Funding Opportunity Submissions due 11/12/21 by 6pm, no exceptions

FY 2022 Ryan White HIV/AIDS Program Part A

HAHSTA_RWA_ModelRedesign_10.01.21

DC HEALTH
GOVERNMENT OF THE DISTRICT OF COLUMBIA
HIV/AIDS, Hepatitis, STD, and TB Administration

WE ARE WASHINGTON DC

The 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 the 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

DEPARTMENT OF HEALTH (DC Health)

HIV/AIDS, Hepatitis, STD, Tuberculosis Administration (HAHSTA)

NOTICE OF FUNDING AVAILABILITY (NOFA)

FY 2022 Ryan White HIV/AIDS Program Part A

The District of Columbia, Department of Health (DC Health) is seeking applications 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 the 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.

General Information:

Funding Opportunity Title:	FY 2022 Ryan White HIV/AIDS Program Part A
Funding Opportunity Number:	FO-HAHSTA-PG-00113-030
Program RFA ID#:	HAHSTA_RWA_ModelRedesign_10.01.21
Opportunity Category:	Competitive
DC Health Administrative Unit:	HIV/AIDS, Hepatitis, STD, & Tuberculosis Administration
DC Health Program Bureau	Care and Treatment Division
Program Contact:	Ebony Fortune, Ryan White Program Manager HAHSTARFAs@dc.gov
Program Description:	The Government of the District of Columbia, DC Health, HIV/AIDS, Hepatitis, STD and Tuberculosis Administration (HAHSTA) is soliciting applications 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 universities; 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 be located within and provide services in the DC EMA.
Anticipated # of Awards:	40
Anticipated Amount Available:	$26,000,000
Floor Award Amount:	N/A
Ceiling Award Amount:	

Funding Authorization:

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:	Friday, October 1, 2021
Pre-Application Meeting (Location/Conference Call Access)	Visit DC Health's Eventbrite page for the virtual meeting information. https://OGMDCHealth.eventbrite.com
Letter of Intent Due date:	Strongly suggested: October 19, 2021
Application Deadline Date:	Friday, November 12, 2021
Application Deadline Time:	6:00 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://dcdoh.force.com/GO__ApplicantLogin2

Notes:

1. DC Health reserves the right to issue addenda and/or amendments subsequent to the issuance of this NOFA, or to rescind the NOFA.
2. Awards are contingent upon the availability of funds.
3. Individuals are not eligible for DC Health grant funding.
4. Applicants must have a DUNS#, FEIN #, and be registered in the federal Systems for Award Management (SAM).
5. Grant application submissions must be submitted via the DC Health Enterprise Grants Management System (EGMS). Applicants must register to obtain an EGMS account at least two weeks prior to the submission deadline date.

District of Columbia DC Health RFA Terms and Conditions

v.2021

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

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

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

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

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

- 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.

- 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).

- 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.

- DC Health may conduct pre-award on-site visits to verify information submitted in the application and to determine if the applicant's facilities are appropriate for the services intended.

- 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.

- The Applicant Organization must obtain a Data Universal Numbering System (DUNS) number to apply for funding and register for the federal System for Award Management (SAM) at www.sam.gov prior to award.

- 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. This includes DC Health's electronic grants management systems, for which the awardee will be required to register and maintain registration of the organization and all users.

- 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.

- 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 (i.e. the total number of years for which funding has been approved) 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.

- 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.

- 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, and supersedes requirements for any funds received and distributed by DC HEALTH under legacy OMB circulars; 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.

- 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://communityaffairs.dc.gov/content/community-grant-program

If your agency would like to obtain a copy of the **DC Health's RFA Dispute Resolution Policy,** please contact the Office of Grants Management and Resource Development at doh.grants@dc.gov. Your request for this document will not be shared with DC Health program staff or reviewers. Copies will be posted with this RFA.

Table of Contents

NOTICE

PRE-APPLICATION CONFERENCE

RFA HAHSTA_RWA_ModelRedesign_10.01.21

FO-HAHSTA-PG-00113-030

Visit DC Health's Eventbrite page for the virtual meeting information.
https://OGMDCHealth.eventbrite.com

CONTACT: Ebony Fortune
Program Manager, Ryan White HIV/AIDS Program
HIV/AIDS, Hepatitis, STD and TB Administration (HAHSTA)
DC Department of Health (DOH)
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Note that all questions may be archived and shared with the general public.

I. Overview

Ryan White Model Redesign:

The new Ryan White Program model endeavors to promote the core values for the Ryan White HIV/AIDS Program (RWHAP): quality service delivery, improved health outcomes for patients and customers with HIV, and a strong partnership between HIV/AIDS, Hepatitis, STD, Tuberculosis Administration (HAHSTA) and its Ryan White service providers. It employs a thoughtful and strategic approach that the RWHAP believes will continue to support parity across the network of Ryan White providers, support network providers through capacity building efforts, and reward providers for quality service delivery. Just as HAHSTA developed this model using feedback from community partners, it will continue to provide opportunities for providers and stakeholders to communicate with RWHAP administrators as the program continues to fine-tune the model throughout its implementation.

The New Model

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

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

HAHSTA's Ryan White Program will use sub-grant awards exclusively as the mechanism for supporting Ryan White services across the Washington Eligible Metropolitan Area (EMA) for Grant Year 32. The new grant agreements will be used to award funds based on provider capacity, service category and Fee-For-Value designation. This value-based model will replace the existing Fee-For-Service/Unit-Based Cost Reimbursement model. Fee-For-Value (FFV) grants will be limited to five service categories in this initial funding cycle. Those grants will be built using two primary data points: a base award for capacity and a value enhancement award for meeting the Fee-For-Value 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.

Important notes:

- ➢ This funding announcement covers the entire portfolio of Ryan White grants. All services covered under Ryan White Part A for the Washington DC EMA are being re-competed through this effort. *Regardless of the grant's status as sole source or the number of option years remaining on any current awards, none of the grants funded currently by Ryan White Part A will continue beyond Grant Year 31, which ends on February 28, 2022.*
- ➢ The Ryan White HIV/AIDS Program (RWHAP) will discontinue the use of Human Care Agreements (HCA) associated with Ryan White programming after Grant Year 31. *As a result, all HCAs will sunset on February 28, 2022.*
- ➢ If a service category is available for funding through a bundle and/or FFV, it will not be available for application individually under the jurisdictional service area.
- ➢ Each organization applying for funding under this RFA will receive an assessment to determine its performance level in this system: Low, Moderate, or High Capacity. Training and technical

assistance opportunities will be offered for each capacity level. For additional details see "Program and Administrative Requirements" section of this RFA.

- Access to the Fee-For-Value Program will be limited to organizations that score Moderate or High Capacity for the initial award period. Successful applicants that do not meet the threshold for participation in FFV at the time of application may receive targeted technical assistance from HAHSTA and its affiliates and may be admitted to the FFV program during the subsequent grant year, pending an increased capacity assessment to Moderate or High Capacity.

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 these 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 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

Purpose of Ryan White Services:

Ryan White services are intended to support the HIV-related medical and support service needs of eligible individuals. Recipients and 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 with HIV.

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 HIV-infected family member, 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, including mental health services funded by RWHAP Part D only, 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 subsequent to the death of the Ryan White eligible family member.

Ryan White is a "payer of last resort," meaning that all other resources should be exhausted before Ryan White funded services are delivered. Additionally, the RWHAP requires the documentation of

customer eligibility, which is based on residency, financial eligibility, and medical eligibility. U.S. Department of Health and Human Services, Health Resources & Services Administration (HRSA) requires Ryan White customers to enroll annually and recertify their eligibility every six months.

Purpose of this Request for Applications (RFA)

The purpose of this RFA is to support a compendium of services for persons living with HIV and persons affected by HIV that:

- Reduces health disparities in HIV-related health outcomes
- Increases timely access to HIV-related care and treatment
- Increases engagement and retention in HIV care
- Increases viral suppression among persons living with HIV

Focus Population

All Ryan White services are intended to support indigent, uninsured, and under-insured persons living with HIV in the EMA. With the exception of the Minority AIDS Initiative (MAI) service areas, there are no additional focus populations for this RFA.

Available Funding

Approximately $26 million is available for this funding opportunity. The availability of funding is contingent upon the availability of funds to HAHSTA by (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 FY2022/GY32. *Please note, this is the only opportunity to request sub-grant funding for the compendium of services funded under the Washington DC Eligible Metropolitan Area Ryan White Part A Grant.*

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

Available Funding for RFA

RWA_ModelRedesign_10.01.21

1. EMA-Wide Ryan White Core Medical and Support Services Service Categories		
1a) Care Coordination Bundle	**Maximum # Available Awards**	**$ 7,857,370**
i. Mental Health and Wellness Bundle	7 awards	$ 1,148,232
ii. Early Intervention and Retention Bundle	18 awards	$ 6,709,138
1b) Fee-For-Value Service Program	**Maximum # Available Awards**	**$ 12,189,841**
i. Medical Care Coordination	10 awards	$ 6,973,025
ii. Non-Medical Care Coordination	6 awards	$ 2,500,000
iii. Medical Nutrition Therapy	5 awards	$ 316,816
iv. Food Bank and Home-Delivered Meals	5 awards	$ 2,400,000
1c) Oral Health	6 awards	$ 1,514,335
2. Jurisdictional Ryan White Core and Support Services		
2a) Washington, DC	**Maximum # Available Awards**	**$ 682,725**
i. Home and Community Based	2 awards	$ 261,334
ii. Other Professional Services	2 awards	$ 110,668
iii. Linguistic Services	3 awards	$ 86,667
iv. Medical Transportation Services	15 awards	$ 224,056
2b) Suburban, MD	**Maximum # Available Awards**	**$ 401,452**
i. Health Insurance Prem & Cost-Sharing Asst. (HIPCA)	3 awards	$ 64,745
ii. Medical Transportation Services	5 awards	$ 77,718
iii. Outreach Services	4 awards	$ 259,060

2c) West Virginia (Jefferson and Berkeley Counties)	2 awards	**$ 448,822**
3. Emergency Financial Assistance (EFA)	1 award	$2,000,000
4. Minority AIDS Initiative (MAI) – Youth Reach	6 awards	$2,531,823

Period of Funding

The funding period for this RFA will begin on March 1, 2022 and run through February 28, 2023.

HAHSTA may elect to continue the funded programs for an additional period of three years, through 2026. 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.

Eligible Applicants

The following organizations/entities are eligible to 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 in the designated service area.
- 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 solicited services.

Location of Services

Awards are specifically 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 of: Frederick	Prince Georges Calvert	Montgomery Charles
Virginia Cities of:	**Virginia Counties of:**	
Alexandria	Arlington	Loudoun
Fairfax	Clarke	Prince William
Falls Church	Culpeper	Spotsylvania
Fredericksburg	**Virginia Counties of:** *(continued)*	
Manassas	Fairfax	Stafford
Manassas Park	Fauquier King George	Warren

West Virginia Counties of:	Berkeley	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.

II. Service Areas

There are four core service areas within this funding announcement:

1. EMA-Wide Ryan White Core Medical and Support Services, Service Categories**

a) Care Coordination Bundle

b) Fee-For-Value Program

c) Oral Health

2. Jurisdictional Ryan White Core Medical and Support Services

a) Washington, DC

b) Suburban, MD

c) West Virginia (Jefferson and Berkeley Counties)

3. Emergency Financial Assistance (EFA)

4. Minority AIDS Initiative (MAI) – Youth Reach**

****Maryland local health departments and Virginia providers are only eligible to apply for funding under Service Area 1: EMA-Wide Services in this RFA, and Service Area 4: Minority AIDS Initiative Youth Reach.**

The Service Categories Scope of Work (Table A) is a tool used by the Ryan White Program (RWP) to highlight and report on how grant awards and subrecipients contribute to strategic goals and a comprehensive system of care. The Table A form is the basis for tracking the Ryan White Program's progress and performance against stated goals and objectives, evaluating impact and improved health status, and ensuring accountability at the program level. 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 RFA, applicants are asked to complete a Table A for each service category where funds are requested. The Table A's 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.

The Ryan White Compendium of Services in *Appendix 1* contains the definition, key activities and program requirements for each service category funded in this RFA. The service category descriptions

comprised in the compendium provides applicants with the program requirements they must respond to in the project description and program summary sections of their applications.

Applicants must complete a Work Plan (Attachment C), identifying the proposed service category, goals, and objectives which should include the total number of customers to be served. The total number of customers to be served should be realistic and correlate to funding requested. For Core Services, applicants must provide evidence of Medicaid certification or application for certification.

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 patient.

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 patients' needs
- Supporting patients' self-management goals
- Linking to community resources
- Working to align resources with patient and population needs.

1a. Care Coordination Bundle

For this core service area, there are two Care Coordination Bundles available, each of which is comprised of complementary service categories:

1. **Mental Health and Wellness Bundle:** This bundle requires the development of a comprehensive program that includes the provision of Mental Health Services; Substance Abuse Outpatient Services; and Psychosocial Support Services. Customers may not require all services available under this bundle. Successful applicants will be required to assess each customer's needs and develop an appropriate service plan to address them.

2. **Early Intervention and Retention Bundle:** This bundle requires the development of a comprehensive program that includes the provision of Early Intervention Services (EIS) and Psychosocial Support Services service categories. The Early Intervention Services funded through this bundle must comport with the Hi-V Program Model, which was previously funded as Regional Early Intervention Services. This is the only status neutral service bundle within this funding announcement.

Mental Health and Wellness Bundle

Service categories required: Mental Health Services, Substance Abuse Outpatient Services, and Psychosocial Support Services. See detailed descriptions below.

The service categories listed below provide a summary of the services available under this core service area. For specific program requirements see the Ryan White Compendium of Services in Appendix #1.

See funding chart on page #3 for detailed information on the amount of funds available for this service category and expected number of awards.

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.

Key activities include:
(1) Initial evaluation
(2) Individual, couple, and group psychotherapy
(3) Psychiatric, psychological, and/or neuro-psychological assessments
(4) Treatment planning and monitoring
(5) Psychiatric medications
(6) May include professionally facilitated support groups as well as spiritual and bereavement counseling
(7) Participation on a multidisciplinary team

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

Substance Abuse Outpatient Services

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.

Key activities include:
(1) Screening
(2) Assessment
(3) Diagnosis
(4) Treatment of substance use disorder, including: pre-treatment/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; and relapse prevention

Acupuncture therapy may be allowable under this service category only when, as part of a substance use disorder treatment program funded under the RWHAP, it is included in a documented plan.

Psychosocial Support Services

Peer Navigation. Newly diagnosed people with HIV are frequently challenged by the unfamiliarity and complexity of the services available and may be overwhelmed by trying to learn the system of services. A peer support model can improve the ability of customers to understand the service systems and to consume service more effectively. This is a 'learning the ropes' model of peer support and should include focus on skills-building for self-advocacy for a lifetime of care.

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.

Key activities include:

(1) Completion of a comprehensive psychosocial assessment and linking customer with counseling services as needed
(2) HIV support group services led or co-led by peer-facilitators
(3) Child abuse and neglect counseling
(4) Bereavement counseling inclusive of spiritual support to persons with HIV
(5) pastoral care/counseling services.

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.

Early Intervention and Retention Bundle

Service categories required: Early Intervention Services and Psychosocial Support Services. See detailed descriptions below.

Early Intervention Services

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, Regional Early Intervention Services programs that employ the use of the Hi-V model.

Key activities include:

See Service Compendium

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 customer-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.

Psychosocial Support Services

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

1b. 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 is pleased to introduce its Fee-For-Value Program for funding in Grant Year 32, which will reward providers for their service delivery and achievement of quality outcomes.

FFV Services Categories

For the initial iteration of the Fee-For-Value Program, HAHSTA has designated five service categories that will be funded exclusively through Fee-For-Value grants.

- Outpatient Ambulatory Health Services (OAHS)

- Non-medical Case Management
- Medical Case Management
- Medical Nutrition Therapy
- Food Bank and Home-Delivered Meals

FFV Reimbursement Structure

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

Capacity Award: The capacity award will consist of baseline and size.

1. **Baseline Award:** All funded FFV providers will receive a baseline award. HAHSTA will reserve 25% of the overall award for this service category for this purpose. This award will be split equally amongst funded providers.

2. **Service Size:** Funded providers will be awarded commensurate with the size of their proposed program. The process to determine the award is algorithmic considering the number of customers served 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 The performance of the provider will be compared to the network total, and the provider will be awarded the fractional percentage of the award reserved for this input. Funding for Funding Year 1 will be calculated from provider self-report of performance based on Table A 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: The value enhancement award increase is based upon provider performance relative to the network. This portion of the award is algorithmically calculated based on distinct assessment tools and are not guaranteed to every funded sub-recipient that receives a baseline award.

3. **Process Assessment:** Funded providers will be awarded for their performance as a Ryan White sub-recipient as well as for delivering the funded services, commensurate with the size and scope of their service program. The process to determine the award is algorithmic – considering:

   The Process Assessment is an objective tool to evaluate current practices at each organization. The tool will be based on Ryan White Program deliverables and administered by HAHSTA staff. The Process Assessment is specific to each funded service category and evaluates the providers' processes in the following areas: patient care; performance measurement; chart audits; organizational infrastructure; quality; program reporting; data; and fiscal.

   Every funded provider will receive an award for process assessment. Providers will be grouped with like-sized providers. The process assessment award will be distributed commensurate proportionately within like-sized groups, based on providers' process assessment scores.
   In the first grant year of the award period, the process assessment will be completed mid-year and providers will be notified of their award by September 1st, in preparation for an award increase on October 1st. In subsequent years, the process assessment will occur in the last three months of the grant year, in preparation to determine the award for the upcoming year.

HAHSTA reserves the right to amend or revise the Process Assessment tool between grant years, as needed. Funded providers will receive a copy of the scored tool and will be solicited for feedback on emerging best practices or evidence informed activities they are doing, to inform updates to the Process Assessment.

4. **Outcomes:** Providers will be grouped and assessed as described in the Process Assessment. Only the top performing providers in each group will be awarded, proportional to their performance. The award amount allocated to each grouping will be proportional to the number of customers served and outcome achieved. A maximum of two awards will be given in each group. The provider with the highest outcomes will receive 65% of the award for that group. The second highest outcomes provider will receive 35% of the award for that group.

   In the first grant year of the award period, the outcomes will be assessed mid-year and providers will be notified of their award by September 1st, in preparation for an award increase on October 1st. In subsequent years, the outcome assessment will occur in the last three months of the grant year, in preparation to determine the award for the upcoming year.

   Outcome metrics will be shared in advance of the funding year. Data for these metrics must be submitted into CAREWare.

For the initial award, the Capacity portion will be made available at the beginning of the grant year, March 1, 2022. The Value Enhancement portion of the award will be made available mid-year, October 1, 2022. Those additional service dollars will be issued as a result of the sub-recipient meeting performance expectations and quality outcomes. For subsequent years, the Capacity and Value Enhancement awards will be known and made available at the commencement of the grant year.

Importantly, the Fee-for-Value awards will be variable between years, based on the capacity, recent size, provider performance and quality of the service program. In addition to compensating providers for service delivery, this model is designed to reward providers with a reimbursement enhancement for their performance as a Ryan White sub-recipient and the quality of services provided RWHAP customers in the network.

During this introductory transition to FFV, the reimbursement structure for the FFV program will be weighted heavily toward the capacity portion of the award. Seventy percent (70%) of the total award for FFV programs will be capacity based and thirty percent (30%) will be performance based. Since the goal of FFV is to incentivize providers to focus on the quality of services rendered and improved health outcomes, HAHSTA plans to adjust these proportions to favor performance outcomes over capacity. HAHSTA reserves the right to change the award proportions of FFV programs from year to year, as the RWHAP and provider network adjusts to the FFV structure. Providers will be notified of any changes to the proportional distribution of the FFV award at the beginning of the grant period.

Similarly, the FFV program that HAHSTA designed considers network acuity when determining the award for size and scope. In the initial implementation phase of FFV, however, acuity will not be factored into the capacity portion of the awards. Only providers' service delivery will be considered for the proportional distribution of the available funds for this component. HAHSTA reserves the right to amend the service size award allocation to include scope and acuity. Providers will be notified at the beginning of the award period, if/when that transition occurs.

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

The FFV program structure consists of two care coordination bundles and two standalone Fee-For-Value service categories. The bundles require the same level of care coordination outlined in Service Area 1B.

The service categories listed below provide a summary of the services available under this core service area. For specific program requirements see the Ryan White Compendium of Services in Appendix #1.

See funding chart on page #3 for detailed information on the amount of funds available for this service category and expected number of awards

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.

Outpatient Ambulatory Health Services (OAHS)

Definition

Outpatient/Ambulatory Health Services (OAHS) 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 room or urgent care services are not considered outpatient settings. This 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).

Key activities include:

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

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 any other forms of communication).

Key activities include:

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

Non-Medical Case Management Services (NMCM)

Definition

Non-Medical Case Management is the provision of a range of customer-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 healthcare 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:

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

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.

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 any other forms of communication).

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

Non-Medical Case Management Services (NMCM)

Definition
Non-Medical Case Management is the provision of a range of customer-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:
(1) Initial assessment of service needs
(2) Development of a comprehensive, individualized care plan
(3) Timely and coordinated access to medically appropriate levels of health and support services and continuity of care
(4) Client-specific advocacy and/or review of utilization of services
(5) Continuous customer monitoring to assess the efficacy of the care plan
(6) Re-evaluation of the care plan at least every 6 months with adaptation as necessary
(7) Ongoing assessment of the customer's and other key family members' needs and personal support system

3. **Food Bank and Home-Delivered Meals:** Standalone Fee-For-Value service category however, according to the Food Bank and Home-Delivered Meals service standard, all Food Bank providers are required to provide Medical Nutrition Therapy (MNT) services to food service customers. Those MNT services are not required to be provided using Ryan White funds.

Home-Delivered Food key activities include:

(1) Providing home-delivered meals;

(2) The collection and delivery of perishable and nonperishable food items;

(3) Development of meal plans by registered dietitians;

(4) Providing information on safe drinking water

(5) Referrals to other food programs

Food Bank and Home-Delivered Meals

Definition

Food Bank and Home-Delivered Meals (FB/HDM) provides nutritionally appropriate meals or groceries to people living with HIV 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 and Home-Delivered Meals refers to the provision of actual food items, hot meals, or a voucher program to purchase food.

This also includes the provision of essential non-food items that are limited to the following:

- Personal hygiene products
- Household cleaning supplies
- Water filtration/purification systems

in communities where issues of water safety exist

Food Bank key activities include:

(1) Providing food items, including fresh produce, poultry and fish;

(2) Improved coordination of services;

(3) Provision of services that include a mechanism for the delivery of food and/or filtered water to the homebound;

(4) Providing a minimal amount of safe drinking water in the event of a water emergency as declared by the jurisdiction's department of health; and

(5) Providing information on safe drinking water on a regular basis as a part of ongoing services.

4. **Medical Nutrition Therapy:** Standalone Fee-For-Value service category

Medical Nutrition Therapy (MNT)

Definition
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:
(1) Nutrition assessment and screening
(2) Dietary/nutritional evaluation
(3) Food and/or nutritional supplements per medical provider's recommendation
(4) Nutrition education and/or counseling. These services can be provided in individual and/or group settings.

1c. 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 essential for the maintenance of health will be included.

Key activities include:
(1) Initial examinations
(2) Cleanings
(3) Fillings
(4) Extractions
(5) Root canals
(6) Linkages to referral sources to provide portions of services not provided by applicant

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

The Washington EMA is quite complex in that it involves 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, 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, Maryland and Virginia utilize 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 RFA. Applicants located in the Virginia jurisdiction of the EMA may only apply for Service Area 1: EMA-wide Services.

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

The service categories listed below provide a summary of the services available under this core service area. For specific program requirements see the Ryan White Compendium of Services in Appendix #1.

See funding chart on page #3 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 SERVICES

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.

Key activities include:

(1) The provision of home health aide services and personal care services in the home
(2) Provide day treatment or other partial hospitalization services
(3) Home intravenous and aerosolized drug therapy (including prescription drugs administered as part of such therapy)
(4) Routine diagnostics testing administered in the home
(5) Appropriate mental health, developmental, and rehabilitation services.
(6) Inpatient hospitals services, nursing home and other long-term care facilities are NOT included.

SUPPORT SERVICES

Other Professional Services (OPS)

Definition

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

Key activities include:

(1) Legal services
(2) Permanency planning
(3) Income tax preparation

Linguistic Services (LS)

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

Services include:

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

Key activities include:

(1) The provision of interpreter services to assist limited English-speaking individuals who need interpretation in order to be provided care, instructions, education and assistance in communication
(2) Improved coordination of services; (see definition above #16)
(3) Sharing data on improved customer access to services
(4) Collaborating with medical providers to help improve access to care for all customers needing interpreter services
(5) Providing translators and interpreters with knowledge of HIV/AIDS terminology and the technical language and knowledge of health care terms

Medical Transportation (MT)

Definition
Medical transportation services include conveyance services provided, directly or through voucher, to a customer so that he or she may access health care services

Key activities include:

(1) Providing transportation services to medical/clinical appointments for non-Medicaid eligible customers with HIV/AIDS
(2) Utilizing leased vans with drivers, a taxi voucher system, fare cards for metro rail, metro bus passes, disability commuter tickets, reimbursements to family/friends for mileage and parking or a combination of approaches
(3) Providing appropriate modes of transportation for HIV disabled persons needing assistance or wheelchair accommodations
(4) Improve transportation services for customers with dependent children

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 Services

Health Insurance Premium and Cost Sharing Program (HIPCSA)

Definition

Health Insurance Premium and Cost Sharing Assistance (HIPCA) 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.

Key activities include:

Provision of Health Insurance Premium and Cost-sharing Assistance that provides a cost - effective alternative to ADAP by:

(1) Purchasing health insurance that provides comprehensive primary care and pharmacy benefits for low-income customers that provide a full range of HIV medications
(2) Paying co-pays (including co-pays for prescription eyewear for conditions related to HIV infection) and deductibles on behalf of the customer
(3) Providing funds to contribute to a customer's Medicare Part D true out-of-pocked (TrOOP) costs.

SUPPORT SERVICES

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.

Key activities include:

(1) Providing transportation services to medical/clinical appointments for non-Medical eligible customers with HIV/AIDS
(2) Utilizing leased vans with drivers, a taxi voucher system, fare cards for metro rail, metro bus passes, disability commuter tickets, reimbursements to family/friends for mileage and parking or a combination of approaches
(3) Providing appropriate modes of transportation for HIV disabled persons needing assistance or wheelchair accommodations
(4) Improve transportation services for customers with dependent children

Outreach Services (OS)

Definition

Outreach Services includes the identification of individuals at points of entry and access to services and provision of HIV testing and targeted

Key activities include:

(1) Identification of people who do not know their HIV status and linkage into Outpatient/Ambulatory Health Services
(2) Provision of additional information and education on health care coverage options
(3) Reengagement of people who know their status into Outpatient/Ambulatory Health Services

counseling, referral services, linkage to care, and health education and literacy training that enable customers to navigate the HIV system of care.

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

West Virginia Applicants: There are 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 2C: Jurisdictional Ryan White Services—West Virginia.

Providers may choose to bundle the services, similar to those outlined in Service Area 1A, but are not required to do so.

CORE SERVICE AREAS

Outpatient Ambulatory Health Services (OAHS)

Definition

Outpatient/Ambulatory Health Services (OAHS) 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 room or urgent care services are not considered outpatient settings. This 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). See Attachment G for guidelines and definitions related to health outcomes.

Key activities include:

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

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

Key activities include:

(1) Initial evaluation
(2) Individual, couple, and group psychotherapy
(3) Psychiatric, psychological, and/or neuro-psychological assessments
(4) Treatment planning and monitoring
(5) Psychiatric medications
(6) May include professionally facilitated support groups as well as spiritual and bereavement
(7) Participation on a multidisciplinary team

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 any other forms of communication).

Key activities include:

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

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.

Key activities include:

(1) Initial examinations
(2) Cleanings
(3) Fillings
(4) Extractions
(5) Root Canals
(6) Linkages to referral sources to provide portions of services not provided by application

Health Insurance Premium and Cost Sharing Program (HIPCSA)

Definition
Health Insurance Premium and Cost Sharing Assistance (HIPCA) 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.

Key activities include:

Provision of Health Insurance Premium and Cost-sharing Assistance that provides a cost - effective alternative to ADAP by:

(1) Purchasing health insurance that provides comprehensive primary care and pharmacy benefits for low-income customers that provide a full range of HIV medications
(2) Paying co-pays (including co-pays for prescription eyewear for conditions related to HIV infection) and deductibles on behalf of the customer
(3) Providing funds to contribute to a customer's Medicare Part D true out-of-pocked (TrOOP) costs.

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.

Key activities include:
(1) Nutrition assessment and screening
(2) Dietary/nutritional evaluation
(3) Food and/or nutritional supplements per medical recommendation
(4) Nutrition education and/or counseling. These services can be provided in individual and/or group settings

SUPPORT SERVICES

Medical Transportation (MT)

Definition
Medical transportation services include conveyance services provided, directly or through voucher, to a customer so that he or she may access health care services

Key activities include:
(1) Providing transportation services to medical/clinical appointments for non-Medical eligible customers with HIV/AIDS
(2) Utilizing leased vans with drivers, a taxi voucher system, fare cards for metro rail, metro bus passes, disability commuter tickets, reimbursements to family/friends for mileage and parking or a combination of approaches
(3) Providing appropriate modes of transportation for HIV disabled persons needing assistance or wheelchair accommodations
(4) Improve transportation services for customers with dependent children

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, 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. Emergency Financial Assistance must occur as a direct payment to an agency or through a voucher program.

Key activities include:
(1) Emergency rental assistance (first month's rent, past due rent)
(2) Emergency utility payments (gas, electric, oil and water)
(3) Emergency telephone services payments
(4) Emergency food vouchers
(5) Emergency moving assistance
(6) Emergency medication

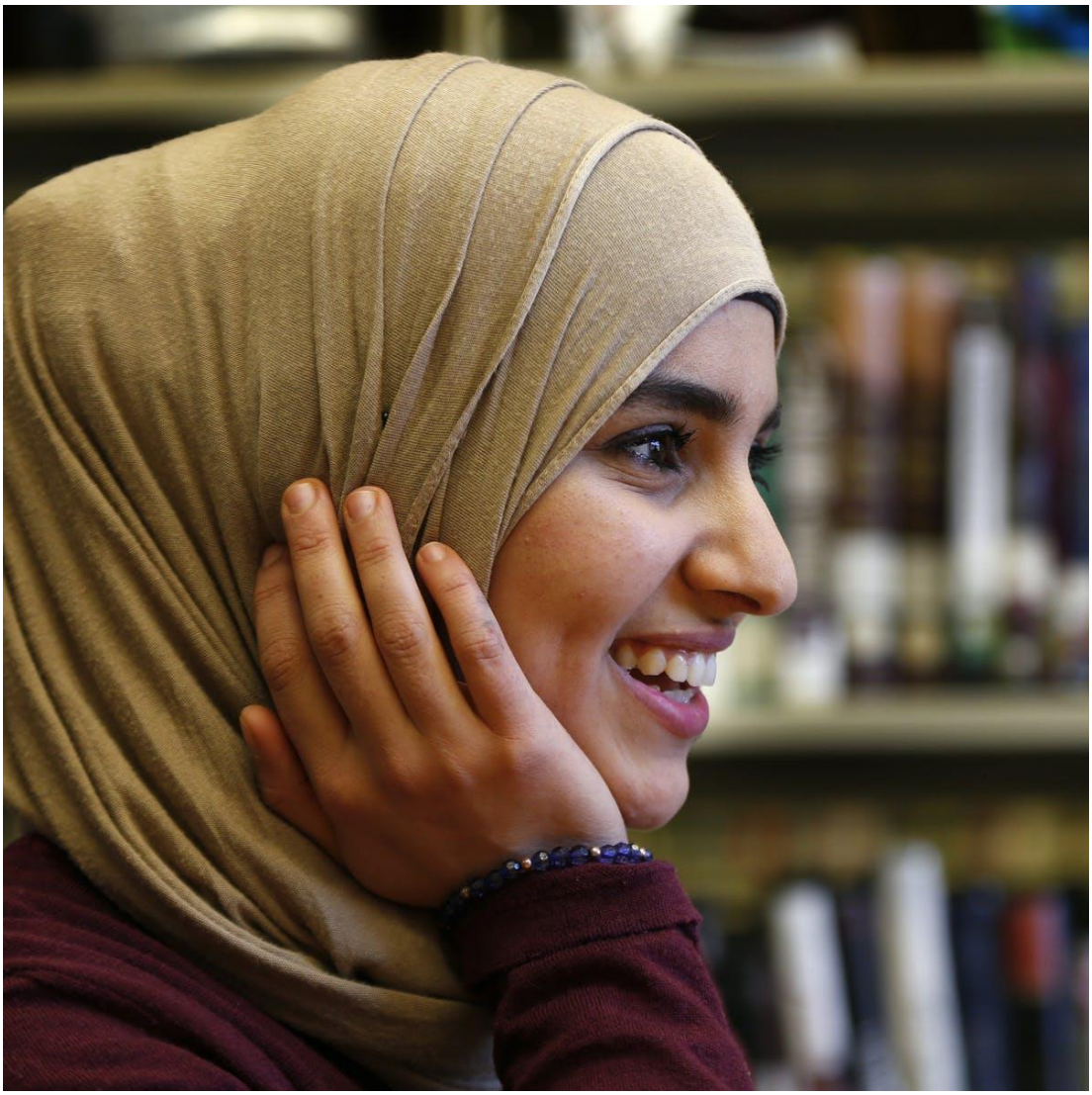
Outreach Services (OS)

Definition

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

Key activities include:

(1) Identification of people who do not know their HIV status and linkage into Outpatient/Ambulatory Health Services
(2) Provision of additional information and education on health care coverage options
(3) Reengagement of people who know their status into Outpatient/Ambulatory Health Services



CORE SERVICE AREA 3:
Emergency Financial Assistance

Through this funding opportunity, DC Health HAHSTA 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. These services are not open to residents of the Virginia portion 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 in at least one county of the suburban Maryland jurisdiction of the EMA.

Emergency Financial Assistance (EFA)

The service category listed below provides a summary of the services available under this core service area. For specific program requirements, see the Ryan White Compendium of Services in Appendix #1.

See funding chart on page #3 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.

Key activities include:

(1) Emergency rental assistance (first month's rent, past due rent)
(2) Emergency utility payments (gas, electric, oil and water)
(3) Emergency telephone services payments
(4) Emergency food vouchers
(5) Emergency moving assistance
(6) Emergency medication

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:

- *African American/Hispanic/Latino MSM*
- *African American Heterosexual Men*
- *African American/Hispanic/Latino Transgender Women*
- *African American Women*

The service categories listed below provide a summary of the services available under this core service area. For specific program requirements, see the Ryan White Compendium of Services in Appendix #1.

See funding chart on page #3 for detailed information on the amount of funds available for this service category and expected number of awards.

Applicants under this service area must submit a project description that includes a plan for the provision of the six service categories that comprise the MAI "Youth Reach" program. Of the six services identified below, successful applicants must offer the following services directly and on-site by the applicant organization: Early Intervention Services, Medical Case Management, Mental Health and Psychosocial Services. The remaining service categories Outpatient Ambulatory Health Services and Substance (Ab) Use Outpatient care may be provided on site or through formalized partnerships.

Core Service Categories

The required MAI "Youth Reach" Service Categories are:

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

Support Service Categories

- Psychosocial Support Services

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 six service categories.

All proposals must detail how each customer served will be re-assessed 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.

PART A MAI

CORE SERVICE AREAS

Outpatient Ambulatory Health Services (OAHS)

Definition

Outpatient/Ambulatory Health Services (OAHS) 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 room or urgent care services are not considered outpatient settings. This 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). See Attachment G for guidelines and definitions related to health outcomes.

Key activities include:

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

Medical Case Management (MCM)

Definition

Medical Case Management (including treatment adherence) 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) that link customers with other services. The coordination and follow-up of medical treatments is a component of medical case management. These services ensure timely and coordinated access to medically

Key activities include:

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

appropriate levels of health and support services and continuity of care, through ongoing assessment of the customer's and other key family members' needs and personal support systems. Medical case management includes the provision of treatment adherence counseling to ensure readiness for, and adherence to, complex HIV treatments.

Early Intervention Services

Early Intervention Services (EIS) will emphasize ensuring the movement of customers along the prevention to care continuum specifically ensuring retention in care and improved health outcomes. These services will be targeted to vulnerable populations either at very high risk of HIV infection or with demonstrated high rates of HIV prevalence or poor engagement in care or at increased risk of loss to care.

Applicants proposing to provide EIS are required to utilize the Anti-Retroviral Treatment and Access to Services (ARTAS) intervention. ARTAS is an individual-level, multi-session, time- limited intervention with the goal of linking recently diagnosed persons with HIV to medical care soon after receiving their positive test result. ARTAS is based on the Strengths-based Case Management (SBCM) model, which is rooted in Social Cognitive Theory (particularly self- efficacy) and Humanistic Psychology. SBCM is a model that encourages the customer to identify and use personal strengths; create goals for himself/herself; and establish an effective, working relationship with the Linkage Coordinator. ARTAS Goals:

- Help the customer overcome barriers to being linked to medical care.
- Build a trusting, effective relationship between customer and the Linkage Coordinator.
- Facilitate the customer's ability to create an action plan for being linked to medical care.

https://www.cdc.gov/hiv/effective-interventions/treat/artas?Sort=Title%3A%3Aasc&Intervention%20Name=ARTAS

Definition
Counseling individuals with respect to HIV; testing (including tests to confirm the presence of the disease, to diagnose the extent of immune deficiency, and to provide information on appropriate therapeutic measures); referrals; other clinical and diagnostic services regarding HIV; periodic medical evaluations for individuals with HIV; and provision of therapeutic measures.

The elements of EIS often overlap with other service category descriptions; however, EIS is the combination of such services rather than a stand-alone service.

Key activities include:
(1) Initial evaluation
(2) Individual, couple, and group psychotherapy
(3) Psychiatric, psychological, and/or neuro-psychological assessments
(4) Treatment planning and monitoring
(5) Psychiatric medications
(6) May include professionally facilitated support groups as well as spiritual and bereavement
(7) Participation on a multidisciplinary team

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

Successful applicants must demonstrate their ability to identify Youth of Color for early intervention services.

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.

Mental Health Services are allowable only for persons living with HIV.
Applicants must demonstrate linkages with culturally and linguistically competent substance abuse counselors and mental health professionals. Applicants may not use interpreters in sessions with non-English speaking customers as a substitute for culturally and linguistically competent substance abuse counselors and mental health professionals.

The mental health services supported in this service category are those services that meet the criteria of those that are reimbursable by Medicaid. All mental health services will be provided by individuals with the necessary credentials and licenses required for Medicaid reimbursement.

Applicants proposing to provide mental health services must describe their proposed program components and detail how it will support the service category program activities.

Category: Substance Abuse Outpatient Services

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, as part of a substance use disorder treatment program funded under the RWHAP, it is included in a documented plan.

Key activities include:
(1) Screening
(2) Assessment
(3) Diagnosis
(4) Treatment of substance use disorder, including: pre-treatment/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; and relapse prevention

Part A MAI Services
- **Support Services**

Psychosocial Support Services

Peer Navigation. Newly diagnosed people with HIV are frequently challenged by the unfamiliarity and complexity of the services available and may be overwhelmed by trying to learn the system of services. A peer support model can improve the ability of customers to understand the service systems and to consume service more effectively. This is a ‘learning the ropes’ model of peer support and should

include focus on skills-building for self-advocacy for a lifetime of care.

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.

Key activities include:

(1) Completion of a comprehensive psychosocial assessment and linking customer with counseling services as needed

(2) HIV support group services led or co-led by peer-facilitators

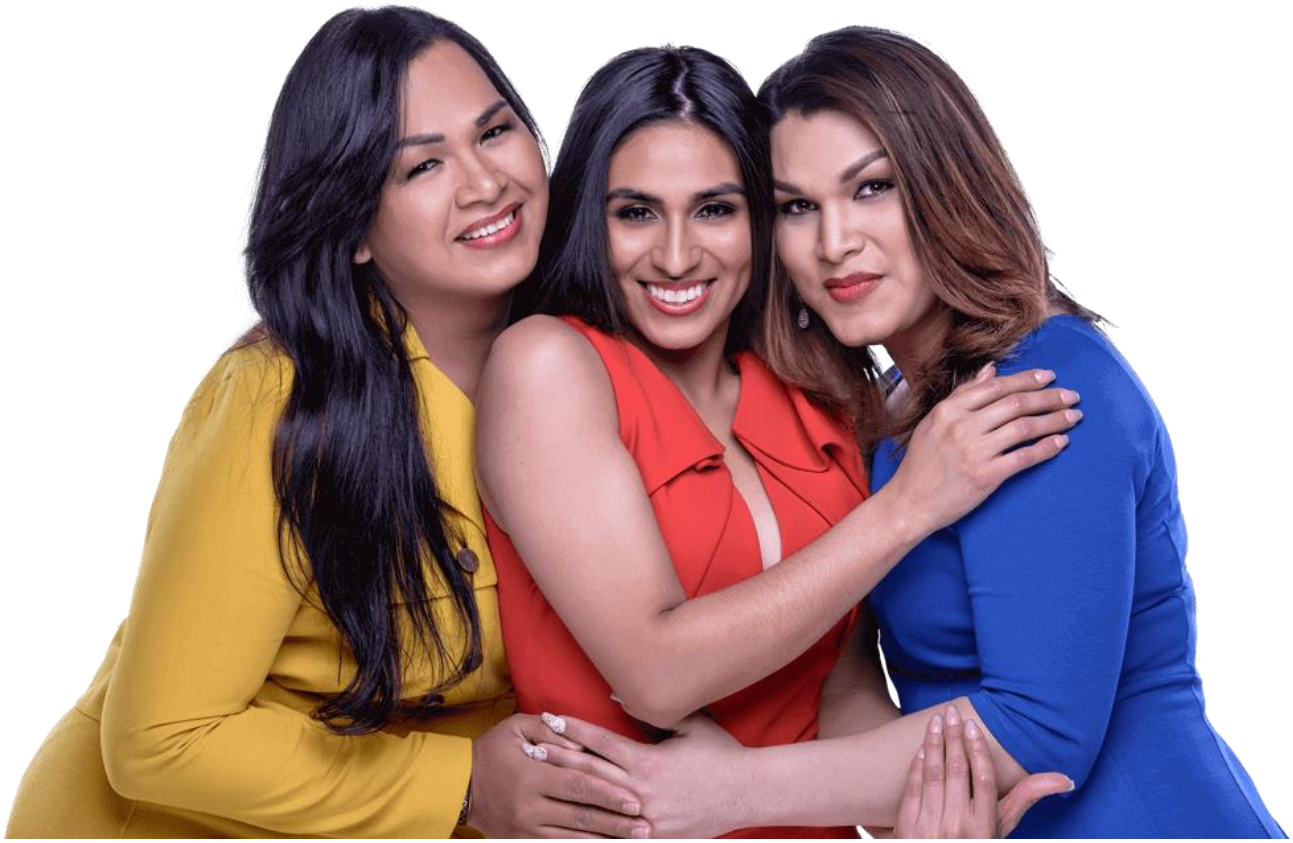
(3) Child abuse and neglect counseling

(4) Bereavement counseling inclusive of spiritual support to persons with HIV

(5) Pastoral care/counseling services

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.



III. General Requirements -- All Services

Items 1-6 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 of each service application.

1. **Program Goal**
   Applicants applying to provide services must demonstrate a) the provision of service delivery impact on process measures specific to service category and to outcomes (health or customer satisfaction) and b) how the program's data management practice to track process and outcome data, including reporting to CAREWare.

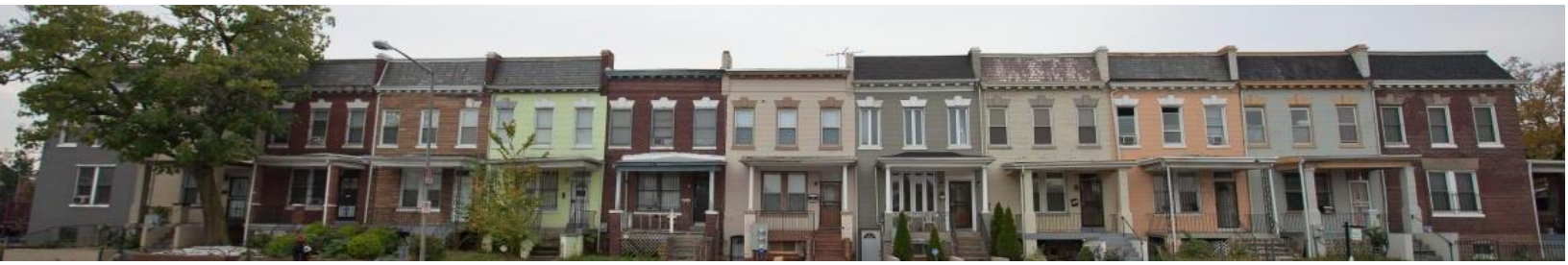
2. **Referral Sources**
   The applicant is responsible for accepting referrals from hospitals, HIV counseling and testing centers, physicians, community organizations, HIV service providers, and

3. **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.

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

5. **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.

6. **Preparation of Project Work Plan, Table A, Budget, and Budget Narrative Justification**
   Applicants are required to prepare a work plan for each proposed service category, a Table A for each proposed service category, a budget for each proposed service category, and a budget narrative justification for each proposed service category and applicable budget line items.



IV. Monitoring, Evaluation & Quality Improvement

Successful applicants shall have data management and quality management systems, plans, processes, and personnel in place for the purpose of monitoring and evaluating the delivery and quality of all 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 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 16-02 is the most recent description of Ryan White HIV/AIDS Program Services, which includes eligible individuals and allowable uses of funds. For the purposes of this RFA, specific information regarding the service category standards is listed in each corresponding service category. The notice can be viewed here: https://hab.hrsa.gov/sites/default/files/hab/landscape-webinars/020316servicecategorieswebinar.pdf.

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 sub-recipients 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 sub-recipient 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 in each jurisdiction by HAHSTA according to the scope of work, 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 should 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 inspections; 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 will include

a pre-award site visit.

d) Quality Management

HRSA's expectation of Ryan White Program grantees with respect to improving the quality of care and establishing quality management programs may be found online at:

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

HRSA guidance in selecting the appropriate service- and client-level performance measures is also available online at:

http://hab.hrsa.gov/deliverhivaidscare/habperformmeasures.html
https://careacttarget.org.

As of the release of this RFA, Health Resources and Services Administration's (HRSA) Clinical Quality Management Policy Clarification Notice 15-02 - found at: https://hab.hrsa.gov/sites/default/files/hab/Global/HAB-PCN-15-02-CQM.pdf is the most recent expectation of Ryan White HIV/AIDS Program Services clinical quality management (CQM) programs, At a minimum, CQM programs must perform quality improvement activities aimed at improving patient care, health outcomes, and patient satisfaction; have adequate infrastructure to support QI to include committees, teams, plans, etc; use a defined approach and systematic evidence-informed methodology; and actively and routinely analyze and use data.

Successful applicants are also required to meet local quality management standards and participate in local quality management activities as directed by HAHSTA.

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, and provides technical assistance 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 providers will be required to submit timely and accurate data to meet reporting requirements, including the Ryan White Services Report (RSR). All providers will be required to collaborate with and share clinical and service information for the purpose of coordinating care. Failure to comply with data requirements can result in the termination of an agency's grant with the District of Columbia government.

For coordination of care and services purposes, each awardee must have the ability to exchange relevant data with each partner agency, as applicable. All data exchanges must be secure, consistent with customer disclosure authorization protocols as determined by all local and federal laws, including the Health Information Portability and Accountability Act (HIPAA).

As HAHSTA seeks to increase the efficiency of its processes and support provider compliance with RWHAP requirements, it created a Centralized Eligibility System (CE), which will launch 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. All providers in the EMA funded to provide Ryan White services would have access to additional CW domains to complete their customer's eligibility status, enter annual review 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- and annual- RSR seasons.

V. Program and Administrative Requirements

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. 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

4. 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 include a copy of their internal customer grievance procedures prior to signing for 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.

5. Sliding Fee Scale and Cap on Charges

Successful applicants will develop a sliding fee scale for customers accessing services through RWHAP Part A. 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. Sub-grantees will develop and post the sliding fee scale so that it is visible to customers and the general public.

The sliding fee scale will be implemented; however, the RWHAP does not require collection of the fee charged to customers. Grantees 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.

6. 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 on 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.

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. Sub-recipients 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 patients with HIV must be returned to benefit the HIV program.

7. 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 – See Data Collection and Reporting above), and to participate in all site visits, evaluation and quality assurance activities as required by HAHSTA. All reports contain required information in the format determined by HAHSTA. Reports may include the following:

- Service Utilization by Service Category
- Performance Measures / Quality Improvement
- Customer Demographics
- Ryan White Services Report (RSR)
- Programmatic Narrative Information
- Financial Expenditure and Supporting Documentation
- Program Income

8. 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 six 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.

Administrative Requirements

1. Redesign Capacity Assessment Tool

HAHSTA remains committed to enhancing the quality of services delivered by its Ryan White funded providers and improving the health outcomes of its eligible Ryan White (RW) customers. Because HAHSTA recognizes strengthening provider capacity as an integral component to keeping this commitment, it developed the Redesign Capacity Assessment Tool (RCAT) (see Attachment J). The key functions of the RCAT are:

- To objectively assess the strengths and areas for improvement of its Ryan White funded providers
- To support areas in need of capacity growth, development, and sustainability that ultimately contribute to improved health outcomes

Results of the assessment help standardize how HAHSTA views the performance and capabilities of its providers, highlight best practices, and pinpoint technical assistance and training needs.

DESIGN AND UTILIZATION

The tool comprehensively assesses providers 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 three-point Likert scale. Use of a Likert scale enables HAHSTA to view the range of capacity levels more accurately across its provider network. Additionally, the Likert scale uses a point system that helps identify a provider's capacity level as low, moderate, or high.

A cross-departmental team of HAHSTA staff uses the RCAT to conduct the assessment. The inaugural assessment using the RCAT is part of the RFA. However, subsequent assessments will occur in the 10th month of the grant period during each continuation year, pending overall provider performance and HAHSTA funding availability.

Rating

RCAT Assessment Areas:
Organizational Infrastructure
Fiscal Management
Program Management
Data Collection, Reporting, and Use
Quality management

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 provider's total point value. The provider's total point value is then divided by the maximum points possible.* This calculation will determine a provider's capacity level as:

Low Capacity
Moderate Capacity
High Capacity

**Applicants will be held harmless for factors deemed beyond a provider's control as determined by the reviewer. The maximum number of points available will be adjusted by any RCAT criteria for which the applicant will be held harmless. Examples include questions that are not applicable to providers new to HAHSTA's Ryan White network or natural disasters that impact organizational operations.*

Capacity Levels

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

Low Capacity

Low-Capacity providers 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 providers are expected to attend all trainings and to complete all quarterly modules as prescribed. It is anticipated that providers with this level of capacity will score a minimum of Moderate Capacity during the RCAT in the following grant year.

Providers identified as Low Capacity are ineligible to participate in HAHSTA's Fee-for-Value (FFV) program model during the initial award period. Low-Capacity providers whose applications are recommended for funding will be categorized as "recommended for future funding" in HAHSTA's RFA decision document. They may become eligible to receive funding in the subsequent grant year (GY33) if they complete the customized TA plan successfully and receive at least a Moderate Capacity rating in the RCAT at the end of the initial award period.

Moderate Capacity

Providers identified as Moderate Capacity work with HAHSTA and its designated contractor to receive targeted technical assistance. Targeted areas of technical assistance include those that score below the benchmark (74%) during the RCAT. Moderate Capacity providers are expected to attend all trainings and to complete all modules as prescribed. Focus is given to process and practice enhancements. Moderate Capacity providers receive support to become more strategic, agile, data-informed, and outcome driven. It is anticipated that providers with this level of capacity will, at a minimum, maintain their status as Moderate Capacity during the RCAT in the following grant year.

High Capacity

Providers 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 encouraged to participate in trainings that support onboarding and refresher opportunities. It is anticipated that providers with this level of capacity will, at a minimum, maintain their status during the RCAT in the following grant year. High-Capacity providers that maintain their

status for two (2) additional years will receive an abbreviated RCAT in the following grant continuation year.

TECHNICAL ASSISTANCE AND TRAINING

Technical assistance and training are provided based on RCAT capacity level.
HAHSTA directly or indirectly provides technical assistance and training in the following broad categories:

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

A more detailed list, inclusive of specific topics and modules, can be found in **Attachment J**.
Identified capacity building requirements will appear as "Conditions of Award" for successful applicants.

2. Staff Requirements

For the purposes of this grant, "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 sub-recipient deliverables fall into four categories: program, data, quality, and fiscal. Each sub-recipient 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 aforementioned staff roles.

Required Roles	Responsibilities
Program Manager/Coordinator	Provides 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	Ensures complete and accurate client level data submission into CAREWare monthly. Ensures timely submission of annual and mid-year RSR.
Quality Management	Quality management staff to manage their clinical quality management (CQM) programs, which perform quality improvement activities aimed at improving patient care, health outcomes, and patient satisfaction Additionally, they must have adequate infrastructure to support quality improvement (QI) to include committees, teams, plans, etc.
Fiscal Management	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 submission into EGMS and E-Invoicing.

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

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

f. Personnel files must be available to the HAHSTA upon request.

g. Successful applicants shall provide orientation sessions for each staff member with respect to administrative procedures, program goals, and policies and practices 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.

3. COVID-19 Vaccine Requirement

The Sub-recipient is required to comply with Mayor's Order 2021-099, COVID-19 Vaccination Certification Requirement for District Government Employees, Contractors, Interns, and Sub-recipients, dated August 10, 2021, and all substantially similar vaccine requirements including any modifications to this Order, unless and until they are rescinded or superseded. At the request of the District government, Sub-recipients may be asked to provide certification of compliance with this requirement and/or documents and records in support of this certification.

The Sub-recipient is required to comply with City Administrator's Order 2021-4, Resumption of Requirement for All Persons to Wear a Mask Inside District Government Buildings and While on Duty as a District Government Employee or Contractor, dated July 30, 2021, and all substantially similar mask requirements including any modifications to this Order, unless and until they are rescinded or superseded.

Use the link below to access the full order.
https://coronavirus.dc.gov/sites/default/files/dc/sites/coronavirus/page_content/attachments/MayorsOrder2021.099.pdf

4. 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 FY 2022 grant period, that is, through February 28, 2022.

c. All proposed MOU/A and subcontracts for the "Youth Reach" MAI cluster will require prior review and approval by HAHSTA.

5. 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 as a result of a catastrophic event of 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.

6. Use of Funds

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

7. Insurance

All applicants that receive awards under this RFA must show proof of all insurance coverages required by the Office of Risk Management (ORM) prior to receiving funds. At minimum, the awardee must meet the insurance coverage requirements outlined in the Appendix D. The coverage levels may be adjusted by ORM following issuance of the NOGA per a review of activities performed under the grant and any other grants with DC Health or other District agencies. DC Health reserves the right to request certificates of insurance pre-award and post-award and adjust coverage limits per requirements promulgated by the District of Columbia Office of Risk Management.

8. Audits

Prior to the issuance of a Notice of Grant Award (i.e. Pre-Award), DC Health will request that the applicant being considered for funding submit for review a copy of its most recent and complete set of audited or unaudited financial statements (applying the 2 CFR 200 audit requirement), to include, but not limited to, the organizational budget, income/profit-loss statement, balance sheet and organizational filings to the IRS dating back to three years.

At any time before final payment and in accordance with federal, state and local laws thereafter, successful applicants will be required to keep all financial records, as the District of Columbia may have the applicant's expenditure statements and source documentation audited.

VI. Pre-Application Requirements

Pre-application Conference

The Pre-Application Conference will be held virtually for services to be funded under this RFA. Visit DC Health's Eventbrite page for the virtual meeting information. https://OGMDCHealth.eventbrite.com

The pre-application conference will provide an overview of the programmatic requirements. Additionally, there will be a 20-minute presentation on insurance requirements from Office of Risk Management (ORM) and an overview of the review process being employed for this RFA.

Notice of Intent to Apply

A notice of intent to apply (NOI) ***is strongly recommended*** for consideration under this funding announcement. The applicant should deliver the notice of intent to the HAHSTA using the format provided in Attachment E, no later than 6:00pm on **Tuesday, October 19, 2021**. Please submit only one NOI per organization. Email submission of the NOI is acceptable via HAHSTARFAs@dc.gov .

Questions Regarding the RFA

Applicants who have questions about the RFA must submit their questions via e-mail to HAHSTARFAs@dc.gov no later than **Wednesday, October 20, 2021 at 6:00pm.**

HAHSTA will notify all potential applicants in writing of any updates, addenda and responses to frequently asked questions by **Monday, October 25, 2021**.

VII. Application Preparation and Submission

A Application Format

a. Font size: 12-point Times New Roman
b. Spacing: Double-spaced
c. Paper size: 8.5 by 11 inches
d. Page margin size: 1 inch
e. 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. program description. Applications must conform to the page requirements by section detailed below. Note that the Attachment B: Linkages Summary is a critical component of the application and will be considered during the scoring of all related areas.

Note: When selecting service categories for application in EGMS, FFV Program applicants must select not only the service categories for application, but also the corresponding "performance" service category. This is the line item for the value enhancement award increases as described in Section 1b.

An application package includes the following elements:

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

1. Applicant Profile (Attachment A. Not counted in page total.)
2. Table of Contents (Not counted in page total.)
3. Organization Background and Capacity (4 pages maximum)
4. Project Description (5 pages **maximum per service category proposed**)
5. Program Proposal Summary (5 pages maximum)
6. Monitoring, Evaluation, and Improvement (5 pages maximum)

The number of pages designated above represents the **maximum number of pages permitted per section.** Applications exceeding the maximum number of pages for each section ***will not*** **be forwarded for review.**

Required Attachments (Not counted in page total) – each attachment must be labeled and submitted individually into the corresponding portal in EGMS

7. Work plan* (Required for each Bundle, Program and or Service Category (if applicable), Attachment C)
8. Linkages Summary* (Attachment B)

9. Table A – Scope of Work* (Required for each Service Category, Attachment G)
10. Categorical Budget and Budget Narrative* (Required for each Service Category where funds are requested.) (Attachment D)
11. Staffing Plan (Attachment H)
12. RCAT Evidence (Attachment J – column h)
13. Other Funding Sources table (Attachment E)
14. Organizational Chart (Attachment M)
15. The Notice of Intent to Apply (Attachment I) is strongly recommended for all applicants. **It is due by Monday, October 19, 2021 at 6pm.**
16. Medicaid Certification are required for organizations applying for any Service Categories that are reimbursable by Medicaid.

C Description of Application Elements

Applicants should include all 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) Applicant Profile – The applicant profile is the application cover sheet identifying the applicant organization, the service categories the organization is applying for and the amount of funds requested per service category.

2) 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.

3) Organizational Background and Capacity

- Description of the history of the agency, specifically, the history in providing services to People Living with HIV/AIDS (PLWHA) in the DC EMA. If the applicant has not provided services to PLWHA in the past, describe why it is proposing to serve this population.

- Level of organization's competence in the provision of the services for which funding is requested including relevant experience and expertise of key management and front-line staff.

- Applications must describe how the agency will verify customer eligibility and enroll and maintain customers in care; and

- Applications must describe how the agency will make services accessible by detailing your hours of operation and flexible schedules that provide for evening and weekend hours of operation.

- Applications 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 and submit a staffing plan (Attachment H) and budget (Attachment D) that illustrates the corresponding staffing level required to administer these grant funds**.** ***See administrative requirements section of this RFA***

for additional details.

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. Applications rated most highly will 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 will contribute to the overall quality, scope and impact of the service area response.

This section will be reviewed in conjunction with Linkages Summary (Attachment B), so direct references to these tables may be included. More specifically, the following elements must be included:

- Applications 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, as well as ways in which you will address those barriers,

- Applications must describe with specific detail how your agency will provide services in accordance with the service category definitions and key activities;

- Applications should pay special attention to addressing the issues highlighted in the 'key activities' sections of the service category. These activities highlight areas of known technical complexities, service gaps, or frequent challenges. Approaches to addressing these issues are critical;

- The applicant describes how the proposed activities will contribute to improved health outcomes, including: 1) Rapid Start ART; 2) Durable viral load suppression; 3) Engagement in medical care; 4) Rapid Re-start; and 5) Decreased acuity for MCM/NMCM customers.

5) Program Proposal Summary

- Applications must describe the services 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.

- Applications must provide a comprehensive summary of the proposed project inclusive of a description of how the program will provide all services within the care coordination bundle; fee-for-value bundle; and or youth reach program

6) 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 a meaningful monitoring, evaluation, and improvement, as detailed in Section IV.

- Applicant must describe how past and current experiences with continuous quality management, including plans, processes, and how personnel, will be used to improve customer satisfaction, outcomes, and/or care in a timely manner.

- Applicant must describe existing or proposed structure for data management, including

processes for data capture, accuracy, completeness, timeliness, reporting, and utilization to determine progress and make improvements to CQM aims.

7) Work Plan - Applicants must complete the work plan (Attachment C) for each proposed Service Category. The work plan should include proposed targets and the goals and objectives for the proposed program. 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.

8) Linkages Summary -Applicants must complete the Linkages Summary Table (Attachment B), which outlines the Service Categories and the level of direct and indirect service provision.

9) Table A - The Service Categories Scope of Work (Table A) is tool used by the Ryan White Program (RWP) to highlight and report on how grant awards and subrecipients contribute to strategic goals and a comprehensive system of care.

For the purposes of this RFA applicants are required to complete a Table A for each service category where funds are requested. The Table A's 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.

10) Budget and Budget Narrative

Applicants must provide a detailed line-item budget and budget narrative that includes the type and number of staff necessary to successfully provide your proposed services. All applicants applying for services must use the HAHSTA approved budget forms. The forms are posted electronically as a separate Microsoft Excel file alongside this RFA. There cannot be any changes made to the format or content areas of the Excel workbook. Applicants must provide a budget for each Service Category submitted.

HAHSTA reserves the right to not approve or fund all proposed activities. For the budget justification, provide as much detail as possible to support each requested budget item. List each cost separately when possible. Provide a brief description for each staff position including job title, general duties and activities related to this grant, including the rate of pay and whether it is hourly, or salary and the level of effort expressed as how much time will be spent on proposed activities for each staff position. Describe this "time spent" as a percentage of full time equivalent or FTE (e.g., 50% FTE for evaluation activities).

A maximum of ten percent (10%) of the amount budgeted for direct services is permitted for all administrative or indirect costs activities.

11) Staffing Plan – Attachment H, 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 administrative requirements section of this RFA for***

additional details.

12) Redesign Capacity Assessment (RCAT) Tool Evidence Submission-

The initial RCAT will be conducted as a part of the application review process. In order for HAHSTA staff to conduct the assessment, applicants must submit support documents as evidence to support RCAT rating. Failure to submit support documents *for each* criterion will default to the lowest rating on the RCAT. During its inaugural use, the HAHSTA will permit applicants to use their discretion to provide the best documents to optimize their rating. To assist, HAHSTA provides examples of support documents that may be used in response to the questions. Applicants are encouraged to review the RCAT and examples of support documents (Attachment J see row h). Additionally, applicants must gather support documents, clearly label which question(s) the documents respond to and scan them all into one PDF document labeled "**RCAT Evidence".** The document must be uploaded in EGMS as an attachment to the application. Any criterion that is missing evidence will default to the lowest rating on the RCAT for that question. **Failure to comply with RCAT Evidence submission instructions will prevent HAHSTA from conducting the assessment and assigning a capacity level to the application, thereby disqualifying the applicant from receiving funding.**

13) Other Funding Sources – Attachment E, 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***.**

14) Organizational Chart – Attachment M, is a required attachment that illustrates the organization structure of the applicant organization.

15) Notice of Intent to Apply– Attachment I, is strongly recommended of all potential applicants for planning purposes to assist HAHSTA in securing adequate external reviewers.

16) Assurances and Certifications - Assurances and certifications are of two types: those required to submit the application and those required to sign grant agreements. DC Health requires all applicants to submit various statements of certification, licenses, other business documents and signed assurances to help ensure all potential awardees are operating with proper credentials. The complete compilation of the requested documents is referred to as the **Assurance Package**.

Note: Failure to submit the required assurance package will make the application ineligible for funding consideration (required to submit applications) or in-eligible to sign/execute grant agreements (required to sign grant agreements).

Successful applicants will be required to submit the following additional documents before executing an award:

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

EGMS Assurances, Disclosures and Certifications

The items listed below are required and must be uploaded in EGMS to submit and complete the application.

1. Federal, District and DC Health Statements of Assurances and Certifications
2. Mandatory Disclosures
3. DC Health Standard Grant Terms and Conditions
4. **Assurance Package** (Required to Submit Application) (Not counted in page total). Scan and upload One pdf file containing all of the following business documents required for submission:

a. Assurances Required to Submit Application (Pre-Application Assurances)

- Current Certificate of Clean Hands from the Office of Tax & Revenue (OTR)- Dated within 60 days of application deadline date
- 501(c)3 Certification Letter for Non-Profit Organizations
- Current Business License/Certificate of Licensure or proof to transact business in local jurisdiction
- Current List of Board of Directors, on letterhead, signed and dated by a certified official from the Board (this cannot be the Executive Director)
- Copy of Cyber Liability Policy
- Certificate of Insurance
- Medicaid Certifications, If applicable
- Federal and District and DC Health Statements of Assurances, Disclosures and Certifications (SIGNED COPY)
- Proof of Liability, Commercial & Professional Insurance Policies

b. Conditions of Funding

- Most Recent Single Audit uploaded to the Federal Audit Clearing House or the submission of your 990

c. Assurances Required for Signing Grant Agreements (Post-Award)

- Certificate of Occupancy

D Application Submission (Enterprise Grants Management System)

All application submissions must be done electronically via Department of Health's Enterprise Grants Management System (EGMS), DC Health's s web-based system for grant-making and grants management. 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.

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 may not be approved by the DC Health Office of Grants Management in time for submission. To register, complete the following:

IMPORTANT: WEB BROWSER REQUIREMENTS

1. **Check web browser requirements for EGMS** - The DC Health EGMS Portal is supported by the following browser versions:

- Microsoft ® Internet Explorer ® Version 11
- Apple ® Safari ® version 8.x on Mac OS X
- Mozilla ® Firefox ® version 35 & above (Most recent and stable version recommended)
- Google Chrome ™ version 30 & above (Most recent and stable version recommended)

2. **Access EGMS**: The user must access the login page by entering the following URL in to a web browser: https://dcdoh.force.com/GO_ApplicantLogin2. Click the button REGISTER and following the instructions. You can also refer to the EGMS External User Guide.

3. 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.

4. Your EGMS registration will require your legal organization name, your **DUNS # 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).

5. When your Primary Account User request is submitted in EGMS, the DC Health 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.

    1) SUBJECT LINE: EGMS
    2) PRIMARY USER
    3) AGENCYNAME

    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.

6. Once you register, your Primary Account User will get an auto-notice to upload a "DUNS Certification" – this will provide documentation of your organization's DUNS. You can simply upload a scanned copy of the cover page of your SAM Registration.

EGMS User Registration Assistance:

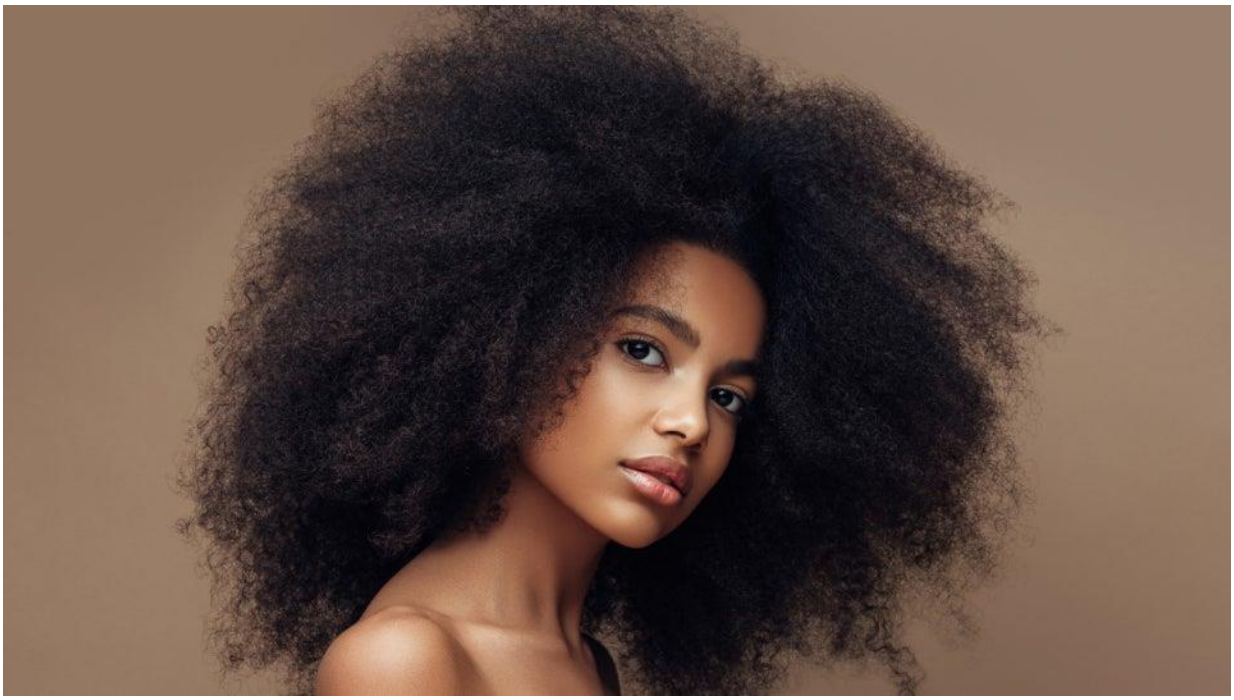
Office of Grants Management at egms.support@dc.gov assists with all end-user registration if you have a question or need assistance. Here are the most common registration issues:

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

Review the EGMS External User Recorded Webinar for information on the submission process and navigation of EGMS.

(If you have trouble linking, try Google Chrome and not Internet Explorer)

Note: When selecting service categories for application in EGMS, FFV Program applicants must select not only the service categories for application, but also the corresponding "performance" service category. This is the line item for the value enhancement award increases as described in Section 1b.



VIII. Review and Selection of Applications

Pre-Screening – 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.

External Review Panel – The review panel will be composed of neutral, qualified, professional individuals that have been selected for their unique experiences in human services, public health, health program planning and evaluation, and social services planning and implementation.

The panel will review, score, and rank each 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.

For this competition, the written proposal will be scored for a maximum of 100 points available.

Written proposal – 100 points available

a. Organizational Background and Capacity - 10 points
b. Project Description – 40 points
c. Program Proposal Summary – 20 points
d. Work Plan (Attachment C) – 10 points
e. Linkages Summary (attachment B) – 10 points
f. Monitoring, Evaluation, and Improvement – 10 points
g. Budget and Budget Narrative – Required, but Not Scored

Internal Review –

Redesign Capacity Assessment (RCAT) - The inaugural RCAT will be conducted as a part of the internal review process. A cross-departmental team of HAHSTA staff will use the RCAT to conduct the assessment. The RCAT assesses providers 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 will be answered based on a three-point Likert scale. Use of a Likert scale enables HAHSTA to view the range of capacity levels more accurately across its provider network. Additionally, the Likert scale uses a point system that helps identify a provider's capacity level as low, moderate, or high.

Subsequently, DC Health program managers will use the individual and summary recommendations of the external review panel and the RCAT scores to make recommendations for awards. Additionally, program managers will consider the following factors: risk assessment and eligibility assessment, including a review of assurances and certifications, and business documents submitted by the applicant, as required in the RFA.

DC Health will also conduct an excluded parties list search (EPLS) of the organization and executives via the federal System for Award Management (SAM) and conduct an DC Clean Hands review to obtain DC Department of Employment Services and DC Office of Tax and Revenue compliance status.

In this phase of the review process, DC Health reserves the right to request clarifying supplemental information from applicants and request on-site pre-decisional reviews for those applicants being considered for award. 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, and conditions of award 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.

Funding Decisions

Based on the total scores from the site visit, written proposal, and internal review of eligible applications, HAHSTA will prepare and submit a formal recommendation of prospective awardees, proposed funding levels and service categories to the DC Health Director for approval. The final funding recommendations will ensure that the overall portfolio of Ryan White funded services meets the overall programming needs of the jurisdiction.

Pre-Award Activities

Successful applicants will receive a letter of Notice of Intent to Fund from HAHSTA. Grant award activities will take place in EGMS. Successful applicants will interact with HAHSTA staff to review draft contract provisions, prepare final Table(s) A: Scope of Work and Budget Format and Budget Narratives.

Organizations receiving Notification of Intent to Fund cannot begin activities until a Notice of Grant Award (NOGA) is issued. The applicant shall not announce publicly receipt or award of funding from DC Health under this RFA until an actual DC Health NOGA is received.

X. Scoring Criteria

For this competition, the written proposal will be scored for a maximum of 100 points available.

a. Written proposal – 100 points available

a. Organizational Background and Capacity - 10 points
b. Project Description – 40 points
c. Program Proposal Summary – 20 points
d. Work Plan (Attachment C) – 10 points
e. Linkages Summary (Attachment B) – 10 points
f. Monitoring, Evaluation, and Improvement – 10 points
g. Budget and Budget Narrative (Attachment D) – Required, but Not Scored

Criterion A: Organizational Background and Capacity (Total 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:

a. Description of the history of the agency, specifically, the history in providing clinical and support services to People Living with HIV/AIDS (PLWHA) in the DC EMA.

b. Level of organization's competence in the provision of the services for which funding is requested including relevant experience and expertise of key management and front-line staff.

c. Applications must describe how the agency will maintain eligibility and retain customers in care; and

d. Applications must describe how the agency will make services accessible by detailing your hours of operation and flexible schedules that provide for evening and weekend hours of operation.

e. Applications 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 and submit a staffing plan (Attachment H) and budget (Attachment D) that illustrates the corresponding staffing level required to administer these grant funds.

Criterion B: Project Description (Total 40 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. Applications rated most highly will 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 will contribute to the overall quality, scope and impact of the service category response.

a. 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, as well as ways in which you will address those barriers.

b. The applicant has described how their agency will provide services in accordance with the service

category definitions, key activities, and detail activities that will focus on the highlighted areas of known technical complexities, service gaps, or frequent challenges;

c. The applicant describes how the proposed activities will contribute to improved outcomes, including: 1) Rapid Start ART; 2) Durable viral load suppression; 3) Engagement in medical care; 4) Rapid Re-start; 5) Decreased acuity for MCM/NMCM customers, 6) Successful linkage to support services, and/or 7) Improved food security.

Criterion C: Program Proposal Summary (Total 20 Points)

This section will be evaluated on the extent to which the linkage summary table includes a thorough illustration of services, which outlines the Service Categories and the level of direct and indirect service provision.

a. Applications must describe the services that 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.

b. Applications must provide a comprehensive summary of the proposed project inclusive of a description of how the program will provide all services within the care coordination bundle; fee-for-value bundle; and/or youth reach program.

Criterion D: Work Plan (Attachment C) (Total 10 Points)

This section will be evaluated on the extent to which there is a work plan for the proposed project. The work plan must include proposed targets for each service category within the care coordination bundle; fee-for-value bundle; and or youth reach program.

a. The goals and objectives of the proposed project are clearly defined, measurable and time-specific, and respond effectively to service category specific goals and priorities.

Criterion E: Linkage Summary (Attachment B) (Total 10 Points)

This section will be evaluated on the extent to which the linkage summary table includes a thorough illustration of services, which outlines the Service Categories and the level of direct and indirect service provision.

a. The extent to which the applicant illustrated the ability to provide or link customers to Outpatient Ambulatory Health Services directly or indirectly.

b. The extent to which the applicant demonstrates the ability to provide care coordination as specified in core service area 1A.

Criterion F: Monitoring, Evaluation, and Improvement (Total 10 Points)

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

a. Applicant describes how past and current experience with continuous quality management, including plans, processes, and personnel, will be used to improve customer satisfaction, outcomes, and/or care in a timely manner.

b. Applicant describes existing or proposed structure for data management, including processes for data capture, accuracy, completeness, timeliness, reporting, and utilization to determine progress and make improvements to CQM aims.

Criterion G: Budget and Budget Narrative (No Points Awarded)

The budget and budget narrative will be reviewed during the selection process but are not included in the scoring of the proposal. Comments on the budget will be accepted from the review panel and the technical reviewers and will guide budget negotiations for selected applications.

In preparing budgets, applicants must:

a. Maximize the cost efficiency of the service provided;
b. Provide a budget for each service category where funds are requested (Note: this applies to all services noted within a required bundle or program)
c. Provide a clear description of the contribution of each budget item proposed toward the overall goals of the program;
d. Support appropriate direct and indirect expenses;
e. Request a maximum 10% for administrative costs.

Grant Terms and Conditions

All grants awarded under this program shall be subject to the DC Health Terms and Conditions for all DC Health issued grants.

Additional program and administrative terms:

Reporting and Continuation of Funding

Grantees must submit monthly data and progress reports and quarterly progress and outcome reports using the tools provided by the HAHSTA and following the procedures determined by the HAHSTA.

Continuation funding for option year(s) is dependent upon the availability of funds for the stated purposes, fiscal and program performance, and willingness to incorporate new directives, policies, or technical advancements that arise from the community planning process, evolution of best practices or other locally relevant evidence.

Drug-Free Workplace

The organization agreement shall contain a provision requiring the organization to abide by the certifications contained in this announcement (Attachment K).

District of Columbia Regulatory Requirements

a. Organizations seeking funding in any service categories that include work with children are required to complete Criminal Background Investigations annually (conducted through local law enforcement agency) on all paid or volunteer service providers.
b. Organizations employing or contracting with Health Care Professionals licensed under Health Occupations Code must include copies of the appropriate jurisdictional licenses with grant proposals.

Confidentiality

The applicant must demonstrate that they will protect the identity of those HIV infected persons receiving services. All records and other identifying information will be maintained in a secure place. The purpose of confidentiality is to protect persons by minimizing disclosure of information about them. Any breach of this policy is liable for civil penalty damage.

All Covered Entities and Business Associates (as defined by the HIPAA Privacy Standards) must comply with HIPAA.

Quality Improvement

The organization will agree to participate in Quality Improvement activities and record review processes established by the Grantee, the District of Columbia Department of Health.

Compliance with the Americans with Disabilities Act

Consistent with the American with Disabilities Act of 1990, all facilities shall be accessible to persons with mobility limitations.

Customer Satisfaction and Grievance Procedure

The organization will agree to maintain and disseminate information regarding the customer grievance process and will provide a mechanism for assessing customer satisfaction with services annually.

Availability of Funds

The funds listed in this RFA are projections and subject to change.

Information Systems

During the term of the grant, organizations are required to obtain and maintain all hardware, software and training necessary to collect and report all data via data collection tools provided by or approved by HAHSTA.

Technical Assistance

HAHSTA shall offer technical assistance for issues related to this RFA.
Contact: Ebony Fortune via e-mail HAHSTARFAs@dc.gov .

Ryan White Part A RFA #HAHSTA_RWA_ReDesignModel_10.01.21

Required Attachments/Appendices	**Definitions**
Appendix #1 – Ryan White Compendium of Services	The service categories provide a summary of the services available under this core service area.
Appendix #2 – Sample Memorandum of Understanding (MOU)	Sample version of an MOU
Attachment A - Applicant Profile	Applicant Demographic Details & Requested Funding
Attachment B - Linkages Summary	Partnership and Collaboration with other Care Providers
Attachment C – Work plan	Itemizing details of Program
Attachment D - Categorical Budget and Budget Narrative	Specific Details of the Budget and Narratives
Attachment E - Other funding sources table	Demonstrates the financial capacity of the organization to support programming
Attachment F – Medicaid Certification	Certification by Center for Medicare and Medicaid Services (CMS) or a state agency or entity under contract with CMS that a health care operation is in compliance with all the conditions of participation set forth in the Medicaid Regulations.
Attachment G - Table A	Description of proposed tasks and deliverables for service delivery
Attachment H -Staffing Plan	Demonstrates applicant's human resources as capacity to deliver services.
Attachment I – Notice of Intent	Allows HAHSTA to anticipate the applicant response to RFA strongly recommended: due October 19, 2021)
Attachment J - RCAT Tool	To objectively assess the strengths and areas for improvement of its Ryan White funded providers. To support areas in need of capacity growth, development, and sustainability that ultimately contribute to improved health outcomes. **See column h for suggested documents to submit.**
Attachment L – RFA dispute policy	Applicant recourse to competitive funding solicitation process
Attachment M – Org Chart	A graphic representation of the structure of an organization showing the relationships of the positions or jobs within it.

Compendium of Services: CARE Act Part A

Government of the District of Columbia
Department of Health
HIV/AIDS Administration

Effective Date: September 2021

Table of Contents

Introduction

The Compendium of Services: Ryan White CARE Act Part A and Part B 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 or Part B 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 and/or Part B programs of the District of Columbia. 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 and Ambulatory Medical Services

Outpatient/Ambulatory Health Services (OAHS) 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 components and detail how they will support the service category program activities.

Proposals should include:

A description of an established a 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 implementation of an 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). All successful applicants will demonstrate their capacity and commitment to these activities.

A description of the agency's Re-Engagement plan which may be included as a service activity in the service categories ambulatory outpatient medical care, 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 description of how customers will have regular and routine access to the services of a psychiatric provider that is able to prescribe psychotropic medications to those for whom it is clinically indicated.

A description of previous experience providing OAHS services, to include a description of the planned continuum of care for the target population.

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 services must describe their proposed program components and detail how it will support the service category program activities.

Proposals should include:

Proposed program components and detail how it will provide guidance and assistance in improving access to and delivery of needed services;

Proposed "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).

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 http://doh.dc.gov/sites/default/files/dc/sites/doh/publication/attachments/MCM%202ND%20EDITION%202014.pdf;

Describe efforts to retain and re-engage customers lost to care. This activity is intended 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;

Provide 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;

Describe 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; and

Detail the 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 components and detail how it will support the service category program activities.

Proposal should include:

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;

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;

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

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;

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;

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.

A description of the agency's Retention and Re-Engagement plan which may be included as a service activity in the service categories ambulatory outpatient medical care, 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;

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.

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;

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; and

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 components and detail how it will support the service category program activities.

Proposal should include:

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.

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 agency's Retention and Re-Engagement plan 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 patients 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 patients 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
- Providing or referring patients, as needed, to health specialists including, but not limited to, periodontists, endodontists, oral surgeons, oral pathologists, oral medicine practitioners and registered dietitians
- Maintaining individual patient dental records in accordance with current standards
- Complying with infection control guidelines and procedures established by the different jurisdictions in the DC EMA Occupation Safety and Health Administration (OSHA)

Category 5: Non-Medical Case Management

Non-Medical Case Management Services Description: 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 components and detail how it will support the service category program activities.

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 (HIPCA) 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 components and detail how it will support the service category program activities.

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).

A RWHAP recipient must implement a methodology that incorporates the following requirements:

- RWHAP recipients must ensure that customers are buying health coverage that, at a minimum, includes at least one drug in each class of core antiretroviral therapeutics from the Department of Health and Human Services (HHS) treatment guidelines along with appropriate HIV outpatient/ambulatory health services.

- RWHAP recipients must assess and compare the aggregate cost of paying for the health insurance option versus paying for the full cost for medications and other appropriate HIV outpatient/ambulatory health services to ensure that purchasing health insurance is cost effective in the aggregate and allocate funding to HIPCA only when determined to be cost effective.

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 HIPCA 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 (aka Regional Early Intervention Services)

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, Regional Early Intervention Services 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 individuals within these 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 (strong recommendation of the World Health Organization and HAHSTA) 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 Regional Early Intervention Services must describe their proposed program components and detail how they will support the service category program activities.

Applicants proposing to provide Early Intervention Services must describe their proposed program components and detail how they will support the service category program activities.

Proposals should include:

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.

Category 7: Early Intervention Services (MAI)

Early Intervention Services (EIS) will emphasize ensuring the movement of customers along the prevention to care continuum – specifically ensuring retention in care and improved health outcomes. These services will be targeted to vulnerable populations either at very high risk of HIV infection or with demonstrated high rates of HIV prevalence or poor engagement in care or at increased risk of loss to care.

Applicants proposing to provide EIS are required to utilize the Anti-Retroviral Treatment and Access to Services (ARTAS) intervention. ARTAS is an individual-level, multi-session, time-limited intervention with the goal of linking recently diagnosed persons with HIV to medical care soon after receiving their positive test result. ARTAS is based on the Strengths-based Case Management (SBCM) model, which is rooted in Social Cognitive Theory (particularly self-efficacy) and Humanistic Psychology. SBCM is a model that encourages the customer to identify and use personal strengths; create goals for himself/herself; and establish an effective, working relationship with the Linkage Coordinator. ARTAS Goals:

- Help the customer overcome barriers to being linked to medical care.
- Build a trusting, effective relationship between customer and the Linkage Coordinator.
- Facilitate the customer's ability to create an action plan for being linked to medical care.

https://effectiveinterventions.cdc.gov/en/highimpactprevention/publichealthstrategies/ARTAS.as px

Definition
Counseling individuals with respect to HIV; testing (including tests to confirm the presence of the disease, to diagnose the extent of immune deficiency, and to provide information on appropriate therapeutic measures); referrals; other clinical and diagnostic services regarding HIV; periodic medical evaluations for individuals with HIV; and provision of therapeutic measures.

The elements of EIS often overlap with other service category descriptions; however, EIS is the combination of such services rather than a stand-alone service.

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

Successful applicants must demonstrate their ability to identify Youth of Color for early intervention services.

Key activities must include the following four components:

1. Targeted HIV testing to help the unaware learn of their HIV status and receive referral to HIV care and treatment services if diagnosed with HIV.

- **HIV testing efforts must be provided through a source of funding other than RWHAP Parts A or B.**

2. Referral services to improve HIV care and treatment services at key points of entry.

3. Access and linkage to HIV care and treatment services such as Outpatient/Ambulatory Health Services, Medical Case Management, and Substance Abuse Care.

4. Outreach Services and Health Education/Risk Reduction related to HIV diagnosis that will provide outreach and education services to increase linkage to primary care and supportive services for youth of color between the ages of (13-30) not engaged in care and have not been in primary care for six or more months.

Key minority populations include and are limited to**:** *Youth of Color ages 13-30 and the inclusive sub-populations of (1) African-American/Hispanic/Latino MSM; (2) African-American Heterosexual Men; (3) African-American/Hispanic/Latino Transgender Women; and (4)*
African-American Women.

Applicants proposing to provide EIS must describe their proposed program components and detail how it will support the service category program activities.

Proposals should include:

1. A detailed and clear plan to move 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;

2. A detailed and clear plan to ensure that customers from among the target populations are effectively linked with HIV primary medical care, medical case management, mental health and substance abuse services as appropriate;

3. A description of services/activities to be implemented with the use of community health workers as patient navigators in order to reach the target population;

4. A description of how identified barriers will be addressed to increase linkage to primary care and supportive services for the target population not engaged in care and have not been in primary care for six or more months.

5. A description of performance measures that demonstrate how the planned service objectives will contribute to the accomplishment of planned outcomes;

6. A description of how the ARTAS intervention will be utilized to serve the target population and any prior use of the ARTAS intervention as applicable;

7. A detailed plan to ensure program managers will be trained on all components of the ARTAS intervention; and

8. Formal agreements with organizations if the plan for delivering any required early intervention services relies on working cooperative with one or more other organizations, including identified point(s) of entry. Such agreements will outline respective responsibilities for engaging the customer in care and methods of ongoing coordination.

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:

1. Emergency rental assistance (first month's rent, past due rent)
2. Emergency utility payments (gas, electric, oil and water)
3. Emergency telephone services payments
4. Emergency food vouchers
5. Emergency moving assistance
6. Emergency medication

Applicants proposing to provide emergency financial assistance must describe their proposed program components and detail how it will support the service category program activities.

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 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.

2. EFA provider must establish frequent communication guidelines for staff to communicate application status at each stage with the case manager who submitted the application.

3. EFA provider agencies must also maintain effective methods of communication with other HIV providers in the jurisdiction to ensure that there is widespread knowledge and understanding of the EFA benefits available for customers.

4. Incomplete Applications: EFA provider staff must contact the case manager who submitted the application within 24 hours of receipt to convey the incomplete status. EFA provider staff and case managers must work together to ensure that the application is completed. If the application is incomplete over seven business days, the EFA provider agency can deny the application and the case manager must re-submit.

5. EFA provider agencies must develop policies, procedures and forms that reflect all requirements of the EFA Service Standards.

Program Guidance: Emergency Financial Assistance funds used to pay for otherwise allowable HRSA RWHAP services must be accounted for under the Emergency Financial Assistance category. Direct cash payments to customers are not permitted. Continuous provision of an allowable service to a customer must not be funded through Emergency Financial Assistance.

Category 9: Substance Abuse Outpatient Care

Substance Use - Outpatient Provision of medical and/or counseling services to address substance abuse issues (including the abuse of alcohol, and/or legal and illegal drugs/substances) 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 components and detail how it will support the service category program activities.

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 strategies for routinely reviewing documented viral load outcomes with customers on ART to provide specific feedback and support for successful outcomes;

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

5. 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.

6. 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;

7. A description of the agency's Retention and Re-Engagement plan which may be included as a service activity in the service categories ambulatory outpatient medical care, 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. 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.

9. 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.

10. 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.

11. 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

12. A description of the agency's current and proposed strategies to include core prevention and harm reduction 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 recipient 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)
- 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 components and detail how they will support the service category program activities.
Proposal should include:

1. A description of the proposed program components and detail how it will support the service category program activities;

2. 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;

3. A description of how the population to be served by the medical transportation services, including target number of customers, average frequency and duration of support;

4. Detail the method and approach for supporting transportation, such as direct provision, vouchers, or reimbursement. Proposal may include requests to support clinic transport services;

5. 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.
6. 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; and

7. 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 and Home-Delivered Meals

The goal of Food Bank and 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; and
- Referrals to other food programs.

Food Bank key activities include:

- Providing food items, including fresh produce, poultry and fish;
- Improved coordination of services;
- Provision of services that include 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; and
- 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 components and detail how it will support the service category program activities.

Proposal should include:

1. A description of the proposed program components and detail how it will support the service category program activities;

2. A description of 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;

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

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

Peer Navigation. Newly diagnosed people with HIV are frequently challenged by the unfamiliarity and complexity of the services available and may be overwhelmed by trying to learn the system of services. A peer support model can improve the ability of customers to understand the service systems and to consume service more effectively. This is a 'learning the ropes' model of peer support and should include focus on skills-building for self-advocacy for a lifetime of care.

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.

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: (1) completion of a comprehensive psychosocial assessment and linking customer with counseling services as needed; (2) HIV support group services led or co-led by peer-facilitators; (3) child abuse and neglect counseling; (4) bereavement counseling inclusive of spiritual support to persons with HIV; and (5) 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 components and detail how it will support the service category program activities.

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; and

2. A description of how the wellness coaching or group sessions will be provided.

Category 14: Psychosocial Support (MAI) Services

Peer Navigation. Newly diagnosed people with HIV are frequently challenged by the unfamiliarity and complexity of the services available and may be overwhelmed by trying to learn the system of services. A peer support model can improve the ability of customers to understand the service systems and to consume service more effectively. This is a 'learning the ropes' model of peer support and should include focus on skills-building for self-advocacy for a lifetime of care.

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.

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: (1) completion of a comprehensive psychosocial assessment and linking customer with counseling services as needed; (2) HIV support group services led or co-led by peer-facilitators; (3) child abuse and neglect counseling; (4) bereavement counseling inclusive of spiritual support to persons with HIV; (5) pastoral care/counseling services; and (6) nutrition counseling provided by a non-registered dietitian (*see* Medical Nutrition Therapy 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

components and detail how it will support the service category program activities. Proposals should include:

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

2. Describe a plan to ensure that peer counselors are appropriately trained and prepared to provide peer counseling and are provided with regular clinical supervision.

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.

Medical Nutrition Therapy includes:

- 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. Services not provided by a registered/licensed dietitian/nutritionist should be considered Psychosocial Support Services under the RWHAP.

Applicants proposing to provide medical nutrition therapy must describe their proposed program components and detail how it will support the service category program activities.

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 nutritional services that are integrated with outpatient HIV primary medical care programs and provide information regarding medication interactions and side effects;

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

4. Provide baseline and targets of 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 identifying PLWH who either do not know their HIV status, or who know their status but are not currently in care.

Outreach Services provide the following activities: 1) identification of 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.

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 must not include outreach activities that exclusively promote HIV prevention education.
Proposal should include:

1. A description of the applicant's proposed program components and detail how it will support the service category program activities.
2. A description of the population of focus
3. 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.

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.

Services 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 home 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 health services must describe their proposed program components and detail how it will support the service category program activities.

Applicants proposing to provide home and community-based care must describe their proposed program components and detail how it will support the service category program activities.
Proposal should include:

1. Describe 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. Detail the proposed strategies to ensure strong linkages to other care and support services;

4. Provide 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. Describe the location and accessibility of services;

6. Detail the communication strategies to make other service providers aware of this service for referral of their customers; and

7. Provide 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 Description: Linguistic Services include interpretation and translation activities, both oral and written, to 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:

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

Applicants proposing to provide linguistic services must describe their proposed program components and detail how it will support the service category program activities.
Proposal should include:

1. Provide 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. Describe the role of Linguistic Services in re-engaging customers who have been previously lost to care;

3. Describe how the program will ensure the provision of translators and interpreters with knowledge of HIV terminology and the technical language and knowledge of health care terms;

4. Describe 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. In the event that 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. Demonstrate the capacity to routinely provide or rapidly mobilize translation services in Spanish, Amharic, Chinese, French, Korean, and Vietnamese;

6. Demonstrate the capacity to routinely provide or rapidly mobilize American Sign Language interpretation; and

7. Provide a 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.

Services include:

1. 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)
- 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

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

2. 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:

- Social service counseling or legal counsel regarding the drafting of wills or delegating powers of attorney
- Preparation for custody options for legal dependents including standby guardianship, joint custody, or adoption

3. 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

Applicants proposing to provide other professional services must describe their proposed program components and detail how it will support the service category program activities.

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.