Ohio | Department of Health

Mike DeWine, Governor
Jon Husted, Lt.Governor

Bruce Vanderhoff, MD, MBA, Director

MEMORANDUM

Date: [February 17, 2022]

To: Subrecipient agencies

From: Kristen Dickerson, PhD, MSN, MPH, RN, MLT (ASCP)
State Epidemiologist and Chief, Bureau of Infectious Diseases
Ohio Department of Health

Subject: IMPLEMENTING ENHANCED HIV PREVENTION AND SURVEILLANCE FOR HEALTH DEPARTMENTS TO END THE HIV EPIDEMIC IN OHIO (EE22) (August 1, 2022 – July 31, 2023)

The Ohio Department of Health (ODH), [Bureau of Infectious Diseases] announces the availability of grant funds.

All electronic applications and attachments are due by 4:00 p.m., **Monday, April 4, 2022.** Applications received after the due date will not be considered for funding. Faxed, hand-delivered or mailed applications will not be accepted.

Electronic application components must be submitted via the on-line Grants Management Information System (GMIS). For new staff requiring GMIS access, you must successfully complete GMIS training offered by ODH.

Any award made through this program is contingent upon the availability of funds for this purpose. The subrecipient agency must be prepared to support the costs of operating the program until receipt of grant payments.

Submission of the **continuation application** constitutes acknowledgment and acceptance of ODH Grants Administration Policies and Procedures (OGAPP) Manual rules, policy and procedure updates posted on the GMIS Bulletin Board, and any other program-specific requirements as outlined in the competitive Solicitation. Reference the competitive Solicitation for more information. The competitive Solicitation for this grant program can be found on the ODH website [(https://odh.ohio.gov/wps/portal/gov/odh/about-us/funding-opportunities/resources/ee-21-implementing-enhance-hiv-p-and-s-for-health-departments)]. Allotments will be established in GMIS by ODH. Please refer to the GMIS bulletin board for current allotment percentage.

If you have questions, please contact Angela Street at 614-644-1852 or e-mail at Angela.Street@odh.ohio.gov.

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I. CONTINUATION FUNDING APPLICATION GUIDANCE

__X__ Base Only Funding_____Base and Deliverable Funding

A. Policy and Procedures: The Continuation Funding Application consists of three parts: Program Updates (if applicable), Program Budget and Budget Narrative, and Other Required Attachments.

Submission of the continuation application constitutes acknowledgment and acceptance of ODH GAPP (OGAPP) manual rules and any other program-specific requirements as outlined in the competitive Solicitation. This Solicitation pertains to budget period: [enter beginning and ending grant dates] of the total project period, [enter beginning and ending grant dates.] Reference the competitive Solicitation for more information.

All budget justifications must include the following language and be signed by the agency head listed in GMIS. Please refer to the budget justification examples listed on the GMIS bulletin board.

- Subrecipient understands and agrees that it must follow the federal cost principle that applies to its type of organization (2 CFR, Part 225; 2 CFR, Part 220; or, 2 CFR, Part 230).
- Subrecipient's budgeted costs are reasonable, allowable and allocable under OGAPP and federal rules and regulations.
- The OGAPP and the rules and regulations have been read and are understood.
- Subrecipient understands and agrees that costs may be disallowed if deemed unallowable or in violation of OGAPP and federal rules and regulations.
- The appropriate programmatic and administrative personnel involved in this application are aware of agency policy in regard to subawards and are prepared to establish the necessary inter-institutional agreements consistent with those policies.
- Subrecipient agrees and understands that costs incurred in the fulfillment of the Deliverables must be allowable under OGAPP and federal rules and regulations to qualify for reimbursement.

B. Number of Grants and Funds Available: Implementing Enhanced HIV Prevention and Surveillance for Health Departments to End the HIV Epidemic in Ohio (EE) is supported by federal funding from the Centers for Disease Control and Prevention (CDC) RFA-PS20-2010: Integrated HIV Programs for Health Departments to Support Ending the HIV Epidemic in the United States. One (1) grant will be awarded to each of the three EHE counties in Ohio – Cuyahoga County, Franklin County and Hamilton County. The funding amount for each EHE county's grant will be up to $1,100,000 to perform activities throughout the county.

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

C. Formatting Requirements for Attachments:

- Properly label each item of the application packet (ex. budget narrative, program narrative).
- Each section should use 1.5 spacing with one-inch margins.
- Program and budget narratives must be submitted in portrait orientation and fit on 8 ½ x 11 paperwhen printed.
- Number all pages (print on one side only). Place agency name and GMIS number on each page.
- Use a 12 -point font.
- Forms must be completed and submitted in the format provided by ODH.

D. Qualified Applicants:

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

1. Applicant does not owe funds in excess of $1,000 to the ODH.
2. Applicant has not been certified to the Attorney General's (AG's) office.
3. Applicant has submitted application and all required attachments by **4:00 p.m. on Monday, April 4, 2022.**

Only the currently funded *3 CDC identified Ohio EHE counties: Cuyahoga, Franklin, and Hamilton* agencies below are qualified to apply for the EE continuation funding in 2022.

Agency	Total $
Columbus City Health Department	$1,200,000.00
Cuyahoga County Health Department	$1,200,000.00
Hamilton County Public Health	$1,200,000.00
Total:	$3,600,000.00

II. PROGRAM UPDATES:

Program should review the Evidence of Health Equity Strategies Checklist in Appendix C when drafting the program narrative, objectives, and workplan.

A. Program Progress Report: 1) Attach the program progress report for the current grant period. If the program progress report is not scheduled to be submitted before the application due date, thenit must be submitted with the application. Not required

B. Program Narrative: Complete and submit a narrative statement (do not exceed [10] pages) which explains any changes to program scope, personnel, partnerships with agencies or organizations, or other information the subrecipient wishes to share for continuation funding. Summarize the agency's structure as it relates to this program and, as the lead agency, how it will manage the program. Briefly describe any substantial changes to your End the HIV Epidemic program for the four required pillars: 1) Diagnose all people with HIV as early as possible; 2) Treat people with HIV rapidly and effectively to reach sustained viral suppression; 3) Prevent new HIV transmissions by using proven interventions, including pre-exposure prophylaxis (PrEP) and syringe services programs (SSPs); 4) Respond quickly to potential HIV outbreaks to get needed prevention and treatment services to people who need them; during the reporting period. Where applicable, please describe the changes made and specify the specific component.

Describe the capacity of your organization, its personnel or contractors to communicate effectively and convey information in a manner that is easily understood by diverse audiences. This includes persons of limited English

proficiency, those who are not literate, have low literacy skills, and individuals with disabilities.

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

C. **Objectives and Work Plan:** Complete and submit a short summary of any changes in the Specific, Measurable, Achievable, Results-Oriented, and Time-Based (SMART) objectives and submit an updated work plan. Reference the competitive Solicitation for information. This should be based on a review of the Progress Plans submitted to date. Provide a brief report addressing elements of each objective and activity, including current status (met, ongoing or unmet); major findings; and barriers and how barriers were addressed. Workplan key objectives and format can be found in Appendix B of this solicitation.

D. **Documentation and Progress on Health Equity and Disparity Reduction Activities:**
Please provide detailed updates on the goals, objectives and deliverables specified in the Competitive Solicitation relating to health equity. This information must be supported by data. Continuation Solicitations should prepare a summary of activities completed, during the previous funding period, to outreach to the priority populations and/or neighborhoods specified in their plan.

E. **Program Budget:** Prior to completion of the budget section, reference the competitive Solicitation for unallowable costs and review criteria.

1. **Budget Narrative:** Provide a detailed budget justification in a narrative that describes how categorical costs are derived. Discuss the necessity, reasonableness, and allocation of the proposed costs. Describe the specific functions of the personnel, consultants and collaborators. Explain and justify equipment, travel, (including plans for out-of-state travel), supplies and training costs. If you have shared costs, refer to OGAPP Chapter 2 Section C2.4 Cost Allocation Plan for additional information. Please refer to the GMIS 2.0 bulletin board for attachment instructions.

For your convenience, a budget justification narrative example is available via the GMIS Bulletin Board.

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

2. **2022 Budget via GMIS:** Complete requested budget information as follows:

- **Personnel, Other Direct Costs, Equipment and Contracts Sections:** Submit a new budget to support costs for the period Date to Date. Funds may be used to support personnel, staff training, travel (see OBM website https://obm.ohio.gov/wps/portal/gov/obm/areas-of-interest/agency-overview/obm-travel-rule/obm-travel-rule, and supplies directly related to planning, organizing and conducting the program activity. Itemize, in the Equipment Section, all equipment (minimum $1,000 unit cost value) to be purchased with grant funds

The applicant shall retain all original fully executed contracts on file. A completed "Confirmation of Contractual Agreement" (CCA) must be submitted via GMIS for each contract once it has been signed by both parties. All contracts must be signed and dated by all parties prior to any services being rendered and must be attached

to the CCA section in GMIS. The submitted CCA and attached contract must be approved by ODH before contractual expenditures are authorized. CCAs and attached contracts cannot be submitted until the first quarter grant payment has been issued.

- **Compliance:** Answer each question on this form. Completion of the form ensures your agency's compliance with the administrative standards of ODH and federal grants.

3. Unallowable Costs: Funds **may not** be used for the following:

1. To advance political or religious points of view or for fund raising or lobbying;
2. To disseminate factually incorrect or deceitful information;
3. Consulting fees for salaried program personnel to perform activities related to grant objectives;
4. Bad debts of any kind;
5. Contributions to a contingency fund;
6. Entertainment;
7. Fines and penalties;
8. Membership fees — unless related to the program and approved by ODH;
9. Interest or other financial payments (including but not limited to bank fees);
10. Contributions made by program personnel;
11. Costs to rent equipment or space owned by the funded agency;
12. Inpatient services;
13. The purchase or improvement of land; the purchase, construction, or permanent improvement of any building;
14. Satisfying any requirement for the expenditure of non-federal funds as a condition for the receipt of federal funds;
15. Travel and meals over the current state rates (see OBM website: http://obm.ohio.gov/TravelRule/default.aspx for the most recent Mileage Reimbursement memo.)
16. Costs related to out-of-state travel, unless otherwise approved by ODH, and described in the budget narrative;
17. Training longer than one week in duration, unless otherwise approved by ODH;
18. Contracts for compensation with advisory board members;
19. Grant-related equipment costs greater than $1,000, unless justified in the budget narrative and approved by ODH;
20. Payments to any person for influencing or attempting to influence members of Congress or the Ohio General Assembly in connection with awarding of grants;
21. Promotional Items;
22. Office Furniture (including but not limited to desks, chairs, file cabinets) unless otherwise stated;

Subrecipients will not receive payment from ODH grant funds used for prohibited purposes. ODH has the right to recover funds paid to subrecipients for purposes later discovered to be prohibited. Please refer to the OGAPP manual for additional information.

4. **Indirect (Facilities and Administration):**
   Use the indirect cost rate included in the agency's Indirect Cost Rate Agreement as negotiated with and approved by the cognizant federal funder. If the applicant chooses this option, then the agreement must be submitted in GMIS as an attachment to the application.

   If the subrecipient has not executed a federally approved Indirect Cost Rate Agreement, the subrecipient may elect to charge a de minimis rate of 10% of modified total direct costs (MTDC) which may be used indefinitely.

   Base the budget solely upon direct costs.

   For further information please see Chapter 2 Section B2.11 of OGAPP.

F. Other Application Requirements:

Program Specific Attachments: Complete and submit the following attachments: Local End the HIV Epidemic Work Plan

a. Other Required Documentation:

- Subrecipients are required to maintain their current supplier information in the State of Ohio Supplier Portal. This information includes, but is not limited to, Electronic Funds Transfer (EFT), 1099 Form and current address.

  This information is maintained on the following website: http://supplier.ohio.gov/.

  Note: Subrecipients future payments will be held if the agency receives a paper check due to the EFT information not being properly maintained in the supplier portal.

- **Audit:** Subrecipient agencies are responsible for submitting an audit report. Once an audit is completed, a copy must be sent to ODH via audits@odh.ohio.gov. Reference the GMIS Bulletin Board for more information.

- **Civil Rights Review Questionnaire — EEO Survey:** The Civil Rights Review Questionnaire (EEO) Survey is a part of the Application Section of GMIS. Subrecipients must complete the questionnaireas part of the application process. This questionnaire is submitted automatically with eachapplication via the Internet.

- **Assurances Certification:** Each subrecipient must acknowledge the Assurances (Federal and StateAssurances for Sub-grantees) form in GMIS. The Assurances Certification sets forth standards of financial conduct relevant to receipt of grant funds and is provided for informational purposes. The listing is not all-inclusive and any omission of other statutes does not mean such statutes arenot assimilated under this certification. Review the form and then press the "Complete" button. By submission of an application, the subrecipient agency agrees by electronic acknowledgment tothe financial standards of conduct as stated therein.

- **Federal Funding Accountability and Transparency Act (FFATA):** All applicants applying for ODH grant funds are required to complete the FFATA reporting form in GMIS. Applicants must ensurethat the information contained in SAM.gov, DUN & Bradstreet and the FFATA reporting form match. ODH will hold all payments if an applicant's information does not successfully upload intothe federal system.

All applicants for ODH grants are required to obtain a Data Universal Number System (DUNS), register in SAM.gov and submit the information in the grant application. For information about the DUNS, go to www.dnb.com. For information about System for Award Management (SAM) go to https://beta.sam.gov/.

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

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

- **For Non-Profit Organizations Only:**

1. **Liability Coverage:** Liability coverage is required for all non-profit agencies. Non-profit organizations must submit documentation validating current liability coverage. Attach the current Certificate of Insurance Liability in GMIS.

2. **Non-Profit Organization Status:** Non-profit organizations must submit documentation validating current status. If changed, attach in GMIS the Internal Revenue Services (IRS) letterapproving non-tax exempt status.

G. Human Trafficking:

The ODH is committed to the elimination of human trafficking in Ohio. If applicable to the subrecipientprogram, ODH will give priority consideration to those subrecipients who can demonstrate the following:

a. Victims of human trafficking are included in your agency's target population;
   1. At-risk population
   2. Mental health population
   3. Homeless population

b. Agency promotes the expansion of services to identify and serve those affected by human trafficking.

X Applicable __Not Applicable to End the HIV Epidemic

H. Post Submission Requirements: Continuation applicants are required to submit subrecipient programand expenditure reports.

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

Reports shall be submitted as follows:

a. Program Reports: Subrecipient Program Reports must be completed and submitted via GMIS bythe following dates. [Additional language is optional.] **Program reports that do not include requiredattachments (non-Internet submitted) will not be approved.** All program report attachments must clearly identify the authorized program name and grant number.

_X_ Program Reports Required _____ No Program Reports Required

Report	*Report Due Date*
Interim Progress Report (August 1, 2022-Feburary 28, 2023)	March 31, 2023
Annual Progress Report (August 1, 2022-July 31, 2023)	August 31, 2023

b. Subrecipient Reimbursement Expenditure Reports: Subrecipient Monthly Expenditure Reports **must** be completed and submitted **via GMIS** by the following dates:

[Period	Report Due Date
July 1 – 31, 2022	August 10, 2022
August 1 – 31, 2022	September 10, 2022
September 1 – 30, 2022	October 10, 2022
October 1 – 31, 2022	November 10, 2022
November 1 – 30, 2022	December 10, 2022
December 1 – 31, 2022	January 10, 2023
January 1 – 31, 2023	February 10, 2023
February 1 – 28, 2023	March 10, 2023
March 1 – 31, 2023	April 10, 2023
April 1 – 30, 2023	May 10, 2023
May 1 – 31, 2023	June 10, 2023
June 1 – 30, 2023	July 10, 2023

Subrecipient Quarterly Reimbursement Expenditure Reports **must** be completed and submitted **viaGMIS** by the following dates:

Period	Report Due Date
July 1 – September 30, 2022	October 10, 2022
October 1 – December 31, 2022	January 10, 2023
January 1 – March 31, 2023	April 10, 2023
April 1 – June 30, 2023	July 10, 2023

Note: Obligations not reported on the final monthly or 4th quarter expenditure report will not be considered for payment with the final expenditure report.

c. **Final Expenditure Reports:** A Subrecipient Final Expenditure Report reflecting total expenditures for the fiscal year must be completed and submitted **via GMIS** by 4:00 p.m. on or before **September 5, 2023**. The information contained in this report must reflect the program's accounting records and supportive documentation. Any cash balances mustbe returned with the Subrecipient Final Expense Report. The Subrecipient Final Expense Report serves as an invoice to return unused funds.

Submission of ALL Subrecipient Program and Expenditure Reports via the ODH's GMIS system indicates acceptance of OGAPP. Clicking the "Submit" or "Approve" button signifies your authorization of thesubmission as an agency official and constitutes your electronic acknowledgment and acceptance ofOGAPP rules and regulations.

III APPENDICES

A. Continuation Solicitation ReimbursementType Form
B. Local End the HIV Epidemic Work Plan
C. Evidence of Health Equity Strategies Checklist

Appendix A

CONTINUATION SOLICITATION
REIMBURSEMENT TYPE FORM

Ohio Department of Health Bureau
of Infectious Diseases

ODH ProgramTitle:
Ending the HIV Epidemic (EE22)

Reimbursement Type (check one) Monthly ☐ **OR** Quarterly ☐
(Please note that no changes to the reimbursement type can be made after the project number is createdin GMIS. No waivers/appeals will be accepted.)

Please print:
Current Project Number _____

Applicant Agency/Organization _____

Applicant Agency Address _____

_____

Agency Contact Person Name andTitle _____

Telephone Number _____

E-mail Address _____

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

Please note that the agency head listed above must match the agency head listed in GMIS. Unless a new agency, NOIAF's willnot be accepted if name doesn't match what is listed in GMIS.

Due to ODH by 3/4/2022
Please email completed form to KarenTinsley (karen.tinsley@odh.ohio.gov).

PS20-2010 Local End the HIV Epidemic Workplan

Instructions: Develop at least two activities based on CDC-established **Sub-strategies** and enter them in the **Local Activities** box. Please note some Sub-strategies have pre-defined local activities that must be performed, while others are blank and sub-recipients should develop their own activities. Local activities should align with End the HIV Epidemic (EHE) Plans. Sub-recipients may develop additional activities for sub-strategies with pre-defined local activities, but this is not required. However, there must be a minimum of 2 activities listed in each Local Activities box.

Enter local staff person or role responsible for activity in Person Responsible box. Use Interim Progress box to report progress made for Interim Progress Report (IPR). Use Annual Progress box to report progress made for Annual Progress Report (APR).

Strategy 1: Diagnose all people with HIV as early as possible

Strategy 1A: Expand or implement routine opt-out HIV screening in healthcare and other institutional settings located in high prevalence communities

Sub-strategies	Local Activities	Person Responsible	Target Date	Interim Progress (report in IPR)	Annual Progress (report in APR)
1.A1: Identify and select healthcare facilities using criteria developed during the local planning process, such as geographic location and populations served, that have not already implemented routine HIV screening, and automate HIV test orders for eligible patients at key healthcare encounters (e.g., emergency department visits, annual physical exams).	1. 2.				
1.A2: Promote routine opt-out screening as part of medical intake evaluation in jails, particularly in large jails located in high prevalence communities, as well as in prison systems if HIV testing is not yet routinely performed, in accordance with state and local policy.	1. 2.				
1.A3: Identify "champions" or key staff (e.g., nurses/other medical staff performing intake medical examinations) to lead activities to routinize HIV screening at intake.	1. 2.				
1.A4: Modify the electronic medical records to routinize the offer of screening and screen all patients (at least once) for HIV regardless of risk.	1. 2.				
1.A5: Establish mechanisms for rapid linkage to HIV medical care and prevention (i.e., PrEP and SSP) services for persons screened for HIV in all healthcare settings.	1. 2.				

1.A6: Rapid linkage to care for persons newly diagnosed with HIV is defined as, ensuring rapid linkage to care and starting antiretroviral therapy, within 7 days.	1. 2.				

Strategy 1B: Develop locally tailored HIV testing programs to reach persons in non-healthcare settings

Sub-strategies	Local Activities	Person Responsible	Target Date	Interim Progress (report in IPR)	Annual Progress (report in APR)
1.B1: Normalize HIV testing in non-traditional settings (e.g., pharmacies and retail venues) by advertising broadly and providing residents multiple options to receive HIV tests in venues that do not traditionally promote tests.	1. 2.				
1.B2: Promote rapid HIV self-test distribution programs, mobile testing units, and technology-based partner services and social network recruiting strategies.	1. 2.				
1.B3: Implement testing at health fairs or pop-up testing events where appropriate (including in rural and resource scarce environments), whereby HIV testing is offered as a service bundled with screening for other conditions relevant to the local population (e.g., STD testing, HBV and HCV testing, blood pressure screening, BMI assessment) in order to reduce stigma and normalize HIV testing.	1. 2.				
1.B4: Incorporate strategies to rapidly link persons to HIV medical care and prevention (i.e., PrEP and SSP) in all non-traditional settings.	1. 2.				
1.B5: Collaborate with laboratories to determine appropriate tests and improve the quality of testing in non-healthcare settings.	1. 2.				

Strategy 1C: Increase at least yearly re-screening of persons at elevated risk for HIV per CDC testing guidelines, in healthcare and non-healthcare settings

Sub-strategies	Local Activities	Person Responsible	Target Date	Interim Progress (report in IPR)	Annual Progress (report in APR)
1.C1: Establish systems whereby patients with elevated risk are routinely identified and HIV tests are ordered at least yearly.	1. 2.				

	1.C2: Identify "champions" (e.g., physicians, nurses, etc.) who can lead all activities in healthcare settings needed to routinize identification of persons at ongoing risk for HIV and conduct at least annual HIV screening for this population.	1. 2.				
	1.C3: Modify the electronic medical records (EMR) to routinize the offer of annual screening for those at ongoing risk for HIV.	1. 2.				
	1.C4: Promote rapid HIV self-test programs in both healthcare and non-healthcare settings that can offer HIV rapid self-tests to persons at ongoing risk.	1. 2.				
	1.C5: Implement novel approaches to make HIV tests widely available in non-healthcare settings where marginalized populations, including people experiencing homelessness and/or those injecting drugs congregate (e.g., homeless shelters, mobile clinics and laboratories, and SSPs).	1. 2.				

PS20-2010 Local End the HIV Epidemic Workplan

Instructions: Develop at least two activities based on CDC-established **Sub-strategies** and enter them in the **Local Activities** box. Please note some Sub-strategies have pre-defined local activities that must be performed, while others are blank and sub-recipients should develop their own activities. Local activities should align with End the HIV Epidemic (EHE) Plans. Sub-recipients may develop additional activities for sub-strategies with pre-defined local activities, but this is not required. However, there must be a minimum of 2 activities listed in each Local Activities box.
Enter local staff person or role responsible for activity in Person Responsible box. Use Interim Progress box to report progress made for Interim Progress Report (IPR). Use Annual Progress box to report progress made for Annual Progress Report (APR).

Strategy 2: Treat people with HIV rapidly and effectively to reach viral suppression

Strategy 2A: Ensure rapid linkage to HIV medical care and antiretroviral therapy (ART) initiation for all persons with newly diagnosed HIV

Sub-strategies	Local Activities	Person Responsible	Target Date	Interim Progress (report in IPR)	Annual Progress (report in APR)
2.A1: Report all new HIV diagnoses to health departments, as rapidly as possible, in accordance with state and local policy by establishing or expanding secure electronic methods or on-call hotline.	1. 2.				
2.A2: Develop a robust network (supported by interagency/facility agreements) for rapid linkage (within 7 days) to clinical care and essential support services.	1. 2.				
2.A3: Conduct a rapid needs assessment (i.e., housing, transportation etc.) for all persons with new HIV diagnoses and link to a disease intervention specialist and/or case manager, as needed.	1. 2.				
2.A4: Develop programs to support and promote rapid linkage (within 7 days) and early ART initiation by HIV medical care and treatment providers in non-Ryan White HIV/AIDS Program facilities.	1. 2.				

Strategy 2B: Support re-engagement and retention in HIV medical care and treatment adherence, especially for persons who are not recipients of Ryan White HIV/AIDS Programs

Sub-strategies	Local Activities	Person Responsible	Target Date	Interim Progress (report in IPR)	Annual Progress (report in APR)

2.B1: Develop, expand and scale up Data to Care (D2C) to identify patients not in care and develop re-engagement strategies.	1. Create and/or refine local D2C protocol. 2. Build staffing capacity to focus on D2C follow-up activities (e.g., additional DIS/LTC staff who focus on D2C). 3. Identify person responsible for coordination, monitoring and oversight of D2C activities, including ensuring secure sharing of Not-in-Care (NIC) lists with local public health staff, health care providers/health care facilities and community-based organizations; ensuring completion and quality of documentation of D2C investigations; and reporting D2C results to ODH. 4. Train all D2C staff (e.g., DIS, LTC coordinators) on use of tools and techniques to locate persons out-of-care for re-engagement. 5. Adhere to D2C related protocols and deadlines established by ODH. 6. Utilize ODH developed forms, databases, IT systems for D2C documentation. 7. Present outcomes of local D2C activities, including metrics on persons re-engaged and those not, in a format to be determined by ODH. 8. Obtain access to electronic medical records (EMR) of major local health systems.				
2.B2: Develop electronic based approaches (e.g., text messaging, virtual case management) to support retention in care activities, patient navigation and distribution of strengths-based case management (e.g., ARTAS) via phone.	1. 2.				
2.B3: Create and maintain an easily accessible provider-initiated retention in care support service (e.g., encrypted online reporting system) for providers to request health department support when patients miss appointments or appear to be lost to follow up.	1. 2.				
2.B4: Provide locally informed, evidence-based incentives (non-monetary) to PWH for retention in care and viral suppression.	1. 2.				

	2.B5: Develop robust telemedicine programs that use electronic information and telecommunications technologies (e.g., videoconferencing, the internet, store-and-forward imaging, streaming media) to support and promote long-distance clinical health care and patient health-related education.	1. 2.				

PS20-2010 Local End the HIV Epidemic Workplan

Instructions: Develop at least two activities based on CDC-established **Sub-strategies** and enter them in the **Local Activities** box. Please note some Sub-strategies have pre-defined local activities that must be performed, while others are blank and sub-recipients should develop their own activities. Local activities should align with End the HIV Epidemic (EHE) Plans. Sub-recipients may develop additional activities for sub-strategies with pre-defined local activities, but this is not required. However, there must be a minimum of 2 activities listed in each Local Activities box.
Enter local staff person or role responsible for activity in Person Responsible box. Use Interim Progress box to report progress made for Interim Progress Report (IPR). Use Annual Progress box to report progress made for Annual Progress Report (APR).

Strategy 3: Prevent new HIV transmission by using proven interventions, including pre-exposure prophylaxis (PrEP) and syringe services programs (SSPs)

Strategy 3A: Accelerate efforts to increase PrEP use, particularly for populations with the highest rates of new HIV diagnoses and low PrEP use among those with indications for PrEP.

Sub-strategies	Local Activities	Person Responsible	Target Date	Interim Progress (report in IPR)	Annual Progress (report in APR)
3.A1: Support development and delivery of PrEP services in clinical and nonclinical sites in communities with the highest rates of new HIV diagnoses. Ensure adequate scale-up of PrEP use among MSM of all races, and particularly young African American and Hispanic/Latino gay and bisexual men, transgender persons, and other communities that would benefit most from its use. Efforts should also be made to co-locate nPEP with PrEP services to prevent possible HIV infections from recent exposure.	1. 2.				
3.A2: Increase PrEP training among private and safety-net clinical providers by increasing the number of trained PrEP detailers (i.e., clinical educators) through collaboration with organizations that have demonstrated success in providing ongoing training and support (e.g., AIDS Education Training Centers, the National Resource Center for Academic Detailing), and adapting resources from CDC and others to meet local provider training needs (e.g., materials from the Prescribe HIV Prevention campaign).	1. 2.				

3.A3: Incentivize PrEP provision that is appropriate to locally specific demographics of persons with new HIV diagnoses while maintaining provision of PrEP to all persons with indications for its use. Examples may include, but are not limited to: annual awards or incentives for clinical sites that exceed annual goals for providing PrEP (not already funded by the HRSA Bureau of Primary Health Care) for success in reducing disparities (i.e., matching the provision of PrEP to the local demographics of persons with new HIV diagnoses).	1. 2.				
3.A4: Support the formation of a locally-driven peer network of African American and Hispanic/Latino persons who are PrEP users, to educate on PrEP and support PrEP uptake and continued PrEP use among persons in their social networks.	1. 2.				
3.A5: Develop and implement locally-specific insurance and cost-assistance navigation protocols for PrEP patients.	1. 2.				
3.A6: Support client access to existing traditional PrEP care delivery systems (e.g., community health centers) and non-traditional PrEP care delivery systems. This may include active referral and linkage to home test kits for some visits, PrEP care in community pharmacies, and use of telemedicine services especially in rural communities.	1. 2.				
3.A7: Disseminate approaches proven effective to support adherence and persistence. Examples include certified health coaches or nurse educators, certified community health workers, PrEP navigators, use of eHealth technology, and pharmacist-based PrEP services. Priority should be given to services that are fiscally sustainable (e.g., billable).	1. 2.				
Strategy 3B: Increase availability, use, and access to and quality of comprehensive Syringe Services Programs (SSPs)					
Sub-strategies	**Local Activities**	**Person Responsible**	**Target Date**	**Interim Progress (report in IPR)**	**Annual Progress (report in APR)**

3.B1: Ensure that SSPs provide clients with the following standard services: needs-based access to sterile needles and syringes and other injection equipment (e.g., sterile water, cookers), condoms, syringe disposal, HIV and HCV testing, linkage to HIV and HCV care, linkage to PrEP, naloxone distribution, and linkage to medication-assisted treatment.	1. 2.				
3.B2: Ensure that SSPs have the following additional services provided directly to clients or available through formal, active referral arrangements facilitated by patient navigators: 1) Infectious disease prevention, detection, care, and treatment; including HIV, viral hepatitis (HAV, HBV, and HCV), sexually transmitted infections (syphilis, gonorrhea, and chlamydia) and wound care, 2) Substance use disorder care and treatment; including low threshold medication-assisted treatment and evidence-based psychological and behavioral treatments (e.g., talk therapies), and 3) Essential support services, including housing, transportation; mental health/substance use counseling.	1. 2.				
3.B3: Promote and establish SSPs strategically distributed across communities with the highest number of new HIV diagnoses attributed to injection drug use, highest number of new HCV diagnoses, and/or highest rates of drug overdose.	1. 2.				
3.B4: Increase access to sterile needles and syringes for persons who inject drugs (PWID) through non-prescription syringe sales in community pharmacies, where allowed by law.	1. 2.				
3.B5: Educate the community about the availability and evidence-base of SSP services, including through the use of evidence-based consumer materials and content.	1. 2.				

3.B6: Develop and implement a quality management program to continuously evaluate and improve SSP service delivery according to evidence-based practices defined by the U.S. Department of Health and Human Services (HHS).	1. 2.				

PS20-2010 Local End the HIV Epidemic Workplan

Instructions: Develop at least two activities based on CDC established **Sub-strategies** and enter them in the **Local Activities** box. Please note some Sub-strategies have pre-defined local activities that must be performed, while others are blank and sub-recipients should develop their own activities. Local activities should align with End the HIV Epidemic (EHE) Plans. Sub-recipients may develop additional activities for sub-strategies with pre-defined local activities, but this is not required. However, there must be a minimum of 2 activities listed in each Local Activities box.

Enter local staff person or role responsible for activity in Person Responsible box. Use Interim Progress box to report progress made for Interim Progress Report (IPR). Use Annual Progress box to report progress made for Annual Progress Report (APR).

Strategy 4: Respond quickly to potential HIV outbreaks to get needed prevention and treatment services to people who need them

Strategy 4A: Develop partnerships, processes, data systems, and policies to facilitate robust, real-time cluster detection and response

Sub-strategies	Local Activities	Person Responsible	Target Date	Interim Progress (report in IPR)	Annual Progress (report in APR)
4.A1: Establish new or expand an existing standing committee that meets routinely to guide cluster response. Include health department leadership and staff with diverse areas of expertise and authority to implement change; routinely review cluster data, prioritize clusters, guide cluster response, review response data, and modify and improve responses, as needed.	1. Identify by name and title, the local HIV cluster/outbreak response plan coordinator, and other key internal stakeholders and subject matter experts (SMEs), and designate their role in HIV cluster detection and response (CDR). 2. Establish monthly CDR committee meetings to review and update existing local HIV CDR plan, including reviewing data sources to determine potential outbreaks or geographic areas of concern, determine next steps, and assign action items for follow-up. For active cluster investigations, document key activities performed and assign further action items. If a local CDR plan does not exist, establish within six months. 3. Develop and test the cluster notification protocol to notify local health department (LHD) senior leadership and ODH of suspected or confirmed HIV clusters.				
4.A2: Actively involve members of local communities in planning, implementation, and evaluation. Include people with or at risk for HIV, local HIV services providers, Ryan White HIV/AIDS Program facility leadership, community-based organizations, HIV planning groups, and, as applicable, correctional and military facilities, tribal organizations, behavioral health providers, housing providers, etc.	1. 2.				

4.A3: Update or establish mechanisms or processes to expedite reporting and entry of case, laboratory, risk factors, vital status, and other key data into the local surveillance system used for CDR to ensure accurate surveillance data for real-time decision-making.	1. Identify local data sources and tools, including current LHD data systems, to be used to detect and monitor clusters, and assign person(s) responsible for developing system-specific processes. 2. Participate in bi-directional submission of data with ODH to identify and understand the networks. 3. Determine molecular testing capacity of the university medical center laboratory in the EHE county or other major hospital system laboratory in the county.				
4.A4: Implement approaches to provide real-time information on cluster detection and response. Rapidly analyze, integrate, visualize, and share data from diverse sources, including surveillance, partner services, Ryan White HIV/AIDS Program, STD, and HIV testing.	1. Collaborate with ODH to build local analytic capacity to synthesize cluster-related data. Identify by name and title the person(s) charged with primary data synthesis and analysis of local data. 2. Participate in ODH offered technical training and/or tools to analyze molecular data, develop reports, tables, graphics and other information to synthesize and display cluster-related data.				
4.A5: Create and maintain flexible funding mechanisms capable of supporting cluster response efforts.	1. 2.				

Strategy 4B: Investigate and intervene in networks with active transmission					
Sub-strategies	**Local Activities**	**Person Responsible**	**Target Date**	**Interim Progress (report in IPR)**	**Annual Progress (report in APR)**
4.B1: Understand the networks: Train key staff to implement methods to identify and understand the entire network, including enhanced partner services, social network strategies, rapid ethnographic assessment, and other innovative approaches.	1. Build local health department staffing capacity to investigate and intervene in networks with active transmission. 2.				
4.B2: Provide linkage to critical services to network members: Prioritize network members for enhanced linkage to services including: testing and future re-testing for HIV, HCV, HBV, and STDs; PrEP; SSPs; HIV medical care; including rapid start of ART and PrEP; and other essential support services (e.g., housing, social services).	1. Review local data and prioritize additional follow-up for members of active clusters, ensuring viral suppression. 2.				

Strategy 4C: Identify and address gaps in programs and services revealed by cluster detection and response					
Sub-strategies	**Local Activities**	**Person Responsible**	**Target Date**	**Interim Progress (report in IPR)**	**Annual Progress (report in APR)**
4.C1: Identify and address programmatic gaps: Review cluster information and data to identify specific gaps in programs such as testing, care, PrEP, partner services, SSPs, other support services, collaborations, and communication, and address these gaps swiftly during cluster response.	1. 2.				
4.C2: Use cluster information and data to guide future program activities.	1. 2.				

Appendix C

ODH Evidence of Health Equity Strategies Checklist

This checklist should be used to support planning, implementation, and evaluation of equitable strategies to reduce disparities and overcome social determinants of health. This checklist is a guide to establish a baseline criterion that all projects funded by ODH to support alignment with established priorities to achieve optimal health for all Ohioans.

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

Racial and ethnic minorities, those living in rural communities, people with disabilities, the LGBTQ community and Ohio's economically disadvantaged residents do not have the same opportunities as other groups to achieve and sustain optimal health. Health disparities occur when these groups experience more disease, death or disability beyond what would normally be expected based on their relative size of the population. Health disparities are often characterized by such measures as disproportionate incidence, prevalence and/or mortality rates of diseases or health conditions. Health is largely determined by where people live, learn, work, play, and age. Health disparities are unnatural and occur because of low socioeconomic status, race/ethnicity, sexual orientation, gender, disability status, geographic location or some combination of these factors. Those most impacted by health disparities also tend to have less access to resources like healthy food, safe housing, quality education, safe neighborhoods and freedom from racism and other forms of discrimination. These are referred to as **social determinants of health (SDOH)**. SDOH are a root cause of health disparities. The systematic nature of health disparities is considered unjust and is referred to as **health inequities**. The ability of everyone to have the same opportunity to achieve the best health possible is referred to as **health equity**. Programs that incorporate social determinants into the planning and implementation of interventions will greatly contribute to advancing health equity.

The ODH is committed to the elimination of health disparities and achieving health equity for all Ohioans. The items below are requirements for all applicants to ensure health equity is embedded within all components of the application (e.g., Goals, Program Narrative, and Objectives.)

1) Identify specific groups who experience a disproportionate burden of disease, health condition or health outcome targeted by this solicitation. See Ohio's State Health Assessment Ohio's health data. https://odh.ohio.gov/wps/portal/gov/odh/explore-data-and-stats/interactive-applications/2019-online-state-health-assessment

2) Identify geographic reference points (i.e., census tracts, census block groups or zip codes) to specify where program activities are focused.

3) Use direct or indirect feedback from the prioritized population, community, group, or community agency to identify specific social and environmental conditions (social determinants of health) associated with health disparities and health inequities.

4) Identify measurable health equity targets that demonstrate reducing disparities and improving health equity are critical goals to be achieved through program activities. This information must also be supported by data. For guidance on methodology to establish equity targets, review 2030 Target Setting Methodologies for Objectives in Healthy People 2030.

5) Outline specific evaluation strategies to measure the impact of program activities on decreasing and/or eliminating health disparities and health inequities.

The following are best practices toward eliminating disparities and achieving health equity and are not required, but highly encouraged.

1) Link proposed activities to health equity strategies identified in local, state or national planning documents. These documents include, but are not limited to strategies, goals and objectives outlined in Healthy People 2030, the State Health Improvement Plan (SHIP) and local Community Health Assessments .
   - State Health Improvement Plan - https://odh.ohio.gov/wps/portal/gov/odh/about-us/sha-ship
   - Healthy People 2030 - https://health.gov/healthypeople

2) Develop staffing plans where board members, leadership and program staff reflect the race, ethnicity, background, and/or culture of the population being served.

3) Identify up- and downstream approaches to address social determinants of health and reduce disparities. Upstream factors like food, housing and income insecurity that focus on addressing social determinants of health decrease barriers and improve supports that provide opportunity for people to achieve their full health potential. Downstream approaches focus on providing equitable access to care and services to reduce the negative impact of social determinants on health outcomes.

4) Establish non-traditional partnerships among different sectors of the community (e.g., faith-based organizations, local industries, businesses, universities, businesses, healthcare) that can provide valuable insight, new perspective, and more effective ways to achieve program goals. Non-traditional partners create opportunity to collaborate across sectors and may serve as a new source of support for the program.

[Note to Program: These requirements and best practices should be tied to deliverables and review criteria when possible and appropriate.]