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Ryan White Grant Year 36 Provider Kickoff Meeting

HIV/AIDS, Hepatitis, STD and TB Administration

February 18, 2026

Meeting Agenda

- Welcome
- Ryan White Program Reminders and Updates
- Program Management
- Reporting
- Monitoring
- Capacity Building
- Quality Management
- Fiscal Management
- Concurrent Sessions: Rapid ART and Data Management
- Closing Remarks

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Housekeeping

All Attendees

- Please engage in the session(s), respect the presenter and your colleagues.
- Complete the evaluation.
- Enjoy the meeting!

In-Person Attendees

- The restrooms are out the door to the left (as you leave this ballroom/conference room)
- If you have questions, please use the notepaper provided to jot down your questions and at the end of each session the moderator will acknowledge you.

Online Attendees

- Please sign-in in the chat with your name, agency and email.
- The Zoom chat will only be monitored during the main session.
- The RAPID ART session will be available in a separate Zoom breakout room and the session will not be recorded.

Welcome and Updates

Avemaria Smith, Division Chief, Care and Treatment

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Ryan White Part A Program Reminders and Updates

Ashley Price, Ryan White Part A Grant Manager

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Emergency Financial Assistance Expansion

- Emergency Financial Assistance (EFA) services have been expanded within the Northern Virginia jurisdiction of the Washington, DC Ryan White Part A Eligible Metropolitan Area (EMA).
- Service Location and Hours
  - NovaSalud Inc. 2946 Sleepy Hollow Rd., Suite 3C Falls Church, VA 22044
    - Tuesday- 9 am- 5pm
    - Thursday- 10am- 6pm
- Available Emergency Services
    - Food vouchers
    - Rental assistance
    - Moving assistance
    - Utility support

Minority AIDS Initiative (MAI)- Youth Reach Program

- COHAH directive since GY27/FY17

- A targeted initiative created to provide a comprehensive set of core and support services to Youth of Color, ages 13 to 30.

- **Service Categories**
  - Core Services
    - Outpatient/Ambulatory Health Services (on-site or approved partnership)
    - Medical Case Management (on-site)
    - Mental Health (on-site)
    - Early Intervention Services (on-site)
    - Substance Abuse Outpatient Care (on-site or approved partnership)
  - **Support Services**
    - Non-Medical Case Management (on-site)
    - Medical Transportation (on-site)
    - Psychosocial Support Services (on-site)

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Fee-For-Value (FFV)

Ekaji Osayande, Program Officer, FFV Coordinator

Fee-for-Value

- A performance-based reimbursement model that offers subrecipients financial incentives based on their performance using standardized variables.
- Value enhancement awards – performance payments based on quality of care, improved health outcomes, and organizational processes for providing care.
- Grant award - includes base capacity funding and the value enhancement award.
- Award Structure:
  - 60/40 split – 60% Capacity, 40% Performance
- Data Source:
  - Integrated Assessment Tool results
  - CAREWare data

Fee-for-Value

Upcoming Activities

- **FFV Award Breakdown Sheets**
  - Provide a detailed summary of your FFV performance by service category
  - Will be distributed in April 2026
- **FFV Advisory Group**
  - Participation from all funded FFV subrecipients is required
  - Next meeting: Spring 2026
- **Program Evaluation**
  - An evaluation of the FFV program to assess impact and identify improvements
- **Integrated Assessment Tool**
  - Assessment conducted annually in November

Ryan White Part B Program Updates

Trammell Walters, Ryan White Part B Grant Manager

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Ryan White Part B GY36 Updates

Status Neutral Evaluation

- Two surveys were conducted
  - Focused on PrEP-eligible customers
- Preliminary results
  - 26 Provider responses
  - 418 Customer responses
    - 22% Are currently on PrEP
    - 5% Used to be on PrEP
    - 19% Considering PrEP
- Additional results will be shared and used to design future programs

Ryan White Part B GY36 Updates

Future Funding

GY36 is the last budget period for the project period

- April 1, 2026 – March 31, 2027
- RFA will be released later this year
- RFA announcements can be found on the funding opportunity website: https://communityaffairs.dc.gov/content/community-grant-program#4

*Program Officers and other HAHSTA staff cannot provide any additional details about the development or release of the RFA.

Ryan White Part B GY36 Updates

Programmatic Reporting

Updates have been made to the following reporting resources to align outcome measures for each service area with viral load suppression rate targets, based on HAHSTA's GY36 performance goals:

- Scope of Services and Outcomes Tables
- Annual Narrative Report Template

*Subrecipients must use the correct templates, including the Monthly Narrative Report, when submitting reports to prevent rejection in EGMS.

Ryan White Part B GY36 Updates

Polypharmacy Pilot: **What is it?**

- Provides Medication Therapy Management (MTM) and Drug Utilization Review (DUR) for customers ***with HIV*** that meet eligibility criteria
- Available for Ryan White Part B customers enrolled in the Status Neutral Program ***who are referred by a clinician***
- Extends through GY36 (April 1, 2026 - March 31, 2027)

Ryan White Part B GY36 Updates

Polypharmacy Pilot: **Who is eligible?**

Customers must be age 50 or older, and meet one of the following eligibility criteria:

- Taking five (5) or more medications for chronic diseases
- Use of high-risk medications, such as anticoagulants
- History of adverse drug reactions or medication side effects
- Recent hospitalization or emergency room visit related to medication
- Documented or suspected medication non-adherence
- Present chronic conditions requiring complex medication regimens

Ryan White Part B GY36 Updates

Polypharmacy Pilot: **Facilitation and Expected Outcomes**

- Facilitation
  - DUR/MTM services will be delivered by Clinical Pharmacy Associates (MOU Required)
  - Currently delivers MTM/DUR to Pharmacy Benefit Program participants (formerly ADAP)
  - Brings 20+ years of experience in clinical pharmacy services
- Expected Outcomes
  - Improve treatment adherence
  - Enhance clinical outcomes
  - Produce measurable, replicable results
  - Inform and expand future Ryan White program offerings

Drug Utilization Review (DUR) and Medication Therapy Management (MTM) for Older HIV Clients

Christopher Keeys, Pharm.D. BCPS, RPh
President, Clinical Pharmacy Associates, Inc
President, DC Medicaid Drug Utilization Review Board
February 18, 2026

HIV Infection in Older Clients- Major Medication Challenges

- Gaps in Scientific Evidence- Studies often exclude HIV populations, older groups, and limited participation-racially, ethnically, transgender
- Comorbidities with higher risk and or severity- DVT/PE, ASCVD, Osteoporosis, Co-infections, Neurocognitive disorders, OAB, and others
- Polypharmacy-RX (specialty drugs), OTC, nutraceuticals
- Potentially Inappropriate Medication Use (Beers' Criteria)
- Coordination of Care/ Multiple Prescribers/ Multiple Pharmacies/ Multiple Care Settings
- Social Determinants of Health

Pharmacy Systems and Services for Older HIV Clients- Complex and Dynamic

- Insurer/ Payor, e.g., Medicaid, Medicare, Pharmacy Health Pharmacy Benefits
- Pharmacy and Medical Benefit Management- includes injectables
- Drug Benefit Coverage/ Drug Formulary Management including Prior Authorizations (Outpatient, Inpatient, Skilled Nursing)
- Pharmaceutical/ Biotech Companies- Patient Assistance Programs, Investigational Drugs (Enrolled in Clinical Trials)
- Pharmacy Network for Access to Medications- Retail, Mail, Specialty, Institutional Settings
- **Clinical Pharmacy Services/Programs- DUR, MTM (Mednovate Connect)- Clinical Pharmacy Associates, Inc**

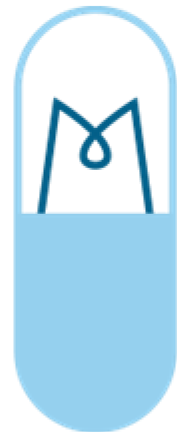
DUR and MTM in Medication Non-Adherence- A Brief Story

The client is not adherent according to pharmacy refill records. Last refilled in October. Client may also be receiving rifampin which interacts with Biktarvy: Use of the combination is contraindicated. The pharmacy confirms that rifampin was filled once in September. No further refills since then even though 1 refill remains on the prescription. HIV-1 RNA = 989,000, CD4 86 (August)

Actions: CPA clinical pharmacist consulted prescriber for major DDI and *Referral of Client for MTM (Mednovate Connect)* Service

Clinical Pharmacy Associates

A Prescription for Accountable Healthcare



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Policies and Procedures

Courtney Brooks, Program Officer

POLICIES AND PROCEDURES

HAHSTA uses policies and procedures to clearly define expectations for subrecipients and provide a structured framework that guides decision-making when delivering Ryan White services.

POLICIES vs. PROCEDURES

Policies

- Provides a higher level of guidance
- Based on federal, state, and local laws, regulations, and grant requirements
- Explains what is allowed, required, and/or prohibited

Procedures

- Operational
- Focuses on specific tasks
- Explains who does *what*, *when*, and *how* things are done
- Based on lessons learned from past challenges and successes

POLICIES AND PROCEDURES COMMITTEE

- The HAHSTA Ryan White Policies and Procedures Committee provides clear guidance by developing, reviewing, and updating policies and procedures to ensure compliance and service delivery requirements are met.
- The committee is led by Ryan White staff and comprised of Program Officers and Subject Matter Experts.
- All Policies and Procedures are reviewed and updated annually.

THE BUILDING BLOCKS OF P&PS

Our policies and procedures are built from five key components:

- Subject
- Purpose
- Definitions and Acronyms
- Procedures
- Related documents, forms, and tools

CURRENT POLICIES

Policy	Status
Customer Incentives	Expires 2/28/2027
Enrollment and Eligibility	Expires 2/28/2027
External Data Security and Confidentiality (Internal)	Expires 2/28/2027
Grant Closeout	Expires 5/14/2026
Imposition of Charges and Sliding fee Scale	Under Annual Review
Occupancy	Under Annual Review
Program Income	Expires 2/28/2027
Remediations/Corrective Actions	Expires 3/31/2027
Site Visits	Expires 2/28/2027
Training, Travel, and Conferences	Under Annual Review

POTENTIAL POLICIES

HAHSTA uses planning, program implementation, day-to day operations, and governing laws and guidelines to determine the need for policies and procedures.

We would also like to hear from you!

Knowledge Check

All policies and procedures remain in effect until a new or updated policy is approved, even if they've expired, are nearing expiration, or are under review.

A. True

B. False

Correct Answer: A

GAIN-SS

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GAIN-SS Tool

- The GAIN-SS tool is used to identify customers with behavioral health disorders and refer them for treatment.

- Ryan White subrecipients funded for Medical and Non-medical Case Management must use the GAIN-SS or an HAHSTA-approved alternative screening tool.

- To obtain a waiver, subrecipients must submit a written request to their program officer on letterhead noting the request and attaching the proposed alternate screening tool.

GAIN-SS Tool

- Subrecipients must submit the ABS User form to their program officer for access to the tool. To obtain the form subrecipients must contact their assigned program officer.
- There are a maximum of two user accounts that can be created per subrecipient. When subrecipient staff with an active GAIN-SS user account departs the organization, the subrecipient must notify HAHSTA to deactivate the user account.
- The GAIN-SS tool can be administered online via Chestnut Systems' website.
- If there are concerns, please contact Courtney Brooks at courtney.brooks@dc.gov and cc your respective program officer.

Knowledge Check

Subrecipients must submit their ABS form to:

A. Program Officer

B. Grants Management Specialist

C. Quality Coach

D. Ryan White GAIN-SS Point Of Contact

Correct Answer: D

Program Income and 340B Overview

Dr. Christie Olejemeh, Program Officer

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Definition of Program Income

- Gross income earned by the non-federal entity that is directly generated by a supported activity or earned because of the federal award during the period of performance.
- Includes reimbursement/payments for services provided to self-pay or sliding fee customers, Medicaid, Medicare, private insurance and other third-party billing.

Policy Requirements

- Program income is revenue generated by subrecipients because of the Ryan White grant.
- Subrecipients generating program income must keep records documenting the amount and disposition of any income received as a direct result of income/expenditure and the source of funds.
- All program income generated by customers with HIV must be used to benefit the HIV program.

Program Income includes but is not limited to:

- Fees for services performed;
- The use or rental of real or personal property acquired under federal awards;
- The sale of commodities or items fabricated under a federal award;
- License fees and royalties on patents and copyrights and principal and interest on loans made with federally awarded funds.
- Program income is also generated through participation in the 340B program.

Ryan White Services that Generate Program Income

Examples of Ryan White Services with third payer sources:

- Outpatient Ambulatory Health Services
- Oral Health Services
- Mental Health
- Substance Use Disorder
- Medical Nutrition Therapy Services

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Annual imposition of charges for Ryan White services, including Pharmacy Benefits Program (formerly ADAP)

By statute, customers with an income greater than 100% of the Federal Poverty Level (FPL) are asked to contribute to the cost of their care through the RWHAP. This is called the Imposition of Charges.

Below is the ***maximum*** a customer can be charged for services.

- 5% for customers with incomes between 100% and 200% of FPL
- 7% for customers with incomes between 200% and 300% of FPL
- 10% for customers with incomes greater than 300% of FPL

Note: DC EMA has a 500% FPL for all services provided in the EMA.

Annual imposition of charges for Ryan White services, including Pharmacy Benefits Program

Instead of the prescribed fee schedule, sub-recipients may impose a lower, nominal fee at their discretion.

- Fee schedules must be posted in a highly visible area
- Customers that do not pay their imposed fee(s) may not be referred to collection agencies.

Note: DC EMA has a 500% FPL for all services provided in the EMA.

Documentation & Reporting

- Subrecipients must track, and report program income quarterly.
- The reporting template will be provided to applicable subrecipients.

Steps to Complete the Template

- Step 1: Document the Ryan White Service to which income is expected (Example of services are provided on the template)
- Step 2: Bill all relevant insurance companies for services provided for every service that has a third-party payer reimbursement.
- Step 3: Develop a tracking system to capture amounts received per service/ per customer.
- Step 4: Document all billed and collected amount per customer in subrecipient tracking system

Steps to Complete the Template cont'd

- Step 5: Add all income collected monthly and aggregate for the quarter.
- Step 6: Complete the program income template with only the sum of all income collected for the quarter and submit with the monthly progress report in EGMS.
- Step 7: No Protected Health Information should be included in the report.
- Step 8: Track all expenditures made with the program income generated and provide records to your program officer upon request.

340B PROGRAM

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340B Program Defined

- Is a federal drug pricing program that allows qualifying hospitals and clinics that treat low-income and uninsured customers to buy outpatient prescription drugs at a discount of 25% to 50%.
- 340B drug pricing enables covered entities to stretch scarce federal resources as far as possible, reaching more eligible customers and providing more comprehensive services.

Key 340B Program Terms

- **Contract Pharmacy** –an entity that is licensed and authorized to provide Pharmacy Services to customers located in the District of Columbia, that has entered into an Agreement with the Covered Entity to dispense 340B Covered Drugs to Customers.
- **Office of Pharmacy Affairs Information System (OPAIS)** - The new 340B Office of Pharmacy Affairs Information System (340B OPAIS) replaced the legacy 340B Database in its entirety and includes security updates and enhancements for covered entity/manufacturer registrations, change requests, recertification, and other updates.
- **Third Party Revenue Capture-** third party revenue capture for prescription medication reimbursement from a pharmaceutical manufacturer(s) for eligible 340B prescription claims submitted on behalf of a covered entity by a contract pharmacy.

340B Contract Pharmacy Agreements & Arrangements

- A covered entity that wishes to utilize contract pharmacy services to dispense section 340B outpatient drugs must have a written contract in place between itself and a specified pharmacy.
- A single covered entity that has more than one 340B eligible site at which it provides health care may have individual contracts for each site or include multiple sites within a single pharmacy services contract.
- 340B Registration Periods- October 1-15, January 1-15, April 1-15, July 1-15

340B Contract Pharmacy Agreements & Arrangements cont'd

- This mechanism is designed to facilitate program participation for those covered entities that do not have access to available or appropriate ''in-house'' pharmacy services, those covered entities that have access to ''in-house'' pharmacy services but wish to supplement these services; and covered entities that wish to utilize multiple contract pharmacies to increase customer access to 340B drugs.
- The covered entity has the responsibility to:
  - Ensure against illegal diversion and duplicate discounts;
  - Maintain readily auditable records;
  - Meet all other 340B Drug Pricing.

Contract Pharmacy Requirements

- Must complete 340B Registration through the 340B Contract Pharmacy Registration link
- Covered entities that utilize contract pharmacies must register with each pharmacy
- Must have a contract in place prior to registration
- Must register during the quarter of open registration
- Information must be accurate

Covered Entity Responsibilities

- Per 45 CFR 74.24 and 92.25. PHS ACT 2617 (b) (iii)
  - Ensure program integrity.
  - Prevent diversion and duplicate discounts.
  - Ensure the prescription is not Medicaid eligible.
  - Prepare for program audits.
- All covered entities utilizing a contract pharmacy must comply with the certification requirements.

DISCLOSURE NOTICE

All subrecipients shall disclose to HAHSTA all 340B contract pharmacy arrangements and their statuses with OPA (Office of Pharmacy Affairs) within 15 business days of receipt of the Ryan White grant award.

Disclosure Notice cont'd

The letter is to be addressed to the program officer, must be on the organization's letterhead and include the following:

- Contract pharmacy participation
- 340B ID in the OPAIS database
- The name of their primary contact in the OPAIS database
- Period for participation (start and end date if applicable)
- Ryan White grant ID number
- Signature of authorizing official

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Steps to Complete Program Income Template

Steps to complete the PI/340B portion of the template

- Step 1: Document all 340B Income per customer.
- Step 2: Develop tracking mechanism to account for all income received per customer served.
- Step 3: Aggregate all funds received.
- Step 4: Submit aggregated quarterly amounts to HAHSTA. Include the report for the quarter with the progress report in EGMS.
- Step 5: Keep a record of expenditures related to program income generated.

Template for Reporting Cumulative Program Income

Sub-Recipient Name:																			
Grant Number:																			
Ryan White Services		Medicare		Medicare MCO		Medicaid		Medicaid MCO		Public Insurance - Local or State		Insurance MCO - Local or State Public		Self-pay / Sliding Fee Scale		340 B Program Revenue		YTD TOTALS	
	Month	Claimed	Collected	Claimed	Collected	Claimed	Collected	Collected	Collected	Claimed	Collected	Claimed	Collected	Claimed	Collected	Claimed	Collected	Claimed	Collected
Outpatient Ambulatory Health Services (OAHS)	MAR																		
	APR																		
	MAY																		
	QRT 1																		
	JUN																		
	JUL																		
	AUG																		
	QTR 2																		
	SEPT																		
	OCT																		
	NOV																		
	QRT 3																		
	DEC																		
	JAN																		
	FEB																		
	QRT 4																	$ -	$ -

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Allowable uses of 340B & Program Income

Program income derived from Ryan White funded services and 340B programs can be used in one or more of the following ways:

- Funds may be added to resources committed to the project or program and used to further eligible project or program objectives.
- Funds may be used to cover program costs.

Note: Program income funds are not subject to the federal limitations on administration (10%), quality management (5%), and core services (75%).

Reporting Program Income Expenditures

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Annual Reporting of Program Income Expenditures

New Requirement for GY35

- Submit Final Program Income expenditure report
- Part A – June 1 – Dec 31, 2025, Due **September 30, 2026**
- Part B -April 1 – December 31, 2025, Due **September 30, 2026**

GY36: Reporting PI Expenditures

- Report expenditures via monthly invoice cover sheet

  -OR-

- Develop and Submit detailed Budget on Program Income at the beginning of the budget period, if not reporting expenditures, itemizing the Ryan White Services to be covered.
- GY36 Program Income Budgets (if not reporting expenditures) are due 30 days after the budget period start date.

Expenditure Documentation

- Expenditure documentation must show compliance with Ryan White requirements.
- Only eligible Ryan White Services are allowable.
- Alignment of expenditures with Ryan White allowable costs.
- When possible, Use all program income before spending Ryan White grant funds.
- Any barriers affecting timely reporting must be reported to the Program Officer within 7 days of the due date.

Monitoring of Program Income

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Monitoring of Program Income

HAHSTA will monitor the subrecipient's compliance with the program income (PI) policy during comprehensive site visits. The review includes but is not limited to the following:

- A review of the subrecipient's policy for schedule of charges.
- A review of the customer eligibility determination application.
- A review of the policy on tracking program income.
- A review of how PI is being used.
- A review of back billing & retroactive insurance charges.
- A review of the program income budget.

Knowledge Check

All subrecipient shall disclose 340B contract pharmacy arrangements and their statuses with OPAIS within 15 days of receipt of the grant award.

A. True

B. False

Correct Answer: A

Reporting

Ekaji Osayande, Program Officer, FFV Coordinator

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Reporting

Narrative

Subrecipients are required to submit a monthly programmatic narrative report for each funded grant program by the 15th day of each month via EGMS.

The narrative report must include:

- Program implementation successes and challenges
- Work plan status updates
- Personnel updates
- Waitlist data, if applicable
- Program expenditures variances
- Corrective action or Remediation plan progress updates
- Quality management updates
- Staff contact information updates, if applicable
- Requests for technical assistance, as needed

Reporting cont'd

- **Program Narrative submission in EGMS** – *due by the 15th day of each month*
    - Monthly Narrative Report
    - Monthly CAREWare Financial Report
- **CAREWare data entry**
    - Daily or monthly uploads
- **Invoice submission in EGMS** – *due by the 15th day of each month*
    - Monthly CAREWare Financial Report
- **PAN submission in DIFS** – *due within 3 days of receipt*

Reporting cont'd

Important Compliance Notes- *All required submissions (Monthly Narrative Report, CAREWare Financial Report, CAREWare data entry, and invoices) must be submitted by the stated deadlines.*

- Failure to adhere to submission deadlines may trigger a Remediation plan, as outlined in Ryan White HIV/AIDS Program policies and procedures.
- Consistent non-compliance or unresolved remediation issues can escalate to a Corrective Action Plan (CAP), which may include mandatory site visits, delayed reimbursements, disallowed expenses, and jeopardized future funding

Knowledge Check

Which of the following consequences can occur due to failure to meet reporting deadlines?

A. Immediate termination of funding

B. A Remediation Plan that can escalate to a Corrective Action Plan (CAP), which may include site visits and delayed reimbursements

C. Automatic exemption from future reporting requirements

D. None of the above

Correct Answer: B

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Monitoring

Robert Ridley, Program Officer

Ryan White Monitoring Team

<table>
<tr><th>Program Officers</th><th>Grants Management Specialist</th><th>Quality Management</th></tr>
<tr><td>Monitors programs that provide medical and support services to eligible customers.</td><td>Ensures that the federal funds are used effectively to provide medical care, support services, and resources to the customers</td><td>Monitors, evaluates, and supports subrecipients in improving the quality of services provided to customers.</td></tr>
<tr><td>▪ Reviews and approves subrecipient invoices and progress reports
▪ Provides programmatic technical assistance
▪ Conducts site visits
▪ Conducts monthly check-in calls
▪ Reviews program budgets and justifications to ensure costs are allowable and in alignment with applicable service standards</td><td>▪ Reviews and approves subrecipient invoices and progress reports
▪ Conducts site visits
▪ Conducts monthly check-in calls
▪ Provides fiscal technical assistance
▪ Reviews program budgets to ensure allocated costs meet federal statues, regulations and grant requirements
▪ Monitors DIFS approval flow</td><td>▪ Provides guidance on required quality deliverables
▪ Provides subrecipients with support on the design and implementation of quality improvement (QI) projects
▪ Provides tailored trainings to help subrecipient staff increase their QI knowledge and skillsets.</td></tr>
<tr><td>Robert Ridley
Dr. Ivan Eaton
Princess Johnson
Dr. Christie Olejemeh
Ekaji Osayande
Courtney Brooks
Lauren Lapointe
Ebony Fortune-Deputy Chief, Care and Treatment Division</td><td>Carroll Ward
April Richardson
Monique Brown
Rony Mohram
Milena Acevedo
Janice Carroll-Supervisory Grants Management Specialist</td><td>Courtney Middlebrook
Laura Whittaker
Airelle Hart
Roger Isom

Jose Delao Hernandez-Planning and Evaluation Manager</td></tr>
</table>

Monthly Check-In Calls

- The purpose of the check-in calls (meetings) are to ensure program and fiscal compliance, obtain program and fiscal updates from the subrecipient and for the HAHSTA monitoring team to provide information, technical assistance and support to the subrecipient as needed.
- Check-in calls are held monthly and scheduled between the subrecipient and their assigned HAHSTA monitoring team.
- An agenda is required and must be sent prior to the meeting.
- The meeting can be held via phone or Microsoft teams and typically last no more than 60 minutes.

Monthly Check-In Calls cont'd

Suggested Monthly Call Attendees	Sample Agenda Items
▪ HAHSTA Monitoring Team ▪ Subrecipient Program Manager or designee ▪ Finance staff ▪ Other relevant staff members	▪ Program success/challenges ▪ Program spending ▪ Staff vacancies ▪ Technical assistance needs ▪ Quality management activities (quality improvement projects, performance measures in CAREWare, etc) ▪ Upcoming HAHSTA trainings (CMOC, etc.) ▪ Corrective action and or remediation plan updates as applicable

Site Visits

Four Types of Site Visits

- **Introductory** - An informal site visit reserved for subrecipients that are newly funded by Ryan White, have opened a new site, or have received funding for a new service category.
- **Comprehensive** – An annual review of the subrecipient's capacity, performance, and compliance across all HIV/AIDS, Hepatitis, STD, and Tuberculosis Administration (HAHSTA)-funded programs.
- **Triggered** - An urgent site visit to review performance issues, either those that violate 2CFR 200 or another grantmaking law or policy, or subrecipient action that produces reasonable suspicion of breaking continuity of services or causing danger to customers served.

Site Visits cont'd

Four Types of Site Visits

- **Condition of Award Site Visit (COA)** -The COA site visit only occurs during a continuation year and is only applicable to subrecipients that had an open corrective action plan at the close of the budget period prior to the new budget period. The visit provides HAHSTA staff with an opportunity to meet with subrecipients to review the status of the existing corrective action plan, determine whether the noted deficiencies have been addressed and make a determination about the status of the CAP moving forward.

Site Visit Schedule

Visits are scheduled in conjunction with subrecipient

1. Introductory – site visits occur within 45 days of the grant start date.
2. Comprehensive – site visits are scheduled annually in the 2nd or 3rd quarter of the grant year.
3. Triggered – site visits occur throughout the grant year as needed.
4. Condition of Award - occurs in the 1st quarter of the new budget period.

Note

1. Virtual Site Visits are allowable but must comply with all in-person comprehensive site visit procedures.
2. Grants Management Specialists serve as the centralized point of contact for coordinating and scheduling of site visits for the HAHSTA.

Site Visit Procedures

- Site Visits are conducted by the Ryan White Program Officer (PO),Grants Management Specialist (GMS) and/or other members of the HAHSTA monitoring team.
- Site Visits consist of:
  - Entrance Conference
  - Tour of Facility
  - Targeted Reviews/Discussions
  - Review of Customer Records
  - Exit Conference

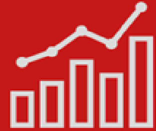
Post Site Visit

- Subrecipients shall receive a comprehensive report within 45 days of the final day of the site visit.
- Subrecipients who had a triggered site visit will receive a site visit summary of findings and next steps within 10 days of the visit.

Report Cards

- Program Officers and Grants Management Specialist use report cards (RC) to provide subrecipients with an objective comprehensive tool that measures performance and provides feedback on service delivery and administrative operations.
- Report cards are distributed quarterly for Ryan White Part A & B programs.
- Subrecipients are required to provide written feedback within 10 days of receiving the RC from their assigned PO.

Report Cards



Washington, DC EMA Ryan White Part A Provider Report Card
Quarter Three (09/01/2023-11/30/2023)

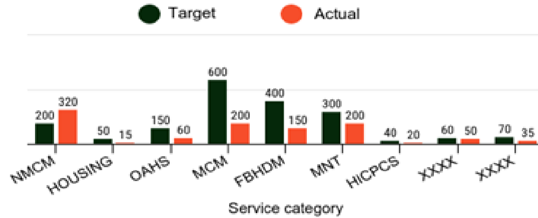
Provider Grade Expectation Met

Purpose for the Report

The purpose of the report card is to provide sub-recipients with data-driven feedback on their Ryan White programmatic, fiscal and quality management performance. The goal of the report card is to optimize the quality and efficiency of the Ryan White services provided. The expectation is that programs will utilize the feedback to make modifications as needed to achieve compliance with funding expectations. Sub-recipients are expected to provide a written response within 10 days of receipt of the report card. HAHSTA, Ryan White staff will utilize the report cards as a tool to monitor performance and provide objective data for future funding decisions.

The Breakdown

Programmatic Progress Review

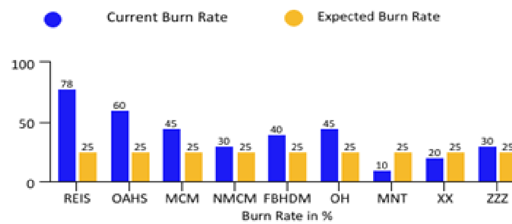


Program Feedback

If there are more service category, please summarize findings using statement here

Program review comment/feedback starts your target looks off compared to your plan. Specially

Fiscal Progress Review

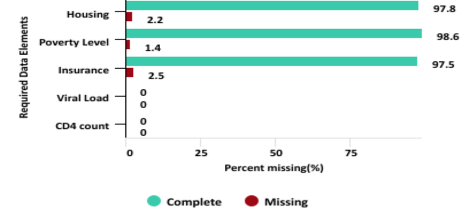


Fiscal Feedback

If there are more service category, please summarize findings using statement here
Fiscal review comment/feedback starts your target looks off compared to your plan. Specially

DC | HEALTH

RSR Completness



insert RSR Completeness comment here

housing seems very low also poverty level has a big missing data values. These will create an issue during your RSR

Quality Management Plan

Measurment Areas	Yes	NO
Quality Management Plan Submission w/in 30 days		No
Performance Measure (status update)	Yes	
Technical Assistance Needs		No

insert QI comments here
quality improvement activities are required under your contracts and all deliverables are due by QI activity calendar

Corrective Action Plan Review

Corrective Action Plan (CAP) Review

	Yes	No
Is there an approved CAP?	Yes	
If Yes, Is the implementation in progress?	Yes	
Is the CAP completed?	Yes	

CAP Comments

Insert CAP comments here

N/A

Findings/Recommendations/Best Practices

Comments goes here

Program Officer Name: Ebony
Email: first.name@dc.gov

Remediation Plans

- Remediation Plans are reserved for minor performance issues commonly addressed through technical assistance. The areas for remediation are identified through various triggers.
- Examples of remediation plans triggers may include, but not be limited to, subrecipients with:
  - Under-performance relating to achievement of program targets as identified in the subrecipient's scope of service and work plan.
  - Over-spending and/or under-spending (e.g., less than or greater than 5% of ideal burn rates).
  - Non-compliance with reporting (e.g., late, incomplete, and/or inaccurate reporting; data reporting; quality reporting; etc.).
  - Unsuccessful corrections of identified triggers.
  - Minor non-compliance with service standards and policies and procedures.

Corrective Action Plan (CAP)

- Corrective action plans (CAP) are requested for triggers that are more severe than remediation triggers but stop short of suspected violations of a law or reasonable suspicion of danger to customers served by the subrecipient.
- CAPs are a formal, written request made by a Program Officer or Grants Management Specialist to subrecipients.
- The request seeks actions to remedy and prevent the recurrence of challenges or deficiencies that negatively impact the administration of the grant and delivery of services.

Corrective Action Plan Triggers

- Any remediation plan deliverables that have been unresolved for more than 3 months after the due date.
- Additional triggers that prompt Corrective Action include, but are not limited to:
    - Inappropriate use of funds for costs that are not allocable, allowable and/or reasonable.
    - Inadequate facilities and environments (e.g., poorly maintained property and failed compliance safety measures that jeopardize the physical wellbeing of customers).
    - Inadequate operations to ensure and maintain customer privacy and confidentiality (e.g., failure to encrypt or physically lock up protected health information).
    - Missing and/or unsecured customer records.
    - Violations of any local or federal laws and regulations.

CAP Implications

- Subrecipients under a CAP will receive at least one site visit to assess whether the areas of non-compliance have been resolved. The Program Officer or Grants Management Specialist, in consultation with the Program Manager or Grants Management Supervisor, will determine whether the follow-up site visit will be conducted in person or through other modalities.
- A subrecipient's history of CAPs has significant programmatic implications. Previous CAPs may influence conditions of award applied to the organization's funding, affect pre-award site visit decisions, jeopardize continued funding, and negatively impact future funding considerations. If for any reason, the CAP fails to address the areas of non-compliance or does not comply within the expected time allowed for completion, the subrecipient is at risk of delayed reimbursements, disallowed expenses and/or a terminated grant award.

Knowledge Check

Which of the following is not a type of site visit?

A. Comprehensive

B. Introductory

C. Remote Monitoring Visit

D. Triggered

E. Condition of Award

Correct Answer: C

Capacity Building

Lauren Lapointe, Program Officer

DC HEALTH
GOVERNMENT OF THE DISTRICT OF COLUMBIA

Capacity Building

HAHSTA builds the capacity of its subrecipients by offering trainings through its Ryan White Training Center (RWTC), focusing on five key areas to improve standardization, quality, and compliance:

- Organizational Infrastructure
- Program Management
- Fiscal Management
- Data Collection, Reporting, and Use
- Quality Management

Annual Capacity Assessment

Each year, subrecipients undergo a capacity assessment, using the Integrated Assessment Tool (IAT). The IAT evaluates five areas of organizational capacity, identifies opportunities for improvement and determines necessary trainings.

As a result:

- Individualized capacity building work plans are developed and monitored.
- Asynchronous trainings that coincide with assessment criterion are made available.
- Subrecipient training usage is tracked monthly.
- Certificates are provided for the successful completion of training courses.
- Reassessments are conducted to gauge improvements and program sustainability.

Capacity Building Course Offerings

Organizational Infrastructure
- Strategic Planning to Enhance Sustainability
- Understanding Implicit Bias in Healthcare

Fiscal Management
- Financial Forecasting
- Categorical Budget Preparation

Program Management
- Identifying, Tracking, and Monitoring Ryan White Program Income to Enhance Patient Outcomes
- Ryan White Service Standards

Data Collection, Reporting & Use
- Data Security Basic Training
- RSR Walk-Through

Quality Management
- The Quality Management Committee: Teamwork Makes Dreamwork
- CQM Evaluation: Assessing Projects, Programs, Infrastructure, and Outcomes

Course Access

HAHSTA Ryan White subrecipients have access to a catalogue of over 50 trainings available through the RWTC.

Access to these trainings:

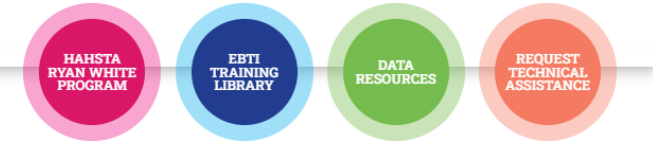
- Can be prescribed by program officers through the development of a capacity building assistance (CBA) work plan.*
- Can be accessed on one's own or at the discretion of their manager.
- Requires registration.
- Can be obtained https://effibarryinstitute.org/ryan-white/training/

***Trainings prescribed by program officers must be completed within the established timeframe.**

Course Access

Effi Barry Training Institute

Effi Barry Training Institute › Ryan White Program › HAHSTA Ryan White Capacity Building Assistance Training Center



HAHSTA Ryan White Capacity Building Assistance Training Center

DC Health's HIV/AIDS, Hepatitis, STI, and TB Administration (HAHSTA) is committed to improving the health outcomes of eligible Ryan White (RW) customers and recognizes sub-recipient capacity as an integral component to getting there. Because of this, HAHSTA, in collaboration with HealthHIV's Effi Barry Training Institute, created the HAHSTA Ryan White Training Center (RWTC) as a required capacity building assistance program for its Ryan White HIV/AIDS Program sub-recipients. The HAHSTA RWTC's focus is placed on the growth and development of capacity across five areas: organizational infrastructure, fiscal management, program management; data collection, reporting, and use; and quality management. Sub-recipients work closely with their RW Program Officers to ensure targeted and value-added educational opportunities to achieve and sustain the level of capacity needed to deliver quality services and help DC Health end the HIV epidemic.

As a sub-recipient of HRSA, DC Health funds organizations in the eligible metropolitan area (EMA) – including the District of Columbia, suburban Maryland, Northern Virginia, and two counties in West Virginia – to provide care and treatment services. Organizational capacity is a critical component to Ending the Epidemic. The HAHSTA RWTC provides self-directed learning opportunities to support ongoing professional development and capacity-building for these organizations to ensure high quality service delivery and successful program outcomes.

Available Courses

Select Subject

- ☐ Data Collection, Reporting, and Use (4)
- ☐ Fiscal Management (8)
- ☐ Organizational Infrastructure (7)
- ☐ Program Management (32)
- ☐ Quality Management (4)

Strategic Planning to Enhance Sustainability

To meet the aspirations of the REIS HI-V model, strategic planning that integrates REIS goals with our organizational goals is imperative to its success. This session will look at where you are with strategic planning as an organization and how to ensure that the REIS goals are integrated into your work. Emphasis will be placed on ensuring those with lived experience are integrated into the planning process.

Learn More...

Fiscal Monitoring Standards

This module provides an overview of the Ryan White HIV/AIDS Program (RWHAP) Part A Fiscal Monitoring Standards. This presentation will discuss the structure of the fiscal monitoring standards and the relationship between the direct recipient of RWHAP Part A funds and sub-

Other RWTC Resources

In addition to course offerings, RWTC resources include:

- CAREWare guides
- Policies and procedures
- Standards of care
- Templates (e.g. quality, fiscal and program)

Other RWTC Resources

About | Contact Us | Stay Informed | Search...

Effi Barry Training Institute

Effi Barry Training Institute > Ryan White Program > Ryan White Subrecipient Resources

Ryan White Subrecipient Resources

Ryan White Provider Deliverables Calendar

- Ryan-White-Provider-Calendar-GY35_June-2025-Feb-2026.pdf

Careware

- CAREWare Supplemental Guide for Ending HIV Epidemic and Status Neutral
- DC EMA CAREWare Centralized Eligibility System User Guide, 2025 Version
- GY34_CAREWare Data Elements – Includes Status Neutral Data Elements

Policies and Procedures

- RyanWhite Sub-Recipient Report Cards SOP for External Users_ May 2024 [.pdf]
- RWHAP Additional Funds Request Program Guidance
- RWHAP Enrollment and Eligibility Policy
- RWHAP GAIN SS One Page Guidance
- RWHAP Imposition of Charges Policy Final 9.14.23
- RWHAP Incentives Policy_1.31.24
- RWHAP Occupancy Policy_1.31.24
- RWHAP Program Income and 340 B _9.14.23
- RWHAP Remediation and CAP Policy Final 10.6.23
- RWHAP Retroactive Medicaid Billing Policy Final 3.7.25

The Effi Barry Training Institute supports innovative, collaborative, programmatic approaches that promote integrated HIV services.

HIGHLIGHTED RESOURCE

More Than a Zip Code: Impacts of Social Determinants of Health in D.C.

The Effi Barry Training Institute, led by HealthHIV and in partnership with DC Health HAHSTA, invites you to join us for the Second Annual L.I.F.T. HIV (Leadership, Innovation, and Future Trends) Summit on Wednesday, February 11, 2026.

Knowledge Check

What is the primary tool used each year to assess subrecipients' capacity and guide the development of the individualized workplans?

A. CAREWare

B. Integrated Assessment Tool (IAT)

C. Monthly Narrative Report

D. EGMS

Correct Answer: B

Knowledge Check

When would HAHSTA Ryan White subrecipient staff access a training on the RWTC?

A. When prescribed by a program officer

B. Whenever the staff wishes

C. When prescribed by a supervisor

D. All of the above

Correct Answer: D

Provider Spotlight

Damien Ministries

DC | HEALTH
GOVERNMENT OF THE DISTRICT OF COLUMBIA

Faith in Action: Turning Service into Empowerment

Mission

Faith in Action. Hope in Practice.

Damien Ministries is a **501(c)(3) faith-based nonprofit** dedicated to empowering people living with or affected by HIV/AIDS, especially those who are economically disadvantaged or socially isolated. Our mission is simple yet powerful: **to serve without judgment, to heal without condition, and to uplift every person with respect, opportunity, and love**. Guided by faith and fueled by equity, we connect mind, body, and soul, offering holistic programs that foster wellness, employment, housing stability, and community belonging. For nearly **four decades**, we have stood as a beacon of **care, dignity, and possibility**, proving that when service is rooted in compassion, lives are not just saved, they are transformed.

History

Born from Compassion. Built on Service.

Founded in **1987 by Louis Tesconi,** Damien Ministries began as a volunteer community dedicated to serving those most marginalized by HIV/AIDS, inspired by the compassion and sacrifice of **Blessed Father Damien of Molokai**. What started as a small group of volunteers sharing homes, meals, and care soon became a vital source of comfort and hope for people facing illness and isolation. By **1996**, the ministry had grown into a trusted faith-based organization with professional staff, case management, faith outreach, and a full-service food bank. Over the decades, Damien Ministries has remained rooted in its founding mission of compassion and dignity, evolving into a cornerstone of care and community empowerment in Washington, DC.

Damien MINISTRIES

Who We Are Today

A Community Anchor. A Partner in Change. A Force for Healing and Hope.

Today, Damien Ministries is a trusted, multi-sector community organization dedicated to improving health, stability, and opportunity across Washington, DC. Building on **more than 38 years** of service, we have grown beyond our HIV/AIDS roots to deliver holistic, community-centered programs that foster wellness, independence, and leadership while meeting people where they are. From our sites in Wards 5 and 7, we provide food and nutrition support, workforce development, case management, and peer-led wellness, along with clothing and donation drives that strengthen community connection. In partnership with local institutions and grassroots organizations, Damien Ministries links health, employment, and education to create **lasting change and dignity** for all.

Service Strategy

The Model – Holistic & Compassionate Care

Wraparound approach bridging to **health, housing, nutrition, workforce development, and purpose through** one seamless flow of support.

Through case management, peer mentorship, and community partnerships, we endeavor to turn care into connection and stability into strength.

The Method – Connection in Action

We meet people where they are, with trust, cultural humility, and respect. By listening first and serving holistically, we transform barriers into bridges, linking every person to the tools, knowledge, and community they need to thrive.

The Impact – From Service to Leadership

We don't just help people survive, we prepare them to lead. Every participant becomes a credible messenger and changemaker, turning lived experience into expertise and compassion into community power.

Damien MINISTRIES

This is the Damien Way

Damien Ministries – Core Service Areas

Ryan White HIV/AIDS Program

Supporting the locally funded, federally invested, integrated system of HIV care and support that improves medical outcomes and quality of life.

Programs includes: Ryan White Part A Services and Outreach

- Early Intervention Services (Ryan White component)
- Food Bank & Nutritional Support
- Burial Assistance Program
- Non-Medical Case Management

Health, Wellness & Case Management

Comprehensive, person-centered programs addressing health access, nutrition, mental wellness, and stability.

Programs include:

- Early Intervention Services (EIS)
- Medical Nutritional Therapy (MNT)
- Non-Medical Case Management (NMCM)
- Mental Health Referrals & Peer Support
- Spiritual Retreats & Community Action Board (CAB)

Food & Nutrition Services

Programs ensuring food security and improved health outcomes through access, education, and innovation.

Programs include:

- Food Bank & Home-Delivered Meals
- Hydroponic Farm (Rhode Island Ave HQ)
- Nutrition Education & Workshops

Workforce Development & Community Engagement

Initiatives that promote economic empowerment, prevention awareness, and community participation.

Programs include:

- Project LEAP Workforce Development
- Job Coaching & Employment Training
- Financial Coaching & Career Support
- Health Wellness Center (Restoration Station)
- Narcan & Condom Distribution Programs
- HIV/HCV Testing & Prevention Outreach

Damien MINISTRIES

Burial Assistance Program

BURIAL
ASSISTANCE
PROGRAM

We are Here to Support

Families Facing Financial
Challenges of Funeral Expenses

LET'S COME TOGETHER TO SPREAD THE WORD
ABOUT THE BURIAL ASSISTANCE PROGRAM
AND ITS IMPORTANCE IN SUPPORTING
INDIVIDUALS AFFECTED BY HIV IN OUR
COMMUNITY

Providing Dignity and Compassion in Times of Loss

The **Burial Assistance Program** was created to support families facing the emotional and financial challenges of laying a loved one to rest. Recognizing that loss can bring both grief and unexpected hardship, Damien Ministries provides **financial assistance to approved applicants** to help cover funeral or cremation expenses. Through this program, families can access **up to $1,950 in funds** for cremation services, offering peace of mind and ensuring every individual is honored with dignity and care. This vital service reflects our commitment to stand beside families in their most difficult moments—providing not only financial relief, but compassion and respect when it matters most.

Outreach Impact 2024 - 2025

Community Prevention

Reached over 1,000 individuals with essential health resources and education in 2025.

Outreach Results

Distributed 5,000 outreach items, impacting lives through education and essential services this year.

Overall Impact

Engaged over 300 volunteers, resulting in increased partnerships and greater community reach in 2025.

Damien MINISTRIES

Strengthening Our Core Impact Through Quality

Expand Integrated Health and Wellness Services

- Broaden access to Early Intervention services through access to nutritional counseling, mental health supports, and peer-led wellness programs across Wards 5, 7, and 8 **through a strong referral network.**
- Strengthen trauma-informed and culturally responsive approaches to care.

Advance Food Security and Sustainability

- Expand food distribution capacity to reach more residents.
- Formalize the Community Reuse Hub and donation drives as part of the District's developing zero-waste strategy

Sustain and Evolve Ryan White Programs

- Continue high-quality medical and non-medical case management with strong viral suppression outcomes.
- Expand ability to help address the needs of aging clients and those with co-occurring health conditions.

Damien MINISTRIES

Thank You for your time, and partnership.

Together, through service We can heal, and uplift our community.

Damien Ministries

Empowering lives. Restoring dignity. Building hope.

Provider Spotlight

Hillcrest Children and Family Center

DC | HEALTH
GOVERNMENT OF THE DISTRICT OF COLUMBIA

Founded in 1815 by former First Lady Dolley Madison | 210 years of experience in Washington, DC

- Embedded within Hillcrest's CCBHC integrated care model
- Outreach and support provided in all Wards
- Two clinical sites: NW (RI Ave) & SE (MLK Ave)

Benefits of Partnering with Hillcrest…

•.

MLK King Jr. Holiday Recognition Outreach

275+ High School Students Participated

Hillcrest hosted several activities during the Martin Luther King, Jr. Holiday, January 20, 2025 designed to educate attendees about health and wellness resources while commemorating the legacy of Dr. King.

Youth Outreach Program

93% Feel more confident after participating in motivational activities

100+ Students ages 14 to 17 Impacted for the month

Through our effective drop-in center, youth are given a safe and engaging place to express themselves each evening. Youth are encouraged to openly talk about self-esteem, bullying, and other peer issues while improving their own mental wellness.

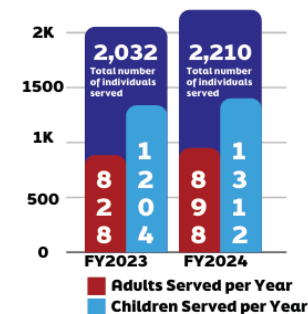
Adult Outreach Program

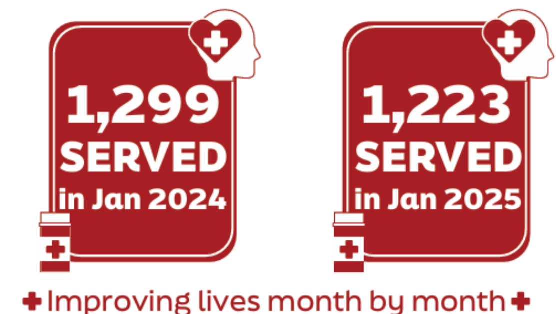
Through our daily group therapy sessions, adults are given a judgment free and engaging place to share their thoughts and challenges. Adults are encouraged to openly talk about their individual issues while improving their own mental wellness.

93% Feel more confident after participating in open dialog conversations

150+ Individuals Impacted for the month

As a **Certified Community Behavioral Health Clinic (CCBHC),** we are in our third year of operating as a successful integrated care clinic. We are eager to continue providing comprehensive mental health and substance use services while emphasizing coordinated care among service providers.





1. **Engaging Service Partners**: Hillcrest Center believes in building trust based working relationships with individuals, families, and community partners to support the recovery of the people we serve.
2. **Understanding The Situation**: Hillcrest Center believes in the ongoing collection of information that will helps us understand the people we serve and inform our practice.
3. **Planning Positive Life Changing Interventions:** Hillcrest Center believes that person centered planning for positive life changes is an ongoing process.
4. **Implementing Services:** Hillcrest Center provides services that are timely and responsive to the needs and preferences of the people we serve.
5. **Getting and Using Results:** Hillcrest Center is results oriented. We gain knowledge through our experiences. We use knowledge and evidence based practices to achieve outcomes for the people we serve.

What we do & How we do it.

Child Services at Hillcrest

- Child Community Support (CST)
- School-Based Services
- Community-Based Intervention (CBI)
- Psychiatric, Nursing, and Medication Management Services
- Therapy
- Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)
- Trauma Systems Therapy (TST)
- PCP Referrals
- Health, Wellness, and Recovery (Substance Use Program for Youth)

Adult Services at Hillcrest

Assertive Community Treatment (ACT): An intensive, team-based program that provides comprehensive mental health support to individuals with severe mental illness, aimed at promoting stability and independence through community integration.

Supportive Employment: Assists individuals in finding and maintaining employment as part of their recovery plan, integrating job support with overall treatment.

Adult Community Support (CST): Services that help adults achieve stability and independence through case management, counseling, and coordination with social and health services.

Housing Support: Short-term rental assistance and support services that help individuals and families quickly secure and maintain housing while promoting self-sufficiency. External referral required.

Psychiatric, Nursing, and Medication Management Services: Clinical services involving mental health assessments, diagnosis, and ongoing management of health and medications to support clients' behavioral health needs.

Therapy: Individualized therapeutic sessions aimed at addressing various mental health issues and fostering emotional well-being through evidence-based approaches. Various groups available.

PCP Referrals: Referrals to primary care providers for general health assessments and follow-ups to ensure clients receive comprehensive care alongside mental health services.

Health, Wellness, and Recovery (Substance Use Program for Adults): Counseling and support programs

Hillcrest Ryan White Part A Program Integrated Behavioral Health & HIV Services | Washington, DC

- Service Categories: Mental Health & Substance Use Outpatient
- Embedded within Hillcrest's CCBHC integrated care model
- Primary Service Areas: Wards 7 & 8
- Outreach and support provided in all Wards
- Two clinical sites: NW (RI Ave) & SE (MLK Ave)

Organizational Infrastructure

- Joint Commission & CARF Accredited
- Multidisciplinary Team:

  - Licensed Clinicians (LICSW, LPC, CAC)
  - APRN (HIV testing & medical coordination)
  - Peer Specialists
  - Data Manager (CAREWare oversight)
  - Program Manager (oversight & compliance)

- Trauma-informed, culturally responsive, harm-reduction framework

Program Execution Model (How It Works)

- Client Flow:

1. Mental and Behavioral Health Intake
2. Risk Assessment by Licensed Clinician
3. On-site HIV Testing (APRN)
4. Immediate Counseling & Results Review
5. Care Coordination & Referrals
6. Peer & Group Integration

- Outreach Methods:

• On-site outreach days
• Community pop-up events
• School-based prevention workshops
• Youth & adult psychoeducation groups
• Telehealth access

Geographic Reach

- Northwest Clinic – 915 Rhode Island Ave NW
- Southeast Clinic – 3029 MLK Jr. Ave SE
- Telehealth expansion
- Monthly community testing pop-ups
- School partnerships
- Engagement at community health events
- Primary Impact Areas: Wards 2, 7 & 8
- 10 to 15 MOUs in FY26
- Underserved and historically marginalized communities

Community Partnerships How to Partner with us!

LET'S PARTNER!

PLEASE CONTACT US!

Syerita Morris, LPC, LCPC, LMFT

Director of School-Based and Children Services

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Jamillah Linkins, Director of Substance Use Disorder Services

Jlinkins@Hillcrest-dc.org

Indira Mohabeer, Therapist, MA, LGPC

Imohabeer@Hillcrest-dc.org

Debra Byrd, Director of Impact and Development

Dbyrd@Hillcrest-dc.org

Ryan White Clinical Quality Management Program Requirements

Courtney Middlebrook, Quality Management Specialist

Arielle Hart, Quality Improvement Specialist

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Objectives

- Provide a Clinical Quality Management (CQM) Program Overview and Requirements
- Provide a list of Required Quality Deliverables
- Provide Important Dates
- What can you expect from your Quality Improvement Coaches
- What do we expect from you

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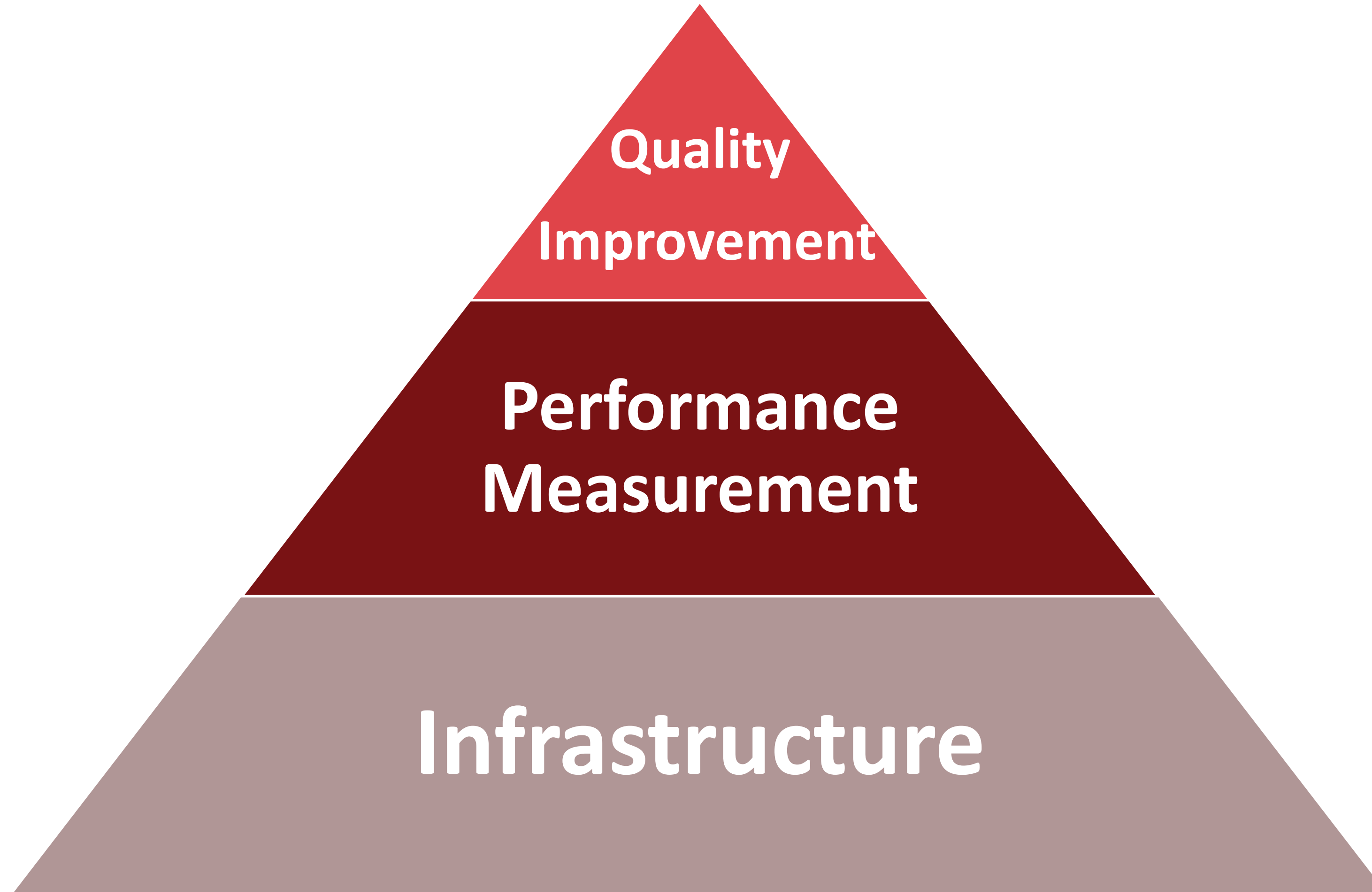
GOVERNMENT OF THE DISTRICT OF COLUMBIA

Ryan White Quality Management Program Requirements

- The Health Resources and Services Administration HIV/AIDS Bureau (HRSA/HAB) requires that all Ryan White HIV/AIDS Program (RWHAP) Part A recipients have a **Clinical Quality Management (CQM) Program.**
- Per HRSA's **Policy Clarification Notice (PCN) 15-02**, a CQM program is the coordination of activities aimed at improving patient care, health outcomes, and patient satisfaction.
- **Subrecipients** are also required to have their own Quality Management Programs.

The Three Quality Management Program Components



Quality Management Program Requirements

<table>
<tr><th>Quality Management Program Components</th><th>Requirements of Each Component</th></tr>
<tr><td>Infrastructure</td><td>1. Leadership Involvement
2. Quality Management Committee
3. Dedicated Staffing
4. Dedicated Resources
5. Quality Management Plan
6. Customer Involvement
7. Stakeholder Involvement
8. Quality Management Program Evaluation</td></tr>
<tr><td>Performance Measures</td><td><table>
<tr><th>Percent of RWHAP eligible clients receiving at least one unit of service for a RWHAP-funded service Category</th><th>Minimum number of performance measures</th></tr>
<tr><td>>=50%</td><td>2</td></tr>
<tr><td>>15% to <50%</td><td>1</td></tr>
<tr><td><=15%</td><td>0</td></tr>
</table></td></tr>
<tr><td>Quality Improvement</td><td>Quality Improvement Projects
• In response to performance data results
• Within at least one (1) funded service category at any given time
• Aimed at improving patient care, health outcomes, and patient satisfaction</td></tr>
</table>

* Subrecipients are also required to participate in the HAHSTA Quality Team Customer Satisfaction Survey.

Quality Management Program Deliverables

- Annual Deliverables:
  - Quality Management Plan (including work plan and performance measure portfolio)
- Quarterly Deliverables:
  - Performance Measure Summary Report
  - Quality Management Committee Meeting Minutes
  - Quality Improvement Project Report
  - Documented Proof of Customer Involvement
- Templates will be provided for your convenience

Quality Deliverable Due Dates

Frequency	Deliverable	Due Dates
Annually	Quality Management Plan (with Work Plan and Performance Measure Portfolio)	Within 30 days of start of Grant Year (by March 30, 2026)
Quarterly	Quality Improvement Project (QIP)	1st Quarter, July 1, 2026 2nd Quarter, October 1, 2026 3rd Quarter, January 2, 2027 4th Quarter, April 1, 2027
	Performance Measure Summary Report (including baseline, target, quarterly data, and analysis)	1st Quarter, July 1, 2026 2nd Quarter, October 1, 2026 3rd Quarter, January 2, 2027 4th Quarter, April 1, 2027
	Quality Management Committee Meeting Minutes	1st Quarter, July 1, 2026 2nd Quarter, October 1, 2026 3rd Quarter, January 2, 2027 4th Quarter, April 1, 2027
	Documented Proof of Customer Involvement (i.e., anonymous survey results, customer participation in quality committee or CAB meetings, compiled suggestion box feedback, etc.).	1st Quarter, July 1, 2026 2nd Quarter, October 1, 2026 3rd Quarter, January 2, 2027 4th Quarter, April 1, 2027

Meet Your Quality Team

Arielle Hart
Quality Coach

Laura Whittaker
Quality Coach

Roger Isom
Quality Coach

Courtney Middlebrook
Quality Management Specialist

Contact us: **RW.QUALITY@DC.GOV**

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GOVERNMENT OF THE DISTRICT OF COLUMBIA

What to Expect from Your Quality Team

- Personalized guidance on completing required quality deliverables.
- Collaboration with you and your team to design and implement impactful quality improvement projects.
- Delivery of tailored training sessions to build knowledge and skills for implementing successful quality initiatives.

What Your Quality Team Expects from You

- On-time submission of Quality deliverables
- Communication – we can’t support if we don’t know you need help
- Collaboration & participation
- If you don’t know, please ask

Knowledge Check

What are the three components of a Quality Management Program?

A. Customer Involvement, Stakeholder Involvement, Leadership Involvement
B. Quality Management Plan, Quality Improvement Project, Performance Measure Summary Report
C. Infrastructure, Performance Measurement, and Quality Improvement
D. Quality Coaching, Deliverables Templates, Customer Satisfaction Survey Participation

Correct Answer: C

DC Quality Learning Collaborative

Courtney Middlebrook, Quality Management Specialist

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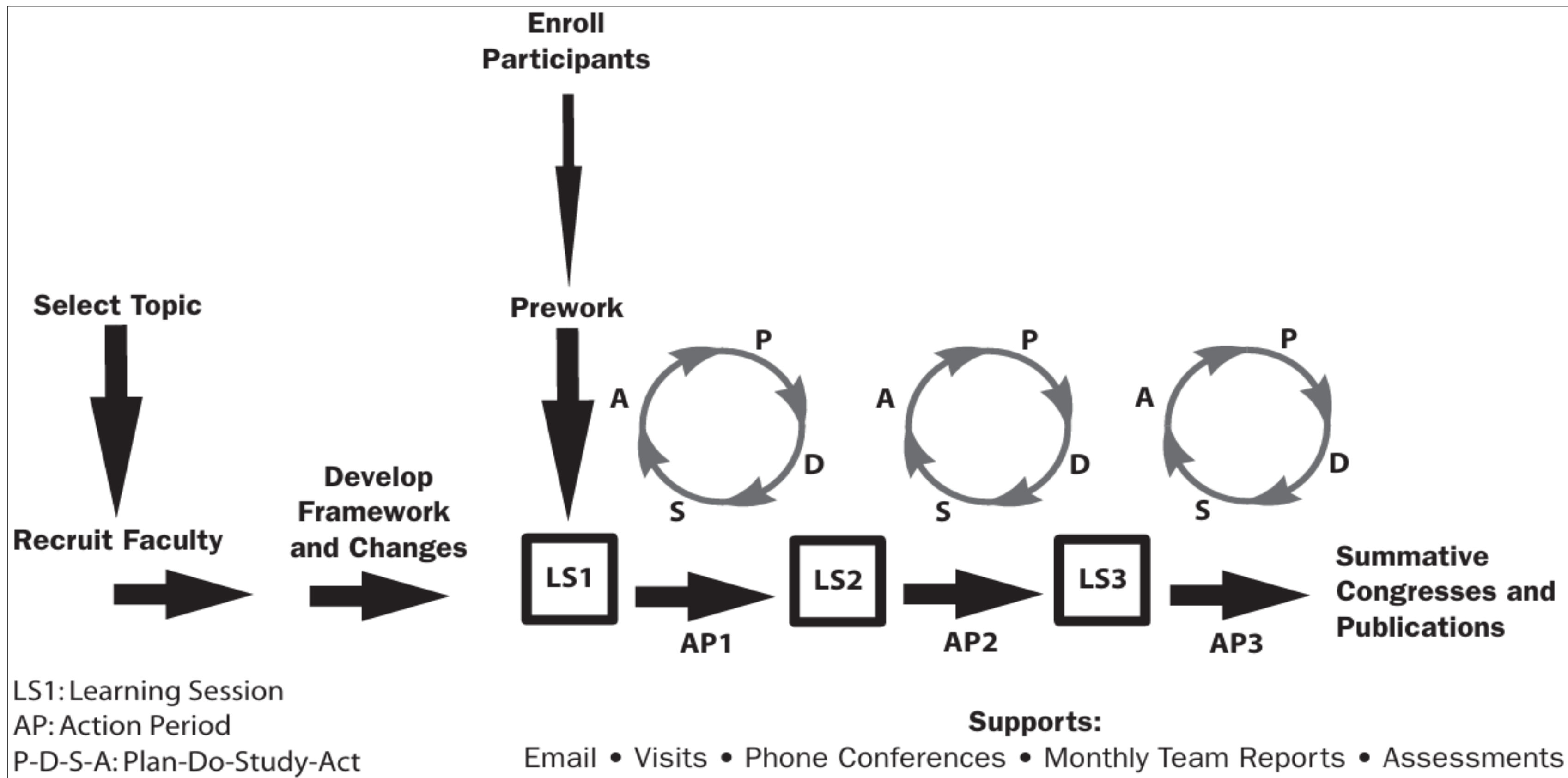
What will be covered

- What is the DC Quality Learning Collaborative?
- What is the DC Quality Response Team?
- Purpose of Learning Collaborative
- Response Team and Subject Matter Expert recruitment
- Response Team and Subject Matter Expert time commitment and expectations
- Tentative Timeline

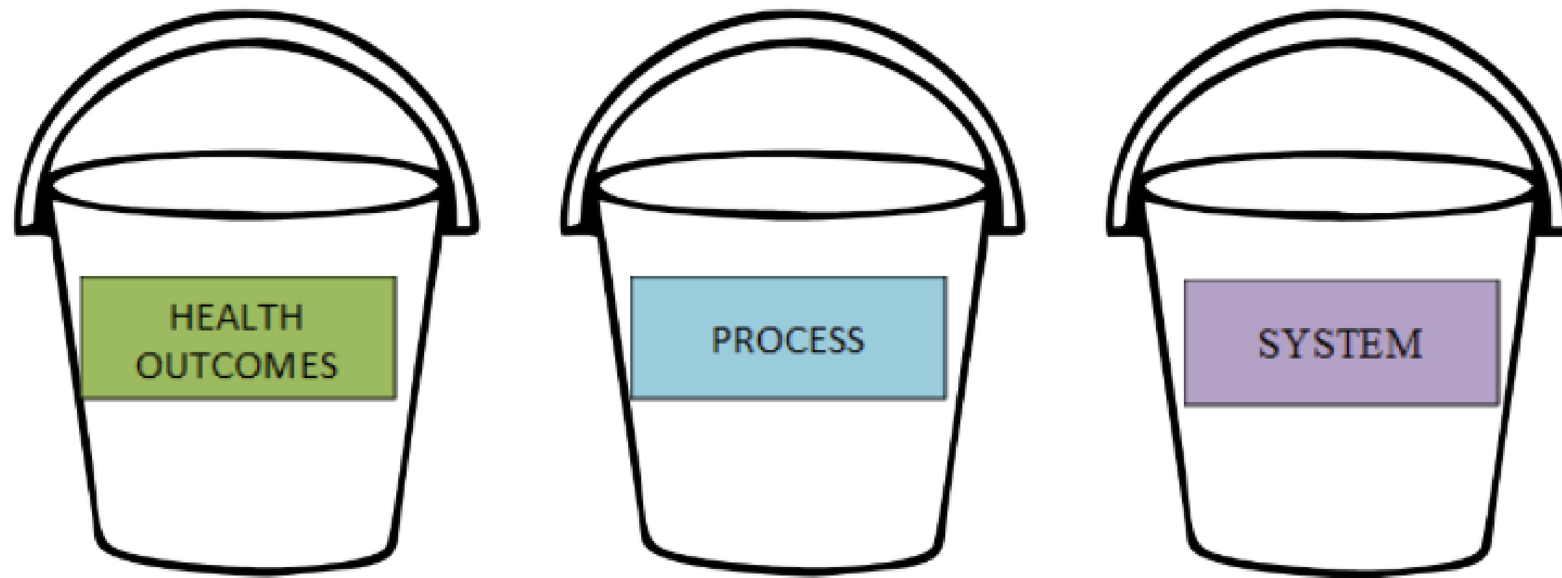
What is the DC Learning Collaborative?

- **Purpose**: to foster collaboration among participating HAHSTA Ryan White subrecipient organizations and achieve the Collaborative aims.



Source: Institute for Healthcare Improvement, The Breakthrough Series IHI's Collaborative Model for Achieving Breakthrough Improvement, 2003.

What are the aims of this Learning Collaborative?



HEALTH OUTCOMES	PROCESS	SYSTEM
1. Increase Rapid StART for newly diagnosed persons.	3. Participating site teams improve their QI acumen as measured using a standardized assessment tool.	4. Define and standardize Collaborative Performance Measures in CAREWare.
2. Increase Rapid PrEP for customers.		

Image 1. This graphic shows the three focus areas that the four aims for the DC Collaborative fall into.

What is the DC Quality Response Team?

- **Purpose:** to serve as the steering committee that plans and leads the Learning Collaborative.
- Comprised of 11 main roles + subject matter experts (SMEs)
  - We are recruiting for 5 main roles and SMEs

Main Role Vacancies
Collaborative Response Team Co-Lead
Quality Improvement Co-Lead
Customer Liaison Co-Lead
Recorder
Communicator

SME Areas of Expertise Needed
PrEP Coordination
Pharmacy
Clinical
Social Work
Rapid StART
Intake specialization

Join the Quality Response Team!

Vacant
Quality Improvement Leads

- Lead the Collaborative in dialogue regarding project improvement activities
- Provide technical assistance and other supports around those activities
- Set Collaborative goals for each improvement project
- Manage the effective communication of best practices related to the project among Collaborative members

Vacant
Collaborative RT Co-Lead

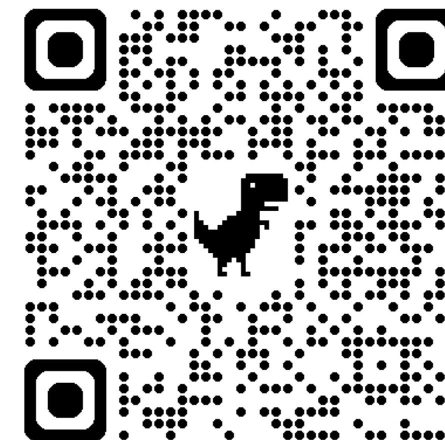
- Facilitate Response Team meetings
- Interface with Response Team, HAHSTA Leadership, participating organizations
- Manage Collaborative project timeline, budget, etc.
- Lead the Response Team in ascertaining and accomplishing goals
- Facilitate planning Collaborative events
- Facilitate identifying key priorities and milestones for the Collaborative
- Set the agenda for the Response Team meetings

Vacant
Communicator

- Coordinate all email communication for the Collaborative participants
- Format and editing all Collaborative products developed for distribution
- Develop web page and workspace content
- Identify a time and working with the Co-Leads to find space for Response Team and Collaborative participant meetings

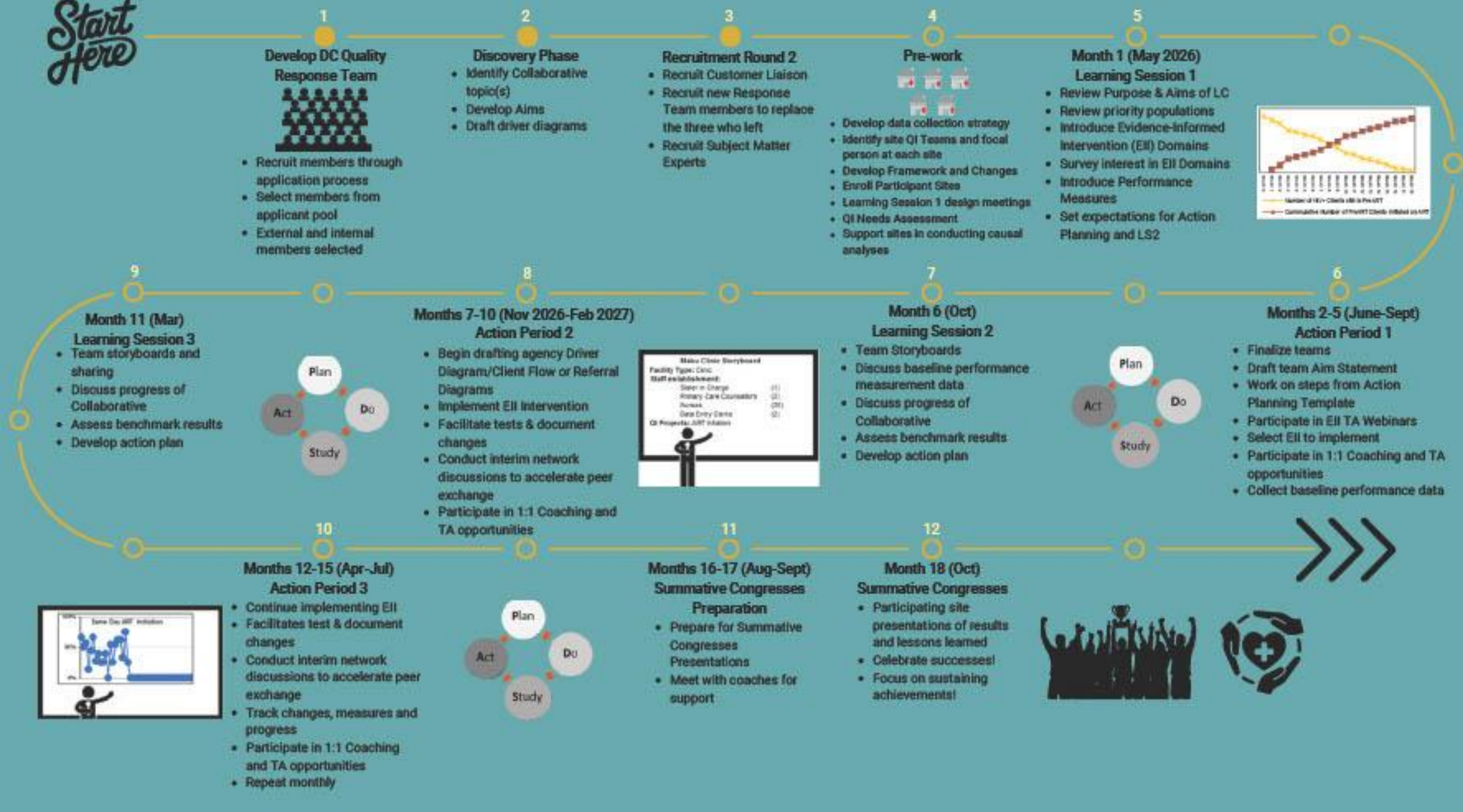
Vacant
Recorder

- Accurately capture the ideas discussed and decisions of the Response Team meetings
- Identify an alternate member to serve as their backup



Time Commitment & Expectations

Response Team Members	SMEs
20-24 months	20-24 months
Attendance at monthly (sometimes twice per month) Response Team meetings	Attendance at Response Team meetings
Completion of assigned tasks between meetings, as needed	Completion of assigned tasks between meetings, as needed
Participate in the design and implementation of the learning sessions	Support the design and implementation of three learning sessions
Provide coaching to participating sites during the three action periods, as needed	Provide coaching to participating sites during action periods, as needed
Present/speak at learning sessions, if/as needed	Present/speak at learning sessions, as needed, and possibly at the final presentation session
Perform the duties of your selected role	Collaborate with/provide expertise input for Response Team, as needed


DC LEARNING COLLABORATIVE ROADMAP TIMELINE
Start Here
1
Develop DC Quality Response Team
Recruit members through application process
Select members from applicant pool
External and internal members selected
2
Discovery Phase
Identify Collaborative topic(s)
Develop Aims
Draft driver diagrams
3
Recruitment Round 2
Recruit Customer Liaison
Recruit new Response Team members to replace the three who left
Recruit Subject Matter Experts
4
Pre-work
Develop data collection strategy
Identify site QI Teams and focal person at each site
Develop Framework and Changes
Enroll Participant Sites
Learning Session 1 design meetings
QI Needs Assessment
Support sites in conducting causal analyses
5
Month 1 (May 2026)
Learning Session 1
Review Purpose & Aims of LC
Review priority populations
Introduce Evidence-Informed Intervention (EII) Domains
Survey interest in EII Domains
Introduce Performance Measures
Set expectations for Action Planning and LS2
6
Months 2-5 (June-Sept)
Action Period 1
Finalize teams
Draft team Aim Statement
Work on steps from Action Planning Template
Participate in EII TA Webinars
Select EII to implement
Participate in 1:1 Coaching and TA opportunities
Collect baseline performance data
Plan
Do
Study
Act
7
Month 6 (Oct)
Learning Session 2
Team Storyboards
Discuss baseline performance measurement data
Discuss progress of Collaborative
Assess benchmark results
Develop action plan
8
Months 7-10 (Nov 2026-Feb 2027)
Action Period 2
Begin drafting agency Driver Diagram/Client Flow or Referral Diagrams
Implement EII intervention
Facilitate tests & document changes
Conduct interim network discussions to accelerate peer exchange
Participate in 1:1 Coaching and TA opportunities
9
Month 11 (Mar)
Learning Session 3
Team storyboards and sharing
Discuss progress of Collaborative
Assess benchmark results
Develop action plan
10
Months 12-15 (Apr-Jul)
Action Period 3
Continue implementing EII
Facilitates test & document changes
Conduct interim network discussions to accelerate peer exchange
Track changes, measures and progress
Participate in 1:1 Coaching and TA opportunities
Repeat monthly
11
Months 16-17 (Aug-Sept)
Summative Congresses Preparation
Prepare for Summative Congresses Presentations
Meet with coaches for support
12
Month 18 (Oct)
Summative Congresses
Participating site presentations of results and lessons learned
Celebrate successes!
Focus on sustaining achievements!

Fiscal Management

Janice Carroll, Supervisory Grants Management Specialist

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Topics of Discussion

- Introductions & Agenda
- Understanding Your Notice of Grant Award and Terms and Conditions
- Budgeting and Adjustments
- Understanding Your Purchase Order
- Monthly Invoicing Requirements
  - A Complete Invoice Package
  - Late Invoice Protocol
  - Invoice Approval Process – EGMS
  - Invoice Payment Process – DIFS
- Understanding the Quarterly Report – Fiscal Summary
- Importance of Continuity of Operations
- Imposition of Charges
- Single Audit Requirements

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Grants Management Team

- Milena Acevedo
- Monique Brown
- Rony Mohram
- April Richardson
- Carroll Ward
- Asaah Chambers, Program Support Specialist
- Donovan Walcott, Administrative Specialist
- Janice Carroll, Supervisory Grants Management Specialist

We hope this training is helpful in monitoring the diverse programs at HAHSTA

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Understanding the Notice of Grant Award

NOTICE OF GRANT AWARD

GRANTEE PROFILE

Grantee Organization:
Address: **City:** **State:** **Zip Code:**
UEI #: **FEIN #:**
Organization Head:
Project Director:
Project Director Email Address:
Telephone #: **Fax #:**

AWARD PROFILE

Grant #: HAHSTA-### **Legacy Grant ID:** **Revision #:** HAHSTA-###-0##
Program ID #: HAHSTA--##.##.##
NOGA Status : (New, Continuation)

Project Period Start Date: ##/##/202# **Project Period End Date:** ##/##/202#

Budget Period Start Date: ##/##/202# **Budget Period End Date:** ##/##/202#

Project Period Maximum Award: $###,###.##
Budget Period Award:
Change in Award this action:
Total Budget Period Award: $##,###.##

Authorizing Statute: Ryan White HIV/AIDS Treatment Extension Act of 2009

Fund Source
Title : Ryan White Part A
CFDA# (if Applicable): 93.914 **FAIN# :** H89HA00012
Federal Award Date: **Total Federal Award Amount:** $#,###,###.00

This grant is subject to the terms and conditions incorporated either directly or by reference in the following:

a. The authorizing statute for grant-making and funding as stated on the Notice of Grant Award (re: CFDA# and FAIN, if applicable)
b. District of Columbia Budget Support Act by the most current, applicable fiscal year
c. The Mayor's Order authorizing the Director of the District of Columbia Department of Health (DC Health) to make grants under the program cited;
d. The rules governing this grant authority, including uniform administrative requirements and cost principles per Office of Management and Budget 2 CFR 200
e. NOGA Standard Terms and Conditions accepted by the Grantee electronically via the Enterprise Grants Management System (EGMS);
f. District of Columbia City-Wide Grants Manual
g. D.C. Government regulations and DC Health standard operating procedures governing this grant authority;
h. DC Health policy and procedures for RFA and NOGA issuance and revisions
i. DC Health Functions Clarification Act of 2001 (D.C. Law 1428; D.C. Official Code § 7731 et seq.).
j. DC Health Requests for Applications under which, if applicable, the Grantee was awarded
k. The Funding Opportunity (FO) Guidance, application, approved pre-award and post-award submissions and revision documents;
l. The Grantee's approved work plan and budget

Grantee Organization	Grant#	Revision#

1

Why is it important to understand your NOGA?

Understanding the Notice of Grant Award

- **What is the Notice of Grant Award (NOGA)?**

The NOGA, also known as a Notice of Award (NoA), is the *official grant award document* notifying the grantee that the award has been made. It is a legally binding document that informs a grantee of the award, and important information about the grant, such as

- The grant number
- The amount of the award
- The project period, the total time frame of the award, i.e., one, three, or five years
- The budget period, the time frame for which a budget is approved for the award
- The receiving organization
- The key personnel for the grant
- Any restrictions or special conditions on the award
- The terms and conditions of the grant
- The funding limits and obligations

The NOGA is created and stored in the Enterprise Grants Management System (EGMS)

Understanding the Notice of Grant Award (continued)

- **Why is the NOGA important?**

To ensure compliance with District of Columbia regulations and federal grant requirements:

Subrecipients must have a fully executed NOGA in place before starting or continuing any services

Please review the NOGA thoroughly to ensure you fully understand your responsibilities and compliance requirements before beginning service delivery

All revisions and/or modifications to the original NOGA must be fully executed in EGMS BEFORE providing or invoicing for services.

Contact your monitoring team, Program Officer or Grant Monitor, if you have any questions.

Understanding the Terms and Conditions

- **What are the Terms and Conditions and Where do I find them?**

The standard Terms and Conditions is a document that sets forth the requirements for DC Health and the subrecipient to comply with District and federal laws, regulations, administrative issuances, and funding authorizations for specific programs or types of services.

Be sure you know the terms and conditions for which you agree before selecting "I read the terms and agree"

Understanding the Terms and Conditions (continued)

- **Why are the Terms and Conditions Important?**

  Key Focus Areas

  - Administrative Requirements – to include Cash Management; Time and Effort Certification; Budget and Work Plan to include Cost Allocation Plan and Summary of Funding Sources; and Staffing Plan
  - Reporting Requirements
  - Fund Disbursement
  - Staffing
  - Procurement & Subcontracting
  - Accounting and Audits
  - Program Closeout
  - Transition for Continuity of Services

Budgeting and Adjustments

Why is the Budget so important?

Understanding Budgeting

- **Why is the budget so important?**

  Your budget is a detailed plan that aligns financial resources with the program's goals and objectives. It provides a roadmap for how funds will be used to achieve the desired outcomes over the specified period.

  A clear understanding of the services and activities provided to meet the monitoring standards of the funded program is crucial in preparing a budget

  The budget comprises a summary of the standard line items per funded service area.

  - Personnel services – salary and fringe benefits
  - Non-personnel services – supplies, consultant fees, client costs, etc.
  - Indirect/Admin costs

It's essential to be transparent, accurate, and realistic in estimating costs and allocating resources to ensure the successful execution of the grant program.

Understanding Budgeting (continued)

- **What are some key factors to consider when preparing the budget?**
  - Service Area details that specify what tasks will be undertaken, the nature of the service, and any related deliverables.
  - Timelines that outline the program's schedule, milestones, and the timing of different program components.
  - Personnel allocation of each staff person responsible for implementing the planned activities, their roles, responsibilities, and the corresponding costs.
  - Budget justification explaining why specific costs are necessary, demonstrating how those costs contribute to achieving the program's goals and objective. It provides a narrative supporting the itemized budget, showing the rationale behind each line item.

Understanding Budgeting (continued)

- **Is there anything else I need to know?**

  Your monthly invoices should be allocated based on the approved budget. It allows the tracking and recording of expenditures based on the services provided and supports the number of clients served (if applicable) for reporting requirements to HAHSTA's Federal Grantor.

  Best Practice: Review the Categorical Budget in EGMS once you receive the NOGA to ensure it is the correct approved budget to avoid the need for budget adjustments based on an incorrect budget.

What happens if we need to adjust the budget?

Understanding Budget Adjustments

- **What are the Budget and Budget Adjustment Requirements?**

  Per 2 CFR §200.308 Revision of budget and program plans and §200.407 Prior written approval - both budget and budget adjustments require prior approval from the PO and GMS. Approval is required prior to any entries in EGMS and invoicing.

  Budget adjustments include the following:

  - *Modifying the budget (Budget Modification)* within a specific service area.
  - *Reprogramming the budget (Reprogramming)* that involves transferring funds between service areas.

  These actions become necessary when expenditures deviate from the approved budget and workplan. Once approved, the initiation of change request in EGMS can be made by the sub-recipient, PO, or GMS.

- *Budget adjustment **ARE NOT** permitted within the last 90 days of the grant budget period without approval from the Program Manager.*
- ***NO** adjustments are permitted within the last 30 days of the grant budget period.*

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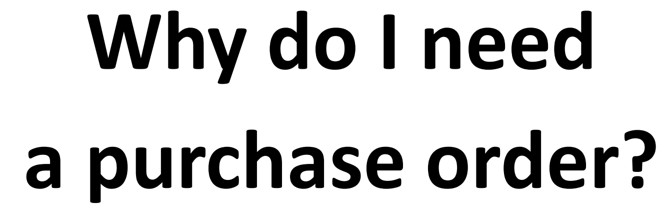
Understanding the Purchase Order


Why do I need
a purchase order?

Understanding Your Purchase Order

- **What is a Purchase Order and Why Do I Need One?**

  A Purchase Order is a document used to legally bind the supplier (sub-recipient) and the District of Columbia for payment of good and services provided according to the NOGA.

  A valid Purchase Order (PO) is also **REQUIRED** to authorize expenditures and service delivery.

  Services provided without both a NOGA and a valid Purchase Order in place run the risk of not getting reimbursed. This policy ensures accountability, financial compliance, and adherence to grant regulations.

  The purchase order is generated by the District's Integrated Financial System (DIFS).

Understanding Your Purchase Order (continued)

- **Why Do I Have Two (2) Purchase Orders**

  The District's fiscal year ends September 30, 2025. All POs are closed during the District's Year-End Close. Therefore, sub-recipients will receive two (2) purchase orders during the NOGA budget period as follows:

Federal Funding Source	PURCHASE ORDER #1	PURCHASE ORDER #2
RWHAP – Part A	March 2026 – September 2026	October 2026 – February 2027
RWHAP – Part B	April 2026 – September 2026	October 2026 – March 2027

  It is advantageous to submit invoices, especially September's invoice, by the due date to ensure timely payment. Invoices submitted after the requested due date for September's invoice will result in a delay in payment.

Understanding Your Purchase Order (continued)

- **Why does the Purchase Order have multiple lines?**

  The purchase order is created according to the funding and reporting requirements of the grant award. The sub-recipient is responsible for ensuring that the correct expenditures are invoiced on the appropriate line item. Please work with your assigned GMS if there are any discrepancies.

  See the next two slides for examples of how to understand your purchase order

Understanding Your Purchase Order (continued)

- **Sample Purchase Orders**

Sample RW Part A Purchase Order

RW Part A w/o MAI Purchase Order

Line	Item	Description		Quantity	UOM	Base Price	Price	Ordered	Status
1		HAHSTA2025-###- RW Part A Reg Direct -Subrecipient Name	PO: 10/01/25 - 02/28/26 Award: 06/01/25 - 02/28/26	###,###	EA	1.00	1.00	###,###.00	Open
2		HAHSTA2025-###- RW Part A Reg Admin -Subrecipient Name	PO: 10/01/25 - 02/28/26 Award: 06/01/25 - 02/28/26	##,###	EA	1.00	1.00	##,###.00	Open

Sample RW Part A/Part A MAI Purchase Order

RW Part A with MAI Purchase Order

Line	Item	Description		Quantity	UOM	Base Price	Price	Ordered	Status
1		HAHSTA2025-###- Part A Reg. Direct- Subrecipient Name	PO: 10/01/25 - 02/28/26 Award: 06/01/25 - 02/28/26	###,###	EA	1.00	1.00	###,###.00	Open
2		HAHSTA2025-###- Part A Reg. Admin- Subrecipient Name	PO: 10/01/25 - 02/28/26 Award: 06/01/25 - 02/28/26	##,###	EA	1.00	1.00	##,###.00	Open
3		HAHSTA2025-###- Part A MAI Direct- Subrecipient Name	PO: 10/01/25 - 02/28/26 Award: 06/01/25 - 02/28/26	###,###	EA	1.00	1.00	###,###.00	Open
4		HAHSTA2025-###- Part A MAI Admin- Subrecipient Name	PO: 10/01/25 - 02/28/26 Award: 06/01/25 - 02/28/26	##,###	EA	1.00	1.00	##,###.00	Open

Sample RW Part B/Funding Source 2 Purchase Order

RW Part B & Funding Source 2 Purchase Order

Line	Item	Description		Quantity	UOM	Base Price	Price	Ordered	Status
1		HAHSTA20##-### - RW Part B Direct -Subrecipient Name	PO: 10/01/25 - 03/31/26	###,###	EA	1.00	1.00	###,###.00	Open
2		HAHSTA20##-### - RW Part B Admin - Subrecipient Name	PO: 10/01/25 - 03/31/26	##,###	EA	1.00	1.00	##,###.00	Open
3		HAHSTA20##-### - RW Part B Source 2 Direct - Subrecipient Name	PO: 10/01/25 - 03/31/26	###,###	EA	1.00	1.00	###,###.00	Open
4		HAHSTA20##-### - RW Part B Source 2 Admin -Subrecipient Name	PO: 10/01/25 - 03/31/26	##,###	EA	1.00	1.00	##,###.00	Open

Understanding Your Purchase Order (continued)

Service Area List EGMS RW Part A/Part A MAI Categorical Budget

Service Area Name	Awarded Amount	Adjustment Amount	Proposed Amount	
Oral Health RW Part A Direct	$ .00	$0.00	$ .00	View Service Area Budget
Mental Health Services RW Part A Direct	$ .00	$0.00	$ .00	View Service Area Budget
Medical Nutrition Therapy RW Part A Direct	$ .00	$0.00	$ .00	View Service Area Budget
Early Intervention Services RW Part A Direct	$ .00	$0.00	$ .00	View Service Area Budget
Psychosocial Support Service RW Part A Direct	$ .00	$0.00	$ .00	View Service Area Budget
Substance Abuse Outpatient Care RW Part A Direct	$ .00	$0.00	$ .00	View Service Area Budget
Medical Care Coordination - Medical Case Management Services (MCM) RW Part A Direct	$ .00	$0.00	$ .00	View Service Area Budget
Medical Care Coordination - Non-Medical Case Management (NMCM) RW Part A Direct	$ .00	$0.00	$ .00	View Service Area Budget
Other Professional Services (OPS) RW Part A Direct	$ .00	$0.00	$ .00	View Service Area Budget
Medical Care Coordination - Outpatient/Ambulatory Health Services (O/AHS) RW Part A Direct	$ .00	$0.00	$ .00	View Service Area Budget
Administration Part A RW Part A Admin	$ .00	$0.00	$ .00	View Service Area Budget
Administration Part A MAI RW Part A MAI Admin	$ .00	$0.00	$ .00	View Service Area Budget
Medical Case Management (MAI) RW Part A MAI Direct	$ .00	$0.00	$ .00	View Service Area Budget
Medical Transportation Services RW Part A Direct	$ .00	$0.00	$ .00	View Service Area Budget
MAI - Non-Medical Case Management (NMCM) RW Part A MAI Direct	$ .00	$0.00	$ .00	View Service Area Budget
MAI - Outpatient/Ambulatory Health Services (O/AHS) RW Part A MAI Direct	$ .00	$0.00	$ .00	View Service Area Budget

Current Budget EGMS Part A/Part A MAI Categorical Budget

Category Name	Awarded Amount	Adjustment	Total
Direct(Total of rows*)	$ .00	$0.00	$ .00
Indirect	$ .00	$0.00	$ 00
Total (Direct+InDirect)	$ .00	$0.00	$ .00

Monthly Invoicing Requirements

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What supporting documents should I include with my invoice?

Invoicing Requirements

- **What is included in a Complete Invoice Package?**

  The submission of a complete invoice package in EGMS includes, but is not limited to, the following:

  - HAHSTA's Invoice cover sheet
  - General ledger
  - Financial summary report for each service category
  - Signed timesheets verifying hours worked*
  - Payroll register
  - Narrative Progress report
  - CareWare Data report

Invoicing Requirements (continued)

- **What is included in a Complete Invoice Package? (continued)**

  Any additional support documentation may include, but not limited to, the following:

  - Signed consultant agreements prior to invoicing
  - Signed lease agreements prior to invoicing
  - Approved Personnel Amendment* forms prior to invoicing
  - Receipts to support charges and incurred costs

  Invoices submitted without the required documents will be rejected

  Be sure to ask your GMS for the revised HAHSTA Invoice Coversheet with the instructions. It's also available on the RWTC website.

REMINDER: RWHAP grants are reimbursable grants. Cost must be incurred and paid for before submitting an invoice for the charges.

Invoicing Requirements (continued)

- **Am I completing the Invoice Cover Sheet correctly?**

  Changes have been made to the HAHSTA Invoice Cover Sheet to align with the information in EGMS for transparency and accountability. Those changes are as follows:

  - Grant number is now the EGMS SubGrant Award number

    HAHSTA2025-###-###

  - **Invoice Number is now the EGMS Payment Request Number**

    HAHSTA2025-###-PD-200##-Month-2025

  - The Year-to-Date Expenditures, Current Balance and % Spent columns and the Subtotal and Total rows auto-populate and are password protected. Columns are provided and hidden for your convenience to record each month's invoice and to track the information in the above columns. Be sure to unhide the column for the month being invoiced and hide the previous and next months.

  In addition, all invoice coversheets must be signed and dated.

Invoicing Requirements (continued)

- **How do I know I'm using the correct Invoice Cover Sheet?**

  Additional changes include the following:

  - Subtotal Direct Cost Line
  - Line 12 is the Total Monthly Invoice (the amount approved in EGMS)
  - *Adjustments to Invoice* line (the amount deducted or added to invoice due to insufficient funds on the purchase order OR disallowance of previously approved cost.)
  - Line 13 is the Total Invoice Amount (the amount to be paid)
  - Multi-funded grants use a different invoice cover sheet that separates the expenditures by funding source, i.e., RW Part B plus Funding Source 2.

See the next slide for samples of the correct Invoice Cover Sheet

Invoicing Requirements (continued)

- **Sample Invoice Cover Sheet**

Single Funding Source Invoice Cover Sheet

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HIV/AIDS, HEPATITIS, STD, TB ADMINISTRATION

INVOICE COVER SHEET

Date Received (Agency Use Only)

Supplier Name
Supplier Payment Address

EGMS SubGrant Award # HAHSTA202#-###-###
Invoice Number HAHSTA20##-###-PD-200##-Month-2025
Billing Period to
Grant Period to

Fed ID No.
Service/Program

	(1) TOTAL DC Health Budget	(2) Expenditure [MONTH 1] TOTAL	(3) Year-to-Date Expenditures	(4) Current Balance	(5) % Spent
1. Salaries and Wages			$ -	$ -	#DIV/0!
2. Fringe Benefits			$ -	$ -	#DIV/0!
3. Consultants/Experts			$ -	$ -	#DIV/0!
4. Occupancy Costs			$ -	$ -	#DIV/0!
5. Travel			$ -	$ -	#DIV/0!
6. Supplies			$ -	$ -	#DIV/0!
7. Capital Expenditures			$ -	$ -	#DIV/0!
8. Client Costs			$ -	$ -	#DIV/0!
9. Communications			$ -	$ -	#DIV/0!
10. Other Direct Cost			$ -	$ -	#DIV/0!
Subtotal Direct Cost	$ -	$ -	$ -	$ -	#DIV/0!
11. Indirect Cost/Admin			$ -	$ -	#DIV/0!
12. Total Monthly Expenditures	$ -	$ -	$ -	$ -	#DIV/0!
Adjustments to Invoice			$ -	$ -	
13. Total Invoice Amount		$ -	$ -	$ -	

Supplier's Certification: I certify that the amounts claimed are true and are fully supported by the detailed accounting records of my organization, which are available for examination and/or audit.

Signature Date

Print Name Phone

The attached Payment Authorization Notice, together with this cover sheet where the amounts listed on both documents are consistent, confirms the approval of this invoice by HAHSTA Staff.

SUBMIT ORIGINAL ONLY

HAHSTA Finance SF-001 05/25

Multiple Funding Source Invoice Cover Sheet

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HIV/AIDS, HEPATITIS, STD, TB ADMINISTRATION

INVOICE COVER SHEET

Date Received (Agency Use Only)

Supplier Name
Supplier Payment Address

EGMS SubGrant Award # HAHSTA202#-###-###
Invoice Number HAHSTA20##-###-PD-200##-Month-202
Billing Period to
Grant Period to

Fed ID No.
Service/Program

	(1) TOTAL DC Health Budget	(2) Expenditure [MONTH 1] TOTAL	(3) Year-to-Date Expenditures	(4) Current Balance	(5) % Spent
Funding Source 1					
1. Salaries and Wages			$ -	$ -	#DIV/0!
2. Fringe Benefits			$ -	$ -	#DIV/0!
3. Consultants/Experts			$ -	$ -	#DIV/0!
4. Occupancy Costs			$ -	$ -	#DIV/0!
5. Travel			$ -	$ -	#DIV/0!
6. Supplies			$ -	$ -	#DIV/0!
7. Capital Expenditures			$ -	$ -	#DIV/0!
8. Client Costs			$ -	$ -	#DIV/0!
9. Communications			$ -	$ -	#DIV/0!
10. Other Direct Cost			$ -	$ -	#DIV/0!
Subtotal Direct Cost	$ -	$ -	$ -	$ -	#DIV/0!
11. Indirect Cost/Admin			$ -	$ -	#DIV/0!
Subtotal RW Part B Regular	$ -	$ -	$ -	$ -	#DIV/0!
Funding Source 2					
1. Salaries and Wages_2			$ -	$ -	#DIV/0!
2. Fringe Benefits_2			$ -	$ -	#DIV/0!
3. Consultants/Experts_2			$ -	$ -	#DIV/0!
4. Occupancy Costs_2			$ -	$ -	#DIV/0!
5. Travel_2			$ -	$ -	#DIV/0!
6. Supplies_2			$ -	$ -	#DIV/0!
7. Capital Expenditures_2			$ -	$ -	#DIV/0!
8. Client Costs_2			$ -	$ -	#DIV/0!
9. Communications_2			$ -	$ -	#DIV/0!
10. Other Direct Cost_2			$ -	$ -	#DIV/0!
Subtotal Direct Cost_2	$ -	$ -	$ -	$ -	#DIV/0!
11. Indirect Cost/Admin_2			$ -	$ -	#DIV/0!
Subtotal Funding Source 2	$ -	$ -	$ -	$ -	#DIV/0!
12. Total Monthly Expenditures	$ -	$ -	$ -	$ -	#DIV/0!
Adjustment to Invoice					
13. Total Invoice Amount	$ -	$ -	$ -	$ -	#DIV/0!

Supplier's Certification: I certify that the amounts claimed are true and are fully supported by the detailed accounting records of my organization, which are available for examination and/or audit.

Signature Date

Print Name Phone

The attached Payment Authorization Notice, together with this cover sheet where the amounts listed on both documents are consistent, confirms the approval of this invoice by HAHSTA Staff.

SUBMIT ORIGINAL ONLY

HAHSTA Finance SF-001 04/25

What happens if I submit the invoice late?

Late Invoicing Protocols

- **What happens if the invoice is late?**

The Office of Grants Management implemented the *Late Invoice Notification Protocol* in fiscal year 2020.

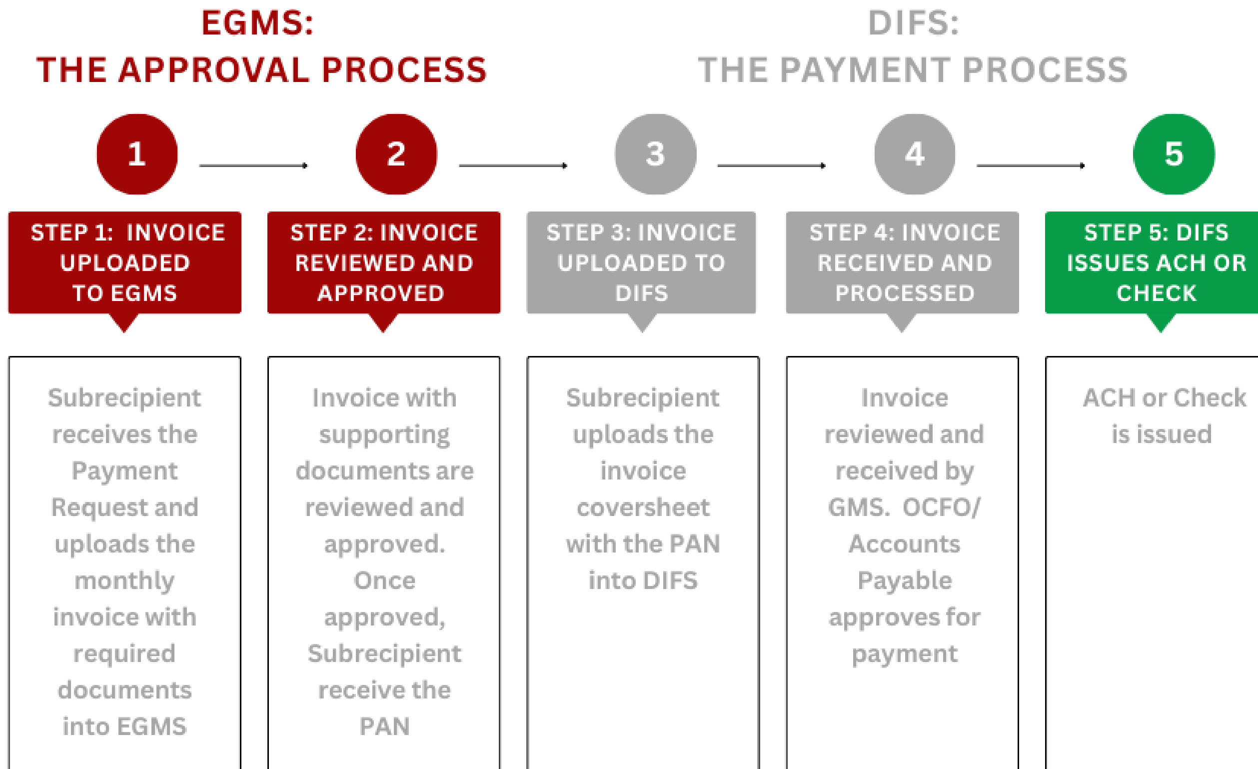
> *The subrecipient must submit the invoice cover sheet with the minimal required supporting documentation in EGMS by the 15th day following the end of each billing period.*

- Submission of invoices is deemed late on the 16th day of the month. The GMS sends the *First Late Invoice Notification* on the 18th day of the month, or the next business day, reminding the subrecipient to submit the invoice within three (3) business days.
- If the subrecipient does not submit the invoice within the requested three (3) business day timeframe, the *Second Late Invoice Notification* is sent requesting the submission of the invoice within the next three (3) business days and issuing a warning of being out of compliance with the grant terms.

Late Invoicing Protocols (continued)

- **What happens if the invoice is late? (continued)**
  - A *Third Notice of Risk of Non-Compliance Letter* is sent from the Supervisory Grants Management Specialist if the invoice remains outstanding after the requested three (3) business days.
  - If the subrecipient remains out of compliance after the additional three (3) business days, at this point, the invoice is now 12 days late, a *formal DC Health Notification of Non-Compliance* is issued from the Office of Grants Management. The subrecipient is assigned a high-risk rating on all grants issued and pending. The subrecipient must submit an agency-level corrective action plan within seven (7) business days. If not received within seven (7) business days, OGM may initiate a change in the grant status (e.g., award reduction, stop work order, or termination.)

Continued failure to comply with the timely submission of monthly invoices will result in being placed on a Remediation or Corrective Action Plan



Why do I have to upload the invoice twice?

Invoice Approval Process - EGMS Payment Request

- **The FIRST STEP of the invoice payment process.**

  EGMS initiates the payment process by automatically generating a monthly ***payment request*** task on the last day of each month or billing period. An email notification and a corresponding task in the portal is created for your convenience. *Please note that the **payment request** is for the previous month's invoice.*

  Sub-recipients enter the details of the monthly invoice per service category per line item and uploads the HAHSTA invoice coversheet and required supporting documentation for approval by the 15th calendar day of the month.

The monthly invoice is approved in EGMS.

Invoice Approval Process - EGMS Payment Request

- **The FIRST STEP of the invoice payment process (continued)**

  The *Primary User* holds the exclusive capability to submit the monthly invoice.

  To ensure a seamless process, sub-recipients must complete any outstanding tasks before proceeding with the current ones.

  Once the payment request receives approval in EGMS, the Payment Authorization Notice (PAN) is sent to all active users.

  For any inquiries, please consult the EGMS 2.0 Reference Guide, specifically Section 07a - Payment Request for Primary Users, accessible through the provided link in EGMS.

Invoice Payment Process - DIFS

- **The SECOND STEP of the invoice payment process.**

The sub-recipient has **three (3) business days** from the receipt of the PAN to upload the *HAHSTA invoice coversheet and PAN* to the purchase order in DIFS.

The information, such as the invoice number, entered in DIFS must match the invoice coversheet and PAN.

The subrecipient is responsible for ensuring that the correct expenditures are invoiced on the appropriate purchase order line item.

Once submitted, the District has 30 days to pay the invoice per the DC Quick Payment Act of 1984.

The monthly invoice is processed for payment in DIFS

DIFS Supplier Portal

- To easily manage and update contact details, addresses, banking information, and business classification, as necessary, please visit https://cfo.dc.gov/supplier_portal and click on 'Existing Suppliers.' It's important to be aware that only the Office of Contracts and Procurement has the authority to update the headquarters address.
- For questions regarding DIFS, please call (202) 442-8700 or send an email to suppliers@dc.gov
- Please refer to the Submit NOGA Invoices and View Payments in the DIFS Supplier Portal Self-Service Job Aid provided for any assistance or visit https://cfo.dc.gov/supplier_portal and click on Resources.

Understanding the Quarterly Report Card – Fiscal Summary

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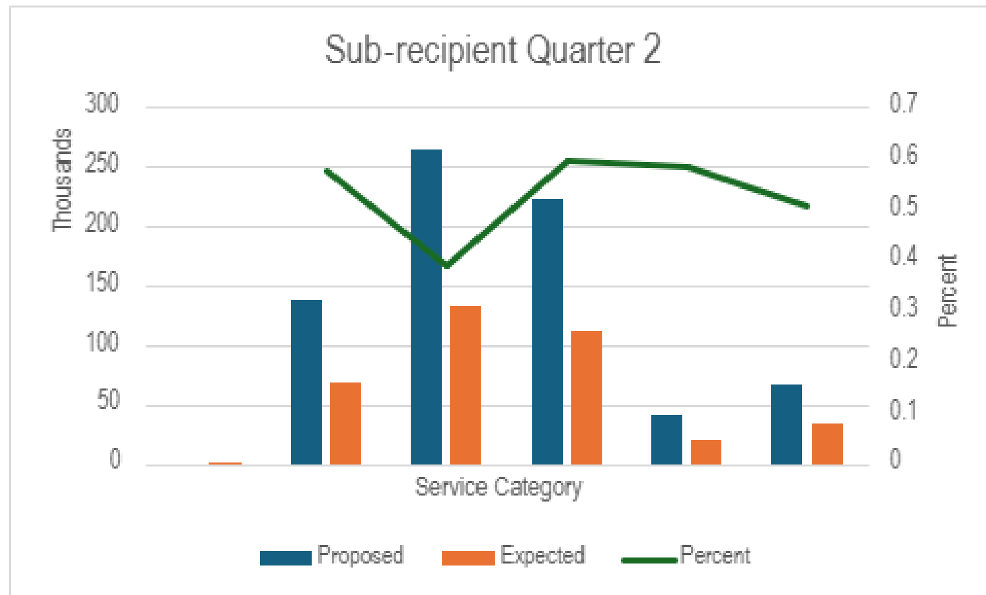
Understanding the Quarterly Report Card – Fiscal Summary



The fiscal portion of the Quarterly Report Card includes the following data for each service category:

- **Budgeted Amount**
- **Projected expenditures** through reported quarter
- **Total amount spent** through the reported quarter
- **Actual expenditures** to date
- **Spend rate** (ratio and percentage of budget spent)

Understanding the Quarterly Report Card – Fiscal Summary

- This data gives a snapshot of the subrecipient's financial performance year to date. Quarterly comments highlight key findings and suggest budget adjustments based on spending trends.
- Also, the data is useful in planning and monitoring the grant project, including identifying opportunities and obstacles to improve service delivery.

Best Practice: Carefully review the combined Programmatic and Fiscal Summaries each quarter to address any over/under-spending by service area and the grant project.

Importance of Continuity of Operations

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Understanding the Importance of Continuity of Operations

- **Ensures uninterrupted service delivery** to clients, even during emergencies or disruptions
- **Protects critical program functions** – including data reporting, fiscal oversight, and client support
- **Demonstrates organizational resilience** and compliance with funding requirements
- **Reduces risk of funding delays** or penalties due to missed deadlines or reporting gaps
- **Supports staff readiness** through clear roles, backup systems, and communication plans

Every organization should have a plan to continue essential operations – because your services matter, even during disruptions.

Imposition of Charges

Imposition of Charges

- **Understanding Imposition of Charges**

Imposition of Charges describe all activities, policies, and procedures related to assessing RWHAP patient charges as outlined in the Public Health Service Act Sections 2605(e), 2617(c), and 2664(e)(1)(B)(ii).

- Based on individual (not family income)
- Prohibits charges imposed on RWHAP patients with incomes at or below the FPL
- Requires charges imposed on RWHAP patients with incomes above the FPL
- Established annual caps on charges

NO RWHAP patient shall be denied service due to an individual's inability to pay

HRSA RWHAP statute does not require that patients that fail to pay be turned over to debt collection agencies

Imposition of Charges (continued)

- **Applicability and Implementation**

  Imposition of Charges applies to those services for which a distinct fee is typically billed within the local health care market.

  It applies to all RWHAP Part A services with assistance provided under the grant

  - RWHAP patients ≤ 100%FPL not charged
  - RWHAP patients > 100% FPL charged
  - **The schedule of charges must be publicly available**
  - Subrecipient must have a system to track imposed charges
  - Subrecipient must have a system to track RWHAP patient reported charges
  - Subrecipient must have a means to cap imposed charges
  - **Subrecipient must ensure services are provided regardless of ability to pay**

Imposition of Charges (continued)

- **Applicability and Implementation (continued)**

  Only Subrecipients operating as free clinics have the option to waive the imposition of charges on RWHAP patients. If services offered are not free, RWHAP patients over 100% FPL should be charged, even if it's only $1

- **Federal Poverty Level Guidelines**

  The FPL measures the level of poverty based on income and is used to determine eligibility for services provided. It varies according to family size and geographical location.

  - Since the schedule of charges is based on individual income, each RWHAP patient's income must be documented, even if the household income is used to determine eligibility
  - The RWHAP patient's placement on the schedule of charges changes if there's a change in the individual's annual gross income or the FPL guidelines

Imposition of Charges (continued)

- **Federal Poverty Level Guidelines (continued)**
  - **Subrecipients may establish a schedule of charges for RWHAP patients with incomes above the FPL by charging a flat rate, regardless of service provided, or a varying rate, such as a sliding fee scale, based on income**
- **Cap on Charges**
  - For individuals with an income greater than 100% FPL but less than 200% FPL, the subrecipient must not impose charges more than 5% of the individual's annual gross income for any calendar year
  - For individuals with an income greater than 200% FPL but less than 300% FPL, the subrecipient must not impose charges more than 7% of the individual's annual gross income for any calendar year
  - For individuals with an income greater than 300% FPL, the subrecipient must not impose charges more than 10% of the individual's annual gross income for any calendar year
  - **If the Cap is met within the calendar year, the subrecipient must stop imposing charges**

Single Audit Requirements

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Single Audit Requirements

- As a recipient of federal funds, your institution may be subject to the federal mandate of an annual single audit. As of October 1, 2024, federal guidelines require that a single audit be generated if an entity expended ***$1,000,000*** or more in federal funds (not just funds from HAHSTA) over the fiscal year. If required, the single audit must be prepared by the ninth (9th) month following the end of your fiscal year, and a copy submitted to the Federal Audit Clearinghouse.
- If your organization is below the threshold for a single audit, you are required to submit an audited financial statement that reflects your organization's financial position, results of operations or changes in net assets, and, where appropriate, cash flows.

Please forward your receipt of acceptance from the FAC or audited financial statement to donovan.walcott@dc.gov

Single Audit Requirements (continued)

- Subrecipients will receive a Single Audit Confirmation Letter to certify the requirements for a Single Audit. Please respond as requested in the letter.
- HAHSTA will acknowledge receipt of the Single Audit via email to Subrecipient.
- HAHSTA will review the filed Single Audit/Audited Financial Statement. Subrecipients placed on a CAP due to findings in Single Audit will be placed on a CAP until the CAP is closed. HAHSTA will notify Subrecipient when HAHSTA's CAP is satisfied.

Failure to adhere to Single Audit requirements places the Subrecipient in a Non-Compliance status and may result in additional Terms and Conditions, and/or the reduction or termination of funding, depending on the nature of Non-Compliance.

Knowledge Check

Does it matter which line I enter the invoice amounts on the purchase order in DIFS?

A. No, as long as there's money on the line it doesn't matter

B. Yes, the purchase order is created based on the approved budget and funding source

C. Yes, but I don't understand why

D. I don't know

Correct Answer: B

Ryan White Program Data Management Requirements

Demarre Richmond, Ryan White Data Manager

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Content

- Data Quality and Monitoring
- Mid-Year RSR/Annual RSR Submission 2026 TIPS
- 2025-2026 RSR Resources
- Data Security and Confidentiality
- DC Health Security Breach Procedure
- DC Health Contact Information

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Ryan White Program
Data Quality and Monitoring

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Ryan White Program Monthly Data Submission

Grant Year (GY)-36

Data Quality and Monitoring

- **Submission Deadline:** Client and Service-level data must be submitted to the DC Health Ryan White Program via CAREWare by the 15th of each month.
- **Purpose of Reports:** These reports play a vital role in ensuring timely program performance monitoring and compliance with federal and local guidelines, underscoring their importance.
- **Consequences of Late Submission:** Delayed data reporting may negatively impact program evaluations and funding decisions. Your punctual submissions are crucial to avoid such situations.

2026 MID-YEAR RSR Timeline and Tips

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Ryan White HIV/AIDS Program Services Report (Mid-Year RSR)

Grant Year (GY)-36

- DC Health will kick off the Mid-Year RSR in **September 2026**. By the end of September 2026, all subrecipients must submit their provider completeness report.
  - The DC Health Ryan White Program Data Manager will provide further instructions in August of 2026.
- Organizations enrolled in the Data Improvement Project (DIP) must submit RSR reports monthly through January 2027.
  - Any Provider with **more than or equal to 10% missing data** for the criteria will be enrolled by DC Health Ryan White Team

Ryan White HIV/AIDS Program Services Report (Mid-Year RSR)

Grant Year (GY)-36

DIP enrollees will be evaluated on the following criteria:

If any of the following data percentages of missing data exceeds 10%

1. CD4
2. Poverty Level
3. Housing Status
4. Health Coverage
5. Syphilis Screenings

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Mid-Year RSR Important Timeline and Deliverables

Mid- Year Program Information	Tentative Dates
Kick Off Month Full RSR Completeness Report Due for all Providers/subrecipients **	September 30, 2026
DIP Provider 1st Submission Due *	October 30, 2026
DIP Provider 2nd Submission Due *	November 27th, 2026
DIP Provider Final Submission Due*	December 30, 2026
Annual RSR 2026 (Tentatively) Due**	Feb- March 2027

** = All Providers and subrecipients for GY 36

*= Providers enrolled in the Quality Improvement (DIP) Project for 2026

2026 Annual RSR Timeline and Tips

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Annual Ryan White HIV/AIDS Program Services Report (RSR)

Grant Year (GY)-36

- HRSA and DC Health will share the Annual RSR Submission dates and timelines for 2026-2027.
    - HRSA will share timeline dates and deliverables around September 2026.
    - The 2026 reporting period will include data from January 1, 2026, through December 31, 2026.
- All providers have received communication about the 2026 Annual season.

Annual Ryan White HIV/AIDS Program Services Report (RSR)

Grant Year (GY)-36

- Tentative Key Dates and Deliverables for the Annual RSR Submission*
- RSR Recipient Reports*
    - Open: **February 1st, 2027**
    - Due: **March 2nd, 2027**

***For all current GY35 and GY36 subrecipients**

2025 Annual Submission RSR Timelines

Important Timelines and Deliverables

Date	Activity
February 2nd, 2026	**RSR Provider Report Opening Start Date** (All providers/Subrecipients)**
March 2nd, 2026	**RSR Provider Report Target Deadline- Suggested deadline for all RSR Provider Reports and client-level data** (RSR Provider Reports should be in “Review” or “Submitted” status)**
March 23rd, 2026	**RSR Provider Report for Changes Deadline:** Last day DC Health may return a Provider Report to the Subrecipient** for changes.
March 30th, 2026	**Final RSR Deadline-All RSRs must be in "Submitted" status by 6pm ET.**

****For all current GY35 and GY36 subrecipients**

Annual Ryan White HIV/AIDS Program Services Report (RSR)

Grant Year (GY)-36

Important Notes:

- Ensure data is accurate and complete before submission deadlines, including below the 10% threshold for any missing data elements.
- Collaborate with your team to address any data-related issues early.
- Contact the Ryan Data Team at care.ware@dc.gov with any questions or concerns.
- Attend DC Health Ryan White Office Hours held weekly on Tuesday's and Thursday's. Please reach out to care.ware@dc.gov to request the link.

2025-2026 RSR Resources

- Ryan White HIV/AIDS Program Services Report (RSR) Instruction Manual
  - Ryan White HIV/AIDS Program Services Report (RSR)
- DISQ TA Resources for the RSR:
  - DISQ TA Resource RSR 2025-2026
- Trainings and Upcoming Webinars: CAI Global

Data Security and Confidentiality

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Data Security and Confidentiality

- Protect patient information with strong security, limited access, and secure storage and sharing practices.
- Always remember that we are here to protect PHI; which includes respecting patient and community privacy while sharing accurate data.

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Security Breach

Security Breach: What to Do?

- Contact the Ryan White Program team by email at care.ware@dc.gov and cc your reporting supervisor.
- Please review the updated data breach policy here: Data-Breach-Policy_External-December-2025.pdf

Security Breach: What to Do?

Please provide the following information in an email to Ryan White Data Team and your Program Officer:

- Name of any entities, parties, agencies, and/or staff involved.
- Time and date of the incident
- Source of the incident (email, text message, hard-copy document, invoice, etc)
- Description of incident and plan of action to resolve the issue

Contact Information and Additional Support

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Contact Information and Additional Support

- DC Health Support Available: Contact the DC Health Ryan White program support team at care.ware@dc.gov for technical assistance or any additional questions.
- DC Health Additional support can be provided by filling out the Technical Assistance form here: Request TA.

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Knowledge Check

Organizations enrolled in the Data Improvement Project (DIP) must only submit RSR data at the end of the grant year.

A. True

B. False

Correct Answer: B

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Centralized Eligibility System

Mebrahtom Zeweli, Data Analyst

What is Centralized Eligibility System?

- DC EMA CAREWare (CW) Centralized Eligibility (CE) is a system whereby network providers can upload and access Ryan White services eligibility fields and documentation for shared clients to determine and confirm client eligibility across multiple providers.
- Eligibility records and supporting documents will be viewable across providers of shared clients.

Centralized Eligibility System

Purpose

- Streamline eligibility determination across providers within the Washington, DC EMA provider network
- Reduce duplication and administrative burden
- Enhance continuity of care and treatment services

How Does Centralized Eligibility Work?

- Providers must have Provider-by-Provider Sharing enabled.
- Permissions are centrally managed by HAHSTA.
- CAREWare checks for possible duplicates; review flagged records before marking as new.

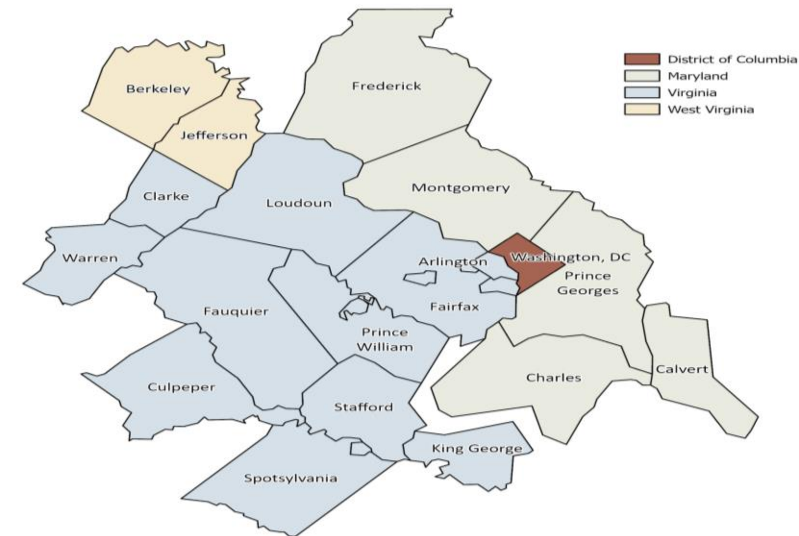
Benefits of Centralized Eligibility

- Reduces burden of Ryan White eligibility determination and recertification requirements (PCN 21-02).
- Enables Program Officers and authorized HAHSTA staff to review eligibility information and documents remotely using CAREWare.

Centralized Eligibility System

Eligibility Requirements

- A documented diagnosis of HIV
- Income: Customer income may not exceed 500% of the Federal Poverty Level (FPL).
- Residency: Proof of residency for Part A is the Washington, DC. Eligible Metropolitan Area (EMA) and the District of Columbia for Part B.



Centralized Eligibility System

Frequency of Eligibility Determination

- Ryan White HIV/AIDS Program (RWHAP) providers must conduct annual eligibility screenings to determine whether a customer's income or residency status has changed (HRSA, PCN-21-02).

CES Core Personal Information

Category	Details Collected
Demographic Details	Full name, Date of birth, Sex at birth, Contact information (address, phone, email)
Residency Information	Proof of residence within the service area (e.g., utility bill, lease agreement)
HIV-Positive Status	Documentation of HIV diagnosis (lab results or physician statement)
Income Information	Household income details; Documentation such as pay stubs, tax returns, proof of no income, or benefits statements; Used to determine if client meets low-income criteria
Insurance & Coverage	Health insurance status (Medicaid, Medicare, private insurance); Documentation of coverage or lack thereof

Link to Resource Materials

- Policy Notices | Ryan White HIV/AIDS Program
- pcn-21-02-determining-eligibility-polr.pdf
- Ryan White HIV/AIDS Program Part A Manual
- HAHSTA's Ryan White Customer Enrollment and Eligibility Policy.
- District of Columbia Department of Health Ryan White HIV/AIDS Program Policies and Procedures: https://effibarryinstitute.org/manage/assets/uploads/2026/01/Enrollment-and-Eligibility-Policy-January-2026.pdf

Knowledge Check

Which of the following is NOT a core piece of personal information collected by the Centralized Eligibility System (CES)?

A. Proof of residency within the service area

B. Documentation of HIV diagnosis

C. Household income details

D. Employment history

Correct Answer: D

Knowledge Check

CAREWare automatically resolves duplicate client records without requiring provider review when a possible duplicate is flagged.

A. True

B. False

Correct Answer: B

Rapid ART/Red Carpet Program

Dr. Christie Olejemeh, Program Officer

Dr. Laura Whittaker, Quality Improvement Specialist

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AGENDA

- Introductions
- Overview of Rapid Antiretroviral Treatment (Rapid ART)
- Overview of Red-Carpet Entry
- Red Carpet Orientation Videos
- Quarter 1&2 Reviews
- Red Carpet/Rapid ART Training Kits
- In-service training sessions

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Overview of Rapid Antiretroviral Therapy

Goal of Program: End the HIV Epidemic

The goal of this program aligns with DC ends HIV epidemic.

- 95% of HIV positive residents of the DC eligible metropolitan area(EMA) know their status.
- 95% of DC EMA residents diagnosed with HIV are in HIV treatment within 0-7days of diagnoses.
- 95% of DC EMA residents with HIV who are in treatment reach viral suppression.

Special Strategy for HIV Care in the DC EMA

The District of Columbia Department of Health supports evidence-based, patient-centered initiatives to:

- Reduce HIV transmission,
- Improve the lives of people diagnosed with HIV, and
- Reduce health disparities

Rapid Antiretroviral Treatment Contd.

Supported by Science and World Health Bodies

- **World Health Organization (2017**): Recommended ART initiation within 0-7 days of confirmed HIV diagnosis.
- **International Antiviral Society-USA Panel (2018**): Recommended ART initiation for all ambulatory patients who are committed to starting ART, unless there is uncertainty about the diagnosis or medical contraindication, such as opportunistic infection.
- **New York State Department of Health AIDS Institute (2019):** Recommended ART initiation on the day of diagnosis or first clinical visit.
- **US Department of Health and Human Services Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents with HIV (2019)**: Recommended ART initiation as soon as possible after HIV diagnosis, facilitated by removal of structural barriers.

Benefits of and Access to Rapid ART

- Rapid ART initiation provides both individual and public health benefits, including faster time to viral suppression and lower risk of transmitting HIV to others.
- People newly diagnosed with HIV are eligible for rapid ART initiation.
- DC Department of Health will work with sites to assist in implementing or enhancing rapid ART initiation through Red Carpet Entry (RCE) program which facilitates enhanced access to HIV treatment.

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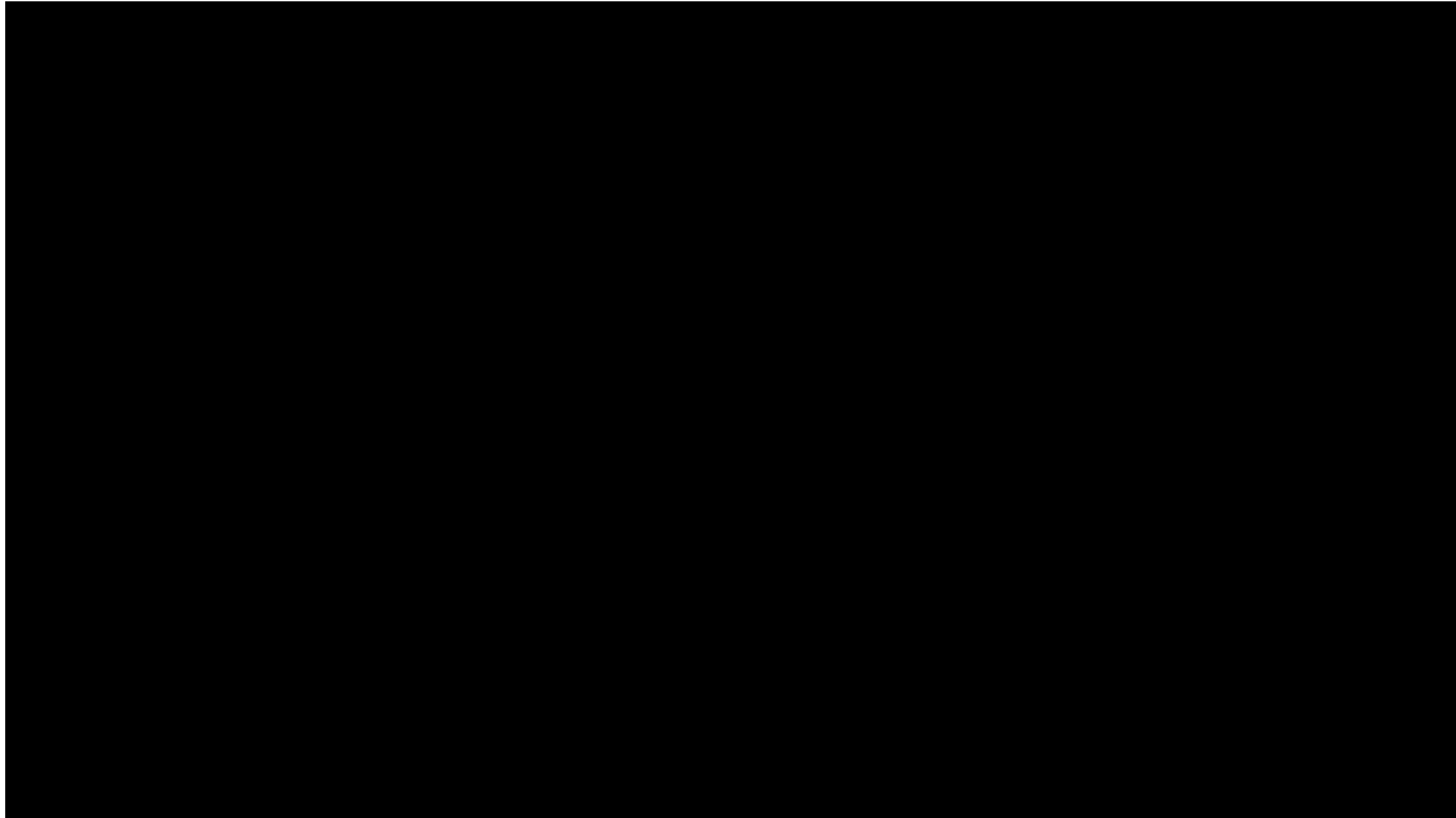
Overview of Red-Carpet Entry (RCE)

Red Carpet Orientation Video



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Rapid ART/Red Carpet
QUARTER 1 & 2 REVIEWS

First Quarter Review

Fifteen organizations participated in the program across the EMA.

A total of five hundred and seventy-six (576) customers were reached.

Within 7 Days of initial contact with a medical provider, prescriptions for ART were given to:

- 5 patients in Northern Virginia,
- 12 patients in Suburban Maryland, and
- 149 patients in the District of Columbia
- 166 patients were prescribed ART.

A total of 411 customers were seen within the same timeframe providing us with the denominator.

First Quarter Review Contd.

- 69% of customers received antiretroviral therapy (ART) prescription within 7 days of initial contact with a medical provider.
- 89% achieved viral suppression within 60 days.
- Viral suppression is having undetectable viral load or viral load of less than 200 copies/ml.
- Other achievements include:
- 37% were linked to medical care within seven days,
- 38% achieved retention in care within 90 days.

Status of Provider A

Measure	Numerator	Denominator	Percent
Rapid Start: ART Within 7 days Among all Virginians	0	10	0%
Rapid Start: ART Within 7 days Among all Maryland	1	59	1.69%
Rapid Start: ART Within 7 days Among all DC	10	44	22.73%
Rapid Start: ART Within 7 days Among ALL	11	115	9.57%
HAB: Prescription of antiretroviral therapy	902	912	98.90%
Rapid Start: Viral Suppression within 60 Days	3	4	75%
Rapid Start: ART within 7 Days_DC_Y _Continuation	37	37	100%
Rapid Start: ART within 7 Days_DC_Y reengaged	92	128	71.88%

Status of Provider B (Need Data Input)

Measure	Numerator	Denominator	Percent
Rapid Start: ART Within 7 days Among all Virginians	0	0	0%
Rapid Start: ART Within 7 days Among all Maryland	1	4	25%
Rapid Start: ART Within 7 days Among all DC	8	14	57.14%
Rapid Start: ART Within 7 days Among ALL	9	20	45%
HAB: Prescription of antiretroviral therapy	39	39	100%
Rapid Start: Viral Suppression within 60 Days	0	0	0%
Rapid Start: ART within 7 Days_DC_Y _Continuation	2	8	25%
Rapid Start: ART within 7 Days_DC_Y reengaged	1	12	8.33%

Second Quarter Review

Seventeen organizations participated in the program across the EMA.

Within 7 Days of initial contact with a medical provider, prescriptions for ART were given to:

- 6 patients in Northern Virginia,
- 9 patients in Suburban Maryland, and
- 128 patients in the District of Columbia for a total of
- 143 patients were prescribed ART.

A total of 366 customers were seen within the same time frame providing us with the denominator.

Second Quarter Review Contd.

- Among all customers served at the 17 locations in the EMA, program data illustrates a 70 percent achievement rate for antiretroviral therapy (ART) prescribed within 7 days of initial contact with a medical provider.
- Eighty nine percent (89.19%) achieved viral suppression within 60 days. Other achievements include thirty-seven percent (37%) were linked to medical care within seven days, and thirty-eight percent (38%) achieved retention in care within 90 days.
- Customers seen through Rapid ART were prescribed Antiretroviral therapy (ART) according to clinical guidelines. This program provided antiretroviral therapy to forty percent (40%) of patients within seven days, and overall viral suppression was reached at 84 percent.
- Overall Prescription Rate is 98%

Status of Rapid ART/Red Carpet Providers (2nd Quarter)

Measure	Numerator	Denominator	Percent
Rapid Start: ART Within 7 days Among all Virginians	6	37	16.22%
Rapid Start: ART Within 7 days Among all Maryland	9	107	8.41%
Rapid Start: ART Within 7 days Among all DC	128	213	60.09%
Rapid Start: ART Within 7 days Among ALL	144	366	39.34%/95
HAB: Prescription of antiretroviral therapy	6,406	6,529	98.12%
Rapid Start: Viral Suppression within 60 Days	66	74	89.19%
Rapid Start: ART within 7 Days_DC_Y _Continuation	75	106	70.75%
Rapid Start: ART within 7 Days_DC_Y reengaged	165	531	31.07%

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Findings

- The data confirm that the program delivers excellent clinical outcomes once patients engage in care.
- However, significant barriers persist during the earliest stages of the care continuum,
- particularly in linkage, retention, and
- Rapid ART initiation for several jurisdictions and specific DC subgroups.
- The contrast between DC_Y initiation (13%) and continuation (70%) indicate that the primary barrier occurs before or at the first point of contact rather than during ongoing care.

Preliminary Observations

Despite challenges, clinical outcomes remain strong for patients who start treatment.

- Viral suppression at 60 days is 89.19%,
- Overall HIV viral suppression is 84.14%, and the
- ART prescription rate is 98.12%.
- The near-universal rate of ART prescribing reflects strong provider adherence to treatment guidelines.
- Rapid initiation of ART through Red Carpet entry is a critical component of Ending the HIV Epidemic (EHE) strategies.

GY36
Rapid ART/Red Carpet Year

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Enhanced Access to HIV Expert (RCE)

- RCE is designed to facilitate expedited entrance into the HIV medical care system for Washington, DC EMA residents who have been newly diagnosed with HIV/AIDS or have fallen out of care.
- Red Carpet Entry providers commit to providing customers with:
  - an appointment with an HIV specialist within 72 hours following initial clinic contact,
  - A designated RCE-site contact or “concierge” to facilitate the first appointment, and
  - A password phrase that would enable a patient to discreetly ask for services once they arrive at the site.

Participation Requirements

All Ryan White funded Outpatient/Ambulatory Health Services (OAHS) Providers must agree to:

- Have open slots for walk-ins.
- Provide care to customers within 72 hours of reactive HIV test.
- Have a designated phone line and contact for Rapid ART/Red Carpet services.
- Prescribe ART same day of visit or within 0-7 days of testing positive or returning to care.

Rapid ART/Red Carpet Entry Visit

The minimum level of care for individuals with HIV requires customers receive the following screenings or referrals during their first appointment with an HIV provider:

- Antiretroviral Medications (Rapid Antiretroviral Therapy)
- Confirmatory HIV test
- Viral Load and CD4 laboratory test (not results)
- Tuberculosis test
- Hepatitis test
- STI testing

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How Can I Sign Onto This Campaign

Send email to redcarpet@dc.gov

Six Training Modules for Rapid ART/RCE

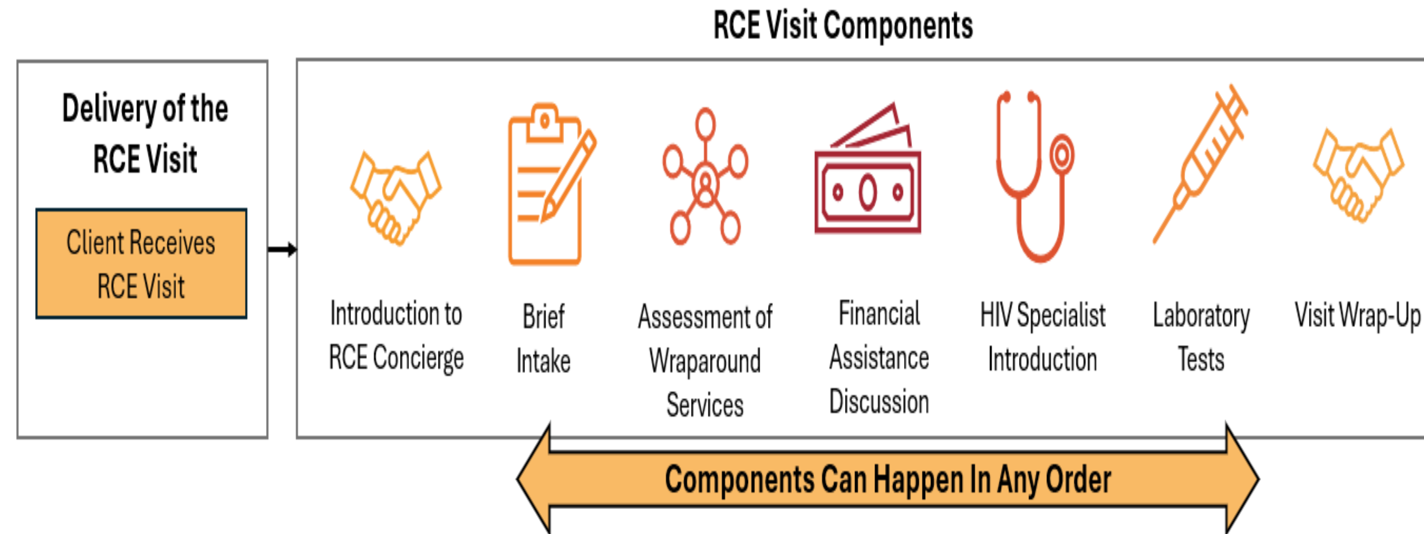
- Module One: Overview of RCE
- Module 2: Patient Centered Care Strategies
- Module 3: Preparing for Referring Into RCE
- Module 4: The RCE Visit
- Module 5: RCE Outreach and Re-engagement
- Module 6: Monitoring RCE Implementation
- Report Card Worksheet

Preparing for Referring Into RCE

Regarding delivery of the RCE Visit, some initial questions to consider are:

- How will your organization accommodate RCE Visits into the schedule?
- Are there days/times that customers are more likely to be available for appointments?
- And if those appointments are needed on afternoons, weekends, or evenings, does your organization have flexibility in providers' schedules to accommodate RCE customers?

Client Journey Through Their RCE Visit



Organization must offer Rapid Start or Same-Day access programs for antiretroviral therapy initiation, integrate into the RCE visit.

Scheduling the RCE Visit

An important component of RCE is that customers should be seen **within 3 days** of referral to RCE.

- If for some reason the customer cannot be seen within 3 days, they should be seen as soon as possible.

Note that it is critical that your organization have various strategies in place to accommodate RCE Visits within 3 days of referral.

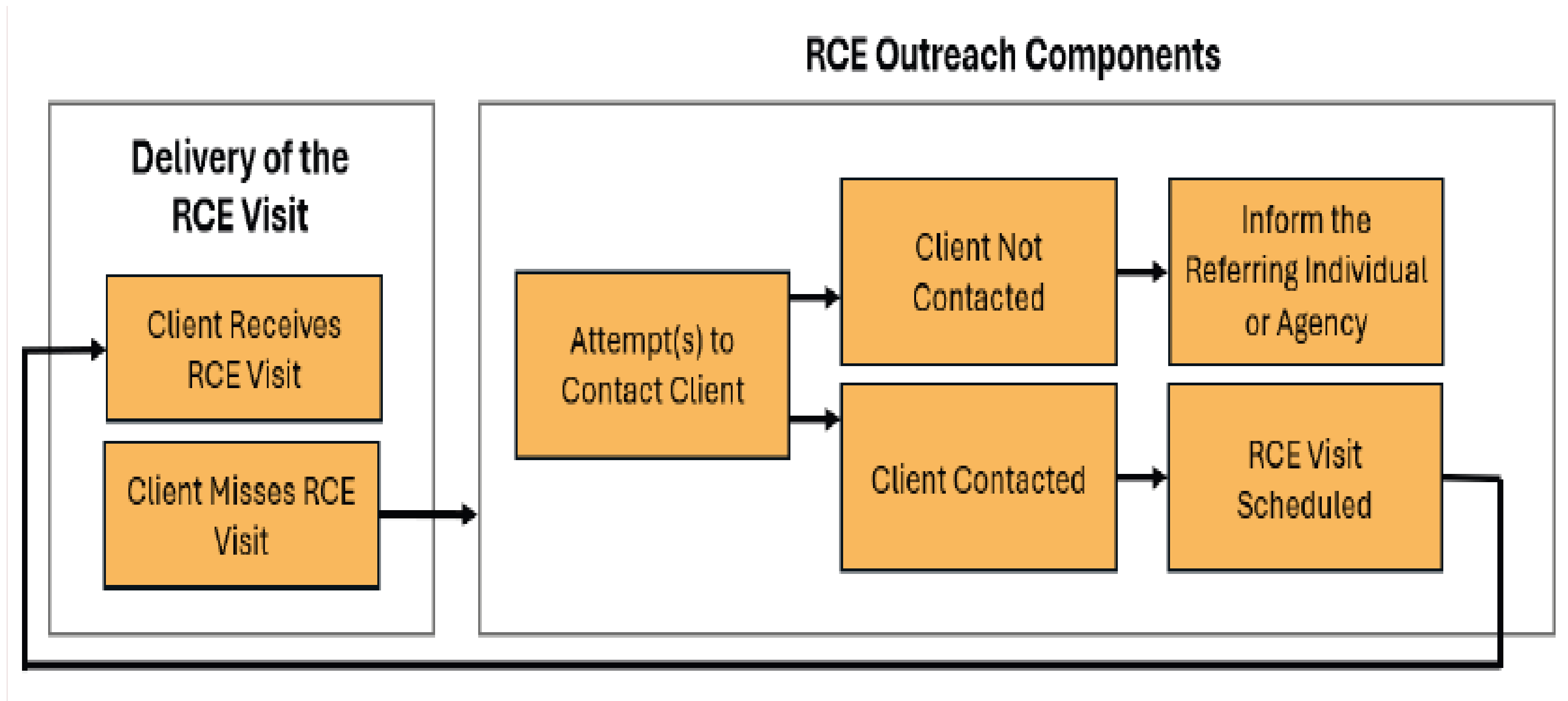
Scheduling the RCE Visit Contd.

- Providers should schedule an RCE visit, whether or not there is availability for a full medical visit. The important thing is to get the customer engaged with care quickly and to introduce the customer to their medical care team. Customers should never be turned away due to a lack of availability for a full medical visit.

- Finally, the RCE visit should take place in a private, dedicated space—such as a consultation area or exam room—to help preserve the customer's privacy. As part of scheduling the visit, the RCE Concierge should ensure that such a space is available.

RCE Outreach and Reengagement

The RCE Outreach Process

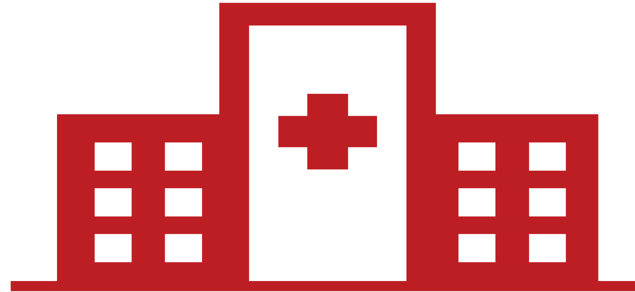


Engagement Attempts

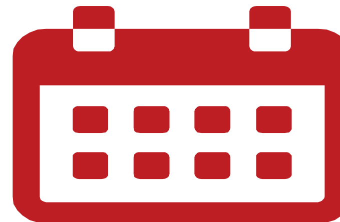
If Contact Is Made:

- Attempt to schedule/reschedule the RCE visit.
- For Referring Individual or Agency: Attempt to conference in the RCE Concierge or forward the call to the RCE Concierge so that the customer can reschedule as soon as possible.
- Ask the customer why they missed their appointment.

In-Service Training Sessions



- Date are available in March, April, and June 2026



- Preferable on Tuesdays, Wednesdays or Thursdays
- First Come Basis of scheduling!
- Email dates to **redcarpet@dc.gov**

Closing Remarks

Ebony Fortune, Deputy Chief, Care and Treatment

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