

FOR IDPH Use Only  
Application No. \_\_\_\_\_

Date Received \_\_\_\_\_



**ILLINOIS DEPARTMENT OF PUBLIC HEALTH**  
**APPLICATION FOR PUBLIC HEALTH GRANT**  
**Office of Health Protection, Division of Infectious Diseases, HIV/AIDS Section,**  
**Request for Applications (RFA) - HIV Prevention Regional Lead Agencies**

**Background and Purpose**

Illinois State Government and the U.S. Centers for Disease Control and Prevention (CDC) allocate grant funds to the Illinois Department of Public Health (IDPH) to provide HIV prevention services to Illinois residents living with and at highest risk for contracting HIV Disease. Priorities for highest risk populations to be served and interventions to be provided to them are established by the Illinois HIV Prevention Community Planning Group (PCPG). PCPG risk population and intervention priorities are included in Appendix 1 and 2 of this application.

In Illinois, HIV Prevention Regional Grant funds are contracted to lead agencies which fund and monitor HIV prevention services provision for HIV positive and highest risk clients in their respective regions (see map, pg 4). Regional lead agencies responsibilities are to:

- ensure that regional services mirror recent regional HIV incidence;
- work with IDPH to select competent local HIV prevention service providers in each region;
- announce provider awards; negotiate service objectives that align proportionally with regional HIV incidence by risk by race/ethnicity, and issue local service contracts;
- convey policy and procedural updates to regional service staff through quarterly Regional Implementation Group meetings, email list-serves and other channels;
- provide sub-grantees with monitoring, technical assistance and training to ensure service staff training requirements compliance, service objectives completion, performance standards achievement, and IDPH guidelines compliance in service delivery and documentation;
- conduct ongoing quality assurance of sub-grantee HIV prevention programs as outlined in the Section's quality assurance guidance, including bi-annual site visits and intervention observations, and provide action plans to improve quality and correct deficiencies;
- coordinate regional needs and resource assessments, and service gap analyses;
- review, approve and process for payment sub-grantees' requests for reimbursement to ensure that funds are utilized exclusively for legal and appropriate grant activities and that no funds are expended for promotional items;
- assist with any HIV/AIDS Section-requested community forum or focus group activity;
- participate in all required lead agency meetings and trainings;
- ensure IDPH approval of grant-funded materials prior to printing, broadcast or publication;
- punctually submit quarterly progress reports on May 1, 2012, August 1, 2012, November, 2012, and February 1, 2013 in the format approved by the Section;
- seek reimbursement from IDPH on a monthly basis using approved forms and submit a final grant expenditure report along with any unclaimed advance funds by the final due date.

Awards under this request for applications (RFA) will be a mix of federal and state funds. The table below shows the expected FY2012 grant awards by region. Per a PCPG recommendation,

total regional awards are proportional to a weighted epidemiologic composite value of 90% HIV-infection Incident cases, 5% HIV Disease Prevalent cases, and 5% Late Diagnosed cases (AIDS diagnoses within 0-12 months of HIV-Infection Diagnosis). Lead Agency grants are calculated with a base award of \$29,000 plus 6% of the total grant amount, averaging 13.1% of total grant funding, the same percentage as in 2011. Any indirect administrative costs requested under this grant must be budgeted within the lead agency budget as program funds are reserved for direct service costs.

Lead Agent	CDC	General Revenue Funds	Lead Agency	Program Funds	Total
Region 1	\$71,637	\$162,116	\$43,025	\$190,728	<b>\$233,753</b>
Region 2	\$61,516	\$139,210	\$41,044	\$159,682	<b>\$200,726</b>
Region 3	\$57,926	\$131,086	\$40,341	\$148,672	<b>\$189,012</b>
Region 4	\$125,248	\$283,436	\$53,521	\$355,163	<b>\$408,684</b>
Region 5	\$41,468	\$93,842	\$37,119	\$98,192	<b>\$135,311</b>
Region 6	\$72,991	\$165,179	\$43,290	\$194,879	<b>\$238,170</b>
Region 7	\$224,092	\$507,122	\$72,873	\$658,342	<b>\$731,215</b>
Region 8	\$351,517	\$795,486	\$97,820	\$1,049,183	<b>\$1,147,003</b>
<b>Total</b>	<b>\$1,006,395</b>	<b>\$2,277,478</b>	<b>\$429,032</b>	<b>\$2,854,841</b>	<b>\$3,283,873</b>

As for program funds, under CDC Funding Opportunity Announcement (FOA) PS12-1201 guidelines, seventy-five percent of Category A funds must be used for “core HIV prevention services,” which include HIV Testing, Partner Services, and Prevention for Positives. Twenty five percent may be spent for Prevention for prioritized risk HIV-negative persons. Program funds will be distributed under a separate competitive Regional HIV Prevention Grant Provider Request for Applications process.

The term of the grant will be January 1, 2012 to December 31, 2012.

### Who may apply?

Only organizations based in Illinois are eligible to compete for these funds. Agencies may apply as sole applicants or as fiscal agent-program monitoring partnerships. Agencies may apply to serve as regional lead agencies for *more* than one region; however, a different application must be submitted for each region to be served.

In fiscal-program partnerships, the application should describe the fiscal agency as the “applicant” or contractor. The program-monitoring partner shall be described as a subcontractor.

### Reminder:

1. Submit a *letter of intent* to apply to [dph.hivconf@illinois.gov](mailto:dph.hivconf@illinois.gov) by 4:00pm on November 2, 2011.
2. Submit one **(1) signed unbound original and three (3) copies** of the complete application package, including the budget and narrative by **Monday, November 21<sup>th</sup>, 4:00pm CST**.
3. Use 12-point font, 1-inch margins, and single spaced lines on 8½ X 11-inch paper.
4. Do not exceed the section page limits.
5. Number all pages including any attachments.
6. Complete the budget and narrative and include with application.

7. **Send an electronic copy of all materials to [dph.hivconf@illinois.gov](mailto:dph.hivconf@illinois.gov).**  
(continued on following page)
8. **Please return one (1) signed, unbound original application package and three (3) copies to:**

**Illinois Department of Public Health  
HIV/AIDS Section  
Attn: Carol Anderson  
525 W Jefferson, 1st Floor  
Springfield, IL 62761**

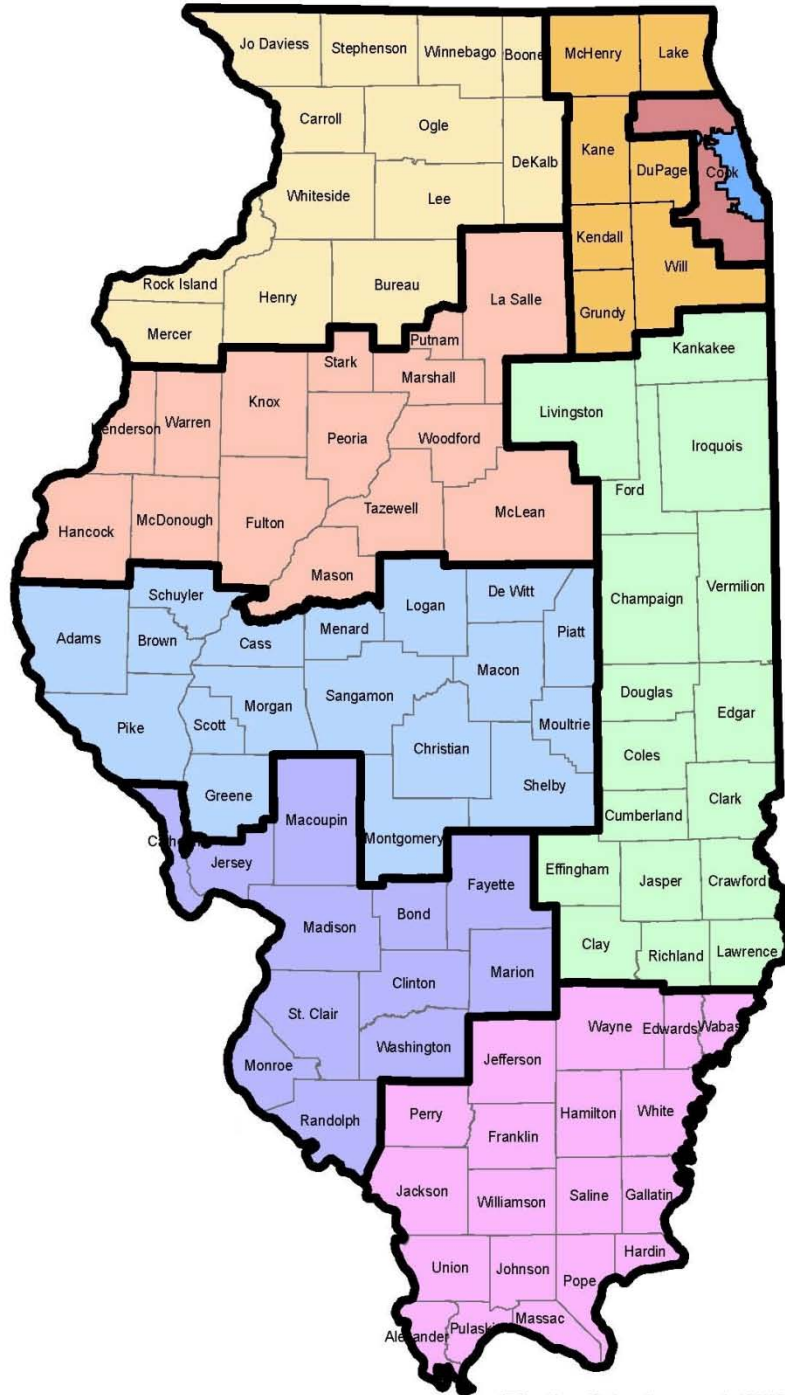
**If ALL forms (electronic and paper) are not completed and received by the Illinois Department of Public Health by Monday, November 21, 2011 at 4:00 pm CST, the proposal will be disqualified from this process.**

**Informational conference call for potential applicants is scheduled for Monday, October 31, 2012 at 3:00 PM. Conference call number: 877-810-9415 780-9330#**

**HIV Prevention and Care Regions – Illinois Department of Public Health**

<b>Region</b>	<b>Counties</b>
<b>R1 – Northwestern IL</b>	Jo Davies, Stephenson, Winnebago, Boone, Carroll, Ogle, DeKalb, Whiteside, Lee, Rock Island, Henry, Bureau and Mercer Counties
<b>R2 – NW Central</b>	LaSalle, Putnam, Stark, Knox, Warren, Henderson, Hancock, McDonough, Fulton, Mason, Tazewell, Peoria, Woodford and McLean
<b>R3 – West Central</b>	Adams, Brown, Schuyler, Cass, Menard, Logan, DeWitt, Piatt, Macon, Sangamon, Morgan, Scott, Pike, Greene, Montgomery and Shelby
<b>R4 – Southwestern</b>	Calhoun, Jersey, Macoupin, Madison, Bond, Fayette, Marlon, Clinton, St. Clair, Monroe, Randolph and Washington
<b>R5 – Southern</b>	Jefferson, Wayne, Edwards, Wabash, White, Hamilton, Franklin, Perry, Jackson, Williamson, Saline, Gallatin, Union, Johnson, Pope, Hardin, Alexander, Pulaski and Massac
<b>R6 – East Central</b>	Kankakee, Livingston, Ford, Iroquois, Champaign, Vermillion, Douglas, Edgar, Coles, Cumberland, Clark, Effingham, Jasper, Crawford, Clay, Richland and Lawrence
<b>R7 – Collar Counties</b>	Lake, McHenry, Kane, Du Page, Kendall, Grundy and Will Counties
<b>R8 – Suburban Cook</b>	Cook excluding the City of Chicago

# ILLINOIS DEPARTMENT OF PUBLIC HEALTH - HIV/AIDS SECTION REGIONAL IMPLEMENTATION GROUP (RIG) JURISDICTIONS



## Regions

- Region 1
- Region 2
- Region 3
- Region 4
- Region 5
- Region 6
- Region 7
- Region 8
- Region 9

Effective Date: January 1, 2010

**Section 1. (FISCAL) APPLICANT INFORMATION**

<b>Legal Name of Applicant:</b> <i>(Attach copy of W-9)</i>	
<b>Name and Title of Chief Officer:</b> <i>(If more than one, attach a list of all officers)</i>	Name: Title: Address: Phone: Fax: E-mail:
<b>Applicant Address:</b>	
<b>City, State, Zip Code:</b>	
<b>Telephone:</b>	
<b>Fax:</b>	
<b>E-Mail:</b>	
<b>Web Site:</b>	
<b>Region Applying For:</b> <b>(Check only one region per application)</b>	<input type="checkbox"/> Region 1 Northwest Illinois HIV Prevention
	<input type="checkbox"/> Region 2 NW Central Illinois HIV Prevention
	<input type="checkbox"/> Region 3 West Central Illinois HIV Prevention
	<input type="checkbox"/> Region 4 Southwest Illinois HIV Prevention
	<input type="checkbox"/> Region 5 Southern Illinois HIV Prevention
	<input type="checkbox"/> Region 6 East Central Illinois HIV Prevention
	<input type="checkbox"/> Region 7 Collar Counties HIV Prevention
	<input type="checkbox"/> Region 8 Suburban Cook HIV Prevention

**Section 2. (FISCAL) APPLICANT GRANT HISTORY**

<b>Description of (Fiscal) Applicant Organization:</b> <i>(200 character maximum)</i>	
<b>Has this (fiscal) Applicant received a grant from the federal government or the State of Illinois within the last 3 years?</b> <b>If yes, provide the following:</b> <i>(Add additional rows if needed)</i>	<p align="center"><input type="checkbox"/> YES      <input type="checkbox"/> NO</p> <p>Agency providing grant funding: Grant Number: Grant Amount: Grant Term: Region(s) served by grant: Populations served by grant: Brief Description of grant:</p>

<b>How long has (fiscal) Applicant been incorporated?</b>	
<b>Is the (fiscal) applicant in “good standing” with the Illinois Office of the Secretary of State?</b>	<p style="text-align: center;"><input type="checkbox"/> YES                      <input type="checkbox"/> NO</p> <p>Attach a copy of the applicant agency’s Certificate of Good Standing or a printed Corporation File Detail Report from <a href="http://www.ilsos.gov/corporatellc/">http://www.ilsos.gov/corporatellc/</a>.</p>
<b>Has the (fiscal) applicant or any principal experienced foreclosure, repossession, civil judgment or criminal penalty (or been a party to a consent decree) within the past seven years as a result of any violation of federal, state or local law applicable to its business?</b>	<p style="text-align: center;"><input type="checkbox"/> YES                      <input type="checkbox"/> NO</p> <p>If yes, identify the nature of the action and the disposition. If the action/proceeding is still pending or unresolved, provide a status identifying the unresolved issues. Be as descriptive as possible.</p>
<b>Is the (fiscal) applicant or any principal the subject of any proceedings that are pending, or to the best of the applicant’s knowledge threatened against applicant and/or any principal that may result in any adverse change in applicant’s financial condition or materially and adversely affect applicant’s operations?</b>	<p style="text-align: center;"><input type="checkbox"/> YES                      <input type="checkbox"/> NO</p> <p>If yes, identify the nature of the proceedings and how they may affect the applicant’s financial situation and/or operations.</p>
<b>Does the (fiscal) applicant or any principal owe any debt to the State of Illinois?</b>	<p style="text-align: center;"><input type="checkbox"/> YES                      <input type="checkbox"/> NO</p> <p>If yes, list the amount and reason for the debt. Attach additional documentation to explain the debt owed to the state.</p>

<b>Section 3. (FISCAL) APPLICANT ORGANIZATION INFORMATION</b>			
<b>Legal Status:</b>	<table style="width: 100%; border: none;"> <tr> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> Individual  <input type="checkbox"/> Sole Proprietor  <input type="checkbox"/> Partnership/Legal Corporation  <input type="checkbox"/> Tax Exempt  <input type="checkbox"/> Corporation providing or billing medical and/or health services  <input type="checkbox"/> Corporation NOT providing or billing medical and/or health services  <input type="checkbox"/> Other (describe): </td> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> Governmental  <input type="checkbox"/> Nonresident alien  <input type="checkbox"/> Estate or Trust  <input type="checkbox"/> Pharmacy (Non-Corporation)  <input type="checkbox"/> Pharmacy/Funeral Home/Cemetery (Corporation)  <input type="checkbox"/> Limited Liability Company (select applicable tax classification)  <input type="checkbox"/> D = Disregarded Entity  <input type="checkbox"/> C = Corporation  <input type="checkbox"/> P = Partnership </td> </tr> </table>	<input type="checkbox"/> Individual <input type="checkbox"/> Sole Proprietor <input type="checkbox"/> Partnership/Legal Corporation <input type="checkbox"/> Tax Exempt <input type="checkbox"/> Corporation providing or billing medical and/or health services <input type="checkbox"/> Corporation NOT providing or billing medical and/or health services <input type="checkbox"/> Other (describe):	<input type="checkbox"/> Governmental <input type="checkbox"/> Nonresident alien <input type="checkbox"/> Estate or Trust <input type="checkbox"/> Pharmacy (Non-Corporation) <input type="checkbox"/> Pharmacy/Funeral Home/Cemetery (Corporation) <input type="checkbox"/> Limited Liability Company (select applicable tax classification) <input type="checkbox"/> D = Disregarded Entity <input type="checkbox"/> C = Corporation <input type="checkbox"/> P = Partnership
<input type="checkbox"/> Individual <input type="checkbox"/> Sole Proprietor <input type="checkbox"/> Partnership/Legal Corporation <input type="checkbox"/> Tax Exempt <input type="checkbox"/> Corporation providing or billing medical and/or health services <input type="checkbox"/> Corporation NOT providing or billing medical and/or health services <input type="checkbox"/> Other (describe):	<input type="checkbox"/> Governmental <input type="checkbox"/> Nonresident alien <input type="checkbox"/> Estate or Trust <input type="checkbox"/> Pharmacy (Non-Corporation) <input type="checkbox"/> Pharmacy/Funeral Home/Cemetery (Corporation) <input type="checkbox"/> Limited Liability Company (select applicable tax classification) <input type="checkbox"/> D = Disregarded Entity <input type="checkbox"/> C = Corporation <input type="checkbox"/> P = Partnership		
<b>Federal Tax Payer Identification (FEIN) Number or Social Security Number (SSN) of Applicant if not an organization:</b>			

<b>If applicable, list all Names and FEINS that are registered to your organization or have been registered during the last 3 years.</b>	<b>Name:</b>	<b>FEIN:</b>
	<b>Name:</b>	<b>FEIN:</b>
	<b>Name:</b>	<b>FEIN:</b>
<b>DUNS Number:</b>		
<b>Illinois Department of Human Rights Number (if applicable):</b>		
<b>Legislative Senate District:</b>		
<b>Legislative House District:</b>		
<b>Congressional District:</b>		

<b>Section 4. (FISCAL) APPLICANT KEY GRANT CONTACT INFORMATION</b>	
<b>Grant Application Contact/Title:</b>	
<b>Telephone:</b>	
<b>Fax:</b>	
<b>E-Mail:</b>	
<b>Fiscal Contact/Title:</b>	
<b>Telephone:</b>	
<b>Fax:</b>	
<b>E-Mail:</b>	

<b>Section 5. GRANT PROJECT PROPOSAL</b>	
<b>Project Title:</b>	<b>Regional HIV Prevention Lead Agency</b>
<b>Brief Project Description:</b> <i>(350 character maximum). Note that the Scope of Work must be completed separately.</i>	Regional HIV Prevention lead agencies fund and monitor regional HIV prevention service delivery to the highest risk clients. They help to assess regional needs, choose providers, negotiate objectives, issue contracts and process billing. They monitor, train, and technically assist sub-grantees to ensure guidelines compliance, service objectives completion, and performance standards achievement.
<b>Project Period:</b> <i>(Include start and end date)</i>	<b>January 1, 2012 – December 31, 2012</b>

<b>Total Amount of Funding Requested from IDPH:</b>	
<b>Total (Fiscal) Applicant Match or In-Kind Contribution:</b>	
<p><b>If subcontractors* will be used under this grant application, provide name, address and description of services. (Insert additional subcontractors as necessary.)</b></p> <p><b>*for Program Monitoring or other Lead Agency functions, <u>not</u> for direct service providers</b></p>	<p>Subcontractor name: Address: City, State, Zip: Phone: Description of services:</p> <p>Subcontractor name: Address: City, State, Zip: Phone: Description of services:</p>
<p><b>AGENCY (OR PARTNERSHIP) ELIGIBILITY</b></p> <p><i>Agencies must be able to check "yes" to <u>all</u> of the following to be eligible to write a project proposal:</i></p>	
<p><b>Given an expected 3 month delay in reimbursement from the State of Illinois, does the agency have sufficient cash flow to begin reimbursement of subgrantee billing immediately upon lead agency contract ratification?</b></p>	<p style="text-align: right;"><input type="checkbox"/> YES      <input type="checkbox"/> NO</p> <p>If yes, explain how:</p>
<p><b>Is the agency able to deliver contracts to providers within 60 days of lead agency contract ratification?</b></p>	<p style="text-align: right;"><input type="checkbox"/> YES      <input type="checkbox"/> NO</p> <p>If yes, explain how:</p>
<p><b>If this application proposes a collaboration between a fiscal agent and a program monitoring agency, is a written agreement between the two agencies attached as documentation?</b></p>	<p style="text-align: right;"><input type="checkbox"/> YES      <input type="checkbox"/> NO      <input type="checkbox"/> NOT APPLICABLE</p> <p>If yes, explain how:</p>
<p><b>Are the (fiscal) agency's board and chief executive officer willing to fund subcontracted service agencies to conduct condom distribution, syringe exchange and HIV prevention services contractually targeted to men who have sex with men, injection drug users, heterosexual sex workers and other groups at very high risk of HIV acquisition or transmission?</b></p>	<p style="text-align: right;"><input type="checkbox"/> YES      <input type="checkbox"/> NO</p> <p>If yes, explain how:</p>
<p><b>Will the (program monitoring) agency limit a conflict of interest by supporting a Lead Agency Coordinator position <i>without</i> partial funding through Regional HIV Prevention <i>Direct Service</i> funds and without direct supervisory responsibilities (apart from quality assurance program monitoring) over positions funded through Regional HIV Prevention <i>Direct Service</i> funds?</b></p>	<p style="text-align: right;"><input type="checkbox"/> YES      <input type="checkbox"/> NO</p> <p>If yes, explain how:</p>

<p><b>Does the (program monitoring) agency have at least 3 years experience conducting Regional HIV Prevention Grant Lead Agency Coordination OR Direct HIV Prevention Services?</b></p>	<p style="text-align: right;"><input type="checkbox"/> YES      <input type="checkbox"/> NO</p> <p>If yes, explain how:</p>
<p><b>Will the (program monitoring) agency employ a Lead Agency Coordinator with at least 3 years experience conducting Regional HIV Prevention Grant Lead Agency Coordination OR who has at least 3 years experience both conducting Regional HIV Prevention Grant Direct Services and conducting Quality Assurance for the performance of other staff in related public health work?</b></p>	<p style="text-align: right;"><input type="checkbox"/> YES      <input type="checkbox"/> NO</p> <p>If yes, explain how:</p>

<b>Section 6. GRANT BUDGET SUMMARY</b>		
<i>(Note: This section is for summary purposes only. A detailed budget is required. See Section 7)</i>		
<b>Budget Line Items Requested</b>	<b>Requested Grant Budget Amount</b>	<b>Applicant Match of In-Kind Contribution</b>
Personal Services (includes salary and wages)		
Fringe benefits (percent use for calculation ____%)		
Contractual Services (detailed information about any program-monitoring contractual services amount must be submitted on the attached budget excel form)		
Travel		
Commodities/Supplies		
Printing		
Equipment		
Telecommunications		
Direct Services (Use “Program Funds” amount from pg 2; Contractual services amount must be listed as “To Be Announced” on the attached budget excel form)		
Administrative costs (program funds may not be used)		
<b>Grand Total</b>		
<p><b>If the proposed budget includes Personal Services (Salary or Wage) related costs, please indicate the type of documentation that will be maintained and used to allocate staff costs to the grant.</b></p>	<p><input type="checkbox"/> Time Sheets</p> <p><input type="checkbox"/> Cost allocation plans</p> <p><input type="checkbox"/> Certifications of time allocable to grant</p> <p><input type="checkbox"/> Other, please describe _____</p> <p><input type="checkbox"/> Not applicable to this grant application</p>	

**Section 7. GRANT SCOPE OF WORK**

**LIMIT:** Twenty (20) pages maximum.

(130 points total)

**1. In this section describe your (program monitoring) agency’s experience in ensuring the provision of HIV prevention services targeted to people prioritized as at highest risk for transmitting or acquiring HIV Disease in the Region (See Appendix 1, 2 for Illinois PCPG Population and Intervention Priorities), assuring service quality, and ensuring that program service delivery objectives and performance standards are achieved.**

A. Document *in the grid below* the following information:

- 1) How many years of experience *implementing* each intervention/strategy does the proposed Program Monitoring Agency have? (Answer: Number of Years)
- 2) Is training and experience in each intervention type *required* in the Lead Agency Coordinator (LAC) *Job Description*? (Answer: Y or N)
- 3) Is the person selected for LAC already *trained* in each intervention? (Answer: Y/N/NA)
- 4) How many years of experience providing *quality assurance monitoring* for this intervention does the individual identified for LAC have?

HIV Prevention Strategy or Intervention	Agency's Years of Experience Implementing this intervention	Training & experience with intervention required in LAC Job Description? (Y/N)	Identified LAC Trained in intervention? (Y/N)	Identified LAC Years of Experience Implementing intervention	Identified LAC Years of Experience Quality Monitoring this intervention
HIV Counseling and Testing with HIV Partner Elicitation & Linkage to Care					
Surveillance-triggered HIV Partner Elicitation, Notification & Testing					
Prevention for Positives: Linkage to HIV Treatment (independent of HIV testing)					
Prevention for Positives: HIV Treatment Adherence Counseling					
Prevention for Positives: Effective Behavioral Risk Reduction Interventions for PWHIV					
Effective Behavioral Interventions for HIV-negative Men who have Sex with Men					
Effective Behavioral Interventions for HIV-negative High Risk Heterosexuals					
Effective Behavioral Interventions for HIV-negative Injection Drug Users					
Effective Behavioral Interventions for HIV-negative Injecting MSM (MSM/IDU)					
Syringe Exchange & Harm Reduction Services					
Risk-targeted Condom distribution					

Program Collaboration and Service Integration: Risk-targeted Hepatitis A & B Vaccinations					
Program Collaboration and Service Integration: Risk-targeted Outreach Hepatitis C Screening					
Program Collaboration and Service Integration: Outreach Syphilis, GC/CT Screening					
Coordinating Regional HIV Prevention & Care services					

- B. Describe your (program monitoring) agency’s history and its mission.
- C. Describe qualitatively your (program monitoring) agency’s experience in providing HIV prevention services for people prioritized as at highest risk for transmitting or acquiring HIV in Illinois within the past five (5) years. Describe for each service type provided by your agency (as noted in 1.A. above) the risk population(s) served and the setting(s) in which it was provided.
- D. Describe your (program monitoring) agency’s experience in designing and administering quality assurance protocols for HIV prevention or related public health work.
- E. Describe the Lead Agency Coordinator (LAC) *position* (i.e. regardless which individual fills that role) your (program monitoring) agency will establish or maintain, including full-time equivalency assigned to LAC duties, full-time equivalency assigned to work within the region, office location, assigned non-LAC duties (if applicable), and other factors relevant to effective regional HIV prevention management and quality assurance.
- 1) Attach a job description (Applicant Appendix 1)
  - 2) Attach an agency organizational chart (Applicant Appendix 2) showing the relationship of the Lead Coordinator’s position within the organization relative to other HIV Prevention, HIV Care, or STD services provided by your agency.
- F. Has an individual has already been identified to fill this position? If not, how and when will staff be recruited? If so, describe their academic credentials, work experience, and training (not already referenced in 1.A. above) preparing them to coordinate and assure quality regional HIV prevention services.
- 1) Attach the selected individual’s resume (Applicant Appendix 3).
  - 2) Attach the selected individual’s certificates for training completed in HIV prevention interventions and strategies, Partner Services, HIV Case Management, Treatment and Support Services, STD and Viral Hepatitis prevention, and Social Marketing.
- G. Given the region’s HIV incidence, the limits of available Regional HIV Prevention Grant funding, and regional services available through other funding streams, identify which specific services listed below your (program monitoring) agency recommends funding or not funding in the region through this grant’s 2012 programmatic funds. Describe how you would target, create (if needed), manage and revise the implementation of each of these services. In your description, identify data and information sources you would use to choose among prioritized interventions to implement for a prioritized population, to

choose between available service sites, and to choose among agencies offering to provide a given service.

- 1) HIV Counseling and Testing with HIV Partner Elicitation & Linkage to Care
  - a) Men who have Sex with Men (MSM)
  - b) High Risk Heterosexuals (HRH)
  - c) Injection Drug Users (IDU)
  - d) Injecting Men who have Sex with Men (MSM/IDU)
- 2) Surveillance-triggered HIV Partner Elicitation, Notification & Testing
- 3) Prevention for Positives:
  - a) Linkage to HIV Treatment (independent of HIV testing)
  - b) HIV Treatment Adherence Counseling
  - c) Effective Behavioral Risk Reduction Interventions for PWHIV
- 4) Effective Behavioral Interventions for HIV-negative Persons
  - a) MSM
  - b) HRH
  - c) IDU
  - d) MSM/IDU
- 5) Syringe Exchange & Harm Reduction Services
- 6) Risk-targeted Condom distribution in the context of counseling
- 7) Program Collaboration and Service Integration:
  - a) Risk-targeted Outreach Hepatitis A & B Vaccinations
  - b) Risk-targeted Outreach Hepatitis C Screening
  - c) Risk-targeted Outreach Syphilis, GC/CT Screening
- 8) Coordinating Regional HIV Prevention & Care services

H. Of the core HIV prevention services not recommended for funding above, describe other resources available in the region through which people living with or at highest risk of acquiring HIV in the region may address their needs.

I. Describe how you will ensure the Regional HIV Prevention workforce will meet training qualifications.

J. Describe how you will ensure that funded providers meet their service delivery objectives and achieve grant performance standards.

**2. In this section describe how the (program monitoring) agency will: coordinate the implementation of a regional needs assessment process for prioritized risk populations, conduct a regional HIV prevention and care resource assessment, and identify service gaps to be addressed in 2013.**

A. Describe how the HIV prevention needs (including HIV treatment engagement/adherence to reduce viral load and thereby infectiousness) of people in the region prioritized as at greatest risk of transmitting or acquiring HIV will be assessed annually and how participation from prioritized populations in the region will be obtained.

- B. Describe how available HIV and STI prevention and care resources will be inventoried and compiled for the region for submission to IDPH and the IL PCPG planning process.
- C. Describe how the (program monitoring) agency will use the regional incidence, needs assessment and resource assessment to identify and quantify unmet HIV prevention and care engagement needs in the region.

**3. In this section describe how your (program monitoring) agency will establish a Regional Implementation Group (RIG) to coordinate services.**

- A. Describe the facilities where quarterly RIG meetings will occur and the amenities (wheelchair accessibility, parking, teleconferencing, computer projection, etc.) to promote access and effective communication.
- B. Describe participants *besides* Regional HIV Prevention Grant Subgrantees who will be regularly or periodically invited to report at or actively participate in RIG meetings to promote regional program integration and collaboration.
- C. Each RIG is required to have one representative acting as a liaison between the local HIV community and the Illinois HIV Prevention Community Planning Group. Describe how RIG representatives will be selected, prepared, and effectively engaged as a communication channel between the State and Regional groups.
- D. Describe other means by which programmatic communications will be conveyed to Regional Implementation Group service providers.

**4. In this section describe collaboration and coordination relationships that the (program monitoring) agency has with the community in the region.**

- A. How will your (program monitoring) agency and its lead agency coordinator maintain a physical presence in the region?
- B. Describe your (program monitoring) agency's current relationship and intended collaborations in service of Regional HIV Prevention grant goals (Appendix 3) with the following types of organizations within the region:
  - 1) HIV Case Management Services.
  - 2) major HIV Primary Medical Care providers
  - 3) major STD service providers
  - 4) Local Health Departments
  - 5) current Regional HIV Prevention Grant providers programs
  - 6) HIV prevention providers funded by other grants, such as IDPH Direct GRF grantees, Quality of Life grantees, Expanded HIV Testing Initiative Grantees, Center for Minority Health grantees, or Department of Alcohol and Substance Abuse (DASA);

- 7) programs working to reduce drug injection harms through syringe exchanges, substance abuse treatment, buprenorphine and methadone therapies, detoxification, recovery programs, substance abuse prevention, etc.
  - 8) social or service organizations serving gay-identified, bisexually active or other men who have sex with men (regardless of sexual self-labeling) of any race or ethnicity.
  - 9) Primary care providers serving homeless, low income and/or uninsured persons.
- C. Describe regional interagency coalitions in which your (program monitoring) agency actively participates which are relevant to HIV prevention targeted to individuals prioritized risk histories and how these coalitions have or could strengthen risk-targeted HIV prevention.
- 5. This section’s purpose is to ensure fiscal and contract monitoring. Each lead agency is accountable for the expenditure of awarded Regional HIV Prevention Grant funds, and must monitor fiscal and contract compliance with all contracts in the region. On-site fiscal and contract monitoring site visits by all lead agencies are required twice annually with each subcontractor (see Application Appendix 5 “Contract Monitoring”).**
- A. Describe the assessments your (fiscal and/or program monitoring) agency will conduct on monthly subgrantee billing to ensure that expenditures are legal, contractually compliant, accurate, timely, and program-focused.
  - B. Describe how your agency (or partnership) will provide on-site fiscal and contract monitoring twice each year for sub-grantees or subcontractors.
  - C. Describe how your (fiscal) agency will ensure compliance with the audit requirements in OMB Circular A-133, for your agency and your sub-grantees and/or sub-contractors. (See <http://www.whitehouse.gov/sites/default/files/omb/circulars/a133/a133.pdf>.)
- 6. This section’s purpose is to ensure the applicant has the ability to provide quality management program monitoring. In this context, quality is defined as the degree to which a prevention service meets or exceeds established professional standards and user expectations. To continuously improve systems of prevention services, evaluations of the quality of service should consider the service delivery process, quality of personnel and resources available, and the outcomes.**
- A. Describe your quality management plan to ensure: staff competencies, service policies adherence, service documentation standards adherence, service delivery objectives achievement, performance outcome standard achievement, quarterly provider and lead agency reporting, and other pertinent information. Include the following:
    - 1) At least 3 Specific Measurable Appropriate Realistic Time-phased (SMART) Outcome Objectives
    - 2) Tools to measure these outcomes
    - 3) Timeline with Quarterly Activity Objectives to accomplish the outcomes

**7. This section’s purpose is to ensure each lead agency can comply with the Department’s data collection plan and Section approved database system, Provide® Enterprise.**

- A. Describe your plan to ensure that all lead agency staff enter data on regional provider agencies, contracts, and staff, and that all HIV prevention provider agencies and prevention counselors manually enter client-level data directly in the Section approved database system, Provide® Enterprise in a timely manner.
- B. Describe your plan to meet or exceed CDC HIV Prevention Performance Measures (see Application Appendix 4) utilizing Provide® Enterprise as the means of collecting the client-level health outcomes data.

**8. This section’s purpose is to ensure that each lead agency can implement a strategy to reduce community viral load by ensuring that persons living with HIV not currently in treatment are identified, made aware of their HIV status, counseled, referred and voluntarily linked into HIV treatment. (See Illinois Unmet Care Needs Assessment by Region, Appendix 6)**

- A. Describe the regional strategy to identify and inform individuals who are *unaware* of their status and to refer and voluntarily link them into HIV treatment.
- B. Describe the regional strategy to identify individuals with HIV who are *aware* of their HIV diagnosis to counsel, refer and voluntarily link them into HIV treatment.
- C. Describe the regional strategy to identify individuals with HIV who are *aware* of their HIV diagnosis, *engaged* in HIV primary medical care, but *not taking antiretroviral medication as prescribed* to counsel them to voluntarily adhere to their prescribed antiretroviral treatment.
- D. Describe the strategy for utilizing HIV-positive peers to ensure linkage and retention in care. See Application Appendix #7 Peer Program.

**Criteria for Scoring Proposals:**

- Initial review will be conducted by the HIV Section of the Illinois Department of Public Health
- Final review will be done by the Grant Review Committee of the Illinois Department of Public Health
- Confidential evaluations of lead agency applicants will be mailed to any current Regional Grant contractors *not* applying for the lead agency grant for direct submission to IDPH to inform the evaluation of applications.

**Illinois Department of Health**  
**Project Budget**

**Please use Excel form (no points awarded) and include as Attachment B.**

**Criteria for Scoring Proposals: The Project Budget and Project Budget Narrative section of the application will be reviewed according to the following criteria:**

- Initial review will be conducted by the HIV Section of the Illinois Department of Public Health
- Final review will be done by the Grant Review Committee of the Illinois Department of Public Health and will include reviewing the project budget, project budget narrative for completeness and consistency with proposed activities

**Section 8. (FISCAL) APPLICANT CERTIFICATION**

Under penalty of perjury, I certify that I have examined this application and the document(s), proposal(s), and statement(s) submitted in conjunction herewith, and that to the best of my information and belief, the information contained herein is true, accurate, correct, and complete. I represent that I am the person authorized to submit this application on behalf of the applicant, and that I am authorized to execute a legally binding grant agreement on behalf of the applicant if this grant application is approved for funding.

I, hereby release to IDPH, the rights to use photographs and/or written statements of information, regardless of the format, contained in or provided after the grant application for the purposes of publication on the IDPH web site, unless the applicant submits a written request asking that the information not be disclosed.

Signature Printed Name/Title Date

**FOR DEPARTMENT USE ONLY - DO NOT WRITE BELOW THIS LINE**

**Type of Grant Application**

- Direct Appropriation
- Allocation by Administrative Rule
- Competitive Request for Application
- Statutory Board Review Required
- Formula and/or Caseload Allocation
- Non-Competitive

<b>Funding Source:</b>	
General Revenue Fund	<input type="checkbox"/>
State Special Fund	<input type="checkbox"/>
Federal	<input type="checkbox"/>

**Grant Application Funding Recommendation by Division/Program:**

<input type="checkbox"/>	Grant Application Disqualified/Not Eligible for Funding under this Award
<input type="checkbox"/>	Grant Application Recommended for Funding at Full Request
<input type="checkbox"/>	Grant Application Recommended for Funding at \$_____.

Division Chief/Program Manager: \_\_\_\_\_ Date: \_\_\_\_\_

**Grant Application Funding Recommendation Approved by:**

Deputy Director: \_\_\_\_\_ Date: \_\_\_\_\_

Assistant Director: \_\_\_\_\_ Date: \_\_\_\_\_

# **APPLICATION APPENDICES**

- Appendix 1: Illinois PCPG Prioritized Populations**
- Appendix 2: Illinois PCPG Prioritized Interventions by Population**
- Appendix 3: Regional HIV Prevention Grant Goals**
- Appendix 4: CDC HIV Prevention Performance Measures**
- Appendix 5: Contract Monitoring**
- Appendix 6: FY2010 Illinois Ryan White Unmet Need**
- Appendix 7: HIV Positive Peer Program**

# APPENDIX #1

## Illinois PCPG Prioritized Populations

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Approved at the August 12, 2011 PCPG Meeting

### 2012 Risk Group Definitions and Points of Consideration

**1. HIV positive and HIV negative Men Who Have Sex with Men (MSM):** A high-risk MSM is defined as a) any male or transgender individual who has had condomless anal sex with a male or transgender individual in the past 12 months, or b) any male or transgender individual who has had condomless anal sex with a male since his last HIV test. A high-risk MSM youth is defined as any male or transgender individual, age 13-19 years, who reports ever having had anal or oral sex with a male or transgender individual, or who states he is sexually attracted to males or transgender individuals (for Health Education/Risk Reduction services only).

**2. HIV positive and HIV negative High Risk Heterosexuals (HRH):** Females and males (including transgender individuals not included as MSM) engaging in condomless vaginal and/or anal sex with partners of the opposite sex, defined as any of the following:

HIV positive individuals

Persons with HIV positive partner(s) of the opposite sex

Persons with IDU partner(s) of the opposite sex

Female partners of MSM

Heterosexual males and females with two or more STDs in 12 months

Persons who have had sex with 6 or more partners in the past month

Females who have had unprotected sex with a male(s) released within the past year from an incarceration of one year or longer in any county, state or federal correctional facility

#### Points of Consideration for HRH individuals only:

The positivity rate of HRH increases as age increases. Blacks and Hispanics are more likely to test positive than whites. Women are less likely to test HIV positive if they report using condoms, but males who reported condom use were not less likely to test positive. Oral sex with someone of the opposite gender was not found to be a predictor of new positive tests. Females who reported having sex with known HIV positive individuals, MSM or IDU are more likely to test positive than the heterosexual population tested.

**3. HIV positive and HIV negative Injection Drug User (IDU):** A high-risk IDU is defined as a person who:

a. Discloses sharing injection equipment or supplies in the last 12 months or since his or her last HIV test; or

b. Does not disclose injection risk, but displays visible signs of recent non-prescribed drug injection (specifically, fresh injection sites, injection abscesses, nodding off, etc.).

**4. HIV positive and HIV negative MSM/IDU:** An MSM/IDU is defined as any male who meets the combined definitions of MSM and IDU (#1 and 3 above).

**Other Important points of consideration:**

**Prevention with HIV positive individuals** falling within any of the risks identified above should be a top priority within each subpopulation category and specific strategies to engage this population should be developed, including linkage to care and treatment. Prevention with positives should include reproductive health education for females and their partners, including linkage to perinatal care.

**Transgender individuals** are considered priority within each of the priority populations due to the alarming national HIV prevalence rates in this population and the severe social determinants impacting this population. Transgender identity does not mean an individual engages in risk behaviors and transgender individuals should be prioritized within each of the risk groups.

## APPENDIX #2

### Illinois PCPG Approved Interventions

Page 21-36

The Illinois HIV Prevention Community Planning Group (PCPG) annually uses an epidemiologically-based process to prioritize high-risk populations that should receive targeted HIV prevention services. The tables below list the proposed 2012 HIV prevention interventions that are appropriate for specific populations.

#### **General Recommendations:**

1. All prioritized populations shall be defined by serostatus, risk, and race/ethnicity for inclusion in prevention funding documents, including, but not limited to, all RFPs and scopes of service.
2. Regional prevention funding will be allocated to ensure that total funding is proportional to recent HIV infections (2006-2009) by risk and race/ethnicity, within that region.
3. In order to account for resource distribution, provider scopes should be written by risk, race/ethnicity, gender (if appropriate) and intervention with a value based upon standardized regional unit costs.
4. DEBIs (Diffusion of Effective Behavioral Interventions) must be used as defined by their core elements.
5. Regional prevention funding must include prevention with HIV-positive individual program(s) that provides linkages to care and treatment, interventions to improve retention in care and treatment, and/or interventions and risk-reduction services for HIV-positive individuals and their sexual or needle-sharing partners.
6. Condom distribution to HIV-positives and those at high risk of infection is a highly recommended structural intervention. Condom distribution must be accompanied by counseling and/or education or incorporated as an element of an approved behavioral intervention.
7. All HIV-positive individuals are prioritized and may be included in appropriate DEBIs.
8. All HIV + individuals should be immediately tracked, and referred into CARE services, including the AIDS Drug Assistance Program (ADAP).
9. All newly and ongoing diagnosed HIV+ individuals shall be offered Partner Services. Agencies must follow protocols specific to their status as a Health Department or a Community Based Organization (Non-Health Department). Health Departments may provide all steps of elicitation and notification associated with providing Partner Services including cases identified through Surveillance records. Community Based Organizations shall provide services up to and including partner elicitation, but shall not provide direct notification services unless officially designated by the Illinois Department of Public Health. Community Based organizations do have the authority to be present during a dual notification as requested by the index patient; however, unless officially designated by the Illinois Department of Public Health, the community based organization's role does not include direct notification of partners of positives identified

- through testing nor identification and direct notification of partners of positives reported through Surveillance records.
10. IDPH shall develop comprehensive Partner Services guidance, delineating the roles and responsibilities for Community-Based organizations and for Health Departments, including roles and responsibilities for select Community Based Organizations that have received contracted Partner Services approval to administer direct notification services.
  11. Any evidence-based, homegrown intervention that is approved by the Illinois Department of Public Health (IDPH) and the regional prevention lead agent may be used.
  12. For IDUs, priority in funding decisions shall be given to agencies conducting comprehensive syringe exchange programs on site or with an agency that comes to their site to provide services.
  13. Transgender individuals should be included in the appropriate population based on their behavioral risk and anatomy.
  14. Persons who have been victims of sexual assault since their last HIV test or have never been tested for HIV shall be included in all population categories.
  15. All funded agencies must demonstrate to the Lead Agency in the RFP process they have the fiscal/organizational capacity to administer and implement all group and community level interventions via the completion of the Agency Readiness Assessment Tool that will be provided by IDPH to Lead Agencies for distribution to subcontracted agencies in the RFP process.
  16. For Group Prevention Support (GPS);
    - a. HIV- positive individuals are the highest priority for targeted GPS. The intervention should focus on improving retention in care and treatment, partner safety, and other skills-building topics such as disclosure, coping skills, and condom negotiation.
    - b. Agencies must target very high risk prioritized populations to include MSM, HRH, IDU and TG who report either condom less anal sex or shared works (syringes and injection drug use paraphernalia) within 12 months or to increase skill sets around treatment adherence, risk reduction, and other skills-building topics.
    - c. Agencies must provide an open or closed ended skills building session to no more than 12 individuals. Agencies should refer to the IDPH RFP for a definition of closed and open-ended skills-building sessions.
    - d. Agencies must submit a copy of the intended curriculum and pre and post test instruments documenting behavioral change measured outcomes to regional lead agent for review and approval.

## **2012 Additional Recommendations:**

1. In SFY12, for all funded interventions, an agency must first assess the cost effectiveness of the intervention, staff time needed to implement the intervention, sustainability of the intervention, and other available fiscal and in-kind resources. Information on the

- requirements and expectations of DEBIs can be found at [effectiveinterventions.org](http://effectiveinterventions.org). A copy of the final “Handout 1: A Description of CDC/IDPH Approved Interventions and 2012 Proposals” will be included in the RFP as an attachment for further reference. Additional information should be provided by IDPH to Lead Agencies and their subcontracted agencies in the RFP process.
2. For all funded interventions, each agency must utilize the comprehensive Community Discovery Assessment tool provided by IDPH to Lead Agents and their subcontracted agencies as an Attachment in the RFP process along with a plan for monitoring and evaluation which will include the collection of standardized process and outcome measures, as identified by IDPH.
  3. All funded public health strategies and interventions must include an approved recruitment component (outreach, social marketing, social networking, health communication/public information, internet, other approved).
  4. Youth must be prioritized within all risk, race/ethnicity, and gender populations, in particular young MSMs.
  5. Lead agents are responsible for evaluating regional epidemiological data and service delivery (essentially conducting a specific gap analysis) to determine regional unmet need. Using the PCPG 2012 Prevention Priority Population Listing as a guide, the regional gap analysis must be used to further identify and prioritize underserved populations within the respective region(s).
  6. HIV positives within each priority population must be prioritized for prevention interventions.
  7. All agencies funded to conduct an intervention (DEBI, Homegrown, GPS, etc.) must themselves conduct, collaborate with another agency, or have referral agreements in place with other agencies to provide an approved public health strategies (CTR, CRCS, STI screenings and vaccinations, Partner Services) to clients receiving the interventions, as needed. This is an example of Program Collaboration and Service Integration (PCSI).
  8. All funded interventions must include an evaluation plan that describes the process/outcomes measurement methods that will be used to ensure the intervention is properly conducted and evaluated.
  9. IDPH must provide a program guidance evaluation plan for funded interventions.
  10. Prior to the implementation of an intervention and/or public health strategy, agencies must attend a federal or state approved training.
  11. IDPH must provide funded agencies with Procedural Guidance to implement an intervention, providing examples, technical assistance and resources such as requesting CDC Capacity Building Assistance (CBA), as needed.
  12. In 2012, it is recommended that the PCPG Interventions and Services Committee research and develop recommendations on the following promising interventions for possible inclusion in the 2013 Interventions Recommendations: Peer Health Navigation , Antiretroviral Treatment Access Study (ARTAS), Salud, Edicacion, Prevencion y Autocuidado (SEPA), Family Life and Sexual Health (FLASH), CTL (Counsel, Test, Link), and Pre-Exposure Prophylaxis (PrEP).

13. Funded agencies shall incorporate STI integration into public health strategies/interventions. The following services are available for provision according to MMWR 2010 STD Treatment Guidelines at STD Clinics outside of the city of Chicago and testing through the IDPH Laboratory: HIV, gonorrhea, Chlamydia, and syphilis testing; herpes PCR for clients with symptomatic lesions; Hepatitis C testing (for IDUs only); and Hepatitis A & B vaccination. .

### **2012 Recommendations for Adapting Evidence Based and Developing Homegrown Interventions:**

Interventions must be adapted to meet the needs of people/populations who were not part of the studies that showed the interventions' efficacy. Adaptations must be consistent with the intervention and culturally relevance to the population with whom the work is to be done. Retain the intent and internal logic of the intervention's core elements in making the intervention practice culturally relevant. Adapting an intervention for new at-risk populations and new venues must involve formative program evaluation.

#### **Adaptation procedures**

Intervention specific adaptation, must engage the following 6 general procedures in accordance with CDC guidance:

1. Identify intervention components that need adaptation
2. Collect information to form the procedures and materials;
3. Test the procedures and materials;
4. Document what you have done;
5. Implement, monitor, and evaluate;
6. Revise implementation materials, as needed.

Intervention specific adaptation must identify the health needs of the persons targeted, as well as their cultural experience. This is a first step to a culturally competent program. Intervention specific adaptation must adhere to the Office of Minority Health (OMH) in the Department of Health and Human Services published national standards for delivering services that reflect a group's culture and language. This is referred to as culturally and linguistically appropriate services (CLAS). Interventions specific adaptations targeting bisexual men of color must adhere to the CDC adaptation guide (adapting HIV behavior change interventions for gay and bisexual latino and black men).

IDPH must provide funded agencies with Procedural Guidance on Adaptations, providing examples, technical assistance and access to CDC CBA providers.

Using an IDPH-specified format, agencies approved to conduct an adaptation of a DEBI must provide the Lead Agent and IDPH with a summary of the outcomes of the intervention adaptation, to also include a qualitative report.

## 2012 Recommendations for Home Grown Interventions

IDPH must identify, evaluate and approve “home-grown” interventions used with special concerns populations when appropriate and when home grown interventions have proven behavioral outcome effectiveness.

Agencies choosing to implement a Home Grown Intervention must assure the following:



- Be feasible, practical, cost-effective, and have good potential for sustainability.
- Have a low potential for adverse short- and long-term, individual-level and community-level outcomes that could be attributed to the implementation of the intervention.
- Be acceptable and relevant to the target population.
- Have sufficient time to allow for the collection of data demonstrating the degree to which the intervention works, as well as the impact the intervention has on broader community health.
- Have the potential for additional health or social benefits that could result from its implementation.

Based on a thorough examination of the health behavioral model literature, the CDC’s Compendium of Effective Interventions, and the Tiers of Evidence Models, the Illinois PCPG recommends that jurisdictions combine a mix of homegrown and DEBI interventions that best fit its operations and target populations.

**When applicable, interventions must address the following HIV-Public Health Strategy related services:**

<b>Proposed Approved Services/Strategies</b>	
<b>1.</b>	<b>Counseling, Testing and Referral Services (CTR)</b>
<b>2.</b>	<b>Comprehensive Risk Counseling Services (CRCS)</b>
<b>3.</b>	<b>Partner Services (Community Based Organizations)</b>
<b>4.</b>	<b>Partner Services (Health Departments)</b>
<b>5.</b>	<b>STI Screening</b>
<b>6.</b>	<b>Hepatitis A &amp; B Vaccinations; Hepatitis B &amp; C testing</b>

## Key to Reading Priority Population Approved Interventions Tables

1.  An arrow across squares in the table means that the intervention can be used with all indicated risk populations.
2.  A dot indicates the intervention can be used with a specific risk population.
3. Specific age, race or gender requirements for an intervention will be noted.

1. **HIV positive and HIV negative Men Who Have Sex with Men (MSM):** A high-risk MSM is defined as a) any male or transgender individual who has had condomless anal sex with a male or transgender individual in the past 12 months, or b) any male or transgender individual who has had condomless anal sex with a male since his last HIV test. A high-risk MSM youth is defined as any male or transgender individual, age 13-19 years, who reports ever having had anal or oral sex with a male or transgender individual, or who states he is sexually attracted to males or transgender individuals (for Health Education/Risk Reduction services only).

Strategies and Interventions for Men Who Have Sex with Men (MSM) (subpopulations in no ranked order)									
Populations >	HIV positive MSM, all races and ages	African-American; age 25+	White; age 25+	Hispanic age 25+	African-American; ages 13-24	White, ages 13-24	Hispanic ages 13-24	Other races age 24+	Other races ages 13-24
Approved Public Health Strategies ▼									
Comprehensive Risk Counseling and Services (CRCS)	●————→								
Counseling, Testing and Referral (CTR)		●————→							
Partner Services (Community Based Organizations)	●————→								
Partner Services (Health Departments)	●————→								
Hepatitis A&B vaccination; Hep B testing	●————→								
STI Screenings (gonorrhea, Chlamydia, and syphilis)	●————→								
Approved Interventions ▼									
CLEAR (age 16 and above)	●————→								
Community PROMISE	●————→								
Cúdate!							●		
d-up: Defend Yourself!		●			●				
Focus on Youth (FOY) with ImPACT					●				
Group Prevention and Support (GPS)	●————→								

<b>Strategies and Interventions for Men Who Have Sex with Men (MSM) (subpopulations in no ranked order)</b>									
<b>Populations ➤</b>	<b>HIV positive MSM, all races and ages</b>	<b>African-American; age 25+</b>	<b>White; age 25+</b>	<b>Hispanic age 25+</b>	<b>African-American; ages 13-24</b>	<b>White, ages 13-24</b>	<b>Hispanic ages 13-24</b>	<b>Other races age 24+</b>	<b>Other races ages 13-24</b>
Healthy Relationships (age 18 and above)	✱								
Internet Risk Reduction Counseling (IRRC)	●—————→								
Many Men, Many Voices (3MV)		✱		✱	✱		✱		
Mpowerment (ages 18-29)	●—————→								
Partnership for Health (PFH)	✱								
Personal Cognitive Counseling (PCC)		●—————→							
Popular Opinion Leader (POL)	●—————→								
Project START	●—————→								
Respect	●—————→								
Risk Reduction Counseling	●—————→								
Safe in the City	●—————→								
Shield	●—————→								
Street Smart (ages 11-18)	✱				✱	✱	✱		✱
Together Learning Choices (ages 13-29)	✱								
VIBES					✱		✱		

**2. HIV positive and HIV negative High Risk Heterosexuals (HRH):** Females and males (including transgender individuals not included as MSM) engaging in condomless vaginal and/or anal sex with partners of the opposite sex, defined as any of the following:

- HIV positive individuals
- Persons with HIV positive partner(s) of the opposite sex
- Persons with IDU partner(s) of the opposite sex
- Female partners of MSM
- Heterosexual males and females with two or more STDs in 12 months
- Persons who have had sex with 6 or more partners in the past month
- Females who have had unprotected sex with a male(s) released within the past year from an incarceration of one year or longer in any county, state or federal correctional facility

**Points of Consideration for HRH individuals only:**

The positivity rate of HRH increases as age increases. Blacks and Hispanics are more likely to test positive than whites. Women are less likely to test HIV positive if they report using condoms, but males who reported condom use were not less likely to test positive. Oral sex with someone of the opposite gender was not found to be a predictor of new positive tests. Females who reported having sex with known HIV positive individuals, MSM or IDU are more likely to test positive than the heterosexual population tested.

Strategies and Interventions for High Risk Heterosexuals (subpopulations in no ranked order)														
Populations >	HIV positive HRH, all races, genders and ages	African-American F age 25+	African-American F ages 13-24	African-American M age 25+	White F age 25+ Hispanic F; age 25+ White, F; ages 13-24	Hispanic M, age 25+	Hispanic F, ages 13-24	White M, age 25+	African-American M ages 13-24	Other M, age 25 + Other F, age 25+	Hispanic M, ages 13-24	White M, ages 13-24	Other F, ages 13-24	Other M, ages 13-24
Approved Public Health Strategies v														
Counseling, Testing and Referral (CTR)		●—————→												
Comprehensive Risk Counseling and Services (CRCS)	●—————→													

Strategies and Interventions for High Risk Heterosexuals (subpopulations in no ranked order)														
Populations ➤	HIV positive HRH, all races, genders and ages	African-American F age 25+	African-American F ages 13-24	African-American M age 25+	White F age 25+ Hispanic F; age 25+ White, F; ages 13-24	Hispanic M, age 25+	Hispanic F, ages 13-24	White M, age 25+	African-American M ages 13-24	Other M, age 25 + Other F, age 25+	Hispanic M, ages 13-24	White M, ages 13-24	Other F, ages 13-24	Other M, ages 13-24
Partner Services (Community Based Organizations)	●													
Partner Services (Health Departments)	●													
Hepatitis A&B Vaccination; Hep B testing	●													
STI Screenings (gonorrhea, Chlamydia, syphilis)	●													
Approved Interventions ▼														
CLEAR ( age 16 and above)	●													
Community PROMISE	●													
CONNECT (age 16 and above)	●													
Cuidate!							✱				✱			
Focus on Youth (FOY) with ImPACT	✱(African-American, ages 12-15)		✱(ages 12-15)								✱(ages 12-15)			
Group Prevention and Support (GPS)	●													
Healthy Relationships	✱(age 18 and above)													


Strategies and Interventions for High Risk Heterosexuals (subpopulations in no ranked order)														
Populations >	HIV positive HRH, all races, genders and ages	African-American F age 25+	African-American F ages 13-24	African-American M age 25+	White F age 25+ Hispanic F; age 25+ White, F; ages 13-24	Hispanic M, age 25+	Hispanic F, ages 13-24	White M, age 25+	African-American M ages 13-24	Other M, age 25 + Other F, age 25+	Hispanic M, ages 13-24	White M, ages 13-24	Other F, ages 13-24	Other M, ages 13-24
Internet Risk Reduction Counseling (IRRC)														
NIA	*(African-American, M 18 and up)			*(ages 18 and above)					*(ages 18 and above)					
Partnership for Health (PfH)	*													
Platicas de Comadres	* Hispanic F				*(Hispanic)		*							
Popular Opinion Leader (POL)														
Project AIM			*		*		*		*		*	*	*	*
Project START														
RAPP	*(female only)	*	*		*		*			*(female only)			*	*
Respect														
Safe in the City														
Shield														
SIHLE			*(ages 14- 18)				*(ages 14- 18) - with approved adaptation							
SISTA		*	*(age 18 and above)											
SISTA adaptation for Latinos age 18 and above)					*(Hispanic F)		*							

Strategies and Interventions for High Risk Heterosexuals (subpopulations in no ranked order)														
African-American F ages 13-24	African-American F ages 13-24	African-American F ages 13-24	African-American F ages 13-24	African-American F ages 13-24	African-American F ages 13-24	African-American F ages 13-24	African-American F ages 13-24	African-American F ages 13-24	African-American F ages 13-24	African-American F ages 13-24	African-American F ages 13-24	African-American F ages 13-24	African-American F ages 13-24	African-American F ages 13-24
Sister to Sister		☼ (ages 18-45)	☼ (ages 18-45)											
Street Smart (ages 11-18)	☼		☼		☼		☼		☼		☼	☼	☼	☼
Together Learning Choices	☼ (ages 13- 29)													
VOICES/VOCES (age 18 and above)	☼(African-American & Hispanic)	☼	☼	☼	☼(Hispanic )	☼	☼		☼		☼			
WILLOW	☼(Females, ages 18-50)													

3. **HIV positive and HIV negative Injection Drug User (IDU):** A high-risk IDU is defined as a person who:
- Discloses sharing injection equipment or supplies in the last 12 months or since his or her last HIV test; or
  - Does not disclose injection risk, but displays visible signs of recent non-prescribed drug injection (specifically, fresh injection sites, injection abscesses, nodding off, etc.).

Strategies and Interventions for Injection Drug Users (IDU) (subpopulations in no ranked order)																	
Populations >	HIV positive IDUs, all races, genders and ages	African- American, M age 25+	African- American, F age 25+	White, M, age 25+	Hispanic, M, age 25+	White, F, age 25+	Hispanic, F, age 25+	African- American, F, ages 13-24	African-American, M, ages 13-24	White, F, ages 13-24	Hispanic, M, ages 13-24	White, M, ages 13-24	Hispanic, F, ages 13-2424+	Other races, M, ages 13-24	Other races, F, ages 13-24	Other races, F, age 25+	Other races, M, age 25+
<b>Approved Public Health Strategies</b> ▼																	
Comprehensive Risk Counseling and Services (CRCS)	●																
Counseling, Testing and Referral (CTR)		●															
Partner Services (Community Based Organizations)	●																
Partner Services (Health Departments)	●																
Hepatitis A & B vaccination; Hepatitis B testing; Hepatitis C testing	●																
STI Screenings (gonorrhea, Chlamydia, syphilis)	●																
<b>Approved Interventions</b> ▼																	
CLEAR (age 16 and above)	●																
Group Prevention and Support (GPS)	●																
Healthy Relationships	★ (age 18 and above)																

**Strategies and Interventions for Injection Drug Users (IDU) (subpopulations in no ranked order)**

Populations 	HIV positive IDUs, all races, genders and ages	African- American, M age 25+	African- American, F age 25+	White, M, age 25+	Hispanic, M, age 25+	White, F, age 25+	Hispanic, F, age 25+	African- American, F, ages 13-24	African-American, M, ages 13-24	White, F, ages 13-24	Hispanic, M, ages 13-24	White, M, ages 13-24	Hispanic, F, ages 13-2424+	Other races, M, ages 13-24	Other races, F, ages 13-24	Other races, F, age 25+	Other races, M, age 25+
Holistic Health Recovery Program (HHRP)	●																→
IDU Harm Reduction Counseling	●																→
Modelo de Intervencion Psicomédica (MIP) (age 18 and above)	●																→
Naloxone (in combination with syringe exchange)	●																→
Partnership for Health	✱																
Popular Opinion Leader (POL)	●																→
Project START	●																→
Respect	●																→
Safety Counts	●																→
Shield (age 18 and above)	●																→
Together Learning Choices	✱ (ages 13- 29)																
<b>WILLOW</b>	✱ (Females , ages 18-50)																

4. **HIV positive and HIV negative MSM/IDU: – Defined** as any male who meets the combined definitions of MSM and IDU (#1 and 3 above), in this document.

Strategies and Interventions for Men Who Have Sex with Men/Injection Drug User (MSM/IDU) (subpopulations in no ranked order)									
Populations >	HIV positive MSM/IDU, all races and ages	African-American age 25+	White age 25+	Hispanic age 25+	African-American ages 13-24	White, ages 13-24	Other races age 24+	Hispanic ages 13-24	Other races ages 13-24
Approved Public Health Strategies and Interventions▼									
All Public Health strategies and interventions approved for MSM or IDU populations are approved for MSM/IDU. See Tables 1 and 3 above for specific interventions.									

5. **Other Important points of consideration:**

**Prevention with HIV positive individuals** falling within any of the risks identified above should be a top priority within each subpopulation category and specific strategies to engage this population should be developed, including linkage to care and treatment. Prevention with positives should include reproductive health education for females and their partners, including linkage to perinatal care.

**Transgender individuals** are considered priority within each of the priority populations due to the alarming national HIV prevalence rates in this population and the severe social determinants impacting this population. Transgender identity does not mean an individual engages in risk behaviors and transgender individuals should be prioritized within each of the risk groups.

**Transgender**

Strategies and Interventions for Transgender									
Populations >	HIV positive transgender individuals, all races and ages;	Male to female transgender individuals, female to male transgender individuals.							
Approved Public Health Strategies▼									
Comprehensive Risk Counseling and Services (CRCS)		→							
Counseling, Testing and Referral (CTR)		→							

Strategies and Interventions for Transgender									
Populations ➤	HIV+ transgender individuals, all races and ages;	Male to female transgender individuals, female to male transgender individuals.							
Approved Public Health Strategies ▼									
Partner Services (Community Based Organizations)	●	→							
Partner Services (Health Departments)	●	→							
Hepatitis A&B vaccination; Hep B testing	●	→							
STI Screenings (gonorrhea, Chlamydia, syphilis)	●	→							
Approved Interventions ▼									
CLEAR (age 16 and above)	●	→							
Group Prevention and Support (GPS)	●	→							
Healthy Relationships	✱ HIV+ (age 18+)								
IDU Harm Reduction	●	→							
Internet Risk Reduction Counseling (IRRC)	●	→							
Partnership for Health (PFH)	✱								
Personal Cognitive Counseling (PCC)	●	→							
Popular Opinion Leader (POL)	●	→							
Project START	●	→							
Respect	●	→							
Risk Reduction Counseling	●	→							
Safe in the City	●	→							

Strategies and Interventions for Transgender									
Populations ➤	HIV positive transgender individuals, all races and ages;	Male to female transgender individuals, female to male transgender individuals.							
Shield									
Street Smart (ages 11-18)									
TWISTA									
WILLOW	* (Females, ages 18-50)								

## APPENDIX #3

# Regional HIV Prevention Grant Goals

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### **Illinois HIV/AIDS Strategy (IHAS) Goals**

**Goal:** Reduce morbidity, mortality, and related health disparities in the Illinois HIV epidemic by:

- reducing new infections,
- increasing access to care,
- improving health outcomes for people living with HIV, and
- promoting health equity.

### **National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP) Measurable Outcome Performance Goals**

- Decrease the annual HIV incidence rate in communities where HIV is most heavily concentrated.
- Decrease the rate of HIV transmission by HIV-infected persons.
- Decrease risky sexual and drug-using behaviors among persons at high-risk for acquiring HIV.
- Increase the proportion of HIV-infected people in the United States who know they are infected.
- Increase the proportion of HIV-infected persons who are linked to prevention and care services.

# APPENDIX #4

## CDC HIV PREVENTION PERFORMANCE MEASURES

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### **CDC performance standards for funded jurisdictions:**

- For targeted HIV testing in non-healthcare settings or venues, achieve at least a 1.0% rate of newly identified HIV-positive tests annually.
- At least 85% of persons who test positive for HIV receive their test results.
- At least 80% of persons who receive their HIV positive test results are linked to medical care and attend their first appointment.
- At least 75% of persons who receive their HIV positive test results are referred and linked to Partner Services.

## **APPENDIX #5 CONTRACT MONITORING**

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Contract monitoring has a dual focus: programmatic and fiscal. These two functions are complementary and interdependent.

Contract monitoring includes both program monitoring (i.e., assessing the quality and quantity of services provided) and fiscal monitoring (assessing how efficiently and appropriately funds are used). Contract monitoring processes should be based on obligations as outlined in a written contract and responsibilities as outlined in a subcontractor agreement.

Fiscal monitoring assesses the validity, cost efficiency, legality, timeliness, and programmatic focus of a contractor's use of the HIV Prevention funding. Fiscal monitoring ensures that purchases of staff and consultant time, services and goods occurred as claimed with proper documentation, at reasonable cost and with good value. It ensures adherence to Federal, State, and local rules and guidelines on the use of HIV Prevention funds. It assesses the regular flow of service activity throughout the contract period. It compares documented expenses to service delivery to ensure that expenditures are focused on facilitating service delivery rather than meeting other organizational needs. Administrative site visits of all subcontractors including fiscal and contract monitoring are required twice annually.

Though many methods used in program and fiscal monitoring are the same as those used in program evaluation, these activities are distinct. Contract monitoring is concerned with oversight of use of funds and accomplishment of activities as outlined in program contracts. Evaluation is similar in that it can also focus on documentation of program accomplishments. However, evaluation also assesses the impact of programs on clients by examining delivery of services and outcomes attributable to service efforts. Contract monitoring cannot typically provide this type of information.

Assessing the quality and quantity of the services being provided by a particular contractor may require staff to review program reports, conduct site visits and review client records or charts. Staff responsible for monitoring contracts generally requires providers to report the number of clients served, the types of services offered, and any barriers or problems associated with delivery of the services.

## **APPENDIX #6**

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# FY2010 ILLINOIS RYAN WHITE UNMET NEED

## Unmet Need Estimate by Care Regions of Diagnosis

Region		Total	Met Need (eHARS + Linked Providers)	Unmet Need (eHARS + Linked Providers)	Percent Unmet Need
PLWA	Winnebago Region	465	267	198	42.6%
	Peoria Region	412	270	142	34.5%
	Sangamon Region	422	235	187	44.3%
	St. Clair Region	531	301	230	43.3%
	Jackson Region	197	111	86	43.7%
	Champaign Region	526	286	240	45.6%
	Collar Region	1,475	809	666	45.2%
	Cook Region	13,475	7,271	6,204	46.0%
	Unknown	6	0	6	100.0%
	Total	17,509	9,550	7,959	45.5%
PLWH	Winnebago Region	357	189	168	47.1%
	Peoria Region	298	145	153	51.3%
	Sangamon Region	388	147	241	62.1%
	St. Clair Region	542	270	272	50.2%
	Jackson Region	227	96	131	57.7%
	Champaign Region	406	168	238	58.6%
	Collar Region	981	480	501	51.1%
	Cook Region	11,019	5,438	5,581	50.6%
	Total	14,218	6,933	7,285	51.2%
PLWA+ PLWH	Winnebago Region	822	456	366	44.5%
	Peoria Region	710	415	295	41.5%
	Sangamon Region	810	382	428	52.8%
	St. Clair Region	1,073	571	502	46.8%
	Jackson Region	424	207	217	51.2%
	Champaign Region	932	454	478	51.3%
	Collar Region	2,456	1,289	1,167	47.5%
	Cook Region	24,494	12,709	11,785	48.1%
	Unknown	6	0	6	100.0%
	Total	31,727	16,483	15,244	48.0%

# APPENDIX #7

## HIV-POSITIVE PEER PROGRAM

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### **How can peers contribute to HIV care?**

People living with HIV/AIDS (PLWHA) play an instrumental role in advancing access to and increasing the quality of their health care services. Since the beginning of the epidemic, PLWHA have advocated for resources that prevent new HIV infections, expand availability and accessibility of care and services, and promote improved HIV treatments.

### **Who is a peer?**

The range of terms used to describe community-based, non-licensed health service providers reflects the wide variety of functions that they perform: peer educator, counselor, or advisor; community health worker; lay health worker; buddy; promotores de salud, or patient navigators. Peers may also be defined as individuals who are from infected or affected communities that share similar characteristics with the clients being served. For the sake of simplicity, this introduction uses the term “peer” to refer to all non-licensed professionals in health and social service programs whose qualifications and roles rest on their connection with the community they serve.

### **Peer Roles and Responsibilities**

The roles and responsibilities of peers can vary widely depending on the focus of the organization or program. Peer roles can include:

- Engaging and supporting HIV-positive persons in the management of the disease, including being adherent to medications
- Providing emotional and practical support to clients
- Supporting clients to practice healthy behaviors
- Identifying HIV-positive persons in the community and linking them to care
- Helping people living with HIV/AIDS (PLWHA) navigate the service system and assisting them to access and participate in care and treatment services
- Providing community work such as awareness, advocacy and prevention education
- Advising programs on all aspects of service delivery

The specific responsibilities or activities of peers in these roles vary, and the qualifications and skills of peers are different depending on their roles.

Peers in these roles often deliver services through a combination of one-on-one support and/or peer-led support groups. For one-on-one conversations, the peer needs to be comfortable disclosing his or her HIV status, be able to ask open-ended questions, and provide accurate information that is relevant to the client’s needs. Support group facilitation requires the peer to disclose his or her HIV status and have the knowledge and skills to manage the group dynamics so that participants feel comfortable and safe in sharing very personal and emotional issues.

Support group facilitation is a specialized skill, which may require additional training or co-facilitation.

The specific peer roles related to engaging and supporting HIV-positive persons to manage the disease and adhere to medications can be as limited or as broad as the organization desires and include:

- Explaining the HIV life cycle and how medications work, providing treatment adherence information and strategies for complex HIV/AIDS treatment regimens
- Engaging in problem solving with clients to address adherence problems
- Engaging “harder-to-reach” clients who have fallen out of care or have not entered care (this is similar to outreach roles described above)
- Becoming familiar with the context of the clients’ lives
- Facilitating client communication with health professionals
- Gathering information for medical providers
- Following up with clients who miss appointments
- Answering clients’ basic questions
- Providing emotional and practical support