV support groups, pastoral care, caregiver support, and bereavement counseling. It includes nutrition counseling provided by a non-registered dietician but excludes the provision of nutritional supplements.

2c. Ryan White Core and Support Services Northern Virginia

This service area details the service categories that are available only for applicants located in the Northern Virginia jurisdiction of the Washington EMA.

CORE SERVICE AREAS

SUBSTANCE ABUSE OUTPATIENT CARE

Definition
Substance abuse outpatient care is the provision of outpatient services for the treatment of drug or alcohol use disorders (i.e., alcohol, and or legal and illegal drugs, injection drugs and non-injection drugs) provided in an outpatient setting, rendered by a physician or under the direct supervisor of a physician, or by other identified qualified personnel. Acupuncture therapy may be allowable under this service category only when it is included in a documented plan, as part of a substance use disorder treatment program funded under the RWHAP.

MENTAL HEALTH SERVICES

Definition
Mental health services are the provision of outpatient psychological and psychiatric screening, assessment, diagnosis, treatment, and counseling services offered to customers living with HIV. Services are based on a treatment plan, conducted in an outpatient group or individual session, and provided by a mental health professional licensed or authorized within the state/jurisdiction to render such services. Such professionals typically include psychiatrists, psychologists, and licensed clinical social workers.

SUPPORT SERVICE AREAS

PSYCHOSOCIAL SUPPORT SERVICES

Definition
Psychosocial support services provide group or individual support and counseling services to assist eligible people living with HIV to address behavioral and physical health concerns. Psychosocial support services are the provision of support and counseling activities, child abuse and neglect counseling, HIV support groups, pastoral care, caregiver support, and bereavement counseling. It includes nutrition counseling provided by a non-registered dietician but excludes the provision of nutritional supplements.

2d. Ryan White Core and Support Services West Virginia (Jefferson and Berkeley Counties)

West Virginia Applicants: Two West Virginia counties included in the Washington EMA: Berkeley County and Jefferson County. Due to the remote location and limited number of Ryan White eligible customers compared to the rest of the EMA, service providers in this region would be negatively impacted by performance comparisons across the network of Ryan White service providers. As such, providers in this region are excluded from consideration for the FFV program. Those FFV services are included in the menu of available service categories for application under Service Area 2D: Jurisdictional Ryan White Services—West Virginia. All service categories available in West Virginia are offered ala carte, with no service category bundles.

CORE SERVICE AREAS

OUTPATIENT/AMBULATORY HEALTH SERVICES (O/AHS)

Definition
Outpatient/Ambulatory Health Services (O/AHS) are diagnostic and therapeutic services provided directly to a customer by a licensed healthcare provider in an outpatient medical setting. Outpatient medical settings include clinics, medical offices, and mobile vans where customers do not stay overnight. Emergency rooms or urgent care services are not considered outpatient settings. O/AHS includes, diagnostic testing, early intervention and risk assessment, preventive care and screening, practitioner examination, medical history taking, diagnosis and treatment of common physical and mental conditions, prescribing and managing medication therapy, education and counseling on health issues, well-baby care, continuing care and management of chronic conditions, and referral to and provision of specialty care (includes all medical subspecialties).

MENTAL HEALTH SERVICES (MHS)

Definition
Mental health services are the provision of outpatient psychological and psychiatric screening, assessment, diagnosis, treatment, and counseling services offered to customers living with HIV. Services are based on a treatment plan, conducted in an outpatient group or individual session, and provided by a mental health professional licensed or authorized within the state/jurisdiction to render such services. Such professionals typically include psychiatrists, psychologists, and licensed clinical social workers.

Mental Health services are allowable only for persons living with HIV.

MEDICAL CASE MANAGEMENT (MCM)

Definition
Medical Case Management is the provision of a range of customer-centered activities focused on improving health outcomes in support of the HIV care continuum. Activities may be prescribed by an interdisciplinary team that includes other specialty care providers. Medical Case Management includes all types of case management encounters (e.g., face-to-face, phone contact, and other forms of communication).

ORAL HEALTH CARE (OH)

Definition
Oral health care includes diagnostic, preventive, and therapeutic services provided by general dental practitioners, dental specialists, dental hygienists and auxiliaries and other trained primary care providers. Dentures essential for the maintenance of health will be included.

HEALTH INSURANCE PREMIUM AND COST SHARING PROGRAM (HIPCSA)

Definition
Health Insurance Premium and Cost Sharing Assistance (HIPCSA) provides financial assistance for eligible customers living with HIV to maintain continuity of health insurance or to receive medical and pharmacy benefits under a health care coverage program. For purposes of this service category, health insurance also includes standalone dental insurance.

MEDICAL NUTRITION THERAPY (MNT)

Definition
Medical Nutrition Therapy is to correct and prevent malnutrition in people living with HIV and reduce the risk of other diseases/comorbidities.

SUPPORT SERVICE AREAS

MEDICAL TRANSPORTATION (MT)

Definition
Medical Transportation is to provide non-emergency transportation services to eligible customers in the Washington, DC Eligible Metropolitan Area (EMA) that enables them to access or be retained in core medical and support services.

EMERGENCY FINANCIAL ASSISTANCE (EFA)

Definition

Emergency Financial Assistance (EFA) provides limited, one-time, or short-term payments to assist Ryan White HIV/AIDS Program customers with an urgent need for essential items or services necessary to improve health outcomes, including utilities, rental assistance, food (including groceries and food vouchers), transportation, and medication not covered by an AIDS Drug Assistance Program or AIDS Pharmaceutical Assistance or another HRSA RWHAP allowable cost needed to improve health outcomes. Emergency Financial Assistance must occur as a direct payment to an agency or through a voucher program, as opposed to cash payments to customers.

OUTREACH SERVICES (OS)

Definition

Outreach Services includes the identification of individuals at points of entry and access to services and provision of HIV testing (with prior approval) and targeted counseling, referral services, linkage to care, and health education and literacy training that enable customers to navigate the HIV system of care.

In the section below is a summary list of the service categories available under this core service area. To respond to this core service area, applicant organizations must use the Ryan White Compendium of Services in Section 14 to obtain information on specific program requirements.

CORE SERVICE AREA 3:

Emergency Financial Assistance

Through this funding opportunity, DC Health seeks to award a single entity to manage the delivery of all Emergency Financial Assistance (EFA) Services for the Washington, DC and the Suburban Maryland jurisdictions of the EMA. Services under this service area are not open to residents of the Virginia or West Virginia portions of the Washington EMA. The Virginia Department of Health supports EFA services for the state of Virginia. As such, Virginia service organizations are excluded from applying under this service area. Applicants for this service area must have a service location in Washington, DC, and one in the Suburban Maryland jurisdiction of the EMA.

EMERGENCY FINANCIAL ASSISTANCE (EFA)

See funding chart on page #13 for detailed information on the amount of funds available for this service category and expected number of awards.

Definition

Emergency Financial Assistance provides limited one-time or short-term payments to assist an HRSA RWHAP customer with an urgent need for essential items or services necessary to improve health outcomes, including utilities, housing, food (including groceries and food vouchers), transportation, medication not covered by an AIDS Drug Assistance Program or AIDS Pharmaceutical Assistance, or another HRSA RWHAP- allowable cost needed to improve health outcomes. Emergency Financial Assistance must occur as a direct payment to an agency or through a voucher program, as opposed to a direct payment to a customer.

In the section below is a summary list of the service categories available under this core service area. To respond to this core service area, applicant organizations must use the Ryan White Compendium of Services in Section 14 to obtain information on specific program requirements.

CORE SERVICE AREA 4:

Minority AIDS Initiative: Youth Reach Jurisdictional

The Washington EMA's earmarked funding under the Minority AIDS Initiative portion of the Ryan White Part A grant award will continue to support the Youth Reach program. Youth Reach is a targeted initiative created to provide a comprehensive set of core and support services to Youth of Color, ages 13 to 30 and within these sub populations:

- *Black/Hispanic/Latino MSM*
- *Black Heterosexual Men*
- *Black/ Hispanic/Latino Transgender Women*
- *Black Women*

See funding chart on page #13 for detailed information on the amount of funds available for this service category and expected number of awards.

Applicants proposing services under this service area must submit one project description that outlines how they will establish a youth focused program inclusive of any of the eligible MAI service categories noted below. **Applicants are not required to provide all eligible service categories.**

The Eligible MAI "Youth Reach" Service Categories are:

Core Service Categories

- Outpatient/Ambulatory Health Services
- Medical Case Management
- Mental Health
- Substance Abuse Outpatient Care
- Early Intervention Services

Support Service Categories

- Psychosocial Support Services
- Non-Medical Case Management (NMCM)
- Medical Transportation (MT)

These funds will support services designed to provide an intensive set of care and support services for high need young people. Applicants must develop a program budget that will support all service categories proposed.

All proposals must detail how each customer served will be reassessed at a minimum of every six

months for continued program eligibility and appropriateness with this intensive approach of service delivery.

Proposals should detail collaborations (through MOUs or shared funding arrangements) with organizations currently receiving HIV prevention, outreach and/or testing funding, provide seamless transition from prevention and testing programs into care, and offer a one stop shop with experienced, diverse, youth-serving staff providing mental health and substance abuse care, early intervention services, medical case management, and outpatient/ambulatory health services.

Successful applicants will provide a detailed plan to promote the proposed program, which will have a name/identity distinct from existing RW programs, to attract youth/young adult persons living with HIV of color through social media, posters, apps, brochures, or word of mouth campaigns.

4.5 Program and Administrative Requirements

4.5.1 Program Requirements

1. Nondiscrimination in the Delivery of Services

In accordance with Title VI of the Civil Rights Act of 1969, as amended, no person shall, on the grounds of race, color, religion, nationality, sex, or political opinion, be denied the benefits of, or be subjected to discrimination under, any service funded by the RWHAP.

2. Customer Eligibility Criteria

The following criteria must be used by service providers to determine customer eligibility for services:

a. Be a resident of the Eligible Metropolitan Area
b. Be HIV positive; and
c. Have an annual gross income no greater than 500% of the Federal Poverty Guidelines.

3. Affected Individuals

Affected individuals (people not identified with HIV) may be eligible to receive RWHAP services in limited situations, however these services must be linked to and benefit people living with HIV. Funds awarded under the RWHAP may be used for services to individuals affected with HIV only in the circumstances described below.

a. The service has as its primary purpose enabling the affected individual to participate in the care of someone with HIV or AIDS. Examples include caregiver training for in-home medical or support service; psychosocial support services, such as caregiver support groups; and/or respite care services that assist affected individuals with the stresses of

providing daily care for someone who is living with HIV.

b. The service directly enables a person living with HIV to receive needed medical or support services by removing an identified barrier to care. Examples include payment of a RWHAP customer's portion of a family health insurance policy premium to ensure continuity of insurance coverage for a low-income family member of an individual living with HIV, or childcare for dependent children, while a Ryan White eligible parent secures medical care or support services.

c. The service promotes family stability for coping with the unique challenges posed by HIV. Examples include psychosocial support services that focus on equipping affected family members, and caregivers to manage the stress and loss associated with HIV.

d. Services to affected, caregiving or dependent individuals that meet these criteria may not continue after the death of the Ryan White eligible family member.

4. Ryan White Service Standards

In the Washington, DC EMA, Service Standards are essential in defining and ensuring that consistent quality care is offered to all customers and will be used as contract requirements, in program monitoring, and in quality management. The purpose of service standards is to outline the elements and expectations all Ryan White service providers are to follow when implementing a specific service category. Service Standards define the minimal acceptable levels of quality in service delivery and to ensure that a uniformity of service exists in the Washington, DC Eligible Metropolitan Area (EMA) such that customers of this service category receive the same quality of service regardless of where or by whom the service is provided. Current standards can be found at the link below.

https://dchealth.dc.gov/page/ryan-white-hivaids-program-services-standards-rwhapss

5. Grievances

a. Successful applicants shall develop and implement an agency grievance procedure that is sensitive to the needs of the target population. Successful applicants must supply a copy of their internal customer grievance procedures prior to executing the grant award.

b. Successful applicants shall inform customers of their rights and responsibilities, agency and EMA-wide grievance procedures, and services offered by the agency and other available community and RWHAP funded resources.

6. Sliding Fee Scale and Cap on Charges

Successful applicants will develop a sliding fee scale for customers accessing services through the Ryan White HIV/AIDS Part A grant program. The scale will be based on the most current federal poverty guidelines. Customers with an income less than or equal to 200% of the most current Federal Poverty Guidelines will not pay a fee for the provision of service. Subrecipients will develop and post the sliding fee scale so that it is visible to customers and the public.

A sliding fee scale must be implemented; however, the Ryan White HIV/AIDS Part A program does not require collection of the fee charged to customers. Subrecipients shall make attempts to collect customer fees and document those attempts; however, customers may not be referred to collection agencies for non-payment of fees.

Ryan White services may not be denied to any eligible HIV-positive customer seeking services.

All Sliding Fee Scale Policies are subject to review and approval by HAHSTA.

7. Program Income

Program income is gross income earned by the non-federal entity that is directly generated by a supported activity or earned as a result of the federal award during the period of performance except as provided under 2 CFR § 200.307. It includes but is not limited to income from fees for services performed, the use or rental of real or personal property acquired under Federal awards, the sale of commodities or items fabricated under a federal award, license fees and royalties on patents and copyrights, and principal and interest on loans made with Federal award funds.

Subrecipients are required to document the amount and disposition of any income received as a direct result of Ryan White funding. All program income generated by customers with HIV must be returned to benefit the HIV program. Successful applicants must report on program income earned on a quarterly basis and submit client-level data for any services that result from those generated funds.

8. Reports

Successful applicants will be required to submit monthly, quarterly, annual, and final reports to HAHSTA; to house and manage a client-level data system (CAREWare); and to participate in all site visits, evaluation and quality assurance activities as required by HAHSTA. All reports must contain required information in the format determined by HAHSTA. Reporting requirements include, but are not limited to the following:

- Service Utilization by Service Category
- Performance Measures / Quality Improvement

- Customer Demographics
- Ryan White Services Report (RSR)
- Programmatic Narrative Information
- Financial Expenditures and Supporting Documentation
- Program Income

9. Records

a. Successful applicants shall keep accurate documentation of all activities of the project. When delivering services to customers, the awardees must maintain records reflecting initial and periodic assessments (if appropriate), eligibility assessments every twelve months, initial and periodic service plans; and the ongoing progress of each customer.

b. Successful applicants shall maintain compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to ensure the confidentiality and security of customer information.

4.5.2. Administrative Requirements

1. Staff Requirements

For the purposes of this funding opportunity, "staff" is defined as any individual employee, individual consultant or individual contracted worker that receives compensation through these funds.

a. Successful applicants shall maintain documentation that staff possess adequate training and competence to perform the duties which they have been assigned.

b. Successful applicants shall maintain a complete written job description for all positions funded through the grant, which must be included in the project files and be available for inspection on request. When hiring staff for this grant project, successful applicants shall obtain written documentation of relevant work experience and personal references.

c. Ryan White HIV/AIDS Program deliverables for subrecipients fall into four categories: program, data, quality, and fiscal. Each subrecipient organization is required to provide dedicated staffing for each area of responsibility. Applicants should use the staffing plan and/budget templates to indicate the staffing (FTE level) commitment for the required roles and responsibilities, including whether the staff will be charged to the administrative or direct budgets, or supplied in-kind. See chart below for details on the staff roles.

Required Roles	Responsibilities
Program Manager/Coordinator	Staff that provide leadership, oversight, strategic planning, and management to ensure that goals and outcomes are compliant with Ryan White program requirements. Directly or indirectly ensures the coordination of day-to-day operations and deliverables of Ryan White grants.
Data Manager	Staff that ensure complete and accurate client level data is submitted in CAREWare monthly. Ensures timely submission of annual and mid-year Ryan White Services Report (RSR).
Quality Management	Staff that manage the organization's clinical quality management (CQM) program, perform quality improvement activities aimed at improving patient care, health outcomes, and patient satisfaction. Additionally, the subrecipient must have adequate infrastructure to support quality improvement (QI) to include committees, quality improvement projects, plans, etc.
Fiscal Management	Staff that are responsible for the creation, improvement and implementation of financial policies and procedures for the organization. Ensures timely and accurate internal and external financial reports, accounts payable, accounts receivable, reconciliations, including monthly and annual financial statements. Ensures timely invoice submissions into EGMS and the District Integrated Financial System (DIFS).

d. Successful applicants that use individual contracted workers and/or individual consultants must have written, signed, and dated contractual agreements maintained in a contract file.

e. Successful applicants shall maintain an individual personnel file for each project staff member.

f. Personnel files and contractor agreements must be available to HAHSTA upon request.

g. Successful applicants shall provide orientation sessions for each staff member with respect to administrative procedures, program goals, and policies and procedures to be adhered to under the grant agreement.

h. Successful applicants shall demonstrate sufficient supervision of staff attached to projects and maintain evidence of continuing education opportunities to keep staff informed of new developments regarding the provision of HIV/AIDS health care and support services.

2. Memoranda of Understanding/Agreement (MOU/A) and Subcontracts

a. MOU and subcontracts must clearly state objectives, goals, mutual obligations, and quantifiable outcomes that are consistent with the terms and conditions required by HAHSTA. See Appendix 2 for sample of a MOU/A.

b. All MOU/A and subcontracts must be signed and dated by both parties within six months prior to the application due date and include an effective term that reflects the first budget period of the award, March 1, 2025, through February 28, 2026.

3. Pre-Award Compliance Site Visit

a. A pre-award compliance site visit will be used to verify compliance with program regulations and guidelines.

b. HAHSTA staff will conduct a pre-award compliance site visit at the applicant's proposed site of services.

c. HAHSTA staff will conduct the IAT assessment during the site visit.

d. Additionally, a tour of the proposed service site will be conducted to verify compliance with program regulations and guidelines regarding allocated spaces.

4. Facility Requirements

a. Regulations

Successful applicants' facilities used during the performance of the grant agreement shall meet all applicable federal, state, and local regulations for their intended use throughout the term of the grant agreement.

b. Emergency Back-up Site

Successful applicants shall submit the address of the identified emergency site facility for use in the event of a catastrophic event at the primary facility.

c. Handicapped Access

All facilities offered for the provision of services must be accessible to persons with mobility limitations, consistent with the Rehabilitation of the Handicapped Act of 1990, Public Law Section 95-602 (Section 504) and the Americans with Disabilities Act, as appropriate.

5. Use of Funds

Funds detailed in this RFA cannot be used to provide cash and/or direct financial assistance or to fund education and training for individuals with HIV.

5. APPLICATION REQUIREMENTS

5.1 Eligibility Documents

Certificate of Clean Hands

This document is issued by the Office of Tax and Revenue and must be dated within 60 days of the application deadline. Entities that do not have any operations in the District of Columbia, must submit a letter signed by the authorized representative attesting that there are no operations within the District of Columbia.

Current Business License

A business license issued by the Department of Licensing and Consumer Protection or certificate of licensure or proof to transact business in local jurisdiction.

Current Certificate of Insurance

This document must be issued by your insurance company. All DC Health grantees must meet the minimum insurance requirements as outlined in Appendix 1: Minimum Insurance Requirements. Should an applicant be awarded the grant, the Office of Risk Management will conduct a review of exposures of the grantee organization based off the final approved workplan and may make changes to the insurance requirements.

Copy of Cyber Liability Policy

This document must be issued by your insurance company. All DC Health grantees must meet the minimum insurance requirements as outlined in Appendix A: Minimum Insurance Requirements. Should an applicant be awarded the grant, the Office of Risk Management will conduct a review of exposures of the grantee organization based off the final approved workplan and may make changes to the insurance requirements.

IRS Tax-Exempt Determination Letter

This applies to nonprofits only.

IRS 990 Form

This must be from the most recent tax year. This applies to nonprofits only.

Current List of Board of Directors, on letterhead, signed and dated by a certified official from the Board.

This CANNOT be signed by the executive director.

ASSURANCES, CERTIFICATIONS AND DISCLOSURES

This document must be signed by an authorized representative of the applicant organization. (see attachment).

Note: Failure to submit **ALL** the above attachments will result in a rejection of the application from the review process. The application will not qualify for review and funds will not be awarded.

5.2 PROPOSAL COMPONENTS

PROJECT ABSTRACT

A one-page project abstract is required. Please provide a one-page abstract that is clear, accurate, concise, and without reference to other parts of the Project Narrative. The project abstract must be **single-spaced, limited to one page in length**, and include the following sections:

- **Annotation:** Provide a three-to-five-sentence description of your project that identifies the population and/or community needs that are addressed.
- **Service Provider Track Selection:** Identify the service provider program track for which you would like your application to be considered.
- **Problem:** Describe the principal needs and problems addressed by the project.
- **Purpose:** State the purpose of the project.
- **Goal(s) And Objectives:** Identify the major goal(s) and objectives for the project. Typically, the goal(s) are stated in a sentence, and the objectives are presented in a numbered list.
- **Methodology:** Briefly list the major activities used to attain the goal(s) and objectives
    - Applicants must briefly describe the need for services within the community. Include both quantitative and qualitative evidence to address this question.
    - Applicants must briefly describe their program design and methodology for leveraging partnerships and resources to improve customer health outcomes.
    - Applicants must describe their broad program objectives and explain how their services proposed will facilitate movement of customers along the continuum from prevention to care: early diagnosis, linkage to medical care and other services, antiretroviral treatment, adherence to medication, retention in medical care, re-engagement in medical care and improved health outcomes.

PROJECT NARRATIVE

Project Narrative Section – must be submitted and uploaded into EGMS as one document file.

1. Table of Contents (Not counted in page total.)
2. Organizational Background and Capacity (4 pages maximum)

3. Project Description (**5 pages maximum per service category proposed and 15 pages maximum for bundles and 25 pages maximum for MAI**)
4. Monitoring, Evaluation, and Improvement (5 pages maximum)
5. Partnerships and Resources (5 pages maximum)

The number of pages designated above represents the **maximum number of pages permitted per section. Reviewers will only be provided with maximum number of pages for each application section. Additional pages will not be reviewed.**

A. Application Format

- Applications must adhere to prescribed page limits
- Font size: 12-point Times New Roman
- Spacing: Double-spaced
- Paper size: 8.5 by 11 inches
- Page margin size: 1 inch
- For tables and figures: 11–point font
- Numbering: Sequentially from page 1 to the end of the application, including all charts, figures, tables, and attachments.

B. Application Elements

Each application is required to contain the following components. Certain application items will be entered directly into EGMS, while others will be uploaded into EGMS as attachments e.g. project description. Applications must conform to the page requirements by section detailed below.

C. Description of Elements

Applicants should include all the information needed to describe adequately and succinctly the services they propose to provide. It is important that applications reflect continuity among the program design and activities, and that the budget supports the level of effort required for the proposed services.

1. **Table of Contents -** Lists major sections of the application with quick reference page indexing. Failure to include an accurate Table of Contents may result in the application not being reviewed fully or completely.

2. **Organizational Background and Accessibility**
   - Applicants must provide a summary highlighting the organization's history, specifically, how their organization is qualified to implement the proposed program model, including relevant experience and expertise of key management and front-line staff. If the applicant has not provided services to PLWHA in the past, they must describe the program's design and methodology for the target population proposed.
   - Describe the services that your organization has provided in the past two years in response to ending the HIV epidemic using the following key pillars (as applicable):

- **Diagnose:** Improve and expand access points for HIV testing among undiagnosed individuals living with HIV within their communities.
- **Treat:** Ensure people living with HIV, newly diagnosed or not-in-care are linked to essential HIV care, treatment, and support services to help them stay in care and adhere to medication where they will reach and maintain an undetectable viral load.
- **Prevent:** Provide HIV prevention services, including outreach, partnerships, and workforce expansion to increase access to and uptake of PrEP for individuals experiencing a disproportionate impact of HIV.
- **Respond:** Support transmission-ending strategies by providing HIV care and treatment and PrEP to those identified through cluster detection activities.
- **Engage:** Address resident-expressed stress barriers to prioritize HIV health, including stigma reduction, stable housing, economic opportunity, and ensuring cultural humility in service delivery.

- Applicants must describe their operations and how customers can access services which may include detailing hours of operation and flexible schedules that provide for evening and weekend service delivery.
- Applicants must describe how first-time customers access their program, which may include intake, eligibility screening, assessment of needs, linkages for services, appointment scheduling and retention.
- Either by narrative description or completion of *Attachment B*, applicants must describe their program staff and how it reflects racial, ethnic, sexual orientation, gender and linguistic diversity.

3. **Administrative Capacity –** Applicants must describe their funding and staffing plans for key roles, detail their process for verifying customer eligibility and maintaining enrollment, and provide an organizational chart to support program administration.
   - Applicants must describe how the positions/roles of program manager, data manager, quality management and financial management (accounts payable, accounts receivable and reconciliation) will be funded through these grant funds or other resources. ***See the administrative requirements section of this RFA on pg. 39 for additional details.***
   - Applicants must describe how their program will verify customer eligibility and enroll and maintain customers in care.

4. **Project Description-** The purpose of this section is to provide a thorough description of the proposed projects and how they will improve health outcomes. Optimal applications include descriptions of programs that effectively reach and serve customers with high need, have a sound technical basis, address known challenges and gaps in services, strive

to build stronger results through innovation, and contribute to the overall quality and impact of the service area response. **Applicants proposing to provide services under one of the care coordination bundles, or MAI Youth Reach are required to submit *only* *one* project description that includes all service categories within the service area.**

- Applicants must describe their program design and methodology for adhering to the service category specific standards of care and key activities.
- Applicants must describe their program design and methodology for the delivery of proposed services and their alignment with ending the HIV epidemic using the following key pillars:
  - **Treat:** Ensure people living with HIV, newly diagnosed or not-in-care are linked to essential HIV care, treatment, and support services to help them stay in care and adhere to medication where they will reach and maintain an undetectable viral load.
  - **Respond:** Support transmission-ending strategies by providing HIV care and treatment and PrEP to those identified through cluster detection activities.
  - **Engage:** Address resident-expressed stress barriers to prioritize HIV health, including stigma reduction, stable housing, economic opportunity, and ensuring cultural humility in service delivery.
- Applicants must describe their methodology for how they will address health equity in their service delivery system.
- The applicant has described their approach to providing customer-centered care.
- Applicants must describe the geographic area where the target population is found, the need for services, the demographic characteristics of the population to be served and the barriers to care experienced by the population to be served, including how the program will address those barriers.

5. **Monitoring, Evaluation, and Improvement-** This section will be evaluated on the extent to which past and current experience and structure provide a strong likelihood for meaningful monitoring, evaluation, and improvement.

   - Applicants must describe prior or current experiences with continuous quality management, including plans, processes, infrastructure, and quality improvement projects.
   - Applicants must describe how their program will engage consumers in their quality activities to promote better customer care and service delivery. Such as customer satisfaction surveys, consumer advisory boards, and other mechanisms for

garnering feedback from customers.

- Applicants must describe how their program data will be used to improve outcomes such as rapid ART start and re-start, durable viral load suppression, engagement in medical care, decreased acuity for case management customers, linkage to support services, and food security.

- Applicants must describe existing or proposed structure for data management, including processes for data security, privacy, collection, accuracy, completeness, timeliness, reporting, and utilization to determine progress and make improvements to CQM aims**.**

6. **Partnerships and Resources –** This section details the applicant's ability to leverage internal and external resources and partnerships to improve health outcomes, engage customers in care, and enhance viral suppression for underserved populations within the EMA.

    - The applicant must describe their program design and methodology for leveraging resources both internal and external to your organization to improve health outcomes, engage customers in care, and improve viral suppression.
    - The applicant must describe their partnerships with other programs and partners in the geographic area that are relevant to your proposed program model and describe how they will leverage these programs to maximize benefit to low income, uninsured, under insured, Black, Latino/Hispanic, MSM and Transgendered persons within the EMA without supplanting other resources.

WORK PLAN

A work plan is required for each proposed Service Category. The required template can be found on DC Health's Grants Management website (https://dchealth.dc.gov/service/grants-management). The work plan should include proposed targets and the goals and objectives for the proposed program. Be as descriptive as possible in your work plan so there is a clear idea of the proposed activities and timelines. All work plans should be labeled clearly by Service Category.

Applications must develop goals and objectives for the proposed project that are clearly defined, measurable, time-specific, and responsive to service area specific goals and priorities.

ORGANIZATIONAL CHART

An organizational chart that illustrates the structure of the applicant organization is required ***(no template provided)*.** The organizational chart should denote clear leadership reporting structure and segregation of administrative responsibilities (fiscal, HR, etc).

STAFFING PLAN

Attachment A is a required attachment which illustrates how the positions/roles of program manager, data manager, quality management and financial management (accounts payable, accounts receivable and reconciliation) will be filled to meet the staffing levels required to administer these grant funds. See the administrative requirements section on page 39 of this RFA for additional details.

CAPACITY TO PROVIDE CULTURALLY COMPETENT SERVICES

Attachment B, applicants are required to either complete this attachment or provide a narrative in the project description section of their application that describes the applicants' program staff and how it reflects racial, ethnic, sexual orientation, gender and linguistic diversity.

BUDGET TABLE

The application should include a project budget table using the excel spreadsheet found on DC Health's Grants Management website (https://dchealth.dc.gov/service/grants-management). The project budget and budget justification should be directly aligned with the work plan and project description. All expenses should relate directly to achieving the key grant outcomes. Budget should reflect the budget period, as outlined below (Key Budget Requirements).

Note: Enterprise Grants Management System (EGMS) will require entry of budget line items and details. This entry does not replace the required upload of a budget using the required templates.

Key Budget Requirements

The budget should reflect a 12-month period, as follows:

- March 1, 2025- February 28, 2026

Costs charged to the award must be reasonable, allowable, and allocable under this program. Documentation must be maintained to support all grant expenditures. Personnel charges must be based on actual, not budgeted labor. Salaries and other expenditures charged to the grant must be for services that occurred during the grant's period of availability.

BUDGET JUSTIFICATION

The application should include a budget justification. The required template can be found on DC Health's Grants Management website (https://dchealth.dc.gov/service/grants-management). The budget justification is a narrative that explains the amounts requested for each line in the budget. The budget justification should specifically describe how each item will support the achievement of proposed objectives. The budget justification MUST be concise. Do NOT use the justification to expand the proposed project narrative.

OTHER FUNDING SOURCES

Attachment C is a required attachment that illustrates all other sources of funding received by the applicant organization. Note the date on the attachment which indicates the applicable time frame (As of October 1, 2024)**.**

MEDICAID CERTIFICATION

Attachment D, documentation of Medicaid certification, must be submitted by all applicants applying for any Service Categories that are reimbursable by Medicaid.

SCOPE OF SERVICES

Attachment E, the service categories scope of services, are tools used by the Ryan White HIV/AIDS Program (RWHAP) to highlight and report on how grant awards and subrecipient s contribute to strategic goals and a comprehensive system of care. For the purposes of this RFA, applicants are required to complete a scope of services for each service category.

Note applicants proposing to leverage resources for a required service category, must include a scope of services and workplan for those leveraged services. The scope of services submitted should be accurate, competitive and contain realistic targets that are in alignment with the applicant's proposed workplan, linkage summary and overall program proposal.

RISK SELF-ASSESSMENT

The risk self-assessment evaluates the risks associated with applicants. This form is available on DC Health's Grants Management website (https://dchealth.dc.gov/service/grants-management) and should be completed by the Executive Director, Board Chairperson or a delegate knowledgeable of the organization's current and past capabilities.

6. EVALUATION CRITERIA

Indicators have been developed for each review criterion to assist the applicant in presenting pertinent information related to that criterion and to provide the reviewer with a standard for evaluation. The five review criteria are outlined below with specific detail and scoring points. Applicants can receive a maximum of 35 points per project description for each service category, care coordination bundle or program proposed. These criteria are the basis upon which the reviewers will evaluate the application. The entire proposal will be considered during objective review.

For this competition, the written proposal will be evaluated out of a total of 100 base points. Note that the total base points increase by 35 points for each additional project description submitted in the application packet. The scoring breakdown is as follows:

- Organizational Background and Accessibility - 10 points
- Administrative Capacity- 25 points
- Project Description (PD) (One PD must be submitted per service category, bundle and program, i.e. medical and non-medical care coordination and MAI)- 35 points
- Monitoring, Evaluation, and Improvement- 20 points
- Partnerships and Resources- 10 points

Applicants will receive organizational scores for all sections except for the project description section, which will receive separate scores for each service category proposed. The medical and non-medical care coordination bundles will be scored as one project description. The MAI Youth Reach program will be scored as one project description.

CRITERION 1: ORGANIZATIONAL BACKGROUND AND ACCESSIBILITY

(10 POINTS)

Organizations will be scored on the extent to which past and current experience and structure provide a strong likelihood for success in the achievement of key activities. Specific areas of review include:

- The applicant has provided a summary highlighting the organization's history, specifically, how their organization is qualified to implement the proposed program model, including relevant experience and expertise of key management and front-line staff. If the applicant has not provided services to PLWHA in the past, they must describe the program's design and methodology for the target population proposed. (2 points)
- The applicant has described the services provided by their organization for the past two years in response to ending the HIV epidemic using the following key pillars (as applicable): (2 points)

- **Diagnose:** Improve and expand access points for HIV testing among undiagnosed individuals living with HIV within their communities.
- **Treat:** Ensure people living with HIV, newly diagnosed or not-in-care are linked to essential HIV care, treatment, and support services to help them stay in care and adhere to medication where they will reach and maintain an undetectable viral load.
- **Prevent:** Provide HIV prevention services, including outreach, partnerships, and workforce expansion to increase access to and uptake of PrEP for individuals experiencing a disproportionate impact of HIV.
- **Respond:** Support transmission-ending strategies by providing HIV care and treatment and PrEP to those identified through cluster detection activities.
- **Engage:** Address resident-expressed stress barriers to prioritize HIV health, including stigma reduction, stable housing, economic opportunity, and ensuring cultural humility in service delivery.

- The applicant has described their operations and how customers can access services which may include detailing hours of operation and flexible schedules that provide for evening and weekend service delivery. (2 points)
- The applicant has described how first-time customers access their program, which may include intake processes, eligibility screening, assessment of needs, linkages for services, appointment scheduling and retention. (2 points)
- Either by narrative description or completion of *Attachment B*, applicants must describe their program staff and how it reflects racial, ethnic, sexual orientation, gender and linguistic diversity. (2 points)

CRITERION 2: ADMINISTRATIVE CAPACITY

(25 POINTS)

This section will be evaluated on the applicant's ability to describe the funding and staffing plans for key roles, detail their process for verifying customer eligibility and maintaining enrollment, and provide an organizational chart to support program administration.

- The applicant has described how the positions/roles of program manager, data manager, quality management and financial management (accounts payable, accounts receivable and reconciliation) will be funded through these grant funds or other resources. ***See the administrative requirements section of this RFA on pg. 39 for additional details.*** (10 points)
- The applicant has described how their program will verify customer eligibility and enroll and maintain customers in care. (10 points)
- The organizational chart denotes clear leadership reporting structure and segregation of administrative responsibilities (fiscal, HR, etc). (5 points)

CRITERION 3: PROJECT DESCRIPTION

(35 POINTS)

This section will be evaluated on the extent to which the proposal includes a thorough description of the proposed projects and how they will improve health outcomes. Optimal applications include descriptions of programs that effectively reach and serve customers with high need, have a sound technical basis, address known challenges and gaps in services, strive to build stronger results through innovation, and contribute to the overall quality and impact of the service area response. ***Note: Project description scores will vary by service category.***

- The applicant has described their program design and methodology for adhering to the service category specific standards of care and key activities. (10 points)
- The applicant has described their program design and methodology for the delivery of proposed services and their alignment with ending the HIV epidemic using the following key pillars: (10 points)
    - **Treat:** Ensure people living with HIV, newly diagnosed or not-in-care are linked to essential HIV care, treatment, and support services to help them stay in care and adhere to medication where they will reach and maintain an undetectable viral load.
    - **Respond:** Support transmission-ending strategies by providing HIV care and treatment and PrEP to those identified through cluster detection activities.
    - **Engage:** Address resident-expressed stress barriers to prioritize HIV health, including stigma reduction, stable housing, economic opportunity, and ensuring cultural humility in service delivery.
- The applicant has described their methodology for how they will address health equity in their service delivery system. (6 points)
- The applicant has described their approach to providing customer-centered care. (3 points)
- The applicant has described the geographic area where the target population is found, the need for services, the demographic characteristics of the population to be served and the barriers to care experienced by the population to be served, including how the program will address those barriers. (6 points)

CRITERION 4: MONITORING, EVALUATION, AND IMPROVEMENT

(20 POINTS)

This section will be evaluated on the extent to which past and current experience and structure provide a strong likelihood for meaningful monitoring, evaluation, and improvement.

- The applicant has described prior or current experiences with continuous quality management, including plans, processes, infrastructure, and quality improvement projects. (5 points)
- The applicant has described how their program will engage consumers in their quality activities to promote better customer care and service delivery. (5 points)
- The applicant has described how their program data will be used to improve outcomes such as rapid ART start and re-start, durable viral load suppression, engagement in medical care, decreased acuity for case management customers, linkage to support services, and food security. (5 points)
- The applicant has described their existing or proposed structure for data management, including processes for data security, privacy, collection, accuracy, completeness, timeliness, reporting, and utilization to determine progress and make improvements. (5 points)

CRITERION 5: PARTNERSHIPS AND RESOURCES

(10 POINTS)

This section will be evaluated on the applicant's ability to leverage internal and external resources and partnerships to improve health outcomes, engage customers in care, and enhance viral suppression for underserved populations within the EMA.

- The applicant has described their program design and methodology for leveraging resources both internal and external to your organization to improve health outcomes, engage customers in care, and improve viral suppression. (5 points)
- The applicant has described their partnerships with other programs and partners in the geographic area that are relevant to your proposed program model and describe how they will leverage these programs to maximize benefit to low income, uninsured, under insured, Black, Latino/Hispanic, MSM and Transgendered persons within the EMA without supplanting other resources. (5 points)

7. REVIEW AND SCORING OF APPLICATION

7.1 ELIGIBILITY AND COMPLETENESS REVIEW

All applications will be reviewed initially for completeness, formatting and eligibility requirements by DC Health personnel prior to being forwarded to the external review panel. **Incomplete applications and applications that do not meet the eligibility criteria will not advance to the external review**. Applicants will be notified that their applications did not meet eligibility.

7.2 EXTERNAL REVIEW

The review panel will be composed of neutral, qualified, professional individuals who have been selected for their unique experiences in public health program planning and implementation, health communications planning and evaluation, and social services planning and implementation. The panel will review, score and rank each applicant's proposal based on the criteria outlined in the RFA. Individual panel members are required to provide a summary of strengths and weaknesses found in the application.

7.3 INTERNAL REVIEW

DC Health program managers will review the individual and summary recommendations of the external review panel and make recommendations for awards. Program Managers will weigh the results of the review panel against other internal and external factors in making the final funding determinations. DC Health will also conduct an excluded parties list search (EPLS) of the organization and executives via the federal System for Award Management (SAM).

In this phase of the review process, DC Health reserves the right to request clarifying supplemental information from applicants and conduct a pre-award site visit for those applicants being considered for award. The pre-award site visit will be conducted to assess the applicants' capacity for award administration, compliance with administrative regulations, and award terms and conditions. Any request for supplemental information or on-site visits is not a commitment by DC Health to fund the applicant.

The internal review panel prepares and submits a formal recommendation of prospective awardees, funding levels and service/activities to the DC Health Director for signature. The DC Health Office of Grants Management is responsible for certifying that all District rules and standards were followed for the RFA process.

7.4 Pre-Award Compliance Site Visit

A pre-award compliance site visit will be conducted to evaluate the applicants' capacity for award administration and their compliance with relevant regulations and terms for any entities that receive a Notice of Intent to Fund. HAHSTA staff will complete the IAT assessment during the visit and tour the service site to ensure compliance with program guidelines concerning allocated spaces. The findings from this site visit will be utilized to confirm adherence to program regulations and guidelines.

8. POST AWARD ASSURANCES & CERTIFICATIONS

8.1 Assurances and Certifications

Should DC Health move forward with an award, additional assurances may be requested in the post award phase. These documents include:

- Certification Regarding Lobbying; Debarment, Suspension and Other Responsibility Matters; and Drug-Free Workplace Requirements
- Certification of current/active Articles of Incorporation from DCLP.
- Certificate of Occupancy
- Most Recent Audit and Financial Statements

Failure to submit the required assurance package will likely make the application ineligible to receive a Notice of Grant Award.

8.2 Notification of Award Status

The Enterprise Grants Management System has an embedded set of applicant notifications that are automatically disseminated during the review and post award processes. Given the number of service areas associated with this funding opportunity, those auto-generated notices will not be accurate. **Please note:** those notifications do not apply to this funding announcement. Final notices of award will be distributed by the Ryan White program team.

9. APPLICATION SUBMISSION

To submit an application under this funding opportunity, the applicant organization must register in EGMS and establish an account for the authorized representative.

If the applicant organization has an account already, please ensure that the Primary Account User is authorized to submit an application on behalf of the organization and his/her account

is active. Currently, Secondary Account Users **do not** have submission privileges but can work in EGMS to prepare (e.g., upload documents, complete forms) the application.

IMPORTANT: When the Primary Account User is submitting an application, ensure that there are no other transactions on another device being attempted in EGMS under that Primary Account User's credentials. For security purposes, the system will only acknowledge one transaction and one of the transaction attempts may fail, if done simultaneously.

9.1 Register in EGMS

DC Health recommends that applicants create an EGMS account, establishing a Primary Account User as the authorized representative **at least two weeks** prior to the application submission deadline. There is no guarantee that the authorized representative would have an approved account if the registration process does not begin at least **two weeks** prior to the deadline. Deadline-day registrations will not be approved by the Office of Grants Management in time for submission. To register, complete the following:

1. **Access EGMS**: The user must access the login page by entering the following URL: https://egrantsdchealth.my.site.com/sitesigninpage. Click the button REGISTER and following the instructions. You can also refer to the EGMS Reference Guides.
2. Determine the agency's Primary User (i.e. authorized to accept terms of agreement, certify and submit documents, request and accept modifications). The Primary User will determine a Secondary User and send a notification via EGMS for him/her to set-up an account.
3. Your EGMS registration will require your legal organization name, your **UEI# and Tax ID#** in order to complete the registration. Your EGMS registration will also require your SAM (System for Award Management) expiration date to be entered into your agency profile. Please ensure that you have an active SAM registration (www.sam.gov).
4. When your Primary Account User request is submitted in EGMS, the Office of Grants Management will review the request. If the requester is NOT the identified Executive Director, DC Health Office of Grants Management will make an additional request for the Executive Director to send an email to DC Health to confirm that the requester is the authorized representative for EGMS. When requested, your authorized representative should send to doh.grants@dc.gov the name, title, telephone number and email address of the desired Primary User for the account. Note: The email will help to support the validation of authorized users for EGMS. DC Health official grant records will also be used. Please reply ASAP to any requests from Office of Grants Management to provide additional information, if needed.

EGMS User Registration Assistance:

Office of Grants Management at doh.grants@dc.gov assists with all end-user registration if you have a question or need assistance. Primary Points of Contact: Jennifer Prats and Clara McLaughlin (202) 442-9237. Here are the most common registration issues:

- Validation of the authorized primary account user
- Tax ID or expired SAM registration
- Web browser

9.2 Uploading the Application

All required application documents must be uploaded and submitted in EGMS. Required documents are detailed below. All of these must be aligned with what has been requested in other sections of the RFA.

- ***Eligibility Documents***
    - Certificate of Clean Hands dated within 60 days of the application deadline or attestation of operations outside of the District of Columbia
    - Current business license or certificate of licensure or proof to transact business in local jurisdiction
    - Current Certificate of Insurance
    - Copy of Cyber Liability Policy
    - IRS Tax-Exempt Determination Letter (for nonprofits only)
    - IRS 990 Form from most recent tax year (for nonprofits only)
    - Current list of Board of Directors, on letterhead, signed and dated by a certified official from the Board (this cannot be the Executive Director)
    - Assurances Certifications Disclosures

- ***Proposal Documents***
    - Proposal Abstract
    - Organizational Background and Accessibility
    - Project Description
    - Monitoring, Evaluation, and Improvement
    - Partnerships and Resources
    - Workplan
    - Organization Chart
    - Staffing Plan
    - Capacity to Provide Culturally Competent Services
    - Budget Table
    - Budget Justification

- Other Sources of Funding
- Medicaid Certification
- Scope of Services
- Risk Self-assessment

9.3 Deadline

Submit your application via EGMS by 3:00 p.m., on the deadline date of December 3, 2024. Applications will **not** be accepted after the deadline.

It is highly recommended that applicants submit their applications at least 48 hours before the deadline.

10. PRE-APPLICATION MEETING

Please visit the Office of Grants Management Eventbrite page to learn the date/time and to register for the event.

The meeting will provide an overview of the RFA requirements and address specific issues and concerns about the RFA. Applicants are not required to attend but it is highly recommended. ***Registration is required***.

RFA updates will also be posted on the District Grants Clearinghouse.

Note that questions will only be accepted in writing. Please submit all question via email to HAHSTARFAs@dc.gov. Answers to all questions submitted will be published on a Frequently Asked Questions (FAQ) document onto the District Grants Clearinghouse every three business days. Questions will not be accepted after November 6, 2024.

11. GRANTEE REQUIREMENTS

If the applicant is considered for funding based on the results of the competition, they will receive a Notice of Intent to Fund. If the applicant subsequently accepts the grant award, the following requirements are in effect:

11.1 Grant Terms & Conditions

All grants awarded under this program shall be subject to the DC Health Standard Terms and Conditions. The Terms and Conditions are embedded within EGMS, where upon award, the applicant organization must accept the terms.

11.2 Grant Uses

The grants awarded under this RFA shall be used exclusively to pay costs associated with the implementation of the grant. Payment requests will be monitored by DC Health to ensure compliance with the approved budget and work plan.

11.3 Conditions of Award

As a condition of award, a successful applicant who is issued a Notice of Grant Award (NOGA) will be required to:

1. Revise and resubmit a work plan and budget with justification in accordance with the approved scope of services. The applicant is required to complete all assignments prescribed by the DC Health Notice of Intent to Fund and all pre-award negotiations with assigned DC Health project and grants management personnel.
2. Meet pre-award requirements, including submission and approval of required assurances and certification documents, documentation of non-disbarment or suspension (current or pending) of eligibility to receive local or federal funds.
3. Adhere to mutually agreed upon terms and conditions of a grant agreement and Notice of Grant Award issued by the Department of Health and accepted by the grantee organization. The NOGA shall outline the scope of services, standards, reporting requirements, fund distribution terms and any special provisions required by federal agreements.
4. Utilize performance monitoring and reporting tools developed and approved by DC Health.

11.4 Indirect Cost

Indirect costs are costs that are not readily identifiable with a particular project or activity but are required for operating the organization and conducting the grant-related activities it performs. Indirect costs encompass expenditures for operation and maintenance of building and equipment, depreciation, administrative salaries, general telephone services and general travel and supplies. For federally funded grants, indirect costs are applied in compliance with 2 CFR 200.332.

For locally-funded grants, DC Law 23-185, the Nonprofit Fair Compensation Act of 2020 (D.C. Official Code sec. 2-222.01 et seq.) allows any grantee to apply a federal Negotiated Indirect Cost Rate Agreement (NICRA) to the grant funds and approved budget, negotiate a new percentage indirect cost rate with the District grantmaking agency, use a previously negotiated rate within the last two years from another District government agency, or use an independent certified public accountant's calculated rate using OMB guidelines. If a grantee does not have an indirect rate from one of the four aforementioned approaches, the grantee may apply a de minimis indirect rate of 10% of total direct costs.

11.6 Vendor Registration in DIFS

All applicants that that are new vendors with any agency of the District of Columbia government require registration in DIFS, the District's payment system. To do so, applicants must register with the Office of Contracting and Procurement. It is recommended that all potential new vendors with the District begin the registration process prior to the application submission.

11.7 Insurance

All applicants that receive awards under this RFA must show proof of all insurance coverage required by law prior to receiving funds.

DC Health reserves the right to request certificates of liability and liability policies pre-award and post-award and make adjustments to coverage limits for programs per requirements promulgated by the District of Columbia Office of Risk Management.

11.8 Audits

At any time or times before final payment and three (3) years thereafter, the District may have the applicant's expenditure statements and source documentation audited. Grantees subject to 2 CFR 200, subpart F rules must have available and submit as requested the most recent audit reports, as requested by DC Health personnel.

11.9 Nondiscrimination in the Delivery of Services

In accordance with Title VI of the Civil Rights Act of 1964 (Public Law 88-352), as amended, no person shall, on the grounds of race, color, religion, nationality, sex, or political opinion, be denied the benefits of, or be subjected to discrimination under, any program activity receiving funds under this RFA.

11.10 Quality Assurance

DC Health will utilize a risk-based management and monitoring assessment to establish a monitoring plan for the grantee. Grantees will submit interim and final reports on progress, successes, and barriers.

Funding is contingent upon the Grantee's compliance with terms of the agreement and progress in meeting milestones and targets outlined in the approved work and evaluation plans. All programs shall be monitored and assessed by assigned program and grants management personnel. The Grantee will receive a performance rating and be subject to review at any time during the budget period.

A final performance rating shall be completed by DC Health and provided to the funded applicant. DC Health will maintain a record of the performance rating and it will be used in making additional funding or future funding available to the applicant. All performance reports are subject to review and oversight by the DC Health Office of Grants Management.

11.11 Monitoring, Evaluation and Quality Improvement

Successful applicants shall have robust data management and quality management systems, plans, processes, and personnel in place for the purpose of monitoring and evaluating the delivery of quality services, and to ensure that improvement opportunities are identified and addressed in a timely manner.

Successful applicants shall develop and implement procedures to ensure data security, accuracy, completeness, timeliness, collection, reporting, and utilization. Applicants should utilize data to assess program performance and quality, at regular intervals, and use information to inform program design, service delivery, decision-making, and improvement activities.

As of the release of this RFA, Health Resources and Services Administration's (HRSA) policy clarification notice (PCN) 16-02 (10.22.2018 revision) is the most recent description of Ryan White HIV/AIDS Program Services, which includes eligible individuals and allowable uses of funds.

The policy clarification notice can be viewed here:

https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/grants/service-category-pcn-16-02-final.pdf.

In the Washington, DC EMA, service standards are essential in defining and ensuring that consistent quality care is offered to all customers. The service standards are also used by HAHSTA program and quality management staff to monitor subrecipient compliance in adhering to service delivery guidelines. Service standards define the minimal acceptable levels of service delivery and to ensure that a uniformity of service exists in the Washington, DC Eligible Metropolitan Area (EMA) such that customers of this service category receive the same quality of service regardless of where or by whom the service is provided. For the purposes of this RFA, current standards follow HRSA's PCN 16-02 and can be found at the link below.

https://dchealth.dc.gov/page/ryan-white-hivaids-program-services-standards-rwhapss.

a) National Monitoring Standards

All successful applicants are required to meet all responsibilities outlined in the National Monitoring Standard expectations for fiscal, programmatic, and universal monitoring of Part A and Part B programs. Any subrecipients found to be non-compliant with the standards at any time will be held responsible and required by the District of Columbia to restore any damages

and costs associated with subrecipient non-compliance. Please see the following website for more information: http://hab.hrsa.gov/manageyourgrant/granteebasics.html.

b) Monitoring

- Successful applicants will be monitored and evaluated by HAHSTA staff according to the scope of services, approved budgets, and related service delivery standards.
- Successful applicants will be responsible for assuring that all customers receiving services provided through funds detailed in this RFA sign the appropriate written consent forms.
- Successful applicants will have all written policies and procedures applicable to the project, as well as monthly, quarterly, bi-annual, annual program, fiscal, and client-level data reports reviewed by HAHSTA. HAHSTA will conduct site visits and hold periodic conferences with the successful applicant to assess performance in meeting the requirements of this funding announcement.

c) Evaluation

The performance of successful applicants shall be assessed to determine the quality of the services delivered. The successful applicants' fiscal performance shall be assessed to determine compliance with accounting standards, 2 CFR 200 and expenditure requirements. These evaluations include a pre-award site visit.

d) Quality Management

At a minimum, HAHSTA requires that successful applicants who are awarded funding establish clinical quality management (CQM) programs that perform quality improvement activities aimed at improving customer care, health outcomes, and customer satisfaction. A CQM program must have three main components: infrastructure, performance measurement, and quality improvement. Successful applicants will also be required to submit annual and quarterly deliverables by prescribed deadlines. The three main CQM program components and the deliverables are described below.

Infrastructure includes:

- Leadership: the applicant should have leadership engagement in the CQM program.
- Quality Management Committee (QMC): the applicant must establish a QMC which serves as the CQM program's guiding body that helps develop the program and its activities.
- Dedicated Staffing: staff and any contractors funded to assist with the CQM program who are responsible for CQM duties and resources.

- Dedicated Resources: adequate funding for the CQM program infrastructure and activities (see HRSA's Policy Clarification Notice 15-02 for allowable CQM costs – link below).
- Quality Management Plan: a written plan that describes all aspects of the CQM program including infrastructure, priorities, performance measures, quality improvement activities, action/work plan with a timeline and responsible parties, and evaluation of the CQM program.
- Involvement of People with HIV: engaging/involving people with HIV who reflect the population that the applicant serves to help ensure that the specific needs of the population are being addressed.
- Stakeholder Involvement: involvement of internal (applicant staff, Quality Management Committee members) and external stakeholders (funder, people with lived experience, other Ryan White subrecipients in the region) that may be impacted by and may provide input on the applicant's CQM program activities.
- CQM Program Evaluation: a written plan (a sub-section of the Quality Management Plan) that details how the applicant will conduct an annual evaluation of its CQM program including, assessing whether activities from the Quality Management Plan and Work Plan were carried out as planned, identifying factors that affect the CQM program activities (i.e., staff acceptance of change, improved performance, etc.); for more detail see HRSA's Policy Clarification Notice 15-02.

Performance Measurement:

Performance Measurement is the process of collecting, analyzing, and reporting data regarding customer care, health outcomes on an individual or population level, and customer satisfaction. To assess outcomes appropriately, measurement is required. The funded applicants should choose performance measures that best assess funded services and should reflect local HIV epidemiology and identified needs of people with HIV. Though not required, it is strongly recommended to include HRSA HIV/AIDS Bureau performance measures.

For information on selecting the appropriate service and client-level performance measures see the HRSA HIV/AIDS bureau guidance, available online at:

https://ryanwhite.hrsa.gov/grants/performance-measure-portfolio) and NHAS indicators.

Performance measures should be selected based on Ryan White HIV/AIDS Program (RWHAP) client service utilization data. Subrecipients must select performance measures for any service category where RWHAP eligible clients received at least one unit of service for any RWHAP service category for which the applicant is funded. Guidance for selecting the minimum required number of performance measures is as follows:

Percent of RWHAP eligible clients receiving at least one unit of service for a RWHAP-funded service Category	Minimum number of performance measures
>=50%	2
>15% to <50%	1
<=15%	0

Quality Improvement:

Successful applicants must use a defined approach or methodology to develop and implement quality improvement activities based on data from performance measures they have selected to track. Defined approaches or methodologies include but are not limited to the Model for Improvement and Lean. Successful applicants are required to have at least one Quality Improvement Project (QIP) at any given time. This means that a subrecipient may have any number of consecutive QIPs in a given grant year, or they may choose to have more than one at a time, but that at any point during the grant year the subrecipient must be able to demonstrate documented proof of an active QIP. Quality Improvement Projects vary in duration of time (i.e., some may only last a few months, whereas others may last a year or more), but QIPs should be focused on starting small and working on incremental changes of one process at a time rather than attempting to tackle a large-scale issue.

As of the release of this RFA, the Health Resources and Services Administration's (HRSA) Clinical Quality Management Policy Clarification Notice (PCN) 15-02 can be found at:

https://hab.hrsa.gov/sites/default/files/hab/Global/HAB-PCN-15-02-CQM.pdf.

This is the most recent RWHAP guidance detailing clinical quality management (CQM) program expectations and applicants are strongly encouraged to review it, as HAHSTA expects successful applicants to follow this PCN.

Additionally, HRSA provides guidance to Ryan White Program subrecipients on the establishment of quality management programs and that resource can be found at:

http://hab.hrsa.gov/deliverhivaidscare/qualitycare.html.

Required Annual and Quarterly Quality Deliverables:

As mentioned above, successful applicants will be required to submit annual and quarterly quality deliverables on time. These deliverables are listed in the table below:

Annual Deliverables	**Template(s) & Due Dates**
Quality Management Plan (QMP) - this includes the Work Plan and the Performance Measure Portfolio (PMP)	Templates for the QMP, the Work Plan, and the PMP will be provided after the grant year kick-off meeting. Due within the first 30 days of the start of the budget period.
Quarterly Deliverables	**Template(s) & Due Dates**
Quality Improvement Project (QIP) Report	A template will be provided after the grant year kick-off meeting. Dues dates will be provided during and after the grant year kick-off meeting.
Performance Measure Summary Report	A template will be provided after the grant year kick-off meeting.
Quality Committee Meeting Minutes	A template will be provided after the grant year kick-off meeting.
Documented Proof of Customer Involvement	There is no template for this. Documentation may vary depending on how the successful applicant involves their customers. More information will be provided during the kick-off meeting.

HAHSTA will provide successful applicants with a Quality Improvement (QI) Coach. QI Coaches provide technical assistance and capacity building support on various aspects of the subrecipient's CQM programs.

e) Data Collection and Reporting

Successful applicants must be able to track and report unduplicated client-level demographic, clinical/medical, and core and support services data as prescribed.

The RWHAP uses CAREWare, a free, HRSA-supported software program to track and report client level data. HRSA provides technical assistance for CAREWare as needed. All successful applicants will be required to use CAREWare, or a system that is compatible with CAREWare, to report client-level data.

General information about CAREWare can be obtained at:

http://hab.hrsa.gov/manageyourgrant/careware.html.

All subrecipients will be required to submit timely and accurate data on key programmatic areas to meet reporting requirements, including the Ryan White Services Report (RSR) and Mid-Year (RSR).

Required Annual Reporting for (RSR) and Mid-Year (RSR) Deliverables:

Annual Deliverables	**Template(s) & Due Dates**
Annual (RSR) Submission	Deliverables dates are TBD and are accounted for annually by HRSA and released annually for the grant year. The DC Health HAHSTA team will share a reporting timeline to review the report accurately and provide feedback to subrecipient s. All templates will be provided to subrecipient s.
Mid- Year (RSR) Submission	Mid-year requirement. The DC Health HAHSTA team will share a reporting timeline to review the report accurately and provide feedback to subrecipient s. All templates will be provided to subrecipient s. HAHSTA requires that subrecipient s with poor data quality participate in HAHSTA's Data Quality Improvement Project.

All subrecipients will be required to collaborate with and share clinical and service information for the purpose of coordinating care. Failure to comply with these data requirements can result in the termination of an agency's Ryan White subgrant with DC Health HAHSTA.

f) Data Security

Ensuring the security and confidentiality of data is of the utmost importance for all subrecipients. It is imperative that subrecipients uphold rigorous standards and protocols to safeguard sensitive information. This includes employing industry-standard encryption methods to protect data during transit and storage, implementing stringent access controls, and maintaining secure storage environments. Adhering to data minimization principles is also essential, ensuring that only necessary information is collected and retained. Additionally, subrecipients must maintain robust incident response plans to promptly and effectively address any potential breaches, thereby safeguarding the integrity and confidentiality of data throughout our engagement in the (RSR) Service report.

g) Centralized Eligibility

As HAHSTA seeks to increase the efficiency of its processes and support provider compliance with RWHAP requirements, it has instituted the use of a Centralized Eligibility System (CE), which launched in Grant Year 32. CAREWare, the RWHAP's existing client-level data system, has

been expanded for this purpose. The CE will provide a single point of application for eligibility data for all Ryan White services (see CW Centralized Eligibility USER GUIDE_Finalrev.pdf (adobe.com) for the current centralized eligibility policy and guidance). All subrecipients in the EMA funded to provide Ryan White services will have access to additional CAREWare domains to complete their customer's eligibility status, enter annual renewal information and upload supporting documents. Eligibility status will be visible across the network of providers. Additionally, providers will be able to import and export eligibility status data during mid-year and annual- RSR seasons.

12. GLOSSARY OF TERMS

Cultural Competence – practices and behaviors that ensure that all customers receive high-quality, effective care irrespective of cultural background, language proficiency, socioeconomic status, and other factors that may be informed by a customer's characteristics. Improving the cultural competency of health materials, personal interactions, and services is an important step toward addressing low health literacy among diverse populations.

"Health Literacy and the Role of Culture." Center for Health Care Strategies, Inc. Center for Health Care Strategies. Accessed January 14, 2022. http://www.chcs.org/media/Health_Literacy_Role_of_Culture.pdf

Health Disparity – A particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion.

"Disparities." Disparities. Office of Disease Prevention and Health Promotion. Accessed June 29, 2021. https://www.healthypeople.gov/2020/about/foundation-health-measures/Disparities

13. ATTACHMENTS, LINKS, AND APPENDICES

Attachments/Appendices	Definitions
Attachment A- Staffing Plan	Details the organization's staffing capacity to provide proposed services.
Attachment B- Capacity to Provide Culturally Competent Services	Details the organization's diversity among program staff, specifically examining their representation across racial, ethnic, sexual orientation, gender, and linguistic backgrounds.
Attachment C- Other Funding Sources Table	A table illustrating the organization's other funding sources received by October 1, 2024.
Attachment D- Medicaid Certification	A table illustrating the applicant's Medicaid certification for all applicable service categories.
Attachment E- Scope of Services	A tool for use by applicants to detail their proposed service targets for each service category where funds are being requested.
Work Plan	Program's SMART goals and objectives. See https://dchealth.dc.gov/service/grants-management for template.
Organizational Chart	A graphic representation of the structure of an organization showing the relationships of the positions or jobs within it. (No template provided)
Budget Table	An excel work sheet that includes all expenses directly related to achieving key grant outcomes. See https://dchealth.dc.gov/service/grants-management for template.
Budget Justification	Narrative that explains the amounts requested for each line in the budget. See https://dchealth.dc.gov/service/grants-management for template.
Appendix 1: Minimum Insurance Requirements	Minimum Insurance Requirements
Appendix 2 – Sample MOU	Sample MOU

14. COMPENDIUM OF SERVICES: CARE ACT PART A

Introduction

The Compendium of Services: Ryan White CARE Act Part A is intended to establish a clear and firm foundation for the important work of providing services to individuals with HIV/AIDS, and to assist sub-grantees of CARE Act Part A funds to plan and provide the necessary services to enroll and retain customers in care, all with the goal of improving the health of those served.

In May 2007, the federal Health Resources and Services Administration (HRSA) released a list of services that can be supported with CARE Act Part A or Part B funding. This compendium provides for each service category the service definition, key goals, and priorities, as well as guidance for developing successful applications.

The HIV/AIDS, Hepatitis, STD and TB Administration (HAHSTA) remains committed to active, ongoing partnership with each provider of HIV care and treatment services and will assist any provider in their efforts to achieve the maximum benefit for customers in need.

A note on numbering: Service categories included in this Compendium are those supported through the CARE Act Part A. Gaps in sequential numbering are a result of omitted service categories that are permissible, but not available for funding in the Washington, DC Eligible Metropolitan Area at this time.

Category 1: Outpatient/Ambulatory Medical Services

Outpatient/Ambulatory Health Services (O/AHS) provide diagnostic and therapeutic-related activities directly to a patient by a licensed healthcare provider in an outpatient medical setting. Outpatient medical settings may include clinics, medical offices, mobile vans, using telehealth technology, and urgent care facilities for HIV-related visits.

Allowable activities include:

- Medical history taking
- Physical examination
- Diagnostic testing (including HIV confirmatory and viral load testing), as well as laboratory testing
- Treatment and management of physical and behavioral health conditions
- Behavioral risk assessment, subsequent counseling, and referral
- Preventive care and screening
- Pediatric developmental assessment
- Prescription and management of medication therapy
- Treatment adherence
- Education and counseling on health and prevention issues
- Referral to and provision of specialty care related to HIV diagnosis, including audiology

and ophthalmology

Applicants proposing to provide outpatient/ambulatory health services must describe their proposed program and detail how they will implement all components of the service category.

Proposals should include:

A description of an established clinical management plan that, at a minimum, addresses confirming HIV status, completing medical assessments, and details developing individualized treatment plans.

A description of the agency's treatment triage plan that includes provisions for addressing any delay of access to primary medical care.

A description of the agency's "Treatment Adherence Support Policy" that defines the roles and responsibilities of the customer and each staff position partnered in the care of the customer (e.g. primary care providers, case managers, nutritionists, mental health professionals, substance abuse counselors, and other staff or volunteers).

The current approved protocol for outpatient/ambulatory medical care can be found at:

https://clinicalinfo.hiv.gov/en/guidelines/adult-and-adolescent-arv/whats-new-guidelines. The guidelines are titled "Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents Living with HIV".

A description of the agency's proposed program components and demonstrate consistency with U.S. Public Health Service guidelines.

A description of the project's implementation of expedited care and treatment services (Red Carpet (re)Entry, Rapid ART (re)Start) as core activities of this service category. Red Carpet Entry into primary care is expected to ensure the ease of enrollment of new customers, and re-enrollment of returning customers. There are three criteria for being a Red Carpet Entry provider in the DC EMA: the commitment to providing appointments for newly diagnosed or previously diagnosed but out of care appointments within 72 hours of contact; a Red Carpet concierge that can be contacted to set up the appointment and navigate the customer through the clinic system; and a phrase for these customers to use when they first arrive for services to ease their transition into care such as "I am here to see Dr. White" or "I am here for Red Carpet Services". Recommended activities to facilitate implementation of this program are additional clinic hours and a dedicated Red Carpet Entry telephone line. Rapid ART ensures that customers are not only linked to medical care expeditiously, but prescribed ART the same day (no later than 7 days).

A description of the organization's efforts to retain and re-engage customers lost to care which may be included as a service activity in the service categories outpatient/ambulatory health, mental health, substance abuse and medical case management. This activity is meant to

identify customers whose ongoing treatment plan has lapsed for reasons unknown to the service provider, and support activities designed to contact the customer and encourage the customer to resume services. Also included in this activity is any set of actions designed to identify the customer in care at another site or service provider.

Category 2: Medical Case Management Services

Medical Case Management is the provision of a range of customer-centered activities focused on improving health outcomes in support of the HIV care continuum. Activities may be prescribed by an interdisciplinary team that includes other specialty care providers. Medical Case Management includes all types of case management encounters (e.g., face-to-face, phone contact, and any other forms of communication).

Key activities include:

- Initial assessment of service needs
- Development of a comprehensive, individualized care plan
- Timely and coordinated access to medically appropriate levels of health and support services and continuity of care
- Continuous customer monitoring to assess the efficacy of the care plan
- Re-evaluation of the care plan at least every 6 months with adaptations as necessary
- Ongoing assessment of the customer's and other key family members' needs and personal support systems
- Treatment adherence counseling to ensure readiness for and adherence to complex HIV treatments
- Customer-specific advocacy and/or review of utilization of services

Applicants proposing to provide medical case management must describe their proposed program and detail how they will implement all components of the service category.

<u>Proposals should include:</u>

1. A description of program components and detail how it will provide guidance and assistance in improving access to and delivery of needed services.

2. A description of "Treatment Adherence Support Policy" that defines the roles and responsibilities of the customer and each staff position partnered in the care of the customer (e.g. primary care providers, case managers, nutritionists, mental health professionals, substance abuse counselors, and other staff or volunteers).

3. A description of how staff will assess customer enrollment in medical care, and, if the customer is not receiving medical care the strategies to ensure that the customer

receives medical care.

Note: The plan should include strategies for new customers, as well as strategies to address the needs of customers who have fallen out of care.

Successful applicants will use the acuity scale developed by HAHSTA to assess the level of need by customers for medical case management. Following the current guidelines for HIV MCM services can be found at https://dchealth.dc.gov/node/320792 .

A description of the organization's efforts to retain and re-engage customers lost to care which may be included as a service activity in the service categories outpatient/ambulatory health, mental health, substance abuse and medical case management. This activity is meant to identify customers whose ongoing treatment plan has lapsed for reasons unknown to the service provider, and support activities designed to contact the customer and encourage the customer to resume services. Also included in this activity is any set of actions designed to identify the customer in care at another site or service provider.

A detailed description of a baseline assessment of total number of current customers; percentages of current customers are on ART; and subsequent percentages of customers with an undetectable viral load. Targets for compliance with care and for viral suppression for those on ART should be set and strategies to reach them from this baseline assessment should be included.

A description of how level of care is assessed and categorized, and how customers are moved from one level to another over time. Please provide data on existing customers (the number and percentages) at which levels of need. Describe techniques to maintain customers in care and to recapture those who have fallen out of care or been lost to follow-up. an

A detailed description of proposed strategy for supervision, quality improvement, and customer service. Describe what systems are implemented and with what frequency to evaluate quality and performance of case managers. Describe trainings or interventions provided to support quality improvement routinely and when deficiencies are identified. Quantify stability of case managers (what percentage of current case managers have been with the proposing organization two years or more) as well as retention strategies for case managers. Describe performance expectations for timeliness of return of customer calls, timeliness and completeness of follow-up on paperwork submission, etc.

Category 3: Mental Health Services

Mental Health Services are the provision of outpatient psychological and psychiatric screening, assessment, diagnosis, treatment, and counseling services offered to customers living with HIV. Services are based on a treatment plan, conducted in an outpatient group or individual session, and provided by a mental health professional licensed or authorized within the state to render

such services. Such professionals typically include psychiatrists, psychologists, and licensed clinical social workers.

Key activities include:

- Intake
- Initial Assessment of Service Needs
- Treatment Plan
- Referrals
- Reassessment
- Transition & Discharge
- Case Closure

Applicants proposing to provide mental health services must describe their proposed program and detail how they will implement all components of the service category.

Proposal should include:

1. A description of how outpatient mental health services will be provided including diagnostic and treatment services to ensure a continuum of mental health services for persons living with HIV with an emphasis on those persons who are dually or triply diagnosed with HIV and mental illness and/or substance abuse.

2. A description of how customers will have routine access to the services of a licensed psychiatric provider, to include a nurse practitioner, that is able to prescribe psychotropic medications to those for whom it is clinically indicated.

3. A description of how customers will have routine access to the services of a licensed psychologist or licensed therapist.

4. A description of how customers will be screened and further assessed (using the Global Appraisal of Individual Needs or GAIN Short Screener or another instrument) for mental health services.

5. A description of how culturally and linguistically competent mental health professionals for individual psychotherapy sessions with non-English speaking customers will be made available either through linkage or direct provision.

6. A description of strategies to ensure joint medical management with HIV primary care, substance abuse, and case management providers, including any routine communications or case conferences; this includes specific attention to understanding the medical management needs of customers with regards to ART adherence and viral suppression when applicable, as well as ensuring that primary medical providers are aware of mental health treatment plan. Barriers to such joint medical management should be clearly described and solutions proposed. Linkages with specific providers

should be clearly detailed.

7. A description of the organization's efforts to retain and re-engage customers lost to care which may be included as a service activity in the service categories outpatient/ambulatory health, mental health, substance abuse and medical case management. This activity is meant to identify customers whose ongoing treatment plan has lapsed for reasons unknown to the service provider, and support activities designed to contact the customer and encourage the customer to resume services. Also included in this activity is any set of actions designed to identify the customer in care at another site or service provider.

8. A description of current and proposed strategy to support retention in mental health and care services. This should include current loss to care rate, tracking, reminder, and support system to minimize no-show rate and most of all minimize loss to follow-up. Retention and no- show rates for scheduled appointments should be provided as baseline and targets.

9. A certification from the DC Department of Behavioral Health to provide and seek reimbursement for services. Proposals from agencies that are not certified by the Department of Behavioral Health should indicate their plan and timeline to secure certification. Describe Medicaid certification for mental health services.

10. A description of current and proposed strategies to include core HIV prevention and harm reduction messages in routine care services. This should include any plans to routinely provide risk screening and counseling; condoms and other safer sex products; linkages to prevention-for-positive programs; services geared towards compulsive behaviors; provision of or linkages to harm reduction programs such as needle exchange services if appropriate; and consideration of emphasize on ART compliance and viral suppression as a risk reduction strategy.

Following the current resources for mental health services found at: https://www.samhsa.gov/find-help/disorders

Category 4: Oral Health Care

Oral Health Care services must be provided by fully registered dental health care professionals authorized to perform dental services under the laws and regulations of the jurisdictions of the Washington, District of Columbia Eligible Metropolitan Area.

Key activities include:

- Initial examinations

- Cleanings
- Fillings
- Extractions
- Root canals
- Linkages to referral sources to provide portions of services not provided by applicant

The following are priorities for HIV oral health treatment:

1. Prevention of oral and/or systemic disease where the oral cavity serves as an entry point
2. Elimination of presenting symptoms
3. Elimination of infection
4. Preservation of dentition and restoration of functioning (Dentures)

Applicants proposing to provide oral health care services must describe their proposed program and detail how they will implement all components of the service category.

<u>Proposal should include:</u>

1. A description of how oral health care services will be provided including diagnostic and treatment services to ensure a continuum of oral health care services for persons living with HIV.

2. A description of how oral health care services will be provided including outpatient diagnosis, prevention, and therapy provided by dental health care professionals, including general dental practitioners, dental specialists, dental hygienists, and licensed dental assistants. Providing or referring customers, as needed, to health specialists including, but not limited to, periodontists, endodontists, oral surgeons, oral pathologists, oral medicine practitioners and registered dietitians.

3. A description of how oral health care services will be provided in accordance with the American Dental Association Dental Practice Parameters, is based on an oral health treatment plan, and adheres to specified service caps as appropriate and defined by HIV/AIDS, Hepatitis, STD and TB Administration (HAHSTA).

4. A description of how oral health care services will address the burden placed on the immune system caused by oral infection and support positive health outcomes.

5. A description of how culturally and linguistically competent oral health care professionals will be made available either through linkage or direct provision.

6. A description of the organization's efforts to retain and re-engage customers lost to care which may be included as a service activity. This activity is meant to identify customers whose ongoing treatment plan has lapsed for reasons unknown to the service provider,

and support activities designed to contact the customer and encourage the customer to resume services. Also included in this activity is any set of actions designed to identify the customer in care at another site or service provider.

Services shall include (but not be limited to):

- Identifying appropriate customers for HIV oral health care services through eligibility screening
- Obtaining a comprehensive medical history and consulting primary medical providers as necessary
- Providing educational, prophylactic, diagnostic and therapeutic dental services to customers with a written confirmation of HIV disease
- Providing medication appropriate to oral health care services, including all currently approved drugs for HIV related oral manifestations

Category 5: Non-Medical Case Management

Non-Medical Case Management Services (NMCM) is the provision of a range of client-centered activities focused on improving access to and retention in needed core medical and support services. NMCM provides coordination, guidance, and assistance in accessing medical, social, community, legal, financial, employment, vocational, and/or other needed services.

NMCM Services may also include assisting eligible customers to obtain access to other public and private programs for which they may be eligible, such as Medicaid, Children's Health Insurance Program, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturer's Patient Assistance Programs, Department of Labor or Education-funded services, other state or local health care and supportive services, or private health care coverage plans. NMCM Services includes all types of case management encounters (e.g., face-to-face, telehealth, phone contact, and any other forms of communication).

Key activities include:

- Initial assessment of service needs
- Development of a comprehensive, individualized care plan
- Timely and coordinated access to medically appropriate levels of health and support services and continuity of care
- Client-specific advocacy and/or review of utilization of services
- Continuous customer monitoring to assess the efficacy of the care plan
- Re-evaluation of the care plan at least every 6 months with adaptations as necessary
- Ongoing assessment of the customer's and other key family members' needs and personal support systems

Applicants proposing to provide non-medical case management services must describe their proposed program and detail how they will implement all components of the service category.

Proposal should include:

1. A description of how non-medical case management services will provide coordination, guidance and assistance in improving access to and retention in needed medical and support services to mitigate and eliminate barriers to HIV care services.
2. A description of how non-medical case management services will provide guidance and assistance in accessing medical, social, community, legal, financial, and other needed services. Under this service category, you can provide NMCM services, Benefits and Entitlement Counseling, and/or Re-entry Planning.
3. A description of how non-medical case management services will provide benefits counseling that assists eligible customers in obtaining access to other public and private programs for which they may be eligible, such as Medicaid, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturer's Patient Assistance Programs, other state or local health care and supportive services, and health insurance plans through health insurance Marketplaces/Exchanges.
4. A description of how non-medical case management services will be provided through the use of several methods of communication including face-to-face, phone contact, and any other forms of communication deemed appropriate by the recipient.
5. A description of how non-medical case management services will provide transitional case management for incarcerated persons as they prepare to exit the correctional system. Non-Medical Case Management Services have as their objective providing guidance and assistance in improving access to needed services whereas Medical Case Management services have as their objective improving health care outcomes. This service category does not include the provision of Treatment Adherence Services.

Category 6: Health Insurance Premium & Cost Sharing Assistance

Health Insurance Premium and Cost Sharing Assistance (HIPCSA) provides financial assistance for eligible customers living with HIV to maintain continuity of health insurance or to receive medical and pharmacy benefits under a health care coverage program. For purposes of this service category, health insurance also includes standalone dental insurance.

Applicants proposing to provide health insurance premium and cost sharing assistance must describe their proposed program and detail how they will implement all components of the service category.

Proposal should include:

1. A description of how health insurance premium and cost sharing assistance will pay health insurance premiums to provide comprehensive HIV Outpatient/Ambulatory Health Services, and pharmacy benefits that provide a full range of HIV medications for eligible

customers.

2. A description of how health insurance premium and cost sharing assistance will pay standalone dental insurance premiums to provide comprehensive oral health care services for eligible customers.

3. A description of how health insurance premium and cost sharing assistance will pay cost sharing on behalf of the customer.

4. A description of how health insurance premium and cost sharing assistance will use RWHAP funds for health insurance premium assistance (not standalone dental insurance assistance).

To use RWHAP funds for standalone dental insurance premium assistance, a RWHAP recipient must implement a methodology that incorporates the following requirement:

- RWHAP recipients must assess and compare the aggregate cost of paying for the standalone dental insurance option versus paying for the full cost of HIV oral health care services to ensure purchasing standalone dental insurance is cost-effective in the aggregate and allocate funding to HIPCSA on when determined to be cost-effective.

- Key Services Components and Activities Provision of Health Insurance Premium and Cost-sharing Assistance that provides a cost-effective alternative to ADAP by:
    a) Purchasing health insurance that provides comprehensive primary care and pharmacy benefits for low-income customers that provide a full range of HIV medications.
    b) Paying co-pays (including co-pays for prescription eyewear for conditions related to HIV infection) and deductibles on behalf of the customer.
    c) Providing funds to contribute to a customer's Medicare Part D true out-of-pocked (TrOOP) costs

Category 7: Early Intervention Services (Hi-V)

Early Intervention Services (EIS) is the bridge in the continuum of care that joins HIV prevention to care services. The goal is to identify persons with HIV that are unaware of their status and link them to medical care and treatment. For this RFA, the only Early Intervention Services programs available for funding will be status neutral, programs that employ the use of the Hi-V model.

The **"Hi-V (high five) model"** consists of five (5) pillars (*find 'em, teach 'em, test 'em, link 'em, keep 'em* as detailed below) of client-centered services that promote equity, whole person health, and eliminate barriers (e.g. employment, housing, and behavioral health) to prevention and/or treatment services. These services will be delivered to focus populations that: are at very high risk

of HIV infection, have demonstrated high HIV prevalence, have inconsistent engagement in care and treatment, and/or are at increased risk of falling out of care and treatment.

Key Considerations:

Status-Neutral Approach

In order to maximize a whole person-based approach, this RFA prioritizes the engagement of both people living with HIV and persons with risk behavior for HIV through a status-neutral approach. This approach focuses on activities that meet the needs of populations overall, rather than dividing services into either HIV prevention or HIV care. Programs should provide all customers with the same level of ongoing, individualized services regardless of their HIV status and will be held to the same level of responsibility and expected outcomes.

HIV-Affected Minority Populations

Substantial disparities continue to exist within the current system. Programs must provide services that are responsive to the needs of focus populations most affected by HIV. HAHSTA aims to identify, test, and scale up creative solutions for engaging and mobilizing minority populations for the purpose of supporting innovative programs.

Returning Citizens

The transition from incarceration back to the community is a critical time when individuals can experience factors that can interrupt adherence to treatment. It also represents an opportunity to engage individuals in healthcare access. HAHSTA is highly interested in addressing the needs of individuals experiencing reentry into the community using proven best practices and increasing the accessibility to treatment and an effective transition-to-community services for returning citizens.

Key activities must include the following components:

1. Identification of a focus population
    a. Focus populations may be identified through available regional data or through organizational experience as evidenced through current program data.
    b. Each proposed service model must be tailored to the specific needs of a focus population.
2. Intentional, innovative outreach
    a. Outreach methods proposed must be able to demonstrate effectiveness in the chosen focus population of focus or have an element of historical effectiveness or promise amongst the focus population.
3. Proposed service models will use the ***"Hi-V" (high-five)*** pillars that promote equity, eliminate barriers, and improve whole-person health for customers:

a. *Find'em* –identify individuals from the focus population unaware of their status.
b. *Teach'em* –educate individuals from the focus population about HIV, STI, Hepatitis C virus, risk reduction strategies, health literacy, healthcare access, and U=U. All proposed programs must integrate U=U into their clinical and non-clinical services and communication with individuals.
c. *Test'em* –test individuals from the focus population for HIV, STIs, and hepatitis C, and initiate drug therapy as appropriate.
d. *Link'em* –link individuals from the focus population to quality culturally competent
    i. services as needed.
e. *Keep'em* –retain individuals from the focus population through active engagement in individualized services designed to eliminate barriers and promote optimal outcomes for overall wellness.

4. All proposed programs must be developed from a Status Neutral approach, delivering the same level of service to individuals from focus populations regardless of current HIV status of the individuals served.

5. Rapid Treatment Initiation: the preference is to start HIV anti-retroviral therapy (ART) on the same day as HIV diagnosis with no later than 7-days for all persons newly diagnosed with HIV or are treatment naïve and ready to start treatment.

6. Initiate Pre-Exposure Prophylaxis (PrEP) same day or within 7 days, as appropriate, or Post-Exposure Prophylaxis (PEP).

7. Comprehensive harm and risk reduction. Harm reduction refers to policies, programs and practices that aim to minimize negative health, social and legal impacts associated with risk behaviors. Harm reduction is grounded in justice and human rights. It focuses on positive change and on working with people without judgment, coercion, discrimination, or requiring that they stop the risky behavior as a pre-condition of support. Risk reduction is a public health strategy employing client-centered techniques to help persons at risk for HIV transmission identify their personal risk behaviors and develop and implement plans for reducing or eliminating those risks.

8. The use of innovative branding and/or marketing strategies to increase the focus population's awareness of the Hi-V program.

9. Innovative use of technology to promote or provide early intervention services.

Applicants proposing to provide early intervention services must describe their proposed program and detail how they will implement all components of the service category.

<u>Proposals should include:</u>

1. A description of the proposed program's population of focus, the geographic area where the focus population is found, the need for services, the demographic characteristics of the population and barriers to care experienced by the intended focus population.

2. A description of the program's proposed innovative and tailored strategies to reach the focus population and increase awareness around HIV, STIs, Hepatitis C, and risk reduction strategies, to include a justification or rationale for the methods selected.

3. A detailed and clear plan to use the status neutral approach in an effort to move customers along the prevention to care continuum using the Hi-V model: Find 'em; Teach 'em; Test 'em; Link 'em; Keep 'em.

4. A detailed and clear plan to ensure that customers are effectively provided directly or linked with primary medical care and offered Rapid ART or PrEP same day as diagnosis or test result and no later than 7 days, as appropriate.

5. A description of the proposed process for identifying and addressing customers' need for comprehensive harm and risk reduction services;

6. A description of innovative branding and/or marketing strategies designed to increase the focus population's awareness of the Hi-V program;

7. A description of the program's plan to use technology to promote and or provide early intervention services.

Category 8: Emergency Financial Assistance

Emergency Financial Assistance (EFA) provides limited, one-time or short-term payments to assist Ryan White HIV/AIDS Program customers with an urgent need for essential items or services necessary to improve health outcomes, including utilities, housing, food (including groceries and food vouchers), transportation, and medication not covered by an AIDS Drug Assistance Program or AIDS Pharmaceutical Assistance or another HRSA RWHAP allowable cost needed to improve health outcomes.

EFA activities are composed of the following eligible services:

- Emergency rental assistance (first month's rent, past due rent)
- Emergency utility payments (gas, electric, oil and water)
- Emergency telephone services payments
- Emergency food vouchers
- Emergency moving assistance

- Emergency medication

Applicants proposing to provide emergency financial assistance must describe their proposed program and detail how they will implement all components of the service category.

Proposal should include:

1. A description of how emergency financial assistance will provide limited, one-time or short-term payments to assist Ryan White HIV/AIDS Program customers with an urgent need for essential items or services necessary to improve health outcomes.

2. A description of how emergency financial assistance will provide services such as a direct payment to an agency or through a voucher program.

3. A description of how emergency financial assistance will be provided in accordance with the Washington DC EMA EFA Service Standard.

EFA Application Tracking System:

1. The EFA provider must develop, implement and maintain a comprehensive tracking system that documents a customer's EFA application status from start to finish, i.e., incomplete draft, complete, submitted, pending, approved, denied, error, requested service provided, etc.

Category 9: Substance Abuse Outpatient Care

Substance Use - Outpatient Services, is the provision of medical and/or counseling services to address substance abuse issues in an outpatient setting; these services are to be rendered by licensed professional as specified by the licensing/regulatory body in the jurisdiction in which the services are provided.

Substance Abuse Outpatient Care is the provision of outpatient services for the treatment of drug or alcohol use disorders.

Activities under Substance Abuse Outpatient Care service category include:

- Screening
- Assessment
- Diagnosis, and/or
- Treatment of substance use disorder, including:
- Pretreatment/recovery readiness programs

- Harm reduction
- Behavioral health counseling associated with substance use disorder
- Outpatient drug-free treatment and counseling
- Medication assisted therapy
- Neuro-psychiatric pharmaceuticals
- Relapse prevention

Applicants proposing to provide substance abuse outpatient care must describe their proposed program and detail how they will implement all components of the service category.

Proposal should include:

1. A description of current and proposed strategies to support ART readiness for those not on treatment and ART adherence and treatment outcomes for those currently on treatment. Customers with current or recent substance use often face unique challenges with medical providers in ART initiation, and often suffer from low treatment expectations of providers and occasionally themselves.

2. A description of strategies for skills-building with customers to demonstrate stability and reliability to providers to overcome misperceptions—this may include regular attendance with medical appointments/focus on eliminating no-shows.

3. A description of how behavior change models with a focus on reshaping sexual behaviors and substance use will be implemented.

4. A description of strategies to ensure joint medical management with HIV primary care, mental health, and case management providers. This includes specific attention to understanding the support needs of customers with regards to ART adherence and viral suppression when applicable, as well as ensuring that primary medical providers are aware of substance use issues and progress when applicable. Barriers to such joint medical management should be clearly described and solutions proposed. Linkages with specific providers should be clearly detailed.

5. A description of how services will be developed and implemented for dually diagnosed customers (substance abuse and HIV) delivered by Certified Supervised Counselors (CSC-AD) or Certified Associate Counselors (CAC-AD) under the supervision of Certified Professional Counselors – Alcohol and Drugs (CPC-AD), or under the supervision of Licensed Clinical Professional Alcohol and Drug Counselors (LCPC); or delivered by CPC-AD or LCPC.

6. A description of the organization's efforts to retain and re-engage customers lost to care which may be included as a service activity in the service categories

outpatient/ambulatory health, mental health, substance abuse and medical case management. This activity is meant to identify customers whose ongoing treatment plan has lapsed for reasons unknown to the service provider, and support activities designed to contact the customer and encourage the customer to resume services. Also included in this activity is any set of actions designed to identify the customer in care at another site or service provider.

7. The substance abuse services supported in this service category are those services that are reimbursable by Medicaid. All substance abuse services will be provided by individuals with the necessary credentials and licenses required for Medicaid reimbursement.
8. Current and projected ability to gain access to and retain customers in care. Define baseline number and targets for customers served, measures of success, retention in services, and frequency and duration of services. Describe strategies to 'recapture' past customers who have been lost to follow up.

9. A description of the agency's harm reduction strategies that incorporate a spectrum of safer use, of drugs to managed use with the goal of abstinence. Harm reduction strategies meet drug users "where they're at," addressing conditions of use along with the use itself.

10. A description of the agency's current and proposed use of the Department of Behavioral Health's approved substance abuse assessment tools: GAIN (targeted for youth assessment, official certification available) and ASI (Addiction Severity Index). Agencies that are not currently using the Department of Behavioral Health-recommended tools should include a plan and timeline for adopting them or explain thoroughly why they are not applicable to the proposed services. Any additional standardized tools routinely used for assessment and monitoring should be described; and

11. A description of the agency's current and proposed strategies to include core prevention messages in routine care services. This should include risk analysis and perception; provision of condoms and other safer sex products; linkages to prevention-for-positive programs for those with need; linkages to services and peer support interventions for persons with compulsive behaviors; provision of or linkages to harm reduction programs such as needle exchange services if applicable; and consideration of emphasize on ART compliance and viral suppression as a risk reduction strategy.

Category 12: Medical Transportation

The goal of Medical Transportation is to provide non-emergency transportation services to eligible customers in the Washington, DC Eligible Metropolitan Area (EMA) that enables them to access or be retained in core medical and support services.

Medical transportation may be provided through:

- Contracts with providers of transportation services
- Mileage reimbursement (through a non-cash system) that enables customers to travel to needed medical or other support services, but should not in any case exceed the established rates for federal Programs (Federal Joint Travel Regulations provide further guidance on this subject)
- Purchase or lease of organizational vehicles for customer transportation programs, provided the subrecipient receives prior approval for the purchase of a vehicle
- Organization and use of volunteer drivers (through programs with insurance and other liability issues specifically addressed)
- Use HIPAA-compliant rideshare, voucher, or token systems

Subrecipient shall not bill the Ryan White program for the following unallowable costs:

- Direct cash payments or cash reimbursements to customers
- Direct maintenance expenses (tires, repairs, etc.) of a privately-owned vehicle
- Any other costs associated with a privately-owned vehicle such as lease, loan payments, insurance, license, or registration fees

Applicants proposing to provide medical transportation services must describe their proposed program and detail how they will implement all components of the service category.

<u>Proposal should include:</u>

1. A description of how HIV-related services will be complemented by the medical transportation services, and the likely contribution of the addition of medical transportation services to improved health outcomes of the customers served.
2. A description of the population to be served by the medical transportation services, including targeted number of customers, average frequency and duration of support.
3. A description of the method and approach for supporting transportation, such as direct provision, vouchers, or reimbursement. The proposal may include requests to support clinic transport services.
4. A description of the use of non-traditional transportation methods such as rideshare services that are HIPAA compliant and allows hospitals and other healthcare professionals to request, manage, and pay for rides for others, at scale.
5. A description of the capacity to assess for and link customers to other District-wide transport options, to ensure that the full-range of low-cost, efficient transportation options are considered and used to address the medical transportation services needs of

customers.

6. A description of the role of the medical transportation services in re-engaging and recapturing customers who have been previously lost to follow up for care.

Category 13: Food Bank/Home-Delivered Meals

The goal of Food Bank/Home-Delivered Meals (FB/HDM) is to provide nutritionally appropriate meals or groceries to HIV+ individuals who are nutritionally compromised in order to improve health outcomes and support the ability of these consumers to remain in their homes and in medical care.

Food bank & home-delivered meals include the provision of actual food or meals. The provision of essential household supplies such as hygiene items and household cleaning supplies may be included. Vouchers to purchase food may be included. Cash disbursements or allotments are not permissible. Pet products, alcohol, tobacco products or other restricted items are not permissible.

Home Delivered Food key activities include:

- Providing home delivered meals.
- The collection and delivery of perishable and nonperishable food items.
- Development of meal plans by registered dietitians.
- Providing information on safe drinking water.
- Referrals to other food programs.

Food Bank key activities include:

- Providing food items, including fresh produce, poultry and fish.
- The provision of essential household supplies such as hygiene items and household cleaning supplies are optional.
- A mechanism for the delivery of food and/or filtered water to the homebound.
- Providing a minimal amount of safe drinking water in the event of a water emergency as declared by the jurisdiction's department of health.
- Providing information on safe drinking water on a regular basis as a part of ongoing services.

Applicants proposing to provide food bank & home-delivered meals services must describe their proposed program and detail how they will implement all components of the service category.

Proposal should include:

1. A description of how the proposed program will provide home-delivered meals, which shall include the delivery of prepared foods to homebound individuals and their dependents who are unable to prepare meals for themselves.

2. A description of how the proposed program will provide foodbank, which shall include the provision of food items, including fresh produce, poultry and fish. The provision of essential household supplies such as hygiene items and household cleaning supplies are optional.
3. A description of how the proposed program will collect and deliver perishable and nonperishable food items, personal care and/or household items and condiments for persons living with HIV/AIDS and their dependents that are homebound or shelter bound or unable to prepare meals for themselves or access other food programs like food banks.

4. A description of how the proposed program will provide information on safe drinking water on a regular basis as part of ongoing services.

5. A description of the proposed program will develop meal plans by registered dietitians in coordination with the customers' caregivers, case managers and physicians.

Category 14: Psychosocial Support Services

Psychosocial Support Services provide group or individual support and counseling services to assist eligible people living with HIV to address behavioral and physical health concerns.

Psychosocial support services are the provision of support and counseling activities, child abuse and neglect counseling, HIV support groups, pastoral care, caregiver support, and bereavement counseling. It includes nutrition counseling provided by a non-registered dietician but excludes the provision of nutritional supplements.

Funds under this service category may not be used to provide nutritional supplements (See Food Bank and Home-Delivered Meals).

Funds may not be used for social/recreational activities or to pay for a customer's gym membership.

Key activities include:

- Completion of a comprehensive psychosocial assessment and linking customers with counseling services as needed.
- Facilitation of HIV support group services led or co-led by peer-facilitators.
- Facilitation of child abuse and neglect counseling.
- Facilitation of bereavement counseling inclusive of spiritual support to persons with HIV.
- Facilitation of pastoral care/counseling services.

Applications must clearly indicate the type of psychosocial services to be offered and state how these services will facilitate the movement of customers along the prevention to care continuum: early diagnosis, linkage to care and other services, offering of antiretroviral treatment, adherence to medication and medical care, retention in medical care, re-engagement in care and improved health outcomes.

Applicants proposing to provide psychosocial support services must describe their proposed program and detail how they will implement all components of the service category.

Proposals should include:

1. A description of the population to be served by psychosocial support services, include proposed customer numbers, frequency, and duration of activities.

Category 15: Medical Nutrition Therapy (MNT)

The goal of Medical Nutrition Therapy is to correct and prevent malnutrition in people living with HIV and reduce the risk of other diseases/comorbidities.

Key activities include:

- Nutrition assessment and screening
- Dietary/nutritional evaluation
- Food and/or nutritional supplements per medical provider's recommendation
- Nutrition education and/or counseling These services can be provided in individual and/or group settings and outside of HIV Outpatient/Ambulatory Health Services.

Program Guidance:

All services performed under this service category must be pursuant to a medical provider's referral and based on a nutritional plan developed by the registered dietitian/nutritionist or

other licensed nutrition professional. Under the RWHAP services not provided by a registered/licensed dietitian/nutritionist are considered Psychosocial Support Services.

Applicants proposing to provide medical nutrition therapy must describe their proposed program and detail how they will implement all components of the service category.

Proposal should include:

1. A description of services that include culturally appropriate nutrition education as well as referral to food assistance programs such as food stamps, the special supplemental food program for women, infants and children (WIC), the Commodity Supplemental Food Program, food banks, home-delivered meals and emergency food.

2. A description of how nutritional services will be integrated with outpatient/ambulatory health services programs and provide information regarding medication interactions and side effects.

3. A description of the population to be served, including how customers are identified and what linkages exist with primary care and case management providers.

4. A description of the baseline and target number of customers to be served, and with what frequency and duration should be specifically included.

Category 18: Outreach Services

The Outreach Services category has as its principal purpose of identifying PLWH who either do not know their HIV status, or who know their status but are not currently in care.

Key activities include:

1. Identification of people who do not know their HIV status.
2. Linkage or re-engagement of PLWH who know their status into HRSA RWHAP services, including provision of information about health care coverage options.

Outreach Services must:

1. Use data to target populations and places that have a high probability of reaching PLWH who:
   - Have never been tested and are undiagnosed,

- Have been tested, diagnosed as HIV positive, but have not received their test results, or
- Have been tested, know their HIV positive status, but are not in medical care;

2. be conducted at times and in places where there is a high probability that PLWH will be identified; and
3. be delivered in coordination with local and state HIV prevention outreach programs to avoid duplication of effort.

Outreach Services may be provided through community and public awareness activities (e.g., posters, flyers, billboards, social media, TV or radio announcements) that meet the requirements above and include explicit and clear links to and information about available HRSA RWHAP services. Ultimately, HIV-negative people may receive Outreach Services and should be referred to risk reduction activities. When these activities identify someone living with HIV, eligible customers should be linked to HRSA RWHAP services.

Program Guidance:

Outreach Services provided to an individual or in small group settings cannot be delivered anonymously, as some information is needed to facilitate any necessary follow-up and care.

Outreach Services may not include outreach activities that exclusively promote HIV prevention education.

Applicants proposing to provide outreach services must describe their proposed program and detail how they will implement all components of the service category.

<u>Proposal should include:</u>

1. A description of how the proposed program will identify people who do not know their HIV status and/or 2) linkage or re-engagement of PLWH who know their status into HRSA RWHAP services, including provision of information about health care coverage options.

2. A description of the population of focus, the geographic area where the target population is found, the need for services and the barriers to care experienced by the population to be served, as well as ways in which the program will address those barriers.

Category 19: Home and Community-Based Health Services

Home and Community-Based Health Services are provided to an eligible customer in an integrated setting appropriate to that customer's needs, based on a written plan of care established by a medical care team under the direction of a licensed clinical provider.

Key activities include:

- Appropriate mental health, developmental, and rehabilitation services.
- Day treatment or other partial hospitalization services.
- Durable medical equipment.
- Home health aide services and personal care services in the home.

Inpatient hospitals services, nursing homes, and other long-term care facilities are NOT included.

Special focus should be given to people who are homeless and to people with mental health and/or substance abuse diagnoses who may or may not have access to services on a daily basis.

Applicants proposing to provide home and community-based care must describe their proposed program and detail how they will implement all components of the service category.

<u>Proposal should include:</u>

1. A description of the methodology by which providers ensure customers are linked to, engaged and receiving regular and quality HIV medical care.

2. A description of how the proposed program will provide medically related services that may include: medical rehabilitation services such as physical therapy, occupational therapy, and assistance to individuals with HIV-related visual impairments; mental health and substance abuse interventions, training in wellness and independent living skills, vocational, recreational, and support services.

3. A description of the proposed strategies to ensure strong linkages to other care and support services.

4. A description of hours of operation and why they are most appropriate for target population; At a minimum, applicants must provide programs that operate from 8:00 a.m. to 5:00 p.m., five days per week unless otherwise approved to operate during hours that meet the needs of the target population. Note: applicants can propose to provide services to customers on a full-time or part-time basis.

5. A description of the location and accessibility of services.

6. A description of the communication strategies to make other service providers aware of this service for referral of their customers.

7. A description of the baseline and proposed target numbers of customers served with which services, including duration of participation in these services, what the criteria are for the transition of customers out of the program and how transition out of these services is effectively supported.

Category 20: Linguistics Services

Linguistic Services include interpretation and translation activities, both oral and written, for eligible customers. These activities must be provided by qualified linguistic services providers as a component of HIV service delivery between the healthcare provider and the customer. These services are to be provided when such services are necessary to facilitate communication between the provider and customer and/or support delivery of HRSA RWHAP-eligible services. Linguistic Services provided must comply with the National Standards for Culturally and Linguistically Appropriate Services (CLAS).

Key activities include:

- Eligibility determination
- Providing linguistically appropriate services
- Assessment of interpretation and/or translation needs

Applicants proposing to provide linguistic services must describe their proposed program and detail how they will implement all components of the service category.

<u>Proposal should include:</u>

1. A description of the HIV-related services that will be value added through the provision of Linguistic Services, and the impact of Linguistic Services to the improvement of health outcomes of the customers served.
2. A description of the role of Linguistic Services in re-engaging customers who have been previously lost to care.
3. A description of how the program will ensure the provision of translators and interpreters with knowledge of HIV terminology and technical language and knowledge of health care terms.
4. A description of the necessary and appropriate experience, skills, standards, licenses and certifications required by those individuals providing direct interpretation or translation services of medical information. Services provided under this service

category will be performed by licensed and/or certified professionals. If no license or certification is required within a given jurisdiction, the applicant will describe the standard to be applied when selecting an interpreter or translator.

5. A demonstration of the capacity to routinely provide or rapidly mobilize translation services in Spanish, Amharic, Chinese, French, Korean, and Vietnamese.
6. A demonstration of the capacity to routinely provide or rapidly mobilize American Sign Language interpretation.
7. A description of the baseline and target of customers to be served, with a description of how customers are assessed or referred to services.

Category 24: Other Professional Services

Other Professional Services allow for the provision of professional and consultant services rendered by members of professions licensed and/or qualified to offer such services by local governing authorities.

Key activities include:

- Legal services provided to and/or on behalf of the individual living with HIV and involving legal matters related to or arising from their HIV disease, including:
    - Assistance with public benefits such as Social Security Disability Insurance (SSDI); and
    - Interventions necessary to ensure access to eligible benefits, including discrimination or breach of confidentiality litigation as it relates to services eligible for funding under the RWHAP.

- Income tax preparation services to assist customers in filing Federal tax returns that are required by the Affordable Care Act for all individuals receiving premium tax credits.

- Preparation of:
    - Healthcare power of attorney
    - Durable powers of attorney
    - Living wills

Permanency planning to help customers/families make decisions about the placement and care of minor children after their parents/caregivers are deceased or are no longer able to care for them, including:

1. Social service counseling or legal counsel regarding the drafting of wills or delegating
2. Powers of attorney
3. Preparation for custody options for legal dependents including standby guardianship, joint custody, or adoption

Applicants proposing to provide other professional services must describe their proposed program and detail how they will implement all components of the service category.

Proposal should include:

1. A description of the baseline and target of customers to be served, with a description of how customers are assessed or referred to services.
2. A description of the estimated (targets) of the service needs of customers by category/topic.
3. A description of the communications or linkages plan that allows the provision of other professional services to serve as an entry point to accessing care when it becomes known that a customer is not currently in care.

APPENDIX 1: MINIMUM INSURANCE REQUIREMENTS

INSURANCE

A. GENERAL REQUIREMENTS. The Grantee at its sole expense shall procure and maintain, during the entire period of performance under this contract, the types of insurance specified below. The Grantee shall have its insurance broker or insurance company submit a Certificate of Insurance to the PM giving evidence of the required coverage prior to commencing performance under this grant. In no event shall any work be performed until the required Certificates of Insurance signed by an authorized representative of the insurer(s) have been provided to, and accepted by, the PM. All insurance shall be written with financially responsible companies authorized to do business in the District of Columbia or in the jurisdiction where the work is to be performed and have an A.M. Best Company rating of A- / VII or higher. Should the Grantee decide to engage a subcontractor for segments of the work under this contract, then, prior to commencement of work by the subcontractor, the Grantee shall submit in writing the name and brief description of work to be performed by the subcontractor on the Subcontractors Insurance Requirement Template provided by the CA, to the Office of Risk Management (ORM). ORM will determine the insurance requirements applicable to the subgrantee and promptly deliver such requirements in writing to the Contractor and the CA. The Grantee must provide proof of the subcontractor's required insurance prior to commencement of work by the subcontractor. If the Grantee decides to engage a subcontractor without requesting from ORM specific insurance requirements for the subcontractor, such subcontractor shall have the same insurance requirements as the Contractor.

   All required policies shall contain a waiver of subrogation provision in favor of the Government of the District of Columbia.

   The Government of the District of Columbia shall be included in all policies required hereunder to be maintained by the Grantee and its subcontractors (except for workers' compensation and professional liability insurance) as an additional insureds for claims against The Government of the District of Columbia relating to this grant, with the understanding that any affirmative obligation imposed upon the insured Grantee or its subcontractors (including without limitation the liability to pay premiums) shall be the sole obligation of the Grantee or its subcontractors, and not the additional insured. The additional insured status under the Grantee and its subcontractors' Commercial General Liability insurance policies shall be effected using the ISO Additional Insured Endorsement form CG 20 10 11 85 (or CG 20 10 07 04 **and** CG 20 37 07 04) or such other endorsement or combination of endorsements providing coverage at least as broad and approved by the PM in writing. All of the Grantee's and its subcontractors' liability policies (except for workers' compensation and professional liability insurance) shall be endorsed using ISO form CG 20 01 04 13 or its equivalent so as to indicate that such

policies provide primary coverage (without any right of contribution by any other insurance, reinsurance or self-insurance, including any deductible or retention, maintained by an Additional Insured) for all claims against the additional insured arising out of the performance of this Statement of Work by the Grantee or its subcontractors, or anyone for whom the Grantee or its subcontractors may be liable. These policies shall include a separation of insureds clause applicable to the additional insured.

If the Grantee and/or its subcontractors maintain broader coverage and/or higher limits than the minimums shown below, the District requires and shall be entitled to the broader coverage and/or the higher limits maintained by the Grantee and subcontractors.

1. Commercial General Liability Insurance ("CGL") - The Grantee shall provide evidence satisfactory to the PM with respect to the services performed that it carries a CGL policy, written on an occurrence (not claims-made) basis, on Insurance Services Office, Inc. ("ISO") form CG 00 01 04 13 (or another occurrence-based form with coverage at least as broad and approved by the PM in writing), covering liability for all ongoing and completed operations of the Contractor, including ongoing and completed operations under all subcontracts, and covering claims for bodily injury, including without limitation sickness, disease or death of any persons, injury to or destruction of property, including loss of use resulting therefrom, personal and advertising injury, and including coverage for liability arising out of an Insured Contract (including the tort liability of another assumed in a contract) and acts of terrorism (whether caused by a foreign or domestic source). Such coverage shall have limits of liability of not less than $1,000,000 each occurrence, a $2,000,000 general aggregate (including a per location or per project aggregate limit endorsement, if applicable) limit, a $1,000,000 personal and advertising injury limit, and a $2,000,000 products-completed operations aggregate limit including explosion, collapse and underground hazards.

2. Automobile Liability Insurance - The Grantee shall provide evidence satisfactory to the PM of commercial (business) automobile liability insurance written on ISO form CA 00 01 10 13 (or another form with coverage at least as broad and approved by the PM in writing) including coverage for all owned, hired, borrowed and non-owned vehicles and equipment used by the Contractor, with minimum per accident limits equal to the greater of (i) the limits set forth in the Contractor's commercial automobile liability policy or (ii) $1,000,000 per occurrence combined single limit for bodily injury and property damage.

3. Workers' Compensation Insurance - The Grantee shall provide evidence satisfactory to the PM of Workers' Compensation insurance in accordance with the statutory mandates of the District of Columbia or the jurisdiction in which the grant is performed.

Employer's Liability Insurance - The Grantee shall provide evidence satisfactory to the PM of employer's liability insurance as follows: $500,000 per accident for injury; $500,000 per employee for disease; and $500,000 for policy disease limit.

All insurance required by this paragraph 3 shall include a waiver of subrogation endorsement for the benefit of Government of the District of Columbia.

4. Cyber Liability Insurance - The Grantee shall provide evidence satisfactory to the PM of Cyber Liability Insurance, with limits not less than $2,000,000 per occurrence or claim, $2,000,000 aggregate. Coverage shall be sufficiently broad to respond to the duties and obligations as is undertaken by Grantee in this agreement and shall include, but not limited to, claims involving infringement of intellectual property, including but not limited to infringement of copyright, trademark, trade dress, invasion of privacy violations, information theft, damage to or destruction of electronic information, release of private information, alteration of electronic information, extortion and network security. The policy shall provide coverage for breach response costs as well as regulatory fines and penalties as well as credit monitoring expenses with limits sufficient to respond to these obligations. This insurance requirement will be considered met if the general liability insurance includes an affirmative cyber endorsement for the required amounts and coverages.

5. Medical Professional Liability - The Grantee shall provide evidence satisfactory to the PM of a Medical Professional Liability policy with limits of not less than $1,000,000 each incident and $2,000,000 in the annual aggregate. The definition of insured shall include the Grantee and all Grantee's employees and agents. The policy shall be either (1) written on an occurrence basis or (2) written on a claims-made basis. If the coverage is on a claims-made basis, Contractor hereby agrees that prior to the expiration date of Contractor's current insurance coverage, Contractor shall purchase, at Contractors sole expense, either a replacement policy annually thereafter having a retroactive date no later than the effective date of this Contract or unlimited tail coverage in the above stated amounts for all claims arising out of this Contract.

6. Professional Liability Insurance (Errors & Omissions) - The Grantee shall provide Professional Liability Insurance (Errors and Omissions) to cover liability resulting from any error or omission in the performance of professional services under this Contract. The policy shall provide limits of $1,000,000 per claim or per occurrence for each wrongful act and $2,000,000 annual aggregate. The Grantee warrants that any applicable retroactive date precedes the date the Grantee first performed any professional services for the Government of the District of Columbia and that continuous coverage will be maintained or an extended reporting period will be exercised for a period of at least ten years after the completion of the professional services.

7. Sexual/Physical Abuse & Molestation - The Grantee shall provide evidence satisfactory to the PM with respect to the services performed that it carries $1,000,000 per occurrence limits; $2,000,000 aggregate of affirmative abuse and molestation liability coverage. Coverage should include physical abuse, such as sexual or other bodily harm and non-physical abuse, such as verbal, emotional or mental abuse; any actual, threatened or alleged act; errors, omission or misconduct. This insurance requirement will be considered met if the general liability insurance includes an affirmative sexual abuse and molestation endorsement for the required amounts. So called "silent" coverage under a commercial general liability or professional liability policy will not be acceptable.

8. Commercial Umbrella or Excess Liability - The Grantee shall provide evidence satisfactory to the PM of commercial umbrella or excess liability insurance with minimum limits equal to the greater of (i) the limits set forth in the Grantee's umbrella or excess liability policy or (ii) $2,000,000 per occurrence and $2,000,000 in the annual aggregate, following the form and in excess of all liability policies. **All** liability coverages must be scheduled under the umbrella and/or excess policy. The insurance required under this paragraph shall be written in a form that annually reinstates all required limits. Coverage shall be primary to any insurance, self-insurance or reinsurance maintained by the District and the "other insurance" provision must be amended in accordance with this requirement and principles of vertical exhaustion.

B. PRIMARY AND NONCONTRIBUTORY INSURANCE
The insurance required herein shall be primary to and will not seek contribution from any other insurance, reinsurance or self-insurance including any deductible or retention, maintained by the Government of the District of Columbia.

C. DURATION. The Grantee shall carry all required insurance until all grant work is accepted by the District of Columbia and shall carry listed coverages for ten years for construction projects following final acceptance of the work performed under this contract and two years for non-construction related contracts.

D. LIABILITY. These are the required minimum insurance requirements established by the District of Columbia. However, the required minimum insurance requirements provided above will not in any way limit the contractor's liability under this contract.

E. CONTRACTOR'S PROPERTY. Contractors and subcontractors are solely responsible for any loss or damage to their personal property, including but not limited to tools and equipment, scaffolding and temporary structures, rented machinery, or owned and leased equipment. A waiver of subrogation shall apply in favor of the District of Columbia.

F. MEASURE OF PAYMENT. The District shall not make any separate measure or payment for the cost of insurance and bonds. The Grantee shall include all of the costs of insurance and bonds in the grant price.

G. NOTIFICATION. The Grantee shall ensure that all policies provide that the CO shall be given thirty (30) days prior written notice in the event of coverage and / or limit changes or if the policy is canceled prior to the expiration date shown on the certificate. The Grantee shall provide the PM with ten (10) days prior written notice in the event of non-payment of premium. The Grantee will also provide the PM with an updated Certificate of Insurance should its insurance coverages renew during the contract.

H. CERTIFICATES OF INSURANCE. The Grantee shall submit certificates of insurance giving evidence of the required coverage as specified in this section prior to commencing work. Certificates of insurance must reference the corresponding contract number. Evidence of insurance must be submitted to the: Enterprise Grants Management System.

The Program Manager may request, and the Grantee shall promptly deliver updated certificates of insurance, endorsements indicating the required coverages, and/or certified copies of the insurance policies. If the insurance initially obtained by the Grantee expires prior to completion of the contract, renewal certificates of insurance and additional insured and other endorsements shall be furnished to the CO prior to the date of expiration of all such initial insurance. For all coverage required to be maintained after completion, an additional certificate of insurance evidencing such coverage shall be submitted to the CO on an annual basis as the coverage is renewed (or replaced).

I. DISCLOSURE OF INFORMATION. The Grantee agrees that the District may disclose the name and contact information of its insurers to any third party which presents a claim against the District for any damages or claims resulting from or arising out of work performed by the Grantee, its agents, employees, servants or subcontractors in the performance of this contract.

J. CARRIER RATINGS. All Grantee's and its subcontractors' insurance required in connection with this contract shall be written by insurance companies with an A.M. Best Insurance Guide rating of at least A- VII (or the equivalent by any other rating agency) and licensed in the District.

APPENDIX 2: SAMPLE MOU

SEE SEPARATE ATTACHMENT