GREATER HAMPTON ROADS HIV HEALTH SERVICES PLANNING COUNCIL

Thursday, August 19, 2021

DAY 1

Priority Setting and Resource Allocation (PSRA) Training and Workshop

Documents Included:

1. Agenda
2. Ryan White Glossary of Terms
3. Ending the HIV Epidemic, a Plan for the United States Snapshot
4. HRSA 22-018 Notice of Funding Opportunity (NOFO) PowerPoint
5. Policy Clarification Notice (PCN) 16-02
6. 2021/22 Notice of Award (NOA)
7. 2021/22 Grant Score
8. PSRA Training PowerPoint
9. 20/21 Attachment 5: Coordination of Services and Funding Streams
10. 2020 End of Year Report
11. 2020 Service Utilization
12. PSRA Procedures
13. PSRA Forms

GREATER HAMPTON ROADS HIV HEALTH SERVICES PLANNING COUNCIL

AGENDA

2022-2023 Priority Setting and Resource Allocations
Mandatory Data Training and Workshop
Thursday, August 19, 2021
ZOOM TELECONFERENCING
9:00a.m. – 12:00p.m

To Join Via Computer/Tablet/Smart Phone:

https://us02web.zoom.us/meeting/register/tZYsdOygrzMsH9zVtMxchx3J_O98EUO0zzO-

I. Welcome by the Chair.

II. Moment of Silence.

III. Roll Call of Members, Introduction of Guests, and Statement of Conflicts of Interest.

IV. Public Comment.
Members of the public (Non-Planning Council members) the opportunity to address the Planning Council and its Membership with issues related to the Council's legislative mandates. Members of the Planning Council cannot propose, discuss, deliberate, or take action on any matter voiced during this time.

V. Priority Setting and Resource Allocations (PSRA) Training and Data Review.
Planning Council members will participate in a mandatory PSRA training and review data used in the PSRA meeting.

VI. PSRA Procedure
Planning Council members will review the PSRA procedure.

VII. Data Training Wrap Up

VIII. Public Comment
Members of the public (Non-Planning Council members) the opportunity to address the Planning Council and its Membership with issues related to the Council's legislative mandates. Members of the Planning Council cannot propose, discuss, deliberate, or take action on any matter voiced during this time.

IX. Next Meeting – Thursday, August 26, 2021, 9:00am – 12:00noon

X. Adjournment

Anyone desiring supporting documentation or additional information is invited to call Deryk Jackson, Planning Council Support Staff at (888) 571-0001 x107 or via email at deryk@collaborativeresearch.us.

Upcoming Greater Hampton Roads Planning Council Meetings:

- **SPECIAL PRIORITY SETTING AND RESOURCE ALLOCATION MEETING – Thursday, August 26th, 9:00am**
- Community Access Committee – Wednesday, September 8th, 6:00pm – 7:00pm
- Quality Improvement and Strategic Planning Committee – Tuesday, September 21st, 4:00pm – 5:30pm
- Priorities, Allocations, and Policies Committee – Thursday, September 30th, 3:00pm – 3:30pm
- Executive/Membership & Nominations Committee – Thursday, September 30th, 3:30pm – 5:00pm
- Planning Council – Thursday, September 30th, 5:00pm – 6:30pm

RYAN WHITE HIV/AIDS PROGRAM GLOSSARY OF TERMS

Below are terms used most frequently in HRSA's Ryan White HIV/AIDS Program (RWHAP).

Administrative or Fiscal Agent
Entity that functions to assist the Ryan White HIV/AIDS Program recipient or planning body in carrying out administrative activities (e.g., disbursing program funds, developing reimbursement and accounting systems, developing funding announcements, monitoring contracts).

Affordable Care Act (ACA)
Federal law comprised of expanded health insurance coverage and health care delivery innovations designed to achieve better health outcomes by increasing the number of insured Americans, reducing care costs, and improving the overall American health care system. Enacted in 2010 as the Patient Protection and Affordable Care Act.

Agency for Healthcare Research and Quality (AHRQ) (link is external)
Federal agency within HHS that supports research designed to improve the outcomes and quality of health care, reduce its costs, address patient safety and medical errors, and broaden access to effective services.

AIDS Drug Assistance Program (ADAP) (link is external)
Administered by States and authorized under Part B of the Ryan White HIV/AIDS Treatment Extension Act. Provides FDA-approved medications to low-income individuals with HIV disease who have limited or no coverage from private insurance or Medicaid. ADAP funds may also be used to purchase insurance for uninsured Ryan White HIV/AIDS Program clients as long as the insurance costs do not exceed the cost of drugs through ADAP and the drugs available through the insurance program at least match those offered through ADAP.

ADAP Data Report (ADR)
Reporting requirement for ADAPs to provide client-level data on individuals served, services being delivered, and costs associated with these services.

AIDS
Acquired Immune Deficiency Syndrome. A disease caused by the human immunodeficiency virus (HIV).

AIDS Education and Training Center (AETC) (link is external)
Regional centers providing education and training for primary care professionals and other AIDS-related personnel. AETCs are authorized under Part F of the Ryan White HIV/AIDS Program.

AIDS Service Organization (ASO)
An organization that provides primary medical care and/or support services to populations infected with and affected by HIV disease.

Annual Gross Income
A measure of income. There are several ways to measure an individual’s Annual Gross Income. For example, these forms of income could be used by the provider for the purposes of imposition of charges:

- Gross Income: the total amount of income earned from all sources during the calendar year before taxes.
- Adjusted Gross Income: gross income less deductions.

Antiretroviral Therapy
An aggressive anti-HIV treatment including a combination of three or more drugs with activity against HIV that is designed to reduce viral load to undetectable levels.

Applicable Services
Any RWHAP service with a distinct fee typically charged in the local market. In the broader healthcare community this distinct fee is often referred to as a usual, customary, and reasonable (UCR) fee.

Cap on Charges
The limitation on aggregate charges imposed during the calendar year based on patient's annual gross income. All fees must be waived once a RWHAP patient reaches their cap for that calendar year.

Capacity
Core competencies that substantially contribute to an organization's ability to deliver effective HIV/AIDS primary medical care and health-related support services. Capacity development activities should increase access to the HIV/AIDS service system and reduce disparities in care among underserved people living with HIV (PLWH) in the EMA.

CARE Act (Ryan White Comprehensive AIDS Resources Emergency Act)
Now referred to as the Ryan White HIV/AIDS Program, this was the name of the original federal legislation (link is external) created to address the unmet health care and service needs of people living with HIV Disease (PLWH) disease and their families. The legislation was enacted in 1990 and reauthorized in 1996 and 2000. The legislation was subsequently reauthorized as the Ryan White HIV/AIDS Treatment Modernization Act of 2006 and later as the Ryan White HIV/AIDS Treatment Extension Act of 2009.

CDC/HRSA Advisory Committee on HIV, Viral Hepatitis and STD Prevention and Treatment
This advisory committee, often referred to as the CHAC, advises the Secretary, HHS; the Director, CDC; and the Administrator, HRSA, regarding objectives, strategies, policies, and priorities for HIV, Viral Hepatitis, and STD prevention and treatment efforts.

Centers for Disease Control and Prevention (CDC) (link is external)
Federal agency within HHS that administers disease prevention programs including HIV/AIDS prevention.

Centers for Medicare and Medicaid Services (CMS) (link is external)
Federal agency within HHS that administers the Medicaid, Medicare, the Children's Health Insurance Program (CHIP) and the Health Insurance Marketplace.

Chief Elected Official (CEO)
The official recipient of Part A or Part B Ryan White HIV/AIDS Program funds. For Part A, this is usually a city mayor, county executive, or chair of the county board of supervisors. For Part B, this is usually the governor. The CEO is ultimately responsible for administering all aspects of their Part's RWHAP Act funds and ensuring that all legal requirements are met.

Client Level Data (CLD)
Information collected on each client eligible for and receiving RWHAP core medical services or support services. The data elements reported per client are determined by the specific RWHAP services that the agency is funded to provide.

Community-based Organization (CBO)
An organization that provides services to locally defined populations, which may or may not include populations infected with or affected by HIV disease.

Community Based Dental Partnership Program (CBDPP)
A program under the Ryan White HIV/AIDS Program (Part F) that delivers HIV/AIDS dental care while simultaneously training dental professionals in these areas in order to expand community capacity to deliver HIV oral health care.

Community Forum or Public Meeting
A small-group method of collecting information from community members in which a community meeting is used to provide a directed but highly interactive discussion. Similar to but less formal than a focus group, it usually includes a larger group; participants are often self-selected (i.e., not randomly selected to attend).

Co-morbidity
A disease or condition, such as hepatitis, mental illness or substance abuse, co-existing with HIV disease.

Comprehensive Planning
The process of determining the organization and delivery of HIV services. This strategy is used by planning bodies to improve decision-making about services and maintain a continuum of care for PLWH.

Community Health Centers
See Health Centers.

Consortium/HIV Care Consortium
A regional or statewide planning entity established by many State recipient under Part B of the Ryan White HIV/AIDS Program to plan and sometimes administer Part B services. An association of health care and support service agencies serving PLWHA under Part B.

Continuous Quality Improvement
An ongoing process that involves organization members in monitoring and evaluating programs to continuously improve service delivery. CQI seeks to prevent problems and to maximize the quality of care by identifying opportunities for improvement.

Continuum of Care (link is external)
The extent to which a person living with HIV disease is engaged in HIV/AIDS care and is realizing the full advantages of care and treatment—from initial diagnosis and engagement in care to full viral suppression. Generally referred to as the HIV Care Continuum.

Core Medical Services
Essential, direct, health care services for HIV/AIDS care specified in the Ryan White legislation. Recipient/subrecipient expenditures are limited to core medical services, support services, and administrative expenses.

Cultural Competence
The knowledge, understanding, and skills to work effectively with individuals from differing cultural backgrounds.

Data Terms
For definitions of terms, see data dictionaries for the Ryan White Services Report (RSR) (link is external) and the ADAP Data Report (ADR) (link is external).

Documentation
Papers and documents required from clients, as defined by the recipient, in order to assure all RWHAP statutory requirements are met.

Early Intervention Services (EIS)
Activities designed to identify individuals who are HIV-positive and get them into care as quickly as possible. As funded through Parts A and B of the Ryan White HIV/AIDS Program, includes outreach, counseling and testing, information and referral services. Under Part C Ryan White HIV/AIDS Program, also includes comprehensive primary medical care for individuals living with HIV/AIDS.

Eligible Metropolitan Area (EMA)
Geographic areas highly-impacted by HIV/AIDS that are eligible to receive Ryan White HIV/AIDS Program Part A funds To be an eligible EMA, an area must have reported more than 2,000 AIDS cases in the most recent 5 years and have a population of at least 50,000. See also Transitional Grant Area, TGA.

Eligible Scope
A method of data collection based on a client's ability to receive federally funded RWHAP services using established recipient criteria.

Epidemiologic Profile
A description of the current status, distribution, and impact of an infectious disease or other health-related condition in a specified geographic area. Specific to HIV planning, a description of the burden of HIV in the population of an area in terms of socio-demographic, geographic, behavioral, and clinical characteristics of persons newly diagnosed with HIV, PLWH, and persons at higher risk for infection.

Epidemiology
The branch of medical science that studies the incidence, distribution, and control of disease in a population.

Ending the HIV Epidemic (EHE)
Ending the HIV Epidemic in the U.S. (EHE) is a bold plan announced in 2019 that aims to end the HIV epidemic in the United States by 2030.

Family-Centered Care
A model in which systems of care under Ryan White Part D are designed to address the needs of PLWHA and affected family members as a unit, providing or arranging for a full range of services. Family structures may range from the traditional, biological family unit to non-traditional family units with partners, significant others, and unrelated caregivers.

Federal Poverty Level (FPL)
A measure of income issued every year by HHS. Federal poverty levels are commonly used to determine eligibility for certain programs and benefits such as Medicaid, Food Stamps, the Children's Health Insurance Program (CHIP), and RWHAP.

Fee-for-Service
The method of billing for health services whereby a physician or other health service provider charges the payer (whether it be the patient or his or her health insurance plan) separately for each patient encounter or service rendered.

Fee Schedule
A complete listing of billable services, those with UCR fees, and their associated fees based on locally prevailing rates or charges. A fee schedule is used by healthcare providers to identify which services they bill for and for how much. A fee schedule is not a schedule of charges. A fee schedule is not required by the RWHAP legislation, but it may be useful as the basis for a schedule of charges. Having one in place is considered a best practice and, for those multi-funded clinics, is a requirement for HRSA Bureau of Primary Health Care (BPHC) grant recipients.

Financial Status Report (FSR - Form 269)
A report that is required to be submitted within 90 days after the end of the budget period that serves as documentation of the financial status of grants according to the official accounting records of the recipient organization.

Food and Drug Administration (FDA) (link is external)
Federal agency within HHS responsible for ensuring the safety and effectiveness of drugs, biologics, vaccines, and medical devices used (among others) in the diagnosis, treatment, and prevention of HIV infection, AIDS, and AIDS-related opportunistic infections. The FDA also works with the blood banking industry to safeguard the nation's blood supply.

Grantee Contract Management System
An electronic data system that RWHAP recipients use to manage their subrecipient contracts.

Health Centers (link is external)

Community-based and patient-directed organizations funded by HRSA that serve populations with limited access to health care. These include low income populations, the uninsured, those with limited English proficiency, migrant and seasonal farmworkers, individuals and families experiencing homelessness, and those living in public housing.

Health Resources and Services Administration (HRSA) (link is external)
The agency of the U.S. Department of Health and Human Services that administers various primary care programs for the medically underserved, including the Ryan White HIV/AIDS Program.

HRSA HIV/AIDS Bureau (HAB) (link is external)
The bureau within HRSA of the U.S. Department of Health and Human Services (HHS) that is responsible for administering the Ryan White HIV/AIDS Program. See the HRSA HAB Program Administration fact sheet (link is external).

HIV Care Continuum
The stages of HIV care, from initial diagnosis to achieving the goal of viral suppression. The effectiveness of HIV testing and care in a given jurisdiction is typically depicted as the proportion of individuals living with HIV who are engaged at each stage.

HIV Disease
Any signs, symptoms, or other adverse health effects due to the human immunodeficiency virus.

HIV-related Charges
Those charges a RWHAP recipient imposes on the patient plus any other out of-pocket charges related to their HIV care (as determined by their provider) that a patient incurs and reports to their RWHAP recipient/provider. These charges can be from any provider as long as the service is a RWHAP allowable service.

Housing Opportunities for People With AIDS (HOPWA) (link is external)
A program administered by the U.S. Department of Housing and Urban Development (HUD) that provides funding to support housing for PLWHA and their families.

HUD (U.S. Department of Housing and Urban Development) (link is external)
The Federal agency responsible for administering community development, affordable housing, and other programs including Housing Opportunities for People with AIDS (HOPWA).

Imposition of Charges
All activities, policies, and procedures related to assessing RWHAP patient charges as outlined in legislation.

Incidence
The number of new cases of a disease that occur during a specified time period.

Incidence Rate
The number of new cases of a disease or condition that occur in a defined population during a specified time period, often expressed per 100,000 persons. AIDS incidence rates are often expressed this way.

Intergovernmental Agreement (IGA)
A written agreement between a governmental agency and an outside agency that provides services.

Lead Agency
The agency within a Part B consortium that is responsible for contract administration; also called a fiscal agent (an incorporated consortium sometimes serves as the lead agency).

Medicaid Spend-down
A process whereby an individual who meets the Medicaid medical eligibility criteria, but has income that exceeds the financial eligibility ceiling, may "spend down" to eligibility level. The individual accomplishes spend-down by deducting

accrued medically related expenses from countable income. Most State Medicaid programs offer an optional category of eligibility, the "medically needy" eligibility category, for these individuals.

Minority AIDS Initiative (MAI)
A national HHS initiative that provides special resources to reduce the spread of HIV/AIDS and improve health outcomes for people living with HIV/AIDS within communities of color. Enacted to address the disproportionate impact of the disease in such communities. Formerly referred to as the Congressional Black Caucus Initiative because of that body's leadership in its development.

Multiply Diagnosed
A person having multiple morbidities (e.g., hepatitis and HIV, substance abuse and HIV infection) (see co-morbidity).

Needs Assessment
A process of collecting information about the needs of PLWH (both those receiving care and those not in care), identifying current resources (Ryan White HIV/AIDS Program and other) available to meet those needs, and determining what gaps in care exist.

Nominal Charge
A fee greater than zero.

Notice of Funding Opportunity (NOFO)
An open and competitive process for selecting providers of services.

Office of Management and Budget (OMB)
The office within the executive branch of the Federal government that prepares the President's annual budget, develops the Federal government's fiscal program, oversees administration of the budget, and reviews government regulations.

Opportunistic Infection
An infection or cancer that occurs in people with weak immune systems due to HIV, cancer, or immunosuppressive drugs such as corticosteroids or chemotherapy. Kaposi’s sarcoma, Pneumocystis jiroveci pneumonia, toxoplasmosis, and cytomegalovirus are all examples of such infections.

Patient Assistance Programs (PAPs)
Programs operated by pharmaceutical companies and foundations that provide medicines at little or no cost to eligible patients.

Part A
The part of the Ryan White HIV/AIDS Program that provides emergency assistance to localities disproportionately affected by the HIV/AIDS epidemic.

Part B
The part of the Ryan White HIV/AIDS Program that provides funds to States and territories for primary health care (including HIV treatments through the AIDS Drug Assistance Program, ADAP) and support services that enhance access to care to PLWHA and their families.

Part C
The part of the Ryan White HIV/AIDS Program that supports outpatient primary medical care and early intervention services (EIS) to PLWH through grants to public and private non-profit organizations. Part C also funds planning grants to prepare programs to provide EIS services.

Part D

The part of the Ryan White HIV/AIDS Program that supports family-centered, comprehensive care to women, infants, children, and youth living with HIV.

Part F: AIDS Education and Training Centers (AETC)
National and regional centers providing education and training for primary care professionals and other AIDS-related personnel.

Part F: Dental Programs
The part of the Ryan White HIV/AIDS Program that provides additional funding for oral health care for people with HIV through the HIV/AIDS Dental Reimbursement Program and the Community-Based Dental Partnership Program.

Part F: SPNS: Special Projects of National Significance
The part of the Ryan White HIV/AIDS Program that funds demonstration and evaluation of innovative models of care delivery for hard-to-reach populations.

Part F: Minority AIDS Initiative
The Minority AIDS Initiative provides funding to evaluate and address the impact of HIV/AIDS on disproportionately affected minority populations.

People Living with HIV (PLWH)
Descriptive term for persons living with HIV disease.

Planning Council/Planning Body
There are various types of planning groups. For Part A of the RWHAP, a planning council is a body appointed or established by the Chief Elected Official with responsibility to assess needs, establish a plan for the delivery of HIV care in the area, and establish priorities for the use of Part A funds. Part B planning bodies conduct similar tasks but do not establish service dollar allocations. In addition, jurisdictions directly funded by CDC are responsible for convening planning bodies to address HIV prevention, care and treatment issues. Many jurisdictions facilitate collaboration through joint care/prevention planning bodies and/or shared planning tasks.

Planning Process
Steps taken and methods used to collect information, analyze and interpret it, set priorities, and prepare a plan for rational decision making.

PrEP
Pre-exposure prophylaxis is a prevention method for people at higher risk for HIV exposure and involves taking an antiretroviral pill every day to greatly reduce, if not eliminate, the risk of becoming infected with HIV if exposed to the virus.

Prevalence
The total number of persons in a defined population living with a specific disease or condition at a given time (compared to incidence, which is the number of new cases).

Prevalence Rate
The proportion of a population living at a given time with a condition or disease (compared to the incidence rate, which refers to new cases).

Primary Health Care Service
Any preventive, diagnostic, or therapeutic health service received on an outpatient basis by a client living with HIV. Examples include medical, subspecialty care, dental, nutrition, mental health, or substance use disorder treatment services; medical case management; pharmacy services; radiology, laboratory, and other tests used for diagnosis and treatment planning; and counseling and testing.

Priority Setting
The process used to establish priorities among service categories, to ensure consistency with locally identified needs, and to address how best to meet each priority.

Prophylaxis
Treatment to prevent the onset of a particular disease (primary prophylaxis) or recurrence of symptoms in an existing infection that has previously been brought under control (secondary prophylaxis).

Provider (or service provider)
The agency that provides direct services to clients (and their families) or the recipient. A provider may receive funds as a recipient (such as under RWHAP Parts C and D) or through a contractual relationship with a recipient funded directly by RWHAP. Also see subrecipient.

Quality
The degree to which a health or social service meets or exceeds established professional standards and user expectations.

Quality Assurance (QA)
The process of identifying problems in service delivery, designing activities to overcome these problems, and following up to ensure that no new problems have developed and that corrective actions have been effective. The emphasis is on meeting minimum standards of care.

Quality Improvement (QI)
Also called Continuous Quality Improvement (CQI). An ongoing process of monitoring and evaluating activities and outcomes in order to continuously improve service delivery. CQI seeks to prevent problems and to maximize the quality of care.

Recipient
An organization that receives RWHAP funds directly from. Recipients may provide direct services and/or may contract with Subrecipients for services. Replaces the term "Grantee." See also Recipient Subrecipient.

Recipient-provider
An organization that receives RWHAP funds directly from HRSA HAB and provides direct client services. Replaces the term “grantee-provider.”

Recipient of record (or recipient)
An organization receiving financial assistance directly from an HHS- awarding agency to carry out a project or program. A recipient also may be a recipient-provider if it provides direct services in addition to administering its grant. Replaces the term “grantee of record.”

Reflectiveness
The extent to which the demographics of the planning body's membership look like the demographics of the epidemic in the service area.

Representative
Term used to indicate that a sample is similar to the population from which it was drawn, and therefore can be used to make inferences about that population.

Resource Allocation
The Part A planning council responsibility to assign Ryan White HIV/AIDS Program amounts or percentages to established priorities across specific service categories, geographic areas, populations, or subpopulations.

Resource Inventory

An inventory of the financial resources available in a jurisdiction to meet the HIV prevention, care, and treatment needs of its population as well as resource gaps. The inventory also details the CDC-funded high impact prevention services and the HRSA-funded core medical and support services.

Ryan White HIV/AIDS Program Services Report (RSR)
Data collection and reporting system for reporting information on programs and clients served (Client Level Data).

Schedule of Charges
Fees imposed on the RWHAP patient for services based on the patient's annual gross income. A schedule of charges may take the form of a flat rate or a varying rate (e.g. sliding fee scale). The schedule of charges is how you know what amount of money to charge a patient. The schedule of charges applies to uninsured patients with incomes above 100% FPL, and may be applied to insured patients as determined by RWHAP recipients' policies and procedures. When applied to insured patients, recipients should consider how their policy will be applied uniformly to all insured patients, rather than on a case-by-case basis.

Section 340B Drug Discount Program
A program administered by the HRSA's Office of Pharmacy Affairs that was established by Section 340B of the Veteran's Health Care Act of 1992, which limits the cost of drugs to Federal purchasers and to certain recipients of federal agencies.

Seroprevalence
The number of persons in a defined population who test HIV-positive based on HIV testing of blood specimens. (Seroprevalence is often presented either as a percent of the total specimens tested or as a rate per 100,000 persons tested.)

Service Gaps
HIV prevention and care services for persons at risk for HIV and PLWH that do not exist in the jurisdiction.

Sexually Transmitted Disease (STD)

Socio-demographics
Demographic (e.g. race, age, gender identity, sex) and socioeconomic data (e.g. income, education, health insurance status) characteristics of individuals and communities. Also known as: SES, demographic data.

Special Projects of National Significance (SPNS)
The part of the Ryan White HIV/AIDS Program under Part F that funds demonstration and evaluation of innovative models of care delivery for hard-to-reach populations.

Statewide Coordinated Statement of Need (SCSN)
The process of identifying the needs of persons at risk for HIV infection and people living with HIV (those receiving care and those not receiving care); identifying current resources available to meet those needs, and determining what gaps in HIV prevention and care services exist. The SCSN is a culminating report which consists of information gathered through needs assessments conducted by three separate entities: RWHAP Part A Recipients, RWHAP Part B Recipients, and CDC funded recipients. Required component of the Integrated HIV Prevention and Care Plan.

Subrecipient
The legal entity that receives Ryan White HIV/AIDS Program funds from a recipient and is accountable to the recipient for the use of the funds provided. Subrecipients may provide direct client services or administrative services directly to a recipient. Subrecipient replaces the term "Provider (or service provider)."

Substance Abuse and Mental Health Services Administration (SAMHSA) (link is external)
Federal agency within HHS that administers programs in substance abuse and mental health.

Support Services
Services needed to achieve medical outcomes that affect the HIV-related clinical status of a person living with HIV/AIDS. Recipient/sub-recipient expenditures are limited to core medical services, support services, and administrative expenses.

Surveillance
An ongoing, systematic process of collecting, analyzing and using data on specific health conditions and diseases (e.g., Centers for Disease Control and Prevention surveillance system for AIDS cases).

Surveillance Report
A report providing information on the number of reported cases of a disease such as AIDS, nationally and for specific sub-populations.

Target Population
A population to be reached through some action or intervention; may refer to groups with specific demographic or geographic characteristics.

Technical Assistance (TA)
The delivery of practical program and technical support to the Ryan White community. TA is to assist recipients/sub-recipients, planning bodies, and affected communities in designing, implementing, and evaluating Ryan White-supported planning and primary care service delivery systems.

Transitional Grant Area (TGA)
Geographic areas highly-impacted by HIV/AIDS that are eligible to receive Ryan White HIV/AIDS Program Part A funds To be an eligible TGA, an area must have reported at least 1,000 but fewer than 2,000 new AIDS cases in the most recent 5 years and a population of at least 50,000. See also Eligible Metropolitan Area, EMA.

Transmission Category
A grouping of disease exposure and infection routes; in relation to HIV disease, exposure groupings include, for example, men who have sex with men, injection drug use, heterosexual contact, and perinatal transmission.

Unmet Need
The unmet need for primary health services among individuals who know their HIV status but are not receiving primary health care.

Viral Load
In relation to HIV, the quantity of HIV RNA in the blood. Viral load is used as a predictor of disease progression. Viral load test results are expressed as the number of copies per milliliter of blood plasma.

Waiver
A waiver of the imposition of charges requirement can only be requested by RWHAP recipients operating as free clinics (recipients who do not impose a charge or accept reimbursement from any third party payor are eligible to request an imposition of charges waiver). Only a handful of RWHAP recipients are operating as free clinics – therefore, every other RWHAP recipient/ subrecipient should be charging patients over 100% FPL for applicable services, even if it is only $1.

Organizations that receive funding from RWHAP and other Federal funding sources (i.e., facilities operated directly by the Indian Health Service or by Tribes through a contract with the Indian Health Service, Community Health Centers) must follow the requirements imposed by each Federal program. To the extent that services under the RWHAP are provided and attributed to the RWHAP, RWHAP statutory requirements on imposition of charges must be followed.

XML (EXtensible Markup Language)
A standard, simple, and widely adopted method of formatting text and data so that it can be exchanged across all of the different computer platforms, languages, and applications.

Ending the HIV Epidemic

Ending the HIV Epidemic:

A Snapshot of 2019 Federal Activities

The Ending the HIV Epidemic (EHE) initiative was announced in 2019. While federal funding to support implementation wasn't awarded until 2020, federal agencies and partners took steps in 2019 to visit jurisdictions, promote EHE, and engage stakeholders.

469
REPORTED EHE EVENTS

- Congressional briefings
- Conferences
- In-person meetings
- Webinars
- Programmatic site visits

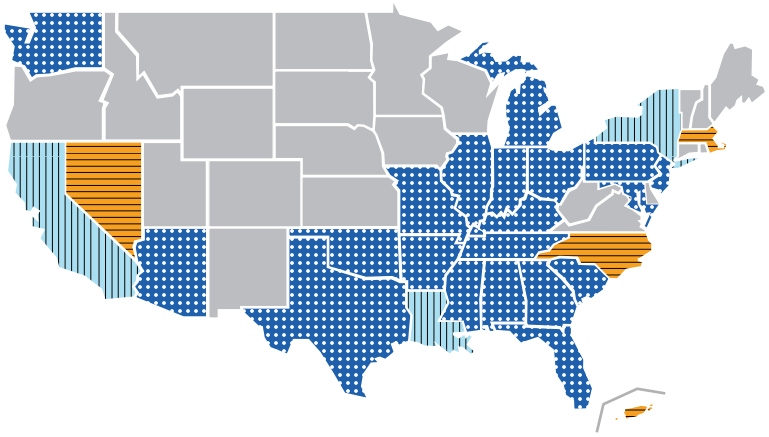
50
Listening Sessions Held

600+
Stakeholders Engaged

$13.5M
in Planning Grants Awarded

HHS in Communities

- Made **133** Phase 1 Jurisdiction visits
- Reached **89%** Phase 1 Jurisdictions
- Participated in **79** events with state/local health departments
- Participated in **19** events with state/local government departments
- Engaged with **60+** stakeholder groups including:
  - National HIV organizations
  - Regional HIV organizations
  - Community-based organizations



All EHE Jurisdictions Reached
Some/Not all Jurisdictions Reached
Planned to Reach in 2020

Key Accomplishments

CDC and IHS distributed **$6M** in funding from the Minority HIV/AIDS Fund to "jumpstart" sites to support innovative efforts to expand HIV diagnosis, treatment, prevention, and response in four U.S. priority areas with high concentrations of new HIV diagnoses. Lessons learned from these jumpstart areas are providing important insights for the 57 EHE jurisdictions as they begin to scale up efforts to reduce HIV transmissions.

Jumpstart Sites

- Cherokee Nation
- DeKalb County, GA
- East Baton Rouge, LA
- Baltimore City, MD

HHS launched the **Ready, Set, PrEP** campaign in December, a public-private partnership to increase PrEP uptake by making PrEP available at no cost to individuals without prescription drug coverage.

Six new PACE officers began supporting EHE activities in the Atlanta, Dallas, and Los Angeles regions. These United States Public Health Service Commissioned Corps officers act as "Prevention through Active Community Engagement" leads within HHS, working collaboratively with jurisdictions to develop targeted interventions specifically geared toward EHE communities.

Ending the HIV Epidemic

Ending the HIV Epidemic:
A Snapshot of 2020 Federal Activities

A Note from Harold J. Phillips, EHE COO

Harold J. Phillips

The exciting first full year of EHE implementation in 2020 resulted in important progress, even in spite of unexpected challenges and turmoil. Propelled by the groundwork laid in 2019 , the 57 jurisdictions engaged stakeholders, developed tailored EHE plans, and began implementing them while the HHS partner agencies continued collaborating and delivering technical assistance and EHE funding to grantees nationwide.

The challenges resulting from the COVID-19 pandemic required all of us to pivot, which, fortunately, has been a particular strength of the HIV community throughout our 40-year history. Thanks to the resilience and innovation of HIV stakeholders at the local, state, and national levels, we continued to serve those with and at risk for HIV, even when they could not access in-person HIV services due to pandemic precautions. Some of those innovations will outlive the pandemic and continue to support our EHE efforts. In addition, as the year unfolded and both the disproportionate impact of COVID-19 on racial and ethnic minority populations and the national movement for racial justice animated by the police shooting of George Floyd focused the nation's attention on issues of equity, we reinforced our commitments to addressing the social and structural determinants of health that drive the HIV epidemic and confronting racism as a serious threat to public health.

This snapshot highlights some of the many EHE achievements in 2020 that advanced us on the path to ending the HIV epidemic in the U.S. by 2030, and that continue to energize our ongoing work in 2021.

Partnerships

EHE is a whole-of-society initiative. HHS engaged with many partners to address HIV in communities, primarily in virtual settings due to the COVID-19 pandemic:

- Academic centers
- Community- and faith-based organizations
- Federal, state, and local government
- Medical associations, pediatric centers, and pharmacies
- Private industry

AHEAD

Launched in August 2020, America's HIV Epidemic Analysis Dashboard (AHEAD) visualizes data on six indicators used to track progress toward ending the HIV epidemic.

This tool provides up-to-date information about EHE progress to help inform national and jurisdictional decision-making.

Ready, Set, PrEP

An expansion of the program allows greater access to mail-order delivery for participants to receive PrEP HIV prevention medication at no cost.

Participants can choose to have their PrEP medication sent directly to their home or healthcare providers when they enroll or continue to use the more than 32,000 co-sponsoring pharmacies.

Agency Updates

CENTERS FOR DISEASE CONTROL AND PREVENTION

CDC funded priority jurisdictions to develop **innovative, locally tailored plans** for scaling up the key strategies of the initiative.

In 2020, **all 57 jurisdictions** developed and submitted EHE plans.

HEALTH RESOURCES AND SERVICES ADMINISTRATION

Ryan White HIV/AIDS Program EHE-funded providers engaged nearly **6,300 clients** for the first time and re-engaged an additional **3,600 clients** from March to August 2020.

Bureau of Primary Health Care funded health centers prescribed PrEP to nearly **63,000 patients** with FY 2020 Primary Care HIV Prevention (PCHP) funds.

NATIONAL INSTITUTES OF HEALTH

In FY 2020, NIH provided funds to stand up **six implementation science coordinating centers** and **consultation hubs** to provide resources, mentoring, feedback, and support for new and ongoing EHE research.

PLANNING COUNCIL TRAINING

GREATER HAMPTON ROADS
HIV HEALTH SERVICES
PLANNING
COUNCIL

Ryan White HIV/AIDS Program Part A
HIV Emergency Relief Grant Program

Funding Opportunity Number: HRSA-22-018
Funding Opportunity Type(s): Competing Continuation
Assistance Listings (CFDA) Number: 93.914

NOTICE OF FUNDING OPPORTUNITY
Fiscal Year 2022

Application Due Date: October 06, 2021

COLLABORATIVE RESEARCH

Executive

Summary

Period of Performance

March 1, 2022, through February 28, 2025 (three years)

Total Funding Ceiling

$6,043,710 Total
$548,342 MAI

Service Area

VA: Chesapeake City, Gloucester County, Hampton City, Isle of Wight County, James City County, Mathews County, Newport News City, Norfolk City, Poquoson City, Portsmouth City, Suffolk City, Virginia Beach City, Williamsburg City, and York County

NC: Currituck County

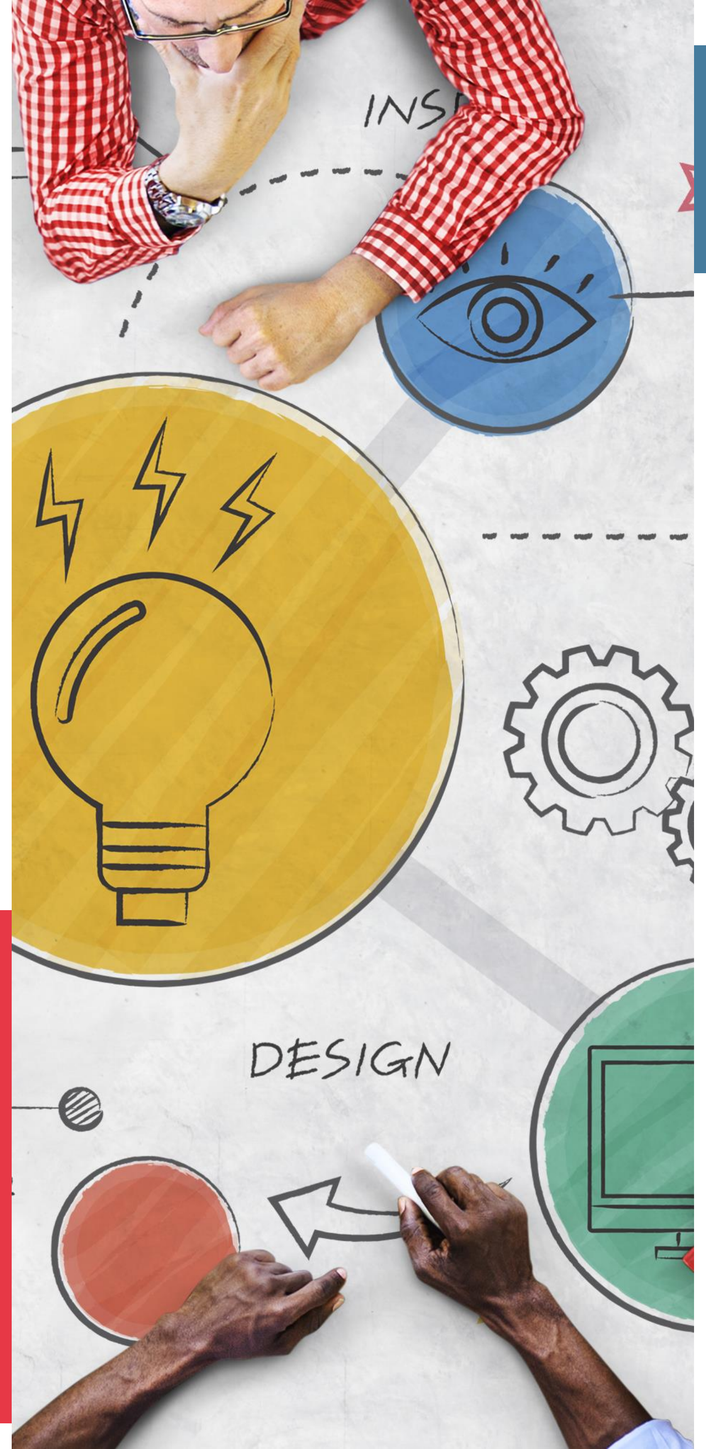
Program Funding Opportunity Description

This notice announces the opportunity to apply for funding under the Ryan White HIV/AIDS Program (RWHAP) Part A HIV Emergency Relief Grant Program. The purpose of this program is to provide direct financial assistance to an eligible metropolitan area (EMA) or a transitional grant area (TGA) that has been severely affected by the HIV epidemic. Grant funds assist eligible jurisdictions to develop or enhance access to a comprehensive continuum of high quality, community-based care for people with HIV who are low-income through the provision of formula, supplemental, and Minority AIDS Initiative (MAI) funds. The goal is to provide optimal HIV care and treatment for people with HIV who are low-income, uninsured, and underserved, to improve their medical outcomes.

Comprehensive HIV care consists of core medical services and support services that enable people with HIV to access and remain in HIV primary medical care to improve their health outcomes. Based on an annual assessment of the services and gaps in the HIV care continuum within a jurisdiction, HIV Planning Councils/Planning Bodies (PCs/PBs) and RWHAP recipients identify specific service categories to fund. Funded service categories should facilitate improvements at specific stages of the HIV care continuum.

Program Funding Opportunity Description

RWHAP Part A EMAs and TGAs must use grant funds to support, further develop, and/or expand systems of care to meet the needs of low-income people with HIV within the EMA/TGA and strengthen strategies to reach disproportionately impacted subpopulations. The Health Resources and Services Administration (HRSA) HIV/AIDS Bureau (HAB) requires EMAs/TGAs to collect and analyze data to identify needs, set priorities, make allocations, and validate the use of RWHAP funding. A comprehensive application should reflect on how you have used those data to develop and expand the system of care in EMA/TGA jurisdictions. HRSA encourages innovation and collaboration with other agencies and organizations to maximize impact on health outcomes and effectively meet the needs of people with HIV within the EMA/TGA.



Important Notes:

MULTI-YEAR FUNDING

HRSA HAB has transitioned the RWHAP Part A program from an annual competitive application program to a three-year funded program effective in FY 2022.

In this new three-year period of performance, eligible applicants will submit a competitive application in the first year (FY 2022), and non-competing continuation (NCC) progress reports for years 2 and 3 (FY 2023 and FY 2024, respectively). The normalized score from the objective review of the demonstration of additional need provided in the competitive application during the first year of the three-year period of performance will be utilized to calculate the discretionary supplemental award in the second and third years.

HRSA HAB stresses the importance of this section, given its effect on the multi-year funding.

HIV CARE CONTINUUM

Eligible applicants will need to provide an HIV care continuum (HCC) that is diagnosis-based using the Centers for Disease Control and Prevention (CDC) definitions. Data are posted on TargetHIV to facilitate the development of the diagnosis-based HIV care continuum. See the Demonstrated Need and Work Plan sections for additional details.

UNMET NEED

HRSA HAB updated the estimation methodology used to determine unmet need for HIV-related services. Eligible applicants will need to provide estimates using the new Unmet Need Framework with their applications. See the Demonstrated Need section for additional detail, and reference TargetHIV for training materials and tools related to estimating and reporting Unmet Need.

SUBPOPULATIONS OF FOCUS

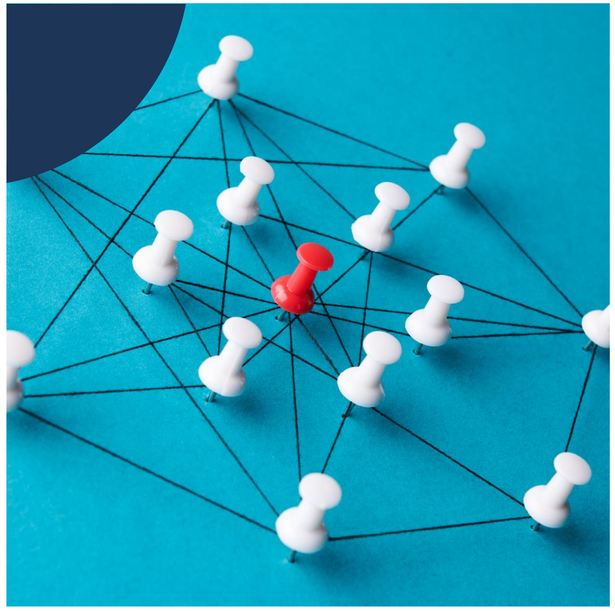
This is a new component of the Needs Assessment section in the NOFO, which requires eligible applicants to identify three subpopulations of focus using a data-driven process, including their specific needs, and subsequently discuss approaches to addressing those needs in the Methodology and Work Plan sections.

INTEGRATED PLAN

The updated Integrated HIV Prevention and Care Plan guidance and plan submission for calendar years 2022 – 2027 was postponed due to the unprecedented Coronavirus Disease 2019 (COVID-19) pandemic. An updated Integrated HIV Prevention and Care Plan guidance was issued in June 2021, with submission of the plans targeted for December of 2022.

INDIRECT COSTS

Negotiated indirect cost rate agreement or other indirect cost documentation will only be required to be submitted in the competitive application.



Background

A Strategic Framework and National Objectives

National objectives and strategic frameworks like the Healthy People 2030, the HIV National Strategic Plan: A Roadmap to End the HIV Epidemic (2021 – 2025); the Sexually Transmitted Infections National Strategic Plan for the United States (2021 – 2025); and the Viral Hepatitis National Strategic Plan for the United States: A Roadmap to Elimination (2021 – 2025) are crucial to addressing key public health challenges facing low-income people with HIV.

B Expanding the Effort: Ending the HIV Epidemic

In February 2019, the Ending the HIV Epidemic in the U.S. (EHE) initiative was launched to further expand federal efforts to reduce HIV infections. This 10-year initiative seeks to achieve the important goal of reducing new HIV infections in the United States to fewer than 3,000 per year by 2030.

C Using Data Effectively: Integrated Data Sharing and Use

HRSA and CDC's Division of HIV/AIDS Prevention support integrated data sharing, analysis, and utilization for the purposes of program planning, conducting needs assessments, determining unmet need estimates, reporting, quality improvement, enhancing the HIV care continuum, and public health action.

D Program Resources and Innovative Models

HRSA has a number of projects and resources that may assist RWHAP recipients with program implementation. These include a variety of HRSA HAB cooperative agreements, contracts, and grants focused on specific technical assistance (TA), evaluation, and intervention activities.

PROJECT NARRATIVE

This section provides a comprehensive framework and description of all aspects of the proposed project. It should be succinct, self-explanatory, consistent with forms and attachments, and well organized so that reviewers can understand the proposed project.

Demonstrated Need

The Demonstrated Need section includes Epidemiologic Overview, HIV Care Continuum, Unmet Need, Co-occurring Conditions, and Complexities of Providing Care sub-sections.

Epidemiologic Overview

An epidemiologic overview provides a description of the demonstrated need for HIV care in the population of an area in terms of the socio-demographic characteristics of persons newly diagnosed with HIV, people with HIV, and persons at higher risk for HIV. Understanding the populations affected by HIV provides the basis for setting priorities, identifying appropriate interventions and services, allocating funding to HIV care services, implementing appropriate service standards, and evaluating programs and policies.

HIV Care Continuum

The HIV care continuum is a public health model that outlines the steps or stages that people with HIV go through from diagnosis to achieving and maintaining viral suppression. There are two approaches to monitor the HIV care continuum—the prevalence-based approach and the diagnosis-based approach.

Unmet Need

Unmet need is defined as the number of individuals with HIV in a jurisdiction who are aware of their HIV/AIDS status and are not in care. RWHAP legislation indicates that RWHAP Part A recipients need to address unmet need by identifying, determining the needs, and facilitating interventions for individuals with unmet need.

Co-occurring Conditions

Using the list below, provide the incidence and prevalence estimates for each of the following conditions co-occurring with HIV in the EMA/TGA in a table format and document the data sources used. The table must include: a) Hepatitis C virus; b) Sexually transmitted infection rates, including syphilis, gonorrhea, and chlamydia; c) Mental illness; d) Substance use disorder; e) Homeless/unstably housed; and f) Former incarceration.

Complexities of Providing Care

If the EMA/TGA experienced a reduction in RWHAP Part A formula funding last year (FY 2021), provide a narrative that addresses both the impact and response to the funding reduction,

Unmet Need Framework

LATE DIAGNOSED

The number of late diagnoses based on first CD4 test performed or documentation of an AIDS-defining condition less than or equal to three months after a new HIV diagnosis.

UNMET NEED

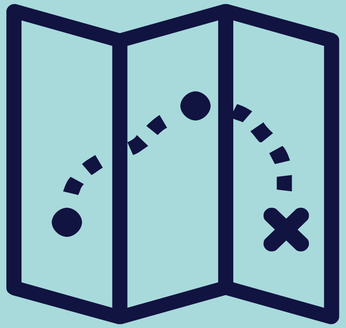
1. Number/percent of people with HIV/aware with no CD4 or VL test in the most recent calendar year. (REQUIRED)
2. Number/percent of RWHAP clients with no CD4 or VL test or outpatient/ambulatory health services (OAHS) visit in the most recent calendar year. (ENHANCED)

NOT VIRALLY SUPPRESSED

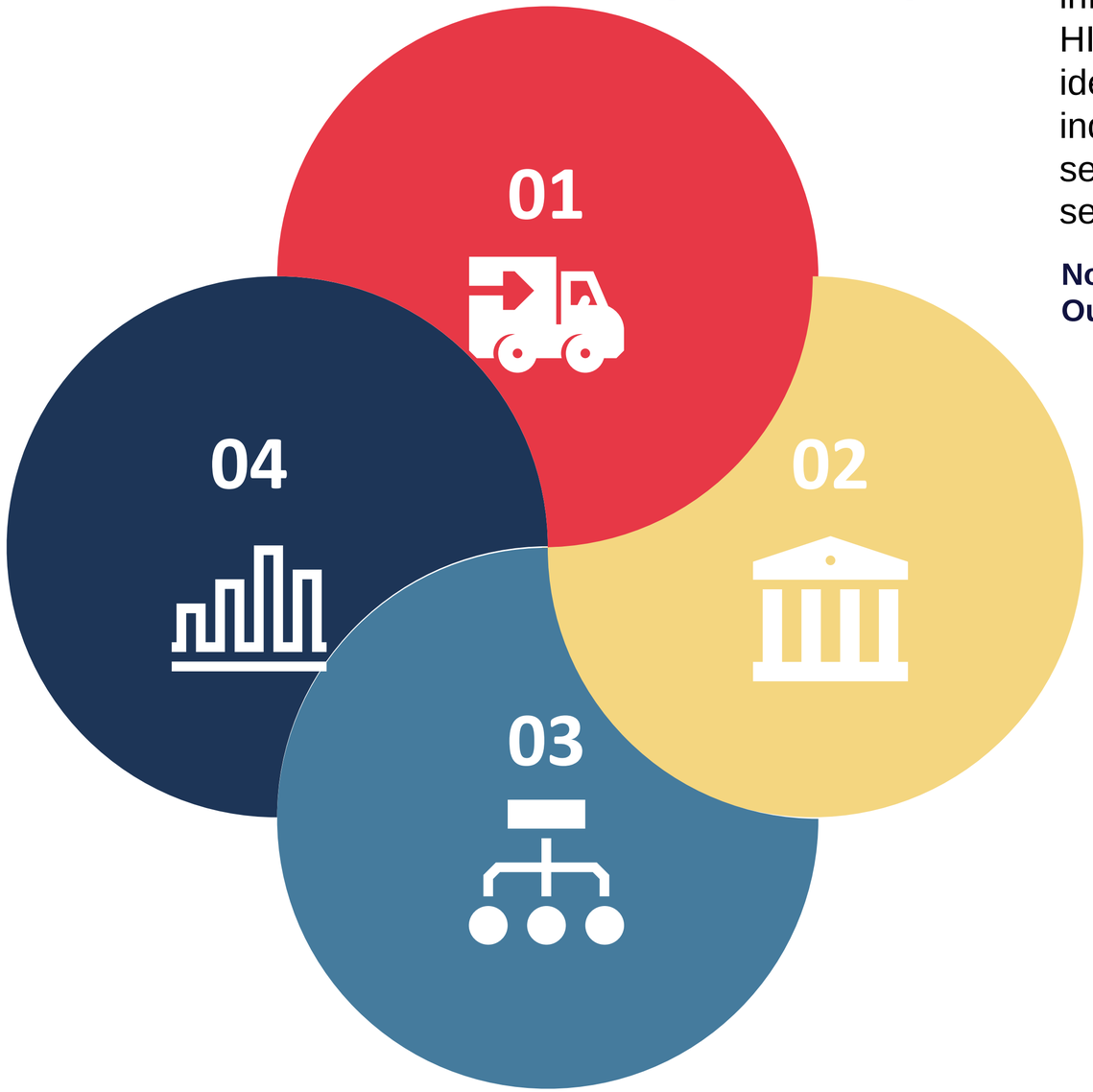
1. Number/percent of people with HIV/aware and in care that have a viral load ≥200 copies/mL at most recent test. (REQUIRED)
2. Number/percent of RWHAP clients in care that have a viral load ≥200 copies/mL at most recent test

Based on the Unmet Need Framework estimates responses to the following:

1. Identify whether the enhanced method was utilized (in addition to the required method) to provide the Unmet Need Framework estimates. Describe any data system and/or other limitations that impacted your ability to provide these estimates.
2. Based on the estimates included in Attachment 4, describe the need(s) of the estimated number of people in your jurisdiction that are 1) late-diagnosed, 2) have unmet need, and 3) are in care but not virally suppressed.



Early Identification of Individuals with HIV/AIDS (EIIHA)



The purpose of this section is to describe the data and information associated with ensuring that individuals who are unaware of their HIV status are identified, informed of their status, referred to supportive services, and linked to medical care if HIV test is positive. The goals of the EIIHA plan are to present a strategy for: (1) identifying individuals with HIV who do not know their HIV status; (2) making such individuals aware of their status and enabling them to use the health and support services; and (3) reducing barriers to routine testing and disparities in access and services among affected subpopulations and historically underserved communities.

Note: The EIIHA activities will remain the same for the three-year period of performance. Outcomes will be reported in the FY 2023 and FY 2024 NCC progress reports.

IDENTIFICATION of UNAWARE

Provide anticipated outcomes for Identification of individuals unaware of their HIV status.

INFORM INDIVIDUALS of HIV Dx

Provide anticipated outcomes for informing individuals that tested positive of their HIV diagnosis.

REFERRAL TO CARE

Provide anticipated outcomes for referrals to care of newly diagnosed individuals.

LINKAGE TO CARE

Provide anticipated outcomes for linkage to care of newly diagnosed individuals.

Subpopulations of Focus

Although HIV affects millions of Americans nationwide and from all social, economic, and racial and ethnic groups, and in all parts of the country, it disproportionately affects certain populations. The disproportionate prevalence of HIV in specific populations increases the risk for HIV transmission with each sexual or injection drug use encounter within those populations. In addition, a range of social, economic, and demographic factors—such as stigma, discrimination, socio-economic status, income, education, age, and geographic region— affect people's risk for HIV or their ability to access or remain engaged in prevention or care services.

A data driven process should be used to identify subpopulations of focus disproportionally affected by HIV. This should include an analysis of the jurisdictional needs assessment, outcomes along the HIV care continuum, data from the unmet need framework, epidemiological data (i.e., incidence of new HIV infections and trends, prevalence of HIV), and potential impact of other major public health threats (e.g., opioid epidemic, COVID-19, etc.).

Subpopulations of focus are specific groups of people with HIV within RWHAP Part A jurisdictions that are disproportionately affected by HIV, as a result of specific needs.

ITEM 1

Identify three (3) subpopulations with disparities in health outcomes in your jurisdiction (e.g., subpopulations with disparities in viral suppression, receipt of care, retention in care, late diagnosis, HIV incidence, etc.), and describe the specific needs for each subpopulation.

ITEM 2

How do the data in the unmet need framework inform the process for identifying the subpopulations of focus for the jurisdiction?

ITEM 3

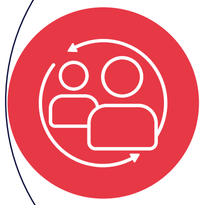
As applicable, identify activities for each required EIIHA component (identification of individuals unaware of HIV status; informing newly diagnosed individuals of HIV status; referral to care of newly diagnosed individuals; and, linkage to care of newly diagnosed individuals) and describe how the activities align with the needs of the identified subpopulations of focus for the jurisdiction.

Planning Responsibilities

The purpose of this section is to document the existence of a functioning planning process in the EMA/TGA that is consistent with RWHAP and HRSA program requirements. A planning process is imperative for effective local and state decision making to develop systems of prevention and care that are responsive to the needs of persons at risk for HIV and people with HIV. HRSA and CDC support activities that facilitate collaboration and/or develop a joint planning body to address prevention and care. Community engagement is an essential component for planning comprehensive, effective HIV prevention and care programs.

Note: The composition of the PC/PB must reflect the demographics of the HIV epidemic in the EMA/TGA and be representative of various required categories of membership.

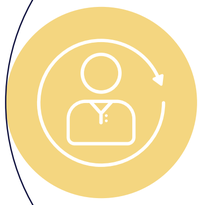
Note: The Letter of Assurance from Planning Council Chair(s) or Letter of Concurrence from Planning Body will be required with the FY 2023 and FY 2024 NCC progress reports.



Letter of Assurance from Planning Council Chair(s)

Provide a letter of assurance signed by the PC chair(s) or a letter of concurrence signed by PB leadership.

1. When (i.e., the year) your most recent comprehensive needs assessment was conducted;
2. Participation in comprehensive planning process (i.e., integrated HIV prevention and care plan) for the jurisdiction, including the statewide coordinated statement of need (SCSN)



Priority Setting and Resource Allocation (PSRA)

1. Data (e.g., comprehensive needs assessment, HIV care continuum, unmet need framework estimates, and epi profile) were used in the FY 2022 priority setting and allocation process to ensure that:
2. People with HIV were involved in the planning and allocation processes and how their priorities were considered in the process;
3. FY 2021 period of performance formula, supplemental, and MAI funds awarded to the EMA/TGA were expended according to the priorities established by the PC

Training

Ongoing, annual membership training occurred, including the date(s)

Assessment of the Administrative Mechanism

Assessment of grant recipient activities ensured timely allocation/contracting of funds and payments to contractors.

Resource Inventory

RWHAP Part A EMA/TGA planning efforts should expand the availability of services, reduce duplication of services, coordinate with all other public funding for HIV, and bring newly diagnosed people with HIV into care or engage people with HIV who know their status but are not presently in HIV care. RWHAP Part A planning efforts should also consider service needs not currently being met (defined as service gaps).

PUBLIC FUNDING SOURCES

A jurisdictional HIV resources inventory that includes public funding sources for HIV prevention, care, and treatment services in the jurisdiction (RWHAP Parts B-D and F, Ending the HIV Epidemic, CARES Act funding, and other federal/state and local sources.

AMOUNT OF FUNDING

A jurisdictional HIV resources inventory that includes the dollar amount and the percentage of the total available funds in the FY 2021 period of performance for each funding source identified above.

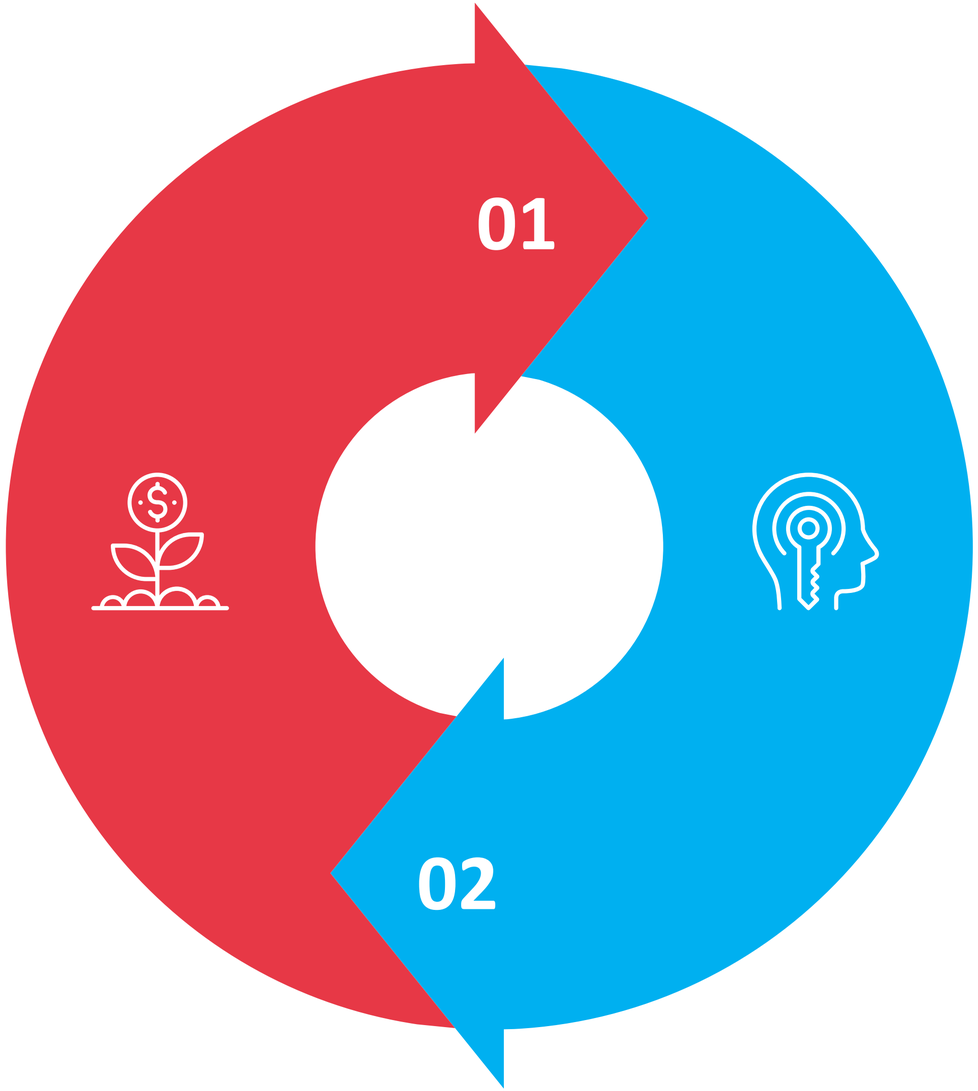
SERVICES DELIVERED

A jurisdictional HIV resources inventory that includes how the resources are being used (i.e., services delivered).

HIV Care Continuum Services Table and Narrative

FY 2022 HIV Care Continuum Services Table

Using CDC HIV Care Continuum definitions and CDC surveillance data, develop a diagnosis-based HIV Care Continuum Services Table. You must include baseline and target indicators as a numerator and denominator, as well as a percentage for each step. List the service categories funded by RWHAP Part A that will aid in achieving the desired target outcomes to be achieved during the FY 2022 budget period (one year).



HIV Care Continuum Narrative

Provide a narrative of your HIV care continuum addressing any changes in your HIV care continuum from CY 2017 to CY 2019, or the most current three (3) years for which data are available, the impact those changes have had on your program, and how you responded or addressed those identified changes.

Funding for Core and Support Services

Service Category Plan

Provide a Service Category Plan in table format, as described below, that utilizes core medical and support service categories as prioritized and funded by the Planning Council and the local community planning processes. The plan should consist of both RWHAP Part A and MAI funds. The Service Category Plan must also correlate with the budget and budget narrative sections of the application.

Note: Please indicate if you have already submitted, submitted with this application, or intend to submit a core medical services waiver for the FY 2022 budget period.

Service Category Plan Table

For every service category funded by RWHAP Part A in the jurisdiction, provide the following in table format.

PART A & MAI

- FY 2021 budget period Part A service categories with priority number, expended amount, number of unduplicated clients served, service unit definitions, and number of service units provided. Include total dollar amounts for core medical services, support services, a total of the combined core medical and support services, and the percentages of expenditures for Part A/MAI core medical and Part A/MAI support services.
- FY 2022 budget period Part A service categories with priority number, anticipated funding amount, projected number of unduplicated clients to be served, service unit definitions, and projected number of service units. Include total dollar amounts for core medical services, support services, a total of the combined core medical and support services, and the percentages of allocations for Part A/MAI core medical and Part A/MAI support services.

MAI Service Category Plan Narrative

- Describe how MAI services will be implemented to address the needs of (each population identified in) the Subpopulations of Focus section.
- Describe how MAI services to be implemented may prevent new HIV infections, improve health outcomes, and decrease health disparities and inequities among the identified subpopulations of focus

Unmet Need

- Identify specific interventions that are focused on improving the outcomes for individuals with unmet need that 1) are late diagnosed, 2) have unmet need, and 3) are in care but not virally suppressed, as outlined in Attachment 4. This information can be provided as a table.
- If applicable, describe how activities related to re-engaging individuals with unmet need into care (along with how activities addressing the needs for the late-diagnosed and not virally suppressed populations) intersect with plans or strategies in your jurisdiction, such as Ending the HIV Epidemic in the U.S., Getting to Zero, and/or 90/90/90 efforts.

Core Medical Services Waiver

You must provide a separate allocation table that is reflective of the results of the priority setting and resource allocation process, **only if you submit a core medical services waiver with this application.** The allocation table must be consistent with the waiver request. Include the allocation table and the core medical services waiver request as **Attachment 10**

Resolution of Challenges Table

In lieu of a narrative for this section, HAB suggests providing information on resolving challenges with implementing RWHAP Part A activities, including HIV care continuum activities, in table format with the following headers.

Describe at least three potential challenges/barriers when completing your table.

Challenge	Resolution	Outcome	Status
Part A Program			
Routine Testing	Advocate for universal HIV testing at private physician practices, FQHCs, clinics, hospitals, and school health services in the TGA.	Increase HIV testing by 25%, emphasizing outreach and education to hard-to-engage individuals at risk of HIV.	In Process – Quarterly updates with Planning Council, QM Committee, and other RWHAP.

CHALLENGES/BARRIERS

Challenges and barriers anticipated in the larger context of implementing RWHAP Part A activities (e.g., changes in the health care landscape, community engagement, barriers for populations experiencing inequities in health outcomes).

INTENDED OUTCOMES

Describe the intended outcome(s) expected from the proposed activities. Strength and feasibility of the approaches to resolve these challenge/barriers should be considered.

PROPOSED RESOLUTIONS

Describe the proposed activities that will assist in overcoming the identified challenge/barrier. Consider the strength and feasibility of the proposed activites.

CURRENT STATUS

Describe the timeline of the proposed activities for resolving the challenge/barrier. Give the current status of the resolutions of challenges.

Clinical Quality Management (CQM) Program

01

CHANGES TO CQM PROGRAM

What changes have been made to your current clinical quality management program based on previous years' experience, outcomes, etc.

02

USE OF CQM DATA

How CQM data improved patient care, health outcomes, patient satisfaction, and/or changed service delivery in the jurisdiction, including strategic long-range service delivery planning.

Note: You will be required to submit an updated Quality Management Plan as a reporting requirement in Year 2 of the Non-Competing Continuation progress report.

You can find more information about the HRSA RWHAP expectations for CQM programs in:

- PCN 15-02 Clinical Quality Management and Frequently Asked Questions
- HIV/AIDS Bureau Performance Measures
- HHS HIV/AIDS Clinical Guidelines
- HIV/AIDS Bureau RWHAP Part A Monitoring Standards (RWHAP Part A specific, Universal Monitoring Standards, and Frequently Asked Questions)
- Part A Manual

Grant Administration

The purpose of this section is to demonstrate the extent to which the CEO or designee in the EMA/TGA has met the legislative requirements to disburse funds quickly, closely monitor their use, and ensure the RWHAP is the payor of last resort. RWHAP stresses the importance of timely obligation of RWHAP funds. Timely obligation of RWHAP funds ensures that services can be provided as rapidly as possible and decreases the possibility that unobligated funds will remain at the end of the budget period. The UOB requirement does not apply to MAI funds.

If the recipient reports unobligated formula funds of five percent or less, HRSA does not impose penalties, although a future year award may be subject to an offset.

UOB PENALTIES

UOB Penalties (applies to each year in the three-year period of performance)
If the UOB of a formula award exceeds five percent, two penalties are imposed:

- The future year award is reduced by the amount of the UOB, less the amount of approved carryover; and
- The grant recipient is not eligible for a future year supplemental award.

OFFSET

The amount of the UOB not approved for carryover is subject to an offset.

SUPPLEMENTAL FUNDS

Under the RWHAP legislation, unobligated supplemental funds cannot be carried over, but are subject to an offset. If a grant recipient has a UOB of supplemental funds, the recipient remains eligible for a future year RWHAP Part A award, including supplemental funds.

Grant Administration

PROGRAM ORGANIZATION

Describe how RWHAP Part A funds are administered within the EMA/TGA with reference to the staff positions, including program and fiscal staff, described in the budget narrative and the program organizational chart. If the RWHAP Part A funds are administered by a contractor or fiscal agent, describe the staffing, fiscal agent scope of work or services to be provided, and how you will evaluate the performance of the work or services being provided.

GRANT RECIPIENT ACCOUNTABILITY

Recipients are required to monitor subrecipient for fiscal and programmatic compliance. Recipients also are required to have on file a copy of each subrecipient's procurement document (contract) and fiscal, program, and site visit reports. Describe the following:

MONITORING

- Describe how subrecipient monitoring was performed during the FY2021 period of performance to ensure fiscal and program compliance.
- The process for ensuring subrecipient compliance with the single audit requirement in Subpart F of the Uniform Administrative Requirements, Cost Principles
- If there were findings in any subrecipient single audit or program-specific audit reports, describe what you have done to ensure that subrecipients have taken appropriate corrective action.

THIRD PARTY REIMBURSEMENT

- The process used to ensure that subrecipients are pursuing third party reimbursement and utilizes contract language or another mechanism to ensure that this takes place;
- Indicate the federal poverty level (FPL) to determine client eligibility within the jurisdiction and methods used to conduct screening and eligibility to ensure the RWHAP is the payor of last resort; and
- How you monitor and track the source and use of any program income earned at the recipient and subrecipient levels.

FISCAL OVERSIGHT

- The process used by program and fiscal staff to coordinate activities, ensuring adequate reporting, reconciliation, and tracking of program expenditures
- The process used to separately track formula, supplemental, MAI, and carryover funds, including information on the data systems utilized; and
- iii. The process for reimbursing subrecipients, from the time a voucher/invoice is received to payment.

Attachments

Attachment 1: Staffing Plan, Job Descriptions, and Biographical Sketches for Key Personnel (Required)

Attachment 2: FY 2022 Agreements and Compliance Assurances, Certifications (Required)

Attachment 3: HIV/AIDS Demographics Table (Required)

Attachment 4: Unmet Need Framework (Required)

Attachment 5: Co-occurring Conditions Table (Required)

Attachment 6: Letter of Concurrence from Planning Council (Required)

Attachment 7: Coordination of Services and Funding Streams Table (Required)

Attachment 8: HIV Care Continuum Services Table (Required)

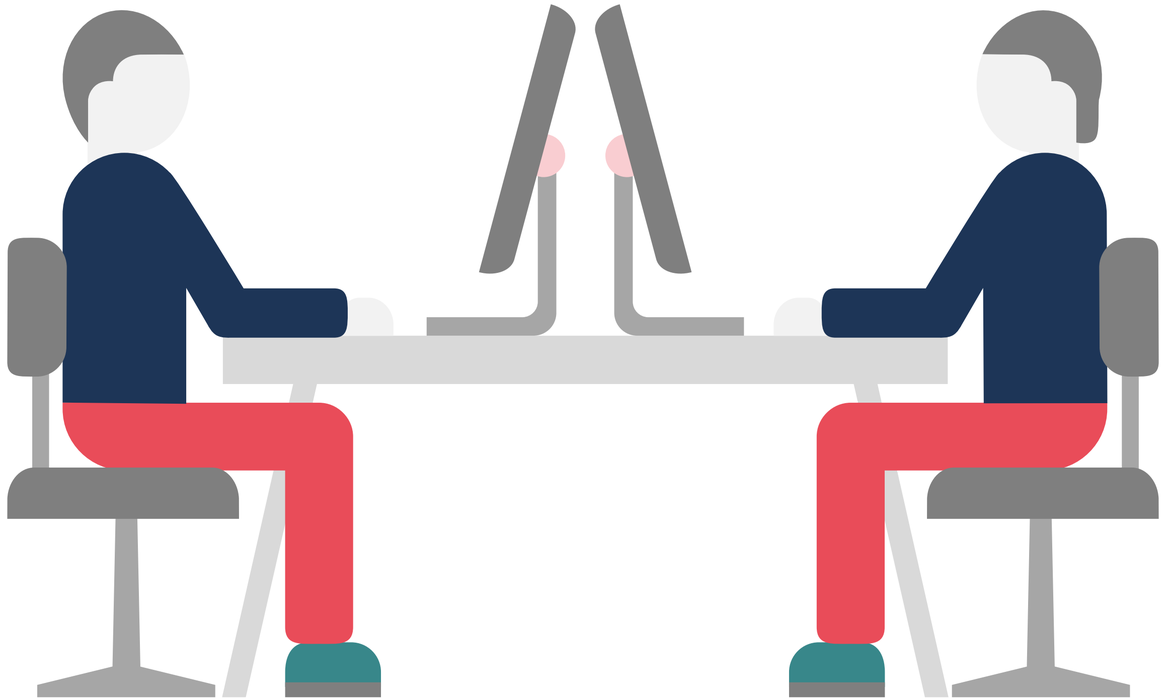
Attachment 9: Service Category Plan Table(s) (Required)

Attachment 10: Core Medical Services Waiver Request and Allocation Table (If Applicable)

Attachment 11: Program Organizational Chart (Required)

Attachment 12: Maintenance of Effort Documentation (Required)

Submission Dates and Times



Application Due Date
The due date for applications under this NOFO is *October 06, 2021, at 11:59 p.m. ET*. HRSA suggests submitting applications to Grants.gov at least **3 calendar days before the deadline** to allow for any unforeseen circumstances.

Questions?

Ryan White HIV/AIDS Program Services: Eligible Individuals & Allowable Uses of Funds

Policy Clarification Notice (PCN) #16-02 (Revised 10/22/18)
Replaces Policy #10-02

Scope of Coverage: Health Resources and Services Administration (HRSA) Ryan White HIV/AIDS Program (RWHAP) Parts A, B, C, and D, and Part F where funding supports direct care and treatment services.

Purpose of PCN

This policy clarification notice (PCN) replaces the HRSA HIV/AIDS Bureau (HAB) PCN 10-02: Eligible Individuals & Allowable Uses of Funds. This PCN defines and provides program guidance for each of the Core Medical and Support Services named in statute and defines individuals who are eligible to receive these HRSA RWHAP services.

Background

The Office of Management and Budget (OMB) has consolidated, in 2 CFR Part 200, the uniform grants administrative requirements, cost principles, and audit requirements for all organization types (state and local governments, non-profit and educational institutions, and hospitals) receiving federal awards. These requirements, known as the "Uniform Guidance," are applicable to recipients and subrecipients of federal funds. The OMB Uniform Guidance has been codified by the Department of Health and Human Services (HHS) in 45 CFR Part 75—Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards. HRSA RWHAP grant and cooperative agreement recipients and subrecipients should be thoroughly familiar with 45 CFR Part 75. Recipients are required to monitor the activities of its subrecipient to ensure the subaward is used for authorized purposes in compliance with applicable statute, regulations, policies, program requirements and the terms and conditions of the award (see 45 CFR §§ 75.351-352).

45 CFR Part 75, Subpart E—Cost Principles must be used in determining allowable costs that may be charged to a HRSA RWHAP award. Costs must be necessary and reasonable to carry out approved project activities, allocable to the funded project, and allowable under the Cost Principles, or otherwise authorized by the RWHAP statute. The treatment of costs must be consistent with recipient or subrecipient policies and procedures that apply uniformly to both federally-financed and other non-federally funded activities.

HRSA HAB has developed program policies that incorporate both HHS regulations

and program specific requirements set forth in the RWHAP statute. Recipients, planning bodies, and others are advised that independent auditors, auditors from the HHS' Office of the Inspector General, and auditors from the U.S. Government Accountability Office may assess and publicly report the extent to which an HRSA RWHAP award is being administered in a manner consistent with statute, regulation and program policies, such as these, and compliant with legislative and programmatic policies. Recipients can expect fiscal and programmatic oversight through HRSA monitoring and review of budgets, work plans, and subrecipient agreements. HRSA HAB is able to provide technical assistance to recipients and planning bodies, where assistance with compliance is needed.

Recipients are reminded that it is their responsibility to be fully cognizant of limitations on uses of funds as outlined in statute, 45 CFR Part 75, the HHS Grants Policy Statement, and applicable HRSA HAB PCNs. In the case of services being supported in violation of statute, regulation or programmatic policy, the use of RWHAP funds for such costs must be ceased immediately and recipients may be required to return already-spent funds to the Federal Government. Recipients who unknowingly continue such support are also liable for such expenditures.

Further Guidance on Eligible Individuals and Allowable Uses of Ryan White HIV/AIDS Program Funds

The RWHAP statute, codified at title XXVI of the Public Health Service Act, stipulates that "funds received...will not be utilized to make payments for any item or service to the extent that payment has been made, or can reasonably be expected to be made under...an insurance policy, or under any Federal or State health benefits program" and other specified payment sources.[1] At the individual client-level, this means recipients must assure that funded subrecipients make reasonable efforts to secure non-RWHAP funds whenever possible for services to eligible clients. In support of this intent, it is an appropriate use of HRSA RWHAP funds to provide case management (medical or non-medical) or other services that, as a central function, ensure that eligibility for other funding sources is vigorously and consistently pursued (e.g., Medicaid, Children's Health Insurance Program (CHIP), Medicare, or State-funded HIV programs, and/or private sector funding, including private insurance).

In every instance, HRSA HAB expects that services supported with HRSA RWHAP funds will (1) fall within the legislatively-defined range of services, (2) as appropriate, within Part A, have been identified as a local priority by the HIV Health Services Planning Council/Body, and (3) in the case of allocation decisions made by a Part B State/Territory or by a local or regional consortium, meet documented needs and contribute to the establishment of a continuum of care.

HRSA RWHAP funds are intended to support only the HIV-related needs of

[1] *See* sections 2605(a)(6), 2617(b)(7)(F), 2664(f)(1), and 2671(i) of the Public Health Service Act.

eligible individuals. Recipients and subrecipients must be able to make an explicit connection between any service supported with HRSA RWHAP funds and the intended client's HIV care and treatment, or care-giving relationship to a person living with HIV (PLWH).

Eligible Individuals:

The principal intent of the RWHAP statute is to provide services to PLWH, including those whose illness has progressed to the point of clinically defined AIDS. When setting and implementing priorities for the allocation of funds, recipients, Part A Planning Councils, community planning bodies, and Part B funded consortia may optionally define eligibility for certain services more precisely, but they may NOT broaden the definition of who is eligible for services. HRSA HAB expects all HRSA RWHAP recipients to establish and monitor procedures to ensure that all funded providers verify and document client eligibility.

Affected individuals (people not identified with HIV) may be eligible for HRSA RWHAP services in limited situations, but these services for affected individuals must always benefit PLWH. Funds awarded under the HRSA RWHAP may be used for services to individuals affected by HIV only in the circumstances described below:

a. The primary purpose of the service is to enable the affected individual to participate in the care of a PLWH. Examples include caregiver training for in-home medical or support service; psychosocial support services, such as caregiver support groups; and/or respite care services that assist affected individuals with the stresses of providing daily care for a PLWH.

b. The service directly enables a PLWH to receive needed medical or support services by removing an identified barrier to care. Examples include payment of a HRSA RWHAP client's portion of a family health insurance policy premium to ensure continuity of insurance coverage that client, or childcare for the client's children while they receive HIV-related medical care or support services.

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

d. Services to affected individuals that meet these criteria may not continue subsequent to the death of the family member who was living with HIV.

Unallowable Costs:
HRSA RWHAP funds may not be used to make cash payments to intended clients of HRSA RWHAP-funded services. This prohibition includes cash incentives and

cash intended as payment for HRSA RWHAP core medical and support services. Where direct provision of the service is not possible or effective, store gift cards,[2] vouchers, coupons, or tickets that can be exchanged for a specific service or commodity (e.g., food or transportation) must be used.

HRSA RWHAP recipients are advised to administer voucher and store gift card programs in a manner which assures that vouchers and store gift cards cannot be exchanged for cash or used for anything other than the allowable goods or services, and that systems are in place to account for disbursed vouchers and store gift cards.[3]

Other unallowable costs include:

- Clothing
- Employment and Employment-Readiness Services, except in limited, specified instances (e.g., Non-Medical Case Management Services or Rehabilitation Services)
- Funeral and Burial Expenses
- Property Taxes
- Pre-Exposure Prophylaxis (PrEP)
- non-occupational Post-Exposure Prophylaxis (nPEP)
- Materials, designed to promote or encourage, directly, intravenous drug use or sexual activity, whether homosexual or heterosexual
- International travel
- The purchase or improvement of land
- The purchase, construction, or permanent improvement of any building or other facility

Allowable Costs:
The following service categories are allowable uses of HRSA RWHAP funds. The HRSA RWHAP recipient, along with respective planning bodies, will make the final decision regarding the specific services to be funded under their grant or cooperative agreement. As with all other allowable costs, HRSA RWHAP recipients are responsible for applicable accounting and reporting on the use of HRSA RWHAP funds.

Service Category Descriptions and Program Guidance

The following provides both a description of covered service categories and program guidance for HRSA RWHAP Part recipient implementation. These service category descriptions apply to the entire HRSA RWHAP. However, for some services, the

[2] Store gift cards that can be redeemed at one merchant or an affiliated group of merchants for specific goods or services that further the goals and objectives of the HRSA RWHAP are allowable as incentives for eligible program participants.
[3] General-use prepaid cards are considered “cash equivalent” and are therefore unallowable. Such cards generally bear the logo of a payment network, such as Visa, MasterCard, or American Express, and are accepted by any merchant that accepts those credit or debit cards as payment. Gift cards that are cobranded with the logo of a payment network and the logo of a merchant or affiliated group of merchants are general-use prepaid cards, not store gift cards, and therefore are unallowable.

HRSA RWHAP Parts (i.e., A, B, C, and D) must determine what is feasible and justifiable with limited resources. There is no expectation that a HRSA RWHAP Part recipient would provide all services, but recipients and planning bodies are expected to coordinate service delivery across Parts to ensure that the entire jurisdiction/service area has access to services based on needs assessment.

The following core medical and support service categories are important to assist in the diagnosis of HIV infection, linkage to and entry into care for PLWH, retention in care, and the provision of HIV care and treatment. HRSA RWHAP recipients are encouraged to consider all methods or means by which they can provide services, including use of technology (e.g., telehealth). To be an allowable cost under the HRSA RWHAP, all services must:

- Relate to HIV diagnosis, care and support,
- Adhere to established HIV clinical practice standards consistent with U.S. Department of Health and Human Services' Clinical Guidelines for the Treatment of HIV[4] and other related or pertinent clinical guidelines, and
- Comply with state and local regulations, and provided by licensed or authorized providers, as applicable.

Recipients are required to work toward the development and adoption of service standards for all HRSA RWHAP-funded services to ensure consistent quality care is provided to all HRSA RWHAP-eligible clients. Service standards establish the minimal level of service or care that a HRSA RWHAP funded agency or provider may offer within a state, territory or jurisdiction. Service standards related to HRSA RWHAP Core Medical Services must be consistent with U.S. Department of Health and Human Services' Clinical Guidelines for the Treatment of HIV, as well as other pertinent clinical and professional standards. Service standards related to HRSA RWHAP Support Services may be developed using evidence-based or evidence-informed best practices, the most recent HRSA RWHAP Parts A and B National Monitoring Standards, and guidelines developed by the state and local government.

HRSA RWHAP recipients should also be familiar with implementation guidance HRSA HAB provides in program manuals, monitoring standards, and other recipient resources.

HRSA RWHAP clients must meet income and other eligibility criteria as established by HRSA RWHAP Part A, B, C, or D recipients.

RWHAP Core Medical Services

AIDS Drug Assistance Program Treatments

[4] https://aidsinfo.nih.gov/guidelines

AIDS Pharmaceutical Assistance

Early Intervention Services (EIS)

Health Insurance Premium and Cost Sharing Assistance for Low-Income Individuals

Home and Community-Based Health Services

Home Health Care

Hospice

Medical Case Management, including Treatment Adherence Services

Medical Nutrition Therapy

Mental Health Services

Oral Health Care

Outpatient/Ambulatory Health Services

Substance Abuse Outpatient Care

RWHAP Support Services

Child Care Services

Emergency Financial Assistance

Food Bank/Home Delivered Meals

Health Education/Risk Reduction

Housing

Legal Services

Linguistic Services

Medical Transportation

Non-Medical Case Management Services

Other Professional Services

Outreach Services

Permanency Planning

Psychosocial Support Services

Referral for Health Care and Support Services

Rehabilitation Services

Respite Care

Substance Abuse Services (residential)

Effective Date
This PCN is effective for HRSA RWHAP Parts A, B, C, D, and F awards issued on or after October 1, 2016. This includes competing continuations, new awards, and non- competing continuations.

Summary of Changes
August 18, 2016 –Updated *Housing Service* category by removing the prohibition on HRSA RWHAP Part C recipients to use HRSA RWHAP funds for this service.

December 12, 2016 – 1) Updated *Health Insurance Premium and Cost Sharing Assistance for Low-Income Individuals* service category by including standalone dental insurance as an allowable cost; 2) Updated *Substance Abuse Services (residential)* service category by removing the prohibition on HRSA RWHAP Parts C and D recipients to use HRSA RWHAP funds for this service; 3) Updated *Medical Transportation* service category by providing clarification on provider transportation; 4) Updated *AIDS Drug Assistance Program Treatments* service category by adding additional program guidance; and 5) Reorganized the service categories alphabetically and provided hyperlinks in the Appendix.

October, 22, 2018 – updated to provide additional clarifications in the following service categories:

Core Medical Services: *AIDS Drug Assistance Program Treatments; AIDS Pharmaceutical Assistance; Health Insurance Premium and Cost Sharing Assistance for Low-income People Living with HIV; and Outpatient/Ambulatory Health Services*
Support Services: *Emergency Financial Assistance; Housing; Non-Medical Case Management; Outreach; and Rehabilitation Services*.

Appendix

RWHAP Legislation: Core Medical Services

AIDS Drug Assistance Program Treatments

Description:
The AIDS Drug Assistance Program (ADAP) is a state-administered program authorized under RWHAP Part B to provide U.S. Food and Drug Administration (FDA)-approved medications to low-income clients living with HIV who have no coverage or limited health care coverage. HRSA RWHAP ADAP formularies must include at least one FDA-approved medicine in each drug class of core antiretroviral medicines from the U.S. Department of Health and Human Services' Clinical Guidelines for the Treatment of HIV.[5] HRSA RWHAP ADAPs can also provide access to medications by using program funds to purchase health care coverage and through medication cost sharing for eligible clients. HRSA RWHAP ADAPs must assess and compare the aggregate cost of paying for the health care coverage versus paying for the full cost of medications to ensure that purchasing health care coverage is cost effective in the aggregate. HRSA RWHAP ADAPs may use a limited amount of program funds for activities that enhance access to, adherence to, and monitoring of antiretroviral therapy with prior approval.

Program Guidance:
HRSA RWHAP Parts A, C and D recipients may contribute RWHAP funds to the RWHAP Part B ADAP for the purchase of medication and/or health care coverage and medication cost sharing for ADAP-eligible clients.

See PCN 07-03: The Use of Ryan White HIV/AIDS Program, Part B AIDS Drug Assistance Program (ADAP) Funds for Access, Adherence, and Monitoring Services

See PCN 18-01: Clarifications Regarding the use of Ryan White HIV/AIDS Program Funds for Health Care Coverage Premium and Cost Sharing Assistance

See also AIDS Pharmaceutical Assistance and Emergency Financial Assistance

AIDS Pharmaceutical Assistance

Description:
AIDS Pharmaceutical Assistance may be provided through one of two programs, based on HRSA RWHAP Part funding.

1. A Local Pharmaceutical Assistance Program (LPAP) is operated by a HRSA RWHAP Part A or B (non-ADAP) recipient or subrecipient as a supplemental means of providing ongoing medication assistance when an HRSA RWHAP ADAP

[5] https://aidsinfo.nih.gov/guidelines

has a restricted formulary, waiting list and/or restricted financial eligibility criteria.

HRSA RWHAP Parts A or B recipients using the LPAP to provide AIDS Pharmaceutical Assistance must establish the following:

- Uniform benefits for all enrolled clients throughout the service area
- A recordkeeping system for distributed medications
- An LPAP advisory board
- A drug formulary that is
    - Approved by the local advisory committee/board, and
    - Consists of HIV-related medications not otherwise available to the clients due to the elements mentioned above
- A drug distribution system
- A client enrollment and eligibility determination process that includes screening for HRSA RWHAP ADAP and LPAP eligibility with rescreening at minimum of every six months
- Coordination with the state's HRSA RWHAP Part B ADAP
    - A statement of need should specify restrictions of the state HRSA RWHAP ADAP and the need for the LPAP
- Implementation in accordance with requirements of the HRSA 340B Drug Pricing Program (including the Prime Vendor Program)

2. A Community Pharmaceutical Assistance Program (CPAP) is provided by a HRSA RWHAP Part C or D recipient for the provision of ongoing medication assistance to eligible clients <u>in the absence of any other resources</u>.

HRSA RWHAP Parts C or D recipients using CPAP to provide AIDS Pharmaceutical Assistance must establish the following:

- A financial eligibility criteria and determination process for this specific service category
- A drug formulary consisting of HIV-related medications not otherwise available to the clients
- Implementation in accordance with the requirements of the HRSA 340B Drug Pricing Program (including the Prime Vendor Program)

Program Guidance:
For LPAPs: HRSA RWHAP Part A or Part B (non-ADAP) funds may be used to support an LPAP. HRSA RWHAP ADAP funds may not be used for LPAP support. LPAP funds are not to be used for emergency or short-term financial assistance. The Emergency Financial Assistance service category may assist with short-term assistance for medications.

For CPAPs: HRSA RWHAP Part C or D funds may be used to support a CPAP to routinely refill medications. HRSA RWHAP Part C or D recipients should use the Outpatient/Ambulatory Health Services or Emergency Financial Assistance service

categories for non-routine, short-term medication assistance.

See also AIDS Drug Assistance Program Treatments, Emergency Financial Assistance, and Outpatient/Ambulatory Health Services

Early Intervention Services (EIS)

Description:
The RWHAP legislation defines EIS for Parts A, B, and C. See § 2651(e) of the Public Health Service Act.

Program Guidance:
The elements of EIS often overlap with other service category descriptions; however, EIS is the combination of such services rather than a stand-alone service. HRSA RWHAP Part recipients should be aware of programmatic expectations that stipulate the allocation of funds into specific service categories.

- HRSA RWHAP Parts A and B EIS services must include the following four components:
    - Targeted HIV testing to help the unaware learn of their HIV status and receive referral to HIV care and treatment services if found to be living with HIV
        - Recipients must coordinate these testing services with other HIV prevention and testing programs to avoid duplication of efforts
        - HIV testing paid for by EIS cannot supplant testing efforts paid for by other sources
    - Referral services to improve HIV care and treatment services at key points of entry
    - Access and linkage to HIV care and treatment services such as HIV Outpatient/Ambulatory Health Services, Medical Case Management, and Substance Abuse Care
    - Outreach Services and Health Education/Risk Reduction related to HIV diagnosis

- HRSA RWHAP Part C EIS services must include the following four components:
    - Counseling individuals with respect to HIV
    - High risk targeted HIV testing (confirmation and diagnosis of the extent of immune deficiency)
        - Recipients must coordinate these testing services under HRSA RWHAP Part C EIS with other HIV prevention and testing programs to avoid duplication of efforts
        - The HIV testing services supported by HRSA RWHAP Part C EIS funds cannot supplant testing efforts covered by other sources
    - Referral and linkage to care of PLWH to Outpatient/Ambulatory Health

Services, Medical Case Management, Substance Abuse Care, and other services as part of a comprehensive care system including a system for tracking and monitoring referrals
- Other clinical and diagnostic services related to HIV diagnosis

Health Insurance Premium and Cost Sharing Assistance for Low-Income Individuals

Description:

Health Insurance Premium and Cost Sharing Assistance provides financial assistance for eligible clients living with HIV to maintain continuity of health insurance or to receive medical and pharmacy benefits under a health care coverage program. For purposes of this service category, health insurance also includes standalone dental insurance. The service provision consists of the following:

- Paying health insurance premiums to provide comprehensive HIV Outpatient/Ambulatory Health Services, and pharmacy benefits that provide a full range of HIV medications for eligible clients; and/or
- Paying standalone dental insurance premiums to provide comprehensive oral health care services for eligible clients; and/or
- Paying cost sharing on behalf of the client.

To use HRSA RWHAP funds for health insurance premium assistance (not standalone dental insurance assistance), an HRSA RWHAP Part recipient must implement a methodology that incorporates the following requirements:

- Clients obtain health care coverage that at a minimum, includes at least one U.S. Food and Drug Administration (FDA) approved medicine in each drug class of core antiretroviral medicines outlined in the U.S. Department of Health and Human Services' Clinical Guidelines for the Treatment of HIV, as well as appropriate HIV outpatient/ambulatory health services; and
- The cost of paying for the health care coverage (including all other sources of premium and cost sharing assistance) is cost-effective in the aggregate versus paying for the full cost for medications and other appropriate HIV outpatient/ambulatory health services (HRSA RWHAP Part A, HRSA RWHAP Part B, HRSA RWHAP Part C, and HRSA RWHAP Part D).

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

- HRSA RWHAP Part recipients must assess and compare the aggregate cost of paying for the standalone dental insurance option versus paying for the full cost of HIV oral health care services to ensure that purchasing standalone dental insurance is cost effective in the aggregate, and allocate funding to Health Insurance Premium and Cost Sharing Assistance only

when determined to be cost effective.

Program Guidance:
Traditionally, HRSA RWHAP Parts A and B recipients have supported paying for health insurance premiums and cost sharing assistance. If a HRSA RWHAP Part C or Part D recipient has the resources to provide this service, an equitable enrollment policy must be in place and it must be cost-effective.

HRSA RWHAP Parts A, B, C, and D recipients may consider providing their health insurance premiums and cost sharing resource allocation to their state HRSA RWHAP ADAP, particularly where the ADAP has the infrastructure to verify health care coverage status and process payments for public or private health care coverage premiums and medication cost sharing.

See PCN 14-01: Clarifications Regarding the Ryan White HIV/AIDS Program and Reconciliation of Premium Tax Credits under the Affordable Care Act

See PCN 18-01: Clarifications Regarding the use of Ryan White HIV/AIDS Program Funds for Health Care Coverage Premium and Cost Sharing Assistance

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

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

Program Guidance:
Inpatient hospitals, nursing homes, and other long-term care facilities are not considered an integrated setting for the purposes of providing home and community-based health services.

Home Health Care
Description:
Home Health Care is the provision of services in the home that are appropriate to an eligible client's needs and are performed by licensed professionals. Activities provided under Home Health Care must relate to the client's HIV disease and may include:

- Administration of prescribed therapeutics (e.g. intravenous and aerosolized treatment, and parenteral feeding)
- Preventive and specialty care
- Wound care

- Routine diagnostics testing administered in the home
- Other medical therapies

Program Guidance:
The provision of Home Health Care is limited to clients that are homebound. Home settings do not include nursing facilities or inpatient mental health/substance abuse treatment facilities.

Hospice Services
Description:
Hospice Services are end-of-life care services provided to clients in the terminal stage of an HIV-related illness. Allowable services are:

- Mental health counseling
- Nursing care
- Palliative therapeutics
- Physician services
- Room and board

Program Guidance:
Hospice Services may be provided in a home or other residential setting, including a non-acute care section of a hospital that has been designated and staffed to provide hospice services. This service category does not extend to skilled nursing facilities or nursing homes.

To meet the need for Hospice Services, a physician must certify that a patient is terminally ill and has a defined life expectancy as established by the recipient. Counseling services provided in the context of hospice care must be consistent with the definition of mental health counseling. Palliative therapies must be consistent with those covered under respective state Medicaid programs.

Medical Case Management, including Treatment Adherence Services
Description:
Medical Case Management is the provision of a range of client-centered activities focused on improving health outcomes in support of the HIV care continuum.

Activities provided under this service category may be provided by an interdisciplinary team that includes other specialty care providers. Medical Case Management includes all types of case management encounters (e.g., face-to-face, phone contact, and any other forms of communication).

Key activities include:

- Initial assessment of service needs
- Development of a comprehensive, individualized care plan
- Timely and coordinated access to medically appropriate levels of health and support services and continuity of care
- Continuous client monitoring to assess the efficacy of the care plan

- Re-evaluation of the care plan at least every 6 months with adaptations as necessary
- Ongoing assessment of the client's and other key family members' needs and personal support systems
- Treatment adherence counseling to ensure readiness for and adherence to complex HIV treatments
- Client-specific advocacy and/or review of utilization of services

In addition to providing the medically oriented activities above, Medical Case Management may also provide benefits counseling by assisting eligible clients in obtaining access to other public and private programs for which they may be eligible (e.g., Medicaid, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturer's Patient Assistance Programs, other state or local health care and supportive services, and insurance plans through the health insurance Marketplaces/Exchanges).

Program Guidance:
Activities provided under the Medical Case Management service category have as their objective improving health care outcomes whereas those provided under the Non-Medical Case Management service category have as their objective providing guidance and assistance in improving access to needed services.

Visits to ensure readiness for, and adherence to, complex HIV treatments shall be considered Medical Case Management or Outpatient/Ambulatory Health Services. Treatment Adherence services provided during a Medical Case Management visit should be reported in the Medical Case Management service category whereas Treatment Adherence services provided during an Outpatient/Ambulatory Health Service visit should be reported under the Outpatient/Ambulatory Health Services category.

Medical Nutrition Therapy
Description:
Medical Nutrition Therapy includes:
- Nutrition assessment and screening
- Dietary/nutritional evaluation
- Food and/or nutritional supplements per medical provider's recommendation
- Nutrition education and/or counseling

These activities can be provided in individual and/or group settings and outside of HIV Outpatient/Ambulatory Health Services.

Program Guidance:
All activities performed under this service category must be pursuant to a medical provider's referral and based on a nutritional plan developed by the registered dietitian or other licensed nutrition professional. Activities not provided by a

registered/licensed dietician should be considered Psychosocial Support Services under the HRSA RWHAP.

See also Food-Bank/Home Delivered Meals

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

Program Guidance:
Mental Health Services are allowable only for PLWH who are eligible to receive HRSA RWHAP services.

See also Psychosocial Support Services

Oral Health Care
Description:
Oral Health Care activities include outpatient diagnosis, prevention, and therapy provided by dental health care professionals, including general dental practitioners, dental specialists, dental hygienists, and licensed dental assistants.

Program Guidance:
None at this time.

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

Allowable activities include:
- Medical history taking
- Physical examination
- Diagnostic testing (including HIV confirmatory and viral load testing), as well as laboratory testing
- Treatment and management of physical and behavioral health conditions
- Behavioral risk assessment, subsequent counseling, and referral
- Preventive care and screening
- Pediatric developmental assessment
- Prescription and management of medication therapy

- Treatment adherence
- Education and counseling on health and prevention issues
- Referral to and provision of specialty care related to HIV diagnosis, including audiology and ophthalmology

Program Guidance:
Treatment adherence activities provided during an Outpatient/Ambulatory Health Service visit are considered Outpatient/Ambulatory Health Services, whereas treatment adherence activities provided during a Medical Case Management visit are considered Medical Case Management services.

Non-HIV related visits to urgent care facilities are not allowable costs within the Outpatient/Ambulatory Health Services Category.

Emergency room visits are not allowable costs within the Outpatient/Ambulatory Health Services Category.

See PCN 13-04: Clarifications Regarding Clients Eligible for Private Insurance and Coverage of Services by Ryan White HIV/AIDS Program

See also Early Intervention Services

Substance Abuse Outpatient Care
Description:
Substance Abuse Outpatient Care is the provision of outpatient services for the treatment of drug or alcohol use disorders. Activities under Substance Abuse Outpatient Care service category include:

- Screening
- Assessment
- Diagnosis, and/or
- Treatment of substance use disorder, including:
    - Pretreatment/recovery readiness programs
    - Harm reduction
    - Behavioral health counseling associated with substance use disorder
    - Outpatient drug-free treatment and counseling
    - Medication assisted therapy
    - Neuro-psychiatric pharmaceuticals
    - Relapse prevention

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

Syringe access services are allowable, to the extent that they comport with current appropriations law and applicable HHS guidance, including HRSA- or HAB-specific

guidance.

See also Substance Abuse Services (residential)

RWHAP Legislation: Support Services

Child Care Services
Description:
The HRSA RWHAP supports intermittent Child Care Services for the children living in the household of PLWH who are HRSA RWHAP-eligible clients for the purpose of enabling those clients to attend medical visits, related appointments, and/or HRSA RWHAP-related meetings, groups, or training sessions.

Allowable use of funds include:

- A licensed or registered child care provider to deliver intermittent care
- Informal child care provided by a neighbor, family member, or other person (with the understanding that existing federal restrictions prohibit giving cash to clients or primary caregivers to pay for these services)

Program Guidance:
The use of funds under this service category should be limited and carefully monitored. Direct cash payments to clients are not permitted.

Such arrangements may also raise liability issues for the funding source which should be carefully weighed in the decision process.

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

Program Guidance:
Emergency Financial Assistance funds used to pay for otherwise allowable HRSA RWHAP services must be accounted for under the Emergency Financial Assistance category. Direct cash payments to clients are not permitted.

Continuous provision of an allowable service to a client must not be funded through Emergency Financial Assistance.

Food Bank/Home Delivered Meals
Description:

Food Bank/Home Delivered Meals refers to the provision of actual food items, hot meals, or a voucher program to purchase food. This also includes the provision of essential non-food items that are limited to the following:

- Personal hygiene products
- Household cleaning supplies
- Water filtration/purification systems in communities where issues of water safety exist

Program Guidance:
Unallowable costs include household appliances, pet foods, and other non-essential products.

See Medical Nutrition Therapy. Nutritional services and nutritional supplements provided by a registered dietitian are considered a core medical service under the HRSA RWHAP.

Health Education/Risk Reduction
Description:
Health Education/Risk Reduction is the provision of education to clients living with HIV about HIV transmission and how to reduce the risk of HIV transmission. It includes sharing information about medical and psychosocial support services and counseling with clients to improve their health status. Topics covered may include:

- Education on risk reduction strategies to reduce transmission such as pre-exposure prophylaxis (PrEP) for clients' partners and treatment as prevention
- Education on health care coverage options (e.g., qualified health plans through the Marketplace, Medicaid coverage, Medicare coverage)
- Health literacy
- Treatment adherence education

Program Guidance:
Health Education/Risk Reduction services cannot be delivered anonymously.

See also Early Intervention Services

Housing
Description:
Housing provides transitional, short-term, or emergency housing assistance to enable a client or family to gain or maintain outpatient/ambulatory health services and treatment, including temporary assistance necessary to prevent homelessness and to gain or maintain access to medical care. Activities within the Housing category must also include the development of an individualized housing plan, updated annually, to guide the client's linkage to permanent housing. Housing may provide some type of core medical (e.g., mental health services) or support services (e.g., residential substance use disorder services).

Housing activities also include housing referral services, including assessment, search,

placement, and housing advocacy services on behalf of the eligible client, as well as fees associated with these activities.

Program Guidance:
HRSA RWHAP recipients and subrecipients that use funds to provide Housing must have mechanisms in place to assess and document the housing status and housing service needs of new clients, and at least annually for existing clients.

HRSA RWHAP recipients and subrecipients, along with local decision-making planning bodies, are strongly encouraged to institute duration limits to housing activities. HRSA HAB recommends recipients and subrecipients align duration limits with those definitions used by other housing programs, such as those administered by the Department of Housing and Urban Development, which currently uses 24 months for transitional housing.

Housing activities cannot be in the form of direct cash payments to clients and cannot be used for mortgage payments or rental deposits,[6] although these may be allowable costs under the HUD Housing Opportunities for Persons with AIDS grant awards.

Housing, as described here, replaces PCN 11-01.

Legal Services
See Other Professional Services

Linguistic Services
Description:
Linguistic Services include interpretation and translation activities, both oral and written, to eligible clients. These activities must be provided by qualified linguistic services providers as a component of HIV service delivery between the healthcare provider and the client. These services are to be provided when such services are necessary to facilitate communication between the provider and client and/or support delivery of HRSA RWHAP-eligible services.

Program Guidance:
Linguistic Services provided must comply with the National Standards for Culturally and Linguistically Appropriate Services (CLAS).

Medical Transportation
Description:
Medical Transportation is the provision of nonemergency transportation that enables an eligible client to access or be retained in core medical and support services.

Program Guidance:
Medical transportation may be provided through:

[6] See sections 2604(i), 2612(f), 2651(b), and 2671(a) of the Public Health Service Act.

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

Costs for transportation for medical providers to provide care should be categorized under the service category for the service being provided.

Unallowable costs include:

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

Non-Medical Case Management Services

Description:

Non-Medical Case Management Services (NMCM) is the provision of a range of client-centered activities focused on improving access to and retention in needed core medical and support services. NMCM provides coordination, guidance, and assistance in accessing medical, social, community, legal, financial, employment, vocational, and/or other needed services. NMCM Services may also include assisting eligible clients to obtain access to other public and private programs for which they may be eligible, such as Medicaid, Children's Health Insurance Program, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturer's Patient Assistance Programs, Department of Labor or Education-funded services, other state or local health care and supportive services, or private health care coverage plans. NMCM Services includes all types of case management encounters (e.g., face-to-face, telehealth, phone contact, and any other forms of communication). Key activities include:

- Initial assessment of service needs
- Development of a comprehensive, individualized care plan
- Timely and coordinated access to medically appropriate levels of health and support services and continuity of care
- Client-specific advocacy and/or review of utilization of services
- Continuous client monitoring to assess the efficacy of the care plan

- Re-evaluation of the care plan at least every 6 months with adaptations as necessary
- Ongoing assessment of the client's and other key family members' needs and personal support systems

Program Guidance:
NMCM Services have as their objective providing coordination, guidance and assistance in improving access to and retention in needed medical and support services to mitigate and eliminate barriers to HIV care services, whereas Medical Case Management Services have as their objective improving health care outcomes.

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

- Legal services provided to and/or on behalf of the HRSA RWHAP-eligible PLWH and involving legal matters related to or arising from their HIV disease, including:
    - Assistance with public benefits such as Social Security Disability Insurance (SSDI)
    - Interventions necessary to ensure access to eligible benefits, including discrimination or breach of confidentiality litigation as it relates to services eligible for funding under the HRSA RWHAP
    - Preparation of:
        - Healthcare power of attorney
        - Durable powers of attorney
        - Living wills
- Permanency planning to help clients/families make decisions about the placement and care of minor children after their parents/caregivers are deceased or are no longer able to care for them, including:
    - Social service counseling or legal counsel regarding the drafting of wills or delegating powers of attorney
    - Preparation for custody options for legal dependents including standby guardianship, joint custody, or adoption
- Income tax preparation services to assist clients in filing Federal tax returns that are required by the Affordable Care Act for all individuals receiving premium tax credits.

Program Guidance:
Legal services exclude criminal defense and class-action suits unless related to access to services eligible for funding under the RWHAP.

See 45 CFR § 75.459

Outreach Services

Description:

The Outreach Services category has as its principal purpose identifying PLWH who either do not know their HIV status, or who know their status but are not currently in care. As such, Outreach Services provide the following activities: 1) identification of people who do not know their HIV status and/or 2) linkage or re-engagement of PLWH who know their status into HRSA RWHAP services, including provision of information about health care coverage options.

Because Outreach Services are often provided to people who do not know their HIV status, some activities within this service category will likely reach people who are HIV negative. When these activities identify someone living with HIV, eligible clients should be linked to HRSA RWHAP services.

Outreach Services must:

1) use data to target populations and places that have a high probability of reaching PLWH who
    a. have never been tested and are undiagnosed,
    b. have been tested, diagnosed as HIV positive, but have not received their test results, or
    c. have been tested, know their HIV positive status, but are not in medical care;
2) be conducted at times and in places where there is a high probability that PLWH will be identified; and
3) be delivered in coordination with local and state HIV prevention outreach programs to avoid duplication of effort.

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

Program Guidance:

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

Outreach Services must not include outreach activities that exclusively promote HIV prevention education. Recipients and subrecipients may use Outreach Services funds for HIV testing when HRSA RWHAP resources are available and where the testing would not supplant other existing funding.

Outreach Services, as described here, replaces PCN 12-01.

See also Early Intervention Services

Permanency Planning
See Other Professional Services

Psychosocial Support Services
Description:
Psychosocial Support Services provide group or individual support and counseling services to assist HRSA RWHAP-eligible PLWH to address behavioral and physical health concerns. Activities provided under the Psychosocial Support Services may include:

- Bereavement counseling
- Caregiver/respite support (HRSA RWHAP Part D)
- Child abuse and neglect counseling
- HIV support groups
- Nutrition counseling provided by a non-registered dietitian (*see* Medical Nutrition Therapy Services)
- Pastoral care/counseling services

Program Guidance:
Funds under this service category may not be used to provide nutritional supplements (*See* Food Bank/Home Delivered Meals).

HRSA RWHAP-funded pastoral counseling must be available to all eligible clients regardless of their religious denominational affiliation.

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

For HRSA RWHAP Part D recipients, outpatient mental health services provided to affected clients (people not identified with HIV) should be reported as Psychosocial Support Services; this is generally only a permissible expense under HRSA RWHAP Part D.

See also Respite Care Services

Rehabilitation Services
Description:
Rehabilitation Services provide HIV-related therapies intended to improve or maintain a client's quality of life and optimal capacity for self-care on an outpatient basis, and in accordance with an individualized plan of HIV care.

Program Guidance:

Allowable activities under this category include physical, occupational, speech, and

vocational therapy.

Rehabilitation services provided as part of inpatient hospital services, nursing homes, and other long-term care facilities are not allowable.

Referral for Health Care and Support Services
Description:
Referral for Health Care and Support Services directs a client to needed core medical or support services in person or through telephone, written, or other type of communication. Activities provided under this service category may include referrals to assist HRSA RWHAP-eligible clients to obtain access to other public and private programs for which they may be eligible (e.g., Medicaid, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturer's Patient Assistance Programs, and other state or local health care and supportive services, or health insurance Marketplace plans).

Program Guidance:
Referrals for Health Care and Support Services provided by outpatient/ambulatory health care providers should be reported under the Outpatient/Ambulatory Health Services category.

Referrals for health care and support services provided by case managers (medical and non-medical) should be reported in the appropriate case management service category (i.e., Medical Case Management or Non-Medical Case Management).

See also Early Intervention Services

Respite Care
Description:

Respite Care is the provision of periodic respite care in community or home-based settings that includes non-medical assistance designed to provide care for an HRSA RWHAP-eligible client to relieve the primary caregiver responsible for their day-to-day care.

Program Guidance:
Recreational and social activities are allowable program activities as part of a Respite Care provided in a licensed or certified provider setting including drop-in centers within HIV Outpatient/Ambulatory Health Services or satellite facilities.

Funds may be used to support informal, home-based Respite Care, but liability issues should be included in the consideration of this expenditure. Direct cash payments to clients are not permitted.

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

See also Psychosocial Support Services

Substance Abuse Services (residential)
Description:
Substance Abuse Services (residential) activities are those provided for the treatment of drug or alcohol use disorders in a residential setting to include screening, assessment, diagnosis, and treatment of substance use disorder. Activities provided under the Substance Abuse Services (residential) service category include:

- Pretreatment/recovery readiness programs
- Harm reduction
- Behavioral health counseling associated with substance use disorder
- Medication assisted therapy
- Neuro-psychiatric pharmaceuticals
- Relapse prevention
- Detoxification, if offered in a separate licensed residential setting (including a separately-licensed detoxification facility within the walls of an inpatient medical or psychiatric hospital)

Program Guidance:
Substance Abuse Services (residential) is permitted only when the client has received a written referral from the clinical provider as part of a substance use disorder treatment program funded under the HRSA RWHAP.

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

HRSA RWHAP funds may not be used for inpatient detoxification in a hospital setting, unless the detoxification facility has a separate license.

Department of Health and Human Services
Health Resources and Services Administration

Notice of Award
FAIN# H8900053
Federal Award Date: 03/23/2021

Recipient Information

1. Recipient Name
CITY OF NORFOLK
710 Monticello Ave
Norfolk, VA 23510-2524

2. Congressional District of Recipient
03

3. Payment System Identifier (ID)
1546001455A6

4. Employer Identification Number (EIN)
546001455

5. Data Universal Numbering System (DUNS)
074740069

6. Recipient's Unique Entity Identifier

7. Project Director or Principal Investigator
Christine M Carroll
Program Manager
Christine.Carroll@norfolk.gov
(757)823-4405

8. Authorized Official

Federal Agency Information

9. Awarding Agency Contact Information
India Smith
GRANTS MANAGEMENT SPECIALIST
Health Resources and Services Administration
ISmith@hrsa.gov
(301) 443-2096

10. Program Official Contact Information
Kristina Barney
Project Officer
Health Resources and Services Administration
kbarney@hrsa.gov
(301) 945-3976

Federal Award Information

11. Award Number
6 H89HA00053-23-01

12. Unique Federal Award Identification Number (FAIN)
H8900053

13. Statutory Authority
42 U.S.C. § 300ff-11-20; 300ff-121

14. Federal Award Project Title
HIV EMERGENCY RELIEF PROJECT GRANTS

15. Assistance Listing Number
93.914

16. Assistance Listing Program Title
HIV Emergency Relief Project Grants

17. Award Action Type
Administrative

18. Is the Award R&D?
No

Summary Federal Award Financial Information

19. Budget Period Start Date 03/01/2021 - End Date 02/28/2022	
20. Total Amount of Federal Funds Obligated by this Action	$4,432,476.00
20a. Direct Cost Amount	
20b. Indirect Cost Amount	
21. Authorized Carryover	$0.00
22. Offset	$0.00
23. Total Amount of Federal Funds Obligated this budget period	$5,755,914.00
24. Total Approved Cost Sharing or Matching, where applicable	$0.00
25. Total Federal and Non-Federal Approved this Budget Period	$5,755,914.00
26. Project Period Start Date 03/01/2021 - End Date 02/28/2022	
27. Total Amount of the Federal Award including Approved Cost Sharing or Matching this Project Period	$5,755,914.00

28. Authorized Treatment of Program Income
Addition

29. Grants Management Officer – Signature
Brad Barney on 03/23/2021

30. Remarks

This award consists of the following amounts:
FY19 MAI-$21,580
FY19 Formula-$116,099
FY19 Supplemental- $180,235
FY21 MAI-$381,141
FY21 Formula-$2,210,199
FY21 Supplemental-$1,523,222

Total FY21 Award-$4,432,476

HRSA
Health Resources & Services Administration

Notice of Award
Award Number: 6 H89HA00053-23-01
Federal Award Date: 03/23/2021

Health Resources and Services Administration

31. APPROVED BUDGET: (Excludes Direct Assistance)

[X] Grant Funds Only

[ ] Total project costs including grant funds and all other financial participation

a.	Salaries and Wages:	$0.00
b.	Fringe Benefits:	$0.00
c.	Total Personnel Costs:	$0.00
d.	Consultant Costs:	$0.00
e.	Equipment:	$0.00
f.	Supplies:	$0.00
g.	Travel:	$0.00
h.	Construction/Alteration and Renovation:	$0.00
i.	Other:	$0.00
j.	Consortium/Contractual Costs:	$0.00
k.	Trainee Related Expenses:	$0.00
l.	Trainee Stipends:	$0.00
m.	Trainee Tuition and Fees:	$0.00
n.	Trainee Travel:	$0.00
o.	TOTAL DIRECT COSTS:	$5,755,914.00
p.	INDIRECT COSTS (Rate: % of S&W/TADC):	$0.00
q.	TOTAL APPROVED BUDGET:	$5,755,914.00
	i. Less Non-Federal Share:	$0.00
	ii. Federal Share:	$5,755,914.00

32. AWARD COMPUTATION FOR FINANCIAL ASSISTANCE:

a.	Authorized Financial Assistance This Period	**$5,755,914.00**
b.	Less Unobligated Balance from Prior Budget Periods	
	i. Additional Authority	$0.00
	ii. Offset	$0.00
c.	Unawarded Balance of Current Year's Funds	$0.00
d.	Less Cumulative Prior Award(s) This Budget Period	$1,323,438.00
e.	AMOUNT OF FINANCIAL ASSISTANCE THIS ACTION	**$4,432,476.00**

33. RECOMMENDED FUTURE SUPPORT:
(Subject to the availability of funds and satisfactory progress of project)

YEAR	TOTAL COSTS
Not applicable	

34. APPROVED DIRECT ASSISTANCE BUDGET: (In lieu of cash)

a. Amount of Direct Assistance	$0.00
b. Less Unawarded Balance of Current Year's Funds	$0.00
c. Less Cumulative Prior Award(s) This Budget Period	$0.00
d. AMOUNT OF DIRECT ASSISTANCE THIS ACTION	**$0.00**

35. FORMER GRANT NUMBER

36. OBJECT CLASS
41.15

37. BHCMIS#

38. THIS AWARD IS BASED ON AN APPLICATION SUBMITTED TO, AND AS APPROVED BY HRSA, IS ON THE ABOVE TITLED PROJECT AND IS SUBJECT TO THE TERMS AND CONDITIONS INCORPORATED EITHER DIRECTLY OR BY REFERENCE IN THE FOLLOWING:
a. The grant program legislation cited above. b. The grant program regulation cited above. c. This award notice including terms and conditions, if any, noted below under REMARKS. d. 45 CFR Part 75 as applicable. In the event there are conflicting or otherwise inconsistent policies applicable to the grant, the above order of precedence shall prevail. Acceptance of the grant terms and conditions is acknowledged by the grantee when funds are drawn or otherwise obtained from the grant payment system.

39. ACCOUNTING CLASSIFICATION CODES

FY-CAN	CFDA	DOCUMENT NUMBER	AMT. FIN. ASST.	AMT. DIR. ASST.	SUB PROGRAM CODE	SUB ACCOUNT CODE
21 - 3772306	93.914	21H89HA00053	$2,210,199.00	$0.00	FRML	21H89HA00053
19 - 3772207	93.914	21H89HA00053	$116,099.00	$0.00	FRML	21H89HA00053
21 - 3772307	93.914	21H89HA00053	$1,523,222.00	$0.00	SUPPL	21H89HA00053
19 - 3772208	93.914	21H89HA00053	$180,235.00	$0.00	SUPPL	21H89HA00053
21 - 3772305	93.914	21H89HA00053	$381,141.00	$0.00	MAI	21H89HA00053
19 - 3772206	93.914	21H89HA00053	$21,580.00	$0.00	MAI	21H89HA00053

HRSA Electronic Handbooks (EHBs) Registration Requirements

The Project Director of the grant (listed on this NoA) and the Authorizing Official of the grantee organization are required to register (if not already registered) within HRSA's Electronic Handbooks (EHBs). Registration within HRSA EHBs is required only once for each user for each organization they represent. To complete the registration quickly and efficiently we recommend that you note the 10-digit grant number from box 4b of this NoA. After you have completed the initial registration steps (i.e.,created an individual account and associated it with the correct grantee organization record), be sure to add this grant to your portfolio. This registration in HRSA EHBs is required for submission of noncompeting continuation applications. In addition, you can also use HRSA EHBs to perform other activities such as updating addresses, updating email addresses and submitting certain deliverables electronically. Visit https://grants3.hrsa.gov/2010/WebEPSExternal/Interface/common/accesscontrol/login.aspx to use the system. Additional help is available online and/or from the HRSA Call Center at 877-Go4-HRSA/877-464-4772.

Terms and Conditions

Failure to comply with the remarks, terms, conditions, or reporting requirements may result in a draw down restriction being placed on your Payment Management System account or denial of future funding.

Grant Specific Term(s)

1. This Notice of Award provides the balance of fiscal year 2021 (FY21) funding based on HRSA's FY21 appropriations and budget allocations. All previously conveyed terms and conditions remain in effect unless specifically removed.
2. This Notice of Award provides the offset of an unobligated balance in the amount of $317,914 from the 03/1/2019-02/29/2020 budget period to the current budget period. Please be advised that if the final resolution of the audit determines that the unobligated balance of Federal Funds is incorrect, HRSA is not obligated to make additional Federal Funds available to cover the shortfall.

Program Specific Term(s)

1. Requirements regarding the timeframe for obligation and expenditure of formula and supplemental RWHAP funds within the designated timeframe, including the requirement to submit an estimated unobligated balance and carryover request prior to the end of the grant year, and associated penalties are waived for FY 2020 and FY 2021. Recipients are still required to submit a final FFR.
2. Recipients are required to participate in the development of the Statewide Coordinated Statement of Need (SCSN) as facilitated by the RWHAP Part B recipient. As the HRSA guidance for the Integrated HIV Prevention and Care Plan indicates the SCSN is a component of the Integrated HIV Prevention and Care Plan, http://hab.hrsa.gov/manageyourgrant/hivpreventionplan062015.pdf, due to HRSA and CDC in September 2016. Therefore, recipients are required to participate in the Integrated HIV Prevention and Care Plan development.

Reporting Requirement(s)

1. **Due Date: Within 90 Days of Award Issue Date**
   The recipient must submit a FY 2021 Program Submission no later than 90 days after receipt of the final award, consistent with reporting guidelines, instructions, and/or reporting templates provided in the HRSA EHBs.
2. **Due Date: Within 90 Days of Award Issue Date**
   The recipient must submit a FY 2021 Program Terms Report no later than 90 days after the receipt of the final award, consistent with reporting guidelines, instructions, and/or reporting templates provided in the HRSA EHBs.
3. **Due Date: 05/29/2021**
   The recipient must submit a Final FY 2021 Part A Annual Progress Report no later than 90 days after the budget period end date, consistent with reporting guidelines, instructions, and/or reporting templates provided in the HRSA EHBs.

Failure to comply with these reporting requirements will result in deferral or additional restrictions of future funding decisions.

All prior terms and conditions remain in effect unless specifically removed.

Contacts

NoA Email Address(es):

Name	Role	Email
Christine M Carroll	Program Director	christine.carroll@norfolk.gov
Robert L Hargett	Business Official	robert.hargett@norfolk.gov
Marsha D Butler	Employee	marsha.butler@norfolk.gov

Note: NoA emailed to these address(es)

All submissions in response to conditions and reporting requirements (with the exception of the FFR) must be submitted via EHBs. Submissions for Federal Financial Reports (FFR) must be completed in the Payment Management System (https://pms.psc.gov/).

Health Resources and Services Administration
HRSA-21-055

HAB: Ryan White HIV/AIDS Program Part A HIV Emergency Relief Grant Program

Objective Review Committee Final Summary Statement

Score: 96

Application Number: 182515
Application Name: Norfolk, City of
State: VA City: Norfolk

NEED

Demonstrated Need

Criterion 1.1.1: Epidemiological Profile

Strength:

The application provides a comprehensive description of the needs of persons with HIV both in and out of care that include the socioeconomic data for the five regions in Virginia, and the disparities experienced by communities of color.

Weakness:

None

Criterion 1.1.2: HIV Care Continuum

Strength:

A detailed description of the viral suppression rate for three of the most disproportionately impacted minority populations with identified health disparities is identified.

Weakness:

None

Criterion 1.1.3: Co-occurring Conditions

Strength:

A detailed description of the co-occurring conditions for the target population is provided, which includes the incidence, prevalence, and estimations with clear data source citations.

Weakness:

None

Criterion 1.1.4: Complexities of Providing Care

Strength:

A comprehensive description of the poverty and health coverage of the target population is provided, including statics of individuals on Medicaid, Medicare, insured, uninsured, and individuals below 138 percent of the Federal Poverty Level (FPL).

Weakness:

None

Early Identification of Individuals with HIV/AIDS (EIIHA)

Criterion 1.2.1: EIIHA Plan

Strength:

The application clearly provides a definition of the Early Identification of Individuals with HIV/AIDS (EIIHA) Plan and activities, including system-level interventions, collaborations with other programs and agencies, prevention and surveillance programs, and anticipated outcomes of the program's strategy.

Weakness:

None

Criterion 1.2.2: 2) Appropriateness of the description of three distinct target populations

Strength:

The applicant organization details why the target population is chosen, specific challenges anticipated for each population, and specific strategies that will be utilized in addressing each of the challenges.

Weakness:

None

Criterion 1.2.3: Clarity and completeness of plans to address legal barriers

Strength:

The applicant organization clearly documents the only legal barrier of HIV testing reimbursement is removed.

Weakness:

None

RESPONSE

Criterion 2.1: Methodology

Strength:

A detailed description of the prioritization and allocation processes with community input is provided.

A detailed description of coordination of services and funding streams is provided with a comprehensive narrative identifying resource needs not offered in the proposed target area.

Weakness:

None

Work Plan

Criterion 2.2.1: Funding for Core Medical and Support Services

Strength:

A comprehensive table illustrating how the proposed project, the Minority AIDS Initiative (MAI) core medical support services, priority number, funded amount, unduplicated clients, and target population are provided.

Weakness:

None

Criterion 2.2.2: MAI Service Category Plan Narrative

Strength:

A thorough explanation is provided documenting how services included in the MAI Service Category Plan are specific and tailored to the three populations that will be served by the proposed project.

Weakness:

None

Criterion 2.3: Resolution of Challenges

Strength:

The applicant organization specifically describes approaches to resolve challenges and barriers, including those challenges in integrating the HIV care continuum into planning and implementing the Ryan White HIV/AIDS Program (RWHAP) Part A grant.

Weakness:

None

Criterion 3: EVALUATIVE MEASURES

Strength:

The applicant organization clearly describes evaluative measures that include how performance data will evaluate disparities, and how Clinical Quality Management (CQM) data will be used to improve change service delivery.

Weakness:

None

Criterion 4: IMPACT

Strength:

A detailed description of changes in the health care landscape for the target area and how it has impacted the health outcome of the proposed target population is provided.

A thorough description of the changes in the HIV care continuum from fiscal years 2017 to 2019 is provided, supporting the need for the proposed project.

Weakness:

None

RESOURCES/CAPABILITIES

Criterion 5.1: Program Organization

Strength:

A detailed description of the staffing plan is provided for the proposed project, accompanied by biographical sketches of key personnel with the expertise and experience to effectively implement the proposed project.

Weakness:

None

Criterion 5.2: Recipient Accountability

Strength:

The applicant organization clearly describes its third-party reimbursements with payor of last resort, tracking source, and use of program income, including conducting annual RWHAP eligibility determinations and re-certifications.

A detailed description of the monitoring processes and fiscal oversight procedures are provided.

Weakness:

None

Criterion 6: SUPPORT REQUESTED

Strength:

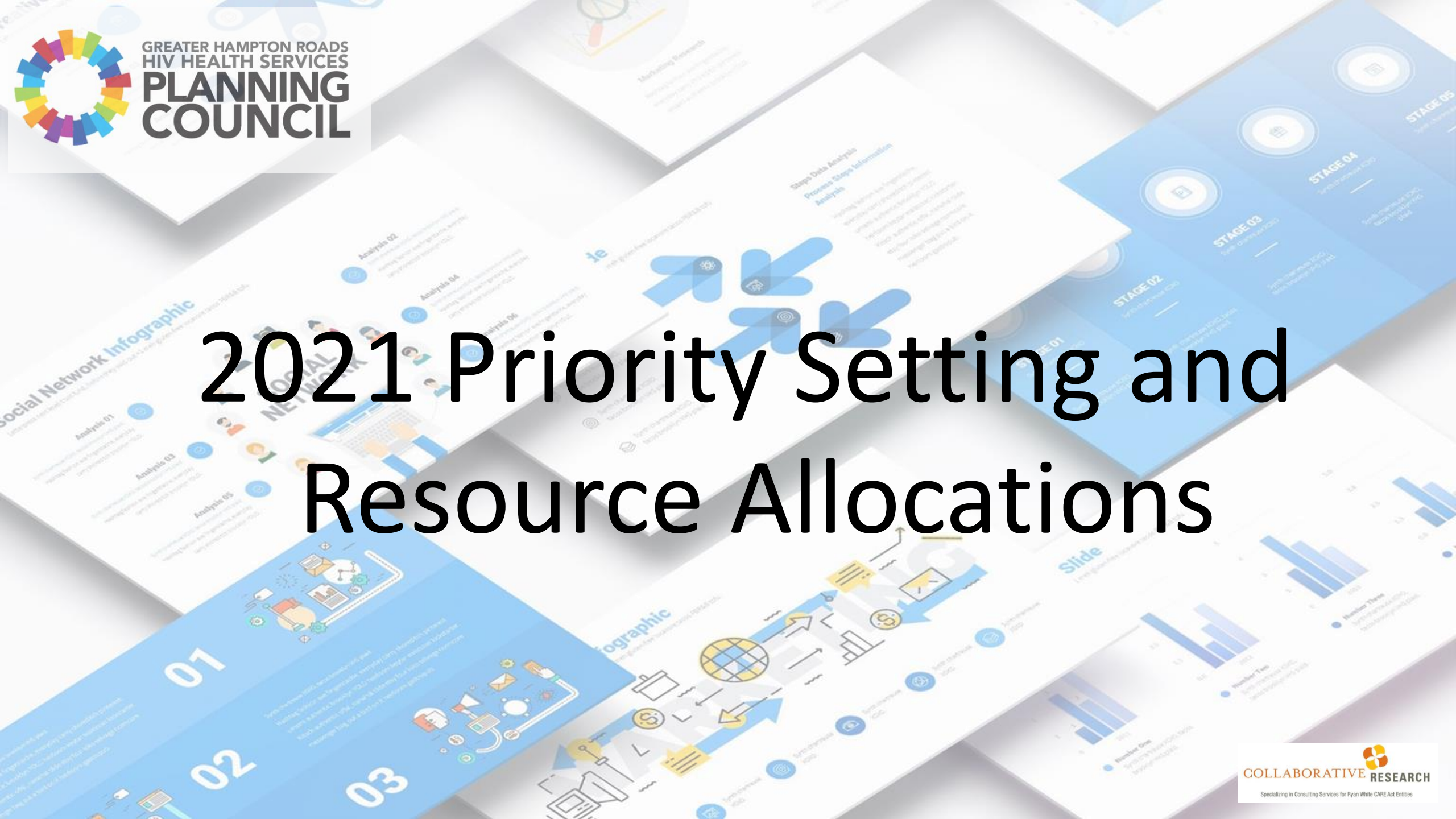
The budget is reasonable as it relates to the scope of work. The budget also reflects that staff designated to perform tasks on the project have adequate time to implement the tasks/activities.

Weakness:

None

GREATER HAMPTON ROADS HIV HEALTH SERVICES PLANNING COUNCIL

2021 Priority Setting and Resource Allocations



COLLABORATIVE RESEARCH
Specializing in Consulting Services for Ryan White CARE Act Entities

Norfolk TGA At-A-Glance

The Norfolk Transitional Grant Area (TGA) is comprised of 14 Cities/Counties in Virginia and one county in North Carolina. The TGA has an estimated population of 1,717,160. The TGA's general population racial/ethic representation is 56% White/Caucasian, 30% Black/African American, 4% Multiracial, 4% Asian, and less than 1% combined for American Indians, Alaskan Natives, Native Hawaiians and/or Pacific Islanders. Approximately 7% of above races identify as being Hispanic or Latin in origin. According to the *US Census Bureau Quick Facts*, the TGA's poverty rate is 33% compared to 13.9% nationally. As of December 31, 2019, there were 7,831 PLWH, with 415 new HIV diagnoses in 2019. African American/Black non-Hispanic communities continue to be disproportionately impacted by HIV. Since 2015, HIV-incidence among White non-Hispanic decreased by 13.1% while African American/Black non-Hispanic increased by 4.5%.

Who we serve:

- Chesapeake
- Norfolk
- Virginia Beach
- Portsmouth
- Suffolk
- Isle of Wight
- Hampton
- Poquoson
- Newport News
- Williamsburg
- James City County
- Gloucester County
- Mathews County
- York County
- Currituck Co., NC

Census.gov. (2019). State and County QuickFacts. Quickfacts.census.gov. Retrieved 25 August 2020, from http://quickfacts.census.gov/qfd/index.html

Norfolk TGA ROLES AND RESPONSIBILITIES

Based on needs assessment, utilization, and epidemiologic data—the Planning Council decides what services are most needed by people living with HIV in the TGA (priority setting) and decides how much RWHAP Part A money should be used for each of these service categories (resource allocations).

Roles/Duties of the CEO, Recipient, and Planning Council

ROLE/DUTY	RESPONSIBILITY		
	CEO	Recipient	Planning Council
Establishment of Planning Council/ Planning Body	✓		
Appointment of Planning Council/ Planning Body Members	✓		
Needs Assessment		✓	✓
Integrated/Comprehensive Planning		✓	✓
Priority Setting			✓
Resource Allocations			✓
Directives			✓
Procurement of Services		✓	
Contract Monitoring		✓	
Coordination of Services		✓	✓
Evaluation of Services: Performance, Outcomes, and Cost-Effectiveness		✓	*Optional*
Development of Service Standards		✓	✓
Clinical Quality Management		✓	*Contributes but not responsible*
Assessment of the Efficiency of the Administrative Mechanism			✓
Planning Council Operations and Support		✓	✓

The planning council may also provide guidance to the recipient on service models, targeting of populations or service areas, and other ways to best meet the identified priorities (directives)

Ryan White HIV/AIDS Program Part A. Planning Council Primer. June 2018. JSI Research & Training Institute, Inc. in collaboration with EGM Consulting, LLC.

Norfolk TGA LEGISLATIVE REQUIREMENTS

The planning council uses needs assessment data as well as data from a number of other sources to set priorities and allocate resources. This means the members decide which services are most important to people living with HIV in the EMA or TGA (priority setting) and then agree on which service categories to fund and how much funding to provide (resource allocations). In setting priorities, the planning council should consider what service categories are needed to provide a comprehensive system of care for people living with HIV in the EMA or TGA, without regard to who funds those services.

ELIGIBLE RWHAP PART A & PART B SERVICES

Core medical-related services, including:

1. AIDS Drug Assistance Program (ADAP) Treatments
2. Local AIDS Pharmaceutical Assistance Program (LPAP)
3. Early Intervention Services (EIS)
4. Health Insurance Premium and Cost Sharing Assistance for Low-Income Individuals
5. Home and Community-Based Health Services
6. Home Health Care
7. Hospice Services
8. Medical Case Management, including Treatment Adherence Services
9. Medical Nutrition Therapy
10. Mental Health Services
11. Oral Health Care
12. Outpatient/Ambulatory Health Services
13. Substance Abuse Outpatient Care

Support services, including:

1. Child Care Services
2. Emergency Financial Assistance
3. Food Bank/Home Delivered Meals
4. Health Education/Risk Reduction
5. Housing
6. Linguistic Services
7. Medical Transportation
8. Non-Medical Case Management Services
9. Other Professional Services [for example, Legal Services and Permanency Planning]
10. Outreach Services
11. Psychosocial Support Services
12. Referral for Healthcare and Support Services
13. Rehabilitation Services
14. Respite Care
15. Substance Abuse Services (residential)

The planning council must prioritize only service categories that are included in the RWHAP legislation as core medical services or support services. These are the same service categories that can be funded by RWHAP Part B and RWHAP Part C programs.

Norfolk TGA LEGISLATIVE REQUIREMENTS

75%
Core

25%
Support

After it sets priorities, the planning council must allocate resources, which means it decides how much RWHAP Part A funding will be used for each of these service priorities. For example, the planning council decides how much funding should go for outpatient/ ambulatory health services, mental health services, etc. In allocating resources, planning councils need to focus on the legislative requirement that at least 75 percent of funds must go to cover medical services and not more than 25 percent to support services, unless the EMA or TGA has obtained a waiver of this requirement. Support services must contribute to positive medical outcomes for clients. Typically, the planning council makes resource allocations using three scenarios that assume unchanged, increased, and decreased funding in the coming program year.

The planning council makes decisions about priorities and resource allocations based on many factors, including:

- Needs assessment findings;
- Information about the most successful and economical ways of providing services;
- Actual service cost and utilization data (provided by the recipient);
- Priorities of people living with HIV who will use services ;
- Use of RWHAP Part A funds to work well with other services like HIV prevention and substance abuse treatment services, and within the changing healthcare landscape; and
- The amount of funds provided by other sources like Medicaid, Medicare, state and local government, and private funders—since RWHAP is the “payor of last resort” and should not pay for services that can be provided with other funding.

Ryan White HIV/AIDS Program Part A. Planning Council Primer. June 2018. JSI Research & Training Institute, Inc. in collaboration with EGM Consulting, LLC.

Norfolk TGA Notice of funding opportunity

Funding Opportunity Number: HRSA-22-018
Funding Opportunity Type(s): Competing Continuation
Catalog of Federal Domestic Assistance (CFDA) Number: 93.914
Application Due Date: October 6, 2021
Funding Ceiling: $6,043,710.00

B. Planning Responsibilities

Section 2602(b)(4)(C) of the PHS Act requires PCs/PBs to determine the priority for RWHAP allowable services and service allocations of RWHAP Part A funds every year. To fulfill this responsibility, EMA/TGA PCs/PBs set service priorities and allocate RWHAP Part A funds based on the size, demographics, and needs of people with or affected by HIV, with particular focus on individuals who know their HIV status but are not in care. The RWHAP Part A PCs/PBs also are responsible for evaluating the efficiency of the recipient in distributing funds to service providers.

PCs/PBs analyze information to develop an in-depth understanding of the current HIV epidemic and its impact on the service area. PCs/PBs review needs assessment data, HIV epidemiologic data, and co-occurring conditions data. The review includes service utilization data related to complexity of providing care, including service availability and unit cost per service, as well as service needs of emerging populations. The purpose of these data reviews is to guide decisions about HIV-related services and resources in the EMA/TGA. Furthermore, planning and implementation of the RWHAP Part A is driven by overall comprehensive planning and the recently developed Integrated HIV Prevention and Care Plan, including the Statewide Coordinated Statement of Need, Calendar Year (CY) 2017-2021 as a roadmap for relevant goals, objectives, and strategies for delivering RWHAP Part A services along the HIV care continuum. Locally developed Ending the HIV Epidemic plans, where available, might also serve as a valuable roadmap.

Norfolk TGA PSRA Procedure

STAGE 1

Planning and Resource Allocation

Planning and Resource Allocation

The purpose of this section is to document the existence of a functioning planning process in the EMA/TGA that is consistent with RWHAP and HRSA program requirements. Section 2602(b)(1)-(4) of the PHS Act delineates the responsibilities of the PC/PB. A planning process is imperative for effective local and state decision making to develop systems of prevention and care that are responsive to the needs of persons at risk for HIV and people with HIV. HRSA and CDC support activities that facilitate collaboration and/or develop a joint planning body to address prevention and care. Community engagement is an essential component for planning comprehensive, effective HIV prevention and care programs in the United States.

The composition of the PC/PB must reflect the demographics of the HIV epidemic in the EMA/TGA and be representative of various required categories of membership as cited in Sec. 2602(b)(1)-(2) of the PHS Act. PC/PB members must be trained regarding their legislatively mandated responsibilities and other competencies necessary for full participation in collaborative decision-making. PCs/PBs are encouraged to educate members about service issues related to the prevention of intimate partner violence, opioid and other drug use, and trauma-informed care as part of their ongoing training. PCs/PBs should also consider recruiting members who are knowledgeable about these issues.

Norfolk TGA PSRA Procedure

STAGE 1

Planning and Resource Allocation

Planning and Resource Allocation

Priority Setting and Resource Allocation (PSRA):

i. Data (e.g., comprehensive needs assessment, HIV care continuum, unmet need framework estimates, and epi profile) were used in the FY 2022 priority setting and allocations process to ensure that:
   a) Needs of the populations with HIV (including those with unmet need for HIV-related services, disparities in access and services among affected subpopulations and historically underserved communities, and those unaware of their HIV status) are addressed.
   b) Resources were allocated in accordance with the local demographic incidence of AIDS including appropriate allocations for services for women infants, children, and youth
ii. People with HIV were involved in the planning and allocation processes and how their priorities were considered in the process
iii. FY 2021 period of performance formula, supplemental, and MAI funds awarded to the EMA/TGA were expended according to the priorities established by the PC or PB

Norfolk TGA PSRA Procedure

1

STAGE 1

Planning and Resource Allocation

Review of Data

- 2019 Service Utilization
- 2020 Service Utilization
- 2020 PC Red Ribbon
- 2017 Trienial Needs Assessment
- 2017 Consumer Survey
- 2021 CAC Red Ribbon
- 2018/2019 CAC Red Ribbon
- 2020 VDH COVID-19 Survey
- 2019 VDH RWB Consumer Needs Assessment

Link

Planning Council "linked" 2022 priorities to the TGA's HIV Care Continuum with the goal of viral suppression as outlined in the Integrated HIV Prevention and Care Plan

Recommend

Planning Council weights each data source based on the relevance and reliability of data. Once a weight is assigned, priorites are populated based on data.

2022/23 Priority Setting Process – Norfolk TGA

Norfolk TGA PSRA Procedure

1

STAGE 1

Planning and Resource Allocation

Review of Data

Planning Council reviews a 4 year trend of cost and service utilization data for all service categories. The following are data sets:

1. Unduplicated client count
2. Unit cost by service category
3. Average cost per client
4. Other funding sources (RWHAP, HOPWA, Medicaid)

Resource Allocation Components

The Planning Council utilizes data sources to determine all resource allocations for GY2022/23 with focus on the following 4 components:

Component 1:
PLWH currently in the RWPA care system (Maintain)

Component 2:
PLWH Newly Diagnosed entering the care system

Component 3:
PLWH Out of Care / Lost to Care

Component 4:
Unaware Population

2022/23 Priority Setting Process – Norfolk TGA

Norfolk TGA PSRA Procedure

STAGE 2

Description of the Community Input Process

Description of the Community Input Process

Describe the overall community input process and how it informs the PC/PB priority setting and resource allocation process for the jurisdiction and include a summary of how the process was conducted. Also, include a discussion of how the input process has helped inform the RWHAP Part A service priorities and resource allocations, as well as a description of how the input process is interwoven into your RWHAP Part A activities.

<u>Specifically, address:</u>

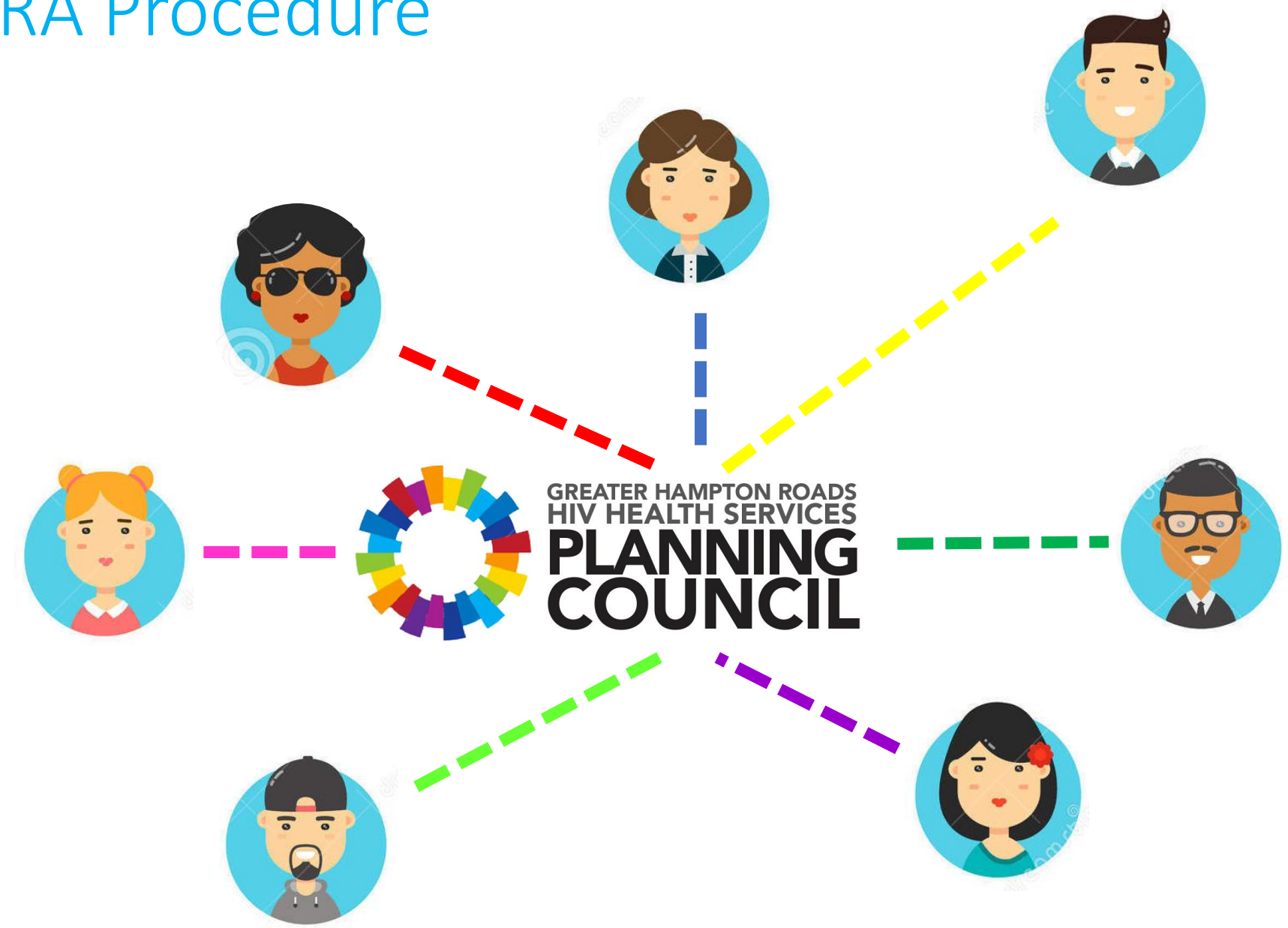
i. How people with HIV were involved in the planning and allocation processes and how their priorities were considered in the process;
ii. How the input of the community was considered and whether the community input process adequately addressed any funding increases or decreases in the RWHAP Part A award;
iii. How MAI funding was considered during the planning process to enhance services to minority populations;
iv. How data were used in the priority setting and allocation processes to increase access to core medical services, ensure access to services for women, infants, children, and youth (WICY) and to reduce disparities in access to HIV care in the EMA/TGA; and
v. Any significant changes in the prioritization and allocation process from 2019 to 2020 project periods and the rationale for making those changes.

Norfolk TGA PSRA Procedure

2

STAGE 2

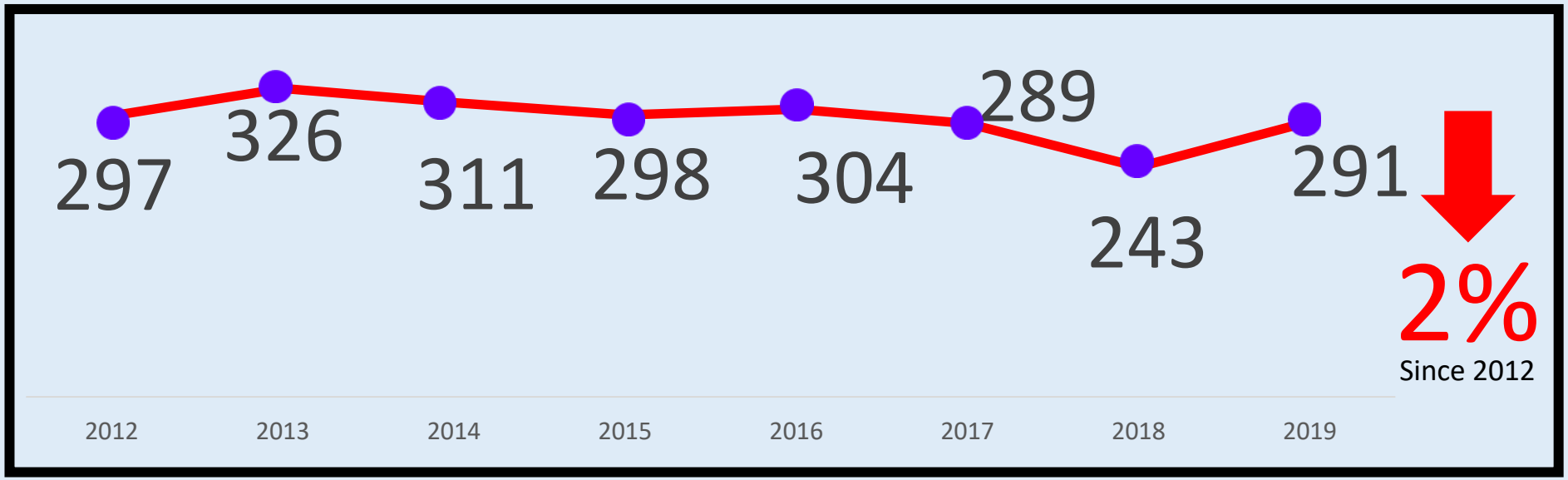
Description of the Community Input Process



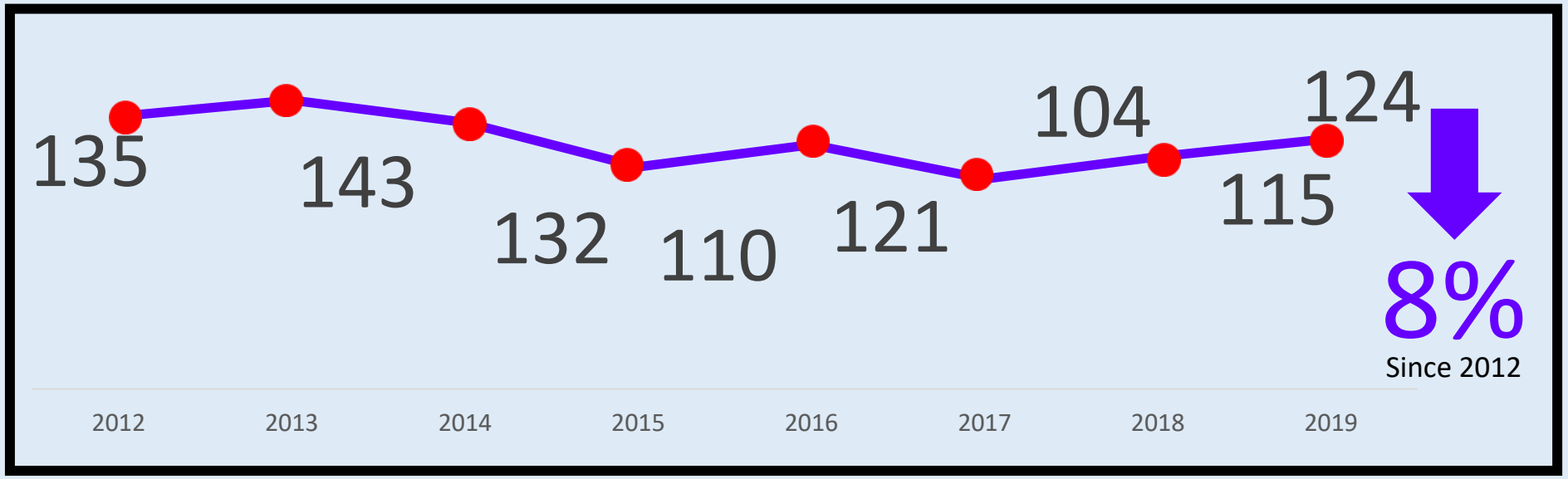

REVIEW OF
DATA

Norfolk TGA EPIDEMOLOGICAL DATA

HIV INCIDENCE



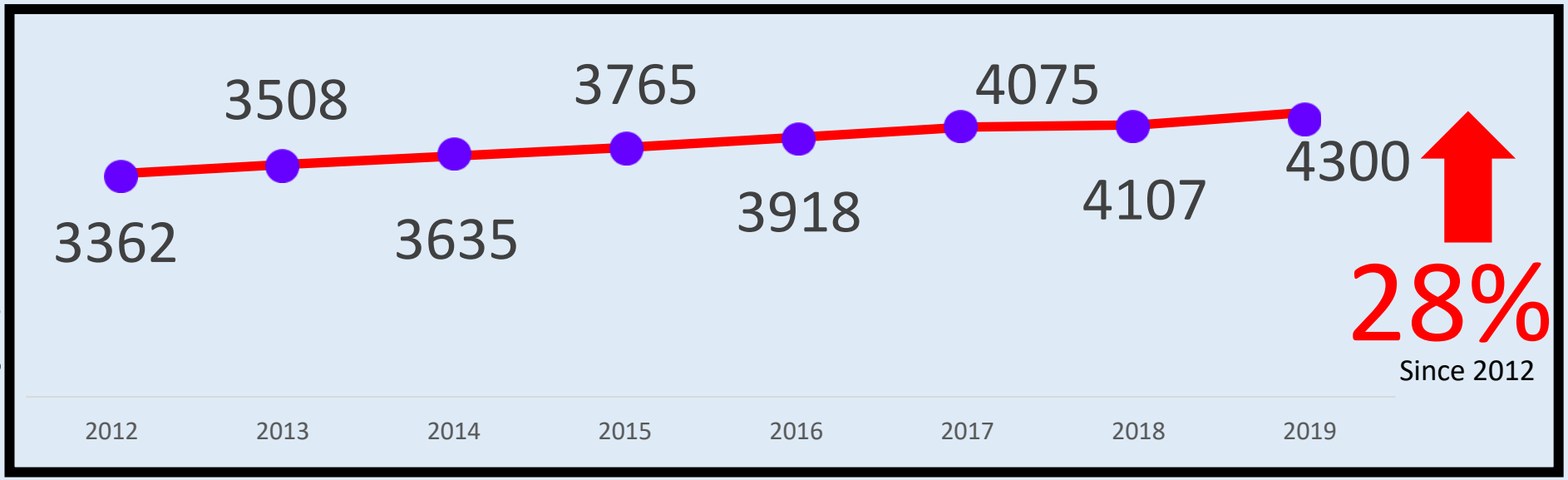
AIDS INCIDENCE



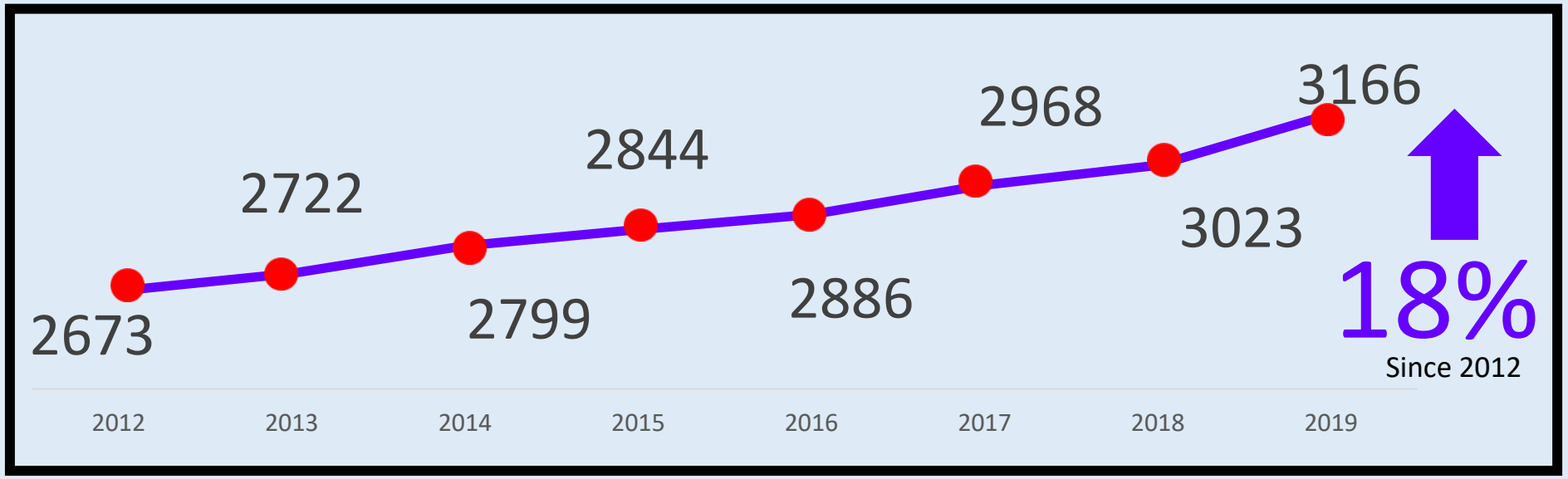
Data as of July 2020; Accessed August 2020, Division of Disease Prevention, Virginia Department of Health

Norfolk TGA EPIDEMOLOGICAL DATA

HIV PREVALANCE



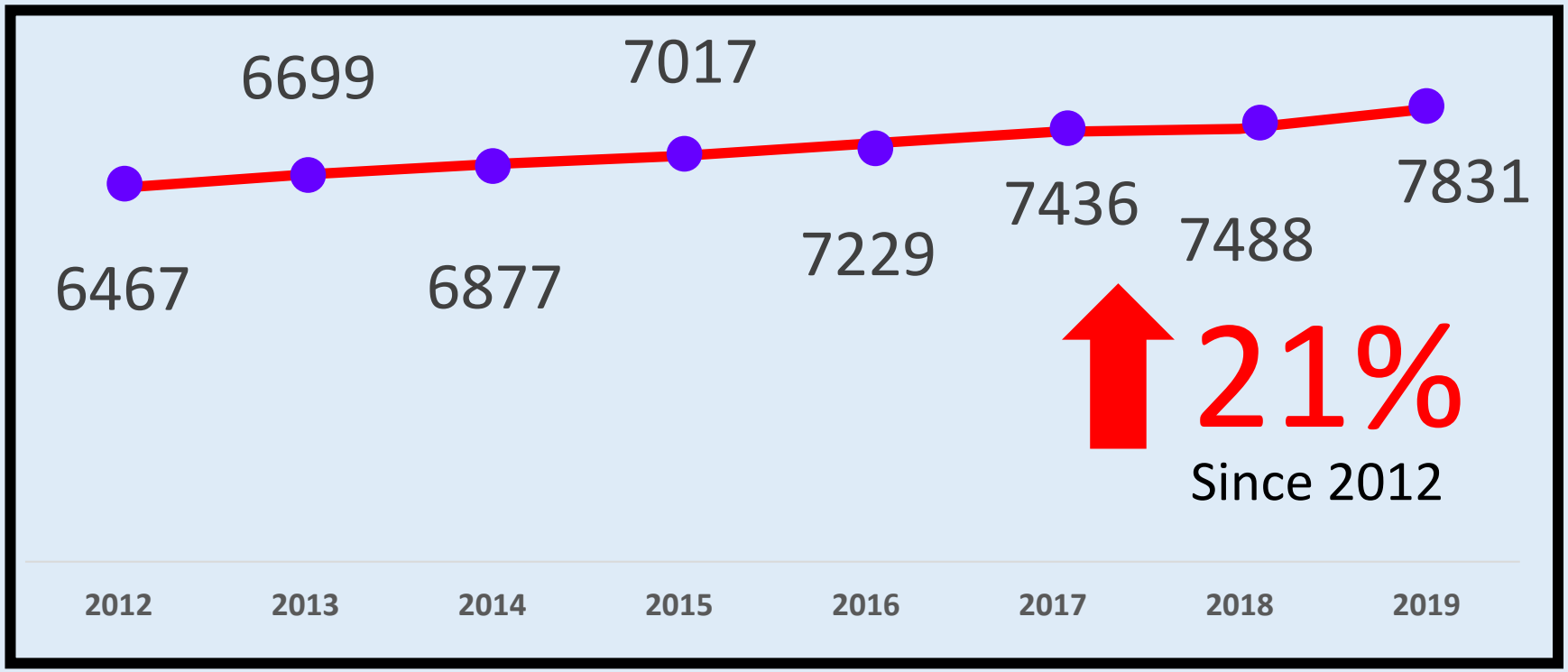
AIDS PREVALANCE



Data as of July 2020; Accessed August 2020, Division of Disease Prevention, Virginia Department of Health

Norfolk TGA EPIDEMOLOGICAL DATA

TOTAL CASES



Data as of July 2020; Accessed August 2020, Division of Disease Prevention, Virginia Department of Health

Norfolk TGA EPIDEMOLOGICAL DATA

TOTAL CASES - Age

Age at Diagnosis (Years) Age at Diagnosis (Incidence) and Current Age (Prevalence)	*2019 Total Cases*
<13 years	**9**
13 - 19 years	**57**
20 - 44 years	**3,411**
45 + years	**4,354**
Unknown	**0**
Total	**7,831**

Data as of July 2020; Accessed August 2020, Division of Disease Prevention, Virginia Department of Health

Norfolk TGA EPIDEMOLOGICAL DATA

TOTAL

CASES –

Race/Ethnicity

Race/Ethnicity	*2019 Total Cases*
White, not Hispanic	**1,724**
African-American, not Hispanic	**5,364**
Hispanic/Latino (all races)	**411**
Asian/Hawaiian/Pacific Islander	**61**
American Indian/Alaska Native	**11**
Multi-race /Other/ Unknown	**260**
Total	**7,831**

Data as of July 2020; Accessed August 2020, Division of Disease Prevention, Virginia Department of Health

Norfolk TGA EPIDEMOLOGICAL DATA

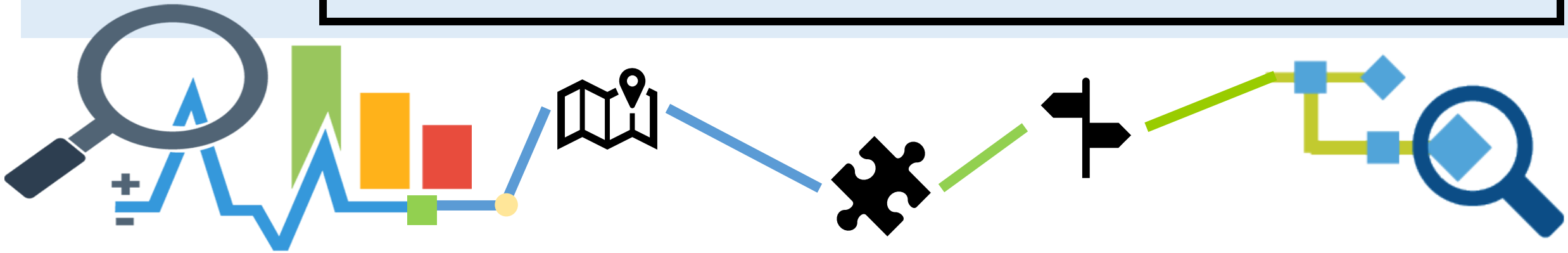
TOTAL CASES – Gender

Age at Diagnosis (Years) Age at Diagnosis (Incidence) and Current Age (Prevalence)	*2019 Total Cases*
Male	**5,808**
Female	**2,023**
Total	**7,831**

Data as of July 2020; Accessed August 2020, Division of Disease Prevention, Virginia Department of Health

74% MALE

26% FEMALE

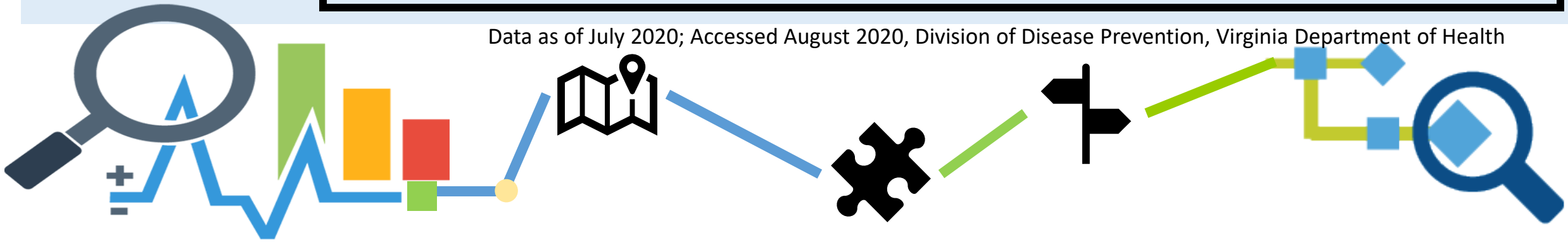


Norfolk TGA EPIDEMOLOGICAL DATA

TOTAL CASES – Method of Exposure

Exposure Category	*2019 Total Cases*
Men who have sex with men	**3,822**
Injection drug users	**527**
Men who have sex with men and inject drugs	**246**
Heterosexuals	**1,342**
Blood recipient (Receipt of blood transfusion/transplant, Adult received clotting factor)	**56**
Risk not reported or identified	**1,250**
Pediatric (perinatal exposure, child received transfusion/transplant, child received clotting factor, child with no reported or identified risk	**588**
Total	**7,831**

Data as of July 2020; Accessed August 2020, Division of Disease Prevention, Virginia Department of Health



Norfolk TGA SERVICE UTILIZATION DATA

EIS

Early Intervention Services
Minority AIDS Initiative

2021 Ranking	2020 Ranking	2019 Ranking
12	12	15

	2017	2018	2019	2020
TOTAL CLIENTS SERVED	197	115	133	86
UNITS OF SERVICE	2,550	2,294	2,417	641
COST PER CLIENT	$ 2,270.06	$ 4,200.26	$ 3,718.98	$ 4,310.03
COST PER UNIT	$ 175.37	$ 210.13	$ 204.64	$ 578.26
TOTAL EXPENDED	$ 447,201.00	$ 482,030.00	$ 494,624.00	$ 370,662.94

Data as of July 2020; Accessed July 2020, Ryan White Part A CAREWare, City of Norfolk

2017 7 2020 17% TOTAL EXPENDED

2017 2020 56% TOTAL CLIENTS SERVED

2020 2017 90% COST PER CLIENT

Norfolk TGA SERVICE UTILIZATION DATA

EIS

Early Intervention Services
REGULAR

2021 Ranking	2020 Ranking	2019 Ranking
12	12	15

	2017	2018	2019	2020
TOTAL CLIENTS SERVED	101	84	66	62
UNITS OF SERVICE	913	908	687	738
COST PER CLIENT	$ 1,600.83	$ 1,741.65	$ 2,034.59	$ 3,027.39
COST PER UNIT	$ 177.09	$ 161.12	$ 195.46	$ 254.33
TOTAL EXPENDED	$ 161,683.00	$ 146,298.00	$ 134,283.00	$ 187,697.88

Data as of July 2020; Accessed July 2020, Ryan White Part A CAREWare, City of Norfolk

2020 ↑ 2017

16% TOTAL EXPENDED

2017 ↓ 2020

39% TOTAL CLIENTS SERVED

2020 ↑ 2017

89% COST PER CLIENT

Norfolk TGA SERVICE UTILIZATION DATA

OAHS

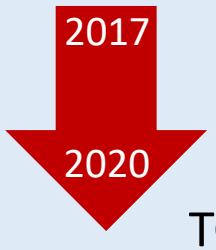
Outpatient
Ambulatory
Health Services

2021 Ranking	2020 Ranking	2019 Ranking
2	3	1

	2017	2018	2019	2020
TOTAL CLIENTS SERVED	737	627	402	345
UNITS OF SERVICE	1,639	1,316	800	651
COST PER CLIENT	$ 1,667.80	$ 2,000.01	$ 2,863.31	$ 3,605.00
COST PER UNIT	$ 749.95	$ 952.89	$ 1,438.82	$ 1,910.49
TOTAL EXPENDED	$ 1,229,170.00	$ 1,254,006.00	$ 1,151,052.00	$ 1,243,726.25

Data as of July 2020; Accessed July 2020, Ryan White Part A CAREWare, City of Norfolk

1%
TOTAL EXPENDED



53%
TOTAL CLIENTS SERVED

116%
COST PER CLIENT

Norfolk TGA SERVICE UTILIZATION DATA

MCM

Medical Case Management Services

2021 Ranking	2020 Ranking	2019 Ranking
1	5	5

	2017	2018	2019	2020
TOTAL CLIENTS SERVED	1,309	1,521	1,286	1,247
UNITS OF SERVICE	68,942	67,884	56,881	53,680
COST PER CLIENT	$ 1,110.05	$ 1,007.91	$ 1,092.43	$ 1,227.84
COST PER UNIT	$ 21.08	$ 22.58	$ 24.70	$ 28.52
TOTAL EXPENDED	$ 1,453,050.00	$ 1,533,029.00	$ 1,404,860.00	$ 1,531,113.71

Data as of July 2020; Accessed July 2020, Ryan White Part A CAREWare, City of Norfolk

2020 / 2017 — 5% TOTAL EXPENDED

2020 / 2017 — 5% TOTAL CLIENTS SERVED

2020 / 2017 — 11% COST PER CLIENT

Norfolk TGA SERVICE UTILIZATION DATA

HIPCSA

Health Insurance Premium and Cost Sharing Assistance

2021 Ranking	2020 Ranking	2019 Ranking
6	7	6

	2017	2018	2019	2020
TOTAL CLIENTS SERVED	1,388	1,169	931	670
UNITS OF SERVICE	4,191	3,173	2,722	1,903
COST PER CLIENT	$ 196.15	$ 166.63	$ 227.67	$ 277.66
COST PER UNIT	$ 64.96	$ 61.39	$ 77.87	$ 97.76
TOTAL EXPENDED	$ 272,251.00	$ 194,796.00	$ 211,964.00	$ 186,030.18

Data as of July 2020; Accessed July 2020, Ryan White Part A CAREWare, City of Norfolk

2017 ↓ 2020 **32%** TOTAL EXPENDED

2017 ↓ 2020 **52%** TOTAL CLIENTS SERVED

2020 ↑ 2017 **42%** COST PER CLIENT

Norfolk TGA SERVICE UTILIZATION DATA

LPAP

Local Pharmaceutical Assistance Program

2021 Ranking	2020 Ranking	2019 Ranking
13	13	13

	2017	2018	2019	2020
TOTAL CLIENTS SERVED	171	129	103	50
UNITS OF SERVICE	503	390	279	152
COST PER CLIENT	$ 411.20	$ 422.19	$ 345.50	$ 67.64
COST PER UNIT	$ 139.79	$ 139.65	$ 127.55	$ 22.25
TOTAL EXPENDED	$ 70,315.00	$ 54,463.00	$ 35,586.00	$ 3,381.80

Data as of July 2020; Accessed July 2020, Ryan White Part A CAREWare, City of Norfolk

2017 2020 95% TOTAL EXPENDED

2017 2020 71% TOTAL CLIENTS SERVED

2017 2020 84% COST PER CLIENT

Norfolk TGA SERVICE UTILIZATION DATA

MH

Mental Health Services

2021 Ranking	2020 Ranking	2019 Ranking
3	1	3

	2017	2018	2019	2020
TOTAL CLIENTS SERVED	102	18	20	24
UNITS OF SERVICE	664	287	316	284
COST PER CLIENT	$ 605.54	$ 1,614.66	$ 1,573.55	$ 1,566.64
COST PER UNIT	$ 93.02	$ 101.27	$ 99.59	$ 132.39
TOTAL EXPENDED	$ 61,765.00	$ 29,064.00	$ 31,471.00	$ 37,599.40

Data as of July 2020; Accessed July 2020, Ryan White Part A CAREWare, City of Norfolk

2017 ↓ 2020 **39%** TOTAL EXPENDED

2017 ↓ 2020 **77%** TOTAL CLIENTS SERVED

2020 ↑ 2017 **159%** COST PER CLIENT

Norfolk TGA SERVICE UTILIZATION DATA

SA

Substance Abuse Services-Outpatient

2021 Ranking	2020 Ranking	2019 Ranking
11	4	8

	2017	2018	2019	2020
TOTAL CLIENTS SERVED	5	3	1	0
UNITS OF SERVICE	1,801	1,260	11,287	0
COST PER CLIENT	$ 2,754.40	$ 2,550.60	$ 2,993.00	N/A
COST PER UNIT	$ 7.62	$ 6.07	$ 0.27	N/A
TOTAL EXPENDED	$ 13,722.00	$ 7,652.00	$ 2,993.00	$ -

Data as of July 2020; Accessed July 2020, Ryan White Part A CAREWare, City of Norfolk

2016 ↓ 2019 **72%** TOTAL EXPENDED

2016 ↓ 2019 **75%** TOTAL CLIENTS SERVED

2019 ↑ 2016 **12%** COST PER CLIENT

Norfolk TGA SERVICE UTILIZATION DATA

OH

Oral Health Services

2021 Ranking	2020 Ranking	2019 Ranking
10	9	9

	2017	2018	2019	2020
TOTAL CLIENTS SERVED	609	518	468	276
UNITS OF SERVICE	2,085	1,851	1,647	652
COST PER CLIENT	$ 709.77	$ 818.88	$ 1,014.50	$ 1,196.32
COST PER UNIT	$ 206.44	$ 229.16	$ 288.27	$ 506.42
TOTAL EXPENDED	$ 430,423.00	$ 424,180.00	$ 474,788.00	$ 330,183.34

Data as of July 2020; Accessed July 2020, Ryan White Part A CAREWare, City of Norfolk

2017 → 2020: 23% TOTAL EXPENDED

2017 → 2020: 55% TOTAL CLIENTS SERVED

2017 → 2020: 69% COST PER CLIENT

Norfolk TGA SERVICE UTILIZATION DATA

NMCM

Non-Medical Case Management

2021 Ranking	2020 Ranking	2019 Ranking
9	11	11

	2017	2018	2019	2020
TOTAL CLIENTS SERVED	2,307	2,358	2,169	423
UNITS OF SERVICE	18,820	19,213	16,769	4,255
COST PER CLIENT	$ 134.61	$ 139.59	$ 142.85	$ 656.06
COST PER UNIT	$ 16.50	$ 17.13	$ 18.48	$ 65.22
TOTAL EXPENDED	$ 310,535.00	$ 329,163.00	$ 309,843.00	$ 277,514.90

Data as of July 2020; Accessed July 2020, Ryan White Part A CAREWare, City of Norfolk

2017 → 2020: 11% TOTAL EXPENDED

2017 → 2020: 82% TOTAL CLIENTS SERVED

2017 → 2020: 77% COST PER CLIENT

Norfolk TGA SERVICE UTILIZATION DATA

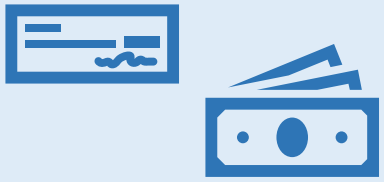
EFA

Emergency Financial Assistance

2021 Ranking	2020 Ranking	2019 Ranking
8	10	7

	2017	2018	2019	2020
TOTAL CLIENTS SERVED	128	145	137	99
UNITS OF SERVICE	218	233	213	155
COST PER CLIENT	$ 1,126.44	$ 1,017.31	$ 1,212.39	$ 1,617.09
COST PER UNIT	$ 661.39	$ 633.09	$ 779.80	$ 1,032.85
TOTAL EXPENDED	$ 144,184.00	$ 147,510.00	$ 166,098.00	$ 160,092.33

Data as of July 2020; Accessed July 2020, Ryan White Part A CAREWare, City of Norfolk



2020 ↑ 2017 **11%** TOTAL EXPENDED

2017 ↓ 2020 **23%** TOTAL CLIENTS SERVED

2020 ↑ 2017 **44%** COST PER CLIENT

Norfolk TGA SERVICE UTILIZATION DATA

MT

Medical Transportation Services

2021 Ranking	2020 Ranking	2019 Ranking
4	2	2

	2017	2018	2019	2020
TOTAL CLIENTS SERVED	480	520	473	314
UNITS OF SERVICE	8,809	9,738	10,624	3,493
COST PER CLIENT	$ 553.16	$ 559.60	$ 625.99	$ 661.76
COST PER UNIT	$ 30.14	$ 29.88	$ 27.87	$ 59.49
TOTAL EXPENDED	$ 265,517.00	$ 290,991.00	$ 296,093.00	$ 207,791.93

Data as of July 2020; Accessed July 2020, Ryan White Part A CAREWare, City of Norfolk

2017 → 2020: 22% TOTAL EXPENDED

2017 → 2020: 35% TOTAL CLIENTS SERVED

2017 → 2020: 20% COST PER CLIENT

Norfolk TGA SERVICE UTILIZATION DATA

FB

Food Bank / Home Delivered Meals

2021 Ranking	2020 Ranking	2019 Ranking
5	8	10

	2017	2018	2019	2020
TOTAL CLIENTS SERVED	226	386	312	356
UNITS OF SERVICE	784	2,516	1,540	1,361
COST PER CLIENT	$ 115.08	$ 151.70	$ 283.81	$ 189.87
COST PER UNIT	$ 33.17	$ 23.28	$ 57.50	$ 49.66
TOTAL EXPENDED	$ 26,008.00	$ 58,577.00	$ 88,550.00	$ 67,592.00

Data as of July 2020; Accessed July 2020, Ryan White Part A CAREWare, City of Norfolk

2020 / 2017 160% TOTAL EXPENDED

2020 / 2017 58% TOTAL CLIENTS SERVED

2020 / 2017 65% COST PER CLIENT

Norfolk TGA SERVICE UTILIZATION DATA

RHSS

Referral for Healthcare and Support Services

2021 Ranking	2020 Ranking	2019 Ranking
16	26	26

	2017	2018	2019	2020
TOTAL CLIENTS SERVED	Not Funded This Year	Not Funded This Year	Not Funded This Year	1,398
UNITS OF SERVICE				9,599
COST PER CLIENT				$ 29.81
COST PER UNIT				$ 4.34
TOTAL EXPENDED				$ 41,680.72

Data as of July 2020; Accessed July 2020, Ryan White Part A CAREWare, City of Norfolk

241%
TOTAL EXPENDED

38%
TOTAL CLIENTS SERVED

147%
COST PER CLIENT

Questions?

Attachment 5: Coordination of Services and Funding Streams Table
Norfolk TGA

Funding Source	Funding Amount	Funded Agency	**Core Medical-Related Services**	Outpatient/Ambulatory Medical Care	AIDS Drug Assistance Program	AIDS Pharmaceutical Assist.	Oral Health Care	Early Intervention Services	Health Insurance Premium/ Cost-Sharing Assistance	Home Health Care	Hospice Services	Mental Health Services	Medical Nutrition Therapy	Medical Case Management	Substance Abuse Services – Outpatient	**Supportive Services**	Non-medical Case Management	Child Care Services	Emergency Financial Assistance	Food Bank/Home-delivered Meals	Health Education/Risk Reduction	Housing Services	Medical Transportation Services	Outreach Services	Psychosocial Support Services	Treatment Adherence Counseling	HIV Testing	**HIV Care Continuum**	HIV Testing and Diagnosis	Linked to Care	Retained in Care	Prescribed Antiretroviral Therapy	Viral Suppression
Part A	$ 5,789,714.00	City of Norfolk[1]		x		x	x	x	x				x	x	x		x		x	x		x	x						x	x	x	x	x
Part B	$ 25,463,162.00	State of Virginia		x	x	x	x	x	x	x	x	x		x	x		x			x			x						x	x	x	x	x
Part C	$ 321,351.00	EVMS		x		x						x	x	x															x	x	x	x	x
VDH - State Services	$ 2,800,000	Virginia Department of Health Subrecipients		x	x	x	x	x	x	x	x	x	x	x	x		x	x	x	x	x	x	x	x	x	x	x		x	x	x	x	x
CDC	$ 588,553	Multiple Agencies [2]																			x						x		x	x	x	x	x
SAMHSA	$ 4,807,926	Multiple Agencies [3]						x				x			x						x	x					x		x	x	x	x	x
HUD	$ 813,133	The LGBT Life Center'												x			x		x	x	x	x		x							x	x	x
HOPWA	$ 1,055,738	City of Virginia Beach																				x									x	x	x

[1] Norfolk TGA 2020/21 Ryan White Part A Grant Award, including Formula, Supplemental and MAI; also includes carry-over

[2] National Alliance of State and Territorial AIDS Directors (NASTAD), Special Data Request, 2017.

[3] SAMHSA FY2017 discretionary funded agencies within the TGA

NORFOLK TGA
RYAN WHITE PART A
FY2020 - 2021
DATA REPORT

FY2020 Service Utilization

CAREWare Data

Services	Clients	Units of Service
Case Management - Non Medical	**423**	**4,255**
Drug Reimbursement	**50**	**152**
Early Intervention Services-MAI	**86**	**641**
Early Intervention Services-REG	**62**	**738**
Emergency Financial Assistance	**99**	**155**
Housing	52	
Utility	64	
Food Bank/Home Delivered Meals	**356**	**1,361**
Health Insurance Premium/Cost Sharing	**670**	**1,903**
Lab Co-pay	21	
Medication Co-pay	89	
Mental Health Co-pay	22	
Office Visit Co-pay	581	
Speciality Co-pay	34	
Medical Case Management	**1,247**	**53,679.5**
Medical Transportation	**314**	**3,493**
Mental Health Services	**24**	**284**
Oral Health Services	**276**	**652**
Outpatient/Ambulatory Health Services	**345**	**651**
Referral for Health Care & Supportive Services	**1,398**	**9,599**
Substance Abuse - Outpatient	**0**	**0**

Total Number Clients (unduplicated)	**2,651**
Total Number Units	**77,563.5**

Norfolk TGA Clients FY2020

DEMOGRAPHICS OF RYAN WHITE PART A CLIENTS

Data from the Ryan White Part A Grantee Office indicates that 2651 PLWH/A in the Norfolk TGA received Ryan White funded services in fiscal year 2020

Demographics	FY2020		
	Populations	Count	Percent %
Client Enrollment Status	Active	2434	91.81%
	Inactive clients	87	3.28%
	Incarcerated	6	0.23%
	Referred/Discharged	51	1.92%
	Relocated	62	2.34%
	Removed	11	0.41%
	Total	**2651**	**100%**
Client Vital Status	Alive	2628	99.13%
	Deceased	23	0.87%
	Total	**2651**	**100%**
Gender	Female	721	27.20%
	Male	1856	70.01%
	Transgender (M+F)	74	2.79%
	Total	**2651**	**100%**
Race (Self Reported)	American Indian	6	0.23%
	Asian	20	0.75%
	Black or African American	2025	76.39%
	Hispanic	126	4.75%
	Multi-Race	42	1.58%
	Pacific Islander	4	0.15%
	White	427	16.11%
	Not Specified	1	0.04%
	Total	**2651**	**100%**
Age	0 mos – 1 yr	1	0.04%
	2 yrs – 12 yrs	3	0.11%
	13 yrs – 24 yrs	106	4.00%
	25 yrs - 54 yrs	1664	62.77%
	55+ yrs	877	33.08%
	Total	**2651**	**100%**

FY2020 CLIENT DEMOGRAPHICS

Demographics	FY2020		
	Populations	Count	Percent %
HIV/AIDS Status	CDC defined AIDS	966	36.44%
	HIV-positive, AIDS status unknown	37	1.40%
	HIV-positive, not AIDS	1648	62.17%
	Total	**2651**	**100%**
Mode of Transmission (Self Reported)	Hemophilia / Coagulation disorder	8	0.30%
	Heterosexual Contact	1097	41.38%
	Injection Drug Use	126	4.75%
	MSM	1336	50.40%
	MSM & IDU	32	1.21%
	Perinatal Transmission	30	1.13%
	Transfusion	19	0.72%
	Not Specified	3	0.11%
	Total	**2651**	**100%**
Insurance Status	Medicaid	1012	38.17%
	Medicare	457	17.24%
	No Insurance	245	9.24%
	Other	14	0.53%
	Private - Employer	184	6.94%
	Private - Individual (ACA)	455	17.16%
	VA, Tricare, & Other Military Health Care	26	0.98%
	Unknown/No CW Entry	258	9.73%
	Total	**2651**	**100%**

Service: Early Intervention Services - MAI

DEMOGRAPHICS OF RYAN WHITE PART A CLIENTS

Data from the Ryan White Part A Grantee Office indicates that 86 PLWH/A in the Norfolk TGA received Ryan White Early Intervention Services-MAI in fiscal year 2020

Demographics	FY2020		
	Populations	Count	Percent %
Client Vital Status	Alive	84	97.67%
	Deceased	2	2.33%
	Total	**86**	**100.00%**
Gender	Female	28	32.56%
	Male	57	66.28%
	Transgender (M+F)	1	1.16%
	Total	**86**	**100%**
Race (Self Reported)	Black or African American	78	90.70%
	Hispanic	2	2.33%
	White	6	6.98%
	Total	**86**	**100%**
Age	13 yrs – 24 yrs	5	5.81%
	25 yrs +	81	94.19%
	Total	**86**	**100%**
Client Type	Newly Diagnosis	8	9.30%
	New to Care	12	13.95%
	Out of Care	66	76.74%
	Total	**86**	**100.00%**
Target Population	MSM of Color	37	
	Transgender	1	
	Youth (18-24)	5	

Type of Client definitions:

New to Care: Client diagnosed but never had a care marker

Newly Diagnosis: Client has a HIV diagnosis during the current grant year

Out of Care: Client was previously in care but no longer has a care marker

Service: Early Intervention Services-REG

DEMOGRAPHICS OF RYAN WHITE PART A CLIENTS

Data from the Ryan White Part A Grantee Office indicates that 62 PLWH/A in the Norfolk TGA received Ryan White Early Intervention Services-REG in fiscal year 2020.

Demographics	FY2020		
	Populations	Count	Percent %
Client Vital Status	Alive	61	98.39%
	Deceased	1	1.61%
	Total	**62**	**100.00%**
Gender	Female	27	43.55%
	Male	34	54.84%
	Transgender (M+F)	1	1.61%
	Total	**62**	**100%**
Race (Self Reported)	Black or African American	58	93.55%
	Multi-Race	1	1.61%
	White	3	4.84%
	Total	**62**	**100%**
Age	13 yrs – 24 yrs	3	4.84%
	25 yrs +	59	95.16%
	Total	**62**	**100%**
Client Type	Newly Diagnosis	2	3.23%
	New to Care	8	12.90%
	Out of Care	52	83.87%
	Total	**62**	**100.00%**
Target Population	MSM of Color	20	
	Transgender	1	
	Youth (18-24)	3	

Type of Client definitions:

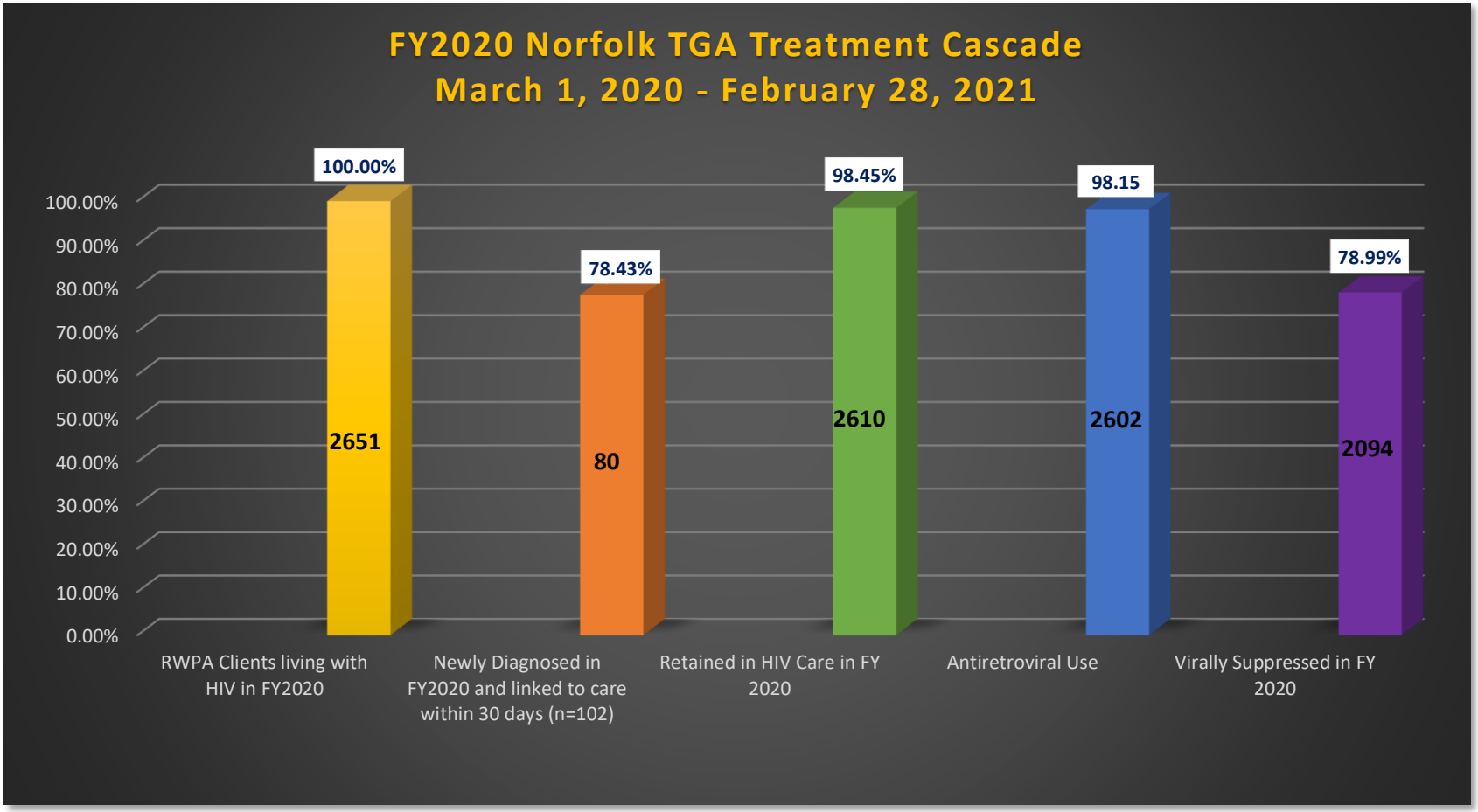
New to Care: Client diagnosed but never had a care marker

Newly Diagnosis: Client has a HIV diagnosis during the current grant year

Out of Care: Client was previously in care but no longer longer has a care marker

WICY Report - FY2020

Service Category	Total Clients Served	Women (25+)		Infant (< 2)		Children (2-12)		Youth (13-24)	
		Clients	%	Clients	%	Clients	%	Clients	%
All Clients for FY	2,651	721	27.20%	1	0.04%	3	0.11%	106	4.00%
Case Management (non-Medical)	423	104	24.59%	-	-	-	0.00%	27	6.38%
Drug Reimbursement	50	17	34.00%	-	-	-	0.00%	5	10.00%
Early Intervention Srv-MAI	86	28	32.56%	-	-	-	0.00%	5	5.81%
Early Intervention Srv-REG	62	27	43.55%	-	-	-	0.00%	3	0.00%
Emergency Financial Assistance	99	29	29.29%	-	-	-	0.00%	4	4.04%
Food Bank/Home Delivered Meals	356	120	33.71%	-	-	-	0.00%	14	3.93%
Health Insurance Premium/ Cost Sharing Assistance	670	173	25.82%	-	-	1	0.15%	17	2.54%
Medical Case Management	1,247	322	25.82%	1	0.08%	2	0.16%	62	4.97%
Medical Transportation	314	87	27.71%	-	-	-	0.00%	10	3.18%
Mental Health	24	5	20.83%	-	-	-	0.00%	2	8.33%
Oral Health	285	96	33.68%	-	-	-	0.00%	6	2.11%
Outpatient/Ambulatory Health Services	345	58	16.81%	-	-	-	0.00%	22	6.38%
Referral for Health Care Support Services	1,398	418	29.90%	-	-	-	0.00%	37	2.65%
Substance Abuse -Outpatient	0	0	0.00%	-	-	-	0.00%	-	0.00%


FY2020 Norfolk TGA Treatment Cascade
March 1, 2020 - February 28, 2021
100.00%
90.00%
80.00%
70.00%
60.00%
50.00%
40.00%
30.00%
20.00%
10.00%
0.00%
100.00%
2651
78.43%
80
98.45%
2610
98.15
2602
78.99%
2094
RWPA Clients living with HIV in FY2020
Newly Diagnosed in FY2020 and linked to care within 30 days (n=102)
Retained in HIV Care in FY 2020
Antiretroviral Use
Virally Suppressed in FY 2020

Service Utilization and Expenditures FY20

Service Category	Total Served	Total Units of Service	Total Amount Available	Total Amount Expended	Total Percent Expended	Definition of Unit	Total Units & Average Cost per unit	Cost per client
Drug Reimbursement	50	152	$50,514.00	$3,381.80	**6.69%**	1 script = 1 unit	units @$22.25 per unit	$67.64
Early Intervention Service - MAI	86	641	$461,738.00	$370,662.94	**80.28%**	1 contact = 1 unit	units @$578.26 per unit	$4,310.03
Early Intervention Services Regular	62	738	$187,934.00	$187,697.88	99.87%	1 contact = 1 unit	units @$254.33	$3,027.39
Emergency Financial Assistance	99	155	$160,664.00	$160,092.33	**99.64%**	1 payment = 1 unit	units @1,032.85 per unit	$1,617.09
Food Bank/Home Delivered Meals	356	1,361	$70,709.00	$67,592.00	95.59%	1 contact = 1 unit	units @$46.66 per unit	$189.87
Health Insurance Premium/Cost Sharing	670	1,903	$197,389.00	$186,030.18	**94.25%**	1 script co-pmt=1 unit	units @$97.76 per unit	$277.66
Medical Case Management	1,247	53,680.00	$1,621,885.00	$1,531,113.71	**94.40%**	15 minutes = 1 unit	units @$28.52 per unit	$1,227.84
Medical Transportation	314	3,493	$211,034.00	$207,791.93	**98.46%**	1 round trip = 1 unit	units @$59.49 per unit	$661.76
Mental Health	24	284	$37,906.00	$37,599.40	**99.19%**	30 min. session=1 unit	units @$132.39 per unit	$1,566.64
Case Management (Non-Medical)	423	4,255	$310,476.00	$277,514.90	**89.38%**	1 contact = 1 unit	units @$65.22 per unit	$656.06
Oral Health	276	652	$423,654.00	$330,183.34	**77.94%**	1 office visit = 1 unit	units @$506.42 per unit	$1,196.32
Outpatient/Ambulatory Health Services	345	651	$1,248,665.00	$1,243,726.25	**99.60%**	1 office visit = 1 unit	units @$1,910.49 per unit	$3,605.00
Referral for Health Care and Supportive Services	1,398	9,599	$42,000.00	$41,680.72	**99.24%**	15 minutes = 1 unit	units @$4.34 per unit	$29.81
Substance Abuse - Outpatient	0	0.00	$6,689.00	$0.00	**0.00%**	30 min. session = 1 unit	N/A	N/A

2022/23 Priority Setting and Resource Allocations Process

On an annual basis, the Planning Council convenes its membership, a culturally diverse group of members representing multiple organizations to include those funded by Ryan White HIV/AIDS Program(RWHAP), Centers for Disease Control and Prevention (CDC), Housing Opportunities for Person's living With HIV/AIDS (HOPWA), State funded HIV/STI Prevention and Care organizations, as well as consumers of the RWHAP and local community members. This group of diverse individuals convenes annually to provide guidance in developing priorities and allocating funds to service categories for the Ryan White Part A program in Chesapeake, Norfolk, Virginia Beach, Portsmouth, Suffolk, Isle of Wight, Hampton, Poquoson, Newport News, Williamsburg, James City County, Gloucester County, Mathews County, York County, and Currituck County., NC which makes up the Norfolk TGA.

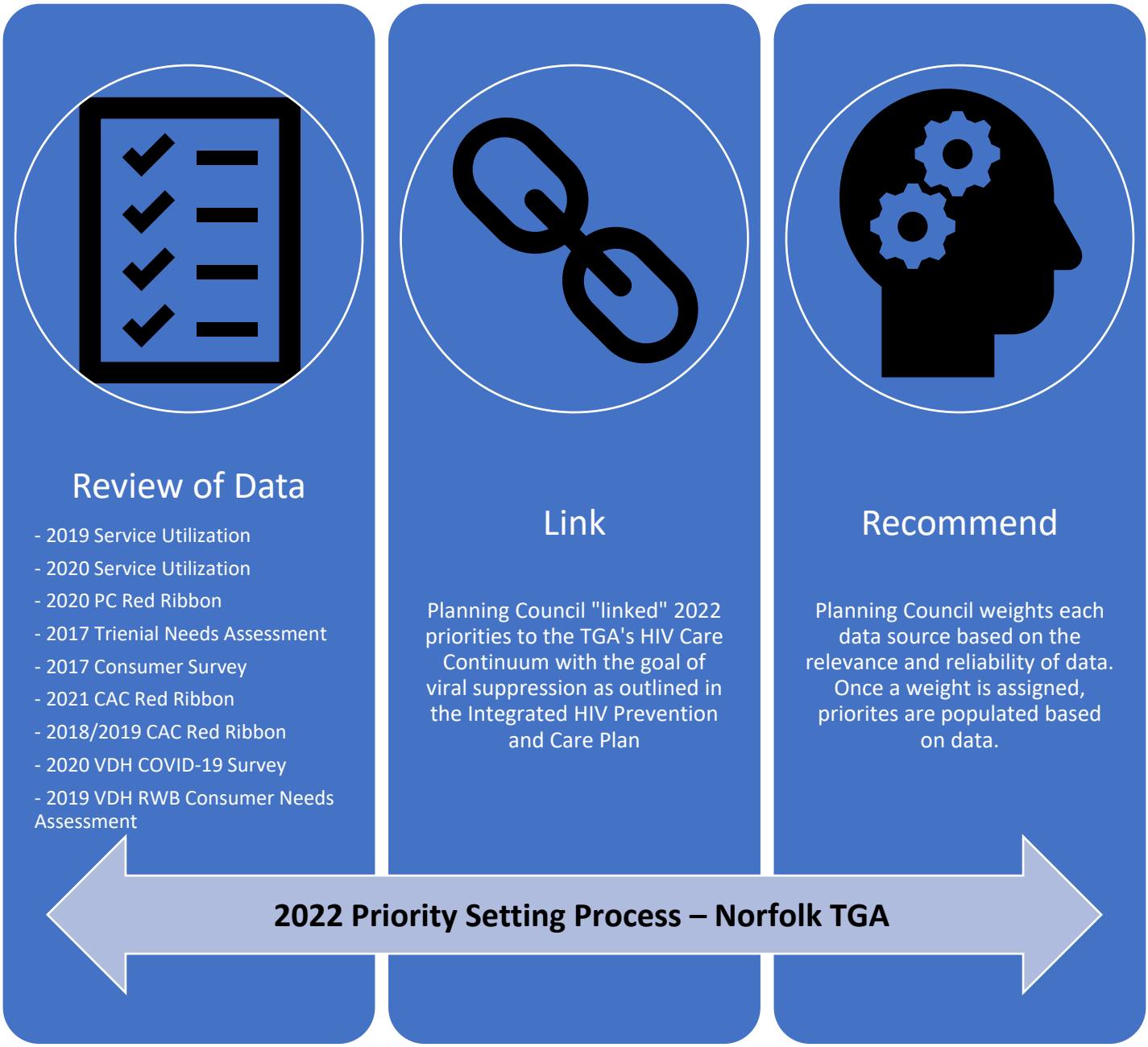
The Planning Council of Norfolk TGA has developed a data driven model for conducting the annual Priority Setting and Resource Allocations (PSRA) process. The process is divided into 4 components: (1) PLWH currently in the RW Part A/MAI care system; (2) PLWH that are newly diagnosed that will enter the RW Part A/MAI program utilizing the TGA's Epidemiological data; (3) out of care individuals to bring into care based on the TGA's underserved populations; and (4) unaware individuals who do not know their HIV status, identifying, testing, and linkage to appropriate medical care. The latter component will occur through the EIS/EIIHA Plan and will work in conjunction with various community partners and funded programs that address HIV and co-morbidities in the TGA.

The Planning Council has developed the following procedures for conducting the 2022/23 PRSA process:

Thursday, August 19, 2020: Mandatory Data Session and PSRA Training. The data session and PSRA training will take place via Zoom Conferencing due to the COVID-19 pandemic and the Planning Council's inability to meet in person. The mandatory data session and PSRA training will be include the review of the following data sets:

1. Glossary of Terms
2. Policy Clarification Notice 16-02
3. 2021/22 Notice of Grant Award
4. 2021/22 Grant Score
5. 2020/21 Attachment 5: Coordination of Services and Funding Streams
6. 2020/21 Service Utilization Data
7. 2020/21 Funded Service Categories
8. 2018/19 Consumer Forum Red Ribbon Survey Results
9. 2020 VDH COVID-19 Consumer Needs Assessment
10. 2019 VDH RWB Consumer Needs Assessment
11. 4-year trend of Service Utilization Data
12. 4-year trend of Expenditures

The Planning Council facilitates the collection of integral PSRA data through the community input process by: 1.) Community Development Committee of the Planning Council; 2.) client satisfaction surveys and needs assessments; 3.) PLWH forums and townhall meetings; 4.) Consumer Advisory Board members; 5.) RW Part B; 6.) RW Part F; 7.) CDC Prevention subrecipients; 8.) HOPWA Recipient/Subrecipients and 9.) State Medicaid representatives. All aspects of planning is linked to the TGA's HIV CoC, NHAS, Integrated HIV prevention and care plan, Ending the HIV Epidemic (EHE) and with the goal of community viral suppression as outlined in the TGA's Integrated HIV Prevention and Care plan.



Review of Data

Planning Council reviews a 4 year trend of cost and service utilization data for all service categories. The following are data sets:

1. Unduplicated client count
2. Unit cost by service category
3. Average cost per client
4. Other funding sources (RWHAP, HOPWA, Medicaid)

Resource Allocation Components

The Planning Council utilizes data sources to determine all resource allocations for GY2022/23 with focus on the following 4 components:

Component 1:
PLWH currently in the RWPA care system (Maintain)

Component 2:
PLWH Newly Diagnosed entering the care system

Component 3:
PLWH Out of Care / Lost to Care

Component 4:
Unaware Population

2022/23 Resource Allocation Process – Norfolk TGA

Resource Allocation Percentages by HRSA defined Service Category

Resource allocation percentages are developed and approved by the Planning Council based on the total grant award. The approved percentages are reported to the Recipient with the directive to apply service dollars in accordance with the approved resource allocations. The TGA's service priorities and allocations align with the updated National HIV/AIDS Strategy, the Integrated HIV Prevention and Care Plan and the TGA's Continuum of Care goal of viral suppression.

The PSRA process includes the following steps: ***Determination of data needs*** –The Planning Council identifies data which is needed for the PSRA process, and Planning Council Support staff request this data in advance of the PSRA data session. ***PSRA process review for PC member –*** Planning Council Support staff presents information on the process for PSRA. This includes a review of the requested data sets mentioned previously and Planning Council member expectations. ***Presentation of data*** –RWPA service utilization data over a 4-year period is presented to the Planning Council prior to PSRA. ***Determination of priorities*** – Based on data presented, the Planning Council determines the priority for each service category to be funded by ranking data sets. ***Resource allocation***: Based on the data presented and the assigned priority, the Planning Council determines how much funding should be allocated to each service category. ***Final approval*** – The Planning Council votes to approve the final priorities and allocation of funds for each service category. ***Evaluation of PSRA activities*** – Once the PSRA is complete the Planning Council is given the opportunity to provide feedback on the entire PRSA process.

A survey is conducted requesting feedback and input for the next year's process. The survey results related to the 2022/23 PSRA session indicated the Planning Council is highly satisfied with the current PRSA methodology. Suggestions for process improvement included a longer period for data review, and a Red Ribbon Exercise that asked precise question so that response would be more reflective of needs.

All funding decisions are data driven and include qualitative information on community needs with consideration of consumer input. The Planning Council utilizes past needs assessments, the most recent quality improvement data, service utilization, trending statistics, consumer input and aligns it with the TGA's Continuum of Care with the goal of viral suppression. The PC weighs each data source based on relevance to determine and approve service category priorities. Unless service categories show significant change in utilization, the PC does not deviate greatly from the service category's allocation at the close of the previous grant year. This is to ensure that services are provided at consistent levels.

ANNUAL DEMOGRAPHIC &
CONTACT INFORMATION UPDATE
For Planning Council Members

GREATER HAMPTON ROADS HIV HEALTH SERVICES PLANNING COUNCIL

Print First Name _____ Print Last Name _____

Street Address _____ City _____ State _____ Zip Code _____

Email Address _____ Home Phone Number _____ Cell Phone Number _____

What is your preferred method for receiving notifications about upcoming meetings? (***Check all that apply***)

☐ US Mail ☐ Email ☐ Home Phone ☐ Cell Phone/Text Message

What is your preferred method for receiving meetings materials, including minutes and agendas? (***Check all that apply***)

☐ US Mail ☐ Email ☐ Home Phone ☐ Cell Phone/Text Message

What is your race? *(Choose only 1)*

◯ **White** - The category "White" includes all individuals who identify with one or more nationalities or ethnic groups originating in Europe, the Middle East, or North Africa. Examples of these groups include, but are not limited to, German, Irish, English, Italian, Lebanese, Egyptian, Polish, French, Iranian, Slavic, Cajun, and Chaldean.

◯ **Black or African American -** The category "Black or African American" includes all individuals who identify with one or more nationalities or ethnic groups originating in any of the black racial groups of Africa. Examples of these groups include, but are not limited to, African American, Jamaican, Haitian, Nigerian, Ethiopian, and Somali. The category also includes groups such as Ghanaian, South African, Barbadian, Kenyan, Liberian, and Bahamian.

◯ **American Indian or Alaska Native -** The category "American Indian or Alaska Native" includes all individuals who identify with any of the original peoples of North and South America (including Central America) and who maintain tribal affiliation or community attachment. It includes people who identify as "American Indian" or "Alaska Native" and includes groups such as Navajo Nation, Blackfeet Tribe, Mayan, Aztec, Native Village of Barrow Inupiat Traditional Government, and Nome Eskimo Community.

◯ **Asian -** The category "Asian" includes all individuals who identify with one or more nationalities or ethnic groups originating in the Far East, Southeast Asia, or the Indian subcontinent. Examples of these groups include, but are not limited to, Chinese, Filipino, Asian Indian, Vietnamese, Korean, and Japanese. The category also includes groups such as Pakistani, Cambodian, Hmong, Thai, Bengali, Mien, etc.

◯ **Native Hawaiian and Pacific Islander -** The category "Native Hawaiian or Other Pacific Islander" includes all individuals who identify with one or more nationalities or ethnic groups originating in Hawaii, Guam, Samoa, or other Pacific Islands. Examples of these groups include, but are not limited to, Native Hawaiian, Samoan, Chamorro, Tongan,

Fijian, and Marshallese. The category also includes groups such as Palauan, Tahitian, Chuukese, Pohnpeian, Saipanese, Yapese, etc.

◯ **Other Race -** The category “other race” includes all individuals who do not identify with one of the above listed categories. Examples of these groups include, but are not limited to, multiracial.

Do you have a Hispanic, Latino, or Spanish origin? *(Choose only 1)*

◯ **Yes** - The category “Hispanic, Latino, or Spanish origin" includes all individuals who identify with one or more nationalities or ethnic groups originating in Mexico, Puerto Rico, Cuba, Central and South America, and other Spanish cultures. Examples of these groups include, but are not limited to, Mexican or Mexican American, Puerto Rican, Cuban, Salvadoran, Dominican, and Colombian. “Hispanic, Latino or Spanish origin” also includes groups such as Guatemalan, Honduran, Spaniard, Ecuadorian, Peruvian, Venezuelan, etc. If a person is not of Hispanic, Latino, or Spanish origin, answer "No, not of Hispanic, Latino, or Spanish origin".

◯ **No -** I am not of Hispanic, Latino, or Spanish origin.

Are you willing to disclose your HIV status? *(Choose only 1)*

☐ **Yes** – I am willing to disclose my HIV status publicly at meetings.
☐ **No** – I am **NOT** willing to disclose my HIV status publicly at meeting.
☐ **Abstain** – I **DO NOT** want to answer this question.

Are you HIV positive and do you receive Ryan White Part A services? *(Choose only 1)*

☐ **Yes** – I am HIV positive and I receive Ryan White Part A services.
☐ **Yes** – I am HIV positive **BUT I DO NOT** receive Ryan White Part A services.
☐ **No** – I am not HIV positive.
☐ **Abstain** – I **DO NOT** want to answer this question.

What is your date of birth and year?

____ / ____ / _____

I hereby agree that, to the best of my knowledge the provided information is true and accurate.

Planning Council Member Print Name	Planning Council Member Signature	Date

2022/23 PRIORITY SETTING & RESOURCE ALLOCATION
CONFLICT OF INTEREST DECLARATION
For Planning Council Members

GREATER HAMPTON ROADS HIV HEALTH SERVICES PLANNING COUNCIL

Print First Name _____ Print Last Name _____

Street Address _____ City _____ State _____ Zip Code _____

Email Address _____ Home Phone Number _____ Cell Phone Number _____

What is your preferred method for receiving notifications from Planning Council Support Staff? (Check all that apply)

☐ USPS Mail ☐ Email ☐ Home Phone ☐ Cell Phone/Text Message

CONFLICT OF INTEREST DECLARATION

Planning Council members will be considered to have a conflict of interest if they themselves, their relative, their spouse, or their domestic partner have an interest in issues to be discussed that might affect:

- A profit or non-profit organization in which they have a financial interest in or is serving as an officer, director, trustee, partner, paid employee, or consultant; and/or,
- A public agency in which they are serving as a paid employee or consultant; and/or
- Any person or organization with whom they are negotiating or has an existing arrangement concerning prospective employment.

A relative is defined as the spouse, child, child's child, parent, grandparent, brother, or sister of the whole or half blood and their spouses, and the parent, brother, sister or child of a spouse of a Council member. Unmarried domestic partners of Council members are regarded in the same manner as a spouse. Generally, conflict of interest does not refer to Persons Living with HIV whose sole relationship to a Ryan White Part A service provider is as a person receiving services, or as an uncompensated volunteer working less than 30 hours per week.

☐ **I have a conflict of interest in the following service category(s) because I/my relative/my spouse/my domestic partner serve as an officer, director, trustee, partner, paid employee, or consultant for an organization funded for one or more of the following service Ryan White Part A funded service category(s):**

☐ AIDS Pharmaceutical Assistance Local
☐ Early Intervention Services
☐ Emergency Financial Assistance
☐ Food Bank/Home Delivered Meals
☐ Health Insurance Premium/Cost Sharing
☐ Medical Case Management
☐ Medical Transportation
☐ Mental Health Services
☐ Non-Medical Case Management
☐ Oral Health Services
☐ Outpatient Ambulatory Health Services
☐ Referral for Healthcare & Support Services
☐ Substance Abuse Service - Outpatient

◯ I have a conflict of interest because I/my relative/my spouse/my domestic partner:

- ☐ Serve as an officer, director, trustee, partner, paid employee, or consultant of a profit or non-profit organization receiving funds from Ryan White Part A; and/or
- ☐ Serve as an officer, director, trustee, partner, paid employee, or consultant of public agency receiving funds from Part A; and/or
- ☐ Have an existing arrangement concerning prospective employment with a profit, non-profit, or public agency/organization receiving funds from Part A.

◯ I do not have a conflict of interest, and I: (check one)

- ☐ **RECEIVE** Ryan White Part A services.
- ☐ **DO NOT** receive Ryan White Part A services.

It will be the responsibility of each Planning Council member and the Executive Committee of the Planning Council to determine whether a conflict of interest exists. If a Planning Council member's conflict of interest change, they must announce the change at meetings as soon as it occurs and resubmit this form with the changes as soon as possible.

I hereby state that, to the best of my knowledge, information, and belief, I shall abstain from voting on issues that directly relate to or appear to relate to an action that may result, or appear to result in personal, organizational, or professional gain. I agree to abstain from voting on the processes and the issues of the Planning Council that present a conflict of interest as determined above.

Planning Council Member Print Name	Planning Council Member Signature	Date

For Planning Council Members

GREATER HAMPTON ROADS HIV HEALTH SERVICES PLANNING COUNCIL

Purpose: This Code of Conduct has been created by the Greater Hampton Roads HIV Health Services Planning Council in order to ensure Council members, individually and collectively, adhere to the highest possible ethical standards.

1. Every Council member will treat every other Council member, support staff, Recipient staff, and members of the public with courtesy and professionalism. Each Council member is reminded to respect and recognize the legitimate right of all Council members to be a part of any discussions and decision-making processes. This means that all Council members and guests at any given meeting will have the opportunity to speak and be listened to without interruptions.

2. Every Council member will be truthful and honest.

3. Any Council member who has a conflict of interest shall identify themselves as such when participating in Council discussions and decision-making processes relevant to their conflict of interest related to Ryan White Part A services.

4. Personal attacks on anyone will not be tolerated. Disagreements will focus on issues, not upon individuals**.**

5. While recognizing an individual's right to dissent, once decisions are made, every Council member will abide by the decision, regardless of their personal position.

6. Recognizing that within the confines of the Open Meeting Statute (V.A. Stat. §§ 2.2-3707.01 and 2.2-3711), all information presented at a Council or Committee meeting is part of the public record. Council members are encouraged to exercise discretion when discussing confidential or sensitive information, most notably an individual's HIV status.

7. Every Council member will honor their responsibility to present and consider the concerns of specific communities or populations but shall also consider the overall needs of people living with HIV and balance the interests of both in discussion and decision making.

8. Every Council member will make every reasonable effort to honor their responsibility to participate in Planning Council and committee meetings and come to meetings prepared to work and discuss business listed on the agenda.

9. Every Council member will make every reasonable effort to speak positively about the Council in public. The Council will strive to address problems internally.

10. Any Council member who feels they cannot support the mission, goals, strategies, programs, and/or policies of the Council as agreed upon by the membership should consider resignation.

11. Every Council member will take responsibility not only for abiding by these rules of conduct personally, but also for speaking out to assure that all members abide by them.

12. Only the Council Chair may speak, publish materials, provide endorsements on behalf of, or represent the Council. Council members may take any of these actions only if they clearly articulate that they are speaking strictly on behalf of themselves and not the Council.

13. Every Council member will participate and allow the participation of every other Council member and guest without discrimination with respect to race, gender, religious belief, color, national origin, ancestry, age, physical or mental disability status, or sexual or gender orientation.

14. No Council member shall use alcohol or illegal drugs, or be under the influence of such, at any Council or committee meeting, or another Council sponsored events.

15. Violation of this Code of Conduct may lead to corrective action up to and including removal from Council membership.

I hereby state that, I agree to adhere to the Planning Council Code of Conduct, and that any violation of the code of conduct may be subject to removal from Council membership.

Planning Council Member Print Name	Planning Council Member Signature	Date