

Funding Opportunity : Ryan White Part B: Status-Neutral Care Continuum (SNCC)

Pre-Application Conference

Funding Opportunity Number: HAHSTA-RWPartB_SNCC-9.25.26

Tuesday, October 6, 2026

Agenda

- Welcome and Housekeeping
- Overview of DC Health
- Funding and Eligibility Information
- Background
- Purpose of Grant
- Overview of Performance Requirements, Allowable Activities, and Program Strategies
- Monitoring, Evaluation, and Learning (MEL) Plan
- Overview of Application Requirements
- Key Dates, Contact Information, and Q&A Protocol

Housekeeping

- **Sign in:** enter your name, title, email, and organization in the chat
- **Questions:** type all questions in the chat, even if you ask them aloud. Questions are reviewed at the end of each section
- **Official answers:** responses are posted in the FAQ on the District Grants Clearinghouse (see the Q&A slide)
- **Recording:** this session is being recorded

DC Health

Mission Statement

- The District of Columbia Department of Health promotes health, wellness and equity across the District, and protects the safety of residents, visitors, and those doing business in our nation's capital.

Strategic Priorities

- Promote a culture of health and wellness
- Address the social determinants of health
- Strengthen public-private partnerships
- Close the chasm between clinical medicine and public health
- Implement data driven and outcome-oriented approaches to program and policy development

Funds Available (p. 11)

- **Approximately \$1,000,000** is available for **two (2) awards** in the first budget period
- **Project period:** April 1, 2027 – March 31, 2032 (first budget period plus up to four additional 12-month budget periods)
- **Contingent funding:** depends on annual RWHAP Part B awards to DC Health from HRSA, continued availability of funds, and grantee performance
- **No cost sharing or match** is required
- **Non-supplantation:** funds must supplement, not supplant, other funds for the same or similar initiatives

Applicant Eligibility (p. 12)

- **Eligible organizations/entities who can apply for grant funds under this RFA:**
 - Not-for-profit health and support service providers
 - Not-for-profit universities
 - For-profit entities, only if no non-profit is willing and able to deliver the services
 - Individuals are not eligible

Background (pp. 12–13)

- **11,842** DC residents were living with HIV in 2024, one of the highest prevalence rates in the country (about 1.7% of residents)
- **79%** of people living with HIV receive care; **70%** are virally suppressed (89% among those in care), against a 95% target
- Only **56%** of people newly diagnosed reached viral suppression within 90 days
- About three in four people nationally who could benefit from PrEP are not on it; DC's EHE plan aims to help **13,000+** residents access PrEP
- A prior program evaluation found PrEP was not consistently offered and follow-up and reengagement were uneven for both PrEP and ART users

Purpose of this Funding Opportunity (pp. 10–11)

- A distinct, independent initiative focused exclusively on a **status-neutral service model**
- Support services for Ryan White–eligible customers seeking HIV-related care and support in Washington, DC
- Deliver biomedical, clinical, and supportive interventions to District residents, regardless of HIV status
- Prevent HIV acquisition among HIV-negative individuals and promote viral suppression among people living with HIV
- Improve linkage, engagement, and adherence to PrEP and ART through the four AIR strategies

Allowable Activities (pp. 17–23)

- **Required service areas (all three):**
 - Medical Case Management (MCM), Non-Medical Case Management (NMCM), and Outpatient/Ambulatory Health Services (OAHS)
- **Optional service areas:**
 - Health Education/Risk Reduction, Medical Transportation, Mental Health Services, and Psychosocial Support Services
- Treatment adherence is required in every service area except Medical Transportation
- **Not allowable:** HIV testing, cash or direct financial assistance, and customer education or training. RWHAP funds may serve only people living with HIV (braided funding must be tracked separately)

Program Strategies (pp. 15–16)

Access-Initiation-Retention (AIR) Strategies

- AIR Strategy 1 – **Linkage to Care/Navigation:** quick, verified connection to prevention or care
- AIR Strategy 2 – **Rapid ART/PrEP Initiation:** timely ART or PrEP per clinical guidelines using the Red-Carpet model (same day, when possible, no later than seven days)
- AIR Strategy 3 – **Treatment Adherence and Retention:** counseling, reminders, peer support, and partner coordination
- AIR Strategy 4 – **Reengagement and Recapture:** find and reconnect customers who have fallen out of care or prevention

Target Population and Location of Services (p. 17)

- **Applicants must successfully serve BOTH populations:**
 - **People living with HIV:** Ryan White–eligible; not virally suppressed, not in care, or at risk of falling out of care (at or below 500% FPL; un/underinsured; DC resident)
 - **PrEP-eligible individuals:** recently tested HIV negative and determined to be vulnerable to acquiring HIV
- **Location:** services must be located in DC and provided only to District residents

Applicant Capacity Needs (pp. 16–17)

- **Successful applicants will need:**
 - Staff trained in both HIV prevention and HIV care protocols (PrEP, ART, lab monitoring, harm reduction)
 - Culturally responsive, customer-centered services in a stigma-free environment
 - Evidence-based outreach, navigation, and adherence support strategies
 - Infrastructure to braid funding and stay compliant across multiple sources
 - Staffing, supervision, and readiness to manage a unified status-neutral service model
- **Strong data systems** for documentation, tracking, reporting, and performance monitoring which are the foundation of the Monitoring, Evaluation, And Learning (MEL) Plan.

MEL at a Glance (pp. 34, 37, 41–42)

- **What to submit and where:**
 - **Project Description:** half-page service model summary, at the opening
 - **Project Narrative:** your CQM program; it may point to the MEL Plan instead of repeating it
 - **MEL Plan Attachment:** full service model logic and required indicator tables (3 pages maximum, tables not included)
- **Keep in mind:** MEL is separate from compliance monitoring and from CQM
- HAHSTA runs the project-wide MEL system

MEL: Who Does What (pp. 24–25)

- **HAHSTA's role:**

- Runs the project-wide MEL system and leads project-level evaluation
- Provides MEL orientation, TA, and feedback
- Shares site summaries, data quality reports, and evaluation findings

- **Your role:**

- Routine monitoring, data quality, and quality improvement
- Document implementation and join learning activities
- Give HAHSTA timely access to records, systems, and staff

Program Logic: Inputs and Core Activities (pp. 25–26)

- **Inputs:** HAHSTA funding and oversight; clinical, prevention, and navigation staff; CAREWare; referral and partner networks
- **Core activities:**
 - Single status-neutral entry point
 - Rapid linkage to ART or PrEP/PEP; rapid initiation protocols
 - Adherence support using pharmacy and clinical data
 - Stigma reduction and embedded behavioral health
 - Enhanced outreach and testing cadence
 - Reengagement, including PrEP-to-ART transitions
 - Feedback loops: CAB cycles and cross-agency case reviews
- **Your task:** confirm you will deliver all core activities; describe your approach and any adaptations

Program Logic: Outputs and Outcomes (pp. 26–27)

- **Outputs:** counts assessed, linked, and initiated; adherence contacts; people re-engaged; seroconversion transitions; CAB cycles and case reviews
- **Outcomes:**
 - **Short-term:** faster linkage and rapid initiation
 - **Intermediate:** retention, adherence, reengagement, fewer missed referrals
 - **Long-term:** sustained viral suppression and PrEP coverage; fewer new diagnoses
- **Your MEL Plan:** explain why your approach should produce these results, focusing where it differs most from a standard model or where evidence is limited

Required System Components (pp. 25–26)

- **Workforce:** testing, prevention, and linkage capacity; competencies kept current
- **Referral & Navigation:** streamlined entry to testing, PrEP/PEP, and rapid ART; closed-loop referrals
- **Clinical & Biomedical:** testing cadence, PrEP initiation and adherence, PEP, rapid ART
- **Health Info Systems:** testing reminders, PrEP adherence flags, linkage metrics, seroconversion
- **Partnerships & MOUs:** prevention networks, testing centers, CBOs, pharmacies, and labs
- **Consumer Feedback:** CAB, peer input, and lived experience to reduce stigma barriers
- **Strong proposals** show all six working together as one connected system

Indicators and Reporting Calendar (pp. 27–28)

- **Monthly:** customer-level data entry in CAREWare
- **Quarterly:** indicator report; implementation documentation; barriers and adaptations
 - **Indicators:** reach; enrollment timeliness; viral suppression; linkage rate; rapid initiation; reengagement; PrEP continuity; seroconversion transition to ART
- **Semi-annual:** indicator report (indicator: retention)
- **Annual:** full MEL report (indicator: customer feedback participation)
- **As needed:** material changes; data quality escalations
- **Local indicators:** propose up to five, each with rationale, definition, source, frequency, baseline, and target

Learning Activities and Participation (pp. 28–29, 41–43)

- **Learning activities:** MEL orientation at start-up, quarterly data review sessions, an annual learning convening, and topic-specific sessions
- HAHSTA gives templates and due dates at orientation
- **What you commit to:**
 - Send appropriate staff to each session
 - Keep staff available for quarterly sessions and the annual convening
 - Share findings and review HAHSTA feedback internally
 - Document decisions; share on request
 - Support evaluation and data sharing, with timely access to records, systems, and staff

Clinical Quality Management (pp. 29–30, 37)

- **Where it goes:** Project Narrative, not the MEL Plan
- **CQM programs must:**
 - Perform QI activities to improve care, outcomes, and satisfaction
 - Maintain QI infrastructure: committees, teams, plans
 - Use a defined, systematic methodology and analyze data routinely to drive improvement
- **Required measure areas:** clinical outcomes (viral suppression; ART and PrEP initiation); engagement and retention; PrEP navigation and uptake (offer, acceptance, declination, follow-up); customer experience
- **Also required:** review CQM findings on a set schedule and use them in decisions on services, staffing, workflows, and partners

MEL Plan: Six Required Elements (pp. 41–43)

- **Service model & logic:** population, activities, outputs, causal pathways, adaptations, context
- **Baselines & targets:** required indicator tables; plan for missing baselines; local indicators
- **MEL staffing:** positions responsible for MEL and their relevant experience
- **Data systems & quality:** confirm CAREWare; reconcile other tools; quality procedures
- **Implementation documentation:** quarterly records; who maintains them and when
- **Participation commitments:** learning sessions, evaluation support, and timely access to records, systems, and staff
- **Length:** 3 pages maximum, excluding required tables

Application Components (pp. 32–43)

- A complete application package must include the following:

❖ Eligibility Documents

- Certificate of Clean Hands
- Current Business License
- Current Certificate of Insurance
- Copy of Cyber Liability Policy
- IRS Tax-Exempt Determination Letter
- IRS 990 Form
- Current List of Board of Directors, on Letterhead, Signed and Dated by a Certified Official from the Board
- Assurances, Certifications, and Disclosures

❖ Proposal Components

- Project Abstract
- Project Narrative
- MEL Plan
- Work Plan
- Scope of Services
- Budget Table & Justification
- Organizational Chart
- Risk Self-Assessment
- Other Funding Sources Table
- Cultural Competency Form
- Medicaid Certification (if applicable)

Compliance Readiness

- Should you be awarded a grant with DC Health, you will be required to comply with all laws as outlined in the Terms and Conditions
- Please review the [Office of Grants Management \(OGM\) webpage](#) for a copy of the Terms and Conditions
- There is additional information on the OGM webpage and trainings on:
 - Americans with Disabilities Act
 - Protecting Pregnant Workers Fairness Act
 - Language Access Act

Evaluation Criteria (pp. 43–45)

- ❖ **Criterion 1:** Need (22 points)
- ❖ **Criterion 2:** Implementation (49 points)
- ❖ **Criterion 3:** Evaluative Measures (14 points)
- ❖ **Criterion 4:** Capacity (15 points)
- ❖ **Criterion 5:** Budget (reviewed, not scored)

Key Dates

- **Notice of Funding Announcement Date:** September 11, 2026
- **Request for Application Release Date:** September 25, 2026
- **Letter of Intent Due:** October 7, 2026, by 6:00PM
- **Last Day to Register in EGMS for new accounts:** October 23, 2026
- **Last Day to Submit Questions:** October 26, 2026
- **Application Submission Deadline:** November 10, 2026, *by 3:00PM*

LATE APPLICATIONS WILL NOT BE ACCEPTED

- **Anticipated Notice(s) of Intent to Fund:** January 15, 2027
- **Anticipated Award Start Date:** April 1, 2027

Questions and Answers

- Questions will **ONLY** be accepted in writing
 - Please submit questions to HAHSTARFAs@dc.gov and reference “Status-Neutral Care Continuum RFA” in subject line
- **Last Day to Submit Questions:** October 26, 2026
- **All responses will be made available on the District Grants Clearinghouse in a FAQ document that will be released every three business days**

Application Submission Recommendations

- Do NOT wait until the last minute to submit
- Submit at least 48 hours before deadline
- Applications will **not** be accepted after the deadline

Contact information

- Email: HAHSTARFAs@dc.gov

DC | HEALTH

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