AIDSNET
REQUEST FOR PROPOSALS
FOR 2017-2018 HIV SERVICES

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GENERAL INFORMATION

Introduction

AIDSNET is a private, non-profit organization created to prevent the spread of HIV Disease and meet the health care and supportive service needs of people infected with, and affected by, the disease. Founded in 1991, "[t]he mission of AIDSNET is to Build Healthier Communities By Planning and Funding HIV Care and Prevention Services." As one of seven Regional Sub-recipients in the Commonwealth of Pennsylvania, AIDSNET serves the counties of Berks, Carbon, Lehigh, Monroe, Northampton and Schuylkill.

The goals of AIDSNET are to develop and implement:

- A coordinated and unified regional HIV prevention program that includes education and risk reduction strategies;
- A coordinated and unified regional HIV care program through which persons infected with HIV and their families have access to basic health care and human services regardless of where they live or their ability to pay;
- A coordinated and unified regional HIV housing program through which persons living with HIV and their families have access to appropriate housing, based upon their special needs and the stage of their illness; and
- A regional network of community-based service providers through which integrated and comprehensive components of regional programs are delivered to neighborhoods and communities in ways that are cost-effective, responsive to changing needs and meet quality standards.

AIDSNET seeks to accomplish these goals by allocating the necessary funding for services in the areas of prevention and care.

Each year, AIDSNET receives funding from the Pennsylvania Department of Health (PA-DOH). The funding comes from three grant programs: one state and two federal sources. State 656 funds are from the PA-DOH and have the greatest flexibility in their use. AIDSNET usually uses the bulk of these dollars for prevention activities, which generally are not eligible costs under the other two programs.

The largest funding source is Part B of the Ryan White HIV/AIDS Treatment Modernization Act of 2006 (ACT). The program has been reauthorized by Congress four times since first created (1996, 2000, 2006, and 2009), and is currently authorized through FY 2013. No changes have been made since then, extending the Act while discussions about how best to structure the program since the inception of the Patient Protection and Affordable Care Act (PPACA), commonly called the Affordable Care Act (ACA) in March of 2010.[1] The ACA is an historic opportunity for people living with HIV, including those currently receiving services through the Ryan White Program, to

[1] http://www.hhs.gov/healthcare/about-the-law/index.html

increase their access to affordable, quality health care. In this new environment, some have even questioned whether Ryan White will be necessary or what level of funding will be warranted.

Most Ryan White clients today (90%) have insurance coverage (an increase of 17% over the last two years due to the ACA and Medicaid expansion). Yet they must continue to rely on the program to supplement limits in their coverage or help with co-pays, indicating that insurance coverage, on its own, does not necessarily protect against the high cost of HIV care or provide the range of services needed to keep people with HIV engaged in care and on treatment. [2]

Given that the ACA will not supplant critical Ryan White services, including linkage, retention and adherence supports, and in spite of whatever changes may be made, the program is expected to continue to be a critical part of the HIV care system in the U.S. going forward. Moreover, as increased attention is directed to getting more people with HIV retained in care, the demand for the Ryan White program's services could surpass current levels, even if more people have public or private insurance coverage. At the same time, expanded insurance coverage could also serve to ease pressure on some parts of the Ryan White program in the future.

Ryan White funds represent the largest dollar investment made by the federal government specifically for the provision of services for people living with HIV. The ACT is intended to help communities increase the availability of primary health care and support services (to reduce utilization of more costly inpatient care); increase accesses to care for underserved populations and improve the quality of life of those affected by the epidemic. The funding flows from the United States Department of Health and Human Services, Health Resources and Services Administration (HRSA) to PA-DOH to AIDSNET. The overwhelming majority of the funding is used for care-related services.

AIDSNET's third funding source is The Housing Opportunities for Persons with AIDS (HOPWA) Program. It is used for housing-related services in the six-county area and is administered by the United States Department of Housing and Urban Development (HUD), Community Planning and Development Division. Funding flows from HUD to the PA-DOH to AIDSNET. The program is intended to provide communities with the resources and incentives for meeting the housing needs of persons with HIV disease and their families.

The PA-DOH and AIDSNET operate on a July 1 through June 30 fiscal year. During the 2017-2018 fiscal year, AIDSNET anticipates funding will be $2,202,366.95 from the PA-DOH, Division of HIV (Division) with the appropriation of these funds as follows:

- State 656 -- $528,180.00
- Part B of the ACT -- $1,267,330.93
- HOPWA -- $406,856.02

In addition, Part B of the ACT operates on an April 1 through March 31 fiscal year. Therefore, during AIDSNET's fiscal year, the organization is dealing with two Part B grant years. The appropriation of Part B funding ($1,267,330.93) is as follows:

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[2] http://kff.org/hivaids/fact-sheet/the-ryan-white-program/

- for the period of July 1, 2017, through March 31, 2018, AIDSNET anticipates receiving $948,993.64; and
- for the period of April 1 through June 30, 2018, AIDSNET anticipates receiving $318,337.29.

The subgrant agreement will cover a one-year period from July 1, 2017, through June 30, 2018.

Purpose

The purpose of this Request for Proposals (RFP) is to fund projects designed to provide HIV prevention and care services within the six-county service area to persons who are residents of Berks, Carbon, Lehigh, Monroe, Northampton, and/or Schuylkill counties. This RFP is issued by AIDSNET, which should be the sole point of contact for this document. Responses to this RFP will be accepted from public or private non-profit organizations that propose to develop and/or continue eligible activities in the six-county region.

Although the funding to be received from the Division has been outlined above, AIDSNET reserves the right not to fund all or some of the proposals received, either because of funding constraints or because of the quality of the proposals. Therefore, applicants should not anticipate receiving financial support before receipt of funding notification from AIDSNET. However, even in the case of proposals receiving funding, AIDSNET is not liable for any costs incurred by the applicant prior to the effective date of the grant agreement, which is anticipated to be July 1, 2017.

Care and Prevention Services Eligible for Funding

As mentioned previously, AIDSNET will fund services in the areas of prevention and care. Eligible services are discussed in detail in Appendix A. Please be aware that Non-Medical Case Management is a newly added service and that we have expanded the use of Emergency Financial Services to include utilities and short-term-housing assistance. Medical Transportation Services are to include transportation by an agency staff member to account for time and mileage for transporting a client to an appointment. (Previously, this service, if performed by a Case Manager was billed/recorded as MCM; it is now billed and recorded as Medical Transportation). Proposals may include funding requests for a wide range of allowable costs, including sufficient program staff to support the program and other direct and indirect expenditures that are appropriate to the project.

Organizations submitting proposals for care services should keep in mind that AIDSNET is the payer of last resort, as described in Federal and State regulations. All six counties in the AIDSNET region have managed care. Invoices for services that are eligible for coverage or reimbursement by other resources (medical assistance, Medicare, employer insurance, private insurance, other programs, etc.) must first be submitted to these programs on behalf of the client and denied before AIDSNET will consider reimbursing the Program Subrecipient for the cost of the service. Case management services meeting the definition of Targeted Case Management; however, must be billed to Medicaid whenever a client is eligible. As a general statement, medical services must be directly related to HIV disease.

Standard Grant Agreement

The selected Program Subrecipients will be expected to enter into a Standard Grant Agreement. A copy of the current Standard Grant Agreement can be viewed at the AIDSNET website at http://www.aidsnetpa.org/resources-for-grantees.php

Minimum Applicant Requirements

- Applicant must be a not-for-profit 501(c)(3) organization.
- Applicant can have no record of unsatisfactory performance. Applicant must not be presently debarred, suspended, proposed for debatement, declared ineligible or voluntarily excluded from participation in this transaction by any local, state or federal department or agency.
- Applicant must have the ability to maintain adequate files and records to meet statistical reporting requirements.
- Applicant must have the administrative and fiscal capability to provide and manage the proposed services on a reimbursement basis and ensure adequate documentation related to services provided.
- Applicant must demonstrate the capacity to perform all elements of the proposed scope of work and have the capacity to enter into a Subgrant with AIDSNET.
- Applicant must possess the appropriate license(s) and certification(s) issued by the Commonwealth of Pennsylvania (if required based on the services proposed).
- Applicant must meet other presentation and participation requirements listed in this Request for Proposals (RFP).

Quality Management Specifics

Quality Management (QM) is a systematic process with identified leadership, accountability and dedicated resources that: (1) uses data and measurable outcomes to determine progress towards relevant, evidence-based benchmarks; (2) focuses on linkages, efficiencies and provider and client expectations in addressing outcome improvement; (3) is continuous and adaptive to change; and (4) collects data to feed back into the process to assure that goals are accomplished.

The Health Resources and Service Administration's (HRSA) HIV/AIDS Bureau (HAB), an agency of the United States Department of Health and Human Services, has lead responsibility for implementing all titles of the ACT. HRSA sent guidelines to all states for instituting a QM process. The PA-DOH, in turn, set up a QM committee to begin the process of implementing these guidelines. AIDSNET is charged with insuring that each agency it contracts with implements a QM process.

The goal of QM as defined by HRSA:

- To ensure that HIV services adhere to Public Health Service (PHS) guidelines and established clinical practices. Quality is defined as the degree to which a health or social service meets or exceeds established professional standards and user expectations."

- To ensure that program improvements include supportive services "linked to access and adherence to medical care."
- To ensure that demographic, clinical and utilization data are used to evaluate and address characteristics of the local epidemic. "Evaluation of the quality of care…should consider the quality of outcomes in order to continuously improve systems of care for individuals and populations."

The applicant shall develop/implement/update annually an internal QM program, as a condition of receiving funding. This is to insure that the agency has a methodology in place to allow it to step back from day-to-day activities and to assess, evaluate and improve all aspects of the administrative, personnel, programmatic and fiscal components of the agency. This can be done by setting up a QM plan that addresses each of these components by asking who, what, when, where and how. The applicant must include a QM Plan [including anticipated Quality Improvement (QI) projects to be addressed during the funding year] with its response to this RFP that, at a minimum, addresses the programs to be funded by AIDSNET. For applicants that are part of a larger organization, please limit the QM submitted to those program(s) the proposal is requesting to be funded.

At minimum, this QM program will be a systematic process that includes:

- Identified leadership, accountability, and dedicated resources that use data and measurable outcomes to determine progress.
- Focus on linkages, efficiencies, and provider and client expectations as it addressed outcomes improvement.
- Ability to adapt to change.
- Continuous process that fits within the framework of other quality assurance and quality improvement activity, such as those required by Joint Commission on Accreditation of Healthcare Organizations (JCAHO).
- The process used by HRSA and the PA-DOH is called **Focus PDSA**
    - **F**ind a process
    - **O**rganize a Team
    - **C**larify Current Knowledge
    - **U**nderstand and Analyze Root Causes
    - **S**elect a Process to Change
    - **P**lan the Change
    - **D**o the Change
    - **S**tudy the Change
    - **A**ct

The governing body of the applicant shall, on an annual basis, document its review of the organization's QM program to insure its effective implementation. AIDSNET's staff will review its Program Subrecipients QM plans, status of projects and evaluations at least annually.

<u>Economy of Preparation</u>

Proposals should be prepared simply and economically, providing a straightforward and concise description of the intent and ability of the interested party to meet the requirements of this RFP. Please take note that AIDSNET has implemented page restrictions, which can be found in the description of the proposal components. In addition, it would be appreciated if applicants use font size 12 in preparing their proposals.

Prime Program Subrecipient Responsibility

Each organization selected for funding will be required to assume full responsibility and begin to provide all services offered in its proposal or those services negotiated separately, whether or not it provides them directly, by July 1, 2017. Further, Program Subrecipients may not enter into a grant agreement with another provider for services or functions offered through this proposal without the written permission of AIDSNET. It is expected that the contracting agency will provide services in accordance with the procedures described in this RFP.

Improper Consideration

Applicant will not offer (either directly or through an intermediary) any improper consideration such as, but not limited to, cash, discounts, service, the provision of travel or entertainment, or an item of value to any officer, employee or agent of AIDSNET in an attempt to secure favorable treatment regarding this RFP. AIDSNET, by written notice, may terminate any contract if it determines that any improper consideration as described above was offered to any officer, employee or agent of AIDSNET with respect to the proposal and award process. This prohibition will apply to any amendment, extension or evaluation process once a subgrant has been awarded. Applicant will immediately report any attempt by an AIDSNET officer, employee or agent to solicit (either directly or through an intermediary) improper consideration from Applicant. The report will be made to the supervisor or manager charged with the supervision of the employee. In the event of a termination under this provision, AIDSNET is entitled to pursue any available legal remedies.

Inaccuracies or Misrepresentations

In the course of the RFP process or in the administration of a resulting subgrant, if AIDSNET determines that the applicant has made a material misstatement or misrepresentation or that materially inaccurate information has been provided to AIDSNET, the applicant may be terminated from the RFP process. In the event a subgrant has been awarded, the contract may be immediately terminated.

News Releases

News releases pertaining to this RFP or the project to which it relates should not be made until AIDSNET and the PA-DOH have approved the proposal and the applicant has a fully executed grant agreement with AIDSNET.

Rejection of Proposals

AIDSNET reserves the right to reject any and all proposals as a result of this RFP or to negotiate separately with competing applicants for all or any part of the services described therein. Furthermore, should the evaluation of the applications demonstrate that there are not sufficient proposals of quality to meet the needs of the region; AIDSNET reserves the right to contact organizations submitting quality proposals to determine their level of interest in providing the applicable services. In such cases, the applicants contacted will be given an opportunity to submit addendums to their proposals for these additional services. The addendums will be evaluated using the same criteria as the initial submissions. Should the revised proposals be of sufficient quality, the highest rated applicant(s) will be recommended for funding. If this additional step fails to produce a sufficient number of quality proposals, a subsequent RFP will be issued for the applicable services.

Responses to the RFP

In preparing a response to this RFP, please keep in mind that the quality of the proposal weighs heavily in funding decisions. Therefore, please take the time to be accurate in describing the statement of the problem and the services to address the stated needs. In addition, please be thorough in the review of the proposal before it is submitted. As funding gets tighter, allocations decisions become more difficult. Just because an organization was funded for a specific service previously is not a guarantee that AIDSNET will support it in the coming year. Therefore, agencies that have been funded previously should be careful not to simply submit the same material submitted in the past. In addition, agencies that have been funded previously should take seriously the comments from AIDSNET's staff and Allocations Committee regarding their past proposals.

All responses to this RFP must include information on the subjects described in the "Proposal Components" section. A checklist of requirements to assist applicants in preparing their response to this RFP, a signature page and a proposal summary sheet are included as Appendix B. The material requested should be presented in the order it is described below and listed in the checklist. Please number all of the pages in the proposal. Please be as concise, yet complete, as possible.

Proposal Due Date

Proposals must be received by AIDSNET by 3:00 p.m., Monday, April 24, 2017. AIDSNET is located at 31 South Commerce Way, Suite 400, Bethlehem, PA 18017-8992. To be considered, the **original and 5 copies** of a complete response to the RFP using the format provided must be submitted to AIDSNET. The applicant should not distribute copies of the proposal in response to this RFP to any other parties. Any proposal that does not provide all of the information requested in this RFP may be eliminated from selection. This proposal description and all details must remain firm until at least July 1, 2017.

Each proposal submitted by the **April 24, 2017**, deadline will be reviewed by AIDSNET's staff for completeness and accuracy. Any proposal that does not provide all of the information requested in this RFP may be eliminated from selection. Applicants may be contacted by AIDSNET staff for clarification of particular responses.

PROPOSAL COMPONENTS

Section I: Organizational Profile (Maximum 1 page)

Provide a brief history of the organization, including mission statement, date formed, length of existence, targeted population(s), services provided and major changes in the organization over the last 12 months. **Note: If your organization is currently funded by AIDSNET, you need only provide information regarding any major changes that have occurred over the last 12 months.**

Section II: Cultural Competency (Maximum 1 page)

Briefly describe your organization's capacity to provide services to a targeted population(s) while recognizing the role of culture in comprehensive and supportive care. Describe how clients' language, cultural, educational and religious barriers to accessing services will be minimized by your program. Cite specific examples relating to cultural sensitivities of people living with HIV (i.e. distrust, provider/medical community, gender inequalities and stereotyping). Please explain if any forms, brochures, medication instructions or other healthcare guidelines provided by your agency will be available in the language and reading level of the client, and be inclusive of gender identities and partner/family makeups. Also, discuss how increased cultural sensitivity will enable staff and board members who attend any cultural competency trainings to share information with the whole organization. **Note: If your organization is currently funded by AIDSNET, you do not have to include this section in your proposal.**

Section III: Personnel (No page limitation)

Please include the names and job titles of administrative and programmatic personnel who will be engaged in the providing of services. (See Appendix C for guidelines for standardized prevention job titles, education and experience.) Indicate where the personnel will be physically located during the time they are engaged in the work. Include each staff person's education and employment experience. Indicate the responsibilities each person will have in this project and how long each employee has been with the agency. Also, please include an organizational chart of the entire agency, **current resumes** (for non-vacant positions) and job descriptions. Resumes must include training and continuing education received throughout the year relating to their current job duties. In addition, please include a brief narrative describing how supervision of direct service staff will be conducted, and by which supervisor.

Section IV: Needs Assessment (Maximum 4 pages)

State in succinct terms that the applicant understands the problem being addressed in the response to this RFP. Identify specific problems and/or needs that you want to solve in the areas of client care and prevention through the services you are proposing. Include any needs assessments or surveys as addendums to the proposal document. Provide summarized needs data pertaining to this problem or service need. **Please cite the source of the data,** either in footnotes or endnotes. Applicable local data collected by the organization enhances the proposal. When using internal

statistics, applicants using percentages must parenthetically include the numerator and denominator. If an applicant is requesting funds for case management services, any caseloads quoted must consist of clients receiving Part B case management services. Any clients receiving Part C services and not being case managed cannot be counted in data describing the population to be served under this proposal. In order to be reimbursed by Part B funding, caseloads must be limited to clients who will be case managed and meet the PA-DOH standard of a face-to-face contact within the specified period of at least once every 6 months for Ryan White Recertification. In addition, clients should be seen by their MCM every 3 months, or more frequently for newly diagnosed clients, or as determined by client's level of need. If an applicant is requesting funds for prevention activities, internal statistics must be identified as duplicated or unduplicated clients. **Note: If your organization is currently funded by AIDSNET, you need only include any significant epidemiological changes from last year or any information on emerging populations that would change your previous needs assessment.**

*Section V: Description of Services to be Funded (Maximum 2 pages for **each** care service and prevention intervention)*

Please describe only the service(s) for which funding is being requested. The scope of the service description must include the following for each activity. If the organization is applying for funding for more than one activity, please discuss each of the points listed below for each activity before proceeding to the next activity.

- *Service Description* – The Service Description explains, in detail, the activities or events planned to achieve each stated objective. So that staff and Allocations Committee members reviewing the proposals may get a better sense of the services to be provided, please describe the activities in detailed, narrative form. Include as attachments any curriculum(s) used or, if extensive, a reasonable summary of the curriculum(s) that will provide the Allocations Committee with a sense of what the curriculum covers and accomplishes.
- *Goals* – Goals should describe the overall intent of the service. They do not necessarily need to be measurable.
- *Objectives* – Objectives should be outcome-based and should address the desired effect(s) of the service(s) provided. Include all care and prevention outcomes in this section. The objectives should be realistic, measurable and able to be evaluated. Outcome-based objectives will be required for all contracted services. As guidance, AIDSNET's outcome-based objectives for fiscal years 2017-2018 are included in this RFP as Appendix D for prevention outcomes and Appendix E for care services. The outcome-based objectives listed in Appendix D and E is intended to be minimum standards. Agencies are welcome to establish higher standards by including more rigorous or additional outcome-based objectives in the proposal. It is expected that the agencies' outcome-based objectives will at least address the components listed in Appendix D and E. Outcomes will be incorporated into contracts and must be reported on as follows: Care Performance Measures – bi-monthly via email to AIDSNET, Prevention Outcomes and additional care outcomes established by your agency – quarterly, and Quality Improvement Project Update – mid-year and year-end.

PERFORMANCE MEASURES FOR CARE SERVICES

The PA-DOH Part B Quality Management (QM) Committee adopted the HRSA Performance Measures (PM) designed and implemented for HRSA by the National Quality Center. Most of these measures are medically focused following the medical model of caring for people living with HIV. However, the Part B Committee adopted measures that are in line with the services they fund. The objectives for care services are meeting the national goals or the PA-Part B goals (when specified). Those PM that do not have goals will be reviewed and benchmarks will be established based on the statewide data received.

- **Care Program Objectives**
  - For a complete list of Performance Measures, including Medical CM, see Appendix E
  - List your program objectives and describe how they will address the needs or problems identified in your problem statement/assessment of need and the priorities established by AIDSNET.
  - Identify each group in the area you are proposing to serve and explain how that determination was made**.**
  - List at least one strategy related to serving each of the above-identified groups. Strategies should address specific actions and work plans that will be taken to reach identified target groups (including timelines, responsible staff and specific activities).

- **Prevention Program Objectives**
  - See Appendix D for Prevention Outcomes

- *Personnel* – Please provide the name(s) of the person(s) who will be providing the service.

- *Evaluation* – Describe how you are going to evaluate the effectiveness of the proposed services (both client care and prevention) in meeting the defined objectives. If your agency has developed an evaluation plan or evaluation tool(s), please attach as an appendix to this document. Evaluation should include effectiveness and outcomes.
  - Describe the agency's efforts at Quality Management to date (see previous Quality Management Specifics section). Attach your Quality Management Plan as an appendix to your proposal.
  - Please describe all efforts that have been aimed at measuring Consumer Satisfaction (including Housing Services) and cite examples of actions that have been taken to improve satisfaction.
  - Please include as an addendum any evaluation tool you have created and explain its use.

Section VI: Fiscal Forms

See Appendix F for fiscal forms to be completed and Appendix G for instructions.

HIV-RELATED CARE SERVICE DEFINITIONS
See Appendix A for detailed information

PREVENTION SERVICE DEFINITIONS
See Appendix A for detailed information

- With collaboration from PA CDC and HRSA project officers, the care and prevention committees merged into the HIV Planning Group. Its mission is to provide a forum for key stakeholders across the Commonwealth to formally provide input to the PA-DOH on issues related to HIV care, prevention, and testing in order to address goals of the National HIV/AIDS Strategy. AIDSNET is represented in this committee.
- The PA-DOH shall limit funding to those interventions identified in the April 10, 2015 Policy Guidance and/or interventions that have received prior written approval from the PA-DOH. See Appendix H for the 2015 Interim Policy Guidance on the Implementation of High Impact Prevention Activities document.
- Target populations must be identified by a risk factor. To state that you are targeting racial/ethnic minorities or youth is insufficient. Effective targeting and the matching of interventions require that you identify the risk behaviors (MSM, IDU, high-risk heterosexual).
- Acceptable target populations are identified in the 2015 Interim Policy Guidance on the Implementation of High Impact Prevention Activities document in Appendix H
- Prioritization of target populations must be evidence-based (determined by local HIV epidemiologic data).
- HIV *positive individuals remain the number one priority population for HIV prevention services*. Prevention interventions for persons living with HIV shall be prioritized for funding by the PA-DOH and its Regional Subrecipients.

I. Behavioral Interventions

Interventions Delivered to Individuals (IDI) – Health education and risk-reduction counseling provided to one individual at a time. IDI assists participants in making plans for individual behavior change and ongoing appraisals of their own behavior and includes skills building activities. These interventions also facilitate linkages to services in both clinic and community settings (e.g., substance abuse treatment settings) in support of behaviors and practices that prevent transmission of HIV, and they help clients make plans to obtain these services. It contains screening and recruitment protocols, consists of multiple sessions and the development of a documented Individual Prevention Plan (IPP) including planned participant objectives.

- Interventions Delivered to Groups (IDG) – Health education and risk-reduction counseling that shifts the delivery of service from the individual to groups of varying sizes. IDG uses peer and non-peer models involving a wide range of skills, information, education, and support**.** IDGs are structured interventions with screening procedures, curricula, documented learning objectives, the use of evaluation tools and referrals.

II. Public Health Strategies

As part of the Center for Disease Control and Prevention's High-Impact HIV Prevention Strategy, the PA-DOH has approved Anti-Retroviral Treatment and Access to Services (ARTAS) as a service eligible for prevention funding. ARTAS is an individual-level, multi-session, time-limited intervention with the goal of linking recently (6-12 months) 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 client to identify and use personal strengths; create goals for himself/herself; and establish an effective, working relationship with the Linkage Coordinator (LC). ARTAS can also be adapted for use in reengaging clients that are lost to care.

PRIORITIZATION OF SERVICES

Members of the AIDSNET Planning Committee communicated throughout March 2017 which resulted in the revised table below.

- The prioritization of Risk Behaviors for Prevention services table remained the same to reflect the PA-DOH Division of HIV prioritization, while acknowledging the high incidence of heterosexual transmission in the region due to intravenous drug use.

- The Prioritization of Care Services table was changed by adding the non-medical case management category separate from medical case management with treatment adherence.

Table 1: Prioritization of Risk Behaviors for Prevention Services
People with HIV
Men who have sex with men (MSM)
Intravenous drug users (IDUs)
High Risk Heterosexuals

Table 2: Prioritization of Care Services		
Public Health Issues: **Improving Health while Reducing Transmission**	**Access to Care/Poverty**	**Supportive**
Medical CM (focusing on linking to primary/specialty medical care) including Treatment Adherence (focusing on reducing viral load)	Non-Medical CM	Behavioral Health Services (Mental Health, Substance Abuse)
Oral Health	Health insurance/ Premium Cost Sharing Assistance	Legal
Ambulatory/Outpatient Medical Care	Housing Assistance	
	Emergency Financial Assistance	
	Medical Transportation	

APPENDIX A

Description of Eligible Services

APPENDIX A
DESCRIPTION OF ELIGIBLE SERVICES

CARE SERVICES
Funded by RW PART B:

Outpatient/Ambulatory Medical Care: The provision of professional diagnostic and therapeutic services rendered by a physician, physician's assistant, clinical nurse specialist, nurse practitioner, or other health care professional who is certified in their jurisdiction to prescribe ARV therapy in an outpatient setting. Settings include clinics, medical offices, and mobile vans where clients generally do not stay overnight. Emergency room services are not considered out-patient settings. Services include 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). Primary Medical Care for the Treatment of HIV Infection includes the provision of care that is consistent with the Public Health Service's guidelines. Such care must include access to antiretroviral and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination antiretroviral therapies.

Oral Health: Includes diagnostic, preventive, and therapeutic services provided by a dental health care professional licensed to provide health care in the state or jurisdiction, including general dental practioners, dental specialists, dental hygienists as well as licensed or training dental assistants (depending on the number of clients to be served and the anticipated cost, this service may also be negotiated through a letter of agreement).

Mental Health Services: Psychological and psychiatric treatment and counseling services for individuals with a diagnosed mental illness. These services are conducted in a group or individual setting, and provided by a mental health professional licensed or authorized within the State to render such services. This typically includes psychiatrists, psychologists, and licensed clinical social workers (This service is negotiated through a letter of agreement).

Medical Case Management Services (including Treatment Adherence): A range of client centered services that link clients with health care, psychosocial, and 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 appropriate levels of health and support services and continuity of care, through ongoing assessment of the client 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. Key activities include: (1) initial assessment of service needs, (2) development of a comprehensive, individualized service plan, (3) coordination of services required to implement the plan, (4) client monitoring to assess the efficacy of the plan, and (5) periodic re-evaluation and

adaptation of the plan as necessary over the life of the client. It includes client-specific advocacy and/or review of utilization of services.

Non-Medical Case Management Services: Includes the provision of advice and assistance in obtaining medical, social, community, legal, financial, and other needed services. Non-medical case management does not involve coordination and follow-up of medical treatments, as medical case management does.

Home and Community-based Health Services: Includes skilled health services furnished in the individual's home, based on a written plan of care established by a case management team that includes appropriate health care professionals. Services include: durable medical equipment; home health aide services and personal care services in the home; day treatment or other partial hospitalization services; home intravenous and aerosolized drug therapy (including prescription drugs administered as part of such therapy); routine diagnostics testing administered in the home; and appropriate menta1 health, developmental, and rehabilitation services (This service is negotiated through a letter of agreement).

Health Insurance Premium & Cost Sharing Assistance: The provision of financial assistance for eligible individuals living with HIV to maintain a continuity of health insurance or to receive medical benefits under a health insurance program. This includes premium payments, risk pools, co-payments, and deductibles.

Emergency Financial Assistance: The provision of one time or short term payments to agencies or the establishment of voucher programs when other resources are not available to help with emergency expenses related to essential utilities, housing – including hotel/motel vouchers (TBRA is funded by HOPWA), food (including groceries, food vouchers, and food stamps), transportation and medication.

Legal Services: The provision of services to individuals with respect to powers of attorney, do-not-resuscitate orders and interventions necessary to ensure access to eligible benefits, including discrimination or breach of confidentiality litigation as it relates to services eligible for funding under the Ryan White HIV Program. Legal Services do not include any legal services to arrange for guardianship or adoption of children after the death of their normal caregiver (This service is negotiated through a letter of agreement).

Medical Transportation Services: Include conveyance services provided, directly or through voucher, to a client so that he or she may access health care services. Medical transportation is classified as a support service and is used to provide transportation for eligible Ryan White HIV Program clients to core medical services and support services.

HOPWA is part of care services and it is required that all Program Subrecipients receiving case management funding apply for and offer HOPWA services to clients. Housing services are funded by HOPWA and/or Ryan White under Emergency Financial Assistance.

Housing Assistance:

There are several categories of assistance available through HOPWA funding. Below is a list of the categories funded by AIDSNET for the 2017-2018 grant year:

- Short-term rent, mortgage and utility payments to prevent the homelessness of the eligible tenant or mortgage holder living in a dwelling.
- Tenant-based rental assistance, including assistance for shared housing arrangements.
- Permanent Housing Placement for first-month's rent and/or security deposit.
- Supportive Services – Case Management.

PREVENTION SERVICES
Funded by STATE 656

See detailed fact sheets for each intervention at https://effectiveinterventions.cdc.gov/

ARTAS

Anti-Retroviral Treatment and Access to Services (ARTAS) is an individual-level, multi-session, time-limited intervention to link individuals who have been recently diagnosed with HIV to medical care. 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 case management model that encourages the client to identify and use personal strengths; create goals for himself/herself; and establish an effective, working relationship with the Linkage Coordinator (LC). ARTAS consists of up to five client sessions conducted over a 90-day period or until the client links to medical care – whichever comes first. ARTAS views the community as a resource for the client and client sessions are encouraged to take place outside the office or wherever the client feels most comfortable. Following the final client session, the client may be linked to a long-term/Ryan White case manager and/or another service delivery system to address his/her longer term barriers to remaining in care, such as substance use treatment, mental health services.

CLEAR

Choosing Life: Empowerment! Action! Results! (CLEAR) is an evidence-based, health promotion intervention for males and females ages 16 and older living with HIV/AIDS or at high-risk for HIV. CLEAR is a client-centered program delivered one-on-one using cognitive behavioral techniques to change behavior. The intervention provides clients with the skills necessary to be able to make healthy choices for their lives. The Centers for Disease Control and Prevention's (CDC's) guidelines on Comprehensive Risk Counseling and Services (CRCS), formerly known as Prevention Case Management (PCM), identify CLEAR as a structured intervention that may be integrated into CRCS programs.

Healthy Relationships

Healthy Relationships is a five-session, small-group intervention for men and women living with HIV/AIDS. It is based on Social Cognitive Theory and focuses on developing skills and building self-efficacy and positive expectations about new behaviors through modeling behaviors and practicing new skills. Decision-making and problem-solving skills are developed to enable participants to make informed and safe decisions about disclosure and behavior. The sessions create a context where people can interact, examine their risks, develop skills to reduce their risks, and receive feedback from others.

Partnership for Health – Safer Sex (PfH)

Partnership for Health (PfH) uses message framing, repetition, and reinforcement during patient visits to increase HIV positive patients' knowledge, skills, and motivations to practice safer sex. The program is designed to improve patient-provider communication about safer sex, disclosure of HIV serostatus, and HIV prevention. Implementation of PfH includes development of clinic and staff "buy-in" and training.

Personal Cognitive Counseling (PCC)

Personalized Cognitive Counseling (PCC) is an individual-level, single session counseling intervention designed to reduce unprotected anal intercourse (UAI) among men who have sex with men (MSM) who are repeat testers for HIV. PCC focuses on the person's self-justification (thoughts, attitudes and beliefs) he uses when deciding whether or not to engage in high-risk sexual behavior. PCC is a 30- to 50-minute intervention conducted as a component of Counseling, Testing, and Referral Service (CTRS) for MSM who meet the screening criteria. PCC is a five-step process. The counselor assists the client to: (1) recall a memorable episode of UAI; (2) complete the PCC Questionnaire – list of self-justifications to rationalize risky behavior; (3) discuss the episode and his thoughts/feelings; (4) identify the self-justifications that facilitated the episode; and (5) discuss what he will do in the future.

VOICES/VOCES

Video Opportunities for Innovative Condom Education & Safer Sex: A group-level, single-session video-based intervention designed to increase condom use among heterosexual African American and Latino men and women who visit STD clinics. Health educators convene groups of 4-8 clinic patients in a room that allows privacy for discussions. VOICES/VOCES is based on the theory of Reasoned Action, which explains how people's behaviors are guided by their attitudes, beliefs, and experiences as well as by how they believe others think they should act in a given circumstance. Groups are gender and ethnic specific, so that participants can develop prevention strategies appropriate for their culture. Information on HIV/STD risk behavior and condom use is delivered by viewing a culturally specific video. Skills in condom use and negotiation are modeled in the videos, then role-played and practiced by participants during the facilitated group discussion that follows. A poster board is used to present features of various condom brands in English and Spanish. At the end of the single, 45-minute session, participants are given samples of the types of condoms they have identified as best meeting their needs.

APPENDIX B

Checklist, Signature Page and Summary Sheet

APPENDIX B
PROPOSAL CHECKLIST

ORGANIZATION: _____

ATTACH THIS CHECKLIST TO THE FRONT OF THE ORIGINAL PROPOSAL.

SUBMIT AN ORIGINAL AND 5 COPIES OF THE FOLLOWING COMPONENTS IN THE ORDER LISTED. IF THERE ARE ANY COMPONENTS YOU WILL NOT BE SUBMITTING, PLEASE MARK N/A:

_____ Cover sheet with appropriate signatures *in blue ink on the original*

_____ Proposal Summary Sheet

_____ Organizational Profile

_____ Cultural Competency

_____ Personnel (Include agency organizational chart, current resumes and job descriptions)

_____ Needs Assessment

_____ Description of the service(s) to be funded. (Include in the description for each service: Service Description, Goals, Objectives, Prior Program Experience, Personnel and Evaluation)

_____ Form B-1, HIV Personnel Form

_____ Form B-2, Budget Form

_____ Form B-3, Narrative to Budget Form(s) (one for each service proposed)

_____ Quality Management Plan (QM)

_____ Any other documentation referenced in the proposal

In addition to the hard copies of fiscal forms B-1, B-2 and B-3, please submit them in Excel format via email to Kevin Westgate, Fiscal Officer, at aidsntkw@ptd.net

.

THIS APPLICATION MUST BE RECEIVED NO LATER THAN
3:00 P.M. MONDAY, APRIL 24, 2017

APPLICATION TO CONTRACT FOR AIDSNET FUNDED SERVICES

FISCAL YEAR 2017-2018

SUBMITTED BY: _____
Agency/Organization providing proposed Subgrant services

WE, THE UNDERSIGNED, SUBMIT THIS PROPOSAL FOR PROGRAM SUBRECIPIENT STATUS.

Board Representative _____
(Signature)

_____
(Print Name)

_____
(Title)

Agency Director _____
(Signature)

_____
(Print Name)

_____
(Title)

AIDSNET PROPOSAL SUMMARY SHEET
APPLICATION FOR PROGRAM SUBRECIPIENT STATUS, FISCAL YEAR 2017-2018

I. APPLICANT AGENCY/ORGANIZATION

AGENCY NAME: _____

STREET ADDRESS: _____

SUITE/FLOOR: _____

CITY: _____ STATE:_____ ZIP + 4 digits: _____

AGENCY TELEPHONE: _____ FAX: _____

CONTACT PERSON: _____ TITLE: _____

CONTACT PERSON E-MAIL ADDRESS: _____

CONTACT PERSON TELEPHONE: _____

GEOGRAPHIC AREA OF SERVICE: _____

EMPLOYER FEDERAL TAX ID NO.: * _____
*A 9-digit number that usually begins with 22 or 23

II. SERVICE CATEGORY

FOLLOWING ARE INCLUDED IN CONTRACTS FOR CARE SERVICES (FEE FOR SERVICE)

- Medical Case Management (includes treatment adherence)
- Non-Medical Case Management
- Health Insurance Premium & Cost Sharing Assistance
- Medical Transportation Services
- Outpatient/Ambulatory Medical Care
- Emergency Financial Assistance (includes prescriptions and Ryan White Housing Support)
- Tenant-Based Rental Assistance
- Short Term Rent Mortgage Utility
- Permanent Housing Placement
- Support Services (Housing Case Management)

PREVENTION INTERVENTIONS:
_____Interventions Delivered to Individuals (IDI)
_____Interventions Delivered to Groups (IDG)
_____ARTAS Public Health Strategy

_____ORAL HEALTH SERVICES

APPENDIX C

Prevention Job Titles, Education and Experience Guidelines

APPENDIX C
GUIDELINES FOR STANDARDIZED PREVENTION JOB TITLES, EDUCATION AND EXPERIENCE

Job Title*	Minimum Education	Other Minimum Qualifications
Prevention Services Manager	BS/BA degree in education or related field	Minimum: Experience in health related prevention education; supervisory and management experience; Additional: Strong organization skills; non-profit experience a plus; willingness to work with diverse populations; participate in mandatory trainings in HIV fundamentals and DOH C&T certification; effective communication skills and reliable transportation.
Prevention Education Specialist II	Bachelor's degree in public health, health education, social work, psychology, human service or related field; or comparable experience may be accepted	Willingness to work with diverse populations; certification or willingness to become certified in ARC HIV fundamentals & Prevention Instruction and CDC HIV Prevention Counselor; bi-lingual; reliable transportation.
Prevention Education Specialist I	Associates degree; related experience in community outreach or health/education related field or comparable experience may be accepted	Willingness to work with diverse populations; participate in mandatory trainings in HIV fundamentals and DOH C&T certification; bi-lingual; reliable transportation.
Prevention Educator	HS diploma or equivalent	Basic knowledge of HIV; experience in community outreach, health/education or related field desirable; willingness to work with diverse populations; take mandatory trainings in HIV fundamentals and DOH C&T certification; bi-lingual; reliable transportation.

*unless constricted by established institutional titles

APPENDIX D

Outcome-Based Objectives: Prevention

APPENDIX D

AIDSNET PREVENTION MINIMUM OBJECTIVES 2017-2018

ARTAS

- 60% of ARTAS participants will successfully link to medical care on or before the end of the 5th session or 90 days, whichever comes first. Successful linkage is defined as confirmed attendance at one appointment with an HIV health care provider. ***(Number of ARTAS participants linked to care over the total number of participants for this quarter)***
- 50% of ARTAS participants, who successfully link to medical care, will be retained in care, as defined by attending at least two appointments with an HIV health care provider within 12 months of completing the intervention. ***(Number of linked ARTAS participants that attended at least 2 appointments 12 months after the intervention over the total number of participants linked to care)***

CLEAR

- 50% of CLEAR participants will complete the five required core skill sessions and identify both a life goal and at least one prevention goal. ***(Number of CLEAR participants that "completed the core" over the total number of participants for this quarter)***
- 30% of CLEAR participants who identify a life goal and at least one prevention goal will complete all of the additional sessions under the corresponding domain. ***(Number of CLEAR participants that "completed the core" and additional domain sessions over the total number of participants who "completed the core" this quarter)***

Healthy Relationships (HR)

- 60% of HR participants will complete the entire intervention, as defined by attending a minimum of 4 of the 5 sessions in a Healthy Relationships cycle. One of these sessions must be session 2, as required by the intervention guidelines. ***(Number of HR participants that completed the group over the total number of group participants for this quarter)***
- 40% of HR participants who complete the intervention will report on an evaluation that the intervention helped them to feel more comfortable with disclosure. ***(Number of HR participants that completed the intervention and report that it helped over the total number of participants that completed the group for this quarter)***

Partnership for Health – Safer Sex (PfH)

- 100% of patients will be counseled to discuss safer sex with either the consequences or advantages frame messaging during the program year. ***(Number of patients that received PfH over the total number of patients seen this quarter)***
- 90% of patients who practice safer sex with one partner or are abstinent will continue to practice safer sex. ***(Number of PfH participants seen this quarter that reported continuing to practice safer sex over the total number of PfH participants seen this quarter that previously reported practicing safer sex)***

- 38% of patients with two or more partners will report a reduction in unprotected anal or vaginal sex and/or disclosure to partners. ***(Number of PfH participants seen this quarter that reported a reduction in unprotected anal or vaginal sex and/or disclosure to partners over the total number of PfH participants seen this quarter that previously reported unprotected sex/non-disclosure)***

Personal Cognitive Counseling (PCC)

- 30% of individuals screened and recruited for PCC will agree to participate in the intervention and complete the required questionnaire. ***(Number of PCC participants this quarter over the total number of individuals screened and recruited for this quarter)***
- 75% of PCC participants will identify at least one step to decrease high-risk behavior(s) and commit to a risk reduction strategy. ***(Number of PCC participants that identified a step and committed to a strategy over the total number of participants this quarter)***

VOICES/VOCES

- 75% of VOICES participants will, through the completion of a pre- and post-test, show that the intervention increased their knowledge. ***(Number of Voices participants this quarter that report increased knowledge over the total number of participants this quarter)***

APPENDIX E

Performance Measures – Care Outcomes

APPENDIX E

AIDSNET 2017-2018 Ryan White Part B Subrecipient Care Outcomes
(Performance Measures [PM] for Web Portal Reporting & Quality Management [QM] Measure)

PERFORMANCE MEASURE #1 (JHF2): MENTAL HEALTH HISTORY AND TREATMENT STATUS	
Service Category:	Case management (non-medical) and Medical case management
Definition:	Percentage of clients with HIV infection who received mental health history and treatment status
Numerator:	Number of HIV clients who have their mental health history and treatment status documented at least once during the measurement year
Denominator:	Number of clients who have at least one face-to-face case management visit during the measurement year
Patient Exclusions:	Patients who died or relocated, were discharged by a provider or were incarcerated during the measurement year
Data Sources	1. Client Files 2. CAREWare
National Goals, Targets, or Benchmarks For Comparison: None available at this time	
Rationale: Mental health problems can escalate quickly and significantly alter the lifestyle and health of a patient. Patients referred to mental health programs should be assessed within thirty days in order to address and alleviate the mental condition before related problems arise. Distressed or mentally unstable patients may be less likely to adhere to treatment plans and are at risk for poor judgment. Without counseling, patients are more likely to engage in risky sexual behaviors, are more likely to miss appointments, and are at risk for poor health related decisions. Suspected mental illnesses must be quickly addressed to ensure the patient is capable of properly caring for him/her and is not a danger to themselves or those around them.	

UNIVERSAL (ALL CM AGENCIES)

PERFORMANCE MEASURE #2 (JHF3): SUBSTANCE ABUSE HISTORY AND TREATMENT	
Service Category:	Case management (non-medical) and Medical case management
Definition:	Percentage of clients with HIV infection who have their substance abuse history and treatment status documented
Numerator:	Number of HIV clients who have their substance history and treatment status documented at least once during the measurement year
Denominator:	Number of clients who have at least one face-to-face case management visit during the measurement year
Patient Exclusions:	Patients who died or relocated, were discharged by a provider or were incarcerated during the measurement year
Data Sources:	1. Client Files 2. CAREWare
National Goals, Targets, or Benchmarks For Comparison: None available at this time	
Rationale: Substance abuse is a growing problem in HIV infected communities. Patients successfully completing substance abuse programs are in need of less acute medical care, have less frequent trips to emergency rooms, and are more likely to adhere to treatment plans and attend scheduled doctors' appointments. Patients able to maintain recovery are more socially, financially, and medically stable. Immune function and overall wellness is increased after a decrease in substance abuse and use. Successful programs teach patients the skills needed to maintain and identify triggers related to addiction, and patients are expected to incorporate learned behaviors into everyday life.	

APPENDIX E

AIDSNET 2017-2018 Ryan White Part B Subrecipient Care Outcomes
(Performance Measures [PM] for Web Portal Reporting & Quality Management [QM] Measure)

PERFORMANCE MEASURE #3 (JHF4): DOCUMENTATION OF RETENTION IN CARE	
Service Category:	Addressing Unmet Need
Definition:	Percentage of clients with HIV infection whose records indicate retention in care
Numerator:	Number of clients whose records indicate 1. CD4 count performed within the measurement year; OR 2. Viral load test administered within the measurement year; OR 3. ARV therapy prescribed or discussed with a medical provider within the measurement year
Denominator:	Number of HIV clients who have accessed services at least once during the measurement year
Patient Exclusions:	Patients who died or relocated, were discharged by a provider or were incarcerated during the measurement year
Data Sources:	1. Client Files 2. CAREWare
National Goals, Targets, or Benchmarks For Comparison: None available at this time	
Rationale: All agencies (both medical and supportive service providers) must obtain documentation of when the most recent CD4 and/or viral load tests were performed and/or when the most recent prescription for ARV therapy was issued and maintain it on file as evidence that their clients are participating in care. If a supportive service agency cannot obtain the documentation that confirms a client is participating in care, the supportive service agency cannot continue to provide supportive services for that client. Client self reporting is not acceptable; rather documentation should be obtained from medical providers Supportive services are designed to support a person's ability to participate in care. Obtaining documentation related to the timing of CD4 counts, viral load tests and prescriptions of ARV therapy is one way to insure that services are provided as intended, while reducing the level of unmet need within the system.	

APPENDIX E

AIDSNET 2017-2018 Ryan White Part B Subrecipient Care Outcomes
(Performance Measures [PM] for Web Portal Reporting & Quality Management [QM] Measure)

CLINICAL PM (AAO & ASC ONLY)

(These measures are linked to an Outpatient/Ambulatory visit)

PERFORMANCE MEASURE #4 (HAB01): TWO PRIMARY CARE VISITS>= 3MOS APART	
Service Category:	
Definition:	Percentage of clients with HIV infection who had two or more medical visits in an HIV care setting in the measurement year.
Numerator:	No. of HIV-infected clients who had a medical visit with a provider with prescribing privileges in an HIV care setting two or more times at least 3 months apart during the measurement year.
Denominator:	No. of HIV-infected clients who had a medical visit with a provider with prescribing privileges at least once in the measurement year.
Exclusions:	
Data Sources:	1. Client files 2. CAREWare
National Goals, Targets, or Benchmarks For Comparison: None available at this time	
Rationale:	

PERFORMANCE MEASURE #5 (HAB02): PERCENTAGE WITH >=2 CD4 COUNTS	
Service Category:	
Definition:	No. of HIV-infected clients who had at least one medical visit with a provider with prescribing privileges in the measurement year.
Numerator:	No. who had at least 2 CD4 counts at least 3 months apart.
Denominator:	No. of HIV-infected clients who had a medical visit with a provider with prescribing privileges at least once in the measurement year.
Exclusions:	
Data Sources:	3. Client files 4. CAREWare
National Goals, Targets, or Benchmarks For Comparison: None available at this time	
Rationale:	

APPENDIX E

AIDSNET 2017-2018 Ryan White Part B Subrecipient Care Outcomes
(Performance Measures [PM] for Web Portal Reporting & Quality Management [QM] Measure)

PERFORMANCE MEASURE #6 (HAB03): PCP PROPHYLAXIS	
Service Category:	Prevention of PCP
Definition:	Percentage of clients with HIV infection and a CD4 T-cell count below 200 cells/mm who were prescribed PCP prophylaxis
Numerator:	Number of HIV-infected clients with CD4 T-cell counts below 200 cells/mm who were prescribed PCP prophylaxis
Denominator:	Number of HIV-infected clients who: 1. Had a medical visit with a provider with prescribing privileges, i.e. MD, PA, NP at least once in the measurement year, and 2. Had a CD4 T-cell count below 200 cells/mm
Patient Exclusions:	1. Patients with CD4 T-cell counts below 200 cells/mm^3 repeated within 3 months rose above 200 cells/mm 2. Patients newly enrolled in care during last three months of the measurement year
Data Sources:	CAREWare
National Goals, Targets, or Benchmarks for Comparison: IHI Goal: 95%	
Rationale: Pneumocystis pneumonia (PCP) is the most common opportunistic infection in people with HIV. Without treatment, over 85% of people with HIV would eventually develop PCP. It is a major cause of mortality among persons with HIV infection, yet is almost entirely preventable and treatable. Measure reflects important aspect of care that significantly impacts survival and mortality.	

PERFORMANCE MEASURE #7 (HAB04): HAART	
Service Category	HIV Monitoring
Definition:	Percentage of clients with AIDS who are prescribed HAART
Numerator:	Number of clients with AIDS who were prescribed a HAART regimen
Denominator:	Number of clients who: 1. Have a diagnosis of AIDS (history of a CD4 T-cell count below 200 cells/mm or other AIDS-defining condition), and 2. Had at least one medical visit with a provider with prescribing privileges, i.e. MD, PA, and NP in the measurement year.
Patient Exclusions:	Patients newly enrolled in care during last three months of the measurement year
Data Sources:	CAREWare
National Goals, Targets, or Benchmarks for Comparison: IHI Goal: 90%	
Rationale: Randomized clinical trials provide strong evidence of improved survival and reduced disease progression by treating symptomatic patients and patients with CD4 T-cells <200 cells/mm. Measure reflects important aspect of care that significantly impacts survival, mortality and hinders transmission.	

APPENDIX E

AIDSNET 2017-2018 Ryan White Part B Subrecipient Care Outcomes
(Performance Measures [PM] for Web Portal Reporting & Quality Management [QM] Measure)

PERFORMANCE MEASURE #8 (HAB05): ARV THERAPY FOR PREGNANT WOMEN	
Service Category:	Prevention of Perinatal Transmission
Definition:	Percentage of pregnant women with HIV infection who are prescribed antiretroviral therapy
Numerator:	Number of HIV-infected pregnant women who were prescribed antiretroviral therapy during the 2nd and 3rd trimester
Denominator:	Number of HIV-infected pregnant women who had a medical visit with a provider with prescribing privileges, i.e. MD, PA, NP at least once in the measurement year
Patient Exclusions:	1. Patients whose pregnancy is terminated 2. Pregnant patients who are in the 1st trimester and newly enrolled in care during last three months of the measurement year
Data Sources:	CAREWare
National Goals, Targets, or Benchmarks for Comparison: None available at this time.	
Rationale: Treatment recommendations for pregnant women infected with HIV-1 have been based on the belief that therapies of known benefit to women should not be withheld during pregnancy unless there are known adverse effects on the mother, fetus, or infant and unless these adverse effects outweigh the benefit to the woman. Antiretroviral therapy can reduce Perinatal HIV-1 transmission by nearly 70%. Measure reflects important aspect of care that significantly impacts survival, mortality and hinders transmission.	

PERFORMANCE MEASURE #9 (JHF1): VIRAL LOAD TESTING	
Service Category:	HIV Monitoring
Definition:	Percentage of clients with HIV-infection who had a viral load test administered within 3 to 4 months of most recent medical visit
Numerator:	Number of HIV-infected clients who had a viral load test administered within 3 months of most recent medical visit
Denominator:	Number of HIV-infected clients who had a medical visit with a provider with prescribing privileges, i.e. MD, PA, NP, at least once in the measurement year
Exclusions:	Patients newly enrolled in care during last six months of the year
Data Sources:	5. Client files 6. CAREWare
National Goals, Targets, or Benchmarks For Comparison: None available at this time	
Rationale: A viral load test is ordered when a patient is first diagnosed with HIV. The test result functions as a baseline measurement that shows how actively the virus is reproducing and whether treatment is immediately necessary. If the viral load measurement is high, it indicates that HIV is reproducing and that the disease will likely progress faster than if the viral load is low. Change in viral load is also a very important measurement. A rising count indicates an infection that is getting worse, while a falling count indicates improvement and suppression of the HIV infection.	

APPENDIX E

AIDSNET 2017-2018 Ryan White Part B Subrecipient Care Outcomes

(Performance Measures [PM] for Web Portal Reporting & Quality Management [QM] Measure)

ORGANIZATIONAL (ALL CARE/PREVENTION PROVIDERS)

PERFORMANCE MEASURE #10: ORGANIZATIONAL ASSESSMENT		
Service Category:	Quality Infrastructure and Activities	
Definition:	A.1. Are appropriate resources committed to support the HIV quality program?	
	A.2. Does the HIV leadership support the HIV quality program?	
	A.3. Does the HIV quality program have a comprehensive quality plan?	
	B.1. Did the HIV program routinely measure the quality of care?	
	C.1. Did the HIV program conduct quality projects to improve the quality of care?	
	D.1. Is the staff routinely educated about quality?	
	E.1. Is a process in place to evaluate the HIV quality program?	
	F.1. Does the HIV program have an information system in place to track patient care and measure quality?	
Numerator:	None	
Denominator:	None	
Exclusions:	None	
Data Sources:	1. Quality Plan 2. Interviews with leadership, staff, medical providers 3. Organizational chart 4. QM Committee minutes 5. Other committee minutes 6. Data Reports	7. Team meeting minutes 8. Education logs 9. Training agendas and attendance records 10. Evaluation tools 11. Organizational documents, i.e., policies and procedure manuals, IT disaster recovery plans
National Goals, Targets, or Benchmarks For Comparison: None available at this time		

Rationale: A formal quality of care program that embraces quality improvement (QI) philosophy should be developed and implemented as part of the HIV service delivery program. An effective HIV quality management program includes the following components:

- Adequate resources
- Clear staff expectations related to quality
- Engagement of multidisciplinary team(s) and a QM Committee
- Commitment of leadership
- Quality management plan that is periodically reviewed and updated as needed
- Processes and systems in place to routinely collect and analyze data

The infrastructure of the quality program should be fully described in the quality plan, with a clear indication of responsibilities and accountability, and elaboration of processes for ongoing evaluation and assessment.

Performance measurement should include clearly defined indicators that address clinical, case management, and other services as prioritized by the program. A plan for follow-up of results should be outlined.

QI activities should be based on performance data results. Specific QM projects should be undertaken, which include action steps and a mechanism for integrating change into routine activities.

QI activities should be based on performance data results. Specific QI projects should be undertaken, which include action steps and a mechanism for integrating change into routine activities.

Staff should be actively involved in the HIV Quality Program and its QM activities. Participation in the quality program should be part of job expectations. Provisions should be made for ongoing education of staff about quality management.

APPENDIX F

Open Excel file included in email
to access Fiscal Forms B1, B2 and B3

APPENDIX G

Fiscal Forms Instructions

APPENDIX G

Instructions for 2017-2018 AIDSNET RFP Fiscal Forms

Complete one of each of the following forms:

B-1: HIV Personnel Form

B-2: Budget Form

Complete the following form for **each** service proposed:

B-3: Narrative to Budget Form

Record all amounts in whole dollars.

INSTRUCTIONS FOR COMPLETING FORMS

B-1: HIV Personnel Form

Column 1: List the position titles for all program staff, whether or not reimbursement for their line item is being sought.

Column 2: List the name of the employee in each position, list "vacant" for unfilled positions.

Column 3: List the amount budgeted for each position in the 2016-17 fiscal year. If it will be a new position during the 2017-18 fiscal year, list as "new" in column 3.

Column 4: List the amounts proposed for each position for fiscal year 2017-18.

Columns 5 – 8: List the direct cost portion of the total salary for each position proposed for each specific service in the 2017-18 fiscal year. In the column heading, list the name of the service. (If more than four services are proposed in this proposal, please add columns as needed.)

Note: The total of each of these columns must match the total budgeted salary reported on the Budget form for the corresponding service.

Columns 9: List the amount of the salary for each position that is agency indirect costs.

Columns 10: List the amount of each position's salary that is budgeted in programs not included in this RFP.

Note: The total of Columns 5 through 10 should always be equal to the amount in Column 4.

B-2: Budget Form

The purpose of this form is to report direct costs of providing the service proposed. Direct costs relate directly to the service. This includes salaries, benefits, travel and service-related training costs for employees who provide that service and supplies and materials used in the provision of the service. Expenses such as rent, telephone and postage can also be direct costs for some services if they can be directly and exclusively attributed to the provision of the service.

- List the care service or prevention intervention name on the top of each column. If more than four services are proposed, add additional columns as needed.
- Itemize direct cost expenses only in the appropriate row by service or intervention.
- The Salaries row must equal the total from the Personnel form.

B-3: Narrative to Budget Form

Prepare a Narrative to Budget Form for each service proposed.

The narrative is the line-by-line description of items listed in the budget form (B-2) for each service proposed. In the description column (Column 2), list the detail describing the nature of the expense proposed. For example, if benefits are a direct percentage of salaries, list the types of benefits provided plus the percentage used to calculate the total. In Column 3, record the budgeted amount as listed on the Budget Form (B-3).

In addition to the hard copies, please submit completed fiscal forms in Excel format via email to Kevin Westgate, Fiscal Officer, at aidsntkw@ptd.net

APPENDIX H

Policy Guidance on the Implementation of High Impact Prevention Activities

APPENDIX H

DATE: April 10, 2015

SUBJECT: Interim Policy Guidance on the Implementation of High Impact Prevention Activities

TO: County/Municipal Health Departments and Ryan White Part B Regional Grantees

FROM: Kenneth McGarvey, Director
Division of HIV/AIDS
Bureau of Communicable Diseases

Background Information:

In August 2010, the Department of Health (Department) distributed policy guidance on the implementation of evidence-based HIV prevention interventions (EBI), at which time grantees were informed that approved EBIs for implementation and funding through sub-grants included, but were not limited to interventions disseminated by the Center for Disease Control and Prevention's (CDC) Diffusion of Effective Behavioral Interventions (DEBI) Project.

The National HIV/AIDS Strategy, released by the White House in July 2010, called for a shift in the HIV prevention approach in order to maximize the impact of prevention efforts for those at greatest risk of HIV infection. In response, CDC and its partners are pursuing a High Impact Prevention (HIP) approach, which encourages the use of a combination of scientifically proven, cost-effective, and scalable interventions targeted to the right populations in the right geographic areas.

Since that time, CDC engaged in an exhaustive process to determine which of the interventions that were diffused as part of the DEBI Project provided the greatest benefit in the most cost-effective way. As a result, CDC selected a number of interventions that would continue to be supported as part of HIP, as well those that would not.

In addition to Behavioral Interventions, research has a led to a number of proven approaches to reduce the risk of HIV infection, which includes: Biomedical Interventions, Public Health Strategies, Structural Interventions and Social Marketing. More information about CDC's efforts in all of these key areas can be found at https://www.effectiveinterventions.org

Department Supported HIP Activities

The Department implements HIP activities both directly and through grants/contracts. This Guidance serves to communicate the interventions and strategies that have been selected for support by the Department in future contracts/grants (including sub-grants/sub-contracts) utilizing Federal CDC HIV Prevention and State funds, effective July 1, 2015 for Ryan White Part B Grantees, and January 1, 2016 for County/Municipal Health Departments. It also serves to replace the August 2010 "Policy Guidance on the Implementation of Evidence-Based HIV Prevention Interventions; Priority Populations; and Incentives."

County/Municipal Health Departments (CMHD), excluding Philadelphia – CDC and State Funding

The Department requires the CMHDs to implement the following HIP activities:

- HIV Testing
  - Routine HIV Testing in STD Clinics (stand-alone HIV testing clinics will no longer be supported)
- Comprehensive Prevention with Positives
  - Partner Services (PS) for newly identified HIV positive individuals (includes testing of partners)
  - Ongoing PS for previously diagnosed HIV positive individuals in cases where:
    - persons previously diagnosed are named as partners in the course of conducting PS with other index patients. These persons shall be interviewed to assess behavioral risk, provided partner services, and referred for prevention interventions, when indicated; and/or,
    - there is evidence of ongoing risk behavior among persons previously diagnosed with HIV (such as a new STD or injection drug use).
  - Coordination and collaboration with Ryan White Part B and C Grantees to ensure successful referral and linkage to HIV care, treatment, prevention services, and other medical and social services as needed, for persons testing HIV-positive or currently living with HIV/AIDS
- Integrated HIV Surveillance and HIV Prevention Activities – investigative activities to gather information:
  - to assist the Bureau of Epidemiology, HIV Surveillance Unit to document and complete HIV case reports; and,
  - to provide prevention/intervention activities to identified clients.

Ryan White Part B Grantees – State Funding

The Department requires that each Ryan White Part B Grantee shall implement and/or coordinate:

- Linkage coordination to ensure HIV positive individuals are engaged into HIV care, treatment, prevention, and other medical and social services. The Department's required intervention for linkage coordination is ARTAS.
- Medical case management services that include navigation services.

- Activities/strategies for HIV positive individuals who have fallen out of care in order to re-engage them into care. **Specific activities/strategies must receive prior written approval from the Department.**

The Department will support the following recommended HIP activities for:

- People Living with HIV (PLWH)
    - Healthy Relationships
    - Partnership for Health-Safer Sex
    - Strategies/Interventions from CDC's Compendium of Effective Behavioral Interventions (Compendium). These may be adapted for use with populations other than those for which they were originally intended (e.g. MSM or transgender persons). **Must receive prior written approval from Department.**
- Prevention for populations at high risk, with unknown HIV status (as identified by local HIV/AIDS epidemiologic data) with identified unmet HIV Prevention needs. Priority shall be given to strategies/interventions targeting African-American men who have sex with men (MSM).
    - Strategies/Interventions from CDC's Compendium of Effective Behavioral Interventions (Compendium). These may be adapted for use with populations other than those for which they were originally intended (e.g. MSM or transgender persons). **Must receive prior written approval from Department.**
    - Other Strategies/Interventions with evidence of effectiveness will be considered on a case-by-case basis. **Must receive prior written approval from Department.**

As indicated above, prior written approval from the Department is necessary for Ryan White Part B Grantees that request to implement certain activities, strategies, and interventions. For those requests to be considered, the following information (at a minimum) must be provided to your assigned project officer**:

- The identified activity/intervention/strategy (include explanation of adaptation, if applicable).
- The target population to be served.
- A brief summary of how you determined the need for this intervention to include:
    - Identified geographic area to be served (zip code, or set of zip codes).
    - How/what epi data was utilized to determine the target population.
    - Why this specific intervention was selected.
- Anticipated annual budget for the intervention.
- The selected provider, including:
    - Current capacity of provider to implement the intervention
    - Anticipated capacity building and/or training needs identified
- Implementation Plan, and Monitoring & Evaluation Key Activities (must include smart objectives, including number of clients to be served) - Templates for most interventions are available at https://effectiveinterventions.cdc.gov

**A response from the Department for each request will be provided within two weeks of receipt.

Key Points for the selection/implementation of HIP activities:

- **Condom Distribution must be incorporated into all activities/interventions.** Condoms are available at no cost, from the Department.
- When selecting a recommended HIP activity, please ensure that your agency has the appropriate capacity to deliver the strategies and interventions with fidelity (in a way that adheres to the procedures and content that determined its effectiveness). For example:
    - Agency budgets should take into consideration all necessary costs associated with implementing an intervention, such as travel costs for staff to attend training, training and implementation materials, etc.
    - In addition to the trainings specific to each strategy/intervention, please consider that some basic courses such as HIV/AIDS 101 and Cultural Competency are also a critical foundation for the successful implementation of any HIP activity.
    - The Department is committed to providing the necessary tools to facilitate the successful implementation of HIP activities. Please direct all requests for training/technical/capacity building assistance to Department's HIV Training Program Administrator Marijane Salem-Noll at: masalemnol@pa.gov or 717-783-0572.

  When implementing a strategy/intervention, a target population must be specifically identified, and be supported by local epidemiologic data. Please refer to the Department's Integrated Epidemiologic Profile of HIV/AIDS In Pennsylvania, which can be found at:
  http://www.health.pa.gov/My%20Health/Diseases%20and%20Conditions/E-H/HIV%20And%20AIDS%20Epidemiology/Documents/Epi-Profile-of-HIV-in-PA-2012-2013-1stEd-F.pdf
- When using incentives to enhance recruitment/retention into HIP activities, you must adhere to the following requirements;
    - Obtain prior written approval from the Department (detailed documentation of incentives in a Department approved budget constitutes prior written approval)
    - Develop/maintain a written procedure for use of incentives to include:
        - Clear guidelines for when and to whom incentives are to be provided, and under what circumstances
        - A tracking mechanism for the purchase/distribution of incentives
        - Responsible parties for the purchase, handling and distribution of incentives, including security protocols.
    - The use of incentives that violate state or federal law is prohibited, including the purchase of alcohol.
    - Direct cash payments to recipients of services are prohibited.
    - Some examples of acceptable incentives includes but are not limited to:
        - Gift cards, bus tokens, certificates of appreciation, food and refreshments (non-alcoholic), clothing items, toiletries, etc.
    - Incentives may be provided to individuals on a one-time or periodic basis to encourage participation; however the value of each incentive must be reasonable and must not exceed a maximum of $50.00. No Grantee or employee of the Grantee is eligible to receive an incentive.

This updated Guidance reflects some of the changes being made within the Department's HIV Program, to ensure the greatest impact for the clients we serve throughout the continuum of HIV Prevention and Care.

Please note that other than that which is listed above, HIV testing shall not be implemented through CMHD HIV Prevention, or Ryan White Part B Grants. Department-supported HIV testing, other than that which is listed above will be implemented through a variety of direct agreements with the Department (e.g. fee-for-service, letters of agreement) and will be engaged/supported based on a variety of factors, including but not limited to: an identified need for testing in the geographic area; epidemiologic data; a testing provider's ability to reach persons/populations at high risk for HIV; past performance (if applicable); and the recommendation/support of the local health department (if applicable). Additionally, monitoring and evaluation of testing sites in a CMHD jurisdiction would be done in collaboration with the CMHD. If you or an agency in your jurisdiction has: identified unmet HIV testing needs; identified organizations that can provide targeted HIV testing to high risk population; or, questions regarding the implementation of HIV testing, please contact the Department's HIV Testing Program Administrator Jonathan Steiner at: jsteiner@pa.gov or 717-783-0572.

If you have questions regarding this Guidance, please direct them to your Project Officer or to the Department's HIV Prevention Program Manager, Jill Garland at jigarland@pa.gov or 717-547-3425. Thank you for your support.

APPENDIX I

Integrated Epidemiologic Profile of HIV/AIDS
in Pennsylvania – 2012-2013
(See Adobe pdf available at http://www.aidsnetpa.org/resources-for-grantees.php)

APPENDIX J

Supplements to the Integrated Epidemiologic Profile of
HIV/AIDS in Pennsylvania – February 2015
(See Adobe pdf available at http://www.aidsnetpa.org/resources-for-grantees.php)

APPENDIX K

Annual HIV Surveillance Summary Report
(See Adobe pdf available at http://www.aidsnetpa.org/resources-for-grantees.php)