

**U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Health Resources and Services Administration**

*HIV/AIDS Bureau
National Training and Technical Assistance*

***Replication of a Public Health Information Exchange
to Support Engagement in HIV Care Initiative***

Announcement Type: New
Announcement Number: HRSA-12-179

Catalog of Federal Domestic Assistance (CFDA) No. 93.145

FUNDING OPPORTUNITY ANNOUNCEMENT

Fiscal Year 2012

Application Due Date: July 13, 2012

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Release Date: May 16, 2012

Issuance Date: May 16, 2012

Modified on 6/27/2012 - Application deadline extended until July 13, 2012

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Authority: Public Health Service Act, Title III, Section 301; Public Health Service Act, Sections 2606, 2619, 2654, 2671, and 2692 (42 U.S.C. §300ff-111), as amended by the Ryan White HIV/AIDS Treatment Extension Act of 2009 (P.L. 111-87) and the Consolidated Appropriations Act of 2012 (PL.112-74), Division F, Title II.

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I. Funding Opportunity Description

1. Purpose

This announcement solicits applications for the fiscal year (FY) 2012 *Replication of a Public Health Information Exchange to Support Engagement in HIV Care Initiative*. Supported through funding from the Department of Health and Human Services (HHS) Secretary's Minority AIDS Initiative, the purpose of this 3-year non-research capacity building demonstration project initiative is to increase rates of linkage, engagement and retention in care among people of color living with HIV/AIDS. The primary target population of this initiative is people of color who have tested positive but are unaware of their status, and those with confirmed HIV diagnoses who have never been engaged in care; have refused referral to care; or have dropped out of care.

The goal of this project is to improve the health of uninsured and underinsured people of color living with HIV through applied public health informatics. This initiative will use a community-level, public health approach to support the development of statewide Health Information Exchange (HIE) demonstration projects that ensure the timely transfer of HIV surveillance data to health care providers. More specifically, this initiative will support the replication of the Louisiana Public Health Information Exchange (LaPHIE) funded previously in part by HRSA/HAB's Special Projects of National Significance Electronic Networks of Care Initiative.¹

Applicants must propose plans to design, develop, implement and evaluate a comprehensive statewide public health information exchange (HIE) among collaborating organizations representing HIV surveillance units of State Health Departments and inpatient, outpatient and emergency health care settings such as hospitals and community-based clinics. Applicants must have the cooperation of their State HIV surveillance units and should identify at least three (3) collaborating health care provider partners established through formal agreements. Funds are to be used for Health Information Technology (HIT) capacity building to improve interconnectivity and interoperability between state HIV surveillance data systems and the Electronic Medical Record (EMR) and Electronic Health Record (EHR) systems of hospitals and outpatient clinics, to include acquisition and implementation of network, hardware and software components. Proposed plans must describe the capacity and procedures used to protect patient privacy and electronic protected health information (PHI), and adherence to Security and Confidentiality Guidelines that govern protection of HIV surveillance data.²

HIE demonstration projects are to be completed in three (3) phases. The first 12 to 18 months will focus on the development and integration of the various information systems of the collaborating organizations. This process will transform the information exchange infrastructure from one that consists of organizational data silos to one that is integrated, timely, secure, and promotes the sharing of information. Phase 2 will involve rollout and pilot testing of the HIE in a limited number of settings, and Phase 3 will expand the number of clinical settings participating in the HIE and conduct outcomes evaluation for the project.

Successful applicants will be expected to evaluate the implementation of their HIE and its application to the identification of people of color living with HIV/AIDS who currently are not in HIV primary care, linking them to care, and retaining them in care. Applicants must submit

¹ See <http://hab.hrsa.gov/about/special/underservedcommunities.html#b>

² See http://www.cdc.gov/hiv/resources/guidelines/security_confidentiality_hiv.htm

detailed plans for evaluating their HIE projects, and if awarded, these plans will be subject to review by HRSA/HAB program staff for revision and final approval, under the terms of their cooperative agreement. Applicants must also include plans for disseminating complete and accurate documentation of their HIE system development, its implementation and its outcomes for the purpose of replication by other Ryan White Part B grantees.

According to the Centers for Disease Control and Prevention (CDC), 80 percent of the approximately 1.2 million individuals in the United States living with HIV have been diagnosed.³ Among those diagnosed with HIV, approximately 77 percent were linked to care within 3 to 4 months of diagnosis and an estimated 51 percent were retained in care.^{4,5} Timely entry into HIV care post-diagnosis has been found to have a number of benefits, including decreased morbidity, mortality and infectiousness,⁶ as well as exposure to secondary prevention through clinical interventions.⁷

It is important to understand the fluidity of “being in care.” The care continuum seen in Figure 1 (on the following page) provides a fluid definition of engagement/retention in care.⁸ At one end of the continuum are individuals who are completely unaware of their HIV status and thus not in care, while at the other extreme, persons living with HIV/AIDS are fully engaged in continuous HIV care. Various degrees of engagement are found in between. Ideally, clients would progress from learning they are HIV positive to immediate linkage to HIV care to maintaining full engagement in quality HIV care. However, the reality is quite different. HIV-infected individuals may move bi-directionally along the continuum as life situations change.^{9,10,11}

³ CDC. Vital Signs: HIV Prevention Through Care and Treatment – United States. Morbidity and Mortality Weekly Report, Early Release, Volume 60: 1618-1623, November 29, 2011. Available from: <http://www.cdc.gov/mmwr/pdf/wk/mm60e1129.pdf?source=govdelivery>

⁴ Mark G, Gardner LI, Craw J, Crepaz N. Entry and retention in medical care among HIV-diagnosed persons: a meta-analysis. *AIDS*, 24(17): 2665-78, November 13, 2010. Abstract available from: <http://www.ncbi.nlm.nih.gov/pubmed/20841990>

⁵ Torian LV and Wiewell EW. Continuity of HIV-related Medical Care, New York City, 2005-2009: Do Patients Who Initiate Care Stay in Care? *AIDS Patient Care and STDs*, 25(2): 79-88, February 2011. Abstract available from: <http://www.ncbi.nlm.nih.gov/pubmed/21284498>

⁶ Panel on Antiretroviral Guidelines for Adults and Adolescents. Guidelines for the Use of Antiretroviral Agents in HIV-1-infected Adults and Adolescents. Department of Health and Human Services. March 27, 2012. Accessed March 29, 2012 from: <http://aidsinfo.nih.gov/contentfiles/AdultandAdolescentGL.pdf>

⁷ Myers JJ, Shade SB, Rose CD, et al. Interventions Delivered in Clinical Settings are Effective in Reducing Risk of HIV Transmission Among People Living with HIV: Results from the Health Resources and Services Administration (HRSA)'s Special Projects of National Significance Initiative. *AIDS and Behavior*, 2010 June; 14 (3): 483-492. Abstract available from: <http://www.ncbi.nlm.nih.gov/pubmed/20229132>

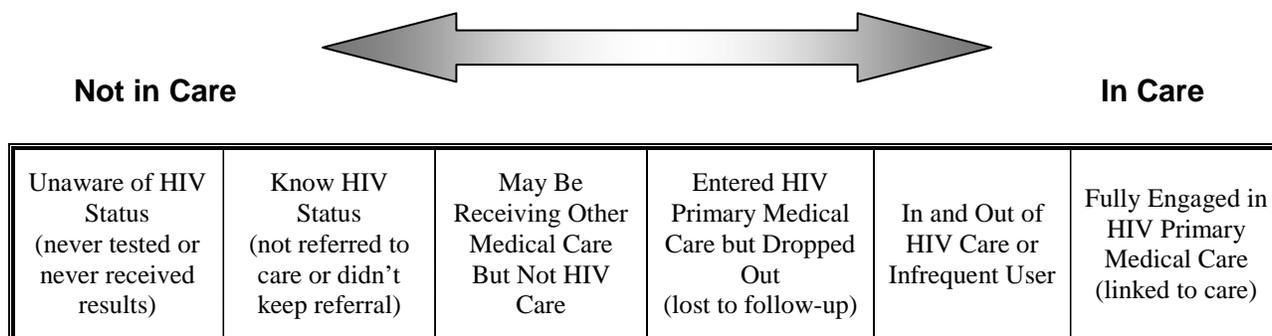
⁸ Health Resources and Services Administration, HIV/AIDS Bureau. August 2006. Outreach: Engaging People in HIV Care Summary of a HRSA/HAB 2005 Consultation on Linking PLWH Into Care. Available from: <ftp://ftp.hrsa.gov/hab/HIVoutreach.pdf>

⁹ Eldred L and Malitz F. Introduction to Making the Connection: The Importance of Engagement and Retention in HIV Medical Care, *AIDS Patient Care STDs*, 21 (Supplement 1): S1-S2, 2007.

¹⁰ Cheever LW. Engaging HIV-infected patients in care: their lives depend on it. *Clinical Infectious Diseases*, 44 (11): 1500-1502, June 1, 2007.

¹¹ Rajabium S, Mallinson RK, McCoy K, Coleman S, Drainoni M-L, Rebholz C, Holbert T. “Getting me back on track”: the role of outreach interventions in engaging and retaining people living with HIV/AIDS in medical care. *AIDS Patient Care STDs*, 21 (Supplement 1): S20-S29. Abstract available from: <http://www.ncbi.nlm.nih.gov/pubmed/17563286>

Figure 1: Engagement in Care Continuum



There are many reasons why HIV-positive persons may delay entering or fail to remain in care upon diagnosis, including structural, financial and personal/cultural barriers arising from racial, ethnic and gender disparities.¹² Continuous retention in care has benefits similar to those of timely entry, and a number of strategies have been developed to promote retention such as intensive case management, patient navigation, peer support groups, and mobile van outreach to find clients who were lost to follow-up.^{11,13} Despite the relative success of these strategies, retention or engagement in care among HIV-positive persons continues to be a significant public health issue and increasingly, community-level public health approaches are being utilized to address this problem. CDC's Enhanced Comprehensive HIV Prevention Planning (ECHPP),¹⁴ the 12 Cities Project directed by the Department of Health and Human Services (HHS) and HRSA's Systems Linkages and Access to Care for Populations at High Risk of HIV Infection Initiative¹⁵ are examples of projects utilizing a community-level, public health approach to promote HIV testing, identify HIV-positive persons and link and retain them to care.

The National HIV/AIDS Strategy (NHAS¹⁶) developed by the White House Office of National AIDS Policy (ONAP¹⁷) and released in July 2010 has three primary goals: 1) reducing the number of people who become infected with HIV, 2) increasing access to care and improving health outcomes for people living with HIV, and 3) reducing HIV-related health disparities. The NHAS states that more must be done to ensure that new prevention methods are identified and that prevention resources are more strategically deployed. Further, the NHAS recognizes the importance of getting people with HIV into care early after infection to protect their health and reduce their potential of transmitting the virus to others. HIV disproportionately affects people who have less access to prevention and treatment services and, as a result, often have poorer health outcomes. Therefore, the NHAS advocates adopting community-level approaches to reduce HIV infection in high-risk communities and reduce stigma and discrimination against people living with HIV. To ensure success, the NHAS requires the Federal Government and

¹² Tobias C, Cunningham WE, Cunningham CO, & Pounds MB. Making the Connection: The Importance of Engagement and Retention in HIV Medical Care. *AIDS Patient Care & STDs*, 2007; 21 (Supplement 1): S3-S8. Abstract available from: <http://www.ncbi.nlm.nih.gov/pubmed/17563287>

¹³ Gardner L, Marks G, Metsch L, et al. Psychological and Behavioral Correlates of Entering Care for HIV Infection: The Antiretroviral Treatment Access Study (ARTAS) *AIDS Patient Care and STDs*, 2007; 21 (6): 418-425. Abstract available from: <http://www.ncbi.nlm.nih.gov/pubmed/17594251>

¹⁴ See <http://www.cdc.gov/hiv/strategy/echpp/index.htm>

¹⁵ See <http://spnsetac.ucsf.edu/Default.aspx>

¹⁶ Office of National AIDS Policy. National HIV/AIDS Strategy for the United States, July 2010. ONAP, The White House. Available from: <http://www.whitehouse.gov/sites/default/files/uploads/NHAS.pdf>

¹⁷ See <http://www.whitehouse.gov/administration/eop/onap/>

State, tribal and local governments to increase collaboration, efficiency, and innovation. Therefore, Ryan White program activities should strive to support the three primary goals of the National HIV/AIDS Strategy.

This initiative aligns with Goal 2 of the NHAS, *to increase access to care and improve health outcomes of people living with HIV/AIDS*; and Goal 3, *to reduce HIV-related health disparities*. Moreover, the metrics to be used to assess the NHAS will depend upon the accurate measurement of programmatic outcome data which will be greatly improved through the effective use of health information exchange systems. The NHAS Implementation Plan¹⁸ also calls for a more coordinated national response to the HIV epidemic in the U.S., and the expansion of HIE systems will likely play a key role in efforts towards improved care coordination for those living with HIV/AIDS.

The population of focus for this MAI-funded initiative is people of color who have tested positive but are unaware of their status, and those with confirmed HIV diagnoses who have never been engaged in care; have refused referral to care; or have dropped out of care. For the purposes of this announcement, *people of color* is a phrase used to describe those who identify as belonging to one or more of the following racial and ethnic categories as defined by the Office of Management and Budget's (OMB) Standards for Data on Race and Ethnicity¹⁹ and used by the U.S. Census Bureau. To date, there are five categories for data on race: American Indian or Alaska Native; Asian; Black or African American; Native Hawaiian or Other Pacific Islander; and White; and two categories for data on ethnicity: Hispanic or Latino, and Not Hispanic or Latino. These standardized racial and ethnic classifications have been developed by the U.S. government to provide a common language for uniformity and comparability in the collection and use of data on race and ethnicity by Federal agencies. They also provide a minimum standard for maintaining, collecting, and presenting data on race and ethnicity for all Federal reporting purposes. The categories in this classification are social-political constructs and should not be interpreted as being scientific or anthropological in nature. Excluding White, persons who identify with one or more of the other categories are the target population for this initiative. However, this does not preclude the provision of services under this grant to persons of any race, ethnicity, sexual orientation, sex or gender, although the collection of evaluation data is limited to the study population.

2. Background

This initiative is funded through the Secretary's Minority AIDS Initiative (MAI) funding as authorized under the Consolidated Appropriations Act of 2012 (P.L. 112-74), Division F, Title II.

In 2007 HRSA's HIV/AIDS Bureau (HAB) funded six demonstration sites and an evaluation center for its Special Projects of National Significance (SPNS) *Electronic Networks of Care Initiative*.²⁰ The initiative sought to promote and evaluate the enhancement of existing health information electronic network systems for people living with HIV/AIDS in underserved

¹⁸ Office of National AIDS Policy. National HIV/AIDS Strategy Federal Implementation Plan, July 2010. ONAP, The White House. Available from: <http://www.whitehouse.gov/files/documents/nhas-implementation.pdf>

¹⁹ Office of Management and Budget. Revisions to the Standards for the Classification of Federal Data on Race and Ethnicity, Federal Register Notice, October 30, 1997. <http://www.whitehouse.gov/omb/fedreg/1997standards.html>

²⁰ See <http://hab.hrsa.gov/abouthab/special/underservedcommunities.html>

communities. SPNS grantees identified six factors that HIV care providers should consider before moving forward with an IT solution to their problems. These include existing IT infrastructure, programmatic capacity, expectations of and participation of stakeholders and administrators, organizational model, types of end users, and implementation challenges.²¹

The initiative defined an electronic network as the *electronic exchange of health information by a group of HIV care providers, including providers of both medical and ancillary care*. Ideally, a health information exchange should collect, report and utilize electronic client-level data for laboratory, diagnostic, and medical service utilization; ancillary care support, such as case management, counseling and testing, transportation; and referrals for substance use and mental health services. Interconnectivity should enable tracking of client medical and supportive care information from one point of service to another. Effective use of an HIE can be demonstrated by the early detection of HIV infection and reduced time of entry into care; improved management of patient health information, including referrals, appointments, maintenance, and retention of clients in the care system; and better health outcomes and quality of life.²²

One of these demonstration projects was LaPHIE – the Louisiana Public Health Information Exchange. LaPHIE is an ongoing collaboration between the Louisiana Office of Public Health (OPH) and the Louisiana State University Health Care Services Division (LSU HCSD). This demonstration project linked statewide public health surveillance data with patient-level EMR data through the creation of a secure, bi-directional connection between a protected list of out of care persons housed in OPH computers and an electronic medical record (EMR) system at LSU. LaPHIE was designed, developed and then implemented in seven of LSU HCSD's emergency departments, primary care and specialty ambulatory clinics, and inpatient units over a two-year period. Over 400 physicians and nurses received initial training in its use.²³ To address the legal and ethical concerns that arose over the sharing of protected health information, the LaPHIE partners formed a legal compliance and ethics workgroup consisting of public health officials, HIV-infected persons, doctors and nurses, attorneys familiar with Federal and State health laws, HIV advocates, and a medical ethicist.

LaPHIE alerts medical providers when persons with HIV who have not received HIV care for 12 months or more (as defined by the lack of laboratory reports of viral load and/or CD4 tests in the 12-month period post diagnosis) are seen within the LSU HCSD system. For example, each time a patient checks into a participating LSU emergency room, clinic, or hospital, LaPHIE logic automatically examines the OPH out of care list to determine if the patient is in it. If LaPHIE determines that the patient is out of care, it automatically sends a message to LSU's EMR, which sends a real-time alert to the medical staff. Alert message content varies depending on the patient's illness and type of care needed.

²¹ Magnus, M, Herwehe J, Proescholdbell RJ et al. Guidelines for effective integration of information technology in the care of HIV-infected populations. *Journal of Public Health Management Practice*, 2007; 13:39-48. Abstract available from: <http://www.ncbi.nlm.nih.gov/pubmed/17149099>

²² Results of this SPNS initiative are being published in a special supplement of the *International Journal of Medical Informatics* later in 2012.

²³ Herwehe J, Wilbright W, Abrams A, et al. Implementation of an innovative, integrated electronic medical record (EMR) and public health information exchange for HIV/AIDS. *Journal of the American Medical Informatics Association*, October 28, 2011 (Epub ahead of print). Abstract available from: <http://www.ncbi.nlm.nih.gov/pubmed/22037891>

In 488 patient encounters over a two-year period, LaPHIE successfully identified and provided exchange messages on 345 unique, HIV-positive patients found to be out of HIV primary care. Among these out of care patients, 72% were African-American and 62% were men. Seventy-six percent knew their HIV positive status but had not been in HIV primary care for 12 or more months, with a median time from last being seen of 20 months. Among those who knew their status and were not in care, 68% had been seen in non-HIV care settings where referral back to treatment could have been made. Seventy-three percent of the alerts resulted in clinician action as documented in the evaluation of the demonstration project. Among all out of care patients identified, 82% re-entered HIV primary care and received at least a CD4 count during an 18 month follow-up period, with 62% going to at least one HIV specialty care appointment.²⁴

LaPHIE's innovative use of HIE using surveillance data and real time clinical messaging, facilitates rapid provider notification of those in need of treatment. It reduces missed opportunities to re-engage people who had fallen out of care; those who were never followed up after receiving their test results; and those who never received their test results. LaPHIE thus demonstrated the successful use of data traditionally collected only for public health purposes, not health care delivery, to improve public health outcomes. However, questions remain regarding whether the application of its model will work in other States with different levels of HIT infrastructure, administrative structures and funding streams, and legal and privacy requirements. Accordingly, this initiative seeks to build capacity and replicate the LaPHIE project over a three-year time period in three other States to determine whether its methods are readily adaptable in other locations.

The principal evaluation question of interest is whether the HIE improves linkage, engagement, re-engagement and retention in care of hard to reach people living with HIV. Each demonstration project and its collaborating partners will be required to conduct a system-wide evaluation utilizing appropriate qualitative and/or quantitative methods during each phase of the project. Key evaluation questions to be considered include:

- How do electronic methods for identifying HIV-positive persons not in care compare to traditional outreach? Are individuals linked or re-linked to HIV care?
- What are the utilization rates of clinical messages and do the clinical messages result in clinical intervention and linkage to care?
- To what extent does the HIE result in improvement in specific measures related to the quality of HIV care on the individual level?
- Is the HIE network associated with a reduction in missed opportunities for identification of HIV-positive persons?
- Is the HIE network associated with improved identification of previously diagnosed HIV-positive persons not in care?

Data collected in this initiative is classified as either public health evaluation data or client-level data. Public health evaluation data, such as HIV surveillance data and Ryan White Services Report (RSR) data, are reported without disclosure of protected health information (PHI). The Privacy Rule of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 grants exemptions to covered entities who collect and report PHI for the purposes of communicable disease surveillance in public health activities and quality improvement in health care

²⁴ Herwehe et al, 2011

operations.²⁵ However, in order to fully evaluate their HIE systems, applicants may propose to engage in client-level data collection with their collaborating health care provider partners that includes the potential for PHI disclosure. Collection of client-level data beyond data that is routinely reported to HRSA, CDC and state and local entities for public health activities or health care operations will be subject to the Privacy Rule of HIPAA²⁶ and to human subjects research protections²⁷ which require state and local institutional review board approval and annual renewal.

II. Award Information

1. Type of Award

Funding will be provided in the form of a cooperative agreement. A cooperative agreement, as opposed to a grant, is an award instrument of financial assistance where substantial involvement is anticipated between HRSA and the recipient during performance of the contemplated project.

In addition to the usual monitoring and technical assistance provided under the cooperative agreement, **HRSA Program responsibilities shall include:**

- Making available the services of experienced HRSA/HAB personnel as participants in the planning and development of all phases of the demonstration project;
- Ongoing review of activities, procedures, measures, and tools to be established and implemented for accomplishing the goals of the cooperative agreement;
- Participation in conference calls, meetings and conferences, to be conducted during the period of the cooperative agreement;
- Provision of information resources;
- Review of all project information prior to dissemination; and
- Participation in the dissemination of project findings, best practices and lessons learned.

The cooperative agreement recipient's responsibilities are as follows.

HIE demonstration projects are to be completed in three (3) phases:

1) Phase 1 – Design and Development of the HIE system

These activities will take place during the first 12 to 18 months of the project. Demonstration project organizations will work with at least three (3) collaborating health care provider partners that serve areas with high prevalence of HIV, to be established through formal agreements. Demonstration projects will design and develop a HIE system that integrates data from its statewide HIV surveillance system with the EMR/EHR systems of three or more partnering organizations. For this project to be successful, states must laws and regulations requiring complete laboratory reporting of all viral load and CD4 values to surveillance. The project may

²⁵ See Summary of the HIPAA Privacy Rule at:

<http://www.hhs.gov/ocr/privacy/hipaa/understanding/summary/index.html>

²⁶ See HIPAA and the Privacy Rule at: <http://www.hhs.gov/ocr/privacy/hipaa/understanding/index.html>

²⁷ See Code of Federal Regulations Title 45 Part 56 Protection of Human Subjects at:

<http://www.hhs.gov/ohrp/humansubjects/guidance/45cfr46.htm>

be either the enhancement of an existing but under-developed HIE, or the development of an entirely new system based on the Louisiana Public Health Information Exchange model or a similar model. Systems developers at each participating site will need to address interconnectivity and interoperability issues and capabilities, creating new modules as necessary to receive, interpret and respond to electronic communications from other organizations. These new components must be incorporated in the EMR/EHR systems of the partner sites without disruptions to their care settings and clinician workflows.

During Phase 1, demonstration projects will establish three workgroups to design and develop the HIE system and address relevant concerns. These shall include:

- a. A Legal Compliance and Ethics Workgroup as described on page 5, to include public health officials, consumers, physicians and nurses, attorneys familiar with federal and state health laws, HIV advocates, and medical ethicists. The workgroup will review relevant legislation related to sharing of health care and public health information and consult with national experts in confidentiality and biomedical ethics. The group will also conduct focus groups and interviews with state residents including consumers to determine the acceptability of sharing protected information with medical personnel.
- b. A Service Integration Workgroup to study and identify the strengths and limitations of surveillance data. Design a series of clinical decision support prototypes for participating partners' EMRs with clinicians and public professionals.
- c. An Information Exchange Workgroup, to assess and modify the technical infrastructure across all participating partner sites as detailed in the design and development plan. This workgroup will also develop and refine patient inclusion criteria for the HIE's out of care database, and also be responsible for the review of security protocols and confidentiality policies. This workgroup will develop the technical specifications for a Partnership Affiliation and Data Sharing Agreement with the collaborating partner organizations. This agreement will detail the protocol for sharing and using PHI data within the HIE, its limits and its security procedures for PHI, and will be executed during Phase 1.

During the start of Phase 1, HRSA/HAB staff will work with demonstration projects to finalize their local evaluation plans. Please note that proposed evaluation plans must be informed by the recently released Institute of Medicine report entitled *Monitoring HIV Care in the United States - Indicators and Data Systems*.²⁸ Additionally, the Office of HIV/AIDS Policy (OHAP) of the Department of Health and Human Services will issue guidance in the spring of 2012 requiring use of a standard set of metrics to assure consistent outcome evaluation for the National HIV/AIDS Strategy. To assure the expeditious translation of evaluation findings into practice, successful applicants will be required to incorporate these data standards where appropriate in planning their HIE evaluation plans.

After approval of their evaluation plans, demonstration projects will then begin to compile evaluative data for their HIE implementation, focusing on pre-implementation questions as noted below:

²⁸ Institute of Medicine. *Monitoring HIV Care in the United States - Indicators and Data Systems*. March 15, 2012. Washington, DC: The National Academies Press. Available from: http://www.nap.edu/catalog.php?record_id=13225

- Is the HIE aligned with the strategic plan and priorities of the collaborating partner agencies?
- Are necessary managerial, hardware, and software structure in place, available, and supported, including data quality and system performance?
- What are barriers and facilitators of HIE data use in terms of training; consumer perception; community needs and desires; system characteristics, provider satisfaction; and the underlying interpersonal dynamics driving original system development (e.g., did providers have input? What was their level of buy-in).

Qualitative process and some outcome data to address the questions listed above will be collected through interviews and surveys administered by a local evaluator. Please note that if the cooperative agreement recipient requires client-level data collection with its collaborating medical provider partners beyond what is routinely reported to HRSA, CDC and state and local entities for public health activities or health care operations, such data collection will be subject to the Privacy Rule of HIPAA and human subjects research protections, which require state and local institutional review board approval and annual renewal.

2) Phase 2 – Initial Implementation and Pilot Testing of the HIE system

These activities will begin no later than the 18th month of the project. Demonstration projects will begin the initial rollout of the HIE system, pilot-testing its various components and making adjustments as necessary. The goal of this pilot testing will be to address any necessary corrective improvements to HIE system's operability, especially with regard to interconnectivity and interoperability between systems. The work of the Service Integration and Information Exchange Workgroups will continue.

Demonstration projects will continue to compile evaluative data during Phase 2 for their process evaluation, and gather benchmark/baseline data for the outcome evaluation of their HIE implementation. Evaluative questions will include the following questions regarding the functionality of the HIE:

- Are the constituent networks compatible?
- Are patients concerned with the potential for unintended data disclosure?
- Are providers satisfied with the system, in terms of use, outcomes, and benefits?
- Does the system deliver appropriate and necessary information for quality patient care?
- Are the system response times adequate and reliable?
- Is the system user-friendly and accessible?
- Are linkages into HIV care effectively made?
- Do they improve patient access and entry into care?
- Is there adequate local technical support?

3) Phase 3 – Full-scale Implementation of the HIE system and Evaluation Report

These activities will begin no later than the 24th month of the project. Demonstration projects will begin and complete the wider scale implementation of their HIE in additional health care provider settings at the state level. This should involve another 3 to 7 collaborating organizations that serve areas with high prevalence of HIV. Demonstration projects will analyze and complete an evaluation report for their HIE project, for the purposes of replication by other Ryan White Part B grantees.

In Phase 3, post-implementation evaluation questions will focus on the HIE outcomes:

- Did the HIE result in system savings in terms of time, costs and resources?
- Did the HIE result in improvements in linkage to and retention in care?
- Did the HIE result in improved work satisfaction by clinical providers?
- Did the HIE result in improved decision making for patient care?

In addition to the post-implementation evaluation questions, data will be collected on the number of registration messages processed for patient encounters in which the patient was considered out of care. Data also will be collected on the number of HIV-positive patients in need of treatment and the actual number linked to care. Data on the number of clinicians responding to alerts and the specific clinician actions taken as a result of alerts also will be assessed through the HIE. Surveillance and EMR data will be used to follow previously identified out of care patients over time and patients will be characterized by age, race-ethnicity, gender, HIV risk factor, and number of follow-up CD4 or viral load measurement within the project evaluation period. As noted above, surveillance and EMR/EHR data will be used follow patients that have been linked to care as a result of the HIE. All proposed measures assessing linkage and retention in care must be consistent with the metrics/targets outlined in the NHAS.

A Final Evaluation Report of the process and outcome measures will be due at the conclusion of the project. Lessons learned and best practices developed during the demonstration project will be documented in the Final Report. Successful applicants will be expected to participate in limited dissemination activities during Year 3 of the project, to include presentations of their HIE projects at national conferences and collaborative writing of journal article submissions for publication of the initiative's results.

2. Summary of Funding

This program will provide funding during Federal fiscal years 2012 – 2014. Approximately \$1,550,000 is expected to be available annually to fund three (3) grantees. Applicants may apply for funding within a range of \$400,000 up to a ceiling of \$600,000 per year. The project period is three (3) years. Funding beyond the first year is dependent on the availability of appropriated funds for this initiative in subsequent fiscal years; awardee satisfactory performance; and a decision that continued funding is in the best interest of the Federal Government.

III. Eligibility Information

1. Eligible Applicants

Eligible applicants are limited to Ryan White Part B funded State health department grantees of record (to include their lead administrative agencies). State Health Departments are responsible for managing the state HIV/AIDS surveillance and care systems and conducting critical HIV/AIDS surveillance, investigation, and epidemiologic activities, core requirements of this replication project. Eligible State health departments must be in States and territories where racial/ethnic minorities comprise 65 percent or more of the people living with HIV/AIDS. According to the CDC,^[1] these are Alabama, Connecticut, Delaware, District of Columbia, Florida, Georgia, Illinois, Maryland, Michigan, Mississippi, New Jersey, New Mexico, New York, North Carolina, Pennsylvania, Puerto Rico, South Carolina, Texas, Virginia, and the Virgin Islands. (Louisiana, where the original LaPHIE demonstration project was conducted, is not eligible to apply).

2. Cost Sharing/Matching

Cost Sharing/Matching is not required for this program.

3. Other

Applications that exceed the ceiling amount will be considered non-responsive and will not be considered for funding under this announcement.

Funding under this announcement may not be used to supplant or supplement Ryan White activities or services already funded under concurrent Parts A, B, C, D, or F grants.

Any application that fails to satisfy the deadline requirements referenced in *Section IV.3* will be considered non-responsive and will not be considered for funding under this announcement.

NOTE: Multiple applications from an organization are not allowable.

IV. Application and Submission Information

1. Address to Request Application Package

Application Materials and Required Electronic Submission Information

HRSA *requires* applicants for this funding opportunity announcement to apply electronically through Grants.gov. The registration and application process protects applicants against fraud and ensures that only authorized representatives from an organization can submit an application. Applicants are responsible for maintaining these registrations, which should be completed well in advance of submitting an application. All applicants *must* submit in this manner unless they obtain a written exemption from this requirement in advance by the Director of HRSA's Division

^[1] CDC. Diagnoses of HIV Infection and AIDS in the United States and Dependent Areas, 2010. HIV Surveillance Report, Volume 22. Available from: <http://www.cdc.gov/hiv/surveillance/resources/reports/2010report/index.htm>

of Grants Policy. Applicants must request an exemption in writing from DGPWaivers@hrsa.gov, and provide details as to why they are technologically unable to submit electronically through the Grants.gov portal. If requesting a waiver, include the following in the email request: the HRSA announcement number for which you are seeking relief, the organization's DUNS number, the name, address, and telephone number of the organization and the name and telephone number of the Project Director as well as the Grants.gov Tracking Number (GRANTXXXX) assigned to the submission along with a copy of the "Rejected with Errors" notification as received from Grants.gov. **HRSA and its Digital Services Operation (DSO) will only accept paper applications from applicants that received prior written approval.** However, the application must still be submitted by the deadline. Suggestion: submit application to Grants.gov at least two days before the deadline to allow for any unforeseen circumstances.

Note: Central Contractor Registration (CCR) information must be updated at least every 12 months to remain active (for both grantees and sub-recipients). As of August 9, 2011, Grants.gov began rejecting submissions from applicants with expired CCR registrations.

Although active CCR registration at time of submission is not a new requirement, this systematic enforcement will likely catch some applicants off guard. According to the CCR Website it can take 24 hours or more for updates to take effect, so ***check for active registration well before the grant deadline.***

An applicant can view their CCR Registration Status by visiting <http://www.bpn.gov/CCRSearch/Search.aspx> and searching by their organization's DUNS number. The [CCR Website](#) provides user guides, renewal screen shots, FAQs and other resources you may find helpful.

Applicants that fail to allow ample time to complete registration with CCR and/or Grants.gov will not be eligible for a deadline extension or waiver of the electronic submission requirement.

All applicants are responsible for reading the instructions included in HRSA's *Electronic Submission User Guide*, available online at <http://www.hrsa.gov/grants/apply/userguide.pdf>. This Guide includes detailed application and submission instructions for both Grants.gov and HRSA's Electronic Handbooks. Pay particular attention to Sections 2 and 5 that provide detailed information on the competitive application and submission process.

Applicants are also responsible for reading the Grants.gov Applicant User Guide, available online at <http://www.grants.gov/assets/ApplicantUserGuide.pdf>. This Guide includes detailed information about using the Grants.gov system and contains helpful hints for successful submission.

Applicants must submit proposals according to the instructions in the Guide and in this funding opportunity announcement in conjunction with Application Form SF-424. The forms contain additional general information and instructions for applications, proposal narratives, and budgets. The forms and instructions may be obtained by:

- 1) Downloading from <http://www.grants.gov>, or
- 2) Contacting the HRSA Digital Services Operation (DSO) at: HRSADSO@hrsa.gov

Each funding opportunity contains a unique set of forms and only the specific forms package posted with an opportunity will be accepted. Specific instructions for preparing portions of the application that must accompany Application Form SF-424 appear in the “Application Format Requirements” section below.

2. Content and Form of Application Submission

Application Format Requirements

The total size of all uploaded files may not exceed the equivalent of 80 pages when printed by HRSA. The total file size may not exceed 10 MB. The 80-page limit includes the abstract, project and budget narratives, attachments, and letters of commitment and support. Standard forms are NOT included in the page limit. **HRSA strongly urges applicants to print their application to ensure it does not exceed the 80-page limit. Do not reduce the size of the fonts or margins to save space. See the formatting instructions in Section 5 of the *Electronic Submission User Guide* referenced above.**

Applications must be complete, within the 80-page limit, within the 10 MB limit, and submitted prior to the deadline to be considered under this announcement.

Application Format

Applications for funding must consist of the following documents in the following order:

SF-424 Non-Construction – Table of Contents

-  It is mandatory to follow the instructions provided in this section to ensure that the application can be printed efficiently and consistently for review.
-  Failure to follow the instructions may make the application non-responsive. Non-responsive applications will not be considered under this funding opportunity announcement.
-  For electronic submissions, applicants only have to number the electronic attachment pages sequentially, resetting the numbering for each attachment, i.e., start at page 1 for each attachment. Do not attempt to number standard OMB approved form pages.
-  For electronic submissions, no Table of Contents is required for the entire application. HRSA will construct an electronic table of contents in the order specified.

Application Section	Form Type	Instruction	HRSA/Program Guidelines
Application for Federal Assistance (SF-424)	Form	Pages 1, 2 & 3 of the SF-424 face page.	Not counted in the page limit
Project Summary/Abstract	Attachment	Can be uploaded on page 2 of SF-424 - Box 15	Required attachment. Counted in the page limit. Refer to the funding opportunity announcement for detailed instructions.
Additional Congressional District	Attachment	Can be uploaded on page 3 of SF-424 - Box 16	As applicable to HRSA; Counted in the page limit.
Project Narrative Attachment Form	Form	Supports the upload of Project Narrative document	Not counted in the page limit.
Project Narrative	Attachment	Can be uploaded in Project Narrative Attachment form.	Required attachment. Counted in the page limit. Refer to the funding opportunity announcement for detailed instructions. Provide table of contents specific to this document only as the first page.
SF-424A Budget Information - Non-Construction Programs	Form	Pages 1–2 to support structured budget for the request of Non-construction related funds.	Not counted in the page limit.
Budget Narrative Attachment Form	Form	Supports the upload of Project Narrative document.	Not counted in the page limit.
Budget Narrative	Attachment	Can be uploaded in Budget Narrative Attachment form.	Required attachment. Counted in the page limit. Refer to the funding opportunity announcement for detailed instructions.
SF-424B Assurances - Non-Construction Programs	Form	Supports assurances for non-construction programs.	Not counted in the page limit.
Project/Performance Site Location(s)	Form	Supports primary and 29 additional sites in structured form.	Not counted in the page limit.
Additional Performance Site Location(s)	Attachment	Can be uploaded in the SF-424 Performance Site Location(s) form. Single document with all additional site location(s)	Counted in the page limit.

Application Section	Form Type	Instruction	HRSA/Program Guidelines
Disclosure of Lobbying Activities (SF-LLL)	Form	Supports structured data for lobbying activities.	Not counted in the page limit.
Attachments Form	Form	Supports up to 15 numbered attachments. This form only contains the attachment list.	Not counted in the page limit.
Attachment 1-15	Attachment	Can be uploaded in Other Attachments form 1-15.	Refer to the attachment table provided below for specific sequence. Counted in the page limit.

- 🔔 To ensure that attachments are organized and printed in a consistent manner, follow the order provided below. Note that these instructions may vary across programs.
- 🔔 Evidence of Non-Profit status and invention related documents, if applicable, must be provided in the other attachment form.
- 🔔 Additional supporting documents, if applicable, can be provided using the available rows. Do not use the rows assigned to a specific purpose in the program funding opportunity announcement.
- 🔔 Merge similar documents into a single document. Where several documents are expected in the attachment, ensure that a table of contents cover page is included specific to the attachment. The Table of Contents page will not be counted in the page limit.
- 🔔 Limit the file attachment name to under 50 characters. Do not use any special characters (e.g., %, /, #) or spacing in the file name or word separation. (The exception is the underscore (_) character.) Attachments will be rejected by Grants.gov if special characters are included or attachment names exceed 50 characters.

Attachment Number	Attachment Description (Program Guidelines)
Attachment 1	Line Item Budget Spreadsheet
Attachment 2	Narrative Staffing Plan
Attachment 3	Position Descriptions of Key Personnel
Attachment 4	Biographical Sketches of Key Personnel
Attachment 5	Work Plan
Attachment 6	Project Organizational Chart
Attachment 7	Current and Proposed Letters of Agreement, and/or Memoranda of Agreement or Understanding
Attachment 8	Healthy People 2020 Summary
Attachments 9-15	Other Relevant Documents, as necessary

Application Format

i. Application Face Page

Complete Application Form SF-424 provided with the application package. Prepare according to instructions provided in the form itself. If using the SF-424, include the following: Important note: enter the name of the **Project Director** in 8. f. "Name and contact information of person to be contacted on matters involving this application." If, for any reason, the Project Director will be out of the office, please ensure the email Out of Office Assistant is set so HRSA will be aware if any issues arise with the application and a timely response is required. For information pertaining to the Catalog of Federal Domestic Assistance, the CFDA Number is 93.145.

DUNS Number

All applicant organizations (and subrecipients of HRSA award funds) are required to have a Data Universal Numbering System (DUNS) number in order to apply for a grant or cooperative agreement from the Federal Government. The DUNS number is a unique nine-character identification number provided by the commercial company, Dun and Bradstreet. There is no charge to obtain a DUNS number. Information about obtaining a DUNS number can be found at <http://fedgov.dnb.com/webform> or call 1-866-705-5711. Please include the DUNS number in SF-424 - item 8c; on the application face page. Applications *will not* be reviewed without a DUNS number. Note: A missing or incorrect DUNS number is the number one reason for applications being "Rejected for Errors" by Grants.gov. HRSA will not extend the deadline for applications with a missing or incorrect DUNS number. Applicants should take care in entering the DUNS number in the application.

Additionally, the applicant organization (and any subrecipient of HRSA award funds) is required to register annually with the Central Contractor Registration (CCR) in order to conduct electronic business with the Federal Government. CCR registration must be maintained with current, accurate information at all times during which an entity has an active award or an application or plan under consideration by HRSA. It is extremely important to verify that the applicant organization CCR registration is active and the Marketing Partner ID Number (MPIN) is current. Information about registering with the CCR can be found at <http://www.ccr.gov>.

ii. Table of Contents

The application should be presented in the order of the Table of Contents provided earlier. Again, for electronic applications no table of contents is necessary as it will be generated by the system. (Note: the Table of Contents will not be counted in the page limit.)

iii. Budget

Please complete Sections A, B, E, and F, and then provide a line item budget for each year of the project period. In Section A use rows 1 - 3 to provide the budget amounts for the first three years of the project. Please enter the amounts in the "New or Revised Budget" column- not the "Estimated Unobligated Funds" column. In Section B Object Class Categories of the SF-424A, provide the object class category breakdown for the annual amounts specified in Section A. In Section B, use column (1) to provide category amounts for Year 1 and use columns (2) through (4) for subsequent budget Years 2 and 3. The Cumulative Budget is automatically generated and provides the total budget information for the three-year grant request. Errors found in the Cumulative Budget must be corrected within the incorrect

field(s) in Budget Period 1, 2, or 3; corrections cannot be made to the Cumulative Budget itself.

Applicants must also submit separate line item budget spreadsheet tables **for each year of the proposed three-year project period**, using the budget categories in the SF 424A and breaking down sub-categorical costs. Under Personnel, please list each position by title and name, with annual salary, FTE, and salary charged to the cooperative agreement. Equipment, supplies, and contractual should each have individual items listed separately. The amounts requested on SF424A and listed on the line-item budget must match. The budget must be appropriate and relevant to the activities proposed in the Project Narrative and Work Plan. These line item budgets should be included as **Attachment 1**.

Salary Limitation:

The Consolidated Appropriations Act, 2012 (P.L. 112-74) enacted December 23, 2011, limits the salary amount that may be awarded and charged to HRSA grants and cooperative agreements. Award funds may not be used to pay the salary of an individual at a rate in excess of Executive Level II. The Executive Level II salary of the Federal Executive Pay scale is \$179,700. This amount reflects an individual’s base salary exclusive of fringe and any income that an individual may be permitted to earn outside of the duties to the applicant organization. This salary limitation also applies to subawards/subcontracts under a HRSA grant or cooperative agreement.

As an example of the application of this limitation: If an individual’s base salary is \$350,000 per year plus fringe benefits of 25% (\$87,500) and that individual is devoting 50% of their time to this award, their base salary should be adjusted to \$179,700 plus fringe of 25% (\$44,925) and a total of \$112,312.50 may be included in the project budget and charged to the award in salary/fringe benefits for that individual. See the breakdown below:

Individual’s <i>actual</i> base full time salary: \$350,000	
50% of time will be devoted to project	
Direct salary	\$175,000
Fringe (25% of salary)	\$43,750
Total	\$218,750
Amount that may be claimed on the application budget due to the legislative salary limitation:	
Individual’s base full time salary <i>adjusted</i> to Executive Level II: \$179,700	
50% of time will be devoted to the project	
Direct salary	\$89,850
Fringe (25% of salary)	\$22,462.50
Total amount	\$112,312.50

iv. Budget Justification

Provide a narrative that explains the amounts requested for each line in the budget. The budget justification should specifically describe how each item will support the achievement of proposed objectives. The budget period is for ONE year. However, the applicant **must** submit one-year budgets for each of the subsequent budget periods within the requested project period at the time of application. Line item information must be provided to explain the costs entered in the SF-424A. Be very careful about showing how each item in the

“other” category is justified. For subsequent budget years, the justification narrative should highlight the changes from year one or clearly indicate that there are no substantive budget changes during the project period. The budget justification MUST be concise. Do NOT use the justification to expand the project narrative.

Budget for Multi-Year Award

This announcement is inviting applications for project periods up to three (3) years. Awards, on a competitive basis, will be for a one-year budget period; although the project period may be for up to three (3) years. Submission and HRSA approval of the Progress Report(s) and any other required submission or reports is the basis for the budget period renewal and release of subsequent year funds. Funding beyond the one-year budget period but within the three-year project period is subject to availability of funds, satisfactory progress of the awardee, and a determination that continued funding would be in the best interest of the Federal Government.

Include the following in the Budget Justification narrative:

Personnel Costs: Personnel costs should be explained by listing each staff member who will be supported from funds, name (if possible), position title, percentage of full-time equivalency, and annual salary. Reminder: Award funds may not be used to pay the salary of an individual at a rate in excess of Executive Level II or \$179,700. An individual's base salary, per se, is NOT constrained by the legislative provision for a limitation of salary. The rate limitation simply limits the amount that may be awarded and charged to HRSA grants and cooperative agreements. Please provide an individual’s actual base salary if it exceeds the cap. See the sample below.

Sample:

Name	Position Title	% of FTE	Annual Salary	Amount Requested
J. Smith	Chief Executive Officer	50	\$179,700*	\$89,850
R. Doe	Nurse Practitioner	100	\$75,950	\$75,950
D. Jones	Data/AP Specialist	25	\$33,000	\$8,250

*Actual annual salary = \$350,000

Fringe Benefits: List the components that comprise the fringe benefit rate, for example health insurance, taxes, unemployment insurance, life insurance, retirement plans, and tuition reimbursement. The fringe benefits should be directly proportional to that portion of personnel costs that are allocated for the project. (If an individual’s base salary exceeds the legislative salary cap, please adjust fringe accordingly.)

Travel: List travel costs according to local and long distance travel. For local travel, the mileage rate, number of miles, reason for travel and staff member/consumers completing the travel should be outlined. The budget should also reflect the travel expenses associated with participating in project meetings and other proposed trainings or workshops.

Equipment: List equipment costs and provide justification for the need of the equipment to carry out the program’s goals. Extensive justification and a detailed status of current equipment must be provided when requesting funds for the purchase of computers and

furniture items that meet the definition of equipment (a unit cost of \$5,000 or more and a useful life of one or more years).

Supplies: List the items that the project will use. In this category, separate office supplies from educational purchases. Office supplies could include paper, pencils, and the like; and educational supplies may be pamphlets and educational videotapes. Remember, they must be listed separately.

Contractual: Applicants are responsible for ensuring that their organization or institution has in place an established and adequate procurement system with fully developed written procedures for awarding and monitoring all contracts. Applicants must provide a clear explanation as to the purpose of each contract, how the costs were estimated, and the specific contract deliverables. Reminder: recipients must notify potential subrecipients that entities receiving subawards must be registered in CCR and provide the recipient with their DUNS number.

Other: Put all costs that do not fit into any other category into this category and provide an explanation of each cost in this category. In some cases, rent, utilities and insurance fall under this category if they are not included in an approved indirect cost rate.

Applicants may include the cost of access accommodations as part of their project's budget, including sign interpreters, plain language and health literate print materials in alternate formats (including Braille, large print, etc.); and cultural/linguistic competence modifications such as use of cultural brokers, translation or interpretation services at meetings, clinical encounters, and conferences, etc.

Indirect Costs: Indirect costs are those costs incurred for common or joint objectives which cannot be readily identified but are necessary to the operations of the organization, e.g., the cost of operating and maintaining facilities, depreciation, and administrative salaries. For institutions subject to OMB Circular A-21, the term "facilities and administration" is used to denote indirect costs. If an organization applying for an assistance award does not have an indirect cost rate, the applicant may wish to obtain one through HHS's Division of Cost Allocation (DCA). Visit DCA's website at: <http://rates.psc.gov/> to learn more about rate agreements, the process for applying for them, and the regional offices which negotiate them.

v. *Staffing Plan and Personnel Requirements*

Applicants must present a staffing plan as **Attachment 2**, and provide a justification for the plan that includes education and experience qualifications and rationale for the amount of time being requested for each staff position. Position descriptions that include the roles, responsibilities, and qualifications of proposed project staff must be included in **Attachment 3**. Biographical sketches for any key employed personnel that will be assigned to work on the proposed project must be included in **Attachment 4**. When applicable, biographical sketches should include training, language fluency and experience working with the cultural and linguistically diverse populations that are served by their programs.

vi. *Assurances*

Complete Application Form SF-424B Assurances – Non-Construction Programs provided with the application package.

vii. *Certifications*

Use the Certifications and Disclosure of Lobbying Activities Application Form provided with the application package.

viii. *Project Abstract*

Provide a summary of the application. Because the abstract is often distributed to provide information to the public and Congress, please prepare this so that it is clear, accurate, concise, and without reference to other parts of the application. It must include a brief description of the proposed project including the needs to be addressed, the proposed services, and the population group(s) to be served. Please place the following at the top of the abstract:

- Project Title
- Applicant Organization Name
- Address
- Project Director Name
- Contact Phone Numbers (Voice, Fax)
- E-Mail Address
- Web Site Address, if applicable

The project abstract must be single-spaced and limited to one page in length.

ix. *Project Narrative*

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

Use the following section headers for the Narrative:

- ***INTRODUCTION***
Provide a clear and succinct description of the proposed HIE demonstration project. State the goals of the project and provide a brief summary of the proposed activities. Briefly describe the type of electronic network system, the proposed collaborating entities and the specific sites where the activities will be take place.
- ***NEEDS ASSESSMENT***
Describe the specific target population that will be served by the demonstration project, citing the most recent, available HIV surveillance data for your state or territory. Describe the target population’s demographics and characteristics, using where appropriate relevant sections of the most recent Ryan White Part B application for Unmet Needs and the Early Identification of Individuals with HIV/AIDS (EIIHA). Describe the existing data system for the State’s HIV surveillance system. Discuss how existing limitations in data and data sharing that the project hopes to overcome impact the care of people living with HIV/AIDS in your State or Territory.
- ***METHODOLOGY***
Describe in detail your plan to design, development and implement an HIE within your State or Territory. Identify at least three HIV medical provider partner organizations with whom you will collaborate to implement the HIE, and describe their existing EMR/EHR

systems. Applicants should provide candid assessments of all existing HIT systems involved in the project, and discuss the probable technological, administrative and funding-related challenges to project implementation. Describe your methods for pilot testing the various components of the HIE, and provide a rationale for their use. Describe your capacity and procedures used to protect patient privacy and electronic protected health information (PHI). Since the project will involve the use of existing information technology resources already in place at both the participating medical provider sites and the State's HIV surveillance unit, discuss how interconnectivity or interoperability between those systems will be addressed. Ultimately the project will transform existing HIT infrastructure from unconnected organizational data silos to an integrated, timely, and secure HIE that promotes the sharing of information.

Describe a detailed evaluation plan for your HIE demonstration project, with the understanding that if awarded, it will be subject to revision and review by HRSA. Include a method for process evaluation to document the implementation of the HIE system. Describe the methods to be used to evaluate project outcomes with regard to the HIE's ability to identify people of color living with HIV/AIDS who currently are not in HIV primary care, link them to care, and retain them in care. Provide a rationale for those methods. At a minimum, include process and outcome measures that address the evaluative questions described earlier in the announcement. If client-level data collection and reporting by collaborating medical provider partners beyond what is routinely reported to HRSA, CDC and state and local entities for public health activities or health care operations (and thus subject to the Privacy Rule of HIPAA and human subjects research protections) state your intent to obtain State institutional review board approval and annual renewals. As previously noted, evaluation plans must be informed by the recently released Institute of Medicine report entitled *Monitoring HIV Care in the United States - Indicators and Data Systems* and metrics to be released by the Office of HIV/AIDS Policy (OHAP) of the Department of Health and Human Services.

Provide an outline for a Final Evaluation Report of the process and outcome measures due at the conclusion of the project. State your intent to participate in limited dissemination activities during Year 3 of the project, to include presentations of your HIE projects at national conferences and collaborative writing of journal article submissions for publication of the initiative's results. Finally, describe how the HIE project might be sustained after the end of the three-year funding period.

- **WORK PLAN**

Provide a Work Plan that delineates the goals, objectives, action steps and responsible staff for the three-year project period. The Work Plan must follow the three (3) phases described earlier in this announcement within a realistic timeline. The Work Plan should directly relate to the methods described in the Methodology section. All aspects of the project including the design, development, pilot testing, implementation and evaluation of the HIE project, along with the role of everyone, including contractors, involved in each activity, must be included in this section. The time line should include action steps that are specific, time-framed, and measurable, and that identify the project staff responsible. Please note that although goals for the work plan are to be written for the entire three-year project period, objectives and action steps are required only for the goals set for Year 1. Clearly indicate the anticipated start date of the demonstration project, and provide

numbers for targeted outcomes where applicable, not just percentages. Include the project's Work Plan as **Attachment 5**.

- ***RESOLUTION OF CHALLENGES***

Discuss challenges that are likely to be encountered in planning and implementing the activities described in the work plan. Describe realistic and appropriate approaches to be used to resolve those challenges.

- ***EVALUATION AND TECHNICAL SUPPORT CAPACITY***

Describe your capacity to conduct an evaluation of the proposed project. Each demonstration project must have a qualified evaluator or evaluation staff at a minimum 25% full time equivalent (.25 FTE) level who will collect, analyze and compile relevant data for Final Report and any dissemination materials. As appropriate, describe the proposed methods to collect and analyze process and outcome data, and explain how these data may be used to improve HIV service delivery in your State or Territory. Include a discussion of applicant's capacity and ability to provide direction, HIT technological consultation, and capacity building assistance for the development and implementation of HIT projects and if applicable, HIEs and regional health information networks. Describe current experience, skills, and knowledge, including individuals on staff, materials published, and previous work of a similar nature.

- ***ORGANIZATIONAL INFORMATION***

Provide information on the applicant organization's current mission and structure, scope of current activities, and an organizational chart, and describe how these all contribute to the ability of the organization to conduct the demonstration project and meet the expectations of this initiative. If subcontractors will be used to provide services, describe their proposed roles and responsibilities. Include a project organizational chart as **Attachment 6**.

Applicants must demonstrate they have secured the cooperation and commitment of their State or Territory's HIV surveillance unit through a formal Letter of Agreement to fully participate in the capacity building demonstration project. Identify at least three (3) collaborating health care provider partners established through formal agreements and include a brief description of the identified collaborating partner organizations, including the mission, structure and scope of current services or activities. Additionally, each collaborating medical provider organization must demonstrate its formal commitment to participate in the project through a Letter of Support or a Memorandum of Agreement or Understanding. Documents that confirm current or proposed contractual agreements between the applicant and collaborating medical provider or contractor organizations should clearly describe the roles of the contractors and major deliverables. If client-level data collection and reporting by collaborating medical provider partners beyond what is routinely reported to HRSA, CDC and state and local entities for public health activities or health care operations is required (and thus subject to the Privacy Rule of HIPAA and human subjects research protections) each collaborating medical provider organization must identify an IRB for such review and approval. Each collaborating medical provider organization also must state its willingness to submit to HRSA proof of initial IRB approvals and annual renewals for all client-level data collection instruments, informed consents and evaluation materials. All these documents must be signed, dated and each are not to exceed two pages in length. Include all documents specified above as **Attachment 7**.

x. Attachments

Please provide the following items to complete the content of the application. Please note that these are supplementary in nature, and are not intended to be a continuation of the project narrative. Unless otherwise noted, attachments count toward the application page limit. **Each attachment must be clearly labeled.**

Attachment 1: *Line Item Budgets Spreadsheets*

Attachment 2: *Staffing Plan*

Keep each job description to one page in length as much as is possible. Include the role, responsibilities, and qualifications of proposed project staff.

Attachment 3: *Position Descriptions of Key Personnel*

Attachment 4: *Biographical Sketches of Key Personnel*

Include biographical sketches for persons occupying the key positions described in Attachment 3, not to exceed two pages in length. In the event that a biographical sketch is included for an identified individual who is not yet hired, please include a letter of commitment from that person with the biographical sketch.

Attachment 5: *Work Plan*

Attachment 6: *Project Organizational Chart*

Provide a one-page figure that depicts the organizational structure of the project, including medical provider partner organizations, subcontractors and other significant collaborators.

Attachment 7: *Letters of Agreement and/or Memoranda of Agreement*

Provide any documents that describe working relationships between the applicant organization, its HIV surveillance unit and other entities and programs cited in the proposal. Documents that confirm current or proposed contractual agreements between the applicant and collaborating medical provider or contractor organizations should clearly describe the roles of the contractors and major deliverables. If applicable, collaborating organizations must confirm their willingness to obtain local IRB approval and meet IRB submission requirements. All letters of Agreement and Memoranda of Understanding must be signed and dated.

Attachment 8: *Healthy People 2020 Summary*

Applicants must summarize the relationship of their projects and identify which of their programs objectives and/or sub-objectives relate to the goals of the Healthy People 2020 initiative. Refer to section VI.2 for further information.

Attachments 9–15: *Other Relevant Documents*

Include here any other documents that are relevant to the application and or referenced in the application.

3. Submission Dates and Times

Application Due Date

The due date for applications under this funding opportunity announcement is *July 13, 2012 at 8:00 P.M. ET*. Applications completed online are considered formally submitted when the application has been successfully transmitted electronically by the organization's Authorized Organization Representative (AOR) through Grants.gov and has been validated by Grants.gov on or before the deadline date and time.

Receipt acknowledgement: Upon receipt of an application, Grants.gov will send a series of email messages to document the progress of an application through the system.

1. The first will confirm receipt in the system;
2. The second will indicate whether the application has been successfully validated or has been rejected due to errors;
3. The third will be sent when the application has been successfully downloaded at HRSA; and
4. The fourth will notify the applicant of the Agency Tracking Number assigned to the application.

The Chief Grants Management Officer (CGMO) or designee may authorize an extension of published deadlines when justified by circumstances such as natural disasters (e.g., floods or hurricanes) or other disruptions of services, such as a prolonged blackout. The CGMO or designee will determine the affected geographical area(s).

Late applications:

Applications which do not meet the criteria above are considered late applications and will not be considered in the current competition.

4. Intergovernmental Review

Recipients funded under this announcement are subject to the provisions of Executive Order 12372, as implemented by 45 CFR 100. Executive Order 12372 allows States the option of setting up a system for reviewing applications from within their States for assistance under certain Federal programs. Application packages made available under this funding opportunity will contain a listing of States which have chosen to set up such a review system, and will provide a State Single Point of Contact (SPOC) for the review. Information on States affected by this program and State Points of Contact may also be obtained from the Grants Management Officer listed in the Agency Contact(s) section, as well as from the following Web site:

http://www.whitehouse.gov/omb/grants_spo.

All applicants other than federally recognized Native American Tribal Groups should contact their SPOC as early as possible to alert them to the prospective applications and receive any necessary instructions on the State process used under this Executive Order.

Letters from the State Single Point of Contact (SPOC) in response to Executive Order 12372 are due sixty days after the application due date.

5. Funding Restrictions

Applicants responding to this announcement may request funding for a project period of up to three (3) years, within a range of \$400,000 up to a ceiling of \$600,000 per year. Awards to

support projects beyond the first budget year will be contingent upon Congressional appropriation, satisfactory progress in meeting the project's objectives, and a determination that continued funding would be in the best interest of the Federal Government.

Funds under this announcement may not be used for the following purposes:

- 1) To directly provide health care or testing services that are billable to third party payers (e.g., private health insurance, prepaid health plans, Medicaid, Medicare, other Ryan White Program funding including ADAP);
- 2) To directly provide health care services that duplicate existing services;
- 3) Purchase, construction of new facilities or capital improvements to existing facilities;
- 4) Purchase or improvement to land;
- 5) Purchase vehicles;
- 6) Fundraising expenses;
- 7) Lobbying activities and expenses;
- 8) Reimbursement of pre-award costs;
- 9) International travel; and/or
- 10) Cash payments to intended service recipients, as opposed to various non-cash incentives to encourage participation in evaluation activities.

Funding under this announcement may not be used to supplant or supplement concurrent Ryan White activities or services already funded under any other Part grants. Funds awarded under this grant may not be used for direct services, including HIV care and counseling and testing, that are billable to third party payers.

Salary Limitation: The Consolidated Appropriations Act, 2012 (P.L. 112-74) enacted December 23, 2011, limits the salary amount that may be awarded and charged to HRSA grants and cooperative agreements. Award funds may not be used to pay the salary of an individual at a rate in excess of Executive Level II. The Executive Level II salary of the Federal Executive Pay scale is \$179,700. This amount reflects an individual's base salary exclusive of fringe and any income that an individual may be permitted to earn outside of the duties to the applicant organization. This salary limitation also applies to subawards/subcontracts under a HRSA grant or cooperative agreement.

Per Division F, Title V, Section 503 of the Consolidated Appropriations Act, 2012 (P.L. 112-74) enacted December 23, 2011 (a) No part of any appropriation contained in this Act or transferred pursuant to section 4002 of Public Law 111-148 shall be used, other than for normal and recognized executive-legislative relationships, for publicity or propaganda purposes, for the preparation, distribution, or use of any kit, pamphlet, booklet, publication, electronic communication, radio, television, or video presentation designed to support or defeat the enactment of legislation before the Congress or any State or local legislature or legislative body, except in presentation to the Congress or any State or local legislature itself, or designed to support or defeat any proposed or pending regulation, administrative action, or order issued by the executive branch of any State or local government, except in presentation to the executive branch of any State or local government itself. (b) No part of any appropriation contained in this Act or transferred pursuant to section 4002 of Public Law 111-148 shall be used to pay the salary or expenses of any grant or contract recipient, or agent acting for such recipient, related to any activity designed to influence the enactment of legislation, appropriations, regulation, administrative action, or Executive order proposed or pending before the Congress or any State

government, State legislature or local legislature or legislative body, other than for normal and recognized executive-legislative relationships or participation by an agency or officer of a State, local or tribal government in policymaking and administrative processes within the executive branch of that government. (c) The prohibitions in subsections (a) and (b) shall include any activity to advocate or promote any proposed, pending or future Federal, State or local tax increase, or any proposed, pending, or future requirement or restriction on any legal consumer product, including its sale or marketing, including but not limited to the advocacy or promotion of gun control.

Per Division F, Title V, Section 523 of the Consolidated Appropriations Act, 2012 (P.L. 112-74) enacted December 23, 2011, no funds appropriated in this Act shall be used to carry out any program of distributing sterile needles or syringes for the hypodermic injection of any illegal drug.

6. Other Submission Requirements

As stated in Section IV.1, except in very rare cases HRSA will no longer accept applications in paper form. Applicants submitting for this funding opportunity are **required** to submit **electronically** through Grants.gov. To submit an application electronically, please use the APPLY FOR GRANTS section at <http://www.grants.gov>. When using Grants.gov applicants will be able to download a copy of the application package, complete it off-line, and then upload and submit the application via the Grants.gov site.

It is essential that organizations **immediately register** in Grants.gov and become familiar with the Grants.gov site application process. Applicants that do not complete the registration process, you will be unable to submit an application. The registration process can take up to one month.

To be able to successfully register in Grants.gov, it is necessary that you complete all of the following required actions:

- Obtain an organizational Data Universal Numbering System (DUNS) number
- Register the organization with Central Contractor Registration (CCR)
- Identify the organization's E-Business Point of Contact (E-Biz POC)
- Confirm the organization's CCR "Marketing Partner ID Number (M-PIN)" password
- Register and approve an Authorized Organization Representative (AOR)
- Obtain a username and password from the Grants.gov Credential Provider

Instructions on how to register, tutorials and FAQs are available on the Grants.gov web site at <http://www.grants.gov>. Assistance is also available 24 hours a day, 7 days a week (excluding Federal holidays) from the Grants.gov help desk at support@grants.gov or by phone at 1-800-518-4726. Applicants should ensure that all passwords and registration are current well in advance of the deadline.

It is incumbent on applicants to ensure that the AOR is available to submit the application to HRSA by the published due date. HRSA will not accept submission or re-submission of incomplete, rejected, or otherwise delayed applications after the deadline. Therefore, an organization is urged to submit an application in advance of the deadline. If an application is rejected by Grants.gov due to errors, it must be corrected and resubmitted to Grants.gov before

the deadline date and time. Deadline extensions will not be provided to applicants who do not correct errors and resubmit before the posted deadline.

If, for any reason, an application is submitted more than once prior to the application due date, HRSA will only accept the applicant's last validated electronic submission prior to the Grants.gov application due date as the final and only acceptable application.

Tracking an application: It is incumbent on the applicant to track their application by using the Grants.gov tracking number (GRANTXXXXXXXX) provided in the confirmation email from Grants.gov. More information about tracking an application can be found at <https://apply07.grants.gov/apply/checkApplStatus.faces>. Be sure the application is validated by Grants.gov prior to the application deadline.

V. Application Review Information

1. Review Criteria

Procedures for assessing the technical merit of applications have been instituted to provide for an objective review of applications and to assist the applicant in understanding the standards against which each application will be judged. Critical indicators have been developed for each review criterion to assist the applicant in presenting pertinent information related to that criterion and to provide the reviewer with a standard for evaluation. Review criteria are outlined below with specific detail and scoring points.

Review Criteria are used to review and rank applications. The *Replication of a Public Health Information Exchange to Support Engagement in HIV Care Initiative* has 6 (six) review criteria:

Criterion 1: NEED (10 points)

The extent to which the application demonstrates the problem and associated contributing factors to the problem.

This corresponds to the Introduction and Needs Assessment sections of the Narrative.

i. Introduction

- Strength and clarity of the applicant's succinct description of the proposed Health Information Exchange (HIE) project.
- Strength and clarity of the applicant's brief description of the goals of the capacity building demonstration project and the summary of the proposed activities.
- Strength and clarity of the brief description of electronic network system, the proposed collaborating entities and the specific sites where the activities will be take place.

ii. Needs Assessment

- Strength and clarity of the applicant's description of the specific target population that will be served by the capacity building demonstration project.
- Extent to which the applicant cites the most recent, available HIV surveillance data for its state or territory in its description of the target population.

- Strength and clarity of the applicant’s description of the target population’s demographics and characteristics.
- Extent to which the applicant uses relevant sections where appropriate of the most recent Ryan White Part B application for Unmet Needs and the Early Identification of Individuals with HIV/AIDS (EIIHA) to describe the target population.
- Strength and clarity of the applicant’s description of the existing data system for the State’s HIV surveillance system.
- Strength of the applicant’s discussion of how existing limitations in data and data sharing that the project hopes to overcome impact the care of people living with HIV/AIDS in its State or territory.

Criterion 2: RESPONSE (35 points)

The extent to which the proposed project responds to the Purpose of the initiative as described earlier in this funding opportunity announcement. The strength of the proposed goals and objectives and their relationship to the identified project. The extent to which the activities (scientific or other) described in the application are capable of addressing the problem and attaining the project objectives.

This corresponds to the Methodology, Work Plan and Resolution of Challenges sections of the Narrative.

i. Methodology

- Strength and feasibility of the applicant’s plan to design, development and implement an HIE within its State or Territory.
- Evidence the applicant has the full commitment of the HIV surveillance unit to participate in the capacity building demonstration project.
- Evidence the applicant identifies at least three (3) HIV medical provider partner organizations (minimum of three) to collaborate in implementing the HIE project.
- Strength and clarity of applicant’s description of the existing EMR/EHR systems of it proposed collaborating medical provider organizations.
- Strength and clarity of the applicant’s discussion of the probable technological, administrative and funding-related challenges to project implementation
- Strength and feasibility of the applicant’s description of its proposed methods for pilot testing the various components of the HIE, and the rationale for their use.
- Strength of the applicant’s capacity and procedures used to protect patient privacy and electronic protected health information (PHI).
- Strength and clarity of the applicant’s discussion of how interconnectivity or interoperability issues between the State’s HIV surveillance unit and the participating provider sites those systems will be addressed.
- Strength and feasibility of the applicant’s plan to transform existing HIT infrastructure to an integrated, timely, and secure HIE that promotes the sharing of information.

ii. Work Plan

- Strength, clarity and feasibility of the applicant’s Work Plan and its goals objectives, action steps and responsible staff for the three-year project period (**Attachment 5**).
- Extent to which the applicant’s Work Plan follows the 3 phases described earlier in the announcement within a realistic timeline.

- Extent to which the applicant's Work Plan relates to the methods described in the Methodology section of the Project Narrative.
- Extent to which the applicant's time line includes action steps that are specific, time-framed, and measurable, and that identify the project staff responsible.
- Evidence the applicant clearly identifies the project's anticipated start date of the intervention, and provides numbers for targeted outcomes where applicable, not just percentages.

iii. Resolution of Challenges

- Extent to which the applicant identifies possible challenges that are likely to be encountered during the planning and implementation of the project described in the work plan.
- Extent to which the applicant identifies realistic and appropriate responses to be used to resolve those challenges.

Criterion 3: EVALUATIVE MEASURES (20 points)

The strength and effectiveness of the methods proposed to monitor and evaluate the project results. Evaluative measures must be able to assess the extent to which the program objectives have been met and the extent to which these can be attributed to the project.

This corresponds to the evaluation methodology described in the Methodology section of the Narrative.

- Strength and clarity of the applicant's evaluation plan for its HIE demonstration project.
- Strength and clarity of the applicant's methods for a process evaluation to document the implementation of the HIE system.
- Strength and clarity of the applicant's methods and their rationale for use in evaluating project outcomes with regard to the HIE's ability to identify people of color living with HIV/AIDS who currently are not in HIV primary care, link them to care, and retain them in care.
- Evidence the applicant includes, at a minimum, process and outcome measures that address the evaluative questions described earlier in the announcement in its evaluation plan.
- If applicable, evidence of the applicant stated intent to obtain all relevant institutional review board approval and annual renewals for client-level data subject to the Privacy Rule of HIPAA and human subjects research protections.
- Evidence the applicant's evaluation plan is informed by Institute of Medicine's report entitled *Monitoring HIV Care in the United States - Indicators and Data Systems*, and aligned with additional metrics if released by the Office of HIV/AIDS Policy (OHAP) of HHS.

Criterion 4: IMPACT (10 Points)

The feasibility and effectiveness of plans for dissemination of project results and whether the project results may be national in scope. The extent to which the project activities are replicable, and the sustainability of the program beyond the Federal Funding.

This corresponds to the Methodology and Work Plan sections of the Narrative.

- Strength and clarity of the Final Evaluation Report outline of the process and outcome measures.
- Evidence the applicant clearly expresses its commitment to participate in limited dissemination activities during Year 3 of the project, to include presentations of your HIE projects at national conferences and collaborative writing of journal article submissions for publication of the initiative's results.
- Evidence the applicant describes a means of sustaining the HIE project beyond the three-year project period of this initiative.

Criterion 5: RESOURCES/CAPABILITIES (15 Points)

The extent to which project personnel (including consultants and sub-contractors) are qualified by training and/or experience to implement and carry out the project. The capabilities of the applicant organization, including quality and availability of facilities and personnel to fulfill the needs and requirements of the proposed project.

This corresponds to the Evaluation Capacity and Organizational Information sections of the Narrative.

- Strength of the applicant's capacity to conduct a process and outcome evaluation of the proposed HIE project.
- Strength of the applicant's proposed methods for collection and analysis of process and outcome data, and its explanation of how these data may be used to improve HIV service delivery in its State or Territory.
- Strength of the applicant's capacity and ability to provide direction, HIT technological consultation, and capacity building assistance for the development and implementation of HIT projects and if applicable, HIEs and regional health information networks.
- Extent to which the proposed key project personnel (including any consultants and subcontractors) possess the necessary knowledge, experience, training and skills in designing and implementing HIT evaluations.
- Extent to which proposed key project personnel (including any consultants and subcontractors) have experience in writing and publishing study findings in peer reviewed journals and in disseminating findings to local communities, national conferences and to policy makers.
- The extent to which the applicant's applicant organization's current mission and structure, scope of current activities, and an organizational chart, and describe how these all contribute to the ability of the organization to conduct the demonstration project and meet the expectations of this initiative.
- Strength and clarity of the project organizational chart (**Attachment 6**).
- If applicable, clarity of description and appropriateness of the roles and responsibilities of consultants and/or subcontractors to be used to carry out aspects of the project.
- Strength and appropriateness of signed and dated Letters of Support and/or memoranda of Agreement or Understanding from the State or Territory's HIV surveillance unit and proposed collaborating medical provider organizations (**Attachment 7**).
- If applicable, evidence the proposed collaborating organizations state their willingness to obtain Institutional Review Board approval and annual renewals to collect and report client level data; and their willingness to submit these IRB approvals and renewals to HRSA/HAB staff (**Attachment 7**).

Criterion 6: SUPPORT REQUESTED (10 Points)

The reasonableness of the proposed budget for each year of the project period in relation to the objectives, the complexity of the research activities, and the anticipated results. The extent to which costs, as outlined in the budget and required resources sections, are reasonable given the scope of work. The extent to which key personnel have adequate time devoted to the project to achieve project objectives.

This corresponds to the Budget, Budget Justification, and Staffing Plan sections.

i. Budget and Budget Justification

- Strength of the applicant's line item budgets for each year of three-year project period (**Attachment 1**) and their appropriateness to the proposed work plan.
- Strength and clarity of the application's budget justification narrative's support for each line item.
- Evidence the line item budgets specify allocations for staffing in percentages of full-time equivalents (FTEs) that are adequate for the proposed activities for each year of the project.
- If applicable, the extent to which contracts for proposed subcontractors and consultants are clearly described in terms of contract purposes; how costs are derived; and that payment mechanisms and deliverables are reasonable and appropriate.

ii. Staffing Plan

- The extent to which the staffing plan is consistent with the project description and project activities (**Attachment 3**).
- Evidence the staffing plan includes sufficient personnel to successfully implement all of the project activities throughout the project as described in the work plan.
- Extent to which the time allocated for staff is consistent with their anticipated workload and the goals and objectives of the project.
- Evidence the staffing plan includes a qualified evaluator or evaluation staff at a minimum a 25 percent full-time equivalent (.25 FTE) level.
- Strength and appropriateness of the job descriptions for key staff (**Attachment 3**).
- Strength and appropriateness of the biographical sketches (**Attachment 4**)

2. Review and Selection Process

The Division of Independent Review is responsible for managing objective reviews within HRSA. Applications competing for Federal funds receive an objective and independent review performed by a committee of experts qualified by training and experience in particular fields or disciplines related to the program being reviewed. In selecting review committee members, other factors in addition to training and experience may be considered to improve the balance of the committee, e.g., geographic distribution. Each reviewer is screened to avoid conflicts of interest and is responsible for providing an objective, unbiased evaluation based on the review criteria noted above. The committee provides expert advice on the merits of each application to program officials responsible for final selections for award.

Applications that pass the initial HRSA eligibility screening will be reviewed and rated by a panel based on the program elements and review criteria presented in Section V. 1. Review Criteria of this funding opportunity announcement. The review criteria are designed to enable

the review panel to assess the quality of a proposed project and determine the likelihood of its success. The criteria are closely related to each other and are considered as a whole in judging the overall quality of an application.

3. Anticipated Announcement and Award Dates

It is anticipated that awards will be announced prior to the start date of September 30, 2012.

VI. Award Administration Information

1. Award Notices

Each applicant will receive written notification of the outcome of the objective review process, including a summary of the expert committee's assessment of the application's strengths and weaknesses, and whether the application was selected for funding. Applicants who are selected for funding may be required to respond in a satisfactory manner to Conditions placed on their application before funding can proceed. Letters of notification do not provide authorization to begin performance.

The Notice of Award (NoA) sets forth the amount of funds granted, the terms and conditions of the award, the effective date of the award, the budget period for which initial support will be given, the non-Federal share to be provided (if applicable), and the total project period for which support is contemplated. Signed by the Grants Management Officer, it is sent to the applicant's Authorized Organization Representative, and reflects the only authorizing document. It will be sent prior to the start date of September 30, 2012.

2. Administrative and National Policy Requirements

Successful applicants must comply with the administrative requirements outlined in 45 CFR Part 74 [Uniform Administrative Requirements for Awards and Subawards to Institutions of Higher Education, Hospitals, Other Nonprofit Organizations, and Commercial Organizations](#) or 45 CFR Part 92 [Uniform Administrative Requirements For Grants And Cooperative Agreements to State, Local, and Tribal Governments](#), as appropriate.

HRSA grant and cooperative agreement awards are subject to the requirements of the HHS Grants Policy Statement (HHS GPS) that are applicable based on recipient type and purpose of award. This includes, as applicable, any requirements in Parts I and II of the HHS GPS that apply to the award. The HHS GPS is available at <http://www.hrsa.gov/grants/hhsgrantspolicy.pdf>. The general terms and conditions in the HHS GPS will apply as indicated unless there are statutory, regulatory, or award-specific requirements to the contrary (as specified in the NoA).

Human Subjects Protection

Federal regulations (45 CFR 46) require that applications and proposals involving human subjects must be evaluated with reference to the risks to the subjects, the adequacy of protection against these risks, the potential benefits of the research to the subjects and others, and the importance of the knowledge gained or to be gained. If research involving human subjects is anticipated, you must meet the requirements of the HHS regulations to protect human

subjects from research risks as specified in the Code of Federal Regulations, Title 45 – Public Welfare, Part 46 – Protection of Human Subjects (45 CFR 46), available online at www.hhs.gov/ohrp/humansubjects/guidance/45cfr46.html.

Trafficking in Persons

Awards issued under this funding opportunity announcement are subject to the requirements of Section 106(g) of the Trafficking Victims Protection Act of 2000, as amended (22 U.S.C. 7104). For the full text of the award term, go to <http://www.hrsa.gov/grants/trafficking.html>.

Smoke-Free Workplace

The Public Health Service strongly encourages all award recipients to provide a smoke-free workplace and to promote the non-use of all tobacco products. Further, Public Law 103-227, the Pro-Children Act of 1994, prohibits smoking in certain facilities (or in some cases, any portion of a facility) in which regular or routine education, library, day care, health care or early childhood development services are provided to children.

Cultural and Linguistic Competence

HRSA programs serve culturally and linguistically diverse communities and multiple cultures. Although race and ethnicity are often thought to be dominant elements of culture, HRSA-funded programs embrace a broader definition to incorporate diversity within specific cultural groups including, but not limited to cultural uniqueness within Native American populations, Native Hawaiian, Pacific Islanders, and other ethnic groups, language, gender, socio-economic status, sexual orientation and gender identity, physical and mental capacity, age, religion, housing status, and regional differences. Organizational behaviors, practices, attitudes, and policies across all HRSA-supported entities respect and respond to the cultural diversity of communities, clients and students served. HRSA is committed to ensuring access to quality health care for all. Quality care means 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. Quality also means that, where appropriate, data collection instruments used should adhere to culturally competent and linguistically appropriate norms. For additional information and guidance, refer to the National Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS) published by HHS and available online at <http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=15>. Additional cultural competency and health literacy tools, resources and definitions are available online at <http://www.hrsa.gov/culturalcompetence> and <http://www.hrsa.gov/healthliteracy>.

Healthy People 2020

Healthy People 2020 is a national initiative led by HHS that sets priorities for all HRSA programs. The initiative has four overarching goals: (1) attain high-quality, longer lives free of preventable disease, disability, injury, and premature death; (2) achieve health equity, eliminate disparities, and improve the health of all groups; (3) create social and physical environments that promote good health for all; and (4) promote quality of life, healthy development, and healthy behaviors across all life stages. The program consists of over 40 topic areas, containing measurable objectives. HRSA has actively participated in the work groups of all the topic areas and is committed to the achievement of the Healthy People 2020 goals. More information about Healthy People 2020 may be found online at <http://www.healthypeople.gov/>.

National HIV/AIDS Strategy (NHAS)

The National HIV/AIDS Strategy (NHAS) has three primary goals: (1) reducing the number of

people who become infected with HIV; (2) increasing access to care and optimizing health outcomes for people living with HIV; and (3) reducing HIV-related health disparities. The NHAS states that more must be done to ensure that new prevention methods are identified and that prevention resources are more strategically deployed. Further, the NHAS recognizes the importance of early entrance into care for people living with HIV to protect their health and reduce their potential of transmitting the virus to others. HIV disproportionately affects people who have less access to prevention, care and treatment services and, as a result, often have poorer health outcomes. Therefore, the NHAS advocates adopting community-level approaches to identify people who are HIV-positive but do not know their serostatus and reduce stigma and discrimination against people living with HIV.

To the extent possible, program activities should strive to support the three primary goals of the NHAS. As encouraged by the NHAS, programs should seek opportunities to increase collaboration, efficiency, and innovation in the development of program activities to ensure success of the NHAS. Programs providing direct services should comply with federally-approved guidelines for HIV Prevention and Treatment (see <http://www.aidsinfo.nih.gov/Guidelines/Default.aspx> as a reliable source for current guidelines). More information can also be found at <http://www.whitehouse.gov/administration/eop/onap/nhas>.

Health IT

Health information technology (Health IT) provides the basis for improving the overall quality, safety and efficiency of the health delivery system. HRSA endorses the widespread and consistent use of health IT, which is the most promising tool for making health care services more accessible, efficient and cost effective for all Americans.

Related Health IT Resources:

- [Health Information Technology \(HHS\)](#)
- [What is Health Care Quality and Who Decides? \(AHRQ\)](#)

3. Reporting

The successful applicant under this funding opportunity announcement must comply with the following reporting and review activities:

a. Audit Requirements

Comply with audit requirements of Office of Management and Budget (OMB) Circular A-133. Information on the scope, frequency, and other aspects of the audits can be found on the Internet at http://www.whitehouse.gov/omb/circulars_default.

b. Payment Management Requirements

Submit a quarterly electronic Federal Financial Report (FFR) Cash Transaction Report via the Payment Management System. The report identifies cash expenditures against the authorized funds for the grant or cooperative agreement. The FFR Cash Transaction Reports must be filed within 30 days of the end of each calendar quarter. Failure to submit the report may result in the inability to access award funds. Go to <http://www.dpm.psc.gov> for additional information.

c. Status Reports

1) **Federal Financial Report.** The Federal Financial Report (SF-425) is required according to the following schedule:
<http://www.hrsa.gov/grants/manage/technicalassistance/federalfinancialreport/ffrschedule.pdf>. The report is an accounting of expenditures under the project that year. Financial reports must be submitted electronically through EHB. More specific information will be included in the NoA.

2) **Progress Report(s).** The awardee must submit a progress report to HRSA on a semi-annual basis. Submission and HRSA approval of your Progress Report(s) triggers the budget period renewal and release of subsequent year funds. This report has two parts. The first part demonstrates grantee progress on program-specific goals. The second part collects core performance measurement data including performance measurement data to measure the progress and impact of the project. Further information will be provided in the NoA.

3) **Final Report.** A final report is due within 90 days after the project period ends. The final report collects program-specific goals and progress on strategies; core performance measurement data; impact of the overall project; the degree to which the grantee achieved the mission, goal and strategies outlined in the program; grantee objectives and accomplishments; barriers encountered; and responses to summary questions regarding the grantee's overall experiences over the entire project period. The final report must be submitted on-line by awardees in the Electronic Handbooks system at <https://grants.hrsa.gov/webexternal/home.asp>.

d. Transparency Act Reporting Requirements

New awards issued under this funding opportunity announcement are subject to the reporting requirements of the Federal Funding Accountability and Transparency Act (FFATA) of 2006 (Pub. L. 109–282), as amended by section 6202 of Public Law 110–252, and implemented by 2 CFR Part 170. Grant and cooperative agreement recipients must report information for each first-tier subaward of \$25,000 or more in Federal funds and executive total compensation for the recipient's and subrecipient's five most highly compensated executives as outlined in Appendix A to 2 CFR Part 170 (FFATA details are available online at <http://www.hrsa.gov/grants/ffata.html>). Competing continuation awardees, etc. may be subject to this requirement and will be so notified in the Notice of Award.

VII. Agency Contacts

Applicants may obtain additional information regarding business, administrative, or fiscal issues related to this funding opportunity announcement by contacting:

Tricia Johnson, Grants Management Specialist
Attn: HRSA-12-179, Replication of a Public Health Information Exchange to Support
Engagement in HIV Care Initiative
HRSA Division of Grants Management Operations, OFAM
Parklawn Building, Room 12A-07
5600 Fishers Lane
Rockville, MD 20857
Telephone: (301) 594-4253

Fax: (301) 443-9810
Email: TJohnson@hrsa.gov

Additional information related to the overall program issues and/or technical assistance regarding this funding announcement may be obtained by contacting:

Melinda J. Tinsley
Public Health Analyst, Demonstration and Evaluation Branch
Attn: HRSA-12-179, Replication of a Public Health Information Exchange to Support Engagement in HIV Care Initiative Bureau, HRSA
Parklawn Building, Room 7C-07
5600 Fishers Lane
Rockville, MD 20857
Telephone: (301) 443-3496
Fax: (301) 594-2511
Email: mtinsley1@hrsa.gov

Applicants may need assistance when working online to submit their application forms electronically. Applicants should always obtain a case number when calling for support. For assistance with submitting the application in Grants.gov, contact Grants.gov 24 hours a day, seven days a week, excluding Federal holidays at:

Grants.gov Contact Center
Telephone: 1-800-518-4726
E-mail: support@grants.gov
iPortal: <http://grants.gov/iportal>

VIII. Tips for Writing a Strong Application

A concise resource offering tips for writing proposals for HHS grants and cooperative agreements can be accessed online at:
<http://www.hhs.gov/asrt/og/grantinformation/apptips.html>.