MERCK
FOUNDATION

Merck Foundation
HIV Care Connect

Call for Proposals

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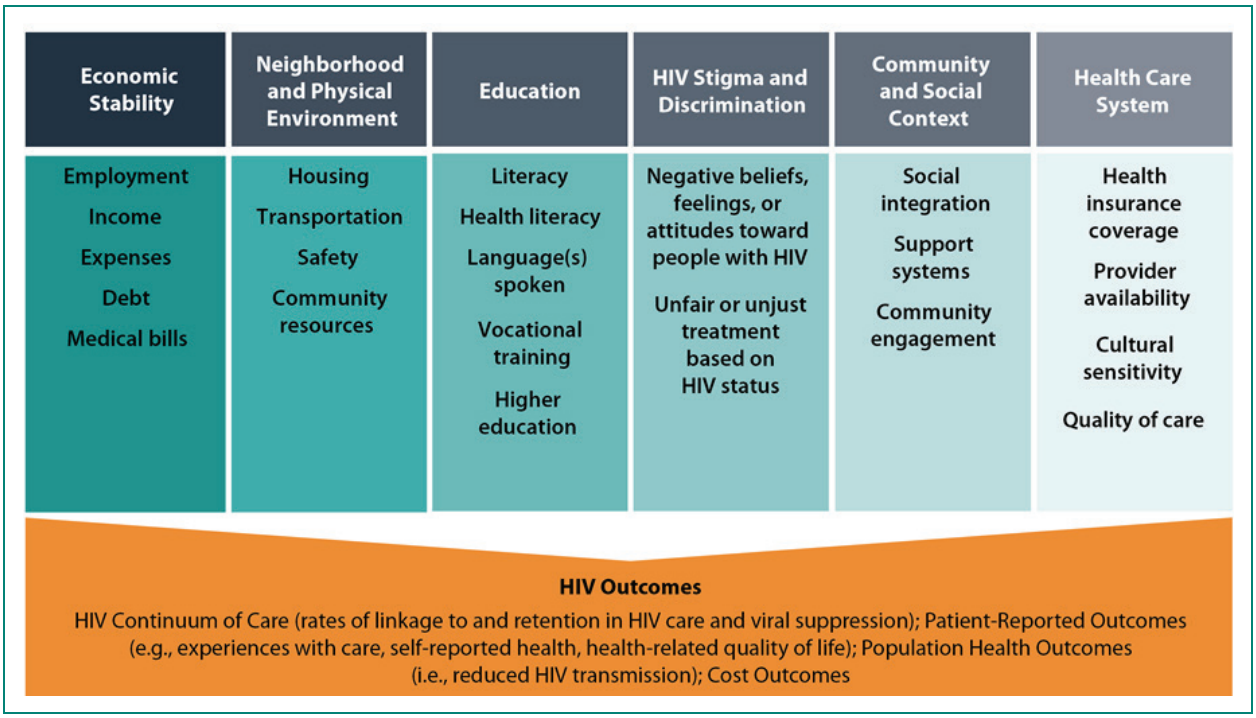
List of Exhibits

1 Intent of Call for Proposals

More than one million people in the United States are living with HIV.[1] Although overall incidence has declined, HIV disproportionately affects certain populations and geographic regions. In particular, people of color (African Americans and Hispanic/ Latinos) have higher rates of HIV and poorer health outcomes than Caucasians.[1] Although people of color represented 28% of the United States population in 2016, they accounted for almost 70% of all HIV diagnoses.[2] Even greater disparities exist among gay, bisexual, and other men who have sex with men (MSM) and women of color. In 2016, two thirds of MSM diagnosed with HIV were men of color and 77% of women diagnosed with HIV were women of color. Almost half of all new HIV diagnoses in the United States in 2016 occurred in the South, with people of color accounting for almost three quarters of the new diagnoses.[2]

A variety of complex and interrelated psychosocial and economic factors influence HIV risk, access to high-quality HIV care, and health outcomes. Known collectively as social determinants of health, these factors include economic stability, the physical environment, level of education, social support, and the health care system[3] (see ***Exhibit 1***). Stigma and discrimination are also important social determinants of health for HIV and other health conditions. Some populations, such as MSM of color, experience overlapping stigma related to their race or ethnicity and sexual identity that contributes to disparities in HIV risk, care, and outcomes.

Exhibit 1. Social Determinants of HIV Risk, Care, and Outcomes



Source: Heiman, H.J. & Artiga, S. (2015). Issue Brief. Beyond health care: The role of social determinants in promoting health and health equity. Melo Park, CA: The Kaiser Commission on Medicaid and the Uninsured, The Henry J. Kaiser Family Foundation. Adapted with permission.[4]

Barriers related to the social determinants of health affect people with HIV in multiple ways and can have short- and long-term consequences. For example:

- Immediate needs for food and shelter may be prioritized over seeking treatments.
- People who do not have access to HIV care in their communities must travel long distances to receive care, a barrier compounded by lack of transportation, which is often related to economic instability.
- Difficulty understanding a health care provider's explanation of the importance of medication adherence or the inability to read and/or understand medication labeling may lead to poor medication adherence.
- Care engagement may decrease over time because of the loss of social support or accumulated exposure to stigma and discrimination in the community and/or health care system.

After a person is diagnosed with HIV, linkage to care is the gateway to HIV treatment and support. Continued retention in care and treatment adherence are essential for achieving and maintaining viral suppression. Viral suppression leads to improved individual health outcomes and prevents further transmission.[5,6,7] However, many people with HIV do not have access to needed care, remain in care, receive treatment, or achieve viral suppression.

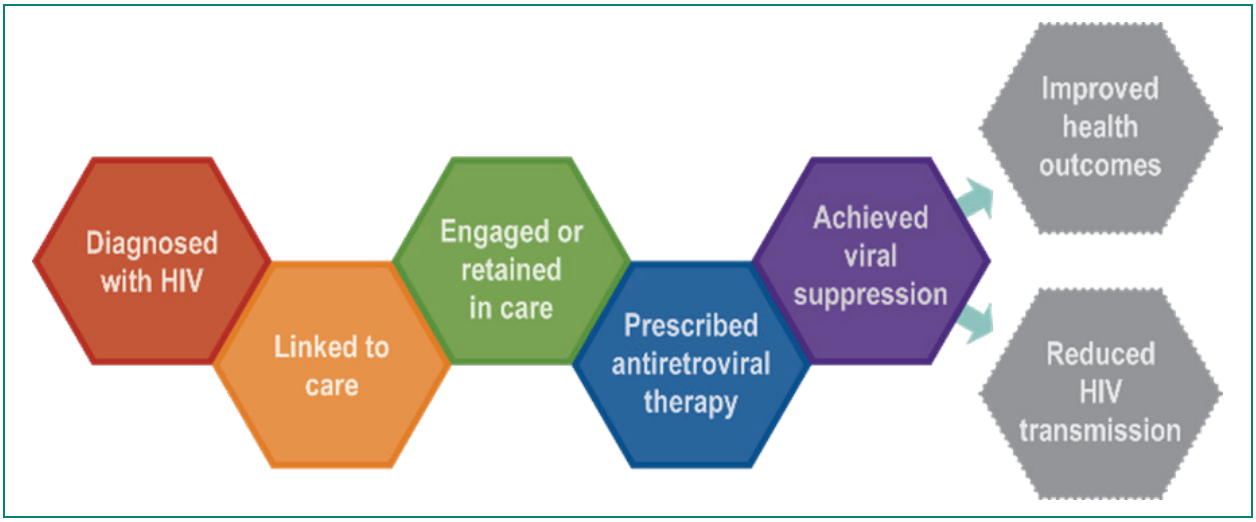
The National HIV/AIDS Strategy, a federal framework to guide the nation's response to the epidemic, prioritizes increasing access to care and improving health outcomes across the HIV care continuum (see ***Exhibit 2***), reducing disparities by addressing the social determinants of health, and focusing on the people and the places with the highest burden of HIV.[7] The Strategy also established goals to increase linkage to care, retention in care, and viral suppression, but progress toward meeting these targets has fallen short, particularly among people of color and people who live in the South.

In alignment with the priorities of the National HIV/AIDS Strategy and to help address long-standing disparities across the HIV care continuum, the Merck Foundation (the Foundation) is announcing a new initiative, ***HIV Care Connect***. **The goal of this initiative is to reduce disparities in access to care and improve health outcomes for people with HIV living in vulnerable and underserved U.S. communities.** This initiative aims to

- improve linkage to and retention in high-quality HIV care by implementing innovative multilevel programs;
- build sustainable collaborations between organizations inside and outside the health care setting to address barriers related to the social determinants of health;

- engage the community in program development to ensure that interventions are effectively tailored to address local needs; and
- disseminate findings and program results to advance best practices for improving HIV care.

Exhibit 2. HIV Care Continuum



Through this Call for Proposals, the Foundation will select highly qualified organizations, informed by recommendations from an external expert review panel, to implement innovative, comprehensive programs serving people of color in the Southeast. The Foundation invites applications from eligible organizations (see eligibility criteria in **Section 2**) in five Southeastern states: **Alabama, Florida, Georgia, Louisiana, and Mississippi**. These states account for a disproportionate number of new HIV diagnoses, particularly among people of color. People living in these states also experience substantial barriers to HIV care and have poorer health outcomes across the HIV care continuum related to gaps in the public health infrastructure and factors related to the social determinants of health (e.g., poverty, overlapping stigma). Through an external evaluation of the funded programs, the Foundation will identify and promote best practices for reducing disparities and improving HIV care among vulnerable and underserved populations.

2 Eligible Organizations

An eligible organization is one that the U.S. Internal Revenue Service has designated as a qualified 501(c)(3) nonprofit organization in the United States. Eligible organizations must receive Ryan White HIV/AIDS Program (RWHAP) funding. The initiative is focused on expanding or enhancing existing programs or activities, many of which may be funded by the RWHAP, and receipt of RWHAP funding may also help enable grantees to sustain the programs after funding from the Foundation concludes. Eligible organizations may include the following:

- Health care organizations, including health centers, integrated health systems, hospitals, community health centers, and clinics
- Community-based or nongovernmental organizations
- Units of state or local government

Organizations that are not eligible for support through this initiative include the following:

- For-profit entities or organizations
- Political organizations
- Fraternal, labor, or veterans' organizations
- Religious organizations or groups whose activities are primarily sectarian in purpose
- Organizations that discriminate based on race, gender, sexual orientation, gender identity, marital status, religion, age, national origin, veteran status, or disability

3 Funding Availability

The Foundation can provide an eligible organization with a maximum grant not to exceed $1,750,000 over a 5-year period. Annual budgets for the proposed programs cannot exceed $350,000 in any single year. The indirect rate for general administrative costs (which cannot include equipment) cannot exceed 15% of the total annual grant amount of up to $350,000. Grant funds cannot be used to displace or supplant existing funding for ongoing programs that address HIV care or health disparities because the intent of the initiative is to enhance and/or expand such programs. Additionally, grants are not intended to support research studies unrelated to evaluation of the initiative.

4 Allowable and Unallowable Uses of Funds

Grant funds may be used for the following purposes:

- Project staff salaries and fringe benefits (Note: Grant funding is not expected to provide full staff support.)
- Project consultants, such as a local program evaluator
- Other essential direct costs, including educational and training materials, limited equipment, general office materials and supplies, printing and copying, telephone and computer costs, postage and delivery, and data processing
- Travel to program activities, including an annual program grantee meeting
- Subcontracts (same allowable and unallowable uses of funds apply)

Grant funds may not be used for the following purposes:

- Core medical services (i.e., direct clinical care), support or social services, or other reimbursable services
- Medical screening or testing
- HIV prevention, including pre- and post-exposure prophylaxis (PrEP and PEP, respectively)
- Purchase of or discounts on medications, vaccines, medical devices, or biologics
- Basic or clinical research projects, including epidemiological studies, clinical trials, outcomes research, or other pharmaceutical studies
- Unrestricted general operating support
- Financial support for political candidates, lobbying, or legislative advocacy
- Fellowship/tuition support intended for a specific individual or institution
- Endowments, including for academic chairs
- Media products that are not an integral part of the program
- Meetings, conferences, or symposia that are not integral parts of the program
- Fundraising events
- Capital or building campaigns, including new construction or renovation of facilities or health information technology installation or improvement

- Grants to one organization to be passed to another, except under specific approved subcontracting arrangements
- Programs that directly support the marketing or sales objectives of Merck & Co., Inc., Kenilworth, NJ, USA

5 Expected Core Elements for Program Development

Core elements for program development are described in ***Sections 5.1*** through ***5.7***. Applicants should address all elements in their proposals.

5.1 Focus on People of Color Living in the Southeast

Applicants will be expected to focus their proposed programs on people of color living in one or more of the following states: **Alabama, Florida, Georgia, Louisiana, or Mississippi**. Programs should prioritize outreach to populations disproportionately affected by HIV, such as MSM and heterosexual women, living in communities with high unmet need.

Applicants should identify the specific populations they will focus on and explain the rationale for including them.

5.2 Implement Multilevel Strategies to Improve Linkage to and Retention in HIV Care

Early linkage to care is a critical first step in the treatment process. However, continuous care engagement and treatment adherence are necessary for achieving and maintaining viral suppression. Because both linkage to and retention in care are necessary for optimizing health outcomes along the HIV care continuum, the Foundation will only support programs that address both. Disparities across the HIV care continuum have multiple interrelated causes. Consequently, multilevel, integrated strategies (i.e., using a combination of individual- and organizational- or system-level approaches) that are mutually reinforcing are needed to improve linkage to and long-term engagement in HIV care.[7]

Applicants should describe how the proposed multilevel intervention strategies are expected to achieve improvements in linkage to and retention in care based on published evidence. Best practices, recommendations and guidelines, or preliminary results should be cited in the absence of published evidence. Applicants should balance innovation with existing evidence.

Exhibit 3 provides examples of individual- and organizational- or system-level intervention strategies included in the Centers for Disease Control and Prevention's (CDC's) *Compendium of Evidence-Based Interventions and Best Practices for HIV Prevention*.[8] These interventions are intended as examples only. Programs should implement at least two intervention strategies, with one aimed at the individual level and the other at the organizational or system level. At least one strategy should be based on scientific evidence. In cases of newer approaches that have not yet been fully evaluated, programs should adopt promising practices from the field.

Exhibit 3. Example Evidence-Based Intervention Strategies

Intervention Level	Example Intervention Strategies
Individual	▪ Patient navigation ▪ Community health worker models ▪ Peer support interventions ▪ Educational and behavioral approaches (e.g., improve skills for self-management or capacity to navigate the health system)
Organization/ System	▪ Strategies to improve care for diverse population groups (e.g., bilingual, bicultural, and multidisciplinary health care teams) ▪ Integration of care (e.g., HIV and behavioral health services) ▪ Co-location of care and services (e.g., primary and specialty care, point-of-care diagnosis)

5.3 Expand or Enhance Existing Efforts

HIV Care Connect aims to enhance or expand organizations' existing programs and activities to address linkage to and retention in care, not to fund completely new efforts. At a minimum, programs that currently focus on either linkage to *or* retention in care must expand services so that both types of services are available (e.g., adding linkage services to an existing retention-in-care program or vice versa). Further, applicants may propose to expand successful approaches by (a) extending them to additional populations or settings, (b) adding intervention components or strategies to address barriers related to the social determinants of health, (c) enhancing collaborations with new partners, and/or (e) combining components of their approaches in different ways.

Applicants should describe and document the successes of existing efforts to improve linkage to and/or retention in HIV care and how grant funding will be used to expand and/or enhance ongoing efforts.

5.4 Establish or Expand Multisectoral Collaborations to Address Barriers Related to the Social Determinants of Health

To improve linkage to and retention in high-quality HIV care, programs should address barriers related to the social determinants of health that are most critical in their local communities. ***Exhibit 4*** provides examples of barriers to HIV care associated with social determinants of health.

Applicants should identify the social determinants of health that impede linkage to and retention in HIV care in their communities and specify how the proposed strategies will address these barriers.

Exhibit 4. Barriers Related to the Social Determinants of Health Affect People with HIV in Multiple Ways

Social Determinants of Health	Example Barriers	Impact
Economic Stability	Competing basic needs	Prioritize securing food and shelter over HIV care
Neighborhood and Physical Environment	Lack of public transportation	Missed medical appointments
Education	Low health literacy	Difficulty understanding importance of medication adherence
Stigma and Discrimination	Unwelcomed by clinic staff because of sexual orientation	Drop out of care
Social Support	Rejected by family because of HIV diagnosis	Reduced motivation to access care
Health Care System	Clinic staff do not speak Spanish	Difficulty communicating health concerns and understanding providers' instructions

Applicants are expected to establish or expand collaborations with organizations in various sectors inside and outside health care, such as food, housing, education, public health, and social services. Cross-sector collaboration will enable grantees to address barriers related to the social determinants of health, extend reach to vulnerable and underserved populations, and increase capacity to expand or enhance the array of services offered. Collaborators may be nonprofit organizations, community groups, faith-based organizations, health departments, social service agencies, health-related organizations, and others that understand the community, offer services relevant to the proposed interventions, or can facilitate outreach to and communication with the populations to be served by the program. Proposals will be strengthened by demonstrating how the program will foster broad and sustainable community collaboration that goes beyond the specific requirements.

Applicants should demonstrate how they will develop and maintain collaborations with organizations inside and outside of the health care sector. Applicants should describe the collaborators' roles and responsibilities, any prior work with the proposed collaborators, and outcomes of the collaboration.

5.5 Engage the Community in Program Development

Programs should begin with a 6-month planning period during which the grantee engages members of the community (and collaborating organizations; see **Section 5.4**) to identify intervention strategies that meet local needs. Involving the community from the outset will help ensure that the program is appropriately tailored; addresses the social determinants of health that hinder linkage to and retention in care for the population(s) being served; and is respectful and responsive to the health beliefs, practices, cultural, and linguistic needs of the service

Applicants should describe their plan for community and stakeholder engagement during an initial 6-month program planning period. Applicants should explain how the proposed planning activities align with existing RWHAP planning processes.

population. For example, people of color who have historically been poorly served by the health care system may distrust clinical recommendations for care.[9] MSM and other people with HIV may not be comfortable talking with health providers about their sexual and health-risk behaviors.[10] Culturally sensitive approaches may include having diverse health care teams (e.g., bilingual and bicultural), offering culturally and linguistically appropriate patient resources, or providing peer support.

5.6 Demonstrate the Feasibility of the Program

Applicants should demonstrate the feasibility of the proposed program, including how staff and resources will be allocated to implement the program effectively and in a timely manner. Applicants should acknowledge potential challenges to implementing the proposed program and offering solutions to how those challenges will be addressed.

Grantees are expected to implement programs that are feasible within the parameters of the grant (such as time frame and funding limit) and the existing infrastructure of their organization. Proposals will be strengthened by demonstrating the availability of in-kind or matching funds from the applicant and/or collaborating organizations.

5.7 Plan for Sustaining the Intervention

Program grantees are expected to implement interventions that can be sustained beyond the grant funding period. The Foundation recognizes that resource constraints may prevent grantees from sustaining all elements of the program. The Foundation expects that grantees will conduct a robust local evaluation (see **Section 6.2**), use the data to determine the most effective program elements, and prioritize sustaining those elements. For example, certain elements may be sustainable through long-term partnerships with program collaborators. Likewise, the ability to demonstrate program effectiveness can help grantees secure additional funding from their organizations or through external sources, such federal, state, and local agencies; foundations; and other entities.

Applicants should discuss their experience with sustainability planning, past success in sustaining interventions, and options for sustaining the program (or specific program elements) beyond the funding period based on the proposed intervention approach.

6 Program Evaluation

To assess the impact of *HIV Care Connect*, the Foundation will use a two-pronged approach to evaluate the grantees' programs. First, the Foundation will conduct a *cross-site* evaluation of all funded programs, and grantees will be expected to participate in the cross-site evaluation. For this purpose, certain core outcomes (see **Section 6.1**) will be essential for all the programs to assess as part of the cross-site evaluation. Second, grantees will be expected to implement a *local* evaluation and articulate what and how they aim to evaluate based on the specific intervention approaches they propose. **Section 6.2** discusses this requirement in more detail.

> Applicants should identify the local evaluation team (if different from the program team) and describe the data systems and processes that will be used to measure improvements in linkage to and retention in care and viral suppression.

6.1 Cross-Site Evaluation (Core Measures)

Comprehensive and thoughtful program evaluation will allow the Foundation to understand *what* is working, *how* it is working, and *why* it is or is not working. Although the *HIV Care Connect* evaluation team will lead the cross-site evaluation design, implementation, and analyses, grantees will be expected to assist in the design and data collection efforts.

During the 6-month planning period, grantees will participate in developing the evaluation design and determining core measures and data collection methods. For example, it will be important to establish processes for collecting, aggregating, and reporting required evaluation data, including how data will be obtained from collaborators. The evaluation will include both a process evaluation to examine how the interventions were implemented and an outcome evaluation to measure results.

The Foundation recognizes that a diverse set of methods, evaluation measures, analytic techniques, and statistical tests will be needed to yield a robust evaluation. It also recognizes that the cross-site evaluation will need to be tailored to the range of interventions funded. Nevertheless, core evaluation measures will need to be included in the cross-site evaluation, which are described below.

6.1.1 Process Evaluation

Documenting and tracking the process of program implementation is key to understanding the relative success of interventions in improving patient outcomes.

The process evaluation will examine the following:

- How interventions were implemented
- Facilitators and barriers to implementation
- Fidelity of program implementation and reasons for changes (if any)

- Organizational- or systems-level changes that occurred as a result of the initiative
- Partnerships developed or enhanced as part of the initiative
- Implementation of the sustainability plan
- Barriers and facilitators to sustainability

6.1.2 Outcome Evaluation

The outcome evaluation will examine the impact of the initiative on the following types of outcomes:

- **Clinical outcomes and health care utilization.** In accordance with indicators of progress identified by the National HIV/AIDS Strategy and with guidelines[11] from CDC and performance measures from the Health Resources and Services Administration's HIV/AIDS Bureau,[12] HIV continuum of care outcomes, as a core requirement, include:
  - ***Linked to care***: Percentage of people receiving a diagnosis of HIV in a given calendar year who had one or more documented viral load or CD4+ tests within 30 days (1 month) of diagnosis
  - ***Receipt of care***: Percentage of patients (a) prescribed antiretroviral therapy for the treatment of HIV infection during the measurement year and (b) who had at least one CD4+ or viral load test
  - ***Retained in care***: Percentage of patients with diagnosed HIV who had two or more viral load or CD4+ tests, performed at least 3 months apart
  - ***Viral suppression***: A viral load test result of <200 copies/ml at the most recent viral load test
  - ***Medical visit frequency***: Percentage of patients who had at least one medical visit in each 6-month period with a minimum of 60 days between medical visits
  - ***Gaps in services***: Percentage of patients who did not have a medical visit in the last 6 months
- **Patient-reported outcomes.** These outcomes include experience with care measures (such as satisfaction with care, provider trust, and communication), patient-reported physical and mental health, and quality of life.
- Patient knowledge, attitudes, beliefs, and behaviors. These outcomes include patient knowledge about HIV and HIV care, self-efficacy, self-management skills and behaviors, and medication adherence.

- Social determinants of health. Patient-reported measures include highest level of education completed, health literacy, language(s) spoken, employment status, income, health insurance, housing instability, food insecurity, transportation needs, utility needs, stigma, discrimination, social support and connectedness, and interpersonal safety.

If data are available and accessible, the Foundation is interested in understanding the implementation context and potential population health outcomes that may be associated with the program. Examples include organizational-, system-, and/or population-level measures of the social determinants of health (e.g., poverty, unemployment) and health outcomes (e.g., local HIV incidence and prevalence).

6.2 Local Evaluation

Program grantees also will be expected to evaluate their own programs. The local evaluation provides the opportunity to examine processes and outcomes specific to the local site, such as how well the intervention approach was implemented and what effect it had on specific population groups.

The ultimate goal of *HIV Care Connect* is to improve long-term health outcomes, such as viral suppression; however, demonstrating changes may take more time than is available during the grant period. Consequently, the local evaluation should identify and measure shorter term health outcomes such as linkage to and retention in care and patient-reported outcomes such as patient experience with care, medication adherence, physical and mental health, and quality of life. Applicants invited to submit a full proposal should provide an overview of their local evaluation plan (instructions for the full proposal are presented in ***Section 8.2***).

Applicants should explain how the local program evaluation will fit within or be coordinated with other evaluation efforts under the RWHAP and/or other external funding mechanisms.

Applicants should identify the evaluation team (if different from the program team) as part of the full proposal. The Foundation will give preference to applications with evaluation teams that demonstrate both a strong record of high-quality research and dissemination, such as peer-reviewed publications, and a history of successful collaboration with intervention teams on prior projects.

7 Project Timeline

Applicants should present the program timeline, including a 6-month planning period, implementation, and evaluation activities.

8 How to Apply

Instructions for submitting a proposal through the two-step application process are outlined below. All questions regarding the application process can be submitted to hivcareconnect@rti.org.

8.1 Step 1: Letter of Intent

The first step in the application process is to submit a letter of intent (LOI) by March 28, 2019, to hivcareconnect@rti.org. The LOI should be no longer than 4 pages (single-spaced, minimum 10-point font size), excluding the cover page. It should include the following components:

Cover Page

- Project director information (name, title, affiliation, mailing/shipping address, telephone number, and e-mail address)
- Contact person information (if different from project director)

Section 1: Project Plan

- Program goals and objectives
- Problems to be addressed through the program and their significance
- Description of disparities in HIV care in the local community to be addressed through the program
- Description of vulnerable and underserved populations to be served, such as age range, race and ethnicity, gender identity, sexual identity, and socioeconomic status
- Geographic area for programs and population statistics for the area, specifically, total population of geographic area and population(s) to be served
- Overview of proposed multilevel intervention strategies, including how they will improve linkage to and retention in HIV care
- Overview of proposed multisectoral collaborations, including how they will address barriers to HIV care related to the social determinants of health
- Discussion of how proposed interventions build on current programs and successes

Section 2: Capabilities and Experience

- Capabilities and experience of the organization, the project director, and key staff such as evaluation staff
- Qualifications of key staff in collaborating organizations and any subcontractors or consultants
- Evidence of prior collaboration with stakeholders and community organizations beyond letters of support; evidence may include a list of grant proposals, coauthored publications, and documented program collaborations

Section 3: Evaluation

- Overview of the proposed local evaluation design

The Foundation will review the LOIs and invite selected applicants to submit full proposals. All applicants will be notified of a selection decision by April 30, 2019.

8.2 Invited Full Proposals

Invited applicants will submit a full proposal by June 7, 2019. The full proposal should include three volumes as separate documents:

- **Volume I:** (1) Cover Page, (2) Table of Contents, (3) Project Plan, (4) Local Evaluation Plan, (5) Organizational Capabilities and Experience, and (6) Key Personnel and Staffing Plan (see ***Exhibit 5***)
- **Volume II:** Appendices
- **Volume III:** Detailed Budget and Narrative Budget Justification

When we invite the full proposals, we will include instructions and the URL for uploading these documents in our online grants management system.

Exhibit 5. Overview of Proposal Sections and Content

Section	Content
1. Cover Page	▪ Project title ▪ Project director information (name, title, affiliation, and contact information) ▪ Contact person, if different from the project director ▪ Person responsible for grant and budget administration, if different from the project director ▪ Period of performance ▪ Total amount of funding requested (not to exceed $1,750,000 over 5 years)
2. Table of Contents	▪ Limited to one page

(continued)

Exhibit 5. Overview of Proposal Sections and Content

Section	Content
3. Project Plan	
3.1 Project goals and objectives	▪ Statement of goals and objectives ▪ Discussion of how project will – Reduce disparities in access, care, and health outcomes for people with HIV – Implement multilevel strategies to improve linkage to and retention in high-quality HIV care – Build or expand collaborations with organizations and stakeholders in the health care and nonhealth care sectors to address barriers related to the social determinants of health – Engage the community in program development to ensure culturally sensitive programs tailored to the needs of the population(s) to be served – Disseminate important findings and program results to advance best practices for improving HIV care
3.2 Implementation context	▪ Disparities in HIV care and health outcomes in the local community to be addressed through the program ▪ Barriers related to the social determinants of health that will be addressed through the program ▪ Populations to be served, such as by race and ethnicity, age range, gender identity, sexual identity, and socioeconomic status – Rationale for focusing on a specific group(s) ▪ Geographic area for the program and population statistics for the area, specifically, total population of geographic area and population(s) to be served by the program – Rationale for focusing on specific geographic area(s)
3.3 Intervention strategies	▪ Description of the proposed multilevel intervention strategies (individual and organizational or system levels) and how they will be used to improve linkage to and retention in high-quality HIV care and viral suppression ▪ Evidence to support proposed intervention strategies ▪ Description of how the proposed intervention strategies will expand or enhance existing efforts to improve linkage to and retention in care
3.4 Multisectoral collaborations	▪ Description of collaborators, including types of organizations, missions, populations served, and relevant capabilities – Description of prior work with proposed collaborators and the outcomes of collaboration ▪ Roles and responsibilities of collaborating organizations ▪ Description of how the collaborations will be developed and maintained ▪ Description of how the collaborations will enable the program to address barriers related to the social determinants of health ▪ Sources of funding for collaborating organization activities ▪ Documentation of proposed collaborating organizations' commitment and evidence of prior collaboration beyond letters of support—may include list of grant proposals, coauthored publications, and documented program collaborations

(continued)

Exhibit 5. Overview of Proposal Sections and Content

Section	Content
3.5 Engage the community in program planning	▪ Demonstration of ability to engage and solicit input from the community during the planning period ▪ Explanation of how the proposed planning activities align with existing RWHAP planning processes
3.6 Feasibility	▪ Demonstration of program feasibility – Description of how staff and resources will be allocated to implement the program in a timely and efficient manner ▪ Identification of potential challenges to program implementation and strategies for addressing them
3.7 Sustainability	▪ Demonstration of experience with sustainability planning ▪ Description of past success in sustaining interventions ▪ Description of options to sustain the program or specific elements beyond the funding period ▪ Identification of potential challenges to program sustainability and strategies for addressing them
3.8 Overall project timeline	▪ Project planning and implementation timeline with specific milestones, including 6-month planning period
4. Program Evaluation	
4.1 Evaluation design	▪ Proposed process and outcome evaluation questions ▪ Description of how the local program evaluation will fit within or be coordinated with other evaluation efforts under the RWHAP and/or other external funding mechanisms ▪ Logic model for the program with inputs, outputs, and anticipated outcomes ▪ Proposed metrics to assess program impact
4.2 Data collection methods	▪ Proposed data collection methods, including how data will be collected from collaborators ▪ Proposed data collection instruments
4.3 Evaluation timeline	▪ Evaluation timeline with specific milestones, including 6-month planning period

(continued)

Exhibit 5. Overview of Proposal Sections and Content

Section	Content
5. Organizational Capabilities and Experience	▪ Existing programs, activities, staffing, and resources in the areas of the proposed project ▪ Detail of similar information for subcontractor(s), if any ▪ Organization's access to and experience with population(s) to be served ▪ Capabilities to implement evaluation activities (may be through arrangement with external evaluation organization), including to collect patient outcomes and track health care utilization ▪ Previously and currently funded relevant projects, including brief description of projects and accomplishments and, if appropriate, how ongoing projects will be integrated with the currently proposed project ▪ Past and current community collaborations and relationship to the currently proposed project ▪ Pending funding from the RWHAP (including amount) and other sources (including potential funding sources and amounts) for projects similar to the proposed project ▪ Key accomplishments, evaluation findings, and lessons learned from previously and currently funded relevant projects
6. Key Personnel and Staffing Plan	▪ Titles, affiliations, experience, and qualifications of project director, project manager, and other key staff ▪ Roles and responsibilities for project director and other key staff, lines of authority (include an organizational chart) ▪ Percentage of time on project anticipated for project director and other key staff ▪ Role of subcontractor(s) staff, if any

8.2.1 Volume I

The specifications for Volume I include a running header comprising the name of the project director and consecutive page numbers covering all of Volume I. Together the cover page, table of contents, Project Plan, and Evaluation Plan should not exceed 20 pages. Please use 1-inch margins; type font no smaller than Arial 11 point, single spaced; and set for one-sided printing.

8.2.2 Volume II

Proposals may include a limited number of appendices:

- Resumes for the project director and other key staff (limited to three pages each)
- Publications (up to three publications directly relevant to the proposed project)
- Samples of training, educational, assessment, or other materials that would be used as part of the intervention or local evaluation

8.2.3 Volume III

The budget should include sufficient detail on labor and other costs for reviewers to assess how project activities will be supported and how adequately the project is staffed. The budget should be submitted in Excel format with a summary worksheet for all 5 years and separate summary worksheets for each year of funding requested. The summary worksheets should present the following information:

- **Salary and fringe benefits.** List personnel individually by title. Include annual salary, percentage of time on the project, and fringe benefits in accordance with applicant's personnel policies.
- **Travel and transportation.** State the number of trips and specify the origin and destination for proposed trips, mode and duration of travel, and number of individuals traveling. Travel expenses should be based on the applicant's standard travel policies.
- **Equipment.** Include a breakdown of equipment by type, including unit cost and quantity.
- **Supplies.** Include a breakdown of supplies by type, including unit cost and quantity.
- **Trainings or workshops.** Break down by type of training or workshop, including number of participants and days.
- **Subcontracts.** List any goods and services being procured through a contract mechanism, including subgrants and consultants. Show each contract separately and provide a breakdown of costs included, such as a daily rate and number of days for consultants.
- **Other direct costs.** Include costs associated with communications, printing, report preparation, telephone and computer, data processing, and so on.
- **Indirect costs.** Indirect rates shall not exceed 15%.
- **In-kind support.** Detail in-kind support and/or matching funds, if any, for the project.

A detailed narrative budget justification should be prepared in Microsoft Word that addresses the following:

- Amount and duration of funding requested
- Explanation and justification for all budget line items (cost items)

9 Full Proposal Review and Evaluation Criteria

The Foundation will review invited proposals using the review criteria outlined below. The Foundation cannot return proposals or provide individual technical critiques.

9.1 Review Criteria

Proposal review criteria include the following (see ***Exhibit 6*** for the technical evaluation weights for invited full proposals):

1. **Potential impact of the program,** including the significance of the project goals as they relate to improving linkage to and retention in care and reducing barriers related to the social determinants of health among the population(s) to be served. Impact will also be assessed on the basis of the scale and reach of the interventions.
2. **Evidence-based innovation,** including interventions that build on the scientific evidence and offer innovative approaches to improve HIV care and address HIV disparities for vulnerable and underserved populations.
3. **Multisectoral collaboration,** including the diversity of organizations and how collaborations will expand the reach and effectiveness of the program and address barriers related to the social determinants of health.
4. **Qualifications and experience** of the organization, project director, and other key staff.
5. **Sustainability plan** for proposed interventions and multisectoral community collaborations.
6. **Evaluation plan and capabilities,** including the local evaluation plan and demonstrated capabilities to contribute to the cross-site evaluation.

Exhibit 6. Evaluation Weights

	Review Criteria	Points
1.	Potential impact of the program, significance of project goals and objectives	20
2.	Evidence-based innovation, multilevel intervention strategies	20
3.	Multisectoral collaborations to address the social determinants of health	15
4.	Qualifications and experience of organization, project director, and other personnel	15
5.	Sustainability plan	15
6.	Evaluation plan and capabilities	15
Total		100

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