



OHIO DEPARTMENT OF HEALTH

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John R. Kasich / Governor

Theodore E. Wymyslo, M.D. / Director of Health

MEMORANDUM

Date: November 7, 2013

To: Prospective HIV and STD Prevention Applicants

From: Steve Wagner, MPH, JD 
Division of Prevention and Health Promotion
Ohio Department of Health

Subject: Notice of Availability of Funds – Federal Fiscal Year 2014
HIV and STD Prevention Grant

The Ohio Department of Health (ODH), Division of Prevention and Health Promotion (DPHP), Bureau of HIV/AIDS, STD, and TB (BHST) announces the availability of grant funds to support the Ryan White Federal HIV Care, Emerging Communities and Client Education Outreach programs.

To obtain a grant application packet:

1. Go to the ODH website at <http://www.odh.ohio.gov/>
2. From the home page, click on "Funding Opportunities";
3. From the next page, click on "ODH Grants";
4. Next click "Grant Request for Proposals," this will give you a pull down menu with current RFPs by name; and
5. Select and highlight the Ryan White Part B grant and click "Submit." This process invokes Adobe Acrobat and displays the entire RFP. You can either read and/or print the document as desired.

In the application packet you will find:

1. Request for Proposals (RFP) – This document outlines detailed information about the background, intent and scope of the grant, policy, procedures, performance expectations, and general information and requirements associated with the administration of the grant.
2. *Notice of Intent to Apply for Funding (NOIAF)* form – The purpose of this document is to ascertain your intent to apply for available grant funds. Please note: The NOIAF must be submitted no later than Friday, December 6, 2013 to be eligible for these funds. NOIAF's not received by the due date will not be accepted.

When you have accessed the application packet:

1. Review the RFP to determine your organization's ability to meet the requirements of the grant and your intent to apply.
2. If after reviewing the RFP you wish to submit an application for the grant, complete the *Notice of Intent to Apply for Funding* form in the application packet. Fax or e-mail it to ODH, per the listed instructions and by the indicated due date of Friday, December 6, 2013.
(The *Notice of Intent to Apply for Funding* form is mandatory, if you intend to apply for the grant.)

Upon receipt of your completed *Notice of Intent to Apply for Funding* form, ODH will:

1. Create a grant application project number for your organization. This project number will allow you to submit an application via the Internet using the Grants Management Information System (GMIS 2.0). All grant applications must be submitted via the Internet using GMIS 2.0.
2. ODH will assess your organization's GMIS 2.0 training needs (as indicated on the completed *Notice of Intent to Apply for Funding* form) and contact you regarding those needs. GMIS 2.0 training is mandatory if your organization has never been trained on GMIS 2.0.

Once ODH receives your completed *Notice of Intent to Apply for Funding* form, creates the project number for your organization and finalizes all GMIS 2.0 training requirements, you may proceed with the application process as outlined in the RFP.

All potential applicants are encouraged to participate in a Bidder's Conference that will be held via conference call on **Thursday, December 5, 2013 from 10:00am – 12:00pm**. Information on how to log in will be sent after the *Notice of Intent to Apply for Funding* form is submitted. The Bidder's Conference will provide an opportunity for interested parties to learn more about the RFP and to ask clarifying questions. Please contact Laurie Rickert, Administrator, Community-Based Program at 614-466-1411 or laurie.rickert@odh.ohio.gov with questions.

All applications and attachments are due Monday, January 13, 2014. Electronic applications received after Monday, January 13, 2014 will not be considered for funding. Faxed, hand-delivered or mailed applications will not be accepted.

All grant applications must be submitted via the Internet, using GMIS 2.0. All organizations are required to attend GMIS 2.0 training. If your organization has not been trained, complete and return the GMIS 2.0 training form by Friday, December 6, 2013.

If you have questions regarding this application, please contact Laurie Rickert, Administrator, Community-Based Program at 614-466-1411 or laurie.rickert@odh.ohio.gov.



ALL APPLICATIONS MUST BE SUBMITTED VIA THE INTERNET

OHIO DEPARTMENT OF HEALTH

**DIVISION OF
PREVENTION**

BUREAU OF

Bureau of HIV/AIDS, STD and TB

*Ryan White Federal HIV Care, Emerging Communities
and Client Education Outreach*

**REQUEST FOR PROPOSALS (RFP)
FOR
FISCAL YEAR 2014
(04/01/14 – 03/31/15)**

**Local Public Applicant Agencies
Non-Profit Applicants**

COMPETITIVE GRANT APPLICATION INFORMATION

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I. APPLICATION SUMMARY and GUIDANCE

An application for an Ohio Department of Health (ODH) grant consists of a number of required parts – an electronic component submitted via the Internet website “ODH Application Gateway” and various paper forms and attachments. All the required parts of a specific application must be completed and submitted by the application due date. **Any required part that is not submitted by the due date indicated in sections D and G will result in the entire application not being considered for review.**

The application summary information is provided to assist your agency in identifying funding criteria:

- A. Policy and Procedure:** Uniform administration of all the ODH grants is governed by the ODH Grants Administration Policies and Procedures (GAPP) manual. This manual must be followed to ensure adherence to the rules, regulations and procedures for preparation of all subgrantee applications. The GAPP manual is available on the ODH website <http://www.odh.ohio.gov>. (Click on Our Programs, Funding Opportunities, ODH Funding Opportunities, ODH Grants). Please refer to Policy and Procedure updates found on the GMIS bulletin board.
- B. Application Name:** Ryan White Part B (Ryan White Federal HIV Care, Emerging Communities and Client Education Outreach)
- C. Purpose:** This program is authorized by the PHS Act, Sections 2611-23 [42 U.S.C. 300ff-21], as amended by the Ryan White HIV/AIDS Treatment Extension Act of 2009 (Public Law 111-87). The U.S. Department of Health and Human Services (DHHS) administers the Ryan White Part B program through the Health Resources and Services Administration (HRSA), the HIV/AIDS Bureau (HAB), Division of State HIV/AIDS Programs (DSHAP). The purpose of this grant program is to assist States and Territories in developing and/or enhancing access to a comprehensive continuum of high quality HIV care and treatment for low-income people living with HIV (PLWH). As such, it supports the National HIV/AIDS Strategy (NHAS) goals of: reducing HIV incidence, increasing access to care and optimizing health outcomes, and reducing HIV-related health disparities.

A comprehensive HIV/AIDS continuum of care includes the following core medical services: outpatient and ambulatory health services, AIDS Drug Assistance Program (ADAP) medications, AIDS pharmaceutical assistance (local), oral health care, early intervention services, health insurance premium and cost sharing assistance, home healthcare, medical nutrition therapy, hospice services, home and community-based health services, mental health services, medical case management, treatment adherence services, and substance abuse outpatient care as well as appropriate supportive services that assist PLWH in accessing treatment of HIV infection that is consistent with HHS Treatment Guidelines. The guidelines provide standards of care recommendations for antiretroviral treatment, including prophylaxis and treatment of opportunistic infections. The current HHS Treatment Guidelines are available at www.aidsinfo.nih.gov.

Comprehensive HIV/AIDS care also includes access to support services: case management (non- medical), childcare services, emergency financial assistance, food bank/home delivered meals, health education/risk reduction, housing services, legal services, linguistic services, medical transportation services, outreach services, psychosocial support services, referral for healthcare/supportive services, rehabilitation services, respite care, residential substance abuse services and treatment adherence counseling.

The Emerging Communities Supplemental Grant program defines emerging communities (ECs) as Metropolitan Statistical Areas (MSAs) that were ineligible for Part A funds, had a population of at least 500,000, and reported to the Centers for Disease Control and Prevention (CDC) a total of 500 to 1,999 AIDS cases during the most recent 5-year reporting period. One city area in Ohio was deemed eligible for this supplemental funding (Cincinnati).

The availability of funding for this combined, competitive grant reflects the support of both the Ohio Department of Health (ODH) and Health Resources & Services Administration (HRSA) for case management opportunities for persons living with HIV/AIDS. In addition, HCS has a commitment to collaborate with HIV testing and counseling sites to minimize the gap between a HIV+ test and the transition to HIV Care Services.

- D. Qualified Applicants:** *All applicants must be a local public or non-profit agency. Applicant agencies must attend or document in writing prior attendance at Grants Management Information System 2.0 (GMIS) training and must have the capacity to accept an electronic funds transfer (EFT).*

Additional requirements for Ryan White Federal HIV Care and Emerging Communities only; (Agencies must meet the criteria listed below to be eligible to apply):

1. Be a community-based medical or social services agency, a community-based/non-residential chemical dependency agency, or a community-based mental health agency;
2. Provide direct social services currently as a part of their mission statement;
3. Have been providing direct HIV social services for the past five (5) consecutive years in Ohio;
4. Operate under the established professional standards and guidelines for the National Association of Social Workers (NASW) and agree to adhere to NASW standards for social work case management;
5. Provide an LISW-S who holds a current Ohio license, on-site supervision to each case manager funded by ODH on a two-hour per week average per FTE and one-hour per week average for ½ FTE, and who will attend ODH sponsored trainings generally two (2) times/year;
6. Shall not deny services based on ethnic, racial, cultural, sexual orientation, at-risk populations and/or disenfranchised groups (including, but not limited to, previously incarcerated individuals);

7. Demonstrate (e.g. in the agency's policy manual and/or goals and objectives) specific language about serving people with HIV and their families;
8. Be fiscally able to administer the Ryan White Emergency Financial Assistance Program, including the ability to advance money for the Ryan White Emergency Financial Assistance Program designed to prevent gaps in services to individuals experiencing an emergency until reimbursed by the program third party administrator; and
9. Provide documentation of Medicaid certification (or progress towards) with the Ohio Department of Medicaid; if Medicaid reimbursable services are being provided by the agency.

The MSA eligible for the supplemental **Emerging Communities** dollars in Ohio is Cincinnati-Middletown.

The following criteria must be met for grant applications to be eligible for review:

1. Applicant does not owe funds in excess of \$1,000 to the ODH.
2. Applicant is not certified to the Attorney General's (AG's) office.
3. Applicant has submitted application and all required attachments by 4:00 p.m. on **Monday, January 13, 2014.**

- E. Service Area:** The RFP requires applicants to provide services to clients from all counties included in the consortia areas specified below.

The state of Ohio has been divided into the following consortia areas for case management:

- Consortium Area #1, which serves Ashtabula, Cuyahoga, Geauga, Lake and Lorain Counties
- Consortium Area #2, which serves Delaware, Fairfield, Franklin, Licking, Madison, Pickaway and Union Counties
- Consortium Area #3, which serves Adams, Brown, Butler, Clermont, Clinton, Hamilton, Highland, and Warren Counties
- Consortium Area #4, which serves Clark, Darke, Greene, Miami, Montgomery, and Preble Counties
- Consortium Area #5, which serves Defiance, Fulton, Henry, Lucas, Ottawa, Sandusky, Williams and Wood Counties
- Consortium Area #6, which serves Medina, Portage and Summit Counties
- Consortium Area #7, which serves Columbiana, Jefferson, Mahoning and Trumbull Counties
- Consortium Area #8, which serves Carroll, Harrison, Holmes, Stark, Tuscarawas, and Wayne Counties
- Consortium Area #9A, which serves Allen, Auglaize, Champaign, Hancock, Hardin, Logan, Mercer, Paulding, Putnam, Shelby and Van Wert Counties
- Consortium Area #9B, which serves Ashland, Crawford, Erie, Huron, Knox, Marion, Morrow, Richland, Seneca and Wyandot Counties

- Consortium Area #9C, which serves Athens, Belmont, Coshocton, Fayette, Gallia, Guernsey, Hocking, Jackson, Lawrence, Meigs, Monroe, Morgan, Muskingum, Noble, Perry, Pike, Ross, Scioto, Vinton, and Washington Counties

Emerging Communities:

The Cincinnati MSA, as defined by the Federal Government, consists of Dearborn County, IN; Franklin County, IN; Ohio County, IN; Boone County, KY; Bracken County, KY; Campbell County, KY; Gallatin County, KY; Grant County, KY; Kenton County, KY; Pendleton County, KY; Brown County, OH; Butler County, OH; Clermont County, OH; Hamilton County, OH; and Warren County, OH.

Client Education Outreach:

Services are provided throughout the entire State of Ohio.

- F. Number of Grants and Funds Available:** Up to 15 grants will be awarded for a total amount up to **\$5,700,000** for the **HIV Federal Care grants and the Client Education Outreach** program. **One (1)** grant for Cincinnati MSA applications will be awarded for an approximate amount of **\$300,000** for the **Emerging Communities** program.

Any award made through this program is contingent upon the availability of funds for Ryan White Part B services and activities. The subgrantee agency must be prepared to cover the costs of operating the program in the event of a delay in grant payments. Authorization of funds for this purpose is contained in Amended Substitute House Bill 1 and the Catalog of Federal Domestic Assistance (CFDA) Number 93.917.

No grant award will be issued for less than \$30,000. The minimum amount is exclusive of any required matching amounts and represents only ODH funds granted. Applications submitted for less than the minimum amount will not be considered for review.

- G. Due Date:** All parts of the application must be completed and received by ODH electronically via GMIS or via ground delivery by 4:00 p.m. on **Monday, January 13, 2014**. Applications and required attachments received late will not be considered for review.

Programmatic and Technical Assistance: inquiries can be submitted to **Laurie Rickert, Administrator, Community-Based Programs** via e-mail at laurie.rickert@odh.ohio.gov.

- H. Authorization:** Authorization of funds for this purpose is contained in Amended Substitute House Bill 1 and/or the *Catalog of Federal Domestic Assistance (CFDA) Number 93.917*.
- I. Goals:** The Ohio Department of Health's purposes in releasing funds for Medical Case Management are to:

1. Provide accessible and culturally competent case management services to a highly diverse population of individuals living with HIV.
2. Assure that case management services are available to people with HIV and their families in every county of the State of Ohio through a subgrantee office, satellite office, or in-home client visits.
3. Assure that all individuals living with HIV have access to core medical care consistent with the guidelines developed by the U.S. Public Health Service.
4. Provide information and education to people living with HIV regarding horizontal or vertical transmission, secondary infection, and resistance.
5. Make individuals aware of, and assist them in, accessing healthcare related resources for which they may be eligible in order to improve the quality of their lives; and as a last resort approve the use of Ryan White Emergency financial assistance funds and/or refer individuals to other Ryan White programs.
6. Provide access to quality case management services, based on the National Association of Social Work (NASW) model of case management to people living with HIV/AIDS (PLWHA).
7. Proactively implement activities which respond to the disproportionate impact of HIV/AIDS among Ohio's racial and ethnic minorities.

The Ohio Department of Health's purposes in releasing funds for **Client Education Outreach** are to:

1. Provide statewide support and promote access to core medical services for persons living with HIV/AIDS.
 2. Facilitate statewide consumer involvement in the provision of AIDS care and services in Ohio.
 3. Increase capacity and skills of community leaders through regional educational forums.
 4. Raise awareness and knowledge of Ohio consumers through statewide informational updates and community planning forums.
 5. Assist in expanding the provider network in targeted regions through collaboration and coordination of efforts with ODH.
- J. Program Period and Budget Period:** The program period will begin **April 1, 2014 and end on March 31, 2017**. The budget period for this application is **April 1, 2014 through March 31, 2015**.
- K. Public Health Accreditation Board (PHAB) Standard(s):** The PHAB Standards that will be addressed by the Ryan White HIV Care and Emerging Communities grant activities include: *PHAB standard 7.1 Assess Health Care Capacity and Access to Health Care Services and standard 7.2: Identify and Implement Strategies to Improve Access to Health Care Services*. The PHAB Standards that will be addressed by Client Education Outreach grant activities include: *PHAB standard 3.2: Provide Information on Public Health Issues and Public Health Functions Through Multiple Methods to a Variety of Audiences, as well as, standard 4.1: Engage with the Public Health System and the Community in Identifying and Addressing Health Problems Through Collaborative Processes*. All successful applicants will incorporate PHAB

Standard 9.2 into their grant activities: Develop and Implement Quality Improvement Processes Integrated Into Organizational Practice, Programs, Processes, and Interventions.

The PHAB standards are available at the following website:

<http://www.phaboard.org/wp-content/uploads/PHAB-Standards-Overview-Version-1.0.pdf>

L. Public Health Impact Statement: All applicant agencies that are not local health districts must communicate with local health districts regarding the impact of the proposed grant activities on the PHAB Standards.

1. *Public Health Impact Statement Summary* - Applicant agencies are required to submit a summary of the proposal to local health districts prior to submitting the grant application to ODH. The program summary, not to exceed one page, must include:

- a) The Public Health Accreditation Board (PHAB) Standard(s) to be addressed by grant activities:
 - A description of the demographic characteristics (e.g., age, race, gender, ethnicity, socio-economic status, educational levels) of the target population and the geographical area in which they live (e.g., census tracts, census blocks, block groups);
 - A summary of the services to be provided or activities to be conducted; and,
 - A plan to coordinate and share information with appropriate local health districts.

The applicant must submit the above summary as part of their grant application to ODH. This will document that a written summary of the proposed activities was provided to the local health districts with a request for their support and/or comment about the activities as they relate to the PHAB Standards.

2. *Public Health Impact Statement of Support* - Include with the grant application a statement of support from the local health districts, if available. If a statement of support from the local health districts is not obtained, indicate that when the program summary is submitted with the grant application. If an applicant agency has a regional and/or statewide focus, a statement of support must be submitted from at least one local health district, if available.

M. Incorporation of Strategies to Eliminate Health Inequities

Health Equity Component (Standard Health Equity Language)

The ODH is committed to the elimination of health inequities. Racial and ethnic minorities and Ohio's economically disadvantaged residents experience health inequities and, therefore, do not have the same opportunities as other groups to be healthy. Throughout the various components of this application (Program Narrative, Objectives, and Workplan), applicants are required to:

- 1) Explain the extent to which health disparities and/or health inequities are manifested within the problem addressed by this funding opportunity. This includes the identification of specific group(s) which experiences a disproportionate burden of disease or health condition (This information must be supported by data.);
- 2) Explain how specific social and environmental conditions (social determinants of health) put groups who are already disadvantaged at increased risk for health inequities; and
- 3) Explain how proposed program interventions will address this problem.

The following section will provide basic framework and links to information to understand health equity concepts.

Understanding Health Disparities, Health Inequities, Social Determinants of Health & Health Equity:

*Certain groups in Ohio face significant barriers to achieving the best health possible. These groups include Ohio's poorest residents and racial and ethnic minority groups. Health disparities occur when these groups experience more disease, death or disability beyond what would normally be expected based on their relative size of the population. Health disparities are often characterized by such measures as disproportionate incidence, prevalence and/or mortality rates of diseases or health conditions. Health is largely determined by where people live, work and play. Health disparities are unnatural and can occur because of socioeconomic status, race/ethnicity, sexual orientation, gender, disability status, geographic location or some combination of these factors. Those most impacted by health disparities also tend to have less access to resources like healthy food, good housing, good education, safe neighborhoods, freedom from racism and other forms of discrimination. These are referred to as **social determinants of health**. Social determinants are the root causes of health disparities. The systematic and unjust distribution of social determinants resulting in negative health outcomes is referred to as **health inequities**. As long as health inequities persist, those aforementioned groups will not achieve their best possible health. The ability of marginalized groups to achieve optimal health (like those with access to social determinants) is referred to as **health equity**. Public health programs that incorporate social determinants into the planning and implementation of interventions will greatly contribute to the elimination of health inequities.*

For more resources on health equity, please visit the ODH website at:
<http://www.healthyohioprogram.org/healthequity/equity.aspx>.

- N. Appropriation Contingency:** Any award made through this program is contingent upon the availability of funds for this purpose. **The subgrantee agency must be prepared to support the costs of operating the program in the event of a delay in grant payments.**

- O. Programmatic, Technical Assistance and Authorization for Internet Submission:** Initial authorization for Internet submission, for new agencies, will be granted after participation in the GMIS training session. All other agencies will receive their authorization after the posting of the RFP to the ODH website and the receipt of the Notice of Intent to Apply for Funding (NOIAF). Please send inquiries to **Laurie Rickert, Administrator, Community-Based Programs** via e-mail at laurie.rickert@odh.ohio.gov. All questions must be submitted via e-mail. Answers will be circulated to all applicants who submit a NOIAF. The NOIAF is due by **Friday, December 6, 2013.**

Applicant must attend or must document in the NOIAF prior attendance at GMIS training in order to receive authorization for Internet submission.

There will be a bidder's conference call on Thursday, December 5, 2013 from 10:00 am to 12:00 pm to provide guidance and answer questions related to the RFP. To participate in this call, please dial 1-800-510-7500 and enter participant code 3972429#.

- P. Acknowledgment:** An 'Application Submitted' status will appear in GMIS that acknowledges ODH system receipt of the application submission.
- Q. Late Applications:** Applications are dated the time of actual submission via the Internet utilizing GMIS. Required attachments and/or forms sent electronically must be transmitted by the application due date. Required attachments and/or forms mailed that are non-Internet compatible must be postmarked or received on or before the application due date of **Monday, January 13, 2014.**

Applicants should request a legibly dated postmark, or obtain a legibly dated receipt from the U.S. Postal Service, or a commercial carrier. Private metered postmarks shall **not** be acceptable as proof of timely mailing. Applicants can hand-deliver attachments to ODH, Grants Services Unit, Central Master Files; but they must be delivered by **4:00 p.m.** on the application due date. Fax attachments will not be accepted. **GMIS applications and required application attachments received late will not be considered for review.**

- R. Successful Applicants:** Successful applicants will receive official notification in the form of a Notice of Award (NOA). The NOA, issued under the signature of the Director of Health, allows for expenditure of grant funds.
- S. Unsuccessful Applicants:** Within 30 days after a decision to disapprove or not fund a grant application for a given period, written notification, issued under the signature of the Director of Health, or his designee, shall be sent to the unsuccessful applicant.
- T. Review Criteria:** All proposals will be judged on the quality, clarity and completeness of the application. Applications will be judged according to the extent to which the proposal:

1. Contributes to the advancement and/or improvement of the health of Ohioans;
2. Is responsive to policy concerns and program objectives of the initiative/program/activity for which grant dollars are being made available;
3. Is well executed and is capable of attaining program objectives;
4. Describe specific objectives, activities, milestones and outcomes with respect to time-lines and resources;
5. Estimates reasonable cost to the ODH, considering the anticipated results;
6. Indicates that program personnel are well qualified by training and/or experience for their roles in the program and the applicant organization has adequate facilities and personnel;
7. Provides an evaluation plan, including a design for determining program success;
8. Is responsive to the special concerns and program priorities specified in the RFP;
9. Has demonstrated acceptable past performance in areas related to programmatic and financial stewardship of grant funds;
10. Has demonstrated compliance to GAPP, Chapter 100;
11. Explicitly identifies specific groups in the service area who experience a disproportionate burden of the diseases, health condition(s); or who are at an increased risk for problems addressed by this funding opportunity; and,
12. Applicant describes activities which supports the requirements outlined in sections I. thru M. of this RFP.

The Application Review-Rating Form is available in Attachment 8.

The ODH will make the final determination and selection of successful/unsuccessful applicants and reserves the right to reject any or all applications for any given RFPs. **There will be no appeal of the Department's decision.**

- U. **Freedom of Information Act:** The Freedom of Information Act (5 U.S.C.552) and the associated Public Information Regulations require the release of certain information regarding grants requested by any member of the public. The intended use of the information will not be a criterion for release. Grant applications and grant-related reports are generally available for inspection and copying except that information considered being an unwarranted invasion of personal privacy will not be disclosed. For guidance regarding specific funding sources, refer to: 45 CFR Part 5 for funds from the U.S. Department of Health and Human Service.
- V. **Ownership Copyright:** Any work produced under this grant, including any documents, data, photographs and negatives, electronic reports, records, software, source code, or other media, shall become the property of ODH, which shall have an unrestricted right to reproduce, distribute, modify, maintain, and use the work produced. If this grant is funded in whole, or in part, by the federal government, unless otherwise provided by the terms of that grant or by federal law, the federal funder also shall have an unrestricted right to reproduce, distribute, modify, maintain, and use the work produced. No work produced under this grant shall include copyrighted matter without the prior written consent of the owner, except as may otherwise be allowed under federal law.

ODH must approve, in advance, the content of any work produced under this grant. All work must clearly state:

“This work is funded either in whole or in part by a grant awarded by the Ohio Department of Health, Division of Prevention, Bureau of HIV/AIDS, STD and TB, HIV Care Services, Ryan White Part B Program and the U.S. Department of Health and Human Services. Please also include the agency name, program grant number, and the CFDA number (97.913).”

- W. **Reporting Requirements:** Successful applicants are required to submit subgrantee program and expenditure reports. Reports must adhere to the requirements of the ODH GAPP manual. Reports must be received in accordance with the requirements of the ODH GAPP manual and this RFP before the department will release any additional funds.

Note: Failure to assure the quality of reporting by submitting incomplete and/or late program or expenditure reports will jeopardize the receipt of future agency payments.

Reports shall be submitted as follows:

1. **Program Reports:** Subgrantees Program Reports must be completed and submitted via GMIS, as required by the subgrant program by the following dates: **July 15, 2013, October 15, 2013, January 15, 2015 and April 15, 2015. Program Reports that do not include required attachments will not be approved.** All program report attachments must clearly identify the authorized program name and grant number.

Submission of Subgrantee Program Reports via GMIS indicates acceptance of the ODH GAPP.

2. **Monthly Expenditure Reports:** Subgrantee Expenditure Reports **must** be completed and submitted **via GMIS** by the 10th of each month. Monthly Subgrantee Expenditure Reports must include a summary sheet of all documentation, monthly and year to date general and payroll ledgers, as well as the monthly program report. The program report consists of the names of all staff persons who are reimbursed on the grant. Additionally, the program report must include a distinct client count based on medical case management visits, or a count of consumers or professionals who participated in community or educational forums.
3. **Final Expenditure Reports:** A Subgrantee Final Expenditure Report reflecting total expenditures for the fiscal year must be completed and submitted **via GMIS** by 4:00 p.m. on or before May 15, 2015. The information contained in this report must reflect the program's accounting records and supportive documentation. Any cash balances must be returned with the Subgrantee Final Expense Report. The Subgrantee Final Expense Report serves as an invoice to return unused funds.

Submission of the Periodic and Final Subgrantee Expenditure reports via the GMIS system indicates acceptance of ODH GAPP. Clicking the "Approve" button signifies authorization of the submission by an agency official and constitutes electronic acknowledgment and acceptance of GAPP rules and regulations.

4. **Inventory Report:** A list of all equipment purchased in whole or in part with **current** grant funds (Equipment Section of the approved budget) must be submitted via GMIS as part of the subgrantee Final Expenditure Report. At least once every two years, inventory must be physically inspected by the subgrantee. Equipment purchased with ODH grant funds must be tagged as property of ODH for inventory control. Such equipment may be required to be returned to ODH at the end of the grant program period.
- X. **Special Condition(s):** Responses to all special conditions **must be submitted via GMIS within 30 days of receipt of the first monthly payment.** A Special Conditions link is available for viewing and responding to special conditions. This link is viewable only after the issuance of the subgrantee's first payment. The 30 day time period, in which the subgrantee must respond to special conditions, will begin when the link is viewable. Failure to submit satisfactory responses to the special conditions or a plan describing how those special conditions will be satisfied will result in the withholding of any further payments until satisfied.
- Y. **Unallowable Costs:** Funds **may not** be used for the following:
1. To advance political or religious points of view or for fund raising or lobbying; but must be used solely for the purpose as specified in this announcement;
 2. To disseminate factually incorrect or deceitful information;
 3. Consulting fees for salaried program personnel to perform activities related to grant objectives;
 4. Bad debts of any kind;
 5. Lump sum indirect or administrative costs;
 6. Contributions to a contingency fund;
 7. Entertainment;
 8. Fines and penalties;
 9. Membership fees -- unless related to the program and approved by ODH;
 10. Interest or other financial payments (including but not limited to bank fees);
 11. Contributions made by program personnel;
 12. Costs to rent equipment or space owned by the funded agency;
 13. Inpatient services;
 14. The purchase or improvement of land; the purchase, construction, or permanent improvement of any building;
 15. Satisfying any requirement for the expenditure of non-federal funds as a condition for the receipt of federal funds;
 16. Travel and meals over the current state rates (see OBM website: <http://obm.ohio.gov/MiscPages/Memos/default.aspx> then click on most recent Mileage Reimbursement memo.)

17. Costs related to out-of-state travel, unless otherwise approved by ODH, and described in the budget narrative;
18. Training longer than one week in duration, unless otherwise approved by ODH;
19. Contracts for compensation with advisory board members;
20. Grant-related equipment costs greater than \$300, unless justified and approved by ODH;
21. Payments to any person for influencing or attempting to influence members of Congress or the Ohio General Assembly in connection with awarding of grants;
22. Non-direct care services that exceed 10 percent of the total award.

Use of grant funds for prohibited purposes will result in the loss and/or recovery of those funds.

- Z. **Client Incentives:** Client incentives are an allowable cost. The following client incentives (permitted for the recipients of the Client Outreach and Education award only) include: The purchasing of gas cards for HIV positive individuals to attend selected meetings, leadership trainings and community forums as necessary to encourage participants to engage in the planning and identification of unmet needs of the community.

Client Enablers: Client enablers are an unallowable cost.

Recipients of incentives must sign a statement acknowledging the receipt of the incentive and agreeing to the purpose(s) of the incentive. Subgrantees are required to maintain a log of all client incentives and enablers purchased and distributed. These files must be readily available for review during your programmatic monitoring visit.

- AA. **Audit:** Subgrantees currently receiving funding from the ODH are responsible for submitting an independent audit report that meets OMB Circular A-133 requirements, a copy of the auditor's management letter, a corrective action plan (if applicable) and a data collection form (for single audits) within 30 days of the receipt of the auditor's report, but not later than nine months after the end of the subgrantee's fiscal year. Subgrantees that expend \$500,000 or more in federal awards per fiscal year are required to have a single audit. The fair share of the cost of the single audit is an allowable cost to federal awards provided that the audit was conducted in accordance with the requirements of OMB Circular A-133.

Subgrantees that expend less than the \$500,000 threshold require a financial audit conducted in accordance with Generally Accepted Government Auditing Standards.

The financial audit is not an allowable cost to the grant funded program.

Once an audit is completed, a copy must be sent to the ODH, Grants Services Unit, Central Master Files address within 30 days. Reference: GAPP Chapter 100, Section 108 and OMB Circular A-133, Audits of States, Local Governments, and Non-Profit Organizations for additional audit requirements.

Subgrantee audit reports (finalized and published, and including the audit Management Letters, if applicable) **which include internal control findings, questioned costs or any other serious findings, must include a cover letter which:**

- Lists and highlights the applicable findings;
- Discloses the potential connection or effect (direct or indirect) of the findings on subgrants passed-through the ODH; and,
- Summarizes a Corrective Action Plan (CAP) to address the findings. A copy of the CAP should be attached to the cover letter.

AB. Submission of Application

Formatting Requirements:

- Properly label each item of the application packet (ex. budget narrative, program narrative, etc.).
- Each section should use 1.5 spacing with one-inch margins.
- Program and Budget narratives must be submitted in portrait orientation on 8 ½ by 11 paper.
- Number all pages (print on one side only).
- Program narrative should not exceed 35 pages (**excludes** appendices, attachments, budget and budget narrative).
- Use a 12 point font.
- Forms must be completed and submitted in the format provided by ODH.

The GMIS application submission must consist of the following:

Complete & Submit Via Internet

1. Application Information
2. Project Narrative
3. Project Contacts
4. Budget
 - Primary Reason
 - Funding
 - Cash Needs
 - Justification
 - Personnel
 - Other Direct Costs
 - Equipment
 - Contracts
 - Compliance Section D
 - Summary
5. Civil Rights Review Questionnaire (EEO Survey)
6. Assurances Certification
7. Federal Funding Accountability and Transparency Act (FFATA) reporting form
8. Electronic Funds Transfer (EFT) form (**Required if new agency, thereafter only if banking information has changed.**)

9. IRS W-9 Form (**Required if new agency, thereafter only when tax identification number or agency address information has changed.**) **One of the following forms must accompany the IRS W-9 Form:**
 - a. Vendor Information Form (**New Agency Only**)
 - b. Vendor Information Change Form (**Existing agency with tax identification number, name and/or address change(s).**)
 - c. Change request in writing on agency letterhead (**Existing agency with tax identification number, name and/or address change(s).**)
10. Public Health Impact Statement
11. Statement of Support from the Local Health Districts
12. Liability Coverage (**Non-Profit organizations only; proof of current liability coverage and thereafter at each renewal period.**)
13. Evidence of Non-Profit Status (**Non-Profit organizations only**)
14. Attachments as required by Program:
 - i. Subgrantee Staffing Information
 - ii. Letters of Collaborations

One copy of the following documents must be e-mailed to audits@odh.ohio.gov or mailed to the address listed below:

**Complete
Copy &
E-mail or
Mail to
ODH**

1. Current Independent Audit (latest completed organizational fiscal period; **only if not previously submitted**)

**Ohio Department of Health
Grants Services Unit
Central Master Files, 4th Floor
246 N. High Street
Columbus, Ohio 43215**

One copy of the following documents must be mailed to the address listed below:

**Complete
Copy &
Mail To
ODH**

1. An original and (N/A) copies of **Attachments** (non-Internet compatible) as required by program: **NONE**

**Ohio Department of Health
Grants Services Unit
Central Master Files, 4th Floor
246 N. High Street
Columbus, Ohio 43215**

II. APPLICATION REQUIREMENTS AND FORMAT

Access to GMIS, will be provided after GMIS training for those agencies requiring training. All others will receive access after the RFP is posted to the ODH website.

All applications must be submitted via GMIS. Submission of all parts of the grant application via the ODH's GMIS system indicates acceptance of ODH GAPP. Submission of the application signifies authorization by an agency official and constitutes electronic acknowledgment and acceptance of GAPP rules and regulations in lieu of an executed Signature Page document.

- A. **Application Information:** Information on the applicant agency and its administrative staff must be accurately completed. This information will serve as the basis for necessary communication between the agency and the ODH.
- B. **Budget:** Prior to completion of the budget section, please review **page 11** of the RFP for unallowable costs.

Match or Applicant Share is not required by this program. Do not include Match or Applicant Share in the budget and/or the Applicant Share column of the Budget Summary. Only the narrative may be used to identify additional funding information from other resources.

- 1. **Primary Reason and Justification Pages:** Provide a detailed budget justification narrative that describes how the categorical costs are derived. Discuss the necessity, reasonableness, and allocability of the proposed costs. Describe the specific functions of the personnel, consultants and collaborators. Explain and justify equipment, travel, (including any plans for out-of-state travel), supplies and training costs. If you have joint costs refer to GAPP Chapter 100, Section 103.3 Cost Allocation Plan and the Compliance Section of the application for additional information.
- 2. **Personnel, Other Direct Costs, Equipment and Contracts:** Submit a budget with these sections and form(s) completed as necessary to support costs for the period **April 1, 2014 to March 31, 2015**. Funds may be used to support personnel, their training, travel (see OBM website) <http://obm.ohio.gov/MiscPages/TravelRule> and supplies directly related to planning, organizing and conducting the initiative/program activity described in this announcement.

The applicant shall retain all contracts on file. The contracts should not be sent to ODH. A completed "Confirmation of Contractual Agreement" (CCA) must be submitted via GMIS for each contract once it has been signed by both parties. The submitted CCA must be approved by ODH before contractual expenditures are authorized.

CCAs cannot be submitted until after the 1st monthly grant payment has been issued.

The applicant shall itemize all equipment (**minimum \$300 unit cost value**) to be purchased with grant funds in the Equipment Section.

3. Compliance Section D: Answer each question on this form in GMIS as accurately as possible. *Completion of the form ensures your agency's compliance with the administrative standards of ODH and federal grants.*

4. Funding, Cash Needs and Budget Summary Sections: This section is not applicable to Ryan White applicants.

C. Assurances Certification: Each subgrantee must submit the Assurances (Federal and State Assurances for Sub-grantees) form within GMIS. This form is submitted as a part of each application via GMIS. The Assurances Certification sets forth standards of financial conduct relevant to receipt of grant funds and is provided for informational purposes. The listing is not all-inclusive and any omission of other statutes does not mean such statutes are not assimilated under this certification. Review the form and then press the "Complete" button. By submission of an application, the subgrantee agency agrees by electronic acknowledgment to the financial standards of conduct as stated therein.

D. Project Narrative:

1. Executive Summary (1 page): Provide a brief summary identifying the following: target population, services and programs to be offered, name of agency or agencies who will provide those services, and the public health problem(s) that the program will address.

2. Description of Applicant Agency/Documentation of Eligibility/Personnel (5-10 pages): Briefly discuss the applicant agency's eligibility to apply. Summarize the agency's structure as it relates to this program and, as the lead agency, how it will manage the program.

Note any personnel or equipment deficiencies that will need to be addressed in order to carry out this grant. Describe plans for hiring and training, as necessary. Describe all personnel who will be directly involved in program activities. Include the relationship between staff members of the applicant agency, and other partners and agencies that will be working on this program. Include position descriptions for all staff members who will be funded under these grant dollars.

Describe the capacity of your organization, its personnel or contractors to communicate effectively and convey information in a manner that is easily understood by diverse audiences. This includes persons of limited English proficiency, those who are not literate, have low literacy skills, and individuals with disabilities.

Describe how your agency will ensure clients will receive culturally appropriate care. Provide information about the hours of operation of your organization, including accommodations made for clients who cannot schedule appointments during “normal” business hours. Provide options for clients who cannot travel to the organization for services.

- 3. Problem/Need (5-10 pages):** Identify and describe the local health status concern that will be addressed by the program. Only restate national and state data if local data is not available. The specific **health status concerns that the program intends to address may be stated in terms** of health status (e.g., morbidity and/or mortality) or health system (e.g., accessibility, availability, affordability, appropriateness of health services) indicators. The indicators should be measurable in order to serve as baseline data upon which the evaluation will be based. Clearly identify the target population. Explicitly describe segments of the target population who experience a disproportionate burden for the health concern or issue; or who are at an increased risk for the problem addressed by this funding opportunity.

Include a description of other agencies/organizations, in your area, also addressing this problem/need. Describe how services will be coordinated with other relevant service providers who provide key points of access to health and support services for PLWHA, and how duplication of services will be avoided. In addition, describe how the program has addressed gaps in services. Describe any changes in the service delivery system that have or will reduce barriers to care. Describe how the agency will collaborate with local HIV testing and counseling sites to minimize the gap between an HIV+ test and the initiation of HIV Care.

- 4. Methodology:** In a brief narrative form, identify the program goals, **Specific, Measureable, Attainable, Realistic & Time-Phased (SMART) process, impact, or outcome objectives** and activities. Indicate how they will be evaluated to determine the level of success of the program. If health disparities and/or health inequities have been identified, describe how program activities are designed will address these issues. Complete a program activities timeline (using the outline below) to identify program objectives and activities and the start and completion dates for each.

Federal HIV Care & Emerging Communities Work Plan

When creating the work plan, please incorporate the following key activities:

1. Initial assessment of service needs (e.g., Psychosocial Assessment and Client Data Intake Report to be completed within 30 days of intake and reassessed annually);
2. Development of a comprehensive, individualized service plan (e.g., Individual Service Plan to be completed within 30 days of intake and reassessed every six months);

3. Coordination of services required to implement the plan (e.g., appropriate referrals for core services, community social services and public assistance programs);
4. Client monitoring to assess the efficacy of the plan (e.g., Case Management Outcome Measures to be completed within 30 days of intake and every six months thereafter); and,
5. Periodic re-evaluation and adaptation of the plan as necessary over the life of the client;
6. Apply a cultural competence framework to provide culturally and linguistically appropriate HIV/AIDS treatment services for, racial and ethnic minorities, women and those living in high poverty areas;

Goal: Improve the health of HIV+ Ohioans through the provision of medical case management.

Objective 1: Case managers will increase the number of clients who have a face to face case management meeting at least once every six months.

Activity 1:

Activity 2:

Outcome 1: Individual service plan will be completed anew at least every six months.

Outcome 2: Client Outcome Measures will be completed a minimum of every six months in the Case Management Information System (CMIS) database.

Timeline: April 1, 2014 to March 31, 2015

Objective 2: Case managers will ensure clients have access to core medical services.

Activity 1:

Activity 2:

Outcome 1: Increase number of clients who have a primary care/ID physician visit every six months.

Outcome 2: Increase number of clients who have CD4/viral load lab work completed every six months.

Timeline: April 1, 2014 to March 31, 2015

Objective 3: Case managers will educate and make referrals for clients to have an initial or follow up visit with an oral health provider at least once during the RW year.

Activity 1:

Activity 2:

Outcome 1: Increase the number of clients who identify having an oral health provider.

Outcome 2: Increase the number of clients who receive at least one oral health evaluation annually.

Timeline: April 1, 2014 to March 31, 2015

Objective 4: Case managers will assist client in treatment adherence through education to ensure readiness for, and adherence to complex HIV/AIDS treatments, including ART and/or other prescribed medication regimen.

Activity 1:

Activity 2:

Activity 3:

Outcome 1: Increase the number of clients who re-enroll in ADAP prior to their enrollment end date (for case manager-assisted ADAP applications).

Outcome 2: Increase number of clients who report taking all doses of prescribed medications, as reported on the Client Outcome Measures.

Outcome 3: Increase awareness of healthcare disparities experienced by racial and ethnic minorities that may be impeding treatment adherence.

Timeline: April 1, 2014 to March 31, 2015

Objective 5: Agencies will ensure clients have access to services, information, materials delivered by competent providers in a manner that factors in the language needs, cultural richness, and diversity of populations served.

Activity 1:

Activity 2:

Outcome: Agencies will integrate Standards 4, 5, 6 and 7 of the National Standards for Culturally and Linguistically Appropriate Services (CLAS) into the daily operations of the organization. This document is available online at <http://www.omhrc.gov/CLAS>.

Timeline: April 1, 2014 to March 31, 2015

Objective 6: Case manager(s) will provide clients with secondary HIV prevention information/education to increase knowledge about transmissions, resistance, and re-infection.

Activity 1:
Activity 2:

Outcome: Increase number of clients receiving education about safer behaviors, as reported on the Client Outcome Measures.

Timeline: April 1, 2014 to March 31, 2015

Objective 7: The agency will assess the organizational strength of its Quality Management Program, including structure, planning, performance measurement, and improvement activities.

Activity 1:
Activity 2:

Outcome: The agency will complete an Organizational Quality Assessment Tool (to be distributed by HCS QM staff).

Timeline: April 1, 2014 to March 31, 2015

Objective 8: The agency will update their current Quality Management (QM) Plan. The QM Plan is a written document that outlines how the quality management program will be implemented, including a clear indication of responsibilities and accountability, performance measurement strategies and goals, and elaboration of processes for ongoing evaluation and assessment of the program. Reference link: NQC Quality Academy: The Quality Management Plan. <http://nationalqualitycenter.org/index.cfm/5928/36097>

Activity 1:
Activity 2:

Outcome: The agency will update their Quality Management Plan and submitted with 1st quarterly report.

Timeline: April 1, 2014 to June 30, 2014

Client Education Outreach Work Plan:

Goal 1: For Client Outreach Coordinators to provide statewide support through community planning efforts and educational events for consumers and providers.

Objective 1.1: Consumers will have the opportunity to participate in community forums to increase their awareness/understanding of the statewide network of coordinated services.

Activity 1:
Activity 2:

Outcome 1: A minimum of 6 community forums will be conducted regionally to increase consumer awareness of the statewide network of coordinated services.

Outcome 2: Racial and ethnic minorities who participate in forums will receive information from professionals who reflect their racial and cultural make-up.

Timeline: April 1, 2014 through March 31, 2015

Objective 1.2: Providers and case managers will have the opportunity to participate in educational forums that will increase their overall capacity to the delivery of HIV-related medical services.

Activity 1:

Activity 2:

Outcome: A minimum of 6 educational forums will be conducted regionally to increase HIV-related capacity building for providers and case managers.

Timeline: April 1, 2014 through March 31, 2015

Goal 2: Client Outreach Coordinators will facilitate statewide informational updates/meetings (in collaboration with ODH) to encourage consumer involvement in the provision of AIDS care and services in Ohio.

Objective: Consumers will have the opportunity to provide written or verbal feedback to the Ryan White program during informational sessions/program updates about the provision of AIDS care in Ohio.

Activity 1:

Activity 2:

Outcome: The agency will disseminate the summarized information to Ryan White administrators during quarterly report submissions. Minimum of five (regional) informational sessions per Ryan White year.

Timeline: April 1, 2014 through March 31, 2015

Goal 3: Produce a centralized access point for informational sharing, HIV-related updates and current events (e.g., changes with service integration or coordination among Ryan White parts, reauthorization notices, medical updates, upcoming meetings/conferences, etc.).

Objective: Increase awareness for consumers, caregivers and other HIV community members through the dissemination of information by means of a website.

Activity 1:

Activity 2:

Outcome: Agency will maintain a website and make at least quarterly updates to share information with the statewide HIV community.

Timeline: April 1, 2014 through March 31, 2015

Goal 4: Assist in expanding the provider network in targeted regions through collaboration and coordination of efforts with ODH.

Objective: Increase the overall number of essential providers (medical, dental and mental health) in regions that have been identified as having limited access for clients.

Activity 1:

Activity 2:

Outcome 1: Clients will have access to a diverse group of providers who are trained and equipped to provide core medical services clients enrolled in the RW program.

Outcome 2: Develop partnerships and referral sources with minority community-based organizations to ensure culturally appropriate social support and core services are available to clients.

Timeline: April 1, 2014 through March 31, 2015

5 Clinical Quality Management (QM) Program: (required for all applicants)

The purpose of this section is to describe the agency's overall clinical quality management (QM) program for Part B and to describe how the results of the Part B QM activities are being or have been used to improve service delivery in the agency.

- a. Describe QM specific goals and objectives for FY 2014 and any plans for improvements to the agency's clinical quality management activities.
 - i. Explain how QM program data and client-level health outcome data will be used in the planning process and ongoing assessment of progress toward achieving goals and objectives.
 - ii. Specify timelines and milestones for implementing activities to accomplish 2014 QM goals.
 - iii. Specify accountability for QM activities including indicating who will initiate them.
 - iv. List the challenges/barriers you have encountered in implementing quality management process for your agency. What have you done to overcome the challenges/barriers noted?
 - v. Indicate your agency's QM contact person along with any QM training needs. Please include desired QM training topics as well as your agency's preferred training method (e.g. face-to-face, online, etc.).

- b. Provide a current Quality Management (QM) Plan as an attachment in GMIS with your **1st quarter report (see work plan objectives 8)**. For more information about QM Plans, please refer to NQC Quality Academy: The Quality Management Plan. <http://nationalqualitycenter.org/index.cfm/5928/36097>. The current QM plan should include:
- i. Mission statement and vision describing the overall goal of the QM Program.
 - ii. Description of the QM program infrastructure including the leadership and quality management committee/team member's role and responsibilities. Include number of staff, staff members accountable for QM, and resources and structure of QM committee/team.
 - iii. The process that has been established to monitor and evaluate the QM program.
 - iv. Identifies routine schedule to update QM Plan at least annually.
 - v. Specifies accountability for QM program as well as indicates who will initiate process to update/revise QM plan.
 - vi. Identifies intervals and format for communication to share QM information and data with all stakeholders.
 - vii. Identifies methods and opportunities for ensuring QI training for staff and, as appropriate, consumer representatives.
 - viii. Description of selected performance measurements and how the measurements will be accomplished. Specify the performance measures that are presently being monitored.
 - ix. Discussion of the annual quality goals (e.g. benchmarks for performance measures) for upcoming year.
 - x. Description of process used to identify, develop and monitor quality improvement projects.

E. Civil Rights Review Questionnaire - EEO Survey: The Civil Rights Review Questionnaire (EEO) Survey is a part of the Application Section of GMIS. Subgrantees must complete the questionnaire as part of the application process. This questionnaire is submitted automatically with each application via the Internet.

F. Federal Funding Accountability and Transparency Act (FFATA) Requirements: FFATA was signed on September 26, 2006. FFATA requires ODH to report all subgrants receiving \$25,000 or more of federal funds. All applicants applying for ODH grant funds are required to complete the FFATA Reporting Form in GMIS.

All applicants for ODH grants are required to obtain a Data Universal Number System (DUNS) and a Central Contractor Registration Number (CCR) and submit the information in the grant application, Attachment B. For information about the DUNS, go to <http://fedgov.dnb.com/webform>. For information about CCR go to www.ccr.gov.

Information on Federal Spending Transparency can be located at www.USAspending.gov or the Office of Management and Budget's website for Federal Spending Transparency at www.whitehouse.gov/omb/open.

(Required by all applicants, the FFATA form is located on the GMIS Application Page and must be completed in order to submit the application.)

- G. Public Health Accreditation Board Standards:** Attach in GMIS the PHAB Standards that will be addressed by grant activities.
- H. Public Health Impact:** Only for applicants which are not local health departments, attach in GMIS the response/statement(s) of support from the local health district(s) to your agency's communication regarding the impact of the proposed grant activities on the PHAB Standards. If a statement of support from the local health districts is not available, indicate that and submit a copy of the program summary your agency forwarded to the local health district(s).
- I. Attachment(s):** Attachments are documents deemed necessary to the application that are not a part of the GMIS system. Attachments that are non-Internet compatible must be postmarked or received on or before the application due date. All attachments must clearly identify the authorized program name and program number. All attachments submitted to GMIS must be attached in the "Project Narratives" section and be in one of the following formats: PDF, Microsoft Word or Microsoft Excel. Please see the GMIS bulletin board for instructions on how to submit attachments in GMIS. An original and the required number of copies of non-Internet compatible attachments must be mailed to the ODH, Grants Services Unit, Central Master Files address by 4:00 p.m. on or before Monday, January 13, 2014. *A minimum of an original and the indicated number of copies of non-Internet attachments are required.*

III. APPENDICES

- a. Notice of Intent to Apply for Funding
- b. GMIS Training Form
- c. Program Specific Attachments:
 - i. Attachment 1: Request for Proposal (RFP) Checklist
 - ii. Attachment 2: Subgrantee Staffing Information
 - iii. Attachment 3: Letters of Collaboration
 - iv. Attachment 4: Standards of Care
 - v. Attachment 5: Position Requirements, Descriptions, Roles and Responsibilities
 - vi. Attachment 6: Quarterly Reports Outline
 - vii. Attachment 7: Case Management Position Grid
 - viii. Attachment 8: Application Review-Rating Form

NOTICE OF INTENT TO APPLY FOR FUNDING

Ohio Department of Health
Division of Prevention
Bureau of HIV/AIDS, STD, and TB

ODH Program Title:
Ryan White Part B

ALL INFORMATION REQUESTED MUST BE COMPLETED.
(Please Print Clearly or Type)

County of Applicant Agency _____ Federal Tax Identification Number _____

NOTE: The applicant agency/organization name must be the same as that on the IRS letter. This is the legal name by which the tax identification number is assigned.

Type of Applicant Agency (Check One) County Agency City Agency Hospital Higher Education Local Schools Not-for Profit

Applicant Agency/Organization _____

Applicant Agency Address _____

Agency Contact Person Name and Title _____
Telephone Number _____ E-mail Address _____

Agency Head (Print Name) _____ Agency Head (Signature) _____

Does your agency have at least two staff members who have been trained in and currently have access to the ODH GMIS 2.0 system? YES NO

If yes, no further action is needed.

If no, at least two people from your agency are REQUIRED to complete the training before you will be able to access the ODH GMIS 2.0 system and submit a grant proposal. Fill out the training request form in the Request for Proposal. **The training form must be submitted with the Notice of Intent to Apply for Funding, W-9 form, EFT form, Proof of Liability (if applicable) and Proof of Non-Profit (if applicable).**

Mail, E-mail or Fax to: Laurie Rickert, laurie.rickert@gmail.com, 866-448-6337
Ohio Department of Health Ryan White Part B
246 North High Street – 6th floor
Columbus, OH 43215
E-mail: Laurie.rickert@odh.ohio.gov
Fax: (866)448-6337

NOTICE OF INTENT TO APPLY FOR FUNDING (NOIAF), W-9 form (one of the following must accompany the W-9: 1) Vendor Information Form (New Agency Only), 2) Vendor Information Change Form (Existing agency with tax identification number, name and/or address change(s), 3) Change request in writing on Agency letterhead (Existing agency with tax identification number, name and/or address change(s)), **EFT form, PROOF OF LIABILITY (if applicable), AND PROOF OF NON-PROFIT (if applicable) MUST BE RECEIVED BY Friday, December 6, 2013**

NOTE: NOIAF's will be considered late if any of the required forms listed above are not received by the due date.

NOIAF's considered late will not be accepted.



OHIO DEPARTMENT OF HEALTH

246 North High Street
Columbus, Ohio 43215

614/466-3543
www.odh.ohio.gov

John R. Kasich / Governor

Theodore E. Wynnyslo, M.D. / Director of Health

GMIS 2.0 TRAINING REQUEST (Competitive Cycle ONLY)

This document is to be used for GMIS 2.0 during a competitive cycle only. **EACH** person requesting training must complete a form. Requests will only be honored when form is signed by your **Agency Head** or **Agency Financial Head**. Confirmation of your GMIS training session will be e-mailed once a date has been assigned by ODH.

Grant Program: _____ **RFP Due Date:** _____

Agency Name: _____

Salutation: (Dr., Mrs., etc.) _____

User's Name: (no nicknames, please) _____

User's Job Title: (ex.: Program Director) _____

Phone Number: _____

Fax Number: _____

E-mail address: _____

Agency/Financial Head Signature: _____
(**Signature of Agency/ Financial Head*)

(**Printed Name of Agency /Financial Head*)

TRAINING REQUEST FORMS MUST BE SUBMITTED WITH THE NOTICE OF INTENT TO APPLY FOR FUNDING FORM

Users will receive his/her username and password via e-mail once they have completed training.

PROGRAM ATTACHMENT 1

Request for Proposal (RFP) Checklist

Documents to be submitted ASAP:

- Notice of Intent to Apply for Funding
- GMIS Training Form, if applicable

Requirements of all applicants eligible to receive awards from ODH (submitted via GMIS):

- Program Narrative
 - Executive Summary
 - Description of Applicant Agency
 - Problem/Need
 - Methodology
 - Quality Management Section Requirements
- Additional attachments required by program
 - Subgrantee Staffing Information
 - Letters of Collaboration
- Civil Rights Review Questionnaire- EEO survey
- Assurances certification
- Federal Funding Accountability and Transparency Act (FFATA) reporting form
- Electronic Funds Transfer Form (EFT)
- IRS W-9

Documents required to be mailed to ODH:

- Current Independent Audit (latest completed organizational fiscal period)

Required of applicants that are not public health departments

- Public Health Impact Statement
- Statement of Support from the Local Health District

(If not able to get a letter of support from the local health district, provide a one page description of the demographic characteristics (e.g., age, race, gender, ethnicity) of the target population and the geographical area in which they live (e.g. census tracts, census blocks, block groups; a summary of the services to be provided or activities to be conducted; and a plan to coordinate and share information with appropriate local health districts.)
- Proof of non-profit status
- Proof of current liability coverage

PROGRAM ATTACHMENT 2

Subgrantee Staffing Information Federal HIV Care and Emerging Communities

Must be submitted in GMIS 2.0

Include all documents that apply to funding requested:

- Copies of the HIV Case Managers' position description;
- Copies of the HIV Case Managers' **CURRENT** Ohio social work license;
- Copies of the HIV Case Managers' resumes;
- A copy of the Clinical Supervisors' position description or Confirmation of Contractual Agreements (CCA);
- A copy of the Clinical Supervisors' **CURRENT** Ohio independent social work license;
- A copy of the Clinical Supervisors' resume;
- A copy of the HIV Case Management Network Fiscal Coordinators' position description;
- A copy of the HIV Case Management Network Fiscal Coordinator's resume;
- A copy of Case Aides' position description;
- A copy of Case Aides' resume
- Copies of other applicable position descriptions or CCA;
- Copies of other current licenses as applicable;
- Copies of other resumes/curriculum vitae as applicable; and
- Agency Table of Organization

Subgrantee Staffing Information Client Education Outreach

Include:

- Biographical Sketches/Resumes/Curricula Vitae for persons who will be serving in funded positions
- Copies of Client Outreach Coordinators' position descriptions
- Agency Table of Organization

PROGRAM ATTACHMENT 3

Letters of Collaboration

Submit a minimum of five letters documenting program collaboration and the process for receiving referrals from key points of entry. Letters must demonstrate a referral relationship that exists between Part B funded agency and key points of entry in the counties/regions covered/shared by the entities. Letters of collaboration must be specific to this program and the current application year.

If the applicant agency is a key point of entry (e.g., applicant agency is a Federally Qualified Health Center, Hospital, etc), and the agency obtains a letter of collaboration from their own agency, then agency must get an additional letter. If agency has multiple offices/sites throughout Ohio, agency must obtain 5 letters of collaboration from each of the regions they provide services.

Key points of entry are defined in legislation as:

- Emergency rooms
- Substance abuse and mental health treatment programs
- Detoxification centers
- Detention facilities
- Clinics regarding sexually transmitted disease
- Homeless shelters
- HIV disease counseling and testing sites
- Health care points of entry specified by eligible areas
- Federally Qualified Health Centers
- Entities such as Ryan White Parts A, C and D grantees **(Required, if applicable)**

HCS coordinators will review client charts during quarterly site visits to determine whether referral relationships are being used. (Per the HRSA/HAB Division of Service Systems Program Monitoring Standards – Part B, pg 46).

Community Based Programs Standards of Care for HIV Case Management 2011



Ohio Department of Health
HIV Care Services Section

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RYAN WHITE PROGRAM: PURPOSE & HISTORY

The Ryan White HIV/AIDS Program is the largest Federal program focused exclusively on HIV/AIDS care. The program is for individuals living with HIV/AIDS who have no health insurance (public or private), have insufficient health insurance coverage, or lack financial resources to get the care they need for their HIV disease. As such, the Ryan White HIV/AIDS Program fills gaps in care not covered by other funding sources.

The legislation that maintains the Ryan White program is the Ryan White HIV/AIDS Treatment Extension Act of 2009 (Public Law 111-87, October 30, 2009). The legislation was first enacted in 1990 as the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act. It has been amended and reauthorized four times: in 1996, 2000, 2006, and 2009. The Ryan White legislation has been adjusted with each reauthorization to accommodate new and emerging needs, such as an increased emphasis on funding of core medical services and changes in funding formulas.

The legislation authorizes programs called Parts. The purpose is to provide a flexible structure under which this national program can address HIV/AIDS care needs on the basis of:

- Different geographic areas (large metropolitan areas, States, and communities across the Nation)
- Varying populations hit hardest by the epidemic
- Types of HIV-AIDS-related services, and
- Service system needs (e.g., technical assistance for programs, training of clinicians, research on innovative models of care).

Legislative provisions, called Sections, address planning and decision-making, type of grants that are available, what funds may be used for, requirements for entities submitting applications for funding, and available technical assistance to help programs run more effectively.

The Ryan White HIV/AIDS Program is administered by the U.S. Department of Health and Human Services (HHS), Health Resources and Services Administration (HRSA), HIV/AIDS Bureau (HAB).

Highlights of the 2009 Ryan White Legislation

Following is a summary of select provisions in the 2009 legislation, with references to key changes from the 2006 legislation.

- The 2009 Ryan White legislation continues the Ryan White HIV/AIDS Program through fiscal year 2013. Authorization levels increase 5 percent for each fiscal year but are dependent on annual appropriations.

- Minority AIDS Initiative (MAI) funds under Parts A and B will be distributed according to a formula (based on the distribution of populations disproportionately impacted by HIV/AIDS), a change from the former competitive process. Also, MAI awards now coincide with grant cycles under each Part.
- Under Part A, the law continues issuance of grant awards to Eligible Metropolitan Areas (EMAs) and Transitional Grant Areas (TGAs). For TGAs that lose their eligibility status, the State in which the former TGA is located shall receive incremental transfers of funding for three years.
- In addition to existing Part A planning council responsibilities, the law adds a new requirement to determine not only the size and demographics of HIV/AIDS infected individuals but also those individuals who are unaware of their HIV status. One-third of Part A supplemental grants are to be based on the area's ability to demonstrate its success in identifying individuals with HIV/AIDS who are unaware of their status and bringing attention to their status.
- Part A and Part B grantees must develop comprehensive plans that include a strategy for identifying individuals with HIV/AIDS who do not know their status and helping them seek medical services. The strategy must focus on reducing barriers to routine testing and disparities in access to services for minorities and underserved communities.
- The law continues hold harmless protections for Part A and Part B grantees for fiscal years 2009-2013.
- Part A and B grantees currently using code-based data reporting will have three more years to convert to names-based data reporting. Penalties will remain for Part A and Part B areas that report code-based data in fiscal years 2009 through 2012. In fiscal year 2013, only name-based data reporting will be accepted.
- The law makes adjustments in Part A and Part B unobligated balances (UOB) provisions. It retains the three penalties, but with some changes. The trigger for the penalty provisions changed from 2% to 5% of unobligated formula funds. If triggered, grantees are subject, in a future year, to: an offset of the amount of UOB less the amount of approved carryover, a reduction of the amount of UOB less the amount of approved carryover, and ineligibility for a supplemental award. Implementation of the UOB provisions was simplified by providing the Secretary with the option to offset unobligated funds rather than cancel those funds.
- Part D funds are not required to be used for primary care services if payments for such services can be provided from other sources (including titles XVIII, XIX, and XXI of the Social Security Act). Public and nonprofit private entities funded under Part D can now provide care through memoranda of understanding in addition to contracts.

Source: <http://hab.hrsa.gov/law/leg.htm>

STANDARDS OF CARE: PURPOSE

The Ohio Department of Health's purpose in creating Standards of Care for HIV Case Management is to:

- To ensure that the quality of case management is high and is consistent for all clients;
- To ensure that HIV case management to clients is beneficial and cost effective;
- To ensure that clients receive the best possible service;
- To ensure that the goals of standards of care are met.

STANDARDS OF CARE: GOALS

The Ohio Department of Health's goal in releasing funds for HIV Case Management is to:

- Provide accessible, and culturally competent case management services to a highly diverse population of individuals living with HIV;
- Assure that case management services are available to people with HIV and their families in every county of the State of Ohio through either a subgrantee office, satellite office, or in-home client visits;
- Assure that all individuals living with HIV have access to medical care and medications per the guidelines developed by the US Public Health Service;
- Provide information and education to people living with HIV regarding horizontal or vertical transmission, secondary infection, and resistance;
- Make individuals aware of, and assist them in, accessing healthcare related resources for which they may be eligible in order to improve the quality of their lives; and as a last resort approve the use of Ryan White Emergency financial assistance funds and/or refer individuals to other Ryan White programs;
- Provide access to quality case management services, based on the National Association of Social Work (NASW) model of case management, to as many individuals with HIV as may be interested in such services regardless of their residence location.
- Provide specialized case management to populations in service areas as identified in "Specialized Case Management Descriptions"

* Goals as stated in the ODH/HCS Federal HIV Care RFP, 2013

MEDICAL CASE MANAGEMENT

Medical Case Management services are a range of client-centered services that link clients with health care, psychosocial, and other services. The coordination and follow-up of medical treatments is a component of medical case management. These services ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care, through ongoing assessment of the client's and other key family members' needs and personal support systems. Medical Case Management includes the provision of treatment adherence counseling to ensure readiness for, and adherence to, complex HIV/AIDS treatments.

Key activities include:

- initial assessment of service needs;
- development of a comprehensive, individualized service plan;
- coordination of services required to implement of plan;
- client monitoring to assess the efficacy of the plan;
- periodic re-evaluation and adaptation of the plan as necessary over the life of the client.

It includes client-specific advocacy and/or review of utilization of services. This includes all types of case management including face-to-face, phone contact, and other forms of communication.

*As defined by the HRSA/HAB Division of Service Systems Program Monitoring Standards, pg 20.

NATIONAL ASSOCIATION OF SOCIAL WORKERS

QUALIFICATIONS FOR CASE MANAGERS*

Case managers should maintain competence in their area(s) of practice by having one of the following:

- a) Current, active, and unrestricted licensure or certification in a health or human services discipline that allows the professional to conduct an assessment independently as permitted within the scope of practice of the discipline; and/or
- b) Baccalaureate or graduate degree in social work, nursing, or another health or human services field that promotes the physical, psychosocial, and/or vocational well-being of the persons being served. The degree must be from an institution that is fully accredited by a nationally recognized educational accreditation organization, and the individual must have completed a supervised field experience in case management, health, or behavioral health as part of the degree requirements.

How Demonstrated:

- Possession of the education, experience, and expertise required for the case manager's area(s) of practice.
- Compliance with national and/or local laws and regulations that apply to the jurisdictions(s) and discipline(s) in which the case manager practices.
- Maintenance of competence through relevant and ongoing continuing education, study, and consultation.
- Practicing within the case manager's area(s) of expertise, making timely and appropriate referrals to, and seeking consultation with, others when needed.

*As outlined in the CMSA Standards of Practice for Case Management, adopted by NASW 2010

CULTURAL COMPETENCY

The case manager should be aware of, and responsive to, cultural and demographic diversity of the population and specific client profiles.

How Demonstrated:

- Documentation demonstrating:
 - Case manager understands relevant cultural information and communicates effectively, respectfully, and sensitively within the client's cultural context
 - Assessment of client linguistic needs and identifying resources to enhance proper communication. This may include use of interpreters and material in different languages and formats, as necessary, and understanding of cultural communication patterns of speech volume, context, tone, kinetics, space, and other similar verbal/nonverbal communication patterns
 - Evidence of pursuit of education in cultural competence to enhance the case manager's effectiveness in working with multicultural populations.

*As outlined in the CMSA Standards of Practice for Case Management, adopted by NASW 2010

*Please refer also the "Indicators for the Achievement of the NASW Standards for Cultural Competence in Social Work Practice"

<http://www.socialworkers.org/practice/standards/NASWCulturalStandardsIndicators2006.pdf>

Agencies should integrate the following into the daily operations of the organization:

National Standards on Culturally and Linguistically Appropriate Services (CLAS)

The CLAS standards are primarily directed at health care organizations; however, individual providers are also encouraged to use the standards to make their practices more culturally and linguistically accessible. The principles and activities of culturally and linguistically appropriate services should be integrated throughout an organization and undertaken in partnership with the communities being served.

The 14 standards are organized by themes: Culturally Competent Care (Standards 1-3), Language Access Services (Standards 4-7), and Organizational Supports for Cultural Competence (Standards 8-14). Within this framework, there are three types of standards of varying stringency: mandates, guidelines, and recommendations as follows:

CLAS **mandates** are current Federal requirements for all recipients of Federal funds (Standards 4, 5, 6, and 7).

Standard 4

Health care organizations must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient/consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation.

Standard 5

Health care organizations must provide to patients/consumers in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services.

Standard 6

Health care organizations must assure the competence of language assistance provided to limited English proficient patients/consumers by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except on request by the patient/consumer).

Standard 7 Health care organizations must make available easily understood patient-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area.

Available online at: <http://www.omhrc.gov/CLAS>

SUPERVISION

Supervision is a way to assist case managers in the development of their social work skills. As required by the Ryan White Part B program, an L.I.S.W. must provide on-site supervision on two hours per week average for each full time case manager and one hour per week average for each part time case manager.

Definition of social work supervision:

(Per the Ohio Revised Code, Chapter 4757-23-01)

(1) "Clinical supervision" of social workers performing social psychotherapy and social workers employed in a private practice, partnership, or group practice means the quantitative and qualitative evaluation of the supervisee's performance; professional guidance to the supervisee; approval of the supervisee's intervention plans and their implementation; the assumption of responsibility for the welfare of the supervisee's clients; and assurance that the supervisee functions within the limits of their license. The assessment, diagnosis, treatment plan, revisions to the treatment plan and transfer or termination shall be cosigned by the supervisor and shall be available to the board upon request.

(2) "Training supervision" means supervision for the purposes of obtaining a license and/or development of new areas of proficiency while providing services to clients. Training supervision may be individual supervision or group supervision.

(a) "Individual supervision" means face-to-face contact between a supervisor and an individual supervisee in a private session wherein the supervisor and supervisee deal with problems unique to the practice of that supervisee.

(b) "Group supervision" means face-to-face contact between a supervisor and a small group (not to exceed six supervisees) in a private session

Purpose of Supervision

The purpose is to provide clinically-based, social work supervision for those who are not independently licensed. If an agency does not have an L.I.S.W. on staff, it should contract out for this service.

Clinical supervision should address the following:

- Clinical skill development
- Use of theories/interventions
- The helping relationship and delivery of clinical services to clients
- Case presentation
- Understanding and identification of transference/counter transference
- Continuing education
- Identification and referral to community resources
- Emotional support of case manager with regard to client-related issues

- Crisis interventions
- Clinical Documentation

Administrative supervision should address the following:

- Documentation
- Punctuality
- Relationships with colleagues
- Job performance
- Reliability
- Continuing education/ professional growth opportunities
- Emotional support to case manager in relation to job performance, organizational issues

ODH-FUNDED LISW/CASE MANAGER CLINICAL SUPERVISION TIME SHEET

Please complete this form and submit it to ODH HIV Care Services with each quarterly report. LISW-S and Case Managers are encouraged to keep copies of this form for their own records. On-site supervision by an LISW-S on a two-hour per week average for a full-time social worker and one-hour per week average for a part-time social worker is **required** per ODH HCS funded HIV Case Management Grants.

LISW/Case Manager's Name: _____

LISW-S Supervisor's Name: _____

DATE	TIME	LSW INITIALS	LISW INITIALS
LSW Signature:		Date:	
LISW Signature:		Date:	

DOCUMENTATION

Importance

Documentation is needed in order to show any interactions between the client and case manager. It contributes to the client's continuity of care and ensures the most up to date information on the client is available in the client file. In addition, it verifies that proper procedures have been followed, including rules, regulations and necessary guidelines. Remember, if it is not documented, it never happened.

It is essential that there are no gaps in service for the client. By documenting every time there is contact with a client, a case manager is able to track what services are needed or have been provided as well as when a client needs to be contacted.

Basics

- Use black ink at all times.
- Write legibly.
- Fill in all of the blanks on forms. If there is nothing to document, enter N/A or put a line through the area.
- Sign off on all of your documentation.
- Be objective in your documentation.
- Ensure that your documentation is clear. When someone else reads it, will they understand what you are stating?
- Include the client name, case number and date of documentation as well as the date of contact (and differentiate between the two).
- Document chronologically.
- Do not make any entries in advance.
- Do not use correction fluid. Place a line through the error and initial it.
- Focus on goals of service plan.
- Reflect all activity or contact with client in progress notes and daily service logs.

CONFIDENTIALITY

One of the most important responsibilities of a case manager is to protect the confidentiality of a client. Confidentiality is defined as one's responsibility of not disclosing privileged information. If confidentiality is broken, the case manager can be held liable.

Guidelines

The case manager is required to have a Release of Information form completed and signed by the client or an authorized representative before information can be shared with designated service providers.

Clinical Records

- Records must be kept in a locked, secure place.
- Records must be stored and accessible for a period of seven years after the closing of the case. After the seventh year, records can be destroyed in a way that will maintain confidentiality.
- Documentation in the record should only include information significant to the client's situation, circumstance and presenting problem.
- All forms and documentation must be completed in a factual and objective manner.
- Records must include a release of information form completed by the client to show verification that information can be shared with other agencies if needed.

All agency employees and volunteers who have access to client records are encouraged to sign a statement adhering to the practice of confidentiality set forth by the agency and HCS.

Electronic Records

- Do not share your password with anyone.
- Exit the computer system when you leave your workstation.

Telephone

- Leave a greeting on your voicemail that does not identify you as an HIV Case Manager. This will prevent a third party from obtaining knowledge of a client's status if they call you.
- When a message is left for a client (if the client permits you to do so), leave only your name and your phone number.

Faxes

- If possible, the fax machine should be located in a locked, secure place, away from unauthorized personnel;
- Released confidential information should not be left unattended

- Before sending a fax, the case manager should contact the professional who is to receive the fax so that the professional is waiting for it. The professional should then contact the case manager to ensure that it was received.

Transporting Client Records and Information

Client records which are transported outside the HIV case management provider agency should be handled in a manner which ensures absolute security and confidentiality

- never left unattended
- transported in a container (envelope, file, briefcase, etc.) which does not disclose client-specific information
- handled only by authorized personnel

CASE TRANSFERS AND TERMINATIONS

Case managed clients should be assigned to a new case manager, if appropriate, after implementing the agency transfer/discharge policy and procedure process and exhausting all other options.

Transfer

A case transfer request can be initiated by:

- client request
- case manager request
- case management supervisor when he or she determines that a transfer is appropriate through routine supervision
- a client moving out of the service area
- a case manager leaving employment

The case manager should appropriately terminate case management services based upon established case closure guidelines. These guidelines may differ in various case management practice settings.

How Demonstrated:

- Identification of reasons for case management termination, such as:
 - Achievement of targeted outcomes or maximum benefit reached
 - Change of health setting
 - Loss or change in benefits (i.e., client no longer meets program or benefit eligibility requirements)
 - Client refuses further medical/psychosocial services
 - Client refuses further case management services
 - Determination by the case manager that he/she is no longer able to provide appropriate case management services (e.g., non-adherence of client to plan of care)
 - Death of the client
- Evidence of agreement of termination of case management services by the client, family or caregiver, payer, case manager, and/or other appropriate parties.
- Documentation of reasonable notice of termination of case management services that is based upon the facts and circumstances of each individual case.
- Documentation of both verbal and/or written notice of termination of case management services to the client and to all treating and direct service providers.
- With permission, communication of client information to transition providers to

maximize positive outcomes.

Corrective actions should be considered when clients are not fulfilling their responsibilities. Conditions can be applied to financial assistance and/or case management. Specifically, a client can be required to attend mental health or substance abuse counseling; if specified conditions are not met, case management can be terminated until they are met. In addition, limitations on what types of financial assistance provided (e.g., only medical appointments will be paid for) can be enacted. *

NOTE: case management can still be provided; even if financial assistance is limited or suspended.

*As outlined in the CMSA Standards of Practice for Case Management, adopted by NASW 2010

QUALITY MANAGEMENT

Client Satisfaction Survey

Ohio Department of Health/HIV Care Services Section (ODH / HCS) requires a Client Satisfaction survey be distributed to clients every other year during the months of October through March. The survey will be used to provide the agency and ODH/HCS with feedback regarding the performance of an agency. The survey will assist agencies and case managers in becoming more aware of client and community needs, and will provide feedback regarding an agency's performance in helping clients achieve their goals. The agency will summarize the results of the survey utilizing the standardized spreadsheet provided by ODH/HCS. The summarized results will be due at the time of the first quarterly report of the grant year (July 15th) Please note, the next Client Satisfaction Survey of the Case Management program will not be conducted until October 2015.

Quality Management

Every Ryan White Part B provider agency should have a quality management program in place, which evaluates HIV case management services based on established case management standards. Quality assurance may include peer review, independent chart audits, and/or other measures of program performance which assess the quality, quantity, and outcome/impact of case management services. These measures are used to examine the case management process and not individual case manager performance.

Program Reports and Reporting Requirements

The administrative staff of HIV case management agencies should complete a quarterly case management program report which documents progress on the work plan objectives, major program activities, accomplishments achieved during the previous quarter and areas requiring additional resources or program improvements. Program evaluation should be conducted on an ongoing basis. Case management data collected as part of grant reporting requirements should be utilized in evaluating case management services throughout the year.

Case Management Outcomes Measures

The purpose of the Case Management Outcome Measures is to assess the impact that case management has on Ryan White Part B case management clients. The results of case management are examined to see what services and information are being provided and if they are being utilized. Improvements to life situations, access to community resources, the reduction of barriers in one's life, and one's knowledge of their environment are examples of what is evaluated. The measures are completed in the CMIS system.

CASE MANAGEMENT CLINICAL AUDIT STANDARDS

The purpose of Case Management audits is to ensure that the program standards and guidelines for Ryan White Part B HIV Case Management funding are met. The goal of the HIV Care Services Section auditing process is to provide assurance that optimal quality HIV case management services are being provided to consumers throughout the State of Ohio.

A clinical audit tool was developed to incorporate the Standards of Care. The Standards were derived from the National Association of Social Workers (NASW) Standards of Social Work Case Management and the NASW Code of Ethics. This audit tool is used to evaluate the timely completion of forms, how Ryan White Emergency Assistance funds are administered, how case managers incorporate assessments and interventions while collaborating with the clients and the overall social work practice is demonstrated. At the conclusion of the audit, preliminary results are provided to the agency's Executive Director. In addition, a narrative summary highlighting the case managers' strengths and areas for growth is mailed to the agency. The audit may also include an audit checklist. Only the areas that can be reasonably corrected will be included on the checklist. The ODH/HCS audit checklist must be completed and returned to ODH/HCS with original signatures (LSW and LISW signatures) by the date requested. The clinical audits occur on an annual basis. Each agency is given a 30-day advance notice of the audit date.

Should an agency fail to meet acceptable standards (75%) for any standard, the HIV Case Management Coordinator will follow up with the agency to schedule a plan of correction meeting and to discuss the re-audit process. Per the 2011 RFP, any agency which scores between 75% and 80% overall or on any standard will be required to submit a written plan of correction to address the deficient areas. The plan must include training with Jennifer Landau, ODH/HCS trainer. The plan will then be monitored during targeted trainings and technical assistance, as well as routine site visits.

Completion of Forms

FORM OR CONTACT	EXPECTED COMPLETION	UPDATED
Client Data Intake Report (CDIR)	Within 30 days of intake (completed in CMIS)	Annually and as changes are known, including transfers to a new case manager
Written documentation of HIV Status* Documentation of current Ohio Residency* Income verification *All forms should be obtained prior to providing RWEA.	At intake At intake At intake	N/A Annually and as changes are known Annually and as changes are known
Release of Information (ROI) form for all coordinated services and the primary case and/or ID physician	Prior to communication with designated service provider(s)	180 days
Psychosocial Assessment (PSA) -signed, dated & credentialed on the last page and each page initialed by the case manager	Within 30 days of intake	Annually
Individual Service Plan (ISP) – signed and dated by both the client and case manager, including case manager’s credentials	Within 30 days of intake	Every 6 months
Case Management Outcome Measures (CMOM)	Within 30 days of intake (completed in CMIS)	Every 6 months

Fiscal Accountability

The case manager and agency must adhere to Ohio Department of Health and HRSA guidelines when administering RWEA funds:

- Prior to authorizing RWEA, income verification must be obtained. Income verification should also be updated on an annual basis. If Medicaid eligible, the client must utilize Medicaid prior to requesting RWEA assistance.
- Case managers must ensure that Ryan White funds are used as a last resort for an emergency need and are noted as such in the case notes.
- Pre-approvals for core medical services must be documented in the file.
- Agencies must follow ODH policies and procedures when submitting exceptions to the guidelines. All exceptions submitted to ODH must be placed in the file with the ODH response.
- Funds are only fronted for allowable services as indicated on the Service Category Code List.
- ODH imposed caps on services are not exceeded.

Assessments/Interventions

Psychosocial Assessment (PSA)

The Psychosocial Assessment is inclusive of the following:

- Insurance status
- Medical information (including medical history and medications)
- Legal assistance needs
- Legal history
- Sources of social/emotional support
- Alcohol/drug use history
- Mental health treatment history
- Housing status
- Ability to care for self/level of care
- Employment information
- Financial information (income vs. expenses)
- Services offered/requested

Individual Service Plan (ISP)

The Individual Service Plan is inclusive of the following:

- The goals are outlined and match the assessed problems/needs specific to the client.
- The actions documented on the ISP are measurable and identify the specific steps the client or case manager will perform to achieve outcome indicated on the ISP.
- Agencies or professionals that are referenced in case notes or the PSA are also indicated on the ISP.
- For those goals identified, the action steps on the ISP specify the responsibilities of both the client and case manager.
- For those goals identified, referrals have been identified in the plan.
- Specific target dates or dates of reassessment are documented on the ISP.

Case Management Notes

The case notes are inclusive of the following:

- Are descriptive of client's psychosocial, medical and socio-economic status.
- Reasons that any services were denied or unavailable are document in the case notes.
- Show contact with the client/support system at least every 6 months.
- Documentation reflects that clients have been informed of purpose of service and limitations.
- The documentation demonstrates the case manager advocated to obtain services as needed and/or advocated for the client to follow-up on a referral.

- Follow-up regarding missed appointments with case manger or other service providers.
- Follow-up regarding client usage of services.
- Crisis intervention provided is documented.
- Copies of correspondence are in the file.
- Case Notes document communication with the client regarding case transfer(s) within the agency.
- If the case was closed: is it justified and appropriate? Are referral documented?

Case notes do not:

- Contain inconsistencies, contradictions or ambiguous statements.
- Leave unexplained gaps in services (i.e., case notes show appropriate interventions/referral are made).
- Contain unsubstantiated “impressions.”
- Contain personal information about the case manager or other staff.

Quality of Care

As a result of case management, and dependent upon the client’s level of functioning, it appears there was impact in terms of:

- Improved/maintained self-sufficiency
- Improved/maintained access to services

Social Work Practice

The case manager demonstrates adherence to the NASW Case Management Standards and Code of Ethics based on the following evidence:

- Chart documentation demonstrates that no conflict of interest exists, which includes no dual/multiple relationships with clients (or former clients).
- The documented assessments and interventions do not exhibit insensitivity to ethnicity, age, sex, sexual orientation or cultural issues.
- The case notes and other forms demonstrate expertise of HIV intervention issues/concerns through documented assessment and interventions.
- Chart documentation demonstrates the case manager provides information/education to people living with HIV regarding transmission, secondary infection and resistance.
- Chart documentation demonstrates that the case manager refers the client to the appropriate professional for medical or other clinical issues for which social workers are not trained.

The case notes demonstrate adherence to the NASW Code of Ethics by including evidence of:

- **Self Determination (1.02)**
The respect and promotion of the rights of clients to self-determination and assistance to clients in efforts to identify and clarify their goals (exceptions include instances in which harm to self or others is assessed).
- **Informed Consent (1.03)**
HCS requires all community-based agencies providing Part B Case Management and allocation of RWEA funds to have a completed Informed Consent for Services form on file.
- **Privacy and Confidentiality (1.07)**
Confidential information will only be disclosed with appropriate, valid consent from a client or person legally authorized to consent on the behalf of a client is obtained. HCS suggests long-term coordination of, or communication regarding services, be in the format of a written release. Short-term/one time only coordination or communication of services may be documented as verbal permission by the client (or legally authorized person) if congruent with interagency policies. An emergency telephone authorization with another professional on the line may be acceptable if there is no other alternative and is congruent with interagency policies, except information regarding HIV status,

mental health, and/or substance abuse information. This information must have a written release.

- **Respect (2.01)**

There is no negative criticism of colleagues and/or other professional (specifically demeaning comments regarding other professionals' levels of competence).

- **Client Records (3.04)**

Reasonable steps are taken to ensure accurate, sufficient, and timely documentation to facilitate the delivery of services and ensure continuity of services.

The case notes demonstrate the Standards of NASW Case Management are being practiced, and documentation specifically reflects:

- **Standard #3**

Clients are involved in all phases of case management practice to the greatest extent possible (specifically indicated through case note entries and Individualized Service Plans).

- **Standard #5**

Intervention documented is at the client level to provide and/or coordinate the delivery of direct services to clients and their families (the definition of families is inclusive of others significant to the client). This entails: a Biopsychosocial Assessment, development of a service plan, implementation of a service plan, coordination/monitoring of a service plan, advocacy for the client/client resources, reassessment (as needed) and termination (as appropriate).

CONTACT INFORMATION

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Sherry Napier, MSW, LSW	Community Linkage Coordinator	614-728-2288
Jennifer Landau, MSW, LSW	HIV Care Services Trainer	614-644-8085

Case Management Position Requirements and Descriptions Client Education Roles and Responsibilities

Medical Case Management Definition

Medical case management services (including treatment adherence) are a range of client-centered services that link clients with health care, psychosocial, and other services. The coordination and follow-up of medical treatments is a component of medical case management. The services ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care, through ongoing assessment of the clients' and other key family members' needs and personal support systems. Medical case management includes the provision of treatment adherence counseling to ensure readiness for, and adherence to, complex HIV/AIDS treatments.

Key activities include:

- Initial assessment of service needs
- Development of a comprehensive, individualized service plan
- Coordination of services required to implement the plan
- Client monitoring to assess the efficacy of the plan;
- Periodic re-evaluation and adaptation of the plan as necessary over the life of the client

Medical case management includes client-specific advocacy and/or review of utilization of services. This includes all types of case management such as face-to-face, phone contact, and any other forms of communication.

Part B Case Management Requirements

The following standards for all case managers (including specialized case managers) must be met in order for an agency to be eligible for ODH funds:

- Be currently Licensed Social Workers in the state of Ohio
- Possess a bachelor's degree in social work
- Have at least six months experience as a social worker, preferably one or more years; (previous employment experience as a community-based case manager is preferred)
- Gather community-based psychosocial HIV spectrum data as a part of the statewide program with data collection tools provided by ODH (Client Data Intake Form)
- Conduct client level assessments, intakes and outcomes
- Attend all the Community-based HIV Case Management Staff Development Trainings sponsored by ODH/HCS (generally two per year)
- Participate in ODH-sponsored training within 45-60 days of hire
- Engage in direct client contact (including all support, referral and advocacy performed either in person or by telephone)
- Participate in minimum of 2 hours of weekly supervision for full time case managers and one hour of weekly supervision for part time case manager to review client chart documentation and engage in quality assurance and peer review activities

- In the absence of a network fiscal coordinator, process provider check disbursement forms and submits to the third party administrator within 60 days from the dates of service and within 10 business days of agencies receipt
- Represent the agency (one representative per agency) at the local HIV Prevention Regional Advisory Groups, as scheduled

Case Management Network Coordinator/Clinical Supervisor Requirements:

- Be currently Licensed Independent Social Worker (LISW-S) in the state of Ohio
- Have at least three years of experience as a social worker, preferably one year of supervisory experience, (previous employment experience in a community-based setting preferred)
- Be responsible for the coordination, implementation, and general oversight of the HIV Case Management Network in their respective consortium areas (not just within their agency of employment)
- Organize and facilitate local HIV Case Management Network Meetings/Steering Committee Meetings
- Be responsible for building ongoing relationships with other service providers serving the HIV/AIDS community in their consortium
- Follow up with chart reviews at network agencies, case reviews, network supervision and technical assistance, as requested
- Collect, analyze, report and track data activities related to the Part B Case Management Network in consortium area
- Streamline network systems for client referrals, linkages, access to services and record keeping
- Provide clinical supervision to case managers, including: development and enhancement of case management skills, documentation skills, knowledge of community resources (general LISW supervision)
- Attend all of the HIV Case Management Supervisors' Trainings sponsored by the ODH/HCS. These are generally held two times a year for supervisors, and two times per year for the Ohio HIV Case Management Network
- Conduct quarterly site visits at local Part B funded agencies and access points in the respective network

HIV Case Management Assistant Network Case Manager/Program Manager Requirements:

- Be currently Licensed Social Worker in the state of Ohio
- Possess a bachelor's degree in social work
- Have at least two or more years of experience as a social worker; (previous employment experience as a community-based case manager is preferred)
- Provide assistance to the HIV Case Management Network by coordinating services and reducing duplication of efforts

- Provide training to newly hired Part B case managers in the assigned consortium area, as well as assist with training opportunities offered during agency Case Management meetings

HIV Case Management Network Fiscal Coordinators Requirements:

- Function as a central point for processing Part B Emergency Assistance funds for HIV Case Management agencies in their consortium area
- Verify disbursements are complete before submitting in the Third Party Administrator (TPA) web portal (e.g., bills contain approved CPT/ADA codes, Explanation of Benefits are included for co-pays, amount(s) on the disbursements match the bill(s))
- Attend the designated community-based HIV Case Management Development Trainings sponsored by ODH/HCS (generally two times per year, as scheduled)
- Utilize the TPA web portal to create and track client disbursements
- Train newly hired case managers and provide verification that training was completed. Training should include researching disbursements, received dates and check dates, etc
- Establish relationship with local providers to assist with billing inquiries
- Submit invoices through the TPA web portal within 60 days from the dates of service and within 10 business days of agencies receipt; if agency is unable to meet this requirement, agency will be placed on a plan of correction

***Part B Case Aide Requirements:**

- Completed coursework towards a social science bachelor's degree, or an associate degree with a minimum of two years of experience working in a community based agency/setting
- Participate in a minimum of one (1) hour of weekly supervision with agency supervisor
- Gather all necessary components of the Ohio HIV Drug Assistance Program (OHDAP) application and ensure thorough completion before submission to ODH
- Assist with data entry of intakes and outcomes in the CMIS database, as assigned
- Assist with the distribution and collection of ODH required surveys (e.g., Client Satisfaction Survey)
- Assist with organizing and submitting disbursements through the TPA web portal

* It should be noted that case aides are not to be utilized for case management activities. For example, case aides will not carry a client caseload, or participate in the process of approving/disapproving a consumer access to Ryan White Emergency Assistance dollars. Case aides will be required to document the completion of all tasks to ensure continuity of care. The responsibilities of the case aides should be clearly communicated and documented to ensure the case aide is not engaging in social work practice.

Specialized Case Management Descriptions:

Early Intervention Specialist Case Managers

Early intervention services include educating newly diagnosed individuals about HIV/AIDS with the objective of providing a better understanding about transmission, treatment adherence,

disclosure, etc. Early intervention case managers also work closely with testing sites in order to obtain referrals for newly diagnosed clients. Efforts are focused on providing HIV/AIDS educational information to the newly diagnosed client, as well as assessing the client's needs and making referrals for medical and support services. Clients will transition to a general case manager within six months to one year of obtaining early intervention case management.

Minority Outreach Case Managers

Case management efforts are focused on identifying minority populations that are either not receiving case management services or that faces barriers to care. Minority outreach case managers are expected to identify the client's diverse needs and be well informed of community services available to the client.

Clinical Outreach Case Managers

Role is to target HIV case management efforts at settings in which people living with HIV/AIDS may be receiving medical care (e.g., physician offices, ID clinics, health department, or federally qualified health centers (FQHCs) in the consortium area. Case management efforts should be closely coordinated with medical staff providing HIV/AIDS care. Case managers should also focus on educating medical centers/clinics who may not be aware of the Ryan White Part B program to provide additional resources for clients that are served at those settings.

Rural/Urban Outreach Case Managers

Rural outreach case managers work primarily with rural populations and provide services at locations that are accessible to the clients (e.g., satellite offices, home visits). In addition, rural outreach case managers work towards linking clients who are not actively being seen by a physician or case manager back into care. Case managers should be well informed of barriers to care including stigma and difficulties accessing services (transportation), and should focus efforts on making case management services client centered and accessible.

Client Education Outreach

Client Outreach Coordinator Responsibilities

- Build relationships / collaborations with other non-profit organizations, government agencies, and healthcare providers
- Coordinate and monitor various program/event time-lines and budgets
- Market programs and events in the local consortium region
- Attend local and state planning committee meetings, as applicable (e.g., Regional Advisory Groups, Advisory Board Meetings, etc)
- Organize on-site program registration process and activities
- Serve as the agency liaison with program facility contacts
- Update and track program / event demographics
- Prepare quarterly and monthly reports and summarize evaluations regarding all programs

PROGRAM ATTACHMENT 6

**General Outline to follow when completing HIV Care Services
Quarterly Program Reports**

Submit a cover page with the following information (in GMIS 2.0):

To: Ryan White Part B Program Administrator
Ohio Department of Health
HIV Care Services
Federal HIV Care, Emerging Communities, Client Education Outreach
Grant Project Number: _____
Quarterly Narrative Report – RW Yr. 24

From: Agency/Organization Name: _____
Funded Case Manager(s)/
Case Management Network
Coordinators/ Network Fiscal
Coordinators/ Consortia Coordinator: _____
Person(s) Completing Report: _____

Reporting Period: (First, Second, Third or Fourth Quarters)

I. Goals/Objectives

For each objective of each goal listed in the RW Year 24 Work Plan of your CARE grant application please use the following process A through D to evaluate each objective.

A. Goal/Objective Statement

State the goal and objective as written in your Work Plan for example:

Goal: Improve the health of HIV+ Ohioans through the provision of medical case management.

Objective 1: Case manager(s) will ensure client has access to medical services.

Progress/ Accomplishments/Successes

State progress made, accomplishments achieved and/or any activities conducted in this objective. Include this section any quantifiable information such as number of clients served, etc. as related to this particular objective.

B. Difficulties/Barriers experienced while accomplishing this objective.

C. Plan of Correction

II. Additional Activities

In this section list any special activities that occurred during this period which you would like to report on. Also describe any aspects of your program which are different from those which were originally proposed. Discuss evolving needs of your target population which have not previously been discussed.

III. Staffing/Personnel

In this section discuss any changes in personnel (e.g., vacancies), dates of vacancies, status of filling vacancies, and information about newly hired personnel. Discuss what impact these changes may have on your clients, your agency and accomplishments of your work plan, as applicable.

IV. Evaluation

Discuss how your agency is evaluating services provided and how it is monitoring the achievement of all activities by the person responsible according to the timetable originally identified in your Work Plan.

V. Technical Assistance Requests

List any concern or issues needing assistance from the Ohio Department of Health's HIV Care Services.

VI. Required Program Report Attachments as specified in the Request for Proposal must be received by ODH on the quarterly program report's due date:

July 15, 2014, October 15, 2014, January 15, 2015 and April 15, 2015

PROGRAM ATTACHMENT 7

Case Management Position Grid

Agency	Medical Case Managers	Minority Outreach Case Manager	Clinical Outreach Case Manager	Rural Outreach Case Manager	Early Intervention Case Manager	Case Management Network Coordinator/Clinical Supervisor	Assistant Network Coordinator/Program Manager	Fiscal Coordinator	Case aide	Total
Consortium #1	X	X	X	X	X	X	X		X	
Consortium #2	X	X	X	X	X	X	X	X	X	
Consortium #3	X	X	X	X	X	X	X	X	X	
Consortium #4	X	X	X	X	X	X	X	X	X	
Consortium #5	X	X	X	X	X	X	X	X	X	
Consortium #6	X	X	X	X	X	X	X		X	
Consortium #7	X	X	X	X	X	X	X		X	
Consortium #8	X	X	X	X	X		X		X	
Consortium #9A	X			X						
Consortium #9B	X			X						
Consortium #9C	X			X						
Total										

The above grid indicates the positions that each consortium area are eligible to apply for in the competitive application. ODH supports quality case management and is committed to recruitment and retention of experienced social workers. Therefore, ODH is recommending no less than \$40,000 (salary plus fringe benefits) be allocated to each case management position, fiscal coordinator, and assistant network coordinator/program manager. It is also recommended that each case management network coordinator/clinical supervisor make no less than \$50,000 (salary plus fringe benefits). Finally, each case aide should make no less than \$30,000 (salary plus fringe benefits). If the agency is unable to meet the recommended funding levels, please provide justification for proposing a reduced salary for each specified position in the budget narrative.

The expected caseload size for each medical case manager is an average of 50-75 active clients in the following regions: Consortium #1, Consortium #2, Consortium #3, Consortium #4, Consortium #5, Consortium #6, Consortium #7, and Consortium #8. The expected caseload size for each case manager in Consortiums #9A, 9B and 9C is an average of 40-50 active clients. The difference in the caseload sizes across the state is based on these areas (Consortium areas 9A, 9B and 9C) being predominately rural.

Agencies applying for five or more case management positions are eligible to apply for network coordinator/clinical supervisor as full-time equivalent positions. These agencies may select only those positions that are indicated above. Agencies applying for three or more case management positions are also eligible to apply for case aide position(s).

PROGRAM ATTACHMENT 8

HIV CARE SERVICES SECTION
RYAN WHITE PART B
[RYAN WHITE FEDERAL HIV CARE,
EMERGING COMMUNITIES AND CLIENT EDUCATION OUTREACH]
GRANT APPLICATION REVIEW-RATING FORM
PROGRAM PERIOD: APRIL 1, 2014 TO MARCH 31, 2015
BUDGET PERIOD: APRIL 1, 2014 TO MARCH 31, 2017

Agency: _____ Consortia: _____

Reviewer: _____ Total Score: _____

Recommended Funding Level: _____

SCORE TABLE:

Use the following table as a guide in completing the review sheet.

Point Value	Criterion Unmet	Criterion Partially Met	Criterion met
1	0		1
2	0	1	2
3	0	1,2	3
4	0	2	4
5	0, 1	2,3	4,5

Criterion Unmet – Does not answer the question nor address any of the required issues.

Criterion Partially Met - Attempts to answer the question, but does not offer specific information. Answers the question and offers some concrete information.

Criterion Met - Offers substantive information; a complete answer in a clear manner. An exemplary answer, uses quantitative measure for example; is concise and to the point.

NOTE: The maximum point value is shown in each section. Please score each section using the score table as a guide. Your comments are important and provide clarification when necessary.

TOTAL MAXIMUM SCORE: 100 points

MINIMUM SCORE TO BE ELIGIBLE FOR FUNDING: 70 points

COMPONENT OF PROPOSAL	Max points possible	SCORE	STRENGTHS / WEAKNESS
PROJECT NARRATIVE	50 points total		
1. Executive Summary: <i>A one page summary of the proposal-should include target population, services and programs to be offered and what agency(ies) will provide those services.</i>	2		
<i>A description of the public health problems that the project will address.</i>	2		
Total	4		
2. Description of Applicant Agency/ Documentation of Eligibility (5-10 pages): <i>Demonstrate the applicant agency's eligibility to apply.</i>	2		
<i>Summarize the agency's structure as it relates to this program and, as the lead agency, how it will manage the program.</i>	3		
<i>Note any personnel or equipment deficiencies that will need to be addressed in order to carry out this grant.</i>	2		
<i>Describe all personnel who will be directly involved in program activities.</i>	3		
<i>Describe plans for hiring and training personnel to assure clients will receive culturally appropriate care.</i>	2		
<i>Include the relationship between program staff members, staff members of the applicant agency, and other partners and agencies that will be working on this program.</i>	2		
<i>Describe the capacity of your organization, its personnel or contractors to communicate effectively and convey information in a manner that is easily understood by diverse audiences</i>	2		
<i>Provide information about the hours of operation of your organization, including accommodations made for clients who cannot schedule appointments during "normal" business hours.</i>	2		
Total	18		

<p>3. Problem/Need (5-10 pages): Application should identify and describe the local (don't restate national and state data) health status concern of people living with HIV that will be addressed by the project. The specific health status concerns that the project intends to address may be stated in terms of health status (morbidity and/or mortality) or health system (e.g., accessibility, availability, affordability, appropriateness of health services) indicators. The indicators should be measurable in order to serve as baseline data upon which the evaluation will be based.</p>	5		
<p>Describe how services will be coordinated with other relevant service providers who provide key points of access to health and support services for PLWHA, and how duplication of services will be avoided.</p>	5		
<p>Describe how the program will address gaps in service. Describe any changes in the service delivery system that have or will reduce barriers to care. Describe how the agency will collaborate with local HIV testing and counseling sites to minimize the gap between an HIV+ test and the initiation of HIV Care.</p>	5		
Total	15		
<p>4. Methodology The work plan should include the required goals and objectives listed in the RFP. The work plan includes measurable activities that coincide with the stated objectives.</p>	5		
<p>Applicant described the agency's overall clinical quality management (CQM) program for Part B. Applicant described how the results of the Part B CQM activities are being or have been used to improve service delivery in the agency.</p>	5		
Total	10		
5. Quality Management	3 Points Total		
<p>Describe QM specific goals and objectives for FY 2014 and any plans for improvements to the agency's clinical quality management activities.</p>	3		
Total	3		

BUDGET	16 Points Total		
Budget Narrative <i>A detailed narrative budget justification which describes how the categorical costs are derived should be provided. This should discuss the necessity, reasonableness and ability to allocate the proposed costs.</i>	4		
<i>Budget narrative matches the budget submitted in GMIS 2.0.</i>	3		
<i>Specific roles of personnel, consultants and contractors are explained and justified.</i>	3		
<i>Equipment, travel, supplies and training costs are explained and justified.</i>	3		
<i>Administrative costs are within the 10% allowable cap.</i>	3		
Total	16		
ADDITIONAL RFP REQUIREMENTS	6 Points Total		
<i>Public Health Impact Statement (includes Public Health Accreditation Board (PHAB) Standards that will be addressed by grant activities)</i>	2		
<i>Public Health Impact Statement of Support</i>	2		
<i>Federal Funding Accountability and Transparency Act (FFATA)- completed in GMIS</i>	2		
Total	6		
ATTACHMENTS	18 Points total		
<i>A copy of the applicable social work License for all funded positions (Clinical Supervisor, Case Manager(s), Case Aide(s), etc) (N/A for the client outreach applicant)</i>	4		
<i>A copy of the resume/biographical sketch/curricula vitae for persons who will be serving in funded positions</i>	4		
<i>A copy of the position descriptions or contracts for all funded positions</i>	4		
<i>A copy of the Agency Table of Organization</i>	1		
<i>Letters of collaboration</i>	5		
Total	18		
6. OVERALL QUALITY	10 Points Total		
<i>Clarity / completeness</i>	3		
<i>Adherence to all RFP guidelines</i>	3		

<i>Formatting requirements met</i> <ul style="list-style-type: none"> • <i>Properly labeled</i> • <i>1.5 spacing with 1 inch margins</i> • <i>Budget and Project Narratives in portrait orientation on 8 ½ by 11 paper</i> • <i>All pages numbered</i> • <i>Project Narrative meets page limit requirement</i> • <i>12 point font</i> 	4		
Total	10		
Total Score	100 Points Total		

Recommendation of Reviewer:

Approval (funding) of proposal as submitted (no conditions)

Approval (funding) of proposal with conditions (please list conditions below)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Disapproval of project. State reason(s) below:

1. _____
2. _____
3. _____

Signature of Reviewer

Date