PRELIMINARY SUMMARY OF APPLICATIONS FOR BOARD APPROVAL

To: Board of Health
From: Jim Diamond
Date: October 14, 2021
Re: Summary of applications presented for Board approval

1. **Ryan White Part A 22-23 application** (pp 9-105)

   This is a grant application to the U.S. Department of Health and Human Services to support the Ryan White Part A and Minority AIDS Initiative program. This grant provides funding for medical and social support services for low-income persons living with HIV disease in Davidson and 12 surrounding counties. It also includes funding for the support of a Mayor appointed planning body that is responsible for allocation of funding to service categories and planning.

   Term: March 31, 2022 – February 28, 2023
   Amount: $4,955,957
   Program Manager: Beverly Glaze-Johnson
   Bureau: Joanna Shaw-KaiKai

PRELIMINARY SUMMARY OF GRANTS & CONTRACTS FOR BOARD APPROVAL

To: Board of Health
From: Jim Diamond
Date: October 14, 2021
Re: Summary of grants & contracts presented for Board approval

1. Nashville Health Accelerator Plan 22 grant (pp 106-112)

This Centers for Disease Control and Prevention grant will establish a multi-sector coalition to develop an action plan to address the social determinants of health including community-clinical linkages and food and nutrition security to improve chronic disease outcomes among persons experiencing health disparities and inequities.

Term: September 30, 2021 – September 29, 2021
Amount: $125,000
Program Manager: Stephanie Kang
Bureau: Stephanie Kang

2. Public Health Associate Program 22-24 grant (pp 113-118)

The Centers for Disease Control awarded MPHD an associate to be placed with the Strategic Planning, Performance and Evaluation program to gain public health experiences in strategic planning, performance measurement and quality improvement.

Term: October 12, 2021 – October 13, 2023
Amount: NA
Program Manager: Tracy Buck
Bureau: Gill Wright

3. Emergency Medical Fund grant (p 119)

This is a donation from the nonprofit Friends of Metro Animal Care & Control for the provision of emergency medical care for animals.

Term: NA
Amount: $5,000
Program Manager: Staci Cannon
Bureau: Hugh Atkins

4. A Step Ahead Foundation 22 grant (pp 120-139)

This is grant from A Step Ahead Foundation of Middle Tennessee to reimburse MPHD for costs associated with providing long-acting reversible contraception.

Term: Execution – December 31, 2022
Amount: $48,000
Program Manager: Laura Varnier
Bureau: Laura Varnier

5. Child Fatality Review Services 19-24 contract amendment (pp 140-144)

This contract funds the review of all Sudden Deaths of Children from birth to the age of 19 that are unexplained. The intention is to prevent and reduce the rate of child deaths in Tennessee. This amendment adds funds and extends the contract an additional year.

Term:	September 30, 2018 – September 29, 2023
Amount:	$28,000
Program Manager:	D'Yuanna Allen-Robb
Bureau:	Fonda Harris

NEW MATERIALS
SUMMARY OF GRANTS & CONTRACTS FOR BOARD APPROVAL

To: Board of Health
From: Jim Diamond
Date: October 14, 2021
Re: Summary of grants & contracts presented for Board approval

6. Ryan White Part A 20-21 A3 grant (p 145-147)

This is a grant amendment from the Health Resources & Services Administration for the provision of prevention, surveillance, diagnosis, and treatment of HIV/AIDS. It also includes the administration for a Minority AIDS Initiative program. This funding is meant to be the "payer of last resort" and removes unspent funds from the previous grant year.

Term:	March 1, 2020 – February 28, 2021
Amount:	-$426,692
Program Manager:	Beverly Glaze-Johnson
Bureau:	Joanna Shaw-KaiKai

7. Ryan White Part A 21-22 A2 grant (pp 148-150)

This is a grant amendment from the Health Resources & Services Administration for the provision of prevention, surveillance, diagnosis, and treatment of HIV/AIDS. It also includes the administration for a Minority AIDS Initiative program. This funding is meant to be the "payer of last resort" and carries-over unspent funds from the previous grant year.

Term:	March 1, 2021 – February 28, 2022
Amount:	$426,692
Program Manager:	Beverly Glaze-Johnson
Bureau:	Joanna Shaw-KaiKai

8. Marjorie A Neuhoff Foundation grant (pp 151-152)

This grant from the Nuehoff Foundation is to Metro Animal Care & Control with restrictions on placing cats and dogs in loving homes.

Term:	NA
Amount:	$7,500
Program Manager:	Staci Cannon
Bureau:	Hugh Atkins

9. Healthy Start Initiative - Nashville Strong Babies 21-22 A1 (pp153-155) & A2 (pp 156-158) grant

This is two grant amendments from Health Resources and Services Administration to the Nashville Strong Babies award. The first amendment adds funds to the doula portion of the program that was applied for and board approved in June. The second amendment changes the Project Director from D'Yuanna to Fonda per MPHD request.

Term:	April 1, 2021 – March 31, 2022
Amount:	$125,000
Program Manager:	D'Yuanna Allen-Robb
Bureau:	Fonda Harris

OMB Number: 4040-0004
Expiration Date: 12/31/2022

Application for Federal Assistance SF-424

* 1. Type of Submission:	* 2. Type of Application:	* If Revision, select appropriate letter(s):
☐ Preapplication	☐ New	
☒ Application	☒ Continuation	* Other (Specify):
☐ Changed/Corrected Application	☐ Revision	

* 3. Date Received:	4. Applicant Identifier:
Completed by Grants.gov upon submission.	

5a. Federal Entity Identifier:	5b. Federal Award Identifier:
	H89HA11433-13

State Use Only:

6. Date Received by State:	7. State Application Identifier:

8. APPLICANT INFORMATION:

* a. Legal Name: Metropolitan Government of Nashville and Davidson County

* b. Employer/Taxpayer Identification Number (EIN/TIN):	* c. Organizational DUNS:
62-0694743	0782176680000

d. Address:

* Street1:	2500 Charlotte Avenue
Street2:	
* City:	Nashville
County/Parish:	
* State:	TN: Tennessee
Province:	
* Country:	USA: UNITED STATES
* Zip / Postal Code:	37209-4129

e. Organizational Unit:

Department Name:	Division Name:
Metro Public Health Department	

f. Name and contact information of person to be contacted on matters involving this application:

Prefix:	Ms.	* First Name:	Beverly
Middle Name:			
* Last Name:	Glaze-Johnson		
Suffix:			

Title:

Organizational Affiliation:

* Telephone Number:	615-340-8605	Fax Number:	

* Email: beverly.glaze-johnson@nashville.gov

Application for Federal Assistance SF-424

*** 9. Type of Applicant 1: Select Applicant Type:**

X: Other (specify)

Type of Applicant 2: Select Applicant Type:

Type of Applicant 3: Select Applicant Type:

* Other (specify):

Metropolitan Government

*** 10. Name of Federal Agency:**

Health Resources and Services Administration

11. Catalog of Federal Domestic Assistance Number:

93.914

CFDA Title:

HIV Emergency Relief Project Grants

*** 12. Funding Opportunity Number:**

HRSA-22-018

* Title:

Ryan White HIV/AIDS Program Part A HIV Emergency Relief Grant Program

13. Competition Identification Number:

HRSA-22-018

Title:

Ryan White HIV/AIDS Program Part A HIV Emergency Relief Grant Program

14. Areas Affected by Project (Cities, Counties, States, etc.):

Add Attachment | Delete Attachment | View Attachment

*** 15. Descriptive Title of Applicant's Project:**

Ryan White Part A - Nashville/Middle TN TGA

Attach supporting documents as specified in agency instructions.

Add Attachments | Delete Attachments | View Attachments

Application for Federal Assistance SF-424

16. Congressional Districts Of:

* a. Applicant: TN-005 * b. Program/Project: 04-08

Attach an additional list of Program/Project Congressional Districts if needed.

Add Attachment | Delete Attachment | View Attachment

17. Proposed Project:

* a. Start Date: 03/01/2022 * b. End Date: 02/28/2023

18. Estimated Funding ($):

* a. Federal	4,955,957.00
* b. Applicant	0.00
* c. State	0.00
* d. Local	0.00
* e. Other	0.00
* f. Program Income	0.00
* g. TOTAL	4,955,957.00

*** 19. Is Application Subject to Review By State Under Executive Order 12372 Process?**

☐ a. This application was made available to the State under the Executive Order 12372 Process for review on .

☐ b. Program is subject to E.O. 12372 but has not been selected by the State for review.

☒ c. Program is not covered by E.O. 12372.

*** 20. Is the Applicant Delinquent On Any Federal Debt? (If "Yes," provide explanation in attachment.)**

☐ Yes ☒ No

If "Yes", provide explanation and attach

Add Attachment | Delete Attachment | View Attachment

21. *By signing this application, I certify (1) to the statements contained in the list of certifications and (2) that the statements herein are true, complete and accurate to the best of my knowledge. I also provide the required assurances** and agree to comply with any resulting terms if I accept an award. I am aware that any false, fictitious, or fraudulent statements or claims may subject me to criminal, civil, or administrative penalties. (U.S. Code, Title 218, Section 1001)**

☒ ** I AGREE

** The list of certifications and assurances, or an internet site where you may obtain this list, is contained in the announcement or agency specific instructions.

Authorized Representative:

Prefix: Dr. * First Name: Gill

Middle Name:

* Last Name: Wright

Suffix:

* Title: Director of Health

* Telephone Number: 615-340-0410 Fax Number:

* Email: gill.wright@nashville.gov

* Signature of Authorized Representative: Completed by Grants.gov upon submission. * Date Signed: Completed by Grants.gov upon submission.

NEW MATERIAL

ATTACHMENTS FORM

Instructions: On this form, you will attach the various files that make up your grant application. Please consult with the appropriate Agency Guidelines for more information about each needed file. Please remember that any files you attach must be in the document format and named as specified in the Guidelines.

Important: Please attach your files in the proper sequence. See the appropriate Agency Guidelines for details.

1) Please attach Attachment 1	Attachment 1 Staffing plan FY	Add Attachment	Delete Attachment	View Attachment
2) Please attach Attachment 2	Attachment 2 RWHAP Part A Eme	Add Attachment	Delete Attachment	View Attachment
3) Please attach Attachment 3	Attachment 3 HIVAIDS Demograp	Add Attachment	Delete Attachment	View Attachment
4) Please attach Attachment 4	Attachment 4 Unmet Need Frame	Add Attachment	Delete Attachment	View Attachment
5) Please attach Attachment 5	Attachment 5 Co-occurring Com	Add Attachment	Delete Attachment	View Attachment
6) Please attach Attachment 6	Attachment 6 Letter of Concur	Add Attachment	Delete Attachment	View Attachment
7) Please attach Attachment 7	Attachment 7 Coordination_of_	Add Attachment	Delete Attachment	View Attachment
8) Please attach Attachment 8	Attachment 8 FY22_Part_A_HIV_	Add Attachment	Delete Attachment	View Attachment
9) Please attach Attachment 9	Attachment 9 FY22_Part_A_MAI_	Add Attachment	Delete Attachment	View Attachment
10) Please attach Attachment 10		Add Attachment	Delete Attachment	View Attachment
11) Please attach Attachment 11	Attachment 11 2022 NOFO MPHD	Add Attachment	Delete Attachment	View Attachment
12) Please attach Attachment 12	Attachment 12 Maintenance of	Add Attachment	Delete Attachment	View Attachment
13) Please attach Attachment 13	Attachment 13 2022 Indirect C	Add Attachment	Delete Attachment	View Attachment
14) Please attach Attachment 14		Add Attachment	Delete Attachment	View Attachment
15) Please attach Attachment 15		Add Attachment	Delete Attachment	View Attachment

ATTACHMENT #1: STAFFING PLAN/BIOSKETCHES 2022-2023

Name	Education	Title	Project Role	Experience	Adm (%)	CQM (%)	MAI (%)	HIV Serv
Beverly Glaze-Johnson	MSP	Program Manager	Oversight of RWHAP award and project implementation	20+ years' experience in HIV/AIDS, supervision/leadership, grants management, program oversight, training, collaboration and coalition building, and financial management	65	30	5	
(TO BE HIRED)		Public Health Administrator (Program Monitor)	Program monitor and capacity building	Currently vacant	65	26	9	
Anthony Bennici	MPH	Epidemiologist (Data Analyst)	Oversight of data collection, analysis, and reporting	Started working as an epidemiologist at MPHD. Previous experience as NIH HIV researcher, HIV clinical coordinator at Emory Univ, and evaluations training as ORISE Fellow at CDC	30	40	10	
Regina Bell	MPH	Public Health Administrator (CQM Coordinator)	Oversight of QMP/QI activities and monitoring	20+ years' experience in HIV/AIDS case management, EIS, Mental Health, 2 years in governmental administrative work	5	85	10	
Quinntana Slaughter	MSP Certificate in Diversity, Equity, and Inclusion in the Workplace	Public Health Administrator (PC Liaison)	Oversight and support of the Planning Council	20+ years administrative work in the government and healthcare field	100	0	0	
Emily Bradberry	Bachelors' Degree	Finance Officer	Submits FFR reports	6+ years of financial and administrative experience (2 of those years as a public government finance officer)	5	0	0	
Sharon Daniel	Bachelors' Degree	Finance Officer	Responsible for managing RFQ, contracting, invoicing, expenditure reports, fiscal monitoring, and reporting process including EHB submissions	35+ years as a public government financial officer	90	0	5	

ATTACHMENT 3. HIV/AIDS Demographic Table, Nashville TGA, 2017-2019												
	2017				2018				2019			
	New Diagnoses		PLWH		New Diagnoses		PLWH		New Diagnoses		PLWH	
	N	Rate	N	Rate	N	Rate	N	Rate	N	Rate	N	Rate
Gender												
Cisgender male	175	19.8	4166	471.4	170	18.9	4236	472.0	201	22.1	4225	464.0
Cisgender female	25	2.7	1153	124.9	34	3.6	1144	122.0	32	3.4	1097	115.2
Transgender person	2	—	58	—	6	—	70	—	4	—	65	—
Age group (current age, years)												
<15	3	0.9	28	8.0	1	0.3	32	9.1	0	0.0	24	6.8
15–24	48	20.1	171	71.6	44	18.3	178	74.0	37	15.3	163	67.2
25–34	77	27.6	934	334.9	85	29.8	945	331.7	101	34.7	987	338.9
35–44	26	10.6	1045	425.2	41	16.3	1023	407.8	40	15.6	1003	391.9
45–54	30	12.4	1690	698.6	23	9.5	1601	664.3	34	14.2	1460	610.3
55–64	13	5.9	1219	556.2	12	5.4	1331	595.6	22	9.7	1378	606.9
≥65	5	2.2	290	125.0	4	1.7	340	140.8	3	1.2	372	147.8
Race/ethnicity												
Non-Hispanic Black	94	33.7	2569	919.9	94	33.2	2604	919.7	99	34.5	2571	896.1
Non-Hispanic white	85	6.5	2311	177.4	74	5.6	2312	175.4	102	7.7	2256	169.2
Hispanic	15	11.4	337	255.2	23	16.8	353	257.4	27	19.1	374	264.0
Other	8	8.6	160	172.6	19	19.6	181	186.3	9	8.9	186	183.4
Transmission risk												
Cisgender male												
Male-to-male sexual contact (MMS)	141	—	2918	—	121	—	2991	—	168	—	3003	—
Injection drug use (IDU)	2	—	260	—	2	—	250	—	5	—	231	—
MMS and IDU	2	—	198	—	6	—	198	—	3	—	189	—
Heterosexual sexual contact	7	—	363	—	28	—	361	—	17	—	370	—
Perinatal exposure	0	—	16	—	0	—	18	—	0	—	17	—
Other	0	—	18	—	0	—	16	—	0	—	14	—
Unknown	23	—	393	—	13	—	402	—	8	—	401	—
Cisgender female												
Heterosexual sexual contact	15	—	789	—	27	—	785	—	17	—	762	—
Injection drug use (IDU)	1	—	178	—	0	—	168	—	9	—	152	—
Perinatal exposure	2	—	24	—	1	—	25	—	0	—	23	—
Other	0	—	5	—	0	—	6	—	0	—	5	—
Unknown	7	—	157	—	6	—	160	—	6	—	155	—
Transgender person												
Any sexual contact	2	—	47	—	5	—	58	—	4	—	55	—
Injection drug use (IDU)	0	—	1	—	0	—	1	—	0	—	1	—
Any sexual contact and IDU	0	—	5	—	0	—	5	—	0	—	4	—
Perinatal exposure	0	—	1	—	0	—	1	—	0	—	1	—
Other	0	—	0	—	0	—	0	—	0	—	0	—
Unknown	0	—	4	—	1	—	5	—	0	—	4	—
Total	202	11.2	5377	297.5	210	11.4	5450	296.9	237	12.7	5387	289.1

Source: Tennessee enhanced HIV/AIDS Reporting System (eHARS) accessed July 13, 2020.
Persons Living with diagnosed HIV (PLWH): persons diagnosed with HIV on or before December 31 and resided in the Nashville TGA on December 31 of the specified year.
Transgender refers to persons whose gender is different than the sex they were assigned at birth.
Age group refers to age as of December 31 of the specified year.
Hispanics can be of any race.
Transmission risk categories are mutually exclusive; heterosexual sexual contact includes high risk heterosexuals and persons who had sexual contact with someone of the opposite sex and said no to injecting drugs; other includes blood transfusion and hemophilia; unknown includes no identified risk (NIR) and no reportable risk (NRR).
X represents suppressed data.
— represents data not available.
Rates per 100,000 persons. Rates were calculated using the US Census Bureau 2019 Population Estimates.

ATTACHMENT 4. Unmet Need Framework Estimates, Nashville TGA and RWHAP, 2019

	Late Diagnosed		Unmet Need				In Care, Not Virally Suppressed			
	TGA		TGA		RWHAP		TGA		RWHAP	
	N	%	N	%	N	%	N	%	N	%
Total	37	16%	654	13%	648	23%	722	17%	384	12%
Gender										
Cisgender Male	32	16%	519	14%	493	23%	529	16%	281	11%
Cisgender Female	5	16%	130	13%	141	23%	177	21%	94	13%
Transgender Person	0	0%	5	8%	14	26%	16	29%	9	19%
Race/Ethnicity										
Non-Hispanic Black	14	14%	334	14%	388	25%	413	21%	247	16%
Non-Hispanic white	15	15%	267	13%	204	22%	260	15%	111	8%
Hispanic	6	22%	35	12%	44	18%	29	11%	18	8%
Non-Hispanic Other	2	22%	18	10%	12	17%	20	13%	8	9%
Age Group (current, years)										
13-24	1	3%	30	18%	44	39%	34	25%	20	23%
25-34	11	11%	152	16%	173	26%	183	23%	122	19%
35-44	10	25%	151	16%	124	22%	143	19%	90	14%
45-54	7	21%	154	12%	148	21%	197	17%	87	10%
55-64	7	32%	126	11%	114	19%	127	12%	54	7%
65+	1	33%	41	11%	45	31%	38	12%	11	5%

Source: Tennessee enhanced HIV/AIDS Reporting System (eHARS) accessed July 13, 2020. CAREWare, accessed July 28, 2021.
Late diagnoses: Number of people with late diagnosed HIV in the most recent calendar year in the jurisdiction based on residence at time of diagnosis. Late diagnosed HIV is based on the first CD4 test result (<200 cells/mL or a CD4 percentage of total lymphocytes of <14) or documentation of an AIDS-defining condition <=3 months after a diagnosis of HIV infection. Required method only, not applicable to RWHAP enhanced estimates.
Unmet need: Number of people living with diagnosed HIV infection in the jurisdiction based on most recent known address without any CD 4 or VL test in the most recent calendar year.
Not virally suppressed: Number of people living with diagnosed HIV infection in the jurisdiction who are in care and whose most recent vira l load test was >=200 copies/mL in the most recent calendar year.

ATTACHMENT 5. Co-occurring Conditions

a,b) Hepatitis C and STI rates, Nashville TGA, 2019

Comorbidity	PLWH (N=5,387)		General Population (N=1,863,108)	
	N	Rate	N	Rate
Chlamydia	248	4603.7	10812	580.3
Gonorrhea	269	4993.5	3686	197.8
Syphilis (primary and secondary)	75	1392.2	259	13.9
Acute Hepatitis C	1	18.6	62	3.3
Chronic Hepatitis C	44	816.8	3540	190.0

Sources: Tennessee enhanced HIV/AIDS Reporting System (eHARS) accessed July 13, 2020. Tennessee Patient Reporting Investigating Surveillance Manager (PRISM) accessed September 7, 2021. STD rates were calculated based on Census Bureau 2019 Population Estimates.

d) Substance Use, Fatal and Non-fatal Overdoses, Nashville TGA, 2019

County	Overdose Type	
	Fatal	Non-fatal
Cannon	8	60
Cheatham	27	222
Davidson	329	2079
Dickson	27	184
Hickman	12	96
Macon	3	67
Robertson	27	193
Rutherford	95	960
Smith	7	43
Sumner	47	506
Trousdale	2	41
Williamson	36	290
Wilson	61	340
Total	681	5081

Sources: Tennessee Department of Health's Vital Statistics Death Statistical File, Hospital Discharge Data System, 2016-2019.

ATTACHMENT 5. Co-occurring Conditions

c) Mental Illness Estimates, 2016-2018

Region	Any Mental Illness	
	%	N
Nashville TGA	18.6	270300

Sources: National Survey on Drug Use and Health, Comparison of 2008-2010 and 2016-2018 NSDUH Substate Region Estimates. Nashville TGA mental illness prevalence estimate based on average of Davidson County and Region 5 (Central Tennessee Region) prevalence rates and apply to adults ≥18 years old. Based on Census estimates, approximately 78% of the TGA population is ≥18 years old. This estimated adult population was used to estimate the number of adults in the TGA with any mental illness in the past year.

e) Homelessness in Nashville TGA, 2019

Region	Homeless	
	N	Rate
Nashville-Davidson	1986	286.1
Murfressboro-Rutherford	384	115.6
Nashville TGA	2370	230.9

Sources: National Alliance to End Homelessness, Point in Time Counts, April 20, 2021. Homelessness rates were calculated based on Davidson and Rutherford County Census Bureau 2019 Population Estimates.

f) Estimated number of prisoners who had HIV in the custody of state and federal correctional authorities, 2013-2015

Region	2013		2014		2015	
	N	%	N	%	N	%
Tennessee	209	1.3	249	1.6	217	1.5

Sources: Bureau of Justice Statistics, HIV in Prisons, 2015 - Statistical Tables, August 2017.

A. PLANNING RESPONSIBILITIES

B. 1. **Planning & Resource Allocation**

A.1.a **Description of the Comprehensive Planning Process**
OVERALL INPUT PROCESS: The TGA obtained community and consumer input through various methods. Consumers and a diversity of community partners, representing ASO and non-ASO organizations participated in the Planning Council's Data Summit and the Priority Setting and Resource Allocation process. The Planning Council strategically invites attendees to the Data Summit specifically to broaden the potential spheres of input that can be drawn upon as needed. Lastly, community members are provided an opportunity to provide input at routine Planning Council meetings.

HOW THE PROCESS WAS CONDUCTED: The PSRA process used by the Planning Council is established by the PSRA Committee of the Planning Council and reviewed each year in advance of the annual PSRA meeting of the Planning Council. The PSRA process is examined in order to ensure that it meets requirements of the grant and a simple process for the council to follow during the meeting.
The PSRA process is designed and facilitated by the PSRA Committee Chair. On an annual basis, the PSRA Committee reviews the PSRA process/procedures to determine if changes are necessary. The PSRA process is data driven using information from the TGA Needs Assessment and Comprehensive/Integrated Plans, as well as service utilization, cost data and information about other funding sources in the community. The committee meets before the full Planning Council PSRA meeting to conduct an intensive review of data and prepare priority setting and resource allocations and directive recommendations for the Recipient. All members of the Planning Council are actively encouraged to participate in this committee meeting, emphasizing the importance of this responsibility. The annual PSRA meeting is held the month after the presentation of the Needs Assessment. Prior to the meeting, all Planning Council members receive a packet of information, including priority setting, funding and directive recommendations from the PSRA Committee. At the full Planning Council meeting, discussion regarding services and their impact on consumer health is held to confirm existing priority rankings for all services. During the second half of the meeting, allocations are decided by the full Council. Decisions are driven by estimated need, capacity, costs, potential impacts of Affordable Health Care and are based on trends and data found in the TGA Needs Assessment and Integrated Plan (e.g., addressing unmet need rate via EIS, EHIIA data, addressing barrier to care of substance abuse, prevalence shifts in age demographics and impacts on the continuum of care).

HOW THE PROCESS INFORMS PC PRIORITY SETTING & RESOURCE ALLOCATION (PSRA): All information presented at the Data Summit and PSRA meeting (epi, service utilization, cost, outcomes, other funding sources and survey results) serve as the main information sources for the Planning Council to make decisions related to funding, priorities, and directives. For example, there are very limited non-Ryan White resources that fund EIS so EIS remains a key funded service through Part A.

HOW THE COMPREHENSIVE/INTEGRATED HIV PREVENTION & CARE PLAN INFORMS THE PROCESS: At the time of the PSRA process this year, the integrated plan did not play a major role. The Planning Council is in the process of updating the Integrated Plan according to HRSA guidelines for a new plan in the 5-year cycle. A new plan will be instrumental in the PSRA process for the upcoming year.

B.1.a.i. How PLWH were involved in PSRA & how their priorities were considered
INVOLVEMENT: Persons living with HIV make up at least one third of the Planning Council. PLWH Planning Council members are fully engaged in the PSRA decision making process. In addition, PLWH, who were not members of the Planning Council were invited to attend the PSRA Process meeting and serve as community members on the PSRA Committee. The Planning Council had access to copies of all data while determining allocations. Our Planning Council is very engaged in ensuring increased engagement with the PLWH community and ensuring ongoing meaningful input from the community.
PLWH PRIORITIES: During the PSRA Committee meeting a decision concerning PLWH priorities will be reviewed and decided on for the month after the PSRA meeting. The changes that will be made will last for a three-year period. The Priorities that may be adjusted this year will result in shaping the directives from the full Planning Council to the Part A Recipient.

B.1.a.ii. How input from the community was considered, including addressing funding increases or decreases
COMMUNITY INPUT: See B.1.a from above.
FUNDING CHANGES: This year the PSRA Committee was aware of the final notice of award and were able to make funding changes with the knowledge of the award.

The council, with the assistance of support staff from the finance department assigned to the Program and the PSRA Committee, made decisions that allowed for changes to occur without affecting areas that were in need within the program. The decision was made by the Co-Chair and agreed upon by the full PSRA committee that another meeting would take place to complete the decision-making process regarding priorities and directives. This is due in part to needing further information from the community Needs Assessment surveys. The previous year's directives will be reviewed and discussed; and if there are any changes to be made to those, then the PSRA committee will discuss and the full PC will take the necessary actions in order to assist the recipient office.

B.1.a.iii. **How MAI funding was considered**
The Council views MAI as a means for enhancing the services provided to minorities, including historically underserved Non-Hispanic Blacks and Latinos. Priorities for MAI are slightly different from Part A priorities. Outreach was a higher priority for MAI and funds continue to be allocated to that service. In addition, the target population faces additional barriers to care and EIS services were maintained in MAI to address this need. MAI providers are represented on

the Planning Council to assure coordination of services. This year there were no significant changes to MAI.

B.1.a.iv. **How data was used in PSRA in increase access to core services, ensuring access to services for WICY and to reduce disparities**

The Planning Council was provided with the TGA Needs Assessment and attended a "Data Summit" before the PSRA meeting. The Planning Council considered the data contained in the 2021 TGA Needs Assessment and cost data from the Recipient Finance department. In addition, the Recipient included a few recommendations for services.

As allocations were discussed, the data provided in the TGA Needs Assessment was available as a point of reference in making decisions, and how such data should be interpreted to support community needs. All allocations to service categories were based on, barriers and the availability of other resources to address these needs. The categories of data used by the Planning Council in their decision-making process included: 1) Demographic data; 2) Epidemiological trends; 3) Service utilization data; 4) Resource inventory information; 5) Direct consumer input including perceived barriers to medical services and satisfaction with services; 6) Unmet need results; 7) Identification of disparities; 8) Cost data and 9) Availability of other funds.

Concerns about access to core services and possible disparities, with an emphasis on the dental program is still an ongoing issue in the TGA. This was a major concern from 2018 to present and it has not changed. We foresee this directive which was recommended to continue to have conversations in which ways to increase provider involvement and find out how to decrease the dental, core service, and disparities issue that still exist within the TGA.

Medical Case Management and EIS continues to be supported via funding allocations as these services are uniquely positioned to help connect PLWH, particularly underserved populations, and keep them engaged, with medical and support services. Their role within the overall system of care will become more critical as additional consumers are enrolled, or disenrolled, in Affordable Health Care and we continue to see how Affordable Health Care functions within our community.

B.1.a.v.**Any significant changes in the PSRA process from FY 2020 to 2021 and if yes, rationale for making changes**

The only changes currently to the PSRA process were concerning the priorities and directives decision. The PC Chair and committees and the full Planning Council voted to hold the priority and directives evaluation in a separate meeting a month after the PSRA meeting since neither would cause any changes to the allocation process. This decision was made to give the Needs Assessment committee enough time to collect survey information from the TGA community in its entirety.

d) Administrative Assessment

The Planning Council will carry out the Assessment of the Administrative Mechanism in

November 2021. Prior to conducting the assessment, the Planning Council was educated on the scope and purpose of the assessment. Two surveys will be administered, one for Planning Council members and one for Part A Sub-Recipients (providers). Survey questions for providers will cover the following areas: procurement issues, timely payments, contract monitoring, communication and assistance and general questions such as identifying areas of success and areas which may need improvement. Survey questions for the Planning Council will include planning activities, information and reports and broader questions relating to areas of improvement. Survey Monkey will continue to be the collection tool that collects responses (anonymous), analyze results, and complete a report for the Planning Council. The Planning Council Executive Committee is the workgroup that will assess the results before they are presented to the full Planning Council. This workgroup will be presented with and review the aggregate data from the surveys. The final report will be submitted to the PC and voted on for approval at the PC meeting in December 2021.

B.2.a. (Results) Assessment of Grant Activities to Ensure Timely Allocation, Contracting, and Payment

CONTRACTING: Contracting is a joint function of Recipient's program and fiscal staff. For this grant year, all contractors were able to begin services on day one of the grant year.
PAYMENT: The Recipient's Finance Department electronically tracks dates of receipt and payment of provider invoices. This information is available to the Program Director and the Planning Council Liaison. On a regular basis the Program Director and the Metro Finance Department meet to review payment status. The Planning Council Liaison, Planning Council Chair and Assessment of the Administrative workgroup meet to review status of payments for the Assessment of the Administrative Mechanism report.

B.2.b. (Results) Response to Any Deficiencies Identified by the PC and Status of Corrective Action for Findings

This is a pending response that will be submitted as a portion of the Assessment of the Administrative Mechanism when it is completed. The findings will be submitted to the Part A Recipient Program Director for response.

B. 3. Letter of Assurance from Planning Council Chair(s)

The Letter of Assurance is included in ATTACHMENT 6.

Attachment 7

Note: Funds shown in table under Local also present EHE and ALL are inclusive if federal funds either issued under listed funding streams to the state and or the local government

Coordination of Services and Funding Streams Table

Funding Source	FY 2020-2021 Funding Amount: Dollar Amount	%	Number of Agencies	Prevention Services	HIV Testing & Policy Alignment Efforts	PLWH/Partner Prevention Services	Condom Distribution	Core Medical-related Services	Outpatient/Ambulatory Health Services	AIDS Drug Assistance Program Treatment (Tx)	AIDS Pharmaceutical Assistance	Oral Health Care	Early Intervention Services	Health Insurance Premium &Cost-Sharing	Home Health Care	Home & Community-based Health Services	Hospice Services	Mental Health Services	Medical Nutrition Therapy	Medical Case Mgmt, incl. Tx Adherence	Substance Abuse Outpatient Care	Supportive Services	Non-Medical Case Management Services	Child Care Services	Emergency Financial Assistance	Food Bank/Home-delivered Meals	Health Education/Risk Reduction	Housing Services	Linguistic Services	Medical Transportation	Other Professional Services: Legal Services	Outreach Services	Psychosocial Support Services	Referral for Health Care & Support Services	Rehabilitation Services	Respite Care	Substance Abuse Services (residential)	Treatment Adherence Counseling
Part A	$3,761,532	3	7						x			x	x					x		x			x		x	x		x	x	x	x		x					
Part B	$								x	x		x	x	x				x		x			x		x	x		x		x			x				x	
Part C	$1,194,175	1	2						x									x		x										x	x							x
Part D	$656,310	1	1																												x							
Part F	$4,605,789	4	1																												x							
CDC	$126,747	0	2		x	x	x																															
SAMHSA	$2,859,647	2	4																																		x	
HOPWA	$1,772,552	1	20															x							x			x									x	
Federal	$N/A		N/A																																			
State	$N/A		N/A																																			
Local	$107,205,800	87	1		x	x	x							x				x									x	x	x		x		x				x	x
EHE	$N/A		N/A																																			
CARES Act (Part A)	$917,764	1	6						x			x						x		x					x	x	x	x		x			x					
Total	$123,100,316	100 %																																				

1

The following attachment is not included in the view since it is not a read-only PDF file.

Upon submission, this file will be transmitted to the Grantor without any data loss.

Attachment 8 FY22_Part_A_HIV_Care_Continuum_Services.pdf

Attachment 9	Part A Service Category Plan Table									
Service Categories	2021 Allocated					2022 Anticipated				
Core Medical Services	Priority #	Allocated Amount (Expensed per instructions)	Unduplicated Clients	Service Unit Definition	Service Units	Priority #	Anticipated Amount	Unduplicated Clients	Service Unit Definition	Service Units
AIDS Drug Assistance Program (ADAP) Treatment	N/A	$ -				N/A	$ 1.00			
AIDS Pharmaceutical Assistance (LPAP)	N/A	$ -				N/A	$ -			
Early Intervention Services	2	$ 251,771.00	308	15 mins -1 unit	4150	2	$ 288,712.00	320	15 mins -1 unit	4200
Health Insurance Premium & Cost Sharing Assistance	N/A					N/A	$ -			
Home & Community Based Health Service	N/A	$ -				N/A	$ 1.00			
Home Health Care	N/A	$ -				N/A	$ 1.00			
Hospice	N/A	$ -				N/A	$ 1.00			
Medical Case Management (Incl. Treatment Adherence)	1	$ 1,165,566.00	1993	15 mins -1 unit	43482	1	$ 1,269,152.00	2200	15 mins -1 unit	45000
Medical Nutrition Therapy	N/A	$ -				N/A	$ -			
Mental Health Services	4	$ 258,137.00	199	15 mins -1 unit	2846	4	$ 274,047.00	220	15 mins -1 unit	3000
Oral Health Care	12	$ -				12	$ 20,000.00			
Outpatient/ Ambulatory Health Services	3	$ 859,828.00	1740	15 mins -1 unit	17086	3	$ 927,747.00	1800	15 mins -1 unit	17500
Substance Abuse Outpatient Care	N/A	$ -				N/A	$ 1.00			
CORE MEDICAL TOTAL		$ 2,535,302.00					$ 2,779,663.00			
Support Services										
Child Care Services	N/A	$ -				N/A	$ 1.00			
Emergency Financial Assistance	8	$ 27,764.00	97	15 mins -1 unit	124	8	$ 78,508.00	150	15 mins -1 unit	200
Food Bank/ Home Delivered Meals	7	$ 115,814.00	717	1 card = 1unit	6079	7	$ 132,510.00	750	1 card = 1unit	6110
Health Education/ Risk Reduction	N/A	$ -				N/A	$ 1.00			
Housing	9	$ 48,321.00	85	15 mins -1 unit	98	9	$ 61,768.00	100	15 mins -1 unit	120
Linguistics Services	13	$ 3,241.00	2	1 referral =1 unit	2	13	$ 5,000.00	5	1 referral =1 unit	5
Medical Transportation	6	$ 83,818.00	657	1 transpt. card or 1 ride = 1 unit	4765	6	$ 118,520.00	750	1 transpt. card or 1 ride = 1unit	4810
Non-Medical Case Management Services	10	$ 51,795.00	59	15 mins -1 unit	429	10	$ 55,000.00	65	15 mins -1 unit	450
Other Professional Services	N/A	$ 1,823.00				N/A	$ -			
Outreach Services	N/A	$ 49,190.00				N/A	$ -			
Psychosocial Support	5	$ 203,931.00	949	15 mins -1 unit	6164	5	$ 263,653.00	1000	15 mins -1 unit	6250
Referral For Health Care Supportive Services	11	$ 33,811.00	12	15 mins -1 unit	25	11	$ 41,546.00	20	15 mins -1 unit	40
Rehabilitation Services	N/A	$ -				N/A	$ 1.00			
Respite Care	N/A	$ -				N/A	$ -			
Substance Abuse-residential	N/A	$ -				N/A	$ 1.00			
SUPPORT TOTAL		$ 619,508.00					$ 756,509.00			
GRAND TOTAL		$ 3,154,810.00					$ 3,536,172.00			

FY 2021 PART A Allocations		
	Core Medical Services	Support Services
2021 Percentages	80.36%	19.64%

FY 2022 PART A Allocations		
	Core Medical Services	Support Services
2022 Percentages	78.61%	21.39%

FY 2021 PART A + MAI Allocations		
	Core Medical Services	Support Services
2021 Percentages	80.03%	19.97%

FY 2022 PART A + MAI Allocations		
	Core Medical Services	Support Services
2022 Percentages	79.36%	20.64%

Attachment 9	MAI Service Category Plan Table											
Service Categories	2021 Allocated						2022 Anticipated					
	Priority #	Allocated Amount (Expensed per instructions)	Unduplicated Clients	Service Unit Definition	Service Units	Priority Population(s)	Priority #	Anticipated Amount	Unduplicated Clients	Service Unit Definition	Service Units	Subpopulation(s) of Focus
Core Medical Services												
AIDS Drug Assistance Program (ADAP) Treatment		$ -						$ -				
AIDS Pharmaceutical Assistance (LPAP)	N/A	$ -					N/A	$ -				
Early Intervention Services	2	$ 84,027.00	133	1unit =15mins	2880	Black MSM, Hispanic	2	$ 87,556.00	140	1unit =15mins	2900	Black, Hispanic, 25-34
Health Insurance Premium & Cost Sharing Assistance	N/A	$ -					N/A	$ -				
Home & Community Based Health Service	N/A	$ -					N/A	$ -				
Home Health Care	N/A	$ -					N/A	$ -				
Hospice	N/A	$ -					N/A	$ -				
Medical Case Management (Incl. Treatment Adherence)	1	$ 65,798.00	268	1unit=15mins	3650	Black MSM, Hispanic	1	$ 105,227.00	285	1unit=15mins	3800	Black, Hispanic, 25-34
Medical Nutrition Therapy	N/A	$ -					N/A	$ -				
Mental Health Services	N/A	$ -					N/A	$ -				
Oral Health Care	N/A	$ -					N/A	$ -				
Outpatient/ Ambulatory Health Services	3	$ -	0	1unit=15mins	0		3	$ 45,148.00	70	1unit=15mins	1200	Black, Hispanic, 25-34
Substance Abuse Outpatient Care	N/A	$ -					N/A	$ -				
CORE MEDICAL TOTAL		$ 149,825.00						$ 237,931.00				
Support Services												
Child Care Services	N/A	$ -					N/A	$ -				
Emergency Financial Assistance	N/A	$ -					N/A	$ -				
Food Bank/ Home Delivered Meals	N/A	$ 32,063.00		1 card = 1unit			N/A	$ -		1 card = 1unit		
Health Education/ Risk Reduction	N/A	$ -					N/A	$ -				
Housing	N/A	$ -					N/A	$ -				
Linguistics Services	N/A	$ -					N/A	$ -				
Medical Transportation	N/A	$ -					N/A	$ -				
Non-Medical Case Management Services	N/A	$ -					N/A	$ -				
Other Professional Services	N/A	$ -					N/A	$ -				
Outreach Services	4	$ 18,578.00	99	1unit=15mins	452	Black MSM, Hispanic, 15-24	4	$ 28,148.00	120	1unit=15mins	490	Black, Hispanic, 25-34
Psychosocial Support	N/A	$ -					N/A	$ -				
Referral For Health Care Supportive Services	N/A	$ -					N/A	$ -				
Rehabilitation Services	N/A	$ -					N/A					
Respite Care	N/A	$ -					N/A					
Substance Abuse-residential	N/A	$ -					N/A					
SUPPORT TOTAL		$ 50,641.00						$ 28,148.00				
GRAND TOTAL		$ 200,466.00						$ 266,079.00				

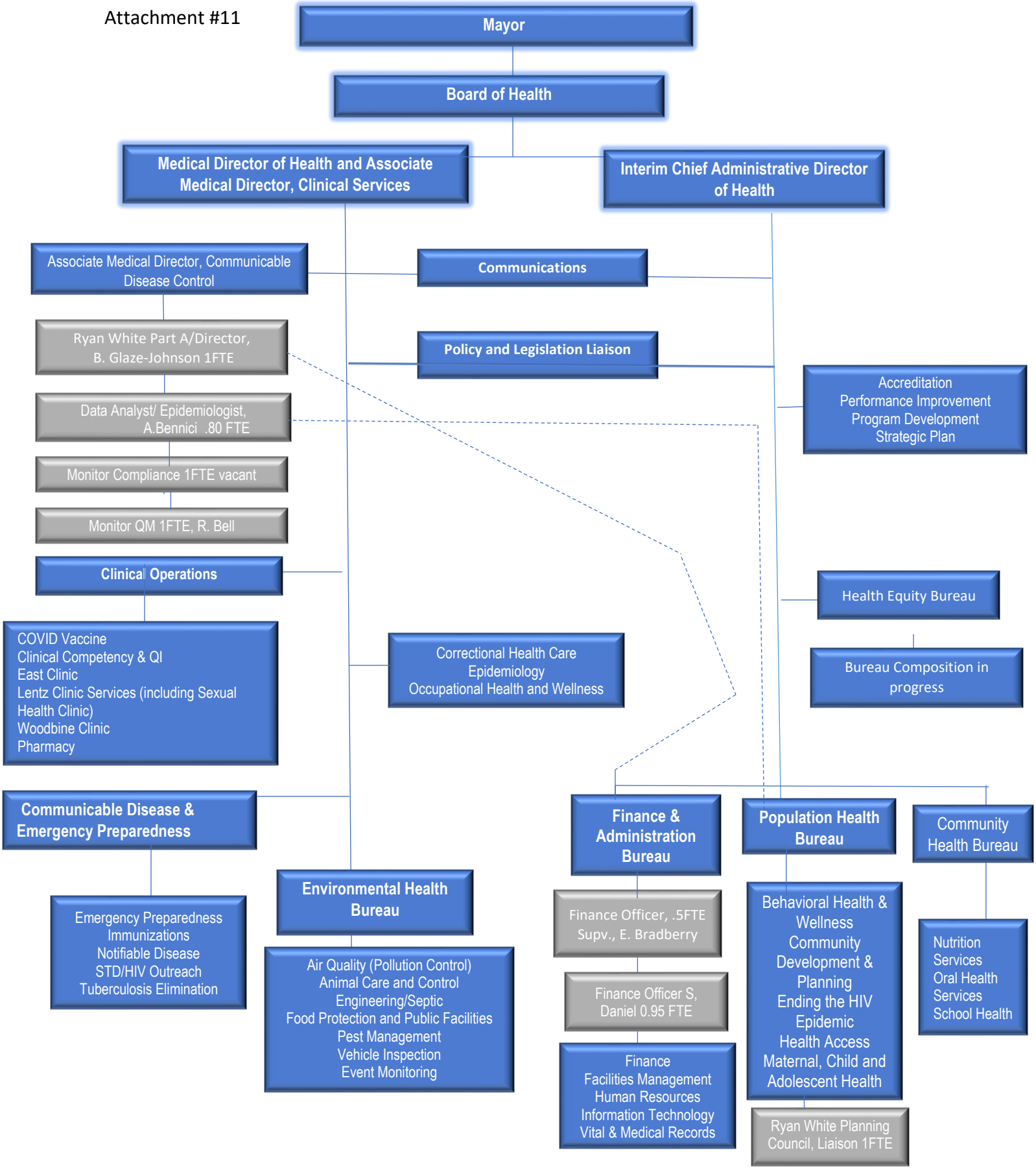
FY 2021 MAI Allocations		
	Core Medical Services	Support Services
2021 Percentages	74.74%	25.26%

FY 2022 MAI Allocations		
	Core Medical Services	Support Services
2022 Percentage	89.42%	10.58%

Metropolitan Nashville Davidson County Public Health Department
Organization Chart

H89HA11433

Attachment #11



Attachment 12: Maintenance of Effort Documentation (9/30/21)

NON-FEDERAL EXPENDITURES	
FY Prior to Application (Actual)	Current to Application (Estimated)
Actual prior FY non-federal EMA/TGA political Subdivision expenditures for HIV-related core medical and support services. Amount: $30,000 (1)	Estimated current FY non-federal EMA/TGA political subdivision expenditures for HIV-related core medical and support services. Amount: $30,000 (1)

Data Source: (1) Salary expenditures for local HIV staff responsible for performing HIV testing services.

The following attachment is not included in the view since it is not a read-only PDF file.

Upon submission, this file will be transmitted to the Grantor without any data loss.

Attachment 13 2022 Indirect Cost.pdf

Project/Performance Site Location(s)

Project/Performance Site Primary Location ☐ I am submitting an application as an individual, and not on behalf of a company, state, local or tribal government, academia, or other type of organization.

Organization Name: Metro Public Health Department of Nashville/Davidson County

DUNS Number:

* Street1: 2500 Charlotte Avenue

Street2:

* City: Nashville County:

* State: TN: Tennessee

Province:

* Country: USA: UNITED STATES

* ZIP / Postal Code: 37209-4129 * Project/ Performance Site Congressional District: TN-005

Project/Performance Site Location 1 ☐ I am submitting an application as an individual, and not on behalf of a company, state, local or tribal government, academia, or other type of organization.

Organization Name:

DUNS Number:

* Street1:

Street2:

* City: County:

* State:

Province:

* Country: USA: UNITED STATES

* ZIP / Postal Code: * Project/ Performance Site Congressional District:

Additional Location(s) Add Attachment Delete Attachment View Attachment

Project Narrative File(s)

*** Mandatory Project Narrative File Filename:** MPHD FY22 NOFO Project Narrative.pdf

Add Mandatory Project Narrative File | Delete Mandatory Project Narrative File | View Mandatory Project Narrative File

To add more Project Narrative File attachments, please use the attachment buttons below.

Add Optional Project Narrative File | Delete Optional Project Narrative File | View Optional Project Narrative File

Abstract

Ryan White HIV/AIDS Program Part A HIV Emergency Relief Grant Program
Metro Public Health Department
2500 Charlotte Avenue, Nashville, TN 37209-4129
Project Director: Beverly Glaze-Johnson
615-485-5574
Beverly.Glaze-Johnson@nashville.gov

The Nashville Transitional Grant Area (TGA) Ryan White HIV/AIDS Part A (RWHAP) program will coordinate with the local community Planning Council to use the HIV Emergency Relief Grant to fund a broad range of core and support services. The Nashville TGA encompasses 13 counties in central Tennessee including Davidson County, the most populous county and location of the state's capitol of Nashville. Between 2015 and 2019, the population of the Nashville TGA increased by 7%, representing 30% of Tennessee's population in 2019.

Overview of population characteristics and HIV epidemic in Nashville TGA, 2019

Selected Demographic Characteristics	Nashville TGA General Population		New HIV Diagnoses		Persons Living With HIV	
	N	%	N	Rate	N	Rate
Gender						
Cisgender male	910,564	48.9	201	22.1	4,225	464.0
Cisgender female	952,544	51.1	32	3.4	1,097	115.2
Transgender person			4	—	65	—
Age group (years)						
<15	355,324	19.1	0	0.0	24	6.8
15–24	242,612	13.0	37	15.3	163	67.2
25–34	291,259	15.6	101	34.7	987	338.9
35–44	255,917	13.7	40	15.6	1,003	391.9
45–54	239,212	12.8	34	14.2	1,460	610.3
55–64	227,038	12.2	22	9.7	1,378	606.9
≥65	251,746	13.5	3	1.2	372	147.8
Race/ethnicity						
Non-Hispanic Black	286,895	15.4	99	34.5	2,571	896.1
Non-Hispanic white	1,333,126	71.6	102	7.7	2,256	169.2
Hispanic	141,647	7.6	27	19.1	374	264.0
Other	101,440	5.4	9	8.9	186	183.4
Total	1,863,108		237		5,387	

Core Medical Services: Early Intervention Services, Medical Case Management, Mental Health, Oral Health Care, Outpatient/Ambulatory Health, and Substance Abuse Outpatient. Support Services: Emergency Financial Assistance, Food Bank, Housing, Linguistics, Medical Transportation, Non-Medical Case Management, Psychosocial Support, and Referral for Health Care. Minority AIDS Initiative (MAI) funds support Early Intervention Services, Medical Case Management, Outpatient, and Outreach Services. MAI funds are focused on providing services for subpopulations disproportionately impacted by HIV. Services are located at Part A funded providers agencies and are concentrated in Davidson County. Overall viral suppression for the TGA was 68% in 2019.

Project Narrative

INTRODUCTION

The Nashville Transitional Grant Area (TGA) Ryan White HIV/AIDS Part A (RWHAP) program will use the HIV Emergency Relief Grant to coordinate with the local community planning body (Planning Council) to fund a broad range of core and support services. The award received will be appropriated to reduce the incidence of HIV diagnoses, quickly identify, and engage and retain persons in HIV medical care, achieve and maintain viral suppression, and eliminate health disparities for people living with HIV disease (PLWH) residing within the Nashville TGA. The Part A program will continue to link PLWH to core medical and support services provided by subrecipient agencies to limit the effects caused by social determinants of health. The following key activities are in place to ensure high quality care: 1) standards of care developed by the Recipient in conjunction with the Planning Council; 2) annual monitoring of providers by the Recipient; 3) collection and reporting of service utilization and performance data; 4) Clinical quality management in increasing use of best practices established at the various jurisdictional level; and 5) the provision of provider training and technical assistance with individual one-on-one advisement and support.

Although progress has occurred over the last several years including improvements in linkage to care, retention in care, and viral suppression, the Nashville TGA continues to face a number of regional challenges: 1) no Medicaid expansion which negatively impacts 54% of Part A clients who are at or below 100% of the federal poverty level (FPL); 2) stigma related to conformity to social conservatism of the South, particularly among the TGA's rural communities; 3) linkage to care, retention in care, and viral suppression in the TGA is below national averages; 4) disparities found in viral suppression continue for specific sub-populations in the TGA; 5) according to a 2016 CDC report, Tennessee was in the 3rd lowest quartile for persons who knew their HIV status and in the 4th lowest quartile for death rates; 6) a significant growth among the general population in the TGA in addition to a steadily increasing HIV population; and 8) increased economic migration by the disenfranchised and disaffected individuals due to a surge in gentrification and urban renewal has led to increasing number of PLWH to outlying areas with less service availability. In recent months, the Nashville TGA has been severely impacted by several natural disasters, namely a tornado and flooding that caused extensive infrastructure damage to two RWHAP funded agencies, mass disruptions due to the COVID-19 pandemic on the community. Continued receipt of Part A grant funds is critical in allowing us to maintain and strengthen our comprehensive continuum of HIV services. Moreover, Part A funds support the ability of our community to help overcome challenges, decrease the number of new HIV infections, increase positive outcomes for PLWH, and decrease disparities in the disproportionately affected subpopulations.

NEEDS ASSESSMENT

A. DEMONSTRATED NEED

A.1 – Epidemiologic Overview

A.1.a – Summary of HIV Epidemic in Nashville TGA

The following epidemiologic overview focuses on data from 2015 to 2019, with 2019 being the most recent year for which the majority of the data are available. In 2019, there were 237 new diagnoses of HIV disease in the Nashville Transitional Grant Area (TGA), an increase of 9% compared to 2015. In 2019, there were 5,387 persons living with HIV/AIDS (PLWH) in the TGA. This population is, and has been, predominantly cisgender male, of non-Hispanic Black or non-Hispanic White descent, and residents of Davidson County.

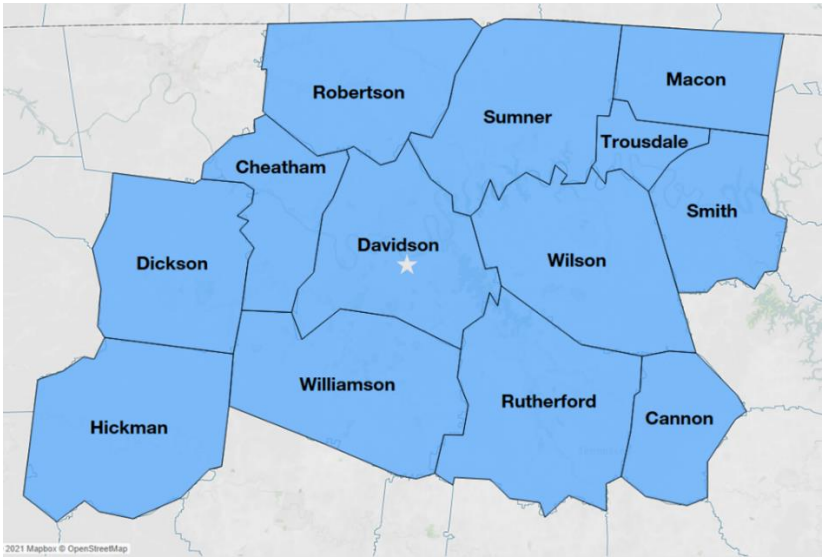
The Nashville TGA includes 13 counties in middle Tennessee. In 2019, the population of Nashville TGA region was 1,863,108 people (Table 1), comprising approximately 30% of the total population of Tennessee. Approximately 37% of the TGA residents live in Davidson County, where the state capitol of Nashville is located. Between 2015 and 2019, the population of the Nashville TGA increased by 7%, with the greatest relative growth seen in Trousdale and Rutherford Counties. Increased cost-of-living in Davidson County may be leading low- and middle-income residents to move to surrounding suburban and rural counties in the TGA. Upon assessing social determinants of health, several TGA counties are significantly impacted by poverty, low levels of health insurance coverage, and low levels of education compared to national and Tennessee averages (Table 1).

Table 1. Selected general population characteristics, United States, Tennessee, Nashville TGA, 2019

	2019 Population	Pop. Change 2015-19 (%)	White (%)	Black (%)	Hispanic (%)	Poverty 2019 (%)2	Uninsured <65 yrs. 2019 (%)	H.S. Graduate 25+ yrs. 2019	Unemployed (%)
United States	328,239,523	2.4	76.3	13.4	18.5	11.4	10.2	88	3.7
Tennessee	6,289,174	3.6	78.4	17.1	5.7	13.9	12.1	87.5	3.5
Nashville TGA	1,863,108	7.0	71.6	15.4	7.6	11.7	11.7	86.8	3.7
Cannon	14,678	6.8	95.9	1.8	2.5	13.0	12.5	84.5	4.2
Cheatham	40,667	2.7	95.1	2.1	3.4	9.6	11.7	87.0	3.3
Davidson	694,144	2.1	63.5	27.6	10.5	15.1	13.5	88.8	3.2
Dickson	53,948	5.1	92.6	4.1	3.9	10.1	11.7	83.7	3.8
Hickman	25,178	3.3	92.3	5.0	2.6	16.3	14.0	78.6	3.9
Macon	24,602	6.6	95.8	1.2	5.1	15.5	15.0	80.3	4.3
Robertson	71,813	4.6	89.0	7.8	7.4	10.5	11.6	87.2	3.6
Rutherford	332,285	11.4	76.6	16.3	8.7	10.0	10.4	91.8	3.4
Smith	20,157	4.4	95.3	2.3	3.1	15.3	12.1	85.3	3.9
Sumner	191,283	9.1	87.6	8.3	5.3	8.6	10.4	89.7	3.4
Trousdale	11,284	40.2	85.6	11.4	2.5	15.8	12.9	84.4	4.0
Williamson	238,412	12.7	88.2	4.5	4.9	4.3	6.3	95.3	3.2
Wilson	144,657	12.5	88.1	7.5	4.6	7.4	9.5	91.6	3.5

Sources accessed Sept. 22, 2021: 1) https://www.census.gov/data/tables/time-series/demo/popest/2010s-counties-detail.html. 2) https://www.census.gov/quickfacts/. 3) https://www.tn.gov/workforce/tennessee-economic-data-/labor-force-statistics/unemployment-rates.html. Nashville TGA poverty, uninsured, high school graduate, and unemployment was the average of the 13 counties in the TGA.

Figure 1. Counties in the Nashville Transitional Grant Area (TGA)

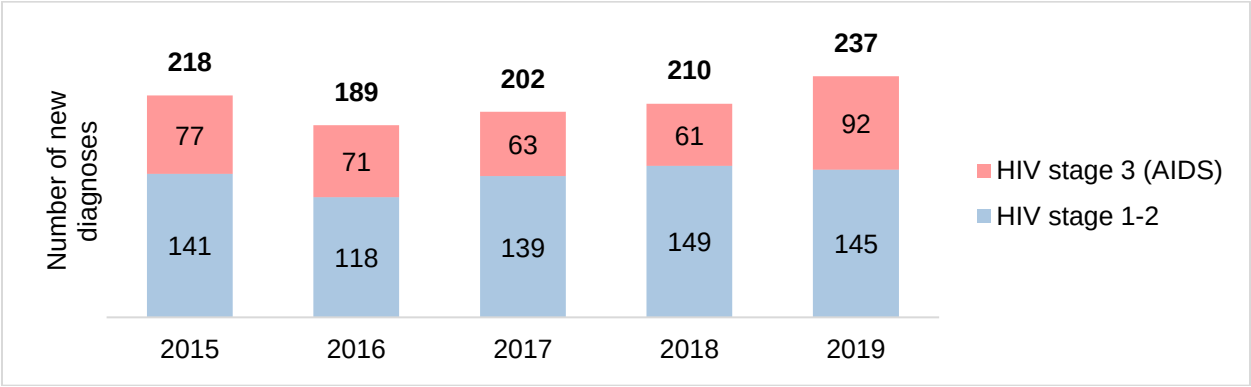


A.1.b – Socio-demographic Characteristics

Incidence – Persons Newly Diagnosed with HIV

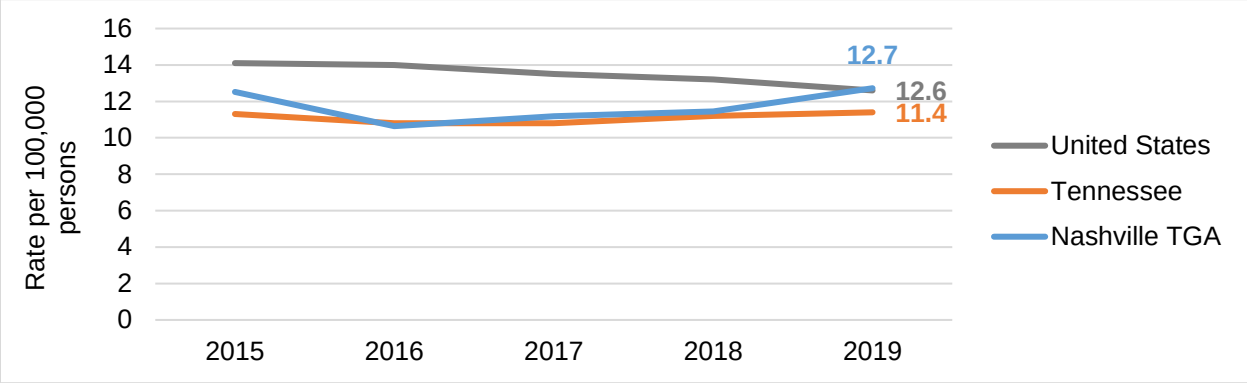
In 2019, there were 776 new diagnoses of HIV in Tennessee (TDH HIV Epi Profile 2019). Of these diagnoses, 237 were residents of the Nashville TGA, representing 31% of new HIV diagnoses in the state (**Figure 2**). Approximately 39% of new diagnoses were HIV stage 3, or AIDS. From 2015-2019, there was a 9% increase in new HIV disease diagnoses. The increase in new diagnoses may be related to improved surveillance and more targeted testing in areas with increased transmission and particularly at-risk groups.

Figure 2. Number of persons newly diagnosed with HIV, Nashville TGA, 2015-2019



Sources: Tennessee enhanced HIV/AIDS Reporting System (eHARS) accessed July 13, 2020.

Figure 3. Number of persons newly diagnosed with HIV, Nashville TGA, 2015-2019



Sources: Tennessee enhanced HIV/AIDS Reporting System (eHARS) accessed July 13, 2020. Tennessee HIV Epidemiological Profile, 2019. Tennessee Department of Health. Estimated Incidence and Prevalence in the United States, 2015-2019. CDC.

The rate of new HIV diagnoses was relatively stable from 2015-2019 with only a 2% increase. However, the rate of new HIV diagnoses in 2019 was higher in the Nashville TGA than the statewide and national rates (**Figure 3**).

Incidence: Geographic Distribution

In 2019, 66% of new HIV diagnoses in the Nashville TGA were residents of Davidson County while no new cases were detected in Macon, Smith, or Trousdale counties (**Table 2**). Data was suppressed for Cannon, Cheatham, Dickson, Hickman, and Robertson counties. Data is suppressed based on a mutual agreement between the Tennessee Department of Health (TDH) and the Centers for Disease Control and Prevention (CDC). If the population of the specified geographic area is greater than or equal to 500,000 persons, data is never suppressed. If the population of the specified geographic area is less than 500,000 persons, data between one and four will be suppressed. However, additional data may be suppressed to ensure data remain secure and not calculable.

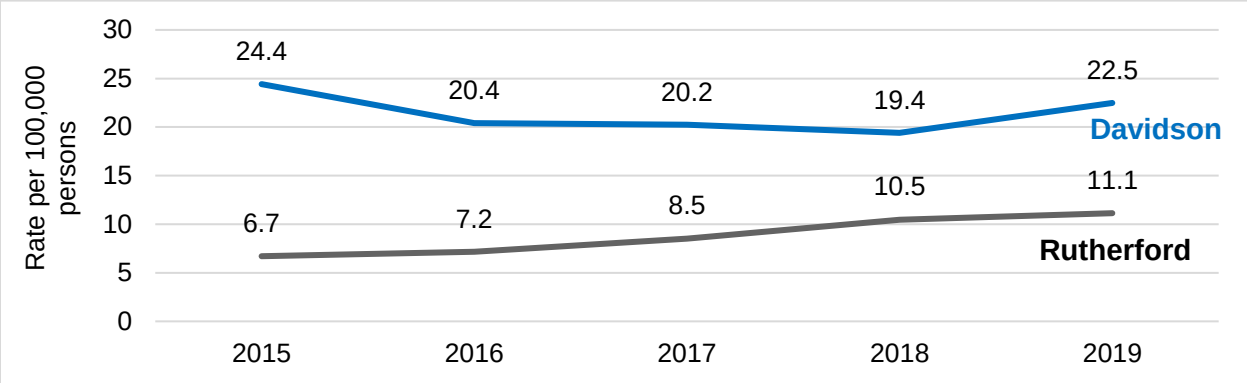
Table 2. Number and rate of persons newly diagnosed with HIV infection by county of residence, 2015-2019, Nashville TGA

	2015		2016		2017		2018		2019	
TGA County	N	Rate	N	Rate	N	Rate	N	Rate	N	Rate
Cannon	-	-	-	-	-	-	-	-	-	-
Cheatham	10	25.3	10	25.1	-	-	-	-	-	-
Davidson	166	24.4	140	20.4	139	20.2	134	19.4	156	22.5
Dickson	-	-	-	-	-	-	-	-	-	-
Hickman	0	0.0	0	0.0	0	0.0	0	0.0	-	-
Macon	-	-	0	0.0	0	0.0	0	0.0	0	0.0
Robertson	5	7.3	-	-	-	-	-	-	-	-
Rutherford	20	6.7	22	7.2	27	8.5	34	10.5	37	11.1
Smith	-	-	0	0.0	-	-	0	0.0	0	0.0
Sumner	7	4.0	5	2.8	12	6.5	8	4.3	8	4.2
Trousdale	0	0.0	-	-	-	-	-	-	0	0.0
Williamson	0	0.0	-	-	8	3.5	13	5.6	10	4.2
Wilson	-	-	-	-	5	3.7	9	6.4	14	9.7

Overall	218	12.5	189	10.6	202	11.2	210	11.4	237	12.7

Sources: Tennessee enhanced HIV/AIDS Reporting System (eHARS) accessed July 13, 2020. - represents suppressed data.

Figure 4. Rate of persons newly diagnosed with HIV infection, 2015-2019, Davidson and Rutherford Counties



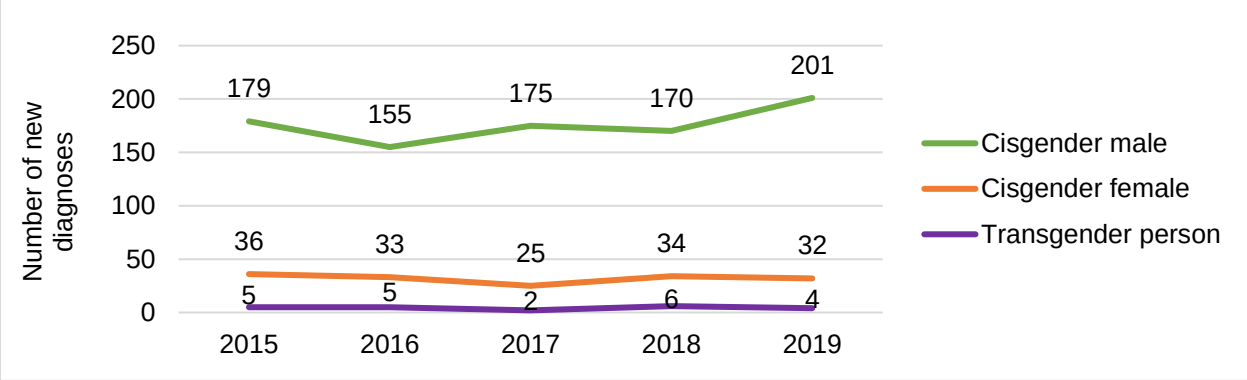
Sources: Tennessee enhanced HIV/AIDS Reporting System (eHARS) accessed July 13, 2020.

Figure 4 above highlights new HIV diagnoses in Davidson and Rutherford counties, the two counties with the highest number of new diagnoses between 2015 and 2019. Davidson County experienced an 8% decrease in rate of new cases as the overall population of the county increased by 2% (**Table 1**). During this same period, Rutherford County experienced a 66% increase in the rate of new cases as the overall population increased by 11%.

Incidence: Gender

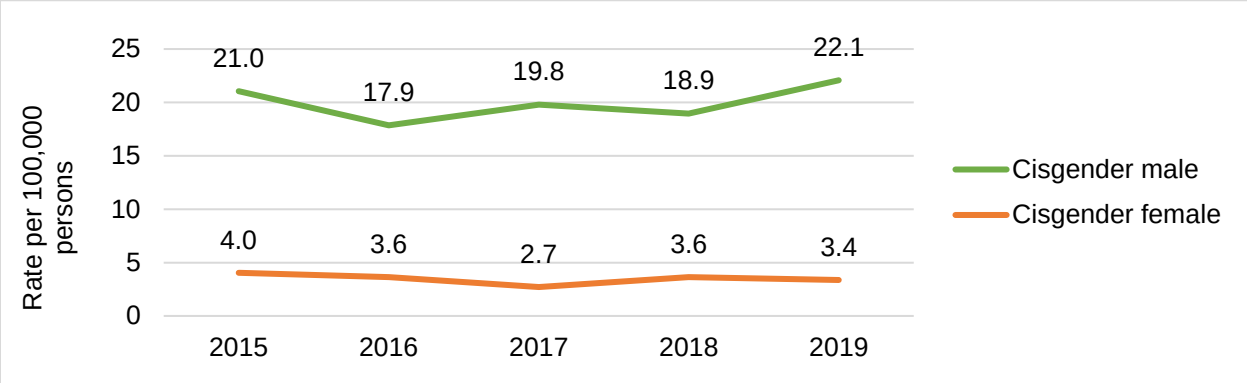
In 2019, 85% of new HIV diagnoses were among cisgender males, 14% were among cisgender females, and 2% were among transgender persons (**Figure 5**). From 2015-2019, the number of new diagnoses among cisgender males increased by 12%. The incidence rate was also highest among cisgender males, with approximately 22.1 new diagnoses per 100,000 cisgender males in the Nashville TGA (**Figure 6**). Incidence rates were unavailable for transgender persons because overall population data for transgender persons is not collected at the state level.

Figure 5. Number of persons newly diagnosed with HIV by gender, Nashville TGA, 2015-2019



Sources: Tennessee enhanced HIV/AIDS Reporting System (eHARS) accessed July 13, 2020.

Figure 6. Rate of persons newly diagnosed with HIV by gender, Nashville TGA, 2015-2019



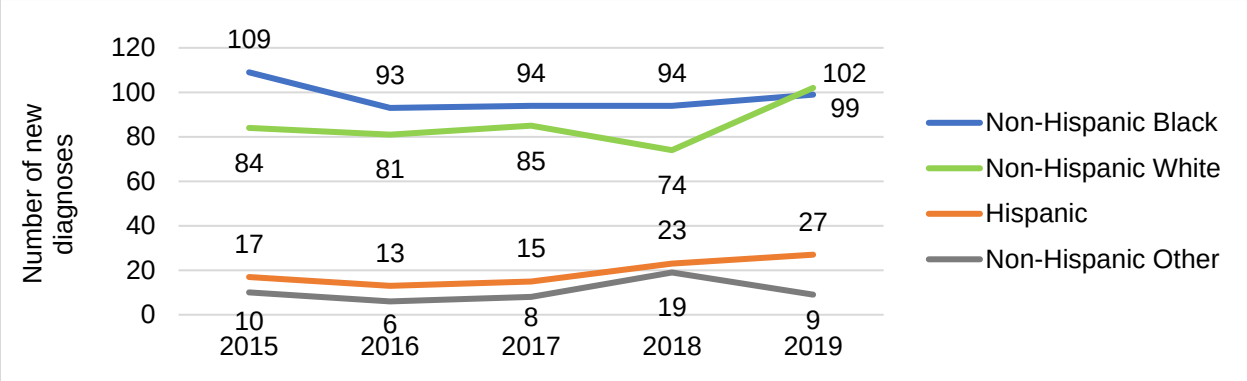
Sources: Tennessee enhanced HIV/AIDS Reporting System (eHARS) accessed July 13, 2020.

Incidence: Race/Ethnicity

In 2019, 43% of new HIV diagnoses were among non-Hispanic (NH) White individuals and 42% were among NH Black individuals (**Figure 7**). This marks the first time within the 2015-2019 time period covered in this report that new HIV diagnoses among NH White persons surpassed new diagnoses among NH Black persons. Although NH White individuals comprised the majority of new HIV diagnoses in 2019, the incidence rate for this demographic group has remained the lowest through 2015-2019. Additionally, although there was a 15% decrease in the incidence rate among NH Black, the incidence rate among this group remained the highest, with approximately 34.5 new HIV diagnoses per 100,000 NH Black individuals in the Nashville TGA (**Figure 8**). The incidence rate was second highest among Hispanic individuals, with 19.1 new diagnoses per 100,000.

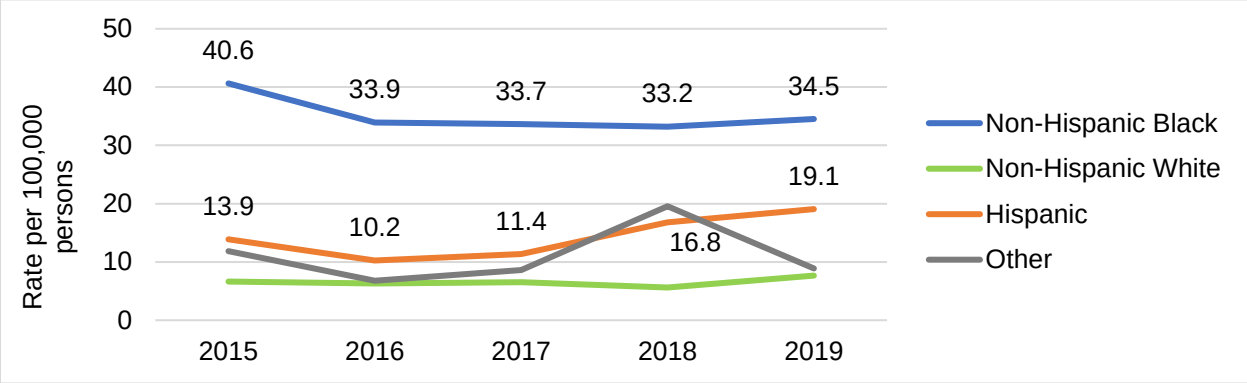
In 2019, NH Black individuals comprised 42% of new HIV diagnoses but were only 15.4% of TGA population (**Figure 7, Table 1**). NH White individuals comprised 43% of new HIV diagnoses but were 71.6% of the TGA population. Hispanic individuals comprised 11.4% of new diagnoses but were 7.6% of the TGA. These differences highlight the increased burden of new HIV diagnoses among the NH Black and Hispanic communities in the Nashville TGA.

Figure 7. Number of persons newly diagnosed with HIV by race/ethnicity, Nashville TGA, 2015-2019



Sources: Tennessee enhanced HIV/AIDS Reporting System (eHARS) accessed July 13, 2020.

Figure 8. Rate of persons newly diagnosed with HIV by race/ethnicity, Nashville TGA, 2015-2019

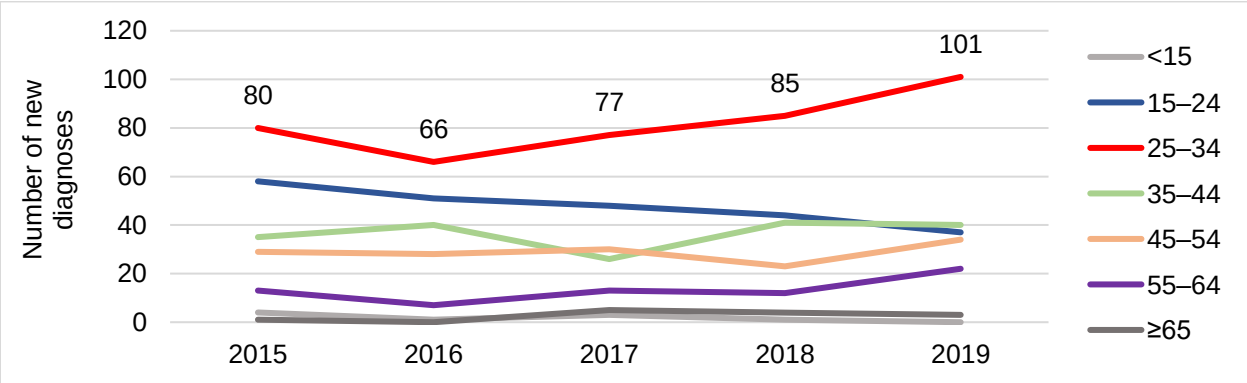


Sources: Tennessee enhanced HIV/AIDS Reporting System (eHARS) accessed July 13, 2020.

Incidence: Age Group

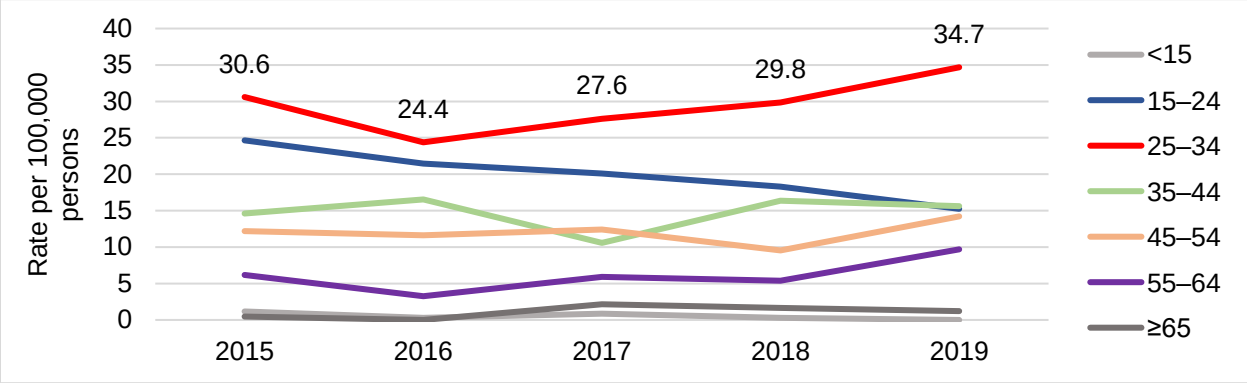
In 2019, 43% of new HIV diagnoses were among 25-34-year-olds (**Figure 9**). From 2015-2019, there was a 26% increase in new HIV diagnoses among this age group. During the same time period, the number of new diagnoses among 15-24-year-olds decreased by 36%. The incidence rates reflect similar trends across all age groups, with 25-34-year-olds having the highest incidence rate of 34.7 new diagnoses per 100,000 25-34-year-olds in the Nashville TGA (**Figure 10**).

Figure 9. Number of persons newly diagnosed with HIV by age group, Nashville TGA, 2015-2019



Sources: Tennessee enhanced HIV/AIDS Reporting System (eHARS) accessed July 13, 2020.

Figure 10. Rate of persons newly diagnosed with HIV by age group, Nashville TGA, 2015-2019



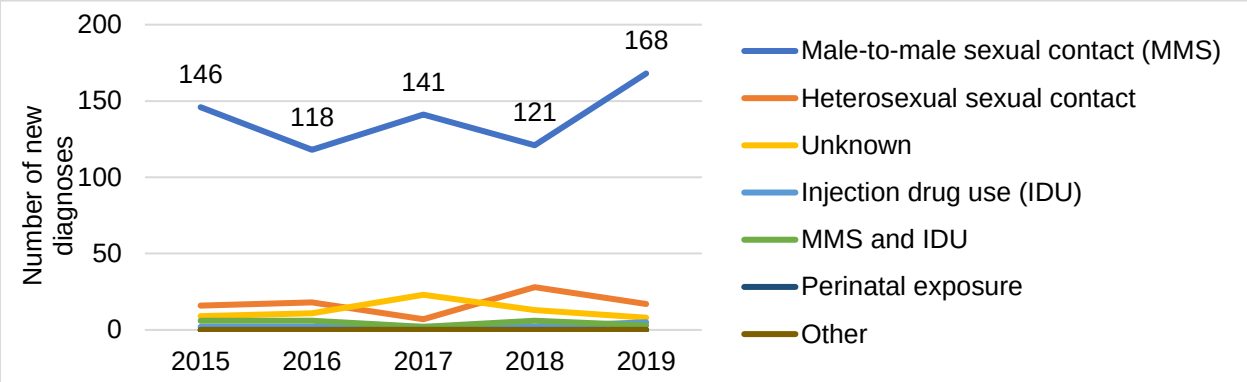
Sources: Tennessee enhanced HIV/AIDS Reporting System (eHARS) accessed July 13, 2020.

Incidence: Transmission Category

Transmission risk categories are defined to be mutually exclusive and refer to the way in which an individual is reported to have acquired HIV. In 2019, male-to-male sexual contact (MMS) was reported as the mode of transmission by 84% of new HIV diagnoses among cisgender males (**Figure 11**). From 2015-2019, the number of new diagnoses associated with MMS increased by 15%.

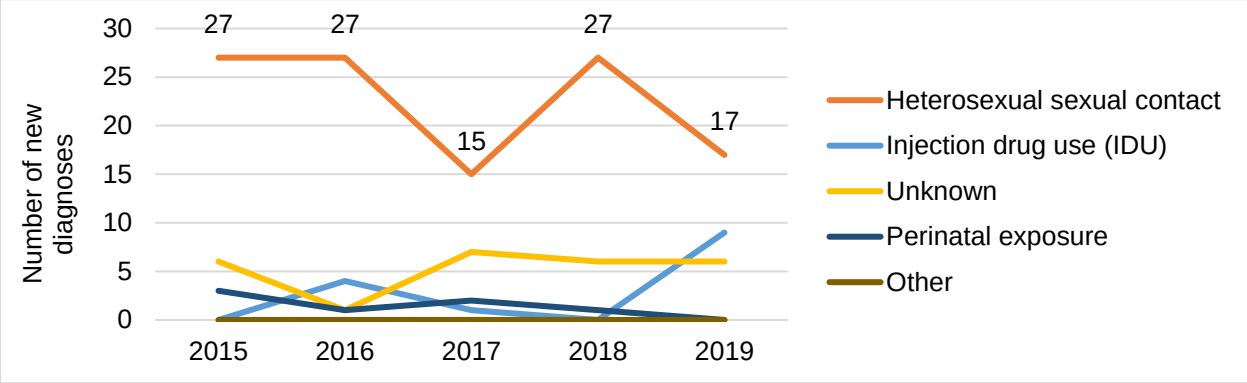
Approximately 53% of new diagnoses among cisgender females were reported as acquired through heterosexual contact in 2019 (**Figure 12**). From 2018-2019, there was also an increase in reported transmission among cisgender females through injection drug use (IDU). This trend will continue to be closely monitored. Any sexual contact was the most commonly reported mode of transmission among transgender persons from 2015-2019.

Figure 11. Number of persons newly diagnosed with HIV by transmission category, cisgender males, Nashville TGA, 2015-2019



Sources: Tennessee enhanced HIV/AIDS Reporting System (eHARS) accessed July 13, 2020.

Figure 12. Number of persons newly diagnosed with HIV by transmission category, cisgender females, Nashville TGA, 2015-2019

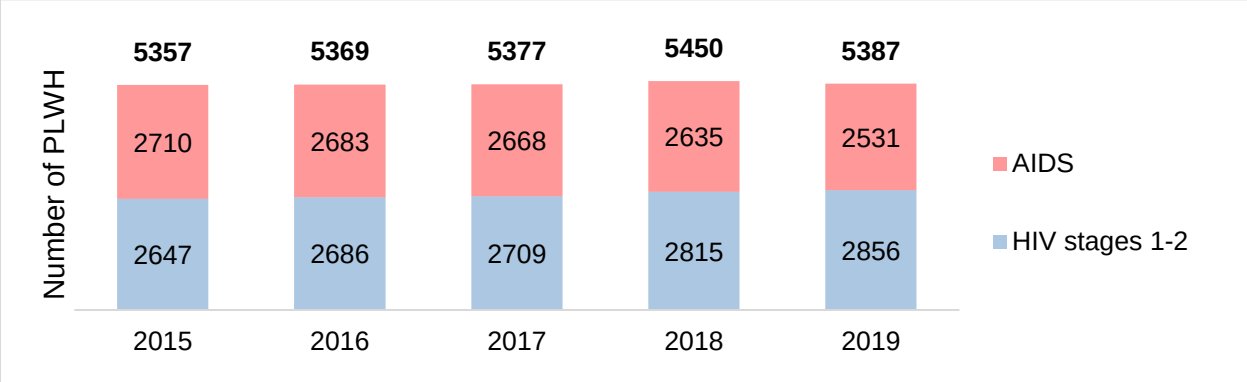


Sources: Tennessee enhanced HIV/AIDS Reporting System (eHARS) accessed July 13, 2020.

Prevalence – Persons living with HIV

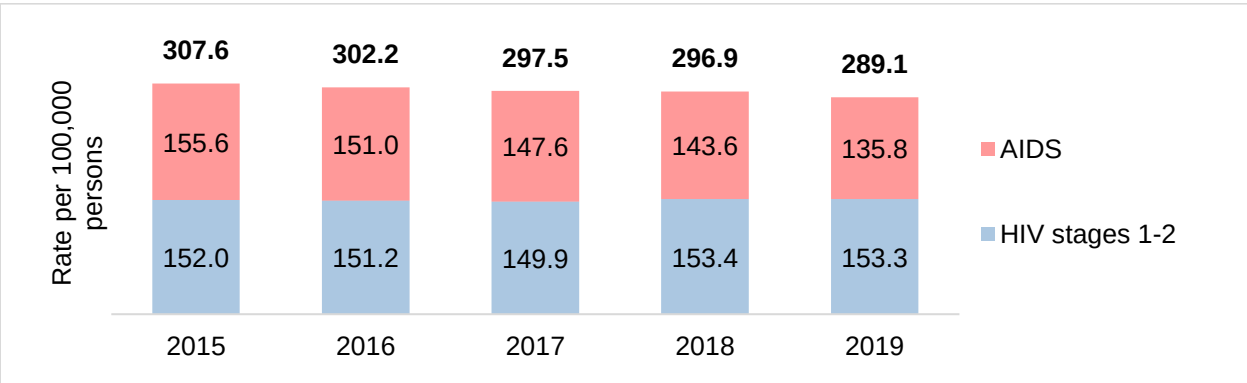
In 2019, there were 17,864 people living with HIV/AIDS (PLWH) in Tennessee (TDH HIV Epi Profile 2019). Of these PLWH, 5,387 were residents of the Nashville TGA, representing 30% of PLWH in the state (**Figure 13)**. Approximately 47% of PLWH in the Nashville TGA in 2019 were living with HIV stage 3, or AIDS. From 2015-2019, there was a 0.5% increase in PLWH.

Figure 13. Numbers of persons living with diagnosed HIV infection, Nashville TGA, 2015-2019



Sources: Tennessee enhanced HIV/AIDS Reporting System (eHARS) accessed July 13, 2020.

Figure 14. Rate of persons living with diagnosed HIV infection, Nashville TGA, 2015-2019



Sources: Tennessee enhanced HIV/AIDS Reporting System (eHARS) accessed July 13, 2020.

Although the number of PLWH increased from 2015-2019, the rate of PLWH in the TGA decreased by 6% (**Figure 14**). During this same time period, the overall population of the TGA increased by 7% (**Table 1**), the HIV- population is growing more quickly than the HIV+ population.

Prevalence: Geographic Distribution

In 2019, approximately 70% of PLWH in the TGA were living in Davidson County (**Table 3**). Rutherford County had the second highest population of PLWH in the TGA and was the residence of approximately 12% of cases. From 2015-2019, Davidson County saw a 9% decrease in PLWH while Rutherford County saw a 51% increase.

Davidson County also had the highest rate of PLWH in 2019, with 546.6 diagnoses per 100,000 residents. Rutherford County had the second highest rate, with 188.4 diagnoses per 100,000 residents. From 2015-2019, Davidson County saw a 11% decrease in the rate of PLWH while Rutherford County saw a 36% increase.

Table 3. Number and rate of persons living with diagnosed HIV infection by year of diagnosis and county of residence, 2015-2019, Nashville TGA

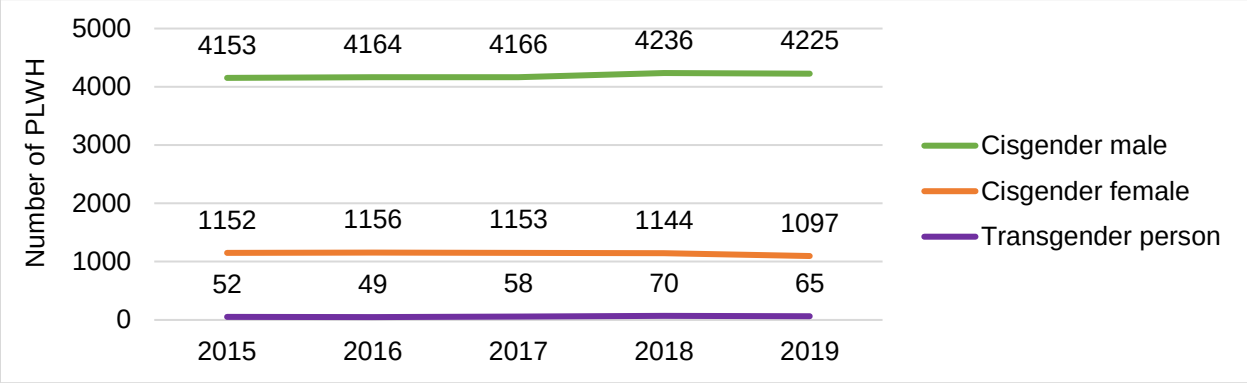
	2015		2016		2017		2018		2019	
TGA County	**N**	**Rate**	**N**	**Rate**	**N**	**Rate**	**N**	**Rate**	**N**	**Rate**
Cannon	-	-	-	-	-	-	-	-	25	170.3
Cheatham	11	27.8	12	30.2	11	27.3	10	24.7	65	159.8
Davidson	4174	614.0	4139	603.5	4101	596.8	4117	596.2	3794	546.6
Dickson	59	114.9	58	111.8	63	119.4	66	123.5	70	129.8
Hickman	41	168.2	57	231.1	59	237.5	53	211.9	35	139.0
Macon	34	147.3	39	167.1	34	142.2	34	140.0	8	32.5
Robertson	83	120.8	83	119.6	92	130.8	81	113.8	118	164.3
Rutherford	414	138.8	434	141.2	454	143.4	484	149.1	626	188.4
Smith	10	51.8	9	46.1	13	65.9	11	55.1	20	99.2
Sumner	207	118.1	213	118.8	222	120.8	240	128.0	227	118.7
Trousdale	0	0.0	0	0.0	0	0.0	0	0.0	8	70.9
Williamson	195	92.2	196	89.5	194	85.8	210	90.5	177	74.2
Wilson	111	86.4	111	83.8	115	84.1	122	86.6	200	138.3
Overall	5357	307.6	5369	302.2	5377	297.5	5450	296.9	5387	289.1

Sources: Tennessee enhanced HIV/AIDS Reporting System (eHARS) accessed July 13, 2020. - represents suppressed data.

Prevalence: Gender

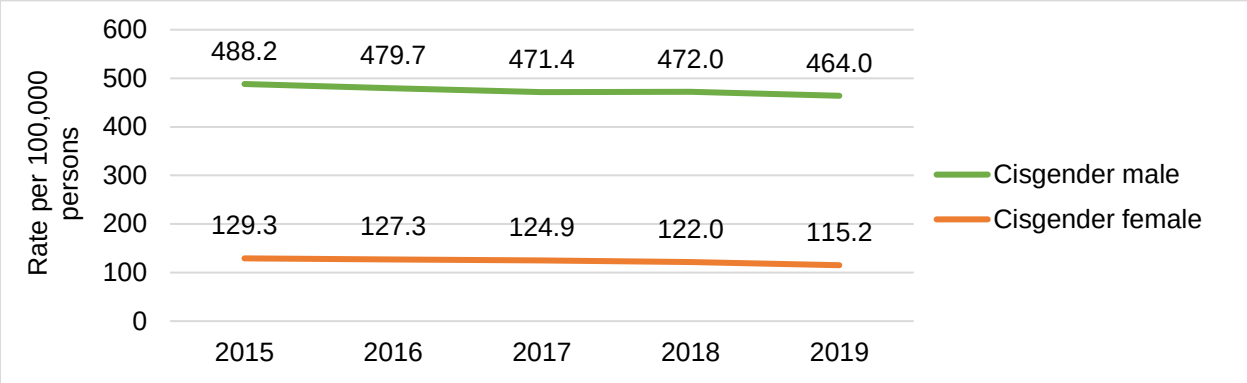
In 2019, cisgender males comprised approximately 78% of PLWH, while cisgender females and transgender persons comprised 20% and 1%, respectively (**Figure 15**). These proportions have remained relatively constant from 2015-2019, though the rates have decreased over the same time period (**Figure 16**). Rates were unavailable for transgender persons because overall population data for transgender persons is not collected at the state level.

Figure 15. Number of persons living with HIV by gender, Nashville TGA, 2015-2019



Sources: Tennessee enhanced HIV/AIDS Reporting System (eHARS) accessed July 13, 2020.

Figure 16. Rate of persons living with HIV by gender, Nashville TGA, 2015-2019

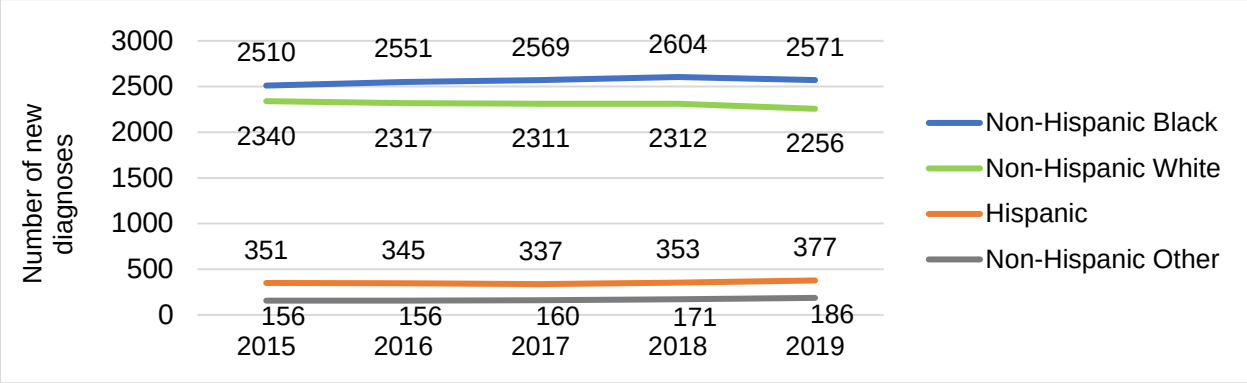


Sources: Tennessee enhanced HIV/AIDS Reporting System (eHARS) accessed July 13, 2020.

Prevalence: Race/Ethnicity

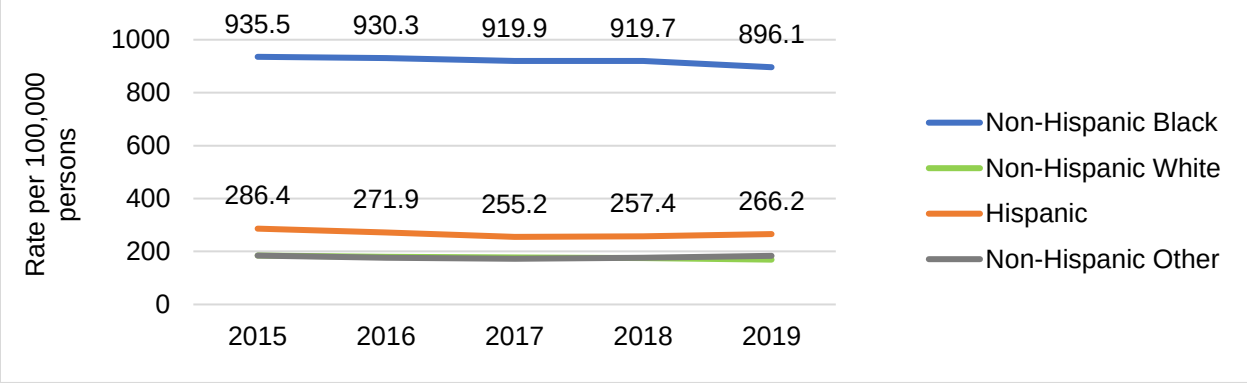
In 2019, the majority of PLWH were either non-Hispanic (NH) Black (48%) or NH White (42%). Approximately 7% of PLWH were Hispanic (**Figure 17**). The prevalence rate was the highest amongst the NH Black population in 2019, with 896.1 cases per 100,000 (**Figure 18**). Although 48% of PLWH were NH Black, only 15% of the total TGA population were NH Black. NH White PLWH comprised 42% of cases but are 72% of the TGA population. Although Hispanic individuals comprise only 7% of PLWH in the TGA, they have the second highest prevalence rate (266.2 cases of HIV per 100,000 Hispanic individuals in the Nashville TGA).

Figure 17. Number of persons living with HIV by race/ethnicity, Nashville TGA, 2015-2019



Sources: Tennessee enhanced HIV/AIDS Reporting System (eHARS) accessed July 13, 2020.

Figure 18. Rate of persons living with HIV by race/ethnicity, Nashville TGA, 2015-2019

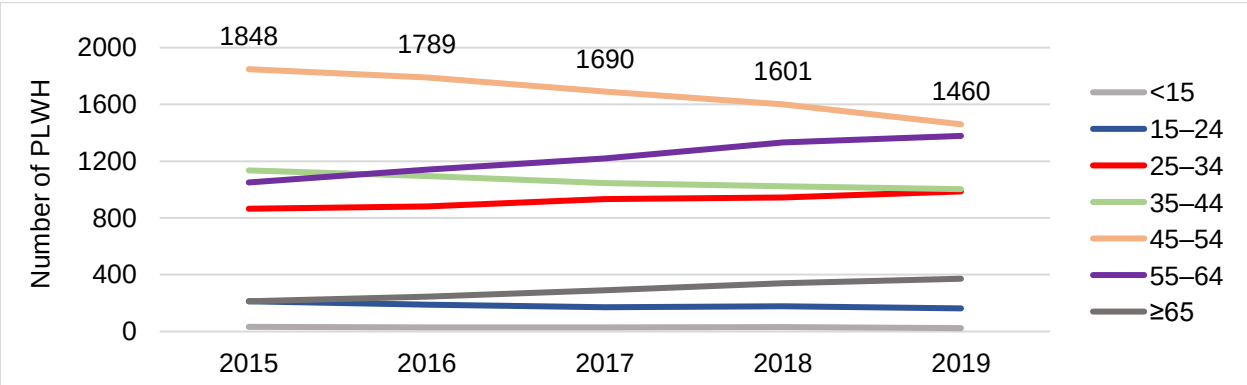


Sources: Tennessee enhanced HIV/AIDS Reporting System (eHARS) accessed July 13, 2020.

Prevalence: Age Group

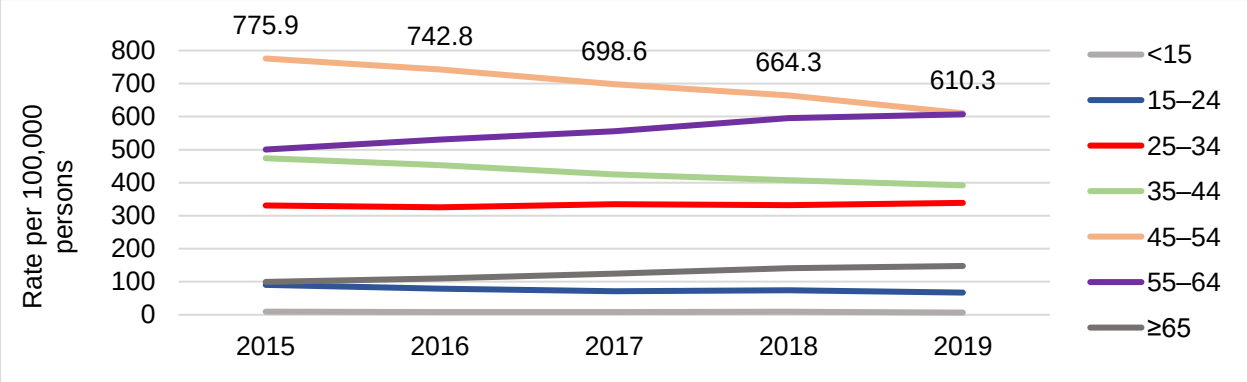
In 2019, the majority of PLWH were ages 45-54 (27%) and 55-64 (26%) (**Figure 19**). This seems to reflect a trend of aging PLWH. From 2015-2019, there was a 21% decrease in PLWH ages 45-54, a 31% increase in PLWH ages 55-64, and a 75% increase in PLWH 65 and older. In 2019, prevalence rates were similar among ages 45-54 and 55-64 (610.3 and 606.9 per 100,000, respectively, **Figure 20**). Prevalence rates were also similar among ages 25-34 and 35-44 (338.9 and 391.9 per 100,000, respectively).

Figure 19. Number of persons living with HIV by age group, Nashville TGA, 2015-2019



Sources: Tennessee enhanced HIV/AIDS Reporting System (eHARS) accessed July 13, 2020.

Figure 20. Rate of persons living with HIV by age group, Nashville TGA, 2015-2019

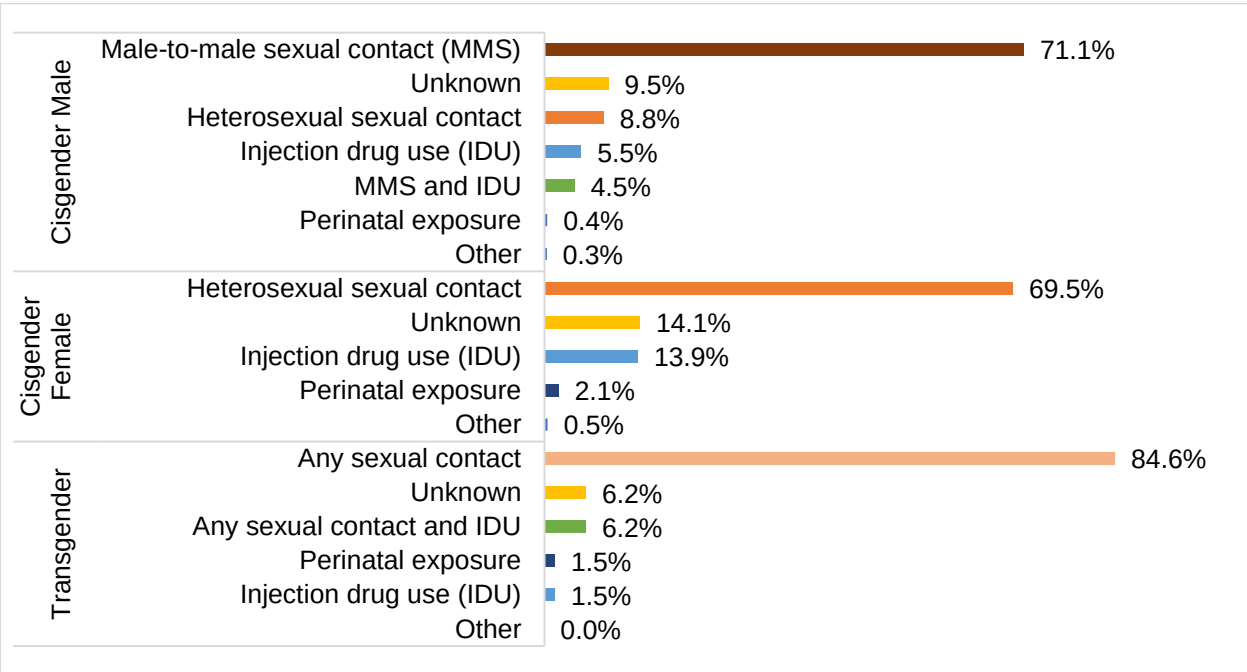


Sources: Tennessee enhanced HIV/AIDS Reporting System (eHARS) accessed July 13, 2020.

Prevalence: Transmission Category

In 2019, sexual contact was the most commonly reported transmission mode for each gender category (**Figure 21**). Unknown mode of transmission was the second most commonly reported transmission mode. Among cisgender males, 71% of infections were attributed to male-to-male sexual contact (MMS). Among cisgender females, approximately 14% of infections were attributed to injection drug use (IDU). IDU trends among PLWH will continue to be closely monitored.

Figure 21. Transmission category proportion among PLWH by gender, Nashville TGA, 2019

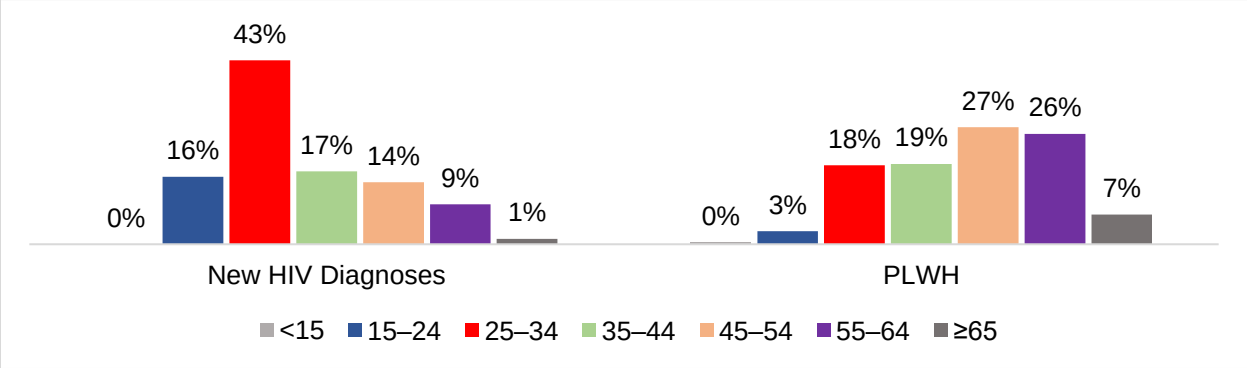


Sources: Tennessee enhanced HIV/AIDS Reporting System (eHARS) accessed July 13, 2020.

Persons at High Risk

Given the data observed from 2015-2019 for new HIV diagnoses and PLWH in the Nashville TGA, individuals at highest risk tend to be cisgender male, NH Black or NH White, and approximately 25-34 years old. Of note, persons newly diagnosed with HIV tend to be younger than PLWH (**Figure 22**). Although there has been a reduction in new diagnoses among ages 15-24 (**Figure 9**), 16% of new diagnoses still occur among this age group.

Figure 22. Age group distribution of persons living with diagnosed HIV infection and new diagnoses of infection, Nashville TGA, 2019



Sources: Tennessee enhanced HIV/AIDS Reporting System (eHARS) accessed July 13, 2020.

Sociodemographic data

Sociodemographic data is not broadly available for all PLWH in the Nashville TGA, so data was instead provided for the Ryan White Part A clients from 2017-2019 (**Table 4**). From 2017-2019, there was an increase in individuals utilizing Part A services that were living in temporary or unstable housing. Approximately one quarter of Part A clients are without health insurance and over half are living at or below the federal poverty level (FPL).

Table 4. Sociodemographic characteristics of Ryan White Part A clients receiving at least one service, 2017-2019, Nashville TGA

	2017		2018		2019	
	N	Percent	N	Percent	N	Percent
Housing Status						
Stable/Permanent	2000	77.1	2017	75.7	2006	80.1
Temporary	368	14.2	139	5.2	432	17.3
Unstable	27	1.0	29	1.1	56	2.2
Unknown	199	7.7	480	18.0	9	0.4
Total	2594		2665		2503	
Insurance						
Medicaid	448	16.3	447	15.93	397	14.8
Medicare (unspecified)	482	17.5	451	16.07	395	14.7
Medicare Part A/B	7	0.3	6	0.21	44	1.6
Medicare Part D	6	0.2	9	0.32	7	0.3
No Insurance	628	22.9	628	22.38	739	27.5
Other	4	0.2	4	0.14	10	0.4
Other public (e.g., Champus, VA)	6	0.2	4	0.14	12	0.5

Private - Employer	560	20.4	627	22.34	502	18.7
Private - Individual	576	21.0	623	22.2	563	20.9
VA, Tricare, other military health care	31	1.1	7	0.25	21	0.8
Total	2748		2806		2690	
Poverty Level						
0-100% FPL	1452	56.0	1385	51.9	1398	53.9
101-138% FPL	241	9.3	311	11.7	246	9.5
139-250% FPL	592	22.8	590	22.1	552	21.3
251-400% FPL	297	11.5	381	14.3	395	15.2
>400% FPL	13	0.5	1	0.0	4	0.2
Total	2595		2668		2595	

Sources: CAREWare, accessed July 28, 2021.

A.1.c – Relative rates of increase

Relative rates of increases in diagnosed HIV cases were described above and were broken down by demographic characteristics. From 2015-2019, there was an increase in new HIV diagnoses, an increase in the number of PLWH but and overall decrease in rate of PLWH. Although Davidson County still has the highest rates of new diagnoses and PLWH, increases in new diagnoses have been observed in Rutherford County. Cisgender males still comprise the majority of new diagnoses and PLWH. New diagnoses among NH Black have decreased but have increased among NH White and Hispanic. PLWH rates remains highest among NH Black and Hispanic. New diagnoses occur primarily among 25-34, then 35-44 and 15-24 age groups. PLWH are generally older. Individuals ages 45-54 and 55-64 comprise the majority of PLWH.

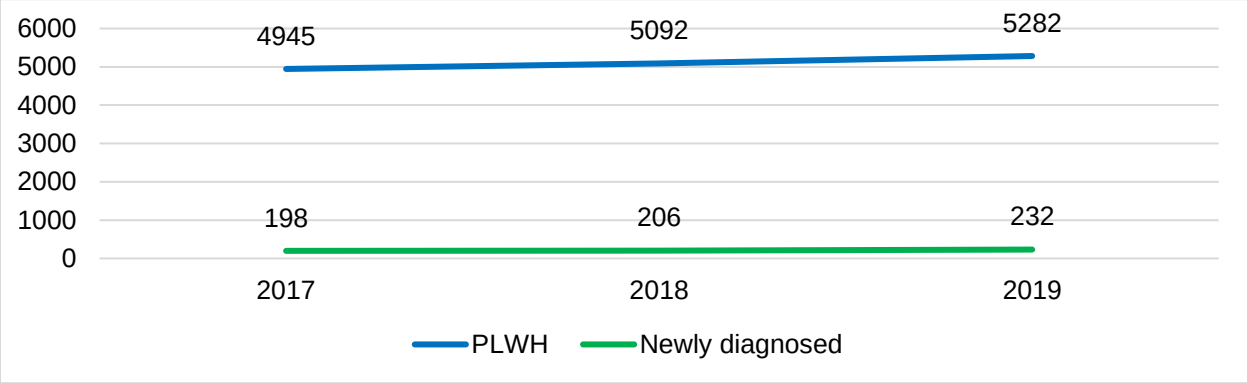
As new diagnoses and overall number of PLWH continue to increase, there will be increasing need for HIV-related services in the Nashville TGA. Prevention services will need to be expanded to reduce new infections, and care services for PLWH, such as services funded by RWHAP, will have to continue to be expanded to meet the needs of PLWH in the TGA. EIIHA strategies will have to continually be refined to improve detection of individuals who are unaware of their status. Community engagement will also be key to improve engagement in care and reduction in HIV-related stigma. Continued identification of gaps and disparities in care will have to be identified through needs assessment and provider-client surveys.

A.2 – HIV Care Continuum

A.2.a – HIV Care Continuum graphic

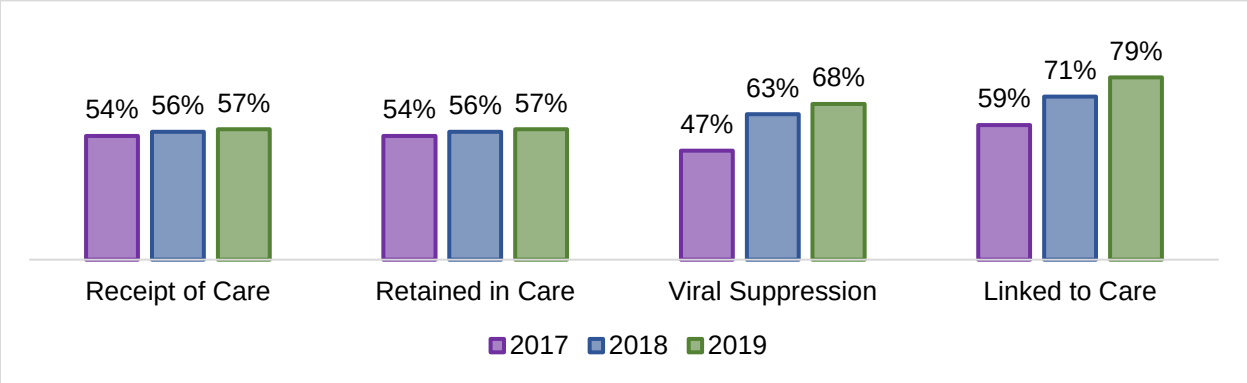
Figures for the HIV Care Continuum steps in the Nashville TGA from 2017-2019 are provided below. The plots utilized data from the CDC 2017-2019 HIV Care Continuum Surveillance Data as provided on TargetHIV. **Figure 23** shows a 7% increase in PLWH and 17% increase in new diagnoses from 2017-2019. Although there has only been slight improvement with receipt of care and retention in care outcomes, there has been more marked improvement with viral suppression and linkage to care outcomes (**Figure 24**).

Figure 23. Number of persons aged ≥13 years with HIV infection at end of calendar year, Nashville TGA, 2017-2019



Sources: CDC 2017-2019 HIV Care Continuum Surveillance Data, May 17, 2021.

Figure 24. HIV Care Continuum Steps, Nashville TGA, 2017-2019



Sources: CDC 2017-2019 HIV Care Continuum Surveillance Data, May 17, 2021.

A.3. – Unmet Need

See **Attachment 4** for Unmet Need Framework estimates.

A.3.a – Identify Unmet Need methods

Enhanced method estimates were provided in addition to the required method estimates. Clients that did not have CD4 or viral load tests or outpatient/ambulatory health services visits in 2019 were considered to have unmet need. Late diagnosed estimates were not provided for RWHAP as it is only applicable to HIV surveillance data. RWHAP data quality requires constant maintenance and estimates may change as missing values and other data quality issues are resolved.

A.3.b – Describe need of PLWH with Unmet Need

Late diagnosed individuals will need improved access to testing and linkage to care. Reducing stigma of getting tested, though increased community engagement, HIV awareness programs, and other means may help to increase the likelihood of high-risk individuals to get tested. Expanding early intervention services (EIS) utilization throughout the TGA can also help get late diagnosed individuals into care.

PLWH with unmet need will need improved follow-up to ensure they are getting CD4, and viral load tests conducted on a regular basis and are visiting providers for outpatient/ambulatory visits. PLWH often need transportation assistance and multiple means of getting to providers and expanding transportation services has been a priority in the Nashville TGA in recent years. Adding more providers in communities (especially rural areas) with high levels of PLWH, improving telehealth services, and increased utilization community health workers can help to ensure PLWH are being retained in care and having consistent CD4 and viral load tests.

PLWH in care but not virally suppressed need to be able to consistently get their antiviral therapy and get CD4 and viral load tests to track progress. Transportation assistance to get to their providers as well as assistance to cover the cost of prescriptions is necessary maintain consistent use of medication.

Increased capacity building is needed particularly in housing, mental health, substance abuse, medical case management (MCM), and peer services. For example, having greater number of and better trained medical case managers, serving newly diagnosed persons or those lost to care, would exercise greater efficiency of service provision due to smaller caseloads and more time to care for individual clients. Additional efforts are also needed to assure that information about the Ryan White program and HIV disease is effectively made available to high-risk persons and communities.

A.4 – Co-occurring Conditions
See **Attachment 5** for table of co-occurring conditions with HIV. Due to limitations in available data, only prevalence estimates for Hepatitis C and STI infection rates were used.

Available data on mental illness, substance use, homelessness, and former incarceration is extremely limited and often does not include associations with HIV infection. The best available found for the TGA was provided. Due to these gaps in data and established associations between these conditions and HIV outcomes, continued effort will be applied to identify PLWH affected by these co-occurring conditions throughout the Nashville TGA.

A.4.a, A.4.b – Hepatitis C, STI rates
Hepatitis C and STI prevalence rates among PLWH and the general Nashville TGA population in 2019 are provided in **Attachment 5**. Rates of these co-occurring conditions are substantially higher than the rates in the general population.

A.4.c – Mental Illness
Mental illness prevalence estimates for adults in the Nashville TGA from 2016-2018 are included in **Attachment 5**. Data were based on National Survey on Drug Use and Health (NSDUH) estimates. NSDUH estimates only applied to adults 18 years and older. Approximately 78% of the TGA population are adults 18 years and older. The NSDUH estimate of 18.6% was then applied to the estimated proportion of the TGA population 18 years and older. Due to high utilization of mental health services and historical associations of increased mental illness among PLWH, we anticipate the prevalence of mental illness among PLWH in the Nashville TGA to be higher than that of the general population.

A.4.d – Substance use disorder

Fatal and non-fatal overdoses in the Nashville TGA from 2019 are included in **Attachment 5**. Several counties in the Nashville TGA are classified as vulnerable to highly vulnerable to HIV/HCV outbreaks based on the Tennessee Department of Health (TDH) 2019 Updated HIV-HCV Vulnerability Index. Several of the more rural counties in the TGA were identified as having higher vulnerability to HIV/HCV outbreaks.

A.4.e – Homeless/unstably housed

Homelessness data for Nashville-Davidson and Murfreesboro-Rutherford, the two most populous regions within the Nashville TGA, were included in **Attachment 5**. Data was unavailable to associate the proportion of homeless individuals at the TGA level that were also PLWH. Housing status among PLWH in the RWHAP can be observed in **Table 4**.

A.4.f – Former incarceration

Estimates for the number of prisoners who had HIV in the custody of state and federal correctional authorities between 2013-2015 were included in **Attachment 5**. Data was only available for the entire state of Tennessee, but efforts will be undertaken to identify rates of incarcerated PLWH specifically within the Nashville TGA. From 2013-2015, the estimated number of prisoners who had HIV in the custody of state and federal correctional authorities in Tennessee hovered around 1.5%, though this figure may differ in the TGA, as the TGA represents approximately 30% of the population of Tennessee.

A.5. Complexities of Providing Care

A.5.a – RWHAP Part A formula

There was no reduction in formula during the FY2021 program year; RWPA received an increase of $40,000**.** However, in FY2021 RWPA NOA received showed a decrease from $314,596 to $304,745 with a difference of $9,852 because of the carry over. This decrease affected only MAI, not Part A formula.

As a result, in the increased funding received under formula, RWPA was able to fund an Antiretroviral Rapid Initiation Pilot in the Nashville TGA. RWPA is unable to provide the data outcomes currently because the program has only been in force for four months.

An explanation of how healthcare coverage impacts PLWH in the Nashville TGA, is outlined in section **A.5.b** below. The explanations detail the coverage options, the TN State Medicaid plans, the insurance gaps, and impact of thereof.

A.5.b – Description of health care coverage options available to all PLWH in the jurisdiction
Medicaid/CHIP Enrollment

TennCare (TNCare) services are offered through managed care entities. Medical, behavioral, and long-term care services are covered by "at risk" Managed Care Organizations (MCOs) in each region of the state, and each participating MCO creates their own contracts with providers, maintains their own fee schedules, processes their own claims, and has their own in-network specialists and providers. All the counties in the Nashville TGA are covered by these MCOs. The TNCare MCOs are below:

- Amerigroup Community Care
- BlueCare
- TennCare Select
- United Healthcare Community Plan

TNCare eligibility for some to meet the criteria can be steep, and there are two types of programs (1.) TNCare Standard is only available for children under age 19 who are already enrolled in TNCare Medicaid and lack access to group health insurance through their parents' employer, or their time of eligibility is ending, and no longer qualify for TNCare Medicaid, (2.) TNCare Medicaid is eligible to, with some stipulations, women who are pregnant, parents or caretakers of a minor child (The child must live with you and be a close relative.), individuals who need treatment for breast or cervical cancer, people who receive an SSI check (Supplemental Security Income), individuals who have gotten both an SSI check and a Social Security check in the same month at least once since April 1977 and who still get a Social Security check. Other eligible groups are persons who live in medical institutions, like nursing home facilities, and has an income below $2,382 per month or receives other long term care services covered by TNCare. Therefore, there is a block of persons ineligible to receive the medical benefits based on age, income, and health status.

In 2019, Tennessee proposed to implement legislation that directs the state to seek federal permission to implement a block grant funding model for TNCare (the state's Medicaid program). Under this plan it will take a while to see the impact of those served under the Ryan White program if any. Most of the program's participants live below the poverty level, so the changes could be minimal.

Table 4 includes sociodemographic data including insurance status for the Ryan White Part A clients from 2017-2019. In 2019, 27.5% of Part A clients did not have insurance.

Table 5 and **Table 6** demonstrate insurance assistance program enrollment at both the state and TGA levels.

Table 5. Tennessee IAP Program Enrollment, Nashville TGA, 2017-2018

	Frequency	Percentage (%)
ACA Marketplace	1,195	45.1%
Regular IAP	1,036	39.1%
Medicare Part D	419	15.8%
Total	2,650	100%

Source: Tennessee Department of Health, accessed September 2019

Table 6. Annual Enrollment and Percent Growth, Nashville TGA, 2016-2019

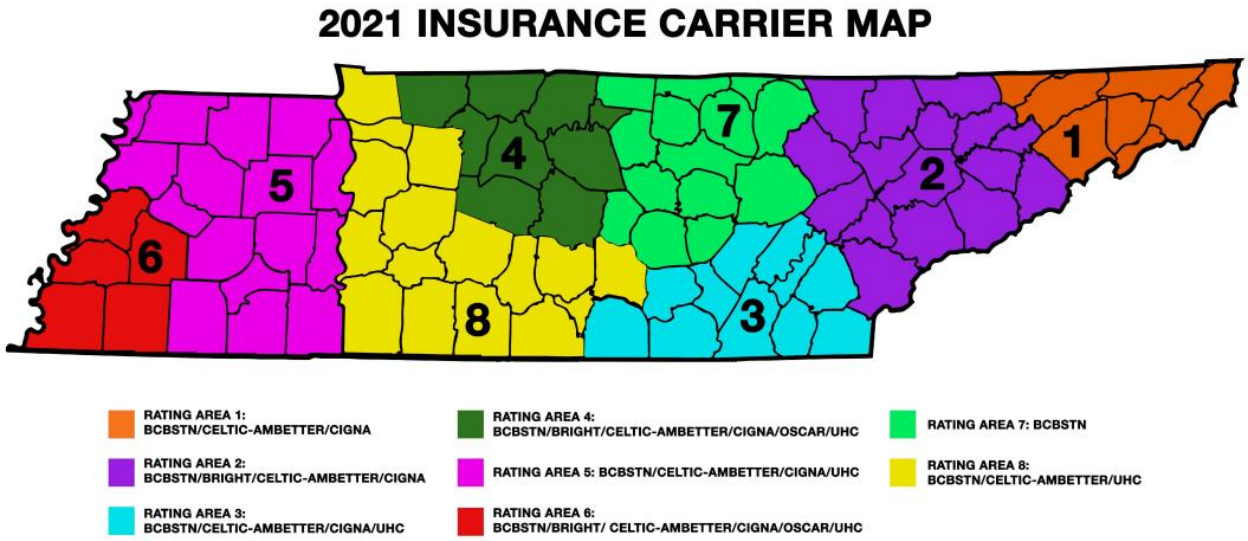
Fiscal Year	HDAP	IAP	Total Part B
2016-2017	-7%	11%	5%
2017-2018	14%	11%	29%
2018-2019	11%	-5%	41%

Source: Tennessee Department of Health; Note: 2011-2012 IAP enrollment numbers are for the 39-county Middle TN region.

A.5.c. Factors that Limit Access to Health Care

Geographic Variation: As noted in **Table 2**, the majority of PLWH in the Nashville TGA reside in Davidson County. Most providers' offices and services are also located in Davidson County. There is one HIV medical clinic located in a rural county. In addition, outwardly deployed Medical Case Management is available in counties outside of Davidson County; this includes access to other key services such as utility assistance, rental assistance, and food. Based on a concern that non-Davidson County residents face issues related to access, qualitative data was collected and showed that there are a significant number of persons who choose to receive care in Davidson County due to concerns related to stigma and privacy. In addition, retention in care data for Davidson County residents and non-Davidson County residents was analyzed and showed similar percentages for each of those geographic groups. Therefore, with continued focus to assure access to transportation, geographic location does not seem to be a major impediment to accessing care. The sole Federally Qualified Health Center HIV medical provider contracted to provide care in Davidson County and the TGA saw its funding cut due to a sudden reduction of approximately $300,000 in the grant award because of fewer HIV cases being present in the updated Tennessee surveillance data. The program and several providers experienced similar disruptions through suspension of specific services and staff reductions.

FIGURE 26: **2021 State of Tennessee's Insurance Carrier**



https://www.tn.gov/content/dam/tn/commerce/documents/insurance/posts/ACA_Insurance_Carrier_Map.pdf

Health Insurance Coverage: The marketplace in Tennessee is operated under the federal exchange. Bright Health joined the Tennessee exchange, offering coverage in 16 counties in the Knoxville area, nine counties in the Nashville area, and five counties in the Memphis area, not all the plans are offered as statewide plans. Additionally, Celtic, is a new plan covering primarily Chattanooga and Memphis, TN. To summarize, there are now has five marketplace providers, BCBST, Cigna, Oscar, Bright and Celtic. The two longest existing companies have approved premium increases (BCBST-21% increase and Cigna-36% increase). However, in 2019 the companies submitted plans including rate decreases to the State of Tennessee, reported as follows.

- Blue Cross Blue Shield of Tennessee: Average premium decrease of 14.9 percent (113,000 members)
- Cigna: Average premium decrease of 12.8 percent (75,568 members)
- Oscar: Average increase of 7.2 percent to 10.84 percent (14,107 members)
- Bright: New to the market
- Celtic: New to the market

https://www.healthinsurance.org/tennessee-state-health-insurance-exchange/#2019rates

Tennessee Department of Health (TDH), a Part B Recipient, uses ADAP funds to pay for insurance for eligible PLWH (covering premiums, copays, and deductibles). TDH completes a thorough assessment of Tennessee plans, reviewing formularies, covered services, and premium costs. From this assessment they develop their strategy for purchasing insurance for PLWH. In 2017, TDH purchased marketplace insurance for eligible PLWH and purchased an “off-market” insurance option (Farm Bureau) for persons below 100% of FPL (which is the majority of PLWH). This group gets redirected from the ACA website to apply for Medicaid which is a very limited option in TN. For 2018, Farm Bureau has decided not to offer ACA compliant plans.

Even with non-Medicaid expansion and the challenges of ACA insurance plans (limited covered areas, a large HIV medical provider not part of the network), Tennessee was successful in 2017 in enrolling persons into insurance programs through the Part B IAP program – primarily because of the "off-market" plan. The Part B Recipient has taken the lead in managing insurance expansion has been very successful in training and keeping MCMs current on ACA information. They have also been very successful in working with stakeholders in completing thorough assessments of available plans, particularly off-market plans in the Nashville TGA. In addition, the state contracts with an administrative agent who has a very solid infrastructure for managing enrollment and payments of premiums/copays/deductibles (also have a solid data system, experienced staff, and a direct connection to majority of MCMs). The insurance administrator has developed direct billing relationships with the most used medical providers and therefore receive bills directly from those providers rather than relying on enrollees to bring bills to the insurance administrator for payment.

Tennessee is among the states with higher uninsured rates. More than 46,000 Tennesseans were without health insurance last year. The state does have a Medicaid exchange option, and enrollment is still possible for Tennessee residents who have qualifying events. Health insurance premiums in Tennessee's individual insurance market decreased for 2019, but that was preceded by two years of sharp increase. Several counties were left with no insurance option at all.

Challenges were faced in 2018 which have implications for many subsequent years. Other than Tennessee being a Medicaid non-expansion state, the primary challenges fall into two categories: commonalities to other Ryan White programs and TN specific challenges. Specific to TN, there is continued concern about significant increases in premiums but most concerning, is related to status of ACA insurance companies. The ACA network continues to have insurance plans drop out or some of the existing plans do not contract with all HIV medical providers. Advocates continue to monitor practices of access to medications based on HIV status (i.e., there are more restrictions on accessing HIV medications than compared to other chronic health conditions). It is still unclear if the TGA's largest HIV medical providers will accept the market-place plans. More recently at least one Medical provider in the Nashville TGA has stated the transition of patients to the ACA, marketplace has reduced their ability to provide services to the patients, given RWPA is the payor of last resort. There is also concern depending on the plan if some of the plans offered are adequate to fully meet the patients' medical needs.

Even with these challenges, the hope is that the Part B program will be able to maintain insurance for PLWH, primarily due to surplus income from the rebate program. If this continues, this assures that the service system under Part A remains the same and continues to be responsive to the service needs and complexities faced by PLWH. If not, we will face an extreme change in our care system and the current system of Part A service funding will have to change drastically.

Language Barriers: The Planning Council has allocated funds to linguistics to address language barriers and over the last several years initiated targeted Hispanic Outreach service under MAI. In addition, the three major Ryan White medical providers in the TGA staff individuals who are fluent in Spanish. The primary language need in the Nashville TGA is for the Hispanic population.

At this time, current funding and funding provided by other non-Ryan White resources meets the need in the community.

Other Barriers that Limit Access to Health Care: Based on consumer surveys conducted in the TGA, the top 5 barriers that limit access to health care from highest to lowest score are as follows and have actually remained consistent for several years: 1) I was worried about other people finding out I have HIV (32.3%); 2) I didn't have transportation to get to my appointment (27.2%); 3) I was not ready to deal with my diagnosis (19.2%); 4) I had insurance but it didn't cover all of the cost of services I needed. (18.9%); and 5) I didn't know where to go or who to ask for help (18.1%).

B. – Early Identification of Individuals with HIV/AIDS (EIIHA)

B.1. EIIHA Activities

B.1.a. Planned Activities, Including System Level

Table 7 documents the pivotal EIIHA administrative activities that impact the entire strategy and are applicable to all target populations. The strategies include system level interventions and are similar across most of the sub-recipients in this TGA to diagnose, link to care, and to treat with a sense of urgency. Re-engagement in care is also a priority that is managed through the Early Interventions Program. In our TGA we are striving to communicate and collaborate in a more seamless manner, which will assist clients in obtaining HIV services with less barriers. These activities are critical for achieving EIIHA goals. The 13 surrounding counties the TGA have their own administrative systems, which can require more time and effort to provide care to clients, thus creating delays for clients receiving care. This is an obstacle that will take some continued work to correct in the future.

Table 7. Primary EIIHA Activities

EIIHA Component	Primary Activity	Responsible Party
Identifying	1. Coordinate & collaborate ALL HIV testing in the TGA, funding (e.g., HRSA, CDC, SAMHSA) and providers via information sharing and planning.	TDH/MPHD
	2. Create a mechanism to assure on-going communication between local TGA and TN state health departments.	MPHD/TDH
	3. Develop relationships with representatives from TennCare, insurance plans under the ACA marketplace to support routine HIV testing for their enrollees per CDC guidelines & to support insurance payment for testing.	MPHD
	4. Ongoing diversification of testing locations targeted to high-risk areas; evaluate and modify locations if indicated.	TDH/MPHD
	5. Continue to promote high risk health screening in community health centers and emergency departments, particularly for communities of color. Increase communication between largest Metro health department and local safety net providers regarding HIV testing practices.	TDH/MPHD
	6. Expand use of technology to reach more at-risk individuals.	All providers
	7. Educate key community gatekeepers on HIV and importance of HIV screening and increase their skills in talking about HIV: ● Mental health and substance abuse providers ● Faith-based community ● Community health centers ● Agencies that primarily serve youth ● Latino leaders and stakeholders ● Agencies that primarily serve women, trans persons, and LGBTQI	Planning Council
	8. Educate mental health and substance abuse providers on assessing risky sexual behavior through use of best practice tools.	MPHD
	9. Increase media coverage on topics related to HIV to targeted groups and/or their gatekeepers. ● Mental health and substance abuse ● Faith-based ● LGBTQ print media ● Hispanic radio ● African American youth	MPHD/ Planning Council TDH/PC
	10. Continue to identify and use targeted efforts to prevent HIV infection using evidence-based interventions.	TDH/MPHD
	11. Target social and sexual networks.	MPHD
	12. Maintain HIV testing program in Metro jail and identify new opportunities for testing for high-risk populations based on role as a Metro agency.	MPHD
	13. Identify new opportunities for increased internal collaboration at Metro health department, to increase identification of new HIV positive individuals (e.g., TB, family planning, mental health, and youth, Behavioral Health).	MPHD
	14. Identify opportunities for STI prevention services for PLWH (health fairs, outreach services, youth event).	Planning Council MPHD/PC

	15. Maintain funding for an Outreach Service specific to young persons, with a focus on young Black MSMs and Transgender youth. 16. Collaborate with sites prescribing PrEP to assure information on HIV is shared with all clients.	
Informing	1. Continue improved lab processes to decrease time to receive test results. 2. Assure effective implementation of partner notification and testing and offering PreP and PEP. 3. Identify evidence based and best practice strategies for informing and provide a report to the Planning Council for considerations in funding and/or directives. 4. Collaborate with sites prescribing PrEP and PEP	TDH Local HD & Pt A providers MPHD MPHD
Referring	1. Identify ways for PLWH to access documentation of their HIV status quickly and easily. 2. Revise release of information forms & processes to increase communication between HIV service providers, to assure linkage and maintenance in care. 3. Part A Standard of Care language requiring medical appointment for newly diagnosed patients within 30 days of request for appointment. 4. Increase education of private providers regarding referring and linkage to care through coordination with Metro health department DIS, EIS, and SHC (sexual health clinic) 5. Maintain point of entry standards of the EIS program. 6. Identify evidence based and best practice strategies for referring/linking to care. Provide recommendations to the Planning Council for considerations in funding and/or directives. 7. Maintain recipient activities and monitoring with Part A providers on "health literacy" to assure effective interventions for linkage. 8. Institute a new "Data to Care" project at a local health department 9. Collaborate with sites prescribing PrEP and PEP linkage to care to assure HIV education is shared with all clients.	TDH/local HD MPHD/Part A providers Planning Council/MPHD MPHD & Part A providers MPHD MPHD MPHD Plan. Council MPHD MPHD
Linking	1. Link client to HIV medical facilities for care in 30 days. 2. Antiviral HIV medications and treatment adherence care 3. Labs and Genotype HIV 4. Health Screening and Vaccinations 5. Improve HIV Education/Counseling 6. Nutrition/Dietary Needs 7. Mental Health Screenings/Referrals 8. HIV maintenance care and follow up	TDH TDH/MPHD TDH/MPHD Plan. Council MPHD MPHD

B.1.b. Major Collaborations

Part B: TDH STD/HIV Section is the Part B Recipient in Tennessee and the state recipient of CDC prevention funds. EIS is also under the STD/HIV Section in the Metro Public Health Department, which is funded by the Ryan White Part A program. TDH funds most of the prevention and testing in the TGA. Therefore, coordination is carried out through regular interactions with TDH representatives and through collaboration between the Part A Ryan White, and the Part B Consortia. Part A and Part B (TDH) both fund the agencies who provide prevention testing and counseling services. This allows for great local coordination and communication among the agencies. In addition, TDH provides Part A with TGA-level data related to EIIHA. Supplementary

data from key individual testing providers is collected (e.g., jail testing data from Metro Public Health Department).

Prevention and Disease Control Programs: The TDH Prevention and Disease Control Program is integrated within the STD/HIV Division. In addition, coordination between actual Disease Control staff is handled at the staff level within each group. Lastly, in Davidson County, the Disease Intervention Specialist (DIS) program is located within the Recipient agency, (Metro Public Health Department) and this allows for faster, more accurate coordination between DIS and EIS and our community partners.

Hospitals/Private Physicians/Primary Care Safety Net Providers: The local health department has formal relationships with private providers through their DIS activities and AIDS Service Organization (ASO) contacts, which helps maintains ongoing relationships with hospitals and safety net providers

Other Community Programs: Representatives from funded testing agencies and other community stakeholders are members of the Part B planning bodies and are responsible for creating a plan for their respective region which is then incorporated into the state's HIV prevention plan. Part A staff also coordinate with Part B to ensure regional consistency. Local health departments, through DIS and outreach activities, maintain ongoing coordination with HIV testing entities. Local testers interact with non-testing entities through their community outreach and testing activities. For agencies funded directly by CDC or SAMHSA, Part A coordinates through ongoing communication and recruitment for Planning Council activities.

B.1.c. Anticipated Outcomes of EIIHA Strategy
Anticipated outcomes for the EIIHA are associated with each of the four required EIIHA components.

Identifying Individuals Unaware of HIV Status: EIIHA activities designed to identify individuals unaware of their status are ultimately expected to lead to improvements in testing services and outreach. Improvements to testing services and outreach may result in increased numbers of new HIV diagnoses in the Nashville TGA, as observed from 2015-2019. Increases in new diagnoses may be related to an increased percentage of people with HIV infection who know their status, not simply increased transmission.

Individuals who are unaware of their status have the potential to be late diagnosed. Improving accessibility and awareness of testing will ideally lead to earlier detection of HIV, though there may be initially an increase in late diagnoses/HIV stage 3(AIDS) diagnoses as people who are unaware of their status are identified. The COVID-19 pandemic is expected to significantly impact testing and new diagnoses in 2020 and 2021.

Informing Individuals that were Newly Diagnosed with HIV: EIIHA activities designed to inform individuals that were newly diagnosed with HIV are expected to lead to better health outcomes and improve quality of life. Notifying individuals of their status should also lead to an increase in linkage and engagement in care and ultimately viral suppression. Awareness of safer sex practices among the newly diagnosed individuals may also help to reduce further transmission of HIV.

Referral to Care of Newly Diagnosed Individuals: EIIHA activities focusing on referral to care are expected to improve PLWH understanding of care options and available social services. Increasing client's knowledge of HIV services and networks in the TGA and surrounding counties will ideally empower PLWH to seek and maintain engagement in care.

Linking Newly Diagnosed Individuals to Care: Linking newly diagnosed clients to care will improve health outcomes through treatment and adherence education. Improved levels of viral suppression will lead to a better quality of life and ultimately aid in the reduction of HIV transmission, reducing the burden of the HIV epidemic in the TGA.

B.2. Efforts to Remove Legal Barriers to Routine HIV Testing

Tennessee does have laws that criminalize behaviors associated with HIV exposure and therefore can impact a person's willingness to participate in routine HIV testing. Like other states, these laws impose criminal penalties on persons who know they have HIV and subsequently engage in certain behaviors, most commonly sexual activity without prior disclosure of HIV positive serostatus and charges of aggravated prostitution. In Tennessee, these charges are viewed as felony offenses and can result not only in incarceration, but also inclusion on the sex offender registry indefinitely. In the past few years, local advocates have engaged with national experts in addressing this issue and have provided education to the Planning Council, PLWH, and others on this topic. Annually, community members convene at the state Capitol when the members of the House and Senate are in session and advocate for legislative changes to decriminalize HIV specific laws based on the science. In 2017, the Tennessee legislature passed syringe services legislation. The bill authorizes syringe services programs administered by non-profit groups, who are permitted to provide persons who inject drugs (PWID) clean needles after one use; this program or service is often referred to as "needle exchange". Part of the legislation requires that persons are offered HIV testing, treatment, counseling, and other social services as identified or needed; this initiative should increase the number of people who receive HIV tests.

In addition, Tennessee Department of Health (TDH) has been proactive to normalize routine HIV testing in healthcare and other clinical settings, since it is not mandated by law or policy. A few of their initiatives included funding rapid testing in two areas of the state, particularly in health care settings (emergency rooms and community health centers). Within the Nashville TGA, the Recipient and TDH continue to build relationships to encourage routine HIV tests in health care settings, particularly those serving high risk populations. EIS will continue to be charged with this task as part of their work with "points of entry." This will be a point of discussion and an ongoing conversation with the EIS program and management team at MPHD particularly because they are readily accessible and there are onsite clinics for immediate access.

C. SUBPOPULATIONS OF FOCUS

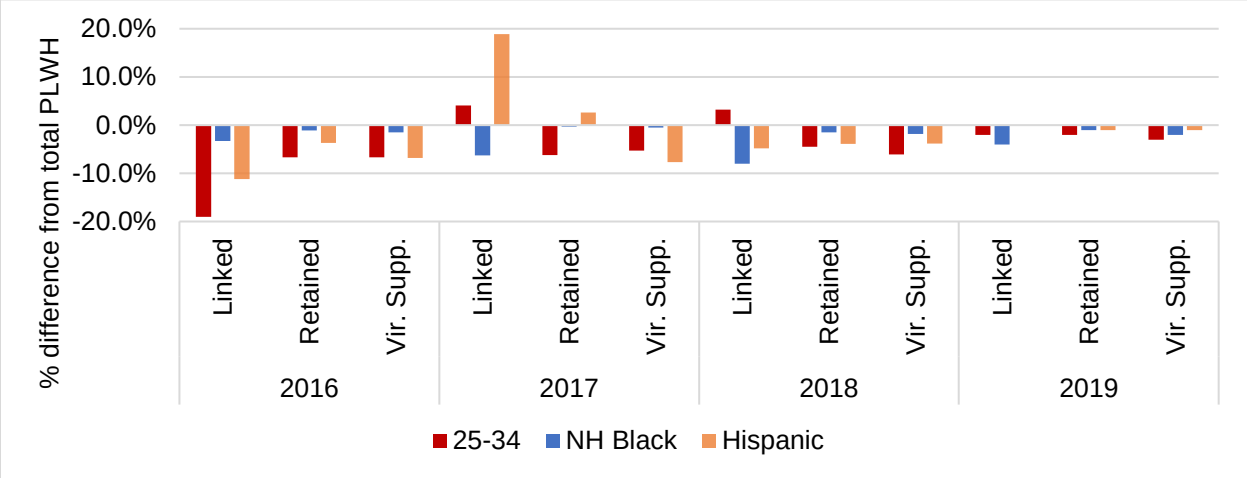
C.1 Identification of subpopulations and their needs: The subpopulations of focus were identified based on disparities observed in the ongoing 2021 Needs Assessment, which focused on data in the Nashville TGA from 2015-2019 (most current data available). The subpopulations of focus are: Non-Hispanic (NH) Black PLWH, Hispanic PLWH, and PLWH ages 25-34.

NH Black and Hispanic PLWH have the highest rates of HIV in the Nashville TGA, with 896 cases of HIV per 100,000 NH Black persons and 266 cases of HIV per 100,000 Hispanic persons (**Figure 18**). In 2019, 48% of PLWH were NH Black while only 15% of the TGA population was NH Black. Additionally, NH Black, and Hispanic PLWH have historically had worse HIV Continuum of Care outcomes when compared to all PLWH in the TGA.

PLWH ages 25-34 were also identified as a subpopulation of focus as the majority of new infections in the TGA have occurred in this age group. In 2019, 43% of new infections occurred among 25-34-years-olds, and the number of new diagnoses among this age group has increased by 26% since 2015. Additionally, 25-34-year-olds have also had worse HIV Continuum of Care outcomes when compared to all PLWH in the TGA.

Figure 27 below shows the HIV Continuum of Care outcomes for these three subpopulations relative to the outcomes of all PLWH in the TGA. From 2016-2019, the subpopulations of focus tended to have worse Continuum of Care outcomes compared to the outcomes of all PLWH in the TGA, though the disparity in outcomes has lessened with time.

Figure 27. Variation in HIV Continuum of Care Outcomes, 25-34 years old, NH Black, and Hispanic PLWH, 2016-2019



Source: Tennessee Department of Health, eHARS, extracted Sept. 8, 2021.

Due to the high burden of HIV among the NH Black and Hispanic subpopulations and their status as minorities in the Nashville TGA, outreach and engagement services will be necessary to allow these groups to have a voice in determining what their optimal care looks like. Coordination with community leaders can help enhance HIV awareness and decrease stigma, which may allow high-risk individuals to feel more comfortable getting tested for HIV, and thus reduce the number of PLWH who are unaware of their status. Ensuring demographic representation in healthcare settings can help to increase trust and retention in care.

Due to the high rates of new diagnoses among 25-34-year-olds, this subpopulation will need care that will focus on ensuring newly diagnosed individuals in this age group are made aware of their status and quickly linked to care. Further analysis is being conducted to determine more specific demographic characteristics of this group. Coordination with HIV prevention services is also

necessary to enhance strategies reduce new infections in this subpopulation. Bringing HIV awareness campaigns to social networks and dating apps may also help to decrease stigma and increase testing and foster a proactive approach to HIV prevention.

C.2 How unmet need framework informs process for identifying subpopulations: The unmet need framework includes three components: late diagnosed, unmet need (aware of status but not in care), and not virally suppressed. This framework can inform the gaps in care and help to identify subpopulations of focus for the jurisdiction. Based on the information above, NH Black, Hispanic, and 25–34-year-old PLWH were identified as subpopulations of focus. Additionally, looking at the unmet need framework estimates in **Attachment 4**, it is observed that in 2019, NH Black and 25-34-year-old PLWH had higher levels of unmet need and in care but not virally suppressed compared to all PLWH in the TGA. Hispanic PLWH had similar outcomes to all PLWH in the TGA for these two components of unmet need but had higher levels of late diagnoses. The unmet need framework outcomes for these groups further the justification for their identification as subpopulations of focus.

C.3 Identify EIIHA activities that align with the needs of the identified subpopulations:

Table 8. EIIHA Activities that align with subpopulations

EIIHA Activities	Needs of Subpopulations
Identifying: • Diversification of testing locations targeting high risk areas • Promote high risk health screening in community health centers, particularly for communities of color • Target social networks and dating apps	• Diversifying testing locations will improve accessibility to HIV testing and allow testing locations to be more demographically representative of the high-risk communities • Promoting high risk health screening in community health centers may help to reduce stigma and facilitate earlier detection of HIV • Targeting social networks and dating apps can help reach minority communities and high-risk adults ages 25-34
Informing: • Continually seek to identify best practice strategies for informing through coordination with Planning Council • Collaborate with sites prescribing PrEP and PEP	• Identifying best strategies for informing individuals of new HIV diagnoses are important to make sure people are not lost to care and can quickly be linked to care. Best strategies may vary based on demographic differences. • Collaboration with HIV prevention/PrEP/PEP sites allows the potential to link individuals to care if they think they had an exposure
Referral: • Increase communication between HIV service providers • Enhance coordination between Metro Public Health Department (MPHD) and private providers regarding referral to care	• Increasing communication between HIV service providers can facilitate more effective referral to care by ensuring newly diagnosed individuals from the subpopulations of focus are aware of their care options and can find a provider best suited to their needs. • Improved coordination between MPHD and private providers is important to ensure

	consistent standards for referring newly diagnosed individuals to care.
Linkage: • Link client to HIV medical facilities for care within 30 days • Enhance coordination between Metro Public Health Department (MPHD) and private providers regarding linkage to care	• Linking newly diagnosed individuals to care within 30 days is necessary to improve the potential of achieving viral suppression and maintenance of care. Given the historically worse linkage to care outcomes among the subpopulations of focus, strategies need to be refined to improve linkage to care. • Improved coordination between MPHD and private providers is necessary to ensure the subpopulations of focus are linked and retained in care.

B.3.c. Specific Strategies for Target Populations

The specific strategies used are driven by the Tennessee Department of Health (TDH) as the primary funder of HIV prevention and testing services. TDH has refined their strategies and focuses their efforts on best practices as defined by CDC, with interventions designed for very specific populations. Key strategies funded by TDH in the TGA are: 1) 4th generation HIV testing; 2) Targeted testing for young, black MSM via Social Network Strategy; 3) Correctional navigation at state prisons; and 4) Data to Care initiatives.

Through Part A, the Planning Council's key strategies include the following: 1) Two Outreach services; one is at a youth serving agency and targets young persons, particularly Black MSM while the other project funds Outreach at a Latino entity for the Latino population; 2) Continuation of EIS services at the largest local jail in the TGA; 3) Continued funding of peer services; and 4) A Data to Care initiative at the largest local health department which will began in 2019 and targets persons who have not received a viral load test within the last year, with an emphasis on persons who have never engaged in the system of care or who have been out of care for three years or longer.

METHODOLOGY

A. Planning Responsibilities

The planning Council response and identified responsibilities are included in ATTACMENT

B. 3. Letter of Assurance from Planning Council Chair(s)

The Letter of Assurance is included in **Attachment 6**.

A.2 – Resource Inventory

A.2.a – Coordination of Services and Funding Streams

The jurisdictional HIV resources inventory is included as **Attachment 7**.

WORK PLAN

A. HIV Care Continuum Table and Narrative

A.1. FY2022 HIV Care Continuum Services Table

The FY2022 HIV Care Continuum Table is included in **Attachment 8**.

A.2. HIV Care Continuum Narrative

A.2.a – Changes in HIV Care Continuum

Attachment 8 contains the FY2022 HIV Care Continuum Services table, displaying the numerator, denominator, and percentage for each step of the HIV Care Continuum. Baseline data was taken from the year with the most current data available (2019) and was based on the CDC 2017-2019 HIV Care Continuum Surveillance Data as provided on TargetHIV.

Diagnosed: To determine the number of people with HIV (both diagnosed and undiagnosed, as described in directions for **Attachment 8**), the numerator was the number of persons aged ≥13 years with diagnosed HIV infection as seen in CDC 2017-2019 HIV Care Continuum Surveillance Data. According to CDC NCHHSTP AtlasPlus, in 2019, approximately 87% of PLWH in the U.S. knew their status. Thus, approximately 13% of PLWH were unaware of their status. To determine the denominator (the number of persons aged ≥13 years with HIV infection, both diagnosed and undiagnosed), the numerator was considered to represent 87% of HIV infections in the Nashville TGA, resulting in the estimated baseline denominator of 6,092.

Receipt of Care, Retained in Care, Viral Suppression: From 2017-2019, the number of diagnosed PLWH in the Nashville TGA increased by approximately 3% each year. This rate was applied to the baseline denominator to estimate the FY2022 denominator. The target proportion of 95% of PLWH who know their status was then applied to the target denominator to determine the target numerator. This target Diagnosed numerator was then used as the denominator for the target denominators for Receipt of Care, Retained in Care, and Viral Suppression, following diagnosis-based Continuum of Care guidelines.

Linkage to Care: On average, from 2017-2019, the number of new HIV diagnoses increased by approximately 8.5%. This rate was applied to the baseline denominator to estimate the FY2022 denominator. The target proportion of 95% of persons newly diagnosed with HIV infection who are linked to HIV medical care within one month of diagnosis was then applied to the target denominator to determine the target numerator.

See **Figures 23** and **24** in the Demonstrated Need section for plots showing changes in the HIV Care Continuum for the Nashville TGA from 2017-2019. As described previously, there was a 7% increase in persons living with diagnosed HIV infection and 17% increase in new diagnoses from 2017-2019. Receipt of care (percentage of persons with diagnosed HIV who had at least one CD4 or viral load test during the calendar year) and retention in care (percentage of persons with documentation of 2 or more CD4 or viral load tests performed at least 3 months apart during the calendar year) both showed increases of 3%. Viral suppression and linkage to care increased by 21% and 20%, respectively.

Although there has been improvement with regard to all stages of the HIV Continuum of Care outcomes in the TGA, the Part A program will continuously adapt the program to further improve health outcomes for PLWH. Local benchmarks have been established for each stage of the

continuum. The Planning Council continues to allocate new funds for community health workers in recognition of poorer outcomes for minority populations. The data reinforces the need to devote resources focused on young, Black, MSMs due to their lower viral suppression and poorer linkage to care. The Planning Council has adopted measures from the Continuum into their Standards of Care and the benchmarks and provider specific results allow the Recipient to focus a portion of monitoring on these important results. Viral suppression results are measured for most services, enforcing the concept that all Ryan White services must address viral suppression.

The PSRA Committee continues to make funding for Early Intervention Services and Outreach to youth and Hispanic populations a priority. The Nashville TGA has supported a robust and increasingly diverse case management system. This can be seen in the more specialized case management services offered by Ryan White providers. Such teams are representative of the minority groups they serve and provide tailored services as follows:

- Teams to engage NH Black MSM
- PLWH 55 years and older
- Intensive housing retention teams for chronically homeless
- Immigrants from non-Hispanic countries as well as those specifically charged with engaging the Hispanic population
- Teams specifically for PLWH who are not virally suppressed

B. Funding for Core and Support Services

B.1.a – Service Category Plan
See **Attachment 9** for the Service Category Plan which includes RWHAP Part A and MAI.

B.1.b – MAI Service Category Plan Narrative
B.1.b.i, ii – Describe how MAI services will address needs of the subpopulations and how MAI services may prevent new infections, improve health outcomes, and decrease health disparities among the subpopulations
As a result of the PSRA process, funding is being directed towards subpopulations highly impacted by the HIV epidemic with the goal of reducing existing racial and ethnic health disparities. As minority populations tend to exhibit poorer outcomes along the HIV Care Continuum, additional funds are being allocated to EIS to identify and inform new diagnoses, which in turn aim to improve linkage to care. EIS funds will also target 25–34-year-old adults, who make up the largest proportion of new diagnoses. Additionally, outreach services will be expanded to improvement engagement with minority communities within the TGA, particularly Hispanic and NH Black PLWH.

To address the needs of the Hispanic population in the Nashville TGA, MAI funds are being directed towards EIS, MCM, Outpatient, and Outreach. For the Outreach service category, a partnership was created between a local minority ASO and a Hispanic-based community organization with the aim of increasing the number of Hispanics aware of their HIV status. By bolstering our ability to identify PLWH in this population, HIV Care Continuum outcomes will consequently be improved. We have already begun to see decreases in health disparities among

the subpopulations of focus, so continued efforts in these areas will help to further reduce inequities.

Increased funding in MCM and Outpatient services will also serve to enhance retention in care and improve viral suppression rates.

B.1.c – Unmet Need

B.1.c.i – Identify interventions to improving outcomes for individuals with unmet need

Table 9. Interventions to improve outcomes for individuals with unmet need

Late Diagnosed	• Increased coordination between EIS, case management, and outpatient to quickly engage late diagnosed individuals into care • Coordination with outreach and prevention services to improve HIV testing awareness and availability
Have unmet need	• Expanded transportation services with new rideshare program – Improves accessibility to care • Increased utilization of community health workers to expand peer navigation of care options, improving engagement and retention in care • Non-medical case management linkage and re-engagement assistance
In care, not virally suppressed	• Expanded transportation services with new rideshare program – Improves accessibility to care • Increased utilization of community health workers to expand peer navigation of care options, improving engagement and retention in care

B.1.c.ii – Activities relating to re-engagement and intersection with other plans or strategies

Ryan White Part A staff are part of the Ending the HIV Epidemic workgroup at the Metro Public Health Department and are continually looking for ways to coordinate activities to re-engage individuals with unmet need into care.

B.1.d – Core Medical Services Waiver

The Core Medical Services Waiver is not applicable currently as the Recipient is not requesting a core medical services waiver. We will continue to monitor the need to apply for a waiver during the grant year.

A. Resolution of Challenges Table

Table 10 summarizes the most significant challenges/barriers the Recipient faces in implementing the Part A program and the HIV Care Continuum, including challenges related to the health care landscape, community engagement, inequities in health outcomes, etc. The table also includes resolutions, intended outcomes, and the current status.

Table 10. Part A Resolution of Challenges

Challenges/ Barriers	Proposed Resolutions	Intended Outcomes	Current Status
No Medicaid expansion and uncertainty of ACA in TN. Without Medicaid expansion, Part A clients have found it difficult to access subsidies that make marketplace insurance affordable. Administratively, Part A remains as the payment source for services. With basically flat Part A funding and increased prevalence and more positive persons entering the care system each year, funding as comprehensive array of services remains challenging.	Part A has joined with Part B's efforts to assure that all eligible Ryan White clients are enrolled into Medicaid and ACA insurances so that Part A funds are to be used as the payer of last resort. The Recipient and the Planning Council regularly and closely monitor the use of funds to assure Part A services have adequate funding (e.g., outpatient, medical case management).	1. Full enrollment of eligible PLWH in marketplace insurance. 2. Assess needed Part A funding for outpatient and carefully track expenditures each month.	The state of Tennessee is currently rapidly enrolling eligible clients in ACA. Ryan White as the Payor of last resort plans will assist eligible non-insured clients with HIV medical care.
Integration of HIV prevention and treatment at all levels (planning body, provider system, funding system, data systems). Without meaningful integration, the effectiveness of the service system is compromised. In addition, without effective collaboration, between systems, there will a loss of continuity of care and possible duplication of services. With the End HIV Epidemic (EHE) initiatives in place the need for collaboration and integration for all parties is essential for reaching prescribed goals.	The newly developed Integrated Plan set the stage for meaningful collaboration, coordination, and communication, on a quarterly basis between systems of care to include, Part A, B, HIV prevention, sexual health clinic and HCV. Increase efforts to share information and best practices to enhance HIV services in TN. lessen barriers and streamline collaboration are needed.	Strengthen the HIV prevention and treatment services in TN. Integrated Plan, including the coordination of systems (data, funding,) Sharing of data and information across systems to lessen HIV barriers and streamline HIV services.	The Integrated Plan is being updated to meet expectations of the EHE initiatives. Part A and Part B are collaborating and update best practices principals. Meetings are taking place on a quarterly basis and sharing HIV plan and activities.

Collection and sharing of quality data with and from sub- recipients, can be challenging, particularly when there are data needs other than the CAREWare. Data system. Data is essential and at the core of defining the epidemic, when measuring data related to disparities, various outcomes, informing QI and monitoring providers. Providers must have capacity to perform this activity, as well as the Recipient must have qualified staff to manage, analyze and report this data. The cost of attracting and maintaining qualified staff can be a barrier for providers and the Recipient.	Maintain and improve documents that specify data requirements and reporting. Continue ongoing TA offered to providers to assure that their data is collected and reported accurately. In response to cost, manage budgets as best possible. The Recipient is considering the use of graduate interns to assist with small projects. Look for means to share data among provider and programmatic staff.	1.Documentation of data requirements. 2. CAREWare database at Recipient site. 3. Custom designed reports. 4. Create memoranda of understanding for releases of information and data sharing.	Maintain current activities and continue to build data quality and enhanced reporting mechanisms. Continued discussions with various parties to engage in data sharing.
Varied HIV Continuum of Care definitions used in Tennessee and across other Ryan White programs can be confusing, particularly for planning bodies, and creates challenges in comparing benchmarks.	In Tennessee, we are addressing this through coordination between Part A and Part B. There is ongoing dialogue regarding presenting or introducing materials with consistent messaging related to the continuum of care.	1. Published reports or materials for the continuum.	Maintain current activities with ongoing focus to improve reporting.

EVALUATION AND TECHNICAL SUPPORT CAPACITY

A. Clinical Quality Management (CQM) Program

A.1. – Changes to CQM program

The needs assessment including service utilization data and client surveys are analyzed to assess disparities in care (e.g., race/ethnicity, age, gender, geographic and income). As such, disparities that follow national trends have been observed: higher rates of new HIV diagnoses and lower viral suppression in non-Hispanic blacks compared to non-Hispanic whites, high prevalence among cisgender males, and individuals between the ages of 25-34 years of age. Results of these analyses are provided to the CQM Committee and the Planning Council to assist in the PSRA process, development of directives, and modifications to Standards of Care. A data-driven approach is necessary to implement needed changes or interventions in the TGA to increase patient care, satisfaction, and health outcomes. The CQM Monitor and the epidemiologist review the performance measure data on a quarterly basis to discuss the performances of the funded agencies. The CQM personnel monitors the funded agencies through various methods: questionnaires, desktop audits, and attending the CQM Committee meetings at the agencies.

A few key interventions conducted by the CQM Committee and the Ryan White Part A Program on the results of data are as follows:

- Continued development of outreach/testing services for Hispanic individuals through a collaborative approach between an ASO and a local Hispanic Foundation and by using Social Media Campaigns.
- Continued development of outreach services such as targeted testing and counseling for the young LGBTQI community of color through a collaborative effort with internal STI Outreach Coordinator, subrecipients and other community agencies that focuses on youth issues and problems
- Targeted outreach for young, black MSM with a peer-based approach
- EIS services targeted to the newly HIV diagnosed and lost to care clients within communities of color, people in the local jails and the campuses of colleges and universities.

The data from the HIV Continuum of Care became a focus for analysis. Analysis at this level provided greater opportunity to develop actions that are focused on the minority targeted population and the sub-population in this TGA. In the past year, we continued to look at the distribution of HIV disease disparities along the continuum using items from a social determinant of health-based framework (e.g., income, housing status). As such, we created a series of reports in CAREWare that assessed four of the five core HAB performance measures (viral suppression, medical visit frequency, prescription of antiretroviral drugs and gaps in medical visits) with an eye toward those social determinants of health factors. A few key examples of actions taken are:

- Added case management positions focused specifically on housing
- Initiated a TGA-wide QI Project targeting viral suppression/retention in care via our clinical quality management group. Open and ongoing communication with follow-up mechanism with Sub-Recipients related to the QI projects.
- Added more community health workers to reach the high-risk targeted population in Nashville Davidson County and the 13 surrounding counties.
- Pathways is a program that has been developed at the clinic level to increase linkage to care to the hard-to-reach clients who are newly diagnosed or lost to care, and whom have other health related issues (e.g., diabetes, heart disease, smoking issues)

The result of these changes and future actions will help to reduce the disparities in our TGA. Future changes will incorporate a more targeted focus on the surrounding areas of the TGA especially in Rutherford County where the HIV diagnoses has increased. Efforts will be made to target this area with utilizing increased testing, counseling, and outreach; RWPA recognizes this as focus of need. Recently the Nashville TGA begun the work of providing Rapid Initiation or ART in one of the clinics serving a primarily urban population. Although data is unavailable at this time, we expect this service to reduce some of the previously seen health disparities, specifically relating to early identification, and linkage to care. We are focused on increasing patient satisfaction, patient health outcomes, and patient care in our TGA.

A.2. Use of CQM Data to Improve Patient Care and Satisfaction, Health Outcomes, or Change Service Delivery and Long-Term Planning

The CQM Committee, CQM Monitor, and the Ryan White Part A Program, examines client level service, and agency level data by meeting with the epidemiologist quarterly to discuss the performances of the funded agencies. Committee meetings also analyze data and performance measures to assess service utilization patterns and measure outcomes (medical visits, viral load, etc.). Data is reported on a TGA-wide basis, through the CQM committee meetings and the Planning Council. The focus is to identify any areas of service gaps and needed interventions to provide quality care to clients. When areas of improvements or concerns are identified either by the Recipient or the Council, actions are taken to address problems or issues.

Medical Case Management data was reviewed to modify services to assure effective service delivery. Specialized case management such as mental health, and housing was added to address needed issues of clients. The Standards of Care for EIS, Case Management, and EFA was revised to assists with the delivery of service to the targeted communities during the COVID-19 Pandemic.

The CQM Committee has recognized the need for collaboration, coordination, and communication among the AIDS Service Organizations (ASO's) and Community Based Organization (CBO's), therefore established an ongoing work plan to increase these efforts. In 2019 the CQM Monitor created a CQM ListSERV, that consists of four other TGAs/EMA's where information regarding best practices and other CQM procedures are shared among partners. The Clinical Quality Monitor is a member HRSA's CQM ListSERV Group.

According to the 2019 Needs Assessment, transportation services increased by 31 percent. The CQM Committee and the Recipient created a plan to incorporate ride share transportation to assist with the increased need in Nashville Davidson County and adjoining counties within the TGA. In October of 2020 the RWPA rolled out the Rideshare This has help clients with self-efficacy and improved health outcomes by clients being able to keep their medical appointments and to obtain their HIV medications and increased adherence. Overall, the Rideshare Program has increased retention to care and viral suppression rates among the targeted population. There have also been efforts to coordinate with our sate Part B CQM program with a goal to create uniformed Standards of Care Policies more to eliminate barriers and confusion, ensuring the sub-recipient are able to accomplish program goals and achieve definitive performance measure. The CQM Committee has worked to educate the committee members who are also stakeholders, clients, and sub-recipients, regarding various public health issues relative to the Nashville TGA. Part A and Part B are focusing efforts on exploring services to address the syndemic (Opioids, HIV and HCV) issues in the Nashville/Davidson and surrounding counties within the TGA, plan is to link these efforts into the EHE plans within the state of TN.

ORGANIZATIONAL INFORMATION

A. Grant Administration

A.1. Program Organization

A.1.a. How Part A Funds are Administered

***Staff Position and Roles**:* The Ryan White Program moved under the Associate Medical Director, who leads the Communicable Disease Control Division, responsible for supervising all the members of the team. The team consists of the full-time Ryan White Program Director (Beverly Glaze-Johnson, MSP) Ms. Glaze Johnson supervises a full time CQM/Monitor (Regina Bell, MPH),

a full time Provider Monitor (currently vacant to be hired), a full time Planning Council Community Liaison (Quinntana Slaughter), and a full-time Epidemiologist/Data Analyst (Anthony Bennici). Two other Ryan White positions are in MPHD Finance (below).

Fiscal Administration (RFP development, contracting, provider payment, budgeting, provider invoice payment, fiscal reporting, and monitoring) is the responsibility of the MPHD Division of Finance and Administration (F&A), including a 0.95 FTE Fiscal Officer (Sharon Daniel) and 0.05 FTE Fiscal Officer (Emily Bradberry). F&A also provides ongoing support for human resources, IT, payroll, purchasing approval/review, contracts, internal auditing, and facilities maintenance and operations as determined by F&A.

Organizational Chart: **The Organizational Chart is included in ATTACHMENT 11.**

Agency Responsible for Grant Administration: The Chief Elected Official (CEO) of the Metropolitan Government of Nashville/Davidson County has designated responsibility of the federal Ryan White Part A to the Metro Public Health Department (MPHD), operating by and through the Board of Health (***See*** **ATTACHMENT 10**). This designation authorizes the Director of MPHD to sign all grant applications, forms, and assurances for Ryan White Transitional Grant Area or (RWMTGA) for 2007 and subsequent years. Approval for the receipt and acceptance of funds is through the Metropolitan Council via resolution.

Intergovernmental agreements are not required for the TGA at this time since the next largest geopolitical jurisdiction outside of Nashville has not yet met the required threshold. However, MPHD, with the support of the Mayor's Office, plans to initiate activities with other county government leadership to increase collaboration.

Staffing Plan, Job Description, and Biographical Sketches*:* These three documents are included in **ATTACHMENT 1**.

A.1.b. Fiscal Agent Description

The Recipient does not use a contractor or fiscal agent to administer the Part A program.

A.2. Grant Recipient Accountability

The Recipient (MPHD) is responsible for ensuring coordinated, timely and cost-effective administration of subcontracts to direct service providers providing Part A services. MPHD staff performs annual fiscal and program monitoring for each Sub-Recipient to ensure the efficient and effective use of Part A funds within the TGA. MPHD verifies compliance with contract terms and conditions, as well as ensure adherence to all Federal, State, and local rules. On an ongoing basis MPHD staff review all reports submitted by Sub-Recipients. Corrective action follow-up and/or special visits are conducted as needed. The Recipient maintains all files, mostly in an electronic format, in accordance with federal requirements.

It is important to note that Recipient program and fiscal staff work together in setting up the system to assure accountability. Monitoring materials are developed together, site visits are often conducted at the same time and communication between the two groups occurs on an ongoing basis. The RWPA Fiscal Officer is frequently a part of program meetings, this helps to

ensure seamless communication between both sides, and provides a greater understanding of the collective work. Additionally, this method has improved the program and increased opportunities to strategize related to programmatic and fiscal needs but to also celebrate and acknowledge strengths.

A.2.a. Monitoring

A.2.a.i. Three Most Common Program and Fiscal Monitoring Findings for 2019 and Process and Timeline for Corrective Action

The three most common monitoring findings are: 1) Weaknesses in fully documenting initial and ongoing client assessments and plans of care (e.g., may be late, need to consistently document goal achievement); 2) Assuring complete accuracy in documenting service utilization in electronic systems (e.g., need to enter all service units, use of correct sub-service terms); and 3) Fully tracking program income and client charges.

The Recipient sends a written report to the Sub-Recipient noting Findings. The Sub-Recipient has thirty days to submit a corrective action plan to the Recipient. The action plan contains specific tasks and due dates and must be approved by the Recipient. Recipient staff maintains ongoing contact with the provider until the corrective action plan is completed to include making a follow-up site visit ensuring the details described in the corrective action plan has or will be carried out as described in the written action plan.

A.2.a. ii. Process for Monitoring Sub-Recipient Compliance with Single Audit Requirement

The RFP contains specific language requiring submission of the previous year's audit ten calendar days after the award letter. The provider contract also contains specific language requiring compliance with the single audit. The audits are submitted with the RFP and submitted prior to the start of each grant year to the Fiscal Officer, or after the provider's audit are completed during the year. The Fiscal Officer reviews audits with a solvency test tool, which is used to determine the financial stability and review liabilities of the organization. The test also states if the recipient received a clean audit report and ensuring all financial statements are correct, to avoid feature errors or other financial inaccuracies including significant material weaknesses or a pattern of unresolved issues. Audits are kept on file and maintained for three years. For providers that are not required to complete the single audit, the Fiscal Officer completes an audit worksheet to test key aspects of financial management systems. In addition to the audit tool, the fiscal monitoring tool contains requirements specified in HRSA's National Monitoring Standards; these items are reviewed as part of the annual fiscal monitoring.

A.2.a.iii. Single Audit Findings and Corrective Action

Single Audit

Seven providers were funded in the grant year 2018-19 and all were compliant with Subpart F of the Uniform Guidance. Therefore, no corrective action was required. It should be noted that four of the providers during the program audit were informed during the process as having a concentration of credit and income risk, as they heavily rely on either single or few grant sources of funding, such as Ryan White. Therefore, encouraged to consider diversified funding sources.

Program-Specific Audits

The Recipient's monitoring process includes careful review of all finance during the monitoring/site visit process the Recipient follows HRSA's legislative required standards related to audit findings. Our policies are to aggressively assure findings are corrected. Each provider receives a monitoring report in writing within 30 calendar days of the visit which includes the finding (s). Providers are then given 30 calendar days to submit a corrective action plan which includes specific activities, due dates, and responsible parties. The Recipient staff must approve the corrective action plan and then follow-up with the plan to assure that the finding and measures to fully address are in place. At the time of the monitoring visit, but also throughout the grant year, the Sub-Recipients are offered training and technical assistance from the Recipient staff. Sub-Recipients are also referred to other training resources, many which are free (use resources included in the Target Center listing).

During the 2019 program year monitoring visits, one of the Sub –Recipients was cited for one finding, related to missing required documentation in the client's chart. The process as outlined above was utilized to fully address the issue and continued oversite was determined as an effective tool aligning with "Best Practices". However, during FY 20-21, given the global pandemic and other local/TGA factors, a major tornado and severe flooding, no in person monitoring has occurred, the Recipient is exploring a tool to use for Desk-top monitoring, one that will ensure the same integrity, best practices and in accordance with HRSA legislation requirements is utilized. Additionally, HRSA approved waivers were extended, limiting in-person on site visit.

A.2.b. Third Party Reimbursement

The Part A Recipient has specific processes in place to assure third party reimbursement including contract language that specifies requirements, annual review of Medicaid status and coordination with Ryan White Part B Recipient regarding eligibility verification at entry of service and every six months.

A.2.b.i Process to Ensure that Sub-Recipients are Pursuing Third Party Reimbursements, Including Contract Language and/or the Mechanism Used

The primary mechanisms to ensure that Sub-Recipients are pursuing third party reimbursements are contractual requirements, and education/technical assistance. Sub-Recipient monitoring and assurance that Medical Case Managers are enrolling clients in insurance programs (Medicaid, Medicare, ACA).

All Ryan White Part A Sub-Recipients providing Medicaid eligible services are required by contract to be Medicaid/TennCare certified; working towards certification or provide documentation that shows they were declined participation. This documentation is examined annually by the Recipient to ensure the provider is pursuing certification. All Sub-Recipient contracts include language that requires the provider to implement practices and procedures that identify Ryan White as the payer of last resort and ensure that alternate sources of payment are pursued. Contract language is phrased as follows:

Requirement of status as Medicaid Provider. GRANTEES that provide services that are reimbursable through Medicaid (TennCare) are required to become a Medicaid provider. Providers that are not currently authorized as a Medicaid provider must provide documentation and demonstrate progress toward becoming a provider.

In accordance with the Ryan White HIV/AIDS Program client eligibility determination and recertification requirements (Policy 13-02), HRSA expects clients' eligibility be assessed during the initial eligibility determination, at least every six months, and at least once a year (whether defined as a 12-month period or calendar year) to ensure that the program only serves eligible clients, and that the Ryan White HIV/AIDS Program is the payer of last resort. CONTRACTORs are not allowed to provide Ryan White services under presumptive eligibility; eligibility must be confirmed prior to enrollment/recertification.

Contractor are required to expend Ryan White funds as payer of last resort.

For Subrecipients providing services that are reimbursable by insurance, Part A Recipient staff will discuss the status of the contract with the insurance companies when there are problems, if needed, and provide resources/technical assistance to support their efforts to gain insurance reimbursement. All Part A medical providers have contracts with various insurance providers and the one CBO providing mental health services but also has contracts with insurance companies; these entities have relationships with insurance companies outside of the Ryan White program which makes securing a contract easier. One ASO provides behavioral health services and has made efforts to secure insurance reimbursement, but at this time has not been able to secure a contract.

The Recipient completes annual monitoring of Sub-Recipients to assure that the provider has policies and procedures regarding these requirements and are complying with these requirements. Lastly, Sub-Recipients report payments received by third party sources.

Medical Case Managers (MCMs) ensure that PLWH are assessed and monitored for access to and utilization of all available third party payer coverage. They screen and manage eligibility for Ryan White funded programming and are skilled in the provisions of ACA, COBRA, State Insurance Regulations, and Standards of the Health Insurance Industry to ensure all possible routes of coverage are fully explored. MCMs document a patient's eligibility standing, third party payers and other provisions of health care, including VA eligibility. They also perform a bi-annual recertification process to update documentation and monitor PLWH ongoing eligibility for Ryan White funded services, as well as options for third party coverage. A centralized web-based data system for Ryan White eligibility is maintained by Part B and accessible to the Part A Recipient that documents this review.

A.2.b. ii. Screening/Eligibility to Assure Ryan White is the Payor of Last Resort

The Recipient adopted the State of Tennessee, Department of Health's (TDH) Ryan White Part B Eligibility policy for direct assistance programming (i.e., Ryan White Medical Services Program, HIV Drug Assistance Program, Dental Assistance Program, and Insurance Assistance Program). Eligibility is based on confirmed HIV positive status, residency within the TGA region, Ryan White funds being used as payer of last resort, income limits at or below Part A/B designated Federal Poverty Level (FPL), and a personal resource limit of $8,000 or less. Part B's FPL is 400% because of significant resources gained through pharmacy rebates. Part A's FPL has changed to match Part B at 400%.

Medical Case Managers are responsible for maintaining documentation of these eligibility criteria in their patient files for each eligible patient as well as on the Ryan White Eligibility System (RWES). RWES is a web-based system for agencies across the state to check on eligibility status of any client. On an ongoing basis, TDH monitors providers by reviewing 100% of enrolled clients to assure compliance with these requirements. The Recipient has an agreement with TDH to receive results of this monitoring each year. Part A also reviews the cases to ensure 400% of FPL to assure that services can be provided.

Affordable Care Act (ACA)
Screening and enrollment for the ACA is integrated into the existing Medical Case Manager processes. The Part A program is following the ACA enrollment system set up by the Part B Recipient. Medical Case Managers are required to assist clients enroll in ACA. Part B provides ongoing technical assistance to MCMs to support their efforts. In addition, TDH as part of their ADAP program and in collaboration with the Part A programs monitors the ACA enrollment status of Ryan White clients. If ACA eligible persons are not enrolled, the issue is addressed by TDH. The Part A Recipient has also established active relationships with the federally funded Patient Navigators/CACs to assure access to enrollment services and support from these entities.

A.2.b.iii. Program Income Monitoring, Tracking Use at Recipient and Sub-Recipient Level
The Part A contract contains language for program income requirements. In addition, the Recipient and Sub-Recipients have policy and procedures for billing, tracking, and reporting of program income. Sub-Recipients are required to submit budgets at the start of the grant year estimating program income for the grant year, must report income on a biannual basis and must submit an annual report documenting use of program income. At the Sub-Recipient level, program income is also monitored at the time of annual site visit to assure that income is reported and is used in compliance with requirements contained in the Fiscal National Monitoring Standards. The Recipient does not provide service and, therefore, does not collect program income.

A.2.c. Fiscal Oversight
At the Recipient site, fiscal and program staff are in different bureaus but are in the same building. This proximity allows regular and ongoing communication; meetings are held as needed to ensure coordination of oversight, joint phone calls to Sub-Recipients occur as needed, etc.

A.2.c.i. Process Used by Program and Fiscal Staff to Coordinate Activities, Ensuring Adequate Reporting, Reconciliation & Tracking of Expenditures
Fiscal
Each provider has a line item budget, including a line for program income, by service area that has been reviewed and approved by Recipient program and fiscal staff. Providers are required to submit monthly invoices. Each month the Fiscal Officer reviews the invoice and supporting documentation, and if necessary, resolves any discrepancies that are discovered. This review also assures that expenditures are reasonable, allowable, and allocable with federal fiscal regulations. Program staff conducts a parallel process but with a program lens (e.g., staff charged are as expected, types of supplies purchased support the program). It is not uncommon for fiscal and program staff to make a joint call to providers to resolve issues.

The approved expenditures are then entered into a spreadsheet which tracks year-to-date expenditures and unobligated balances. This format allows for early identification of any over- or under-spending. A formal meeting is held on a quarterly basis to review under spent funds and funds are re-allocated by the Planning Council if needed.

Program income is reported quarterly by Sub-Recipients and reviewed by MPHD fiscal staff. The Recipient's expenditures undergo a similar review conducted by MPHD fiscal staff.

A.2.c. ii. Tracking of Formula, Supplemental, MAI and Carry Over/Data System Used

To track each specific funding stream, MPHD fiscal staff have implemented an electronic fiscal tracking system at the Recipient level using an excel spreadsheet that separates Part A and MAI, formula dollars from supplemental dollars. Specifically, separate accounts have been established in which we delineate which funds are being spent and these are monitored by the MPHD fiscal staff monthly. Unobligated funds are first tracked by the Fiscal Officer by reviewing contracts to ensure that all funds have been allocated. Then the Fiscal Officer and Quality Management Specialist - Compliance review invoices monthly to track any unspent funds. Providers have also been requested to review their line item expenditures monthly. Unspent funds are identified in each area – administration, quality management and services – and tracked accordingly. Carry over is tracked by the Fiscal Officer. Specifically, we delineate by service and when carry over funds are being spent and this is monitored by the MPHD fiscal staff.

A.2.c.iii. Processing for Reimbursing Sub-Recipients (from invoice to payment)

Provider invoices are due to the Fiscal Officer no later than the 10th business day of each month for services rendered during the previous month. A later submission date may be approved by the Recipient for a particular provider, such as at the end of the grant year, or during the last month of the provider's fiscal year. The invoices must be submitted electronically to the Fiscal Officer. The invoices are reviewed by the Fiscal Officer for accuracy, allocation, allowability, in accordance with the approved budget. Program staff also review program aspects of the invoice and notifies the Fiscal Officer of any problems. If the invoice is accurate and contains all required supporting documentation, the Fiscal Officer sends the invoice to accounts payable for payment and tracks milestones in the payment process, to ensure prompt payment. Payment is issued via direct deposit within 30 days of submission to the Recipient. If an invoice is incomplete, the Fiscal Officer requests the provider to correct any errors after which the complete invoice is then processed for payment. A copy of every invoice document received and processed are stored electronically in the fiscal contract folder for the respective grant year.

In addition to the invoice review, the Fiscal Officer also tracks payment milestones to ensure prompt payment to providers, milestones include invoice date, programmatic approval of expenses, date sent for payment, and the date each payment was made to the provider.

B. MAINTENANCE OF EFFORT (MOE)

B.1. MOE Table

Documentation that identifies the MOE budget elements and expenditures for the fiscal year prior to the application (Actual) and the current fiscal year (Estimated) are included in **ATTACHMENT 12.**

B.2. Process and Elements Used to Determine MOE Expenditures

The Recipient accessed information from two political subdivisions to track local funds that are potential sources of MOE; 1) the Metro Public Health Department (local health department for Davidson County) and 2) TDH-HIV/STD Section which is responsible administrative entity for the twelve local health departments that comprise the rest of the TGA. Only those sources that met the following criteria were included: a) met definition of core and support services; b) funds were re-occurring and c) a line-item could be identified in the local budget.

Current FY 2018-2019

The Recipient's MOE is based on the percentage of locally funded staff time that is dedicated to HIV testing. MPHD has a walk-in HIV/STD clinic where all people in Davidson County can receive HIV/STD testing, counseling, and diagnosis. The clinic provides treatment for selected STDs but does not perform HIV care or treatment. The health department funds a full-time Medical Assistant who performs HIV testing for 50% of her day.

CERTIFICATION REGARDING LOBBYING

Certification for Contracts, Grants, Loans, and Cooperative Agreements

The undersigned certifies, to the best of his or her knowledge and belief, that:

(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of an agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

(2) If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, ''Disclosure of Lobbying Activities,'' in accordance with its instructions.

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) and that all subrecipients shall certify and disclose accordingly. This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by section 1352, title 31, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

Statement for Loan Guarantees and Loan Insurance

The undersigned states, to the best of his or her knowledge and belief, that:

If any funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this commitment providing for the United States to insure or guarantee a loan, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. Submission of this statement is a prerequisite for making or entering into this transaction imposed by section 1352, title 31, U.S. Code. Any person who fails to file the required statement shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

* APPLICANT'S ORGANIZATION	Metropolitan Government of Nashville and Davidson County
* PRINTED NAME AND TITLE OF AUTHORIZED REPRESENTATIVE	
Prefix:	Dr.
* First Name:	Gill
Middle Name:	
* Last Name:	Wright
Suffix:	
* Title:	Director of Health
* SIGNATURE:	Completed on submission to Grants.gov
* DATE:	Completed on submission to Grants.gov

Budget Narrative File(s)

*** Mandatory Budget Narrative Filename:** FY22_NOFO_2021 Budget and Narrative.pdf

Add Mandatory Budget Narrative | Delete Mandatory Budget Narrative | View Mandatory Budget Narrative

To add more Budget Narrative attachments, please use the attachment buttons below.

Add Optional Budget Narrative | Delete Optional Budget Narrative | View Optional Budget Narrative

RWHAP PART A BUDGET SUMMARY

APPLICANT: Metropolitan Public Health Department of Nashville/Davidson County

FISCAL YEAR: March 1, 2022 through February 28, 2023

	Part A			Minority AIDS Initiative (MAI)			Total
Object Class Categories	**Administration**	**CQM**	**HIV Services**	**Administration**	**CQM**	**HIV Services**	
a. Personnel	$ 232,283	$ 121,870	$ -	$ 16,519	$ 9,394	$ -	**$ 380,065**
b. Fringe Benefits	$ 102,230	$ 47,297	$ -	$ 7,472	$ 3,268	$ -	**$ 160,267**
c. Travel	$ 18,175	$ 2,175	$ -	$ 200	$ -	$ -	**$ 20,550**
d. Equipment	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
e. Supplies	$ 7,500	$ -	$ -	$ 250	$ -	$ -	**$ 7,750**
f. Contractual	$ 17,200	$ -	$ 3,958,508	$ -	$ -	$ 273,671	**$ 4,249,380**
g. Other	$ 3,548	$ -	$ -	$ -	$ -	$ -	**$ 3,548**
Direct Charges	**$ 380,936**	**$ 171,342**	**$ 3,958,508**	**$ 24,441**	**$ 12,661**	**$ 273,671**	**$ 4,821,559**
Indirect Charges	**$ 82,662**	**$ 42,527**		**$ 6,066**	**$ 3,143**		**$ 134,398**
TOTALS	**$ 463,598**	**$ 213,868**	**$ 3,958,508**	**$ 30,507**	**$ 15,804**	**$ 273,671**	**$ 4,955,957**
Program Income							**$ -**

FY2022 Funding Ceiling:	
Part A Funding	$ 4,635,975
MAI Funding	$ 319,982
Total:	**$4,955,957**

Indirect Adjustments

93.54% **Administrative Budget 10%**
6.46% **Part A and MAI** Within Limit

CQM Budget 5%
Part A and MAI Within Limit

PART A ADMINISTRATIVE BUDGET

APPLICANT: Metropolitan Public Health Department of Nashville/Davidson County

FISCAL YEAR: March1, 2022 through February 28, 2023

Personnel

Salary *[Insert total annual salary]*	FTE *[Insert as decimal]*	Name, Position *[Insert name, position title]*	Budget Impact Justification *[Description of duties, impact on program goals and outcomes, payment source for balance of FTE.]*	Amount
$ 72,953	0.65	Beverly Glaze-Johnson, Program Manager	Leader of Ryan White program responsible for management and oversight of Ryan White funded HIV care and support service coordination. Also serves as liaison between community-based medical and support service organizations, Federal funders and community advisory board. Provide information, technical assistance and guidance to internal stakeholders across all service lines regarding policies and procedures, workflows, standards of care, program and contractual requirements, guidelines, and regulatory updates to existing programs. Develop and implement policies and procedures as well as recruit, train and hire new staff. Serve as lead and/or support on external audits. Ensure required monthly, quarterly and or annual program reports submission on time.	$ 47,419
$ 60,870	0.65	Public Health Administrator 1(vacant)	Serve as topical expert in the assigned work areas; including identifying current information, best practices, tools, and resources. Develop, update revise and implement a provider monitoring program, which meets HRSA RyanWhite and MPHD guidelines. Set up Implementation plans (annual, quarterly and monthly) requirements and collect the provider plans for all services funded. Maintain, revise, and update monitoring procedures to ensure services provided meet treatmetn guidelines and standards of care. Collect and analyze monitoring data for assigend services and providers to track compliance, improvements and trends. Maintain and update Provider operational manuals, TGA Service Flyers, and any technical assistance tool or resources for programmatic or provider needs. Support project planning process, grantand RFP processes by supplying data and reports to the appropriate party.	$ 39,566
$ 75,871	0.30	Anthony Bennici, Epidemiologist	Responsible for ongoing collection of all grant-related data, data analysis, and reporting of data to ensure compliance with federal requirements. Serve as the point of contact for all data sources and supports Needs Assessment Committee. Reports on HAB, NHAS, and Continuum of Care performance measures.	$ 22,761
$ 63,305	0.05	Regina Bell, Public Health Administrator 1	Maintains, the Standards of Care in accordance with HRSA standards. Assists in quarterly provider spending review.	$ 3,165
$ 64,571	0.00	Quinntana Slaughter, Public Health Administrator 1		$ -
$ 57,372	0.85	Sharon Daniel, Finance Officer 2	Updates and maintains subrecipient expenditure data. Reviews all subrecipient monthly invoices for compliance, allocability, and specified backup documentation. Coordinates with program staff for approval of invoice content, and vouchers subrecipient invoices for payment. Reviews annual provider budgets and amendments, for reasonability, allowability, and proper calculations. Notifies subrecipients of approved budget changes. Prepares quarterly spending reviews and implements subsequent reallocations, as needed. Conducts Annual provider site visit and desk audit. Collects documents and prepares report of concerns and/or findings. Completes expense reporting, Electronic Handbook (EHB) submissions, and Federal Financial Reports (FFRs). Coordinates the development of subrecipient contracts and the annual review of those contracts. Remaining FTE funded by a local MPHD fund.	$ 48,766
$ 63,305	0.05	Emily Bradberry, Finance Officer 3	Supervises the Finance Officer II position. Completes Federal Financial Reports (FFRs). Remaining FTE funded by a local MPHD fund.	$ 3,165
	2.55			
			Personnel Total	**$ 164,843**

Fringe Benefits

Percentage *[Insert as %]*	Components *[List components that comprise the fringe benefit rate.]*	Amount
6.20%	OASDI	$ 10,220
1.45%	SS Med	$ 2,390
	Group Health $13,100 * 2.95 FTE	$ 38,645
	Dental $600 * 2.95 FTE	$ 1,770
	Life $200 * 2.95 FTE	$ 590
12.88%	Pension	$ 21,233
	Fringe Benefit Total	**$ 74,849**

Travel

Local

Mileage Rate	Number of Miles	Name, Position of Traveler(s)	Travel Expenses/Budget Impact Justification *[Lodging, parking, per diem, etc., and the impact of the travel on program objectives/goals.] Show breakdown of costs.*	Amount
0.56	224	Beverly-Glaze Johnson, Program Manager	Mileage reimbursement for TA, Site Visits, Provider monitoring, etc.	$ 125
0.56	223	Vacant, Public Health Administrator	Mileage reimbursement for TA, Site Visits, Provider monitoring, etc.	$ 125
0.56	223	Sharon Daniel, Finance Officer	Mileage reimbursement for TA, Site Visits, Provider monitoring, etc.	$ 125
			Local Travel Sub-Total	**$ 375**

Long Distance

Type of Travel	Name, Position of Traveler(s)	Travel Expenses/Budget Impact Justification *[Lodging, parking, per diem, etc., and the impact of the travel on program objectives/goals.] Show breakdown of costs.*	Amount
Out of State	Staff	Conferences and training, as it becomes available during the pandemic	$ 8,550
In State	Staff	Conferences and training as it becomes available during the pandemic	$ 600
		Long Distance Travel Sub-Total	**$ 9,150**
		Travel Total	**$ 9,525**

Equipment

[Equipment is defined as a unit cost of $5,000 or more and a useful life of 1 or more years. (If your agency uses a different definition, please defer to your agency's definition.)]

List of Equipment	Budget Impact Justification *[Description of need to carry out the program's objectives/goals.] Show breakdown of costs.*	Amount

PART A ADMINISTRATIVE BUDGET APPLICANT: Metropolitan Public Health Department of Nashville/Davidson County FISCAL YEAR: March1, 2022 through February 28, 2023		
Equipment Total		**$ -**

Supplies

*[Supplies is defined as property with a unit cost under $5,000. **Note:** Items such as laptops, tablets, and desktop computers are classified as a supply if the value is under the $5,000 threshold.]*

List of Supplies	Budget Impact Justification *[Description of need to carry out the program's objectives/goals.]*	Amount
Office Supplies	Pens, paper, binders, janitorial/hygiene, and other consummable office supplies	$ 1,800
	Supplies Total	**$ 1,800**

Contractual

List of Contract	Deliverables	Budget Impact Justification *[Description of how the contract impacts the program's objectives/goals and how the costs were estimated.] Show breakdown of costs.*	Amount
CAREWARE TA - Tech-Logix/Phil Byrne	Hours of on-site/remote TA, billed at $130/hour	This will allow us to continue technical assistance follow-up with Tech-Logix, both on-site and remotely, for the CAREWare software suite, which is necessary for the Needs Assessment and Annual Data Summit.	$ 3,900
Annual Provider Meeting - February	Annual meeting. Components include supplies, food, facilitation fee, and meeting space rental	This annual meeting for Part A providers in the Nashville TGA is key to reviewing the year ending, as well as outlining goals and objectives for the upcoming grant year. This meeting will take place during a lunch hour, so meals will be provided at the GSA per diem rate.	$ 6,000
		Contracts Total	**$ 9,900**

Other

[List all costs that do not fit into any other category]

List of Other	Budget Impact Justification *[Impact on the program's objectives/goals.] Show breakdown of costs.*	Amount
Air Card	To enable off site PC internet access. $34/month x 12 months	$ 408
Survey Monkey	Annual license fee for survey software	$ 300
Tableau	Annual license fee for data visualization and publication software	$ 740
SAS Software	Annual license fee for data analytics and statistical modeling software	$ 1,000
	Other Costs Total	**$ 2,448**

Total Direct Cost
$ 263,365

Indirect Cost

Type of Indirect Cost *[Select from dropdown list]*	Rate *[Insert rate below]*	Insert Base	Total [Insert Indirect]
	25%		**$ 65,367**

Part A Administrative Total
$ 328,732

PART A PLANNING COUNCIL BUDGET

APPLICANT: Metropolitan Public Health Department of Nashville/Davidson County

FISCAL YEAR: March 1, 2022 through February 28, 2023

Personnel

Salary *[Insert total annual salary]*	FTE *[Insert as decimal]*	Name, Position *[Insert name, position title]*	Budget Impact Justification *[Description of duties, impact on program goals and outcomes, payment source for balance of FTE.]*	Amount
$ 72,953	0.00	Beverly Glaze-Johnson, Program Manager	Work closely with the Planning Council liaison and Council members in establishing priorities, negotiating and managing budgets, and provide staff expertise to support committee and general body members. Participate in community needs assessment to identify gaps in services and HIV resource allocation activities.	$ -
$ 60,870	0.00	Public Health Administrator 1(vacant)		$ -
$ 75,871	0.00	Anthony Bennici, Epidemiologist	Provide data-related support to foster data-driven decisions. Provide quarterly updates on performance measures / CQM plan. Serve as the point of contact for all data sources and supports Needs Assessment Committee.	$ -
$ 63,305	0.00	Regina Bell, Public Health Administrator 1		$ -
$ 64,571	1.00	Quinntana Slaughter, Public Health Administrator 1	Responsible for the support of the Planning Council and assisting the Planning Council with carrying out its legislative responsibilities in order to operate effectively and work in partnership with the Recipient. Provides support to the Planning Council committees and assists with overseeing training programs for members of the Planning Council. Encourage member involvement and retention and maintains a collaborative partnership with the recipient, community, and at times the Chief Elected Official.	$ 64,571
$ 57,372	0.05	Sharon Daniel, Finance Officer 2	Attend General Planning council meetings, Priority Setting & Resource Allocation Committee (PSRA) and Executive Committee Meetings, as needed. Prepares information regarding budget revisions for the PSRA Committee.	$ 2,869
$ 63,305	0.00	Emily Bradberry, Finance Officer 3		$ -
	1.05			$ -
			Personnel Total	**$ 67,440**

Fringe Benefits

Percentage *[Insert as %]*	Components *[List components that comprise the fringe benefit rate.]*	Amount
6.20%	OASDI	$ 4,181
1.45%	SS Med	$ 978
	Group Health $13,100 * 1 FTE	$ 13,100
	Dental $600 * 1 FTE	$ 600
	Life $200 * 1 FTE	$ 200
12.34%	Pension	$ 8,322
	Fringe Benefit Total	**$ 27,381**

Travel

Local

Mileage Rate	Number of Miles	Name, Position of Traveler(s)	Travel Expenses/Budget Impact Justification *[Lodging, parking, per diem, etc., and the impact of the travel on program objectives/goals.] Show breakdown of costs.*	Amount
			Local Travel Sub-Total	**$ -**

Long Distance

Type of Travel	Name, Position of Traveler(s)	Travel Expenses/Budget Impact Justification *[Lodging, parking, per diem, etc., and the impact of the travel on program objectives/goals.] Show breakdown of costs.*	Amount
Out of State	Planning Council Representatives and Chair	Travel to conferences and educational opportunities as permitted during the pandemic	$ 8,650
		Long Distance Travel Sub-Total	**$ 8,650**
		Travel Total	**$ 8,650**

Equipment

[Equipment is defined as a unit cost of $5,000 or more and a useful life of 1 or more years. (If your agency uses a different definition, please defer to your agency's definition.)] Show breakdown of costs.

List of Equipment	Budget Impact Justification *[Description of need to carry out the program's objectives/goals.]*	Amount
		$ -
	Equipment Total	**$ -**

Supplies

*[Supplies is defined as property with a unit cost under $5,000. **Note** : Items such as laptops, tablets, and desktop computers are classified as a supply if the value is under the $5,000 threshold.] Show breakdown of costs.*

List of Supplies	Budget Impact Justification *[Description of need to carry out the program's objectives/goals].*	Amount
Food/support for PC meeting	Food for the regular Planning Council meetings, as permitted during the pandemic	$ 3,600
Office for PC	Pens, paper, binders, janitorial/hygiene, and other consummable office supplies for use by the planning council and Liason	$ 600
Annual PC Meeting/Training	Food and facilitation support for the annual Planning Council meeting (February) if permitted, due to pandemic	$ 1,500
	Supplies Total	**$ 5,700**

Contractual

List of Contracts	Deliverables	Budget Impact Justification *[Description of how the contract impacts the program's objectives/goals and how the costs were estimated.] Show breakdown of costs.*	Amount
PC Website Maintenance service	Improvements made to the planning council website, specifically infrastucture and design. Billed at $125/hour x 16 hours	The Nashville Ryan White Planning Council's website needs ongoing maintenance to improve traffic, design, address current PC directives, and add any additional features.	$ 2,000
Annual PC Training	Facilitation of the Annual Planning Council meeting/training	A topical/current event training is put on by MPHD for the Planning Council annually. This is to cover the cost of bringing out a facilitation group for that meeting. Estimated total of $2,000, if permitted due to Covid	$ 2,000
Consumer Conference	Facilitation and support for the Annual Planning Council Consumer Conference	This item covers all aspects of the Consumer Conference. Includes space rental, facilitation (if needed), and meeting support such as food and consummable office supplies. Estimated total of $5,000, if permitted due to Covid	$ 3,300
		Contracts Total	**$ 7,300**

Other

[List all costs that do not fit into any other category.] Show breakdown of costs.

List of Other	Budget Impact Justification *[Impact on the program's objectives/goals.]*	Amount
Cell Phone for Liason	To enable the Liason to communicate with MPHD and the Planning Council while off	$ 600
PC website hosting	Annual hosting fee for the Planning Council's website	$ 500
	Other Costs Total	**$ 1,100**

Total Direct Cost

	$ 117,571

Indirect Cost

Type of Indirect Cost *[Select from dropdown list]*	Rate *(Insert rate below)*	Insert Base	Total [Insert Indirect]
	25%		**29,181**

Part A Planning Council Total

	$ 146,752

PART A CLINICAL QUALITY MANAGEMENT BUDGET

APPLICANT: Metropolitan Public Health Department of Nashville/Davidson County

FISCAL YEAR: March 1, 2022 through February 28, 2023

Personnel

Salary *[Insert total annual salary]*	FTE *[Insert as decimal]*	Name, Position *[Insert name, position title]*	Budget Impact Justification *[Description of duties, impact on program goals and outcomes, payment source for balance of FTE.]*	Amount
$ 72,953	0.30	Beverly Glaze-Johnson, Program Manager	Assists CQM Coordinator in developing and implementing policies and procedures to ensure PLWHA receive quality care in clinical settings. Assists CQM Coordinator in planning and developing Quality Management and Improvement Programs and evaluating their effectiveness. Develops collaborative relationships with administrative staff, stakeholders, and sub-recipients, to ensure ongoing effectiveness of service quality. Involved in data and performance measures analysis and facilitation of a Continuous Quality Improvement (CQI) plan.	$ 21,886
$ 60,870	0.26	Public Health Administrator 1(vacant)		$ 15,826
$ 75,871	0.40	Anthony Bennici, Epidemiologist	Charged with development of performance measures included in the Clinical Quality Management (CQM) plan. Responsible for collection, management, and analysis of data related to the CQM plan. Quarterly reporting of performance measure outcomes to appropriate bodies.	$ 30,348
$ 63,305	0.85	Regina Bell, Public Health Administrator 1	Develops and implements policies and procedures to ensure PLWHA receive quality care in clinical settings. Plans and develops Quality Management and Improvement Programs and evaluates their effectiveness. Develops collaborative relationships with administrative staff, stakeholders, and sub-recipients, to ensure ongoing effectiveness of service quality. Collects data and performance measures, analyzes it, and facilitates the development of a Continuous Quality Improvement (CQI) plan. Directs the development and implementation of the CQI plan, including criteria for evaluating programs and process outcomes. Plans the Quality Management Committee Team and coordinates activities to meet established goals and objectives. Uses monitoring data to provide technical assistance, resources, and tools to subrecipients.	$ 53,809
$ 64,571	0.00	Quinntana Slaughter, Public Health Administrator 1		$ -
$ 57,372	0.00	Sharon Daniel, Finance Officer 2		$ -
$ 63,305	0.00	Emily Bradberry, Finance Officer 3		$ -
	1.81			$ -
			Personnel Total	**$ 121,870**

Fringe Benefits

Percentage *[Insert as %]*	Components *[List components that comprise the fringe benefit rate.]*	Amount
6.20%	OASDI	$ 7,556
1.45%	SS Med	$ 1,767
	Group Health $13,100 * 1.65 FTE	$ 21,615
	Dental $600 * 1.65 FTE	$ 990
	Life $200 * 1.65 FTE	$ 330
12.34%	Pension	$ 15,039
	Fringe Benefit Total	**$ 47,297**

Travel

Local

Mileage Rate	Number of Miles	Name, Position of Traveler(s)	Travel Expenses/Budget Impact Justification *[Lodging, parking, per diem, etc., and the impact of the travel on program objectives/goals.] Show breakdown of costs.*	Amount
0.56	223	Regina Bell, Public Health Administrator 1	Mileage reimbursement for TA, Site Visits, Provider monitoring, etc.	$ 125
			Local Travel Sub-Total	**$ 125**

Long Distance

Type of Travel	Name, Position of Traveler(s)	Travel Expenses/Budget Impact Justification *[Lodging, parking, per diem, etc., and the impact of the travel on program objectives/goals.] Show breakdown of costs.*	Amount

Out of State	Regina Bell, Public Health Administrator 1	Travel expenses for conferences, educational opportunities, if permitted by pandemic	$ 1,850
In-State	Regina Bell, Public Health Administrator 1	Travel expenses for conferences, educational opportunities, if permitted by pandemic	$ 200
		Long Distance Travel Sub-Total	**$ 2,050**
		Travel Total	**$ 2,175**

Equipment

[Equipment is defined as a unit cost of $5,000 or more and a useful life of 1 or more years. (If your agency uses a different definition, please defer to your agency's definition.).] Show breakdown of costs.

List of Equipment	Budget Impact Justification *[Description of need to carry out the program's objectives/goals.]*	Amount
	Equipment Total	**$ -**

Supplies

*[Supplies is defined as property with a unit cost under $5,000. **Note**: Items such as laptops, tablets, and desktop computers are classified as a supply if the value is under the $5,000 threshold.] Show breakdown of costs.*

List of Supplies	Budget Impact Justification *[Description of need to carry out the program's objectives/goals.]*	Amount
	Supplies Total	**$ -**

Contractual

List of Contracts	Deliverables	Budget Impact Justification *[Description of how the contract impacts the program's objectives/goals and how the costs were estimated.] Show breakdown of costs.*	Amount
		Contracts Total	**$ -**

Other

[List all costs that do not fit into any other category]Show breakdown of costs.

List of Other	Budget Impact Justification *[Impact on the program's objectives/goals]*	Amount
	Other Costs Total	**$ -**

Total Direct Cost

	$ 171,342

Indirect Cost

Type of Indirect Cost *[Select from dropdown list]*	Rate *(Insert rate below)*	Insert Base	Total [Insert Indirect]
	25%		**$ 42,527**

Part A Clinical Quality Management Total

	$ 213,868

PART A HIV SERVICES BUDGET

APPLICANT: Metropolitan Public Health Department of Nashville/Davidson County

FISCAL YEAR: March 1, 2022 through February 28, 2023

Personnel

Salary *[Insert total annual salary]*	FTE *[Insert as decimal]*	Name, Position *[Insert name, position title]*	Budget Impact Justification *[Description of duties, impact on program goals and outcomes, payment source for balance of FTE]*	Amount
				$ -
				$ -
				$ -
				$ -
				$ -
			Personnel Total	$ -

Fringe Benefits

Percentage *[Insert as %]*	Components *[List components that comprise the fringe benefit rate]*	Amount
		$ -
		$ -
	Fringe Benefit Total	$ -

Travel

Local

Mileage Rate	Number of Miles	Name, Position of Traveler(s)	Travel Expenses/Budget Impact Justification *[Lodging, parking, per diem, etc., and the impact of the travel on program objectives/goals]Show breakdown of costs.*	Amount
			Local Travel Sub-Total	$ -

Long Distance

Type of Travel	Name, Position of Traveler(s)	Travel Expenses/Budget Impact Justification *[Lodging, parking, per diem, etc., and the impact of the travel on program objectives/goals]Show breakdown of costs.*	Amount
		Long Distance Travel Sub-Total	$ -
		Travel Total	$ -

Equipment

[Equipment is defined as a unit cost of $5,000 or more and a useful life of 1 or more years. (If your agency uses a different definition, please defer to your agency's definition.)]

List of Equipment	Budget Impact Justification *[Description of need to carry out the program's objectives/goals]Show breakdown of costs*	Amount
	Equipment Total	$ -

Supplies

[Supplies is defined as property with a unit cost under $5,000. ***Note:*** *Items such as laptops, tablets, and desktop computers are classified as a supply if the value is under the $5,000 threshold.]Show breakdown of costs.*

List of Supplies	Budget Impact Justification *[Description of need to carry out the program's objectives/goals]*	Amount
	Supplies Total	$ -

Contractual

List of Contracts	Deliverables	Budget Impact Justification *[Description of how the contract impacts the program's objectives/goals and how the costs were estimated]Show breakdown of costs.*	Amount
Nashville Cares	Early Intervention Services, Mental Health, Medical Case Management, Emergency Financial Assistance, Food, Housing, Tranpsortation, Psychosocial	Contract to provide core medical and support HIV services in the Nashville TGA, costs estimated competitive award budget submissions	$ 1,647,594
Streetworks	Medical Case Management, Emergency Financial Assistance, Food Services, Medical Transportation, Psychosocial Services	Contract to provide core medical and support HIV services in the Nashville TGA, costs estimated competitive award budget submissions	$ 303,527
Meharry Medical Center	Outpatient AmbulatoryMental Health Services, Medical Case Management, Food Services, Psychosocial Services	Contract to provide core medical and support HIV services in the Nashville TGA, costs estimated competitive award budget submissions	$ 498,068

Vanderbilt University Medical Center	Outpatient Ambulatory, Referral Services, Psychosocial Services	Contract to provide core medical and support HIV services in the Nashville TGA, costs estimated competitive award budget submissions	$ 808,448
Mental Health Cooperative	Mental Health Services	Contract to provide core medical and support HIV services in the Nashville TGA, costs estimated competitive award budget submissions	$ 115,000
UZURV	Medical Transportation	Contract to provide core medical and support HIV services in the Nashville TGA, costs estimated competitive award budget submissions	$ 30,000
MPHD/Sexual Health Center	Early Intervention Services, Linguistics	Contract to provide core medical and support HIV services in the Nashville TGA, costs estimated competitive award budget submissions	$ 113,526
To Be Contracted	Additional core medical and support services, pending allocation by the PSRA committee and approval for request for purchase	Funding to be allocated to existing core medical and support contracts after review by the PSRA committee and metro contract process	$ 442,346
		Contracts Total	**$ 3,958,508**

Other

[List all costs that do not fit into any other category]Show breakdown of costs.

List of Other	Budget Impact Justification *[Impact on the program's objectives/goals]*	Amount
	Other Costs Total	**$ -**

Total Direct Cost

	$ 3,958,508

Indirect Cost

Type of Indirect Cost [*Select from dropdown list]*	Rate *(Insert rate below)*	Insert Base	Total [Insert Indirect]

Part A HIV Services Total

	$ 3,958,508

MAI ADMINISTRATIVE BUDGET

APPLICANT: Metropolitan Public Health Department of Nashville/Davidson County

FISCAL YEAR: March 1, 2022 through February 28, 2023

Personnel

Salary *[Insert total annual salary]*	FTE *[Insert as decimal]*	Name, Position *[Insert name, position title]*	Budget Impact Justification *[Description of duties, impact on program goals and outcomes, payment source for balance of FTE]*	Amount
$ 72,953	0.05	Beverly Glaze-Johnson, Program Manager	Directs the development and implementation of the MAI plan, including criteria for evaluating programs and process outcomes. Plans and coordinates activities to meet established MAI goals and objectives. Uses monitoring data to provide technical assistance, resources, and tools to subrecipients. Maintains MAI Standards of Care in accordance with HRSA standards.	$ 3,648
$ 60,870	0.05	Public Health Administrator 1(vacant)	Directs the development and implementation of the MAI plan, including criteria for evaluating programs and process outcomes. Plans and coordinates activities to meet established MAI goals and objectives. Uses monitoring data to provide technical assistance, resources, and tools to subrecipients. Maintains MAI Standards of Care in accordance with HRSA standards.	$ 3,044
$ 75,871	0.05	Anthony Bennici, Epidemiologist	Among MAI client population: Responsible for ongoing collection of all grant-related data, data analysis, and reporting of data to ensure compliance with federal requirements regarding MAI. Among MAI client population: Reports on HAB, NHAS, and Continuum of Care performance measures among MAI population.	$ 3,794
$ 63,305	0.05	Regina Bell, Public Health Administrator 1	Maintains, the Standards of Care in accordance with HRSA standards. Assists in quarterly provider spending review.	$ 3,165
$ 64,571	0.00	Quinntana Slaughter, Public Health Administrator 1		$ -
$ 57,372	0.05	Sharon Daniel, Finance Officer 2		$ 2,869
$ 63,305	0.00	Emily Bradberry, Finance Officer 3		$ -
	0.25			$ -
			Personnel Total	**$ 16,519**

Fringe Benefits

Percentage *[Insert as %]*	Components *[List components that comprise the fringe benefit rate]*	Amount
6.20%	OASDI	$ 1,024
1.45%	SS Med	$ 240
	Group Health $13,100 * .30 FTE	$ 3,930
	Dental $600 * .30 FTE	$ 180
	60	$ 60
12.34%	Pension	$ 2,038
		$ -
		$ -
		$ -
		$ -
	Fringe Benefit Total	**$ 7,472**

Travel

Local

Mileage Rate	Number of Miles	Name, Position of Traveler(s)	Travel Expenses/Budget Impact Justification *[Lodging, parking, per diem, etc., and the impact of the travel on program objectives/goals]Show breakdown of costs.*	Amount
0.560	119	Beverly Glaze-Johnson, Program	Mileage reimbursement for TA, Site Visits, Provider monitoring, etc.	$ 67
0.560	119	Administrator 1(vacant)	Mileage reimbursement for TA, Site Visits, Provider monitoring, etc.	$ 67
0.560	119	Regina Bell, Public Health Administrator 1	Mileage reimbursement for TA, Site Visits, Provider monitoring, etc.	$ 66
			Local Travel Sub-Total	**$ 200**

Long Distance

Type of Travel	Name, Position of Traveler(s)	Travel Expenses/Budget Impact Justification *[Lodging, parking, per diem, etc., and the impact of the travel on program objectives/goals]Show breakdown of costs.*	Amount

		Long Distance Travel Sub-Total	$ -
		Travel Total	$ 200

Equipment

[Equipment is defined as a unit cost of $5,000 or more and a useful life of 1 or more years. (If your agency uses a different definition, please defer to your agency's definition.)]Show breakdown of costs.

List of Equipment	Budget Impact Justification *[Description of need to carry out the program's objectives/goals]*	Amount
	Equipment Total	$ -

Supplies

[Supplies is defined as property with a unit cost under $5,000. ***Note:*** *Items such as laptops, tablets, and desktop computers are classified as a supply if the value is under the $5,000 threshold.]Show breakdown of costs.*

List of Supplies	Budget Impact Justification *[Description of need to carry out the program's objectives/goals]*	Amount
Office Supplies	Pens, paper, binders, janitorial/hygiene, and other consummable office supplies	$ 250
	Supplies Total	$ 250

Contractual

List of Contracts	Deliverables	Budget Impact Justification *[Description of how the contract impacts the program's objectives/goals and how the costs were estimated]Show breakdown of costs.*	Amount
		Contracts Total	$ -

Other

[List all costs that do not fit into any other category]Show breakdown of costs.

List of Other	Budget Impact Justification *[Impact on the program's objectives/goals]*	Amount
	Other Costs Total	$ -

Total Direct Cost

	$ 24,441

Indirect Cost

Type of Indirect Cost [*Select from dropdown list]*	Rate *(Insert rate below)*	Insert Base	Total [Insert Indirect]
	25%		$ 6,066

MAI Administrative Total

	$ 30,507

MAI CLINICAL QUALITY MANAGEMENT BUDGET

APPLICANT: Metropolitan Public Health Department of Nashville/Davidson County

FISCAL YEAR: March 1, 2022 through February 28, 2023

Personnel

Salary *[Insert total annual salary]*	FTE *[Insert as decimal]*	Name, Position *[Insert name, position title]*	Budget Impact Justification *[Description of duties, impact on program goals and outcomes, payment source for balance of FTE]*	Amount
$ 72,953	0.00	Beverly Glaze-Johnson, Program Manager	Assists CQM Coordinator in planning and developing Quality Management and Improvement Programs and evaluating their effectiveness. Develops collaborative relationships with administrative staff, stakeholders, and sub-recipients, to ensure ongoing effectiveness of service quality. Involved in data and performance measures analysis and facilitation the development of a Continuous Quality Improvement (CQI) plan. Directs the development and implementation of the CQI MAI plan, including criteria for evaluating programs and process outcomes. Plans with the Quality Management Committee Team and coordinates activities to meet established MAI goals and objectives. Uses monitoring data to provide MAI technical assistance, resources, and tools to subrecipients. Maintains, the MAI relate Standards of Care in accordance with	$ -
$ 60,870	0.04	Public Health Administrator		$ 2,435
$ 75,871	0.05	Anthony Bennici, Epidemiologist	Among MAI client population: Charged with development of performance measures included in the Clinical Quality Management (CQM) plan regarding MAI. Among MAI client population: Responsible for collection, management, and analysis of data related to the CQM plan regarding MAI. Among MAI client population: Quarterly reporting of performance measure outcomes to appropriate bodies regarding MAI.	$ 3,794
$ 63,305	0.05	Regina Bell, Public Health Administrator 1	Develops and implements policies and procedures to ensure PLWHA receive quality care in clinical settings. Plans and develops Quality Management and Improvement Programs and evaluates their effectiveness. Develops collaborative relationships with administrative staff, stakeholders, and sub-recipients, to ensure ongoing effectiveness of service quality. Collects data and performance measures, analyzes it, and facilitates the development of a Continuous Quality Improvement (CQI) plan. Directs the development and implementation of the CQI plan, including criteria for evaluating programs and process outcomes. Plans the Quality Management Committee Team and coordinates activities to meet established goals and objectives. Uses monitoring data to provide technical assistance, resources, and tools to subrecipients. Maintains, the Standards of	$ 3,165
$ 64,571	0.00	Quinntana Slaughter, Public Health Administrator 1		$ -
$ 57,372	0.00	Sharon Daniel, Finance Officer 2		$ -
$ 63,305	0.00	Emily Bradberry, Finance Officer 3		$ -
	0.14			$ -
			Personnel Total	**$ 9,394**

Fringe Benefits

Percentage *[Insert as %]*	Components *[List components that comprise the fringe benefit rate]*	Amount
6.20%	OASDI	$ 582
1.45%	SS Med	$ 136
	Group Health $13,100 * .10 FTE	$ 1,310
	Dental $600 * .10 FTE	$ 60
	Life $200 * .10 FTE	$ 20
12.34%	Pension	$ 1,159
		$ -
	Fringe Benefit Total	**$ 3,268**

Travel

Local

Mileage Rate	Number of Miles	Name, Position of Traveler(s)	Travel Expenses/Budget Impact Justification *[Lodging, parking, per diem, etc., and the impact of the travel on program objectives/goals]Show breakdown of costs.*	Amount
			Local Travel Sub-Total	**$** -

Long Distance

Type of Travel	Name, Position of Traveler(s)	Travel Expenses/Budget Impact Justification *[Lodging, parking, per diem, etc., and the impact of the travel on program objectives/goals]Show breakdown of costs.*	Amount
		Long Distance Travel Sub-Total	$ -
		Travel Total	$ -

Equipment

[Equipment is defined as a unit cost of $5,000 or more and a useful life of 1 or more years. (If your agency uses a different definition, please defer to your agency's definition.)]Show breakdown of costs.

List of Equipment	Budget Impact Justification *[Description of need to carry out the program's objectives/goals]*	Amount
	Equipment Total	$ -

Supplies

[Supplies is defined as property with a unit cost under $5,000. ***Note:*** *Items such as laptops, tablets, and desktop computers are classified as a supply if the value is under the $5,000 threshold.]Show breakdown of costs.*

List of Supplies	Budget Impact Justification *[Description of need to carry out the program's objectives/goals]*	Amount
	Supplies Total	$ -

Contractual

List of Contracts	Deliverables	Budget Impact Justification *[Description of how the contract impacts the program's objectives/goals and how the costs were estimated]Show breakdown of costs.*	Amount
		Contracts Total	$ -

Other

[List all costs that do not fit into any other category]

List of Other	Budget Impact Justification *[Impact on the program's objectives/goals]Show breakdown of costs.*	Amount
	Other Costs Total	$ -

Total Direct Cost

	$ 12,661

Indirect Cost

Type of Indirect Cost *[Select from dropdown list]*	Rate *(Insert rate below)*	Insert Base	Total [Insert Indirect]
	25%		$ 3,143

MAI Clinical Quality Management Total

	$ 15,804

MAI HIV SERVICES BUDGET

APPLICANT: Metropolitan Public Health Department of Nashville/Davidson County

FISCAL YEAR: March 1, 2022 through February 28, 2023

Personnel

Salary *[Insert total annual salary]*	FTE *[Insert as decimal]*	Name, Position *[Insert name, position title]*	Budget Impact Justification *[Description of duties, impact on program goals and outcomes, payment source for balance of FTE]*	Amount
				$ -
				$ -
				$ -
				$ -
				$ -
			Personnel Total	$ -

Fringe Benefits

Percentage *[Insert as %]*	Components *[List components that comprise the fringe benefit rate]*	Amount
		$ -
		$ -
	Fringe Benefit Total	$ -

Travel

Local

Mileage Rate	Number of Miles	Name, Position of Traveler(s)	Travel Expenses/Budget Impact Justification *[Lodging, parking, per diem, etc., and the impact of the travel on program objectives/goals]Show breakdown of costs.*	Amount
			Local Travel Sub-Total	$ -

Long Distance

Type of Travel	Name, Position of Traveler(s)	Travel Expenses/Budget Impact Justification *[Lodging, parking, per diem, etc., and the impact of the travel on program objectives/goals]Show breakdown of costs.*	Amount
		Long Distance Travel Sub-Total	$ -
		Travel Total	$ -

Equipment

[Equipment is defined as a unit cost of $5,000 or more and a useful life of 1 or more years. (If your agency uses a different definition, please defer to your agency's definition.)]Show breakdown of costs.

List of Equipment	Budget Impact Justification *[Description of need to carry out the program's objectives/goals]*	Amount
	Equipment Total	$ -

Supplies

[Supplies is defined as property with a unit cost under $5,000. ***Note:*** *Items such as laptops, tablets, and desktop computers are classified as a supply if the value is under the $5,000 threshold.]Show breakdown of costs.*

List of Supplies	Budget Impact Justification *[Description of need to carry out the program's objectives/goals]*	Amount
	Supplies Total	$ -

Contractual

List of Contracts	Deliverables	Budget Impact Justification *[Description of how the contract impacts the program's objectives/goals and how the costs were estimated]Show breakdown of costs.*	Amount
Nashville CARES	Medical Case Management	Contract to provide core medical HIV services in the Nashville TGA, costs estimated competitive award budget submissions	$ 51,390
Streetworks	Early Intervention Services, Medical Case Management, Outreach Services	Contract to provide core medical and support HIV services in the Nashville TGA, costs estimated competitive award budget submissions	$ 169,541

Meharry	Outpatient	Contract to provide core medical HIV services in the Nashville TGA, costs estimated competitive award budget submissions	$ 45,148
To Be Contracted	Additional core medical and support services, pending allocation by the PSRA committee and approval for request for purchase	Funding to be allocated to existing core medical and support contracts after review by the PSRA committee and metro contract process	$ 7,592
		Contracts Total	**$ 273,671**

Other

[List all costs that do not fit into any other category]Show breakdown of costs.

List of Other	Budget Impact Justification *[Impact on the program's objectives/goals]*	Amount
	Other Costs Total	**$ -**

Total Direct Cost

	$ 273,671

Indirect Cost

Type of Indirect Cost *[Select from dropdown list]*	Rate *(Insert rate below)*	Insert Base	Total [Insert Indirect]

MAI HIV Services Total

	$ 273,671

NEW MATERIAL

BUDGET INFORMATION - Non-Construction Programs

OMB Number: 4040-0006
Expiration Date: 02/28/2022

SECTION A - BUDGET SUMMARY

Grant Program Function or Activity (a)	Catalog of Federal Domestic Assistance Number (b)	Estimated Unobligated Funds		New or Revised Budget		
		Federal (c)	Non-Federal (d)	Federal (e)	Non-Federal (f)	Total (g)
1. Administration	93.914	$	$	$ 494,105.00	$	$ 494,105.00
2. Clinical Quality Management	93.914			229,672.00		229,672.00
3. HIV Services	93.914			4,232,180.00		4,232,180.00
4.						
5. Totals		$	$	$ 4,955,957.00	$	$ 4,955,957.00

Standard Form 424A (Rev. 7- 97)
Prescribed by OMB (Circular A -102) Page 1

SECTION B - BUDGET CATEGORIES

6. Object Class Categories	GRANT PROGRAM, FUNCTION OR ACTIVITY (1) Administration	(2) Clinical Quality Management	(3) HIV Services	(4)	Total (5)
a. Personnel	$ 248,802.00	$ 131,262.00	$	$	$ 380,064.00
b. Fringe Benefits	109,702.00	50,565.00			160,267.00
c. Travel	18,375.00	2,175.00			20,550.00
d. Equipment					
e. Supplies	7,750.00				7,750.00
f. Contractual	17,200.00		4,232,180.00		4,249,380.00
g. Construction					
h. Other	3,548.00				3,548.00
i. Total Direct Charges (sum of 6a-6h)	405,377.00	184,002.00	4,232,180.00		$ 4,821,559.00
j. Indirect Charges	88,728.00	45,670.00			$ 134,398.00
k. TOTALS (sum of 6i and 6j)	$ 494,105.00	$ 229,672.00	$ 4,232,180.00	$	$ 4,955,957.00
7. Program Income	$	$	$	$	$

Authorized for Local Reproduction

Standard Form 424A (Rev. 7- 97)
Prescribed by OMB (Circular A -102) Page 1A

SECTION C - NON-FEDERAL RESOURCES

(a) Grant Program	(b) Applicant	(c) State	(d) Other Sources	(e)TOTALS
8. Administration	$	$	$	$
9. Clinical Quality Management				
10. HIV Services				
11.				
12. TOTAL (sum of lines 8-11)	$	$	$	$

SECTION D - FORECASTED CASH NEEDS

	Total for 1st Year	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
13. Federal	$	$	$	$	$
14. Non-Federal	$				
15. TOTAL (sum of lines 13 and 14)	$	$	$	$	$

SECTION E - BUDGET ESTIMATES OF FEDERAL FUNDS NEEDED FOR BALANCE OF THE PROJECT

(a) Grant Program	FUTURE FUNDING PERIODS (YEARS) (b)First	(c) Second	(d) Third	(e) Fourth
16. Administration	$ 494,105.00	$ 494,105.00	$	$
17. Clinical Quality Management	229,672.00	229,672.00		
18. HIV Services	4,232,180.00	4,232,180.00		
19.				
20. TOTAL (sum of lines 16 - 19)	$ 4,955,957.00	$ 4,955,957.00	$	$

SECTION F - OTHER BUDGET INFORMATION

21. Direct Charges: 4821559

22. Indirect Charges: 134398

23. Remarks:

OMB Number: 4040-0010
Expiration Date: 12/31/2022

Key Contacts Form

*** Applicant Organization Name:**

Metropolitan Government of Nashville and Davidson County

Enter the individual's role on the project (e.g., project manager, fiscal contact).

*** Contact 1 Project Role:** Program Manager

Prefix:	
* First Name:	Beverly
Middle Name:	
* Last Name:	Glaze-Johnson
Suffix:	
Title:	

Organizational Affiliation:

* Street1:	2500 Charlotte Avenue
Street2:	
* City:	Nashville
County:	
* State:	TN: Tennessee
Province:	
* Country:	USA: UNITED STATES
* Zip / Postal Code:	37209-4129
* Telephone Number:	615-340-8605
Fax:	
* Email:	beverly.glaze-johnson@nashville.gov

OMB Number: 4040-0010
Expiration Date: 12/31/2022

Key Contacts Form

*** Applicant Organization Name:**
Metropolitan Government of Nashville and Davidson County

Enter the individual's role on the project (e.g., project manager, fiscal contact).

*** Contact 2 Project Role:** Epidemiologist

Prefix:
* First Name: Anthony
Middle Name:
* Last Name: Bennici
Suffix:
Title:
Organizational Affiliation:

* Street1: 2500 Charlotte Avenue
Street2:
* City: Nashville
County:
* State: TN: Tennessee
Province:
* Country: USA: UNITED STATES
* Zip / Postal Code: 37209-4129
* Telephone Number: 615-416-0465
Fax:
* Email: anthony.bennici@nasville.gov

OMB Number: 4040-0010
Expiration Date: 12/31/2022

Key Contacts Form

*** Applicant Organization Name:**

Metropolitan Government of Nashville and Davidson County

Enter the individual's role on the project (e.g., project manager, fiscal contact).

*** Contact 3 Project Role:** CQM Coordinator

Prefix:

* First Name: Regina

Middle Name:

* Last Name: Bell

Suffix:

Title:

Organizational Affiliation:

* Street1: 2500 Charlotte Avenue

Street2:

* City: Nashville

County:

* State: TN: Tennessee

Province:

* Country: USA: UNITED STATES

* Zip / Postal Code: 37209-4129

* Telephone Number: 615-340-5623

Fax:

* Email: regina.bell@nashville.gov

OMB Number: 4040-0010
Expiration Date: 12/31/2022

Key Contacts Form

*** Applicant Organization Name:**

Metropolitan Government of Nashville and Davidson County

Enter the individual's role on the project (e.g., project manager, fiscal contact).

*** Contact 4 Project Role:** Planning Council Liaison

Prefix:

* First Name: Quinntana

Middle Name:

* Last Name: Slaughter

Suffix:

Title:

Organizational Affiliation:

* Street1: 2500 Charlotte Avenue

Street2:

* City: Nashville

County:

* State: TN: Tennessee

Province:

* Country: USA: UNITED STATES

* Zip / Postal Code: 37209-4129

* Telephone Number: 615-340-8655

Fax:

* Email: quinntana.slaughter@nashville.gov

OMB Number: 4040-0019
Expiration Date: 02/28/2022

Project Abstract Summary

This Project Abstract Summary form must be submitted or the application will be considered incomplete. Ensure the Project Abstract field succinctly describes the project in plain language that the public can understand and use without the full proposal. Use 4,000 characters or less. Do not include personally identifiable, sensitive or proprietary information. Refer to Agency instructions for any additional Project Abstract field requirements. If the application is funded, your project abstract information (as submitted) will be made available to public websites and/or databases including USAspending.gov.

Funding Opportunity Number

HRSA-22-018

CFDA(s)

93.914

Applicant Name

Metropolitan Government of Nashville and Davidson County

Descriptive Title of Applicant's Project

Ryan White Part A - Nashville/Middle TN TGA

Project Abstract

The Nashville Transitional Grant Area (TGA) Ryan White HIV/AIDS Part A (RWHAP) program will coordinate with the local community Planning Council to use the HIV Emergency Relief Grant to fund a broad range of core and support services. The Nashville TGA encompasses 13 counties in central Tennessee including Davidson County, the most populous county and location of the state's capitol of Nashville. Between 2015 and 2019, the population of the Nashville TGA increased by 7%, representing 30% of Tennessee's population in 2019.

The population of the Nashville TGA was 1,863,108 people in 2019. Approximately 72% of the population was non-Hispanic (NH) white, 15% were NH Black, 8% were Hispanic, and 5% were of another race. Approximately 51% of the population were cisgender female. In 2019, there were 237 new diagnoses of HIV infection and there were 5,387 persons living with HIV (PLWH). Roughly 30% of PLWH in Tennessee live in the Nashville TGA. Approximately 70% of PLWH in the Nashville TGA reside in Davidson County. From 2015-2019, the number of new HIV diagnoses increased by 9%. Although new diagnoses have increased, the rate of persons living with diagnosed HIV infection has decreased to 289.1 persons living with HIV per 100,000 persons in the Nashville TGA.

Disparities persist regarding the burden of HIV in the Nashville TGA. In 2019, the rate of persons living with HIV was over 5 times higher among NH Black individuals compared to NH white individuals and approximately 1.5 times higher among Hispanic individuals compared to NH white individuals (896.1 PLWH per 100,000 NH Black, 266.2 PLWH per 100,000 Hispanic, 169.2 PLWH per 100,000 NH white). Approximately 78% of PLWH were cisgender male. Additionally, 43% of new HIV diagnoses occurred among 25-34-year-olds, and there was a 26% increase in new diagnoses among this age group from 2015-2019.

To address the needs of PLWH in the Nashville TGA, the Ryan White Part A Program funds several core medical and support services (Core Medical Services: Early Intervention Services, Medical Case Management, Mental Health, Oral Health Care, Outpatient/Ambulatory Health, and Substance Abuse Outpatient; Support Services: Emergency Financial Assistance, Food Bank, Housing, Linguistics, Medical Transportation, Non-Medical Case Management, Psychosocial Support, and Referral for Health Care). Additionally, the Minority AIDS Initiative (MAI), specifically focused on providing services for subpopulations disproportionately impacted by HIV, funds Early Intervention Services, Medical Case Management, Outpatient, and Outreach Services. Services are located at Part A-funded provider agencies and are concentrated in Davidson County. Overall viral suppression for the TGA was 68% in 2019, reflecting 21% improvement since 2017.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

NEW MATERIAL

Notice of Award

Award# 1 NU58DP007080-01-00

FAIN# NU58DP007080

Federal Award Date: 09/13/2021

Recipient Information

1. Recipient Name

Nashville & Davidson County Metropolitan Government
1 Public Sq
Nashville, TN 37201-5007
(615) 862-8860

2. Congressional District of Recipient
05

3. Payment System Identifier (ID)
1620694743A3

4. Employer Identification Number (EIN)
620694743

5. Data Universal Numbering System (DUNS)
078217668

6. Recipient's Unique Entity Identifier

7. Project Director or Principal Investigator

Ms. Stephanie Kang
stephanie.kang@nashville.gov
615-340-0572

8. Authorized Official

Tina Lester
tina.lester@nashville.gov
615-340-5614

Federal Agency Information
CDC Office of Financial Resources

9. Awarding Agency Contact Information

Ms. Emmanuella Lamothe
omy9@cdc.gov
404.498.5772

10.Program Official Contact Information

Claire Heiser
Lead Public Health Advisor
beq9@cdc.gov
770-488-5284

Federal Award Information

11. Award Number
1 NU58DP007080-01-00

12. Unique Federal Award Identification Number (FAIN)
NU58DP007080

13. Statutory Authority
Section 301(a) of the Public Health Service Act, 42 U.S.C. 241(a)

14. Federal Award Project Title
The Nashville Health Accelerator Plan

15. Assistance Listing Number
93.945

16. Assistance Listing Program Title
Assistance Programs for Chronic Disease Prevention and Control

17. Award Action Type
New

18. Is the Award R&D?
No

Summary Federal Award Financial Information

19. Budget Period Start Date 09/30/2021 **- End Date** 09/29/2022		
20. Total Amount of Federal Funds Obligated by this Action		$125,000.00
20a. Direct Cost Amount		$100,140.00
20b. Indirect Cost Amount		$24,860.00
21. Authorized Carryover		$0.00
22. Offset		$0.00
23. Total Amount of Federal Funds Obligated this budget period		$0.00
24. Total Approved Cost Sharing or Matching, where applicable		$0.00
25. Total Federal and Non-Federal Approved this Budget Period		$125,000.00
26. Project Period Start Date 09/30/2021 **- End Date** 09/29/2022		
27. Total Amount of the Federal Award including Approved Cost Sharing or Matching this Project Period		Not Available

28. Authorized Treatment of Program Income
ADDITIONAL COSTS

29. Grants Management Officer – Signature

Ms. Pamela Render
Grants Management Officer

30. Remarks

NEW MATERIAL

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

Notice of Award

Award# 1 NU58DP007080-01-00
FAIN# NU58DP007080
Federal Award Date: 09/13/2021

Recipient Information

Recipient Name

Nashville & Davidson County Metropolitan Government
1 Public Sq
Nashville, TN 37201-5007
(615) 862-8860

Congressional District of Recipient
05

Payment Account Number and Type
1620694743A3

Employer Identification Number (EIN) Data
620694743

Universal Numbering System (DUNS)
078217668

Recipient's Unique Entity Identifier
Not Available

31. Assistance Type
Project Grant

32. Type of Award
Other

33. Approved Budget
(Excludes Direct Assistance)

I. Financial Assistance from the Federal Awarding Agency Only
II. Total project costs including grant funds and all other financial participation

a. Salaries and Wages	$40,948.00
b. Fringe Benefits	$22,307.00
c. Total Personnel Costs	$63,255.00
d. Equipment	$0.00
e. Supplies	$4,570.00
f. Travel	$2,688.00
g. Construction	$0.00
h. Other	$29,627.00
i. Contractual	$0.00
j. TOTAL DIRECT COSTS	$100,140.00
k. INDIRECT COSTS	$24,860.00
l. TOTAL APPROVED BUDGET	$125,000.00
m. Federal Share	$125,000.00
n. Non-Federal Share	$0.00

34. Accounting Classification Codes

FY-ACCOUNT NO.	DOCUMENT NO.	ADMINISTRATIVE CODE	OBJECT CLASS	AMT ACTION FINANCIAL ASSISTANCE	APPROPRIATION
1-9390H1J	21NU58DP007080	DP	41.51	$125,000.00	75-21-0948

AWARD ATTACHMENTS

Nashville & Davidson County Metropolitan Government 1 NU58DP007080-01-00

1. Terms and Conditions

AWARD INFORMATION

Incorporation: In addition to the federal laws, regulations, policies, and CDC General Terms and Conditions for Non-research awards at https://www.cdc.gov/grants/federal-regulations-policies/index.html, the Centers for Disease Control and Prevention (CDC) hereby incorporates Notice of Funding Opportunity (NOFO) number DP21-2111, titled Closing the Gap with Social Determinants of Health Accelerator Plans, and application dated July 6, 2021, as may be amended, which are hereby made a part of this Non-research award, hereinafter referred to as the Notice of Award (NoA).

Approved Funding: Funding in the amount of **$125,000** is approved for the Year 01 budget period, which is September 30, 2021 through September 29, 2022. All future year funding will be based on satisfactory programmatic progress and the availability of funds.

The federal award amount is subject to adjustment based on total allowable costs incurred and/or the value of any third party in-kind contribution when applicable.

Note: Refer to the Payment Information section for Payment Management System (PMS) subaccount information.

Financial Assistance Mechanism: Grant

BUDGET REQUIREMENTS:

Please provide the following information by submitting a grant note in Grant Solutions by November 1, 2021:

- **FRINGE –** Please provide the fringe rate or the basis for calculation of the requested fringe costs.
- **CONSULTANT –** Please provide all the consultant elements that are required according to the CDC Budget Preparation Guidelines.
- **SUPPLIES –** Please provide detailed information and justification for costs in the amount of $3,000 for one laptop.

FUNDING RESTRICTIONS AND LIMITATIONS

Notice of Funding Opportunity (NOFO) Restrictions:

- Recipients may not use funds for research.
- Recipients may not use funds for clinical care except as allowed by law.
- Recipients may use funds only for reasonable program purposes, including personnel,travel, supplies, and services.
- Generally, recipients may not use funds to purchase furniture or equipment. Any such proposed spending must be clearly identified in the budget.
- Reimbursement of pre-award costs generally is not allowed, unless the CDC provides written approval to the recipient.
- Other than for normal and recognized executive-legislative relationships, no funds may be used for:

  - publicity or propaganda purposes, for the preparation, distribution, or use of any material designed to support or defeat the enactment of legislation before any legislative body
  - the salary or expenses of any grant or contract recipient, or agent acting for such recipient, related to any activity designed to influence the enactment of legislation, appropriations, regulation, administrative action, or Executive order proposed or pending before any legislative body
- See Additional Requirement (AR) 12 for detailed guidance on this prohibition and additional guidance on lobbying for CDC recipients.
- The direct and primary recipient in a cooperative agreement program must perform a substantial role in carrying out project outcomes and not merely serve as a conduit for an award to another party or provider who is ineligible.

Indirect Costs:

Indirect costs are approved based on the recipient's approved Cost Allocation Plan dated March 30, 2021.

REPORTING REQUIREMENTS

Required Disclosures for Federal Awardee Performance and Integrity Information System (FAPIIS): Consistent with 45 CFR 75.113, applicants and recipients must disclose in a timely manner, in writing to the CDC, with a copy to the HHS Office of Inspector General (OIG), all information related to violations of federal criminal law involving fraud, bribery, or gratuity violations potentially affecting the federal award. Subrecipients must disclose, in a timely manner in writing to the prime recipient (pass through entity) and the HHS OIG, all information related to violations of federal criminal law involving fraud, bribery, or gratuity violations potentially affecting the federal award. Disclosures must be sent in writing to the CDC and to the HHS OIG at the following addresses:

CDC, Office of Grants Services
Emmanuella Lamothe, Grants Management Officer/Specialist
Centers for Disease Control and Prevention
Branch 5 Supporting Chronic Diseases and Injury Prevention
2939 Flowers Road South
Atlanta, GA 30341-5507
Email: omy9@cdc.gov (Include "Mandatory Grant Disclosures" in subject line)

AND

U.S. Department of Health and Human Services
Office of the Inspector General
ATTN: Mandatory Grant Disclosures, Intake Coordinator
330 Independence Avenue, SW
Cohen Building, Room 5527
Washington, DC 20201

Fax: (202)-205-0604 (Include "Mandatory Grant Disclosures" in subject line) or

Email: MandatoryGranteeDisclosures@oig.hhs.gov

Recipients must include this mandatory disclosure requirement in all subawards and contracts under this award.

Failure to make required disclosures can result in any of the remedies described in 45 CFR 75.371. Remedies for noncompliance, including suspension or debarment (See 2 CFR parts 180 and 376, and 31 U.S.C. 3321).

CDC is required to report any termination of a federal award prior to the end of the period of performance due to material failure to comply with the terms and conditions of this award in the OMB-designated integrity and performance system accessible through SAM (currently FAPIIS). (45 CFR 75.372(b)) CDC must also notify the recipient if the federal award is terminated for failure to comply with the federal statutes, regulations, or terms and conditions of the federal award. (45 CFR 75.373(b))

PAYMENT INFORMATION

The HHS Office of the Inspector General (OIG) maintains a toll-free number (1-800-HHS-TIPS [1-800-447-8477]) for receiving information concerning fraud, waste, or abuse under grants and cooperative agreements. Information also may be submitted by e-mail to hhstips@oig.hhs.gov or by mail to Office of the Inspector General, Department of Health and Human Services, Attn: HOTLINE, 330 Independence Ave., SW, Washington DC 20201. Such reports are treated as sensitive material and submitters may decline to give their names if they choose to remain anonymous.

Payment Management System Subaccount: Funds awarded in support of approved activities have been obligated in a subaccount in the PMS, herein identified as the "P Account". Funds must be used in support of approved activities in the NOFO and the approved application.

The grant document number identified beginning on Page 2 of the Notice of Award must be known in order to draw down funds.

CDC Staff Contacts

Grants Management Specialist: The GMS is the federal staff member responsible for the day-to-day management of grants and cooperative agreements. The GMS is the primary contact of recipients for business and administrative matters pertinent to grant awards.

GMS Contact:
Emmanuella Lamothe, Grants Management Specialist
Centers for Disease Control and Prevention
Branch 5 Supporting Chronic Diseases and Injury Prevention
Telephone: 404-498-5772
Email: omy9@cdc.gov

Program/Project Officer: The PO is the federal official responsible for monitoring the programmatic, scientific, and/or technical aspects of grants and cooperative agreements, as well as contributing to the effort of the award under cooperative agreements.

Programmatic Contact:
Claire Heiser, Project Officer
Centers for Disease Control and Prevention
National Center for Chronic Disease Prevention and Health Promotion
Telephone: 770-488-5284
Email: beq9@cdc.gov

Grants Management Officer: The GMO is the federal official responsible for the business and other non-programmatic aspects of grant awards. The GMO is the only official authorized to obligate federal funds and is responsible for signing the NoA, including revisions to the NoA that change the terms and conditions. The GMO serves as the counterpart to the business officer of the recipient organization.

GMO Contact:
Pamela Render, Grants Management Officer
Centers for Disease Control and Prevention
Branch 5 Supporting Chronic Diseases and Injury Prevention
Telephone: 770-488-2712
Email: plr3@cdc.gov

NEW MATERIAL

CONTRACT AMENDMENT COVER SHEET

Agency Tracking #	Edison ID	Contract #	Amendment #
34347-49719	61143	GU1961143	1

Contractor Legal Entity Name	Edison Vendor ID
Metropolitan Government of Nashville and Davidson County	4

Amendment Purpose & Effect(s)
To add funds and extend the term

Amendment Changes Contract End Date: ☒ YES ☐ NO **End Date:** September 29, 2023

TOTAL Contract Amount INCREASE or DECREASE per this Amendment (zero if N/A): **$ 7,000.00**

Funding —

FY	State	Federal	Interdepartmental	Other	TOTAL Contract Amount
2019		$5,250.00			$5,250.00
2020		$7,000.00			$7,000.00
2021		$7,000.00			$7,000.00
2022		$7,000.00			$7,000.00
2023		$7,000.00			$7,000.00
2024		$1,750.00			$1,750.00
TOTAL:		**$35,000.00**			**$35,000.00**

Budget Officer Confirmation: There is a balance in the appropriation from which obligations hereunder are required to be paid that is not already encumbered to pay other obligations.

Eric Bucholz

Speed Chart (optional)	Account Code (optional)
HL00017171	70899000

CPO USE

NEW MATERIAL

AMENDMENT 1
OF CONTRACT GU1961143

This Amendment is made and entered by and between the State of Tennessee, Department of Health, hereinafter referred to as the "State" and Metropolitan Government of Nashville and Davidson County, hereinafter referred to as the "Contractor." For good and valuable consideration, the sufficiency of which is hereby acknowledged, it is mutually understood and agreed by and between said, undersigned contracting parties that the subject contract is hereby amended as follows:

1. Contract section A.5. is deleted in its entirety and replaced with the following:

A.5. Service Description. The Contractor shall review deaths of children in Davidson County occurring between 10/1/2018 and 9/29/23, meeting SDY criteria, and provide, at a minimum, the following services:

a. Review all deaths meeting the SDY criteria and categorize SUID cases, using the SUID algorithm (Attachment 2) provided by the Centers for Disease Control, during the review of the case at the child death review meeting.

b. Complete all data fields in the National Child Death Database required by the state CFR program within two (2) weeks of reviewing the death, and in accordance with the entry or submission requirements as set forth by the CFR Program.

c. Conduct a minimum of one (1) prevention activity as approved by the State related to sudden unexplained infant death, sudden cardiac death or sudden death in epilepsy.

2. Contract section A.6.c. is deleted in its entirety and replaced with the following:

c. Progress reports for the period October 1 through March 31st, is due no later that April 30th of each year 2019 through 2023. Submit to the State the SDY Report as detailed in the format attached herein as Attachment 1 via email or U.S. Mail.

3. Contract section A.6.d. is deleted in its entirety and replaced with the following:

d. Progress reports for the period April 1 through September 29th, is due no later than October 31st of each year 2019 through 2023. Submit to the State the SDY Report as detailed in the format attached herein as Attachment 1 via email or U.S. Mail.

4. Contract section B. is deleted in its entirety and replaced with the following:

B.1. This Grant Contract shall be effective for the period beginning on September 30, 2018 ("Effective Date") and ending on September 29, 2023, ("Term"). The State shall have no obligation to the Grantee for fulfillment of the Scope outside the Term.

B.2. Term Extension. It is understood and agreed that the State may extend the Term an additional period of time, not to exceed one hundred-eighty (180) days beyond the expiration date of this Contract, under the same terms and conditions. In no event, however, shall the maximum Term, including all extensions or renewals, exceed a total of sixty (60) months

5. Contract section C.1. is deleted in its entirety and replaced with the following:

C.1. Maximum Liability. In no event shall the maximum liability of the State under this Contract exceed Thirty Five Thousand Dollars ($35,000.00). The payment rates in section C.3 shall constitute the entire compensation due the Contractor for all service and Contractor obligations hereunder regardless of the difficulty, materials or equipment

required. The payment rates include, but are not limited to, all applicable taxes, fees, overheads, and all other direct and indirect costs incurred or to be incurred by the Contractor.

The Contractor is not entitled to be paid the maximum liability for any period under the Contract or any extensions of the Contract for work not requested by the State. The maximum liability represents available funds for payment to the Contractor and does not guarantee payment of any such funds to the Contractor under this Contract unless the State requests work and the Contractor performs said work. In which case, the Contractor shall be paid in accordance with the payment rates detailed in section C.3. The State is under no obligation to request work from the Contractor in any specific dollar amounts or to request any work at all from the Contractor during any period of this Contract.

6. Contract section C.3. is deleted in its entirety and replaced with the following:

C.3. Payment Methodology. The Contractor shall be compensated based on the payment rates herein for units of service authorized by the State in a total amount not to exceed the Contract Maximum Liability established in section C.1.

a. The Contractor's compensation shall be contingent upon the satisfactory completion of units, milestones, or increments of service defined in section A.

b. The Contractor shall be compensated for said units, milestones, or increments of service based upon the following payment rates:

Service Description	**Amount** (per compensable increment)
a. Submission of Progress Report: October 1, 2018 – March 31, 2019	$3,500.00
b. Submission of Progress Report: April 1, 2019 – September 30, 2019	$3,500.00
c. Submission of Progress Report: October 1, 2019 – March 31, 2020	$3,500.00
d. Submission of Progress Report: April 1, 2020 – September 30, 2020	$3,500.00
e. Submission of Progress Report: October 1, 2020 – March 31, 2021	$3,500.00
f. Submission of Progress Report: April 1, 2021 – September 30, 2021	$3,500.00
g. Submission of Progress Report: October 1, 2021 – March 31, 2022	$3,500.00
h. Submission of Progress Report: April 1, 2022 – September 30, 2022	$3,500.00
i. Submission of Progress Report: October 1, 2022 – March 31, 2023	$3,500.00
h. Submission of Progress Report: April 1, 2023 – September 29, 2023	$3,500.00

* NOTICE: The amount(s) per compensable increment detailed above shall be contingent upon the State's receipt of an invoice (Attachment 3) (as required in section C.5., below) for said service(s) within forty-five (45) days after the end of the calendar month in which the service(s) were rendered. At the sole discretion of the State, the amount per compensable increment of any service for which the State receives an invoice later than prescribed herein shall be subject to a reduction in amount of up to 100%. In the case of an untimely invoice, before any payment will be considered by the State, the Contractor must submit a written request regarding the untimely invoice, which shall detail the reason the invoice is untimely as well as the Contractor's plan for submitting all future invoices no later than prescribed herein, and it must be signed by an individual empowered to bind the Contractor to this Contract.

Required Approvals. The State is not bound by this Amendment until it is signed by the contract parties and approved by appropriate officials in accordance with applicable Tennessee laws and regulations (depending upon the specifics of this contract, said officials may include, but are not limited to, the Commissioner of Finance and Administration, the Commissioner of Human Resources, and the Comptroller of the Treasury).

Amendment Effective Date. The revisions set forth herein shall be effective ten (10) days following the last signature. All other terms and conditions of this Grant Contract not expressly amended herein shall remain in full force and effect.

IN WITNESS WHEREOF, the parties have by their duly authorized representatives set their signatures.

METROPOLITAN GOVERNMENT OF NASHVILLE AND DAVIDSON COUNTY

_____ _____
Director Date

Metro Public Health Department

_____ _____
Chair, Board of Health Date

APPROVED AS TO AVAILABILITY OF FUNDS:

_____ _____
Director, Department of Finance Date

APPROVED AS TO RISK AND INSURANCE:

_____ _____
Director of Risk Management Services Date

APPROVED AS TO FORM AND LEGALITY:

_____ _____
Metropolitan Attorney Date

_____ _____
Metropolitan Mayor Date

ATTEST:

_____ _____
Metropolitan Clerk Date

NEW MATERIAL

DEPARTMENT OF HEALTH:

_____ _____

Lisa Piercey, MD, MBA, FAAP
Commissioner

Date

Department of Health and Human Services
Health Resources and Services Administration

Notice of Award
FAIN# H8911433
Federal Award Date: 09/15/2021

Recipient Information

1. Recipient Name
Metro Public Health Department of Nashville/Davidson County
2500 Charlotte Ave
Nashville, TN 37209-4129

2. Congressional District of Recipient
05

3. Payment System Identifier (ID)
1620694743A7

4. Employer Identification Number (EIN)
620694743

5. Data Universal Numbering System (DUNS)
078217668

6. Recipient's Unique Entity Identifier

7. Project Director or Principal Investigator
Rajeev MAVATH
Director, Ryan White Part A
Rajeev.Mavath@nashville.gov
(615)340-5671

8. Authorized Official
Tina Lester
Bureau Director
tina.lester@nashville.gov
(615)340-5687

Federal Agency Information

9. Awarding Agency Contact Information
Marie E Mehaffey
Grants Management Specialist
Office of Federal Assistance Management (OFAM)
Division of Grants Management Office (DGMO)
MMehaffey@hrsa.gov
(301) 945-3934

10. Program Official Contact Information
Melody Barry
HIV/AIDS Bureau (HAB)
mbarry@hrsa.gov
(301) 945-9827

Federal Award Information

11. Award Number
6 H89HA11433-12-03

12. Unique Federal Award Identification Number (FAIN)
H8911433

13. Statutory Authority
42 U.S.C. § 300ff-11-20; 300ff-121

14. Federal Award Project Title
Ryan White Part A HIV Emergency Relief Grant Program

15. Assistance Listing Number
93.914

16. Assistance Listing Program Title
HIV Emergency Relief Project Grants

17. Award Action Type
Administrative

18. Is the Award R&D?
No

Summary Federal Award Financial Information

19. Budget Period Start Date 03/01/2020 - End Date 02/28/2021	
20. Total Amount of Federal Funds Obligated by this Action	($426,692.00)
20a. Direct Cost Amount	
20b. Indirect Cost Amount	
21. Authorized Carryover	$0.00
22. Offset	$0.00
23. Total Amount of Federal Funds Obligated this budget period	$3,947,812.00
24. Total Approved Cost Sharing or Matching, where applicable	$0.00
25. Total Federal and Non-Federal Approved this Budget Period	$3,947,812.00
26. Project Period Start Date 03/01/2020 - End Date 02/28/2021	
27. Total Amount of the Federal Award including Approved Cost Sharing or Matching this Project Period	$3,947,812.00

28. Authorized Treatment of Program Income
Addition

29. Grants Management Officer – Signature
Karen Mayo on 09/15/2021

30. Remarks

Prior Approval Request Tracking Number PA-00099286. Prior Approval Request Type: Carryover

NEW MATERIAL

HRSA
Health Resources & Services Administration

Notice of Award
Award Number: 6 H89HA11433-12-03
Federal Award Date: 09/15/2021

HIV/AIDS Bureau (HAB)

31. APPROVED BUDGET: (Excludes Direct Assistance)

[X] Grant Funds Only

[ ] Total project costs including grant funds and all other financial participation

a.	Salaries and Wages:	$0.00
b.	Fringe Benefits:	$0.00
c.	Total Personnel Costs:	$0.00
d.	Consultant Costs:	$0.00
e.	Equipment:	$0.00
f.	Supplies:	$0.00
g.	Travel:	$0.00
h.	Construction/Alteration and Renovation:	$0.00
i.	Other:	$0.00
j.	Consortium/Contractual Costs:	$0.00
k.	Trainee Related Expenses:	$0.00
l.	Trainee Stipends:	$0.00
m.	Trainee Tuition and Fees:	$0.00
n.	Trainee Travel:	$0.00
o.	TOTAL DIRECT COSTS:	$3,910,655.00
p.	INDIRECT COSTS (Rate: % of S&W/TADC):	$37,157.00
q.	TOTAL APPROVED BUDGET:	$3,947,812.00
	i. Less Non-Federal Share:	$0.00
	ii. Federal Share:	$3,947,812.00

32. AWARD COMPUTATION FOR FINANCIAL ASSISTANCE:

a.	Authorized Financial Assistance This Period	**$3,947,812.00**
b.	Less Unobligated Balance from Prior Budget Periods	
	i. Additional Authority	$0.00
	ii. Offset	$0.00
c.	Unawarded Balance of Current Year's Funds	$0.00
d.	Less Cumulative Prior Award(s) This Budget Period	$4,374,504.00
e.	AMOUNT OF FINANCIAL ASSISTANCE THIS ACTION	**($426,692.00)**

33. RECOMMENDED FUTURE SUPPORT:
(Subject to the availability of funds and satisfactory progress of project)

YEAR	TOTAL COSTS
Not applicable	

34. APPROVED DIRECT ASSISTANCE BUDGET: (In lieu of cash)

a. Amount of Direct Assistance	$0.00
b. Less Unawarded Balance of Current Year's Funds	$0.00
c. Less Cumulative Prior Award(s) This Budget Period	$0.00
d. AMOUNT OF DIRECT ASSISTANCE THIS ACTION	**$0.00**

35. FORMER GRANT NUMBER

36. OBJECT CLASS
41.15

37. BHCMIS#

38. THIS AWARD IS BASED ON THE APPLICATION APPROVED BY HRSA FOR THE PROJECT NAMED IN ITEM 14. FEDERAL AWARD PROJECT TITLE AND IS SUBJECT TO THE TERMS AND CONDITIONS INCORPORATED EITHER DIRECTLY OR BY REFERENCE AS:
a. The program authorizing statue and program regulation cited in this Notice of Award; b. Conditions on activities and expenditures of funds in certain other applicable statutory requirements, such as those included in appropriations restrictions applicable to HRSA funds; c. 45 CFR Part 75; d. National Policy Requirements and all other requirements described in the HHS Grants Policy Statement; e. Federal Award Performance Goals; and f. The Terms and Conditions cited in this Notice of Award. In the event there are conflicting or otherwise inconsistent policies applicable to the award, the above order of precedence shall prevail. Recipients indicate acceptance of the award, and terms and conditions by obtaining funds from the payment system.

39. ACCOUNTING CLASSIFICATION CODES

FY-CAN	CFDA	DOCUMENT NUMBER	AMT. FIN. ASST.	AMT. DIR. ASST.	SUB PROGRAM CODE	SUB ACCOUNT CODE
20 - 3779208	93.914	20H89HA11433	($342,915.00)	$0.00	FRML	HIV1-20
20 - 3779207	93.914	20H89HA11433	($83,777.00)	$0.00	MAI	HIV1-20

HRSA Electronic Handbooks (EHBs) Registration Requirements

The Project Director of the grant (listed on this NoA) and the Authorizing Official of the grantee organization are required to register (if not already registered) within HRSA's Electronic Handbooks (EHBs). Registration within HRSA EHBs is required only once for each user for each organization they represent. To complete the registration quickly and efficiently we recommend that you note the 10-digit grant number from box 4b of this NoA. After you have completed the initial registration steps (i.e.,created an individual account and associated it with the correct grantee organization record), be sure to add this grant to your portfolio. This registration in HRSA EHBs is required for submission of noncompeting continuation applications. In addition, you can also use HRSA EHBs to perform other activities such as updating addresses, updating email addresses and submitting certain deliverables electronically. Visit https://grants3.hrsa.gov/2010/WebEPSExternal/Interface/common/accesscontrol/login.aspx to use the system. Additional help is available online and/or from the HRSA Call Center at 877-Go4-HRSA/877-464-4772.

Terms and Conditions

Failure to comply with the remarks, terms, conditions, or reporting requirements may result in a draw down restriction being placed on your Payment Management System account or denial of future funding.

Grant Specific Term(s)

1. This Notice of Award is issued to de-obligate $426,692 from Document No. 20H89HA11433. $426,692 will be re-obligated under Document No. 21H89HA11433 for the purpose of carryover on the FY21 award.

All prior terms and conditions remain in effect unless specifically removed.

Contacts

NoA Email Address(es):

Name	Role	Email
Tina Lester	Authorizing Official	tina.lester@nashville.gov
Rajeev Mavath	Program Director	rajeev.mavath@nashville.gov
Emily Metscher	Business Official	emily.bradberry@nashville.gov

Note: NoA emailed to these address(es)

All submissions in response to conditions and reporting requirements (with the exception of the FFR) must be submitted via EHBs. Submissions for Federal Financial Reports (FFR) must be completed in the Payment Management System (https://pms.psc.gov/).

Department of Health and Human Services
Health Resources and Services Administration

Notice of Award
FAIN# H8911433
Federal Award Date: 09/17/2021

Recipient Information

1. Recipient Name
Metro Public Health Department of Nashville/Davidson County
2500 Charlotte Ave
Nashville, TN 37209-4129

2. Congressional District of Recipient
05

3. Payment System Identifier (ID)
1620694743A7

4. Employer Identification Number (EIN)
620694743

5. Data Universal Numbering System (DUNS)
078217668

6. Recipient's Unique Entity Identifier

7. Project Director or Principal Investigator
Rajeev MAVATH
Director, Ryan White Part A
Rajeev.Mavath@nashville.gov
(615)340-5671

8. Authorized Official
Tina Lester
Bureau Director
tina.lester@nashville.gov
(615)340-5687

Federal Agency Information

9. Awarding Agency Contact Information
Marie E Mehaffey
Grants Management Specialist
Office of Federal Assistance Management (OFAM)
Division of Grants Management Office (DGMO)
MMehaffey@hrsa.gov
(301) 945-3934

10. Program Official Contact Information
Melody Barry
HIV/AIDS Bureau (HAB)
mbarry@hrsa.gov
(301) 945-9827

Federal Award Information

11. Award Number
6 H89HA11433-13-02

12. Unique Federal Award Identification Number (FAIN)
H8911433

13. Statutory Authority
42 U.S.C. § 300ff-11-20; 300ff-121

14. Federal Award Project Title
Ryan White Part A HIV Emergency Relief Grant Program

15. Assistance Listing Number
93.914

16. Assistance Listing Program Title
HIV Emergency Relief Project Grants

17. Award Action Type
Administrative

18. Is the Award R&D?
No

Summary Federal Award Financial Information

19. Budget Period Start Date 03/01/2021 - End Date 02/28/2022	
20. Total Amount of Federal Funds Obligated by this Action	$426,692.00
20a. Direct Cost Amount	
20b. Indirect Cost Amount	
21. Authorized Carryover	$0.00
22. Offset	$0.00
23. Total Amount of Federal Funds Obligated this budget period	$4,841,906.00
24. Total Approved Cost Sharing or Matching, where applicable	$0.00
25. Total Federal and Non-Federal Approved this Budget Period	$4,841,906.00
26. Project Period Start Date 03/01/2021 - End Date 02/28/2022	
27. Total Amount of the Federal Award including Approved Cost Sharing or Matching this Project Period	$4,841,906.00

28. Authorized Treatment of Program Income
Addition

29. Grants Management Officer – Signature
Karen Mayo on 09/17/2021

30. Remarks

Prior Approval Request Tracking Number PA-00099286. Prior Approval Request Type: Carryover

NEW MATERIAL

HRSA
Health Resources & Services Administration

Notice of Award
Award Number: 6 H89HA11433-13-02
Federal Award Date: 09/17/2021

HIV/AIDS Bureau (HAB)

31. APPROVED BUDGET: (Excludes Direct Assistance)

[X] Grant Funds Only

[ ] Total project costs including grant funds and all other financial participation

a.	Salaries and Wages:	$0.00
b.	Fringe Benefits:	$0.00
c.	Total Personnel Costs:	$0.00
d.	Consultant Costs:	$0.00
e.	Equipment:	$0.00
f.	Supplies:	$0.00
g.	Travel:	$0.00
h.	Construction/Alteration and Renovation:	$0.00
i.	Other:	$0.00
j.	Consortium/Contractual Costs:	$0.00
k.	Trainee Related Expenses:	$0.00
l.	Trainee Stipends:	$0.00
m.	Trainee Tuition and Fees:	$0.00
n.	Trainee Travel:	$0.00
o.	TOTAL DIRECT COSTS:	$4,841,906.00
p.	INDIRECT COSTS (Rate: % of S&W/TADC):	$0.00
q.	TOTAL APPROVED BUDGET:	$4,841,906.00
	i. Less Non-Federal Share:	$0.00
	ii. Federal Share:	$4,841,906.00

32. AWARD COMPUTATION FOR FINANCIAL ASSISTANCE:

a.	Authorized Financial Assistance This Period	**$4,841,906.00**
b.	Less Unobligated Balance from Prior Budget Periods	
	i. Additional Authority	$0.00
	ii. Offset	$0.00
c.	Unawarded Balance of Current Year's Funds	$0.00
d.	Less Cumulative Prior Award(s) This Budget Period	$4,415,214.00
e.	AMOUNT OF FINANCIAL ASSISTANCE THIS ACTION	**$426,692.00**

33. RECOMMENDED FUTURE SUPPORT:
(Subject to the availability of funds and satisfactory progress of project)

YEAR	TOTAL COSTS
Not applicable	

34. APPROVED DIRECT ASSISTANCE BUDGET: (In lieu of cash)

a. Amount of Direct Assistance	$0.00
b. Less Unawarded Balance of Current Year's Funds	$0.00
c. Less Cumulative Prior Award(s) This Budget Period	$0.00
d. AMOUNT OF DIRECT ASSISTANCE THIS ACTION	**$0.00**

35. FORMER GRANT NUMBER

36. OBJECT CLASS
41.15

37. BHCMIS#

38. THIS AWARD IS BASED ON THE APPLICATION APPROVED BY HRSA FOR THE PROJECT NAMED IN ITEM 14. FEDERAL AWARD PROJECT TITLE AND IS SUBJECT TO THE TERMS AND CONDITIONS INCORPORATED EITHER DIRECTLY OR BY REFERENCE AS:
a. The program authorizing statue and program regulation cited in this Notice of Award; b. Conditions on activities and expenditures of funds in certain other applicable statutory requirements, such as those included in appropriations restrictions applicable to HRSA funds; c. 45 CFR Part 75; d. National Policy Requirements and all other requirements described in the HHS Grants Policy Statement; e. Federal Award Performance Goals; and f. The Terms and Conditions cited in this Notice of Award. In the event there are conflicting or otherwise inconsistent policies applicable to the award, the above order of precedence shall prevail. Recipients indicate acceptance of the award, and terms and conditions by obtaining funds from the payment system.

39. ACCOUNTING CLASSIFICATION CODES

FY-CAN	CFDA	DOCUMENT NUMBER	AMT. FIN. ASST.	AMT. DIR. ASST.	SUB PROGRAM CODE	SUB ACCOUNT CODE
20 - 3779208	93.914	21H89HA11433	$342,915.00	$0.00	FRML	21H89HA11433
20 - 3779207	93.914	21H89HA11433	$83,777.00	$0.00	MAI	21H89HA11433

HRSA Electronic Handbooks (EHBs) Registration Requirements

The Project Director of the grant (listed on this NoA) and the Authorizing Official of the grantee organization are required to register (if not already registered) within HRSA's Electronic Handbooks (EHBs). Registration within HRSA EHBs is required only once for each user for each organization they represent. To complete the registration quickly and efficiently we recommend that you note the 10-digit grant number from box 4b of this NoA. After you have completed the initial registration steps (i.e.,created an individual account and associated it with the correct grantee organization record), be sure to add this grant to your portfolio. This registration in HRSA EHBs is required for submission of noncompeting continuation applications. In addition, you can also use HRSA EHBs to perform other activities such as updating addresses, updating email addresses and submitting certain deliverables electronically. Visit https://grants3.hrsa.gov/2010/WebEPSExternal/Interface/common/accesscontrol/login.aspx to use the system. Additional help is available online and/or from the HRSA Call Center at 877-Go4-HRSA/877-464-4772.

Terms and Conditions

Failure to comply with the remarks, terms, conditions, or reporting requirements may result in a draw down restriction being placed on your Payment Management System account or denial of future funding.

Grant Specific Term(s)

1. This Notice of Award authorizes the carryover of an unobligated balance in the amount of $426,692 from budget period 3/1/2020 - 2/28/2021 into the current budget period. These funds can only be used for the purposes stated in your Prior Approval request.
   Please be advised that if the final resolution of the audit determines that the unobligated balance of Federal Funds requested for the carryover is incorrect, HRSA is not obligated to make additional Federal Funds available to cover the shortfall.

All prior terms and conditions remain in effect unless specifically removed.

Contacts

NoA Email Address(es):

Name	Role	Email
Emily Metscher	Business Official	emily.bradberry@nashville.gov
Rajeev Mavath	Program Director	rajeev.mavath@nashville.gov
Tina Lester	Authorizing Official	tina.lester@nashville.gov

Note: NoA emailed to these address(es)

All submissions in response to conditions and reporting requirements (with the exception of the FFR) must be submitted via EHBs. Submissions for Federal Financial Reports (FFR) must be completed in the Payment Management System (https://pms.psc.gov/).

Department of Health and Human Services
Health Resources and Services Administration

Notice of Award
FAIN# H4932719
Federal Award Date: 09/07/2021

Recipient Information

1. Recipient Name
NASHVILLE & DAVIDSON COUNTY, METROPOLITAN GOVERNMENT OF
PO BOX 196300
Nashville, TN 37219-6300

2. Congressional District of Recipient
05

3. Payment System Identifier (ID)
1620694743A7

4. Employer Identification Number (EIN)
620694743

5. Data Universal Numbering System (DUNS)
078217668

6. Recipient's Unique Entity Identifier

7. Project Director or Principal Investigator
D'Yuanna Allen-Robb
Project Director
dyuanna.allen-robb@nashville.gov
(615)340-0487 Ext. 0487

8. Authorized Official
Tina Lester
Interim Administrative Director of Health
Tina.Lester@nashville.gov
(615)340-5687

Federal Agency Information

9. Awarding Agency Contact Information
Tonya Randall
Grants Management Specialist
Office of Federal Assistance Management (OFAM)
Division of Grants Management Office (DGMO)
trandall@hrsa.gov
(301) 594-4259

10. Program Official Contact Information
Judith D Harvilchuck
Maternal and Child Health Bureau (MCHB)
JHarvilchuck@hrsa.gov
(301) 443-5803

Federal Award Information

11. Award Number
3 H49MC32719-03-01

12. Unique Federal Award Identification Number (FAIN)
H4932719

13. Statutory Authority
Public Health Service Act, Section 751
Public Health Service Act: Title III, Part D, Section 330H ; 42 U.SC. 254c-8
Public Health Service Act, Title III, Part D, § 330H (42 U.S.C. 254c-8), as amended by the Healthy Start Reauthorization Act of 2007 (P.L. 110-339)
42 U.S.C. § 254c-8 (Title III, Part D, § 330H of the Public Health Service Act)

14. Federal Award Project Title
Healthy Start Initiative-Eliminating Racial/Ethnic Disparities

15. Assistance Listing Number
93.926

16. Assistance Listing Program Title
Healthy Start Initiative

17. Award Action Type
Competing Supplement

18. Is the Award R&D?
No

Summary Federal Award Financial Information

19. Budget Period Start Date 04/01/2021 - End Date 03/31/2022	
20. Total Amount of Federal Funds Obligated by this Action	$125,000.00
20a. Direct Cost Amount	
20b. Indirect Cost Amount	
21. Authorized Carryover	$0.00
22. Offset	$0.00
23. Total Amount of Federal Funds Obligated this budget period	$1,111,796.00
24. Total Approved Cost Sharing or Matching, where applicable	$0.00
25. Total Federal and Non-Federal Approved this Budget Period	$1,269,121.00
26. Project Period Start Date 04/01/2019 - End Date 03/31/2024	
27. Total Amount of the Federal Award including Approved Cost Sharing or Matching this Project Period	$3,348,816.00

28. Authorized Treatment of Program Income
Addition

29. Grants Management Officer – Signature
LaShawna Smith on 09/07/2021

30. Remarks

NEW MATERIAL

HRSA
Health Resources & Services Administration

Notice of Award
Award Number: 3 H49MC32719-03-01
Federal Award Date: 09/07/2021

Maternal and Child Health Bureau (MCHB)

31. APPROVED BUDGET: (Excludes Direct Assistance)

[X] Grant Funds Only

[ ] Total project costs including grant funds and all other financial participation

a.	Salaries and Wages:	$341,339.00
b.	Fringe Benefits:	$143,128.00
c.	Total Personnel Costs:	$484,467.00
d.	Consultant Costs:	$0.00
e.	Equipment:	$0.00
f.	Supplies:	$24,505.00
g.	Travel:	$10,552.00
h.	Construction/Alteration and Renovation:	$0.00
i.	Other:	$201,181.00
j.	Consortium/Contractual Costs:	$365,612.00
k.	Trainee Related Expenses:	$0.00
l.	Trainee Stipends:	$0.00
m.	Trainee Tuition and Fees:	$0.00
n.	Trainee Travel:	$0.00
o.	TOTAL DIRECT COSTS:	$1,086,317.00
p.	INDIRECT COSTS (Rate: % of S&W/TADC):	$182,804.00
q.	TOTAL APPROVED BUDGET:	$1,269,121.00
	i. Less Non-Federal Share:	$0.00
	ii. Federal Share:	$1,269,121.00

32. AWARD COMPUTATION FOR FINANCIAL ASSISTANCE:

a.	Authorized Financial Assistance This Period	**$1,269,121.00**
b.	Less Unobligated Balance from Prior Budget Periods	
	i. Additional Authority	$0.00
	ii. Offset	$157,325.00
c.	Unawarded Balance of Current Year's Funds	$0.00
d.	Less Cumulative Prior Award(s) This Budget Period	$986,796.00
e.	AMOUNT OF FINANCIAL ASSISTANCE THIS ACTION	**$125,000.00**

33. RECOMMENDED FUTURE SUPPORT:
(Subject to the availability of funds and satisfactory progress of project)

YEAR	TOTAL COSTS
04	$1,144,121.00
05	$1,144,121.00

34. APPROVED DIRECT ASSISTANCE BUDGET: (In lieu of cash)

a. Amount of Direct Assistance	$0.00
b. Less Unawarded Balance of Current Year's Funds	$0.00
c. Less Cumulative Prior Award(s) This Budget Period	$0.00
d. AMOUNT OF DIRECT ASSISTANCE THIS ACTION	**$0.00**

35. FORMER GRANT NUMBER

36. OBJECT CLASS
41.51

37. BHCMIS#

38. THIS AWARD IS BASED ON THE APPLICATION APPROVED BY HRSA FOR THE PROJECT NAMED IN ITEM 14. FEDERAL AWARD PROJECT TITLE AND IS SUBJECT TO THE TERMS AND CONDITIONS INCORPORATED EITHER DIRECTLY OR BY REFERENCE AS:
a. The program authorizing statue and program regulation cited in this Notice of Award; b. Conditions on activities and expenditures of funds in certain other applicable statutory requirements, such as those included in appropriations restrictions applicable to HRSA funds; c. 45 CFR Part 75; d. National Policy Requirements and all other requirements described in the HHS Grants Policy Statement; e. Federal Award Performance Goals; and f. The Terms and Conditions cited in this Notice of Award. In the event there are conflicting or otherwise inconsistent policies applicable to the award, the above order of precedence shall prevail. Recipients indicate acceptance of the award, and terms and conditions by obtaining funds from the payment system.

39. ACCOUNTING CLASSIFICATION CODES

FY-CAN	CFDA	DOCUMENT NUMBER	AMT. FIN. ASST.	AMT. DIR. ASST.	SUB PROGRAM CODE	SUB ACCOUNT CODE
21 - 3898020	93.926	19H49MC32719	$125,000.00	$0.00	N/A	19-HIS-ERED

HRSA Electronic Handbooks (EHBs) Registration Requirements

The Project Director of the grant (listed on this NoA) and the Authorizing Official of the grantee organization are required to register (if not already registered) within HRSA's Electronic Handbooks (EHBs). Registration within HRSA EHBs is required only once for each user for each organization they represent. To complete the registration quickly and efficiently we recommend that you note the 10-digit grant number from box 4b of this NoA. After you have completed the initial registration steps (i.e.,created an individual account and associated it with the correct grantee organization record), be sure to add this grant to your portfolio. This registration in HRSA EHBs is required for submission of noncompeting continuation applications. In addition, you can also use HRSA EHBs to perform other activities such as updating addresses, updating email addresses and submitting certain deliverables electronically. Visit https://grants3.hrsa.gov/2010/WebEPSExternal/Interface/common/accesscontrol/login.aspx to use the system. Additional help is available online and/or from the HRSA Call Center at 877-Go4-HRSA/877-464-4772.

Terms and Conditions

Failure to comply with the remarks, terms, conditions, or reporting requirements may result in a draw down restriction being placed on your Payment Management System account or denial of future funding.

Grant Specific Term(s)

1. This Notice of Award (NoA) reflects funding to support the Healthy Start Supplement: Community-Based Doulas. Grant funds totaling 25% or more of the authorized total must receive prior approval before being reallocated.

All prior terms and conditions remain in effect unless specifically removed.

Contacts

NoA Email Address(es):

Name	Role	Email
D'yuanna Allen-Robb	Business Official	dyuanna.allen-robb@nashville.gov
D'yuanna Allen-Robb	Program Director	dyuanna.allen-robb@nashville.gov
Tina Lester	Authorizing Official, Point of Contact	tina.lester@nashville.gov

Note: NoA emailed to these address(es)

All submissions in response to conditions and reporting requirements (with the exception of the FFR) must be submitted via EHBs. Submissions for Federal Financial Reports (FFR) must be completed in the Payment Management System (https://pms.psc.gov/).

Department of Health and Human Services
Health Resources and Services Administration

Notice of Award
FAIN# H4932719
Federal Award Date: 10/04/2021

Recipient Information

1. Recipient Name
NASHVILLE & DAVIDSON COUNTY, METROPOLITAN GOVERNMENT OF
PO BOX 196300
Nashville, TN 37219-6300

2. Congressional District of Recipient
05

3. Payment System Identifier (ID)
1620694743A7

4. Employer Identification Number (EIN)
620694743

5. Data Universal Numbering System (DUNS)
078217668

6. Recipient's Unique Entity Identifier

7. Project Director or Principal Investigator
Fonda Harris
Bureau Director - Project Director
fonda.harris@nashville.gov
(615)340-5686

8. Authorized Official
Tina Lester
Interim Administrative Director of Health
Tina.Lester@nashville.gov
(615)340-5687

Federal Agency Information

9. Awarding Agency Contact Information
Tonya Randall
Grants Management Specialist
Office of Federal Assistance Management (OFAM)
Division of Grants Management Office (DGMO)
trandall@hrsa.gov
(301) 594-4259

10. Program Official Contact Information
Judith D Harvilchuck
Maternal and Child Health Bureau (MCHB)
JHarvilchuck@hrsa.gov
(301) 443-1568

Federal Award Information

11. Award Number
6 H49MC32719-03-02

12. Unique Federal Award Identification Number (FAIN)
H4932719

13. Statutory Authority
Public Health Service Act, Section 751
Public Health Service Act: Title III, Part D, Section 330H ; 42 U.SC. 254c-8
Public Health Service Act, Title III, Part D, § 330H (42 U.S.C. 254c-8), as amended by the Healthy Start Reauthorization Act of 2007 (P.L. 110-339)
42 U.S.C. § 254c-8 (Title III, Part D, § 330H of the Public Health Service Act)

14. Federal Award Project Title
Healthy Start Initiative-Eliminating Racial/Ethnic Disparities

15. Assistance Listing Number
93.926

16. Assistance Listing Program Title
Healthy Start Initiative

17. Award Action Type
Administrative

18. Is the Award R&D?
No

Summary Federal Award Financial Information

19. Budget Period Start Date 04/01/2021 - End Date 03/31/2022	
20. Total Amount of Federal Funds Obligated by this Action	$0.00
20a. Direct Cost Amount	
20b. Indirect Cost Amount	
21. Authorized Carryover	$0.00
22. Offset	$0.00
23. Total Amount of Federal Funds Obligated this budget period	$1,111,796.00
24. Total Approved Cost Sharing or Matching, where applicable	$0.00
25. Total Federal and Non-Federal Approved this Budget Period	$1,269,121.00
26. Project Period Start Date 04/01/2019 - End Date 03/31/2024	
27. Total Amount of the Federal Award including Approved Cost Sharing or Matching this Project Period	$3,348,816.00

28. Authorized Treatment of Program Income
Addition

29. Grants Management Officer – Signature
LaShawna Smith on 10/04/2021

30. Remarks

Prior Approval Request Tracking Number PA-00099999. Prior Approval Request Type: Project Director(PD) Change

NEW MATERIAL

HRSA
Health Resources & Services Administration

Notice of Award
Award Number: 6 H49MC32719-03-02
Federal Award Date: 10/04/2021

Maternal and Child Health Bureau (MCHB)

31. APPROVED BUDGET: (Excludes Direct Assistance)

[X] Grant Funds Only

[ ] Total project costs including grant funds and all other financial participation

a.	Salaries and Wages:	$341,339.00
b.	Fringe Benefits:	$143,128.00
c.	Total Personnel Costs:	$484,467.00
d.	Consultant Costs:	$0.00
e.	Equipment:	$0.00
f.	Supplies:	$24,505.00
g.	Travel:	$10,552.00
h.	Construction/Alteration and Renovation:	$0.00
i.	Other:	$201,181.00
j.	Consortium/Contractual Costs:	$365,612.00
k.	Trainee Related Expenses:	$0.00
l.	Trainee Stipends:	$0.00
m.	Trainee Tuition and Fees:	$0.00
n.	Trainee Travel:	$0.00
o.	TOTAL DIRECT COSTS:	$1,086,317.00
p.	INDIRECT COSTS (Rate: % of S&W/TADC):	$182,804.00
q.	TOTAL APPROVED BUDGET:	$1,269,121.00
	i. Less Non-Federal Share:	$0.00
	ii. Federal Share:	$1,269,121.00

32. AWARD COMPUTATION FOR FINANCIAL ASSISTANCE:

a.	Authorized Financial Assistance This Period	**$1,269,121.00**
b.	Less Unobligated Balance from Prior Budget Periods	
	i. Additional Authority	$0.00
	ii. Offset	$157,325.00
c.	Unawarded Balance of Current Year's Funds	$0.00
d.	Less Cumulative Prior Award(s) This Budget Period	$1,111,796.00
e.	AMOUNT OF FINANCIAL ASSISTANCE THIS ACTION	**$0.00**

33. RECOMMENDED FUTURE SUPPORT:
(Subject to the availability of funds and satisfactory progress of project)

YEAR	TOTAL COSTS
04	$1,144,121.00
05	$1,144,121.00

34. APPROVED DIRECT ASSISTANCE BUDGET: (In lieu of cash)

a. Amount of Direct Assistance	$0.00
b. Less Unawarded Balance of Current Year's Funds	$0.00
c. Less Cumulative Prior Award(s) This Budget Period	$0.00
d. AMOUNT OF DIRECT ASSISTANCE THIS ACTION	**$0.00**

35. FORMER GRANT NUMBER

36. OBJECT CLASS
41.51

37. BHCMIS#

38. THIS AWARD IS BASED ON THE APPLICATION APPROVED BY HRSA FOR THE PROJECT NAMED IN ITEM 14. FEDERAL AWARD PROJECT TITLE AND IS SUBJECT TO THE TERMS AND CONDITIONS INCORPORATED EITHER DIRECTLY OR BY REFERENCE AS:
a. The program authorizing statue and program regulation cited in this Notice of Award; b. Conditions on activities and expenditures of funds in certain other applicable statutory requirements, such as those included in appropriations restrictions applicable to HRSA funds; c. 45 CFR Part 75; d. National Policy Requirements and all other requirements described in the HHS Grants Policy Statement; e. Federal Award Performance Goals; and f. The Terms and Conditions cited in this Notice of Award. In the event there are conflicting or otherwise inconsistent policies applicable to the award, the above order of precedence shall prevail. Recipients indicate acceptance of the award, and terms and conditions by obtaining funds from the payment system.

39. ACCOUNTING CLASSIFICATION CODES

FY-CAN	CFDA	DOCUMENT NUMBER	AMT. FIN. ASST.	AMT. DIR. ASST.	SUB PROGRAM CODE	SUB ACCOUNT CODE
21 - 3898020	93.926	19H49MC32719	$0.00	$0.00	N/A	19-HIS-ERED

HRSA Electronic Handbooks (EHBs) Registration Requirements

The Project Director of the grant (listed on this NoA) and the Authorizing Official of the grantee organization are required to register (if not already registered) within HRSA's Electronic Handbooks (EHBs). Registration within HRSA EHBs is required only once for each user for each organization they represent. To complete the registration quickly and efficiently we recommend that you note the 10-digit grant number from box 4b of this NoA. After you have completed the initial registration steps (i.e.,created an individual account and associated it with the correct grantee organization record), be sure to add this grant to your portfolio. This registration in HRSA EHBs is required for submission of noncompeting continuation applications. In addition, you can also use HRSA EHBs to perform other activities such as updating addresses, updating email addresses and submitting certain deliverables electronically. Visit https://grants3.hrsa.gov/2010/WebEPSExternal/Interface/common/accesscontrol/login.aspx to use the system. Additional help is available online and/or from the HRSA Call Center at 877-Go4-HRSA/877-464-4772.

Terms and Conditions

Failure to comply with the remarks, terms, conditions, or reporting requirements may result in a draw down restriction being placed on your Payment Management System account or denial of future funding.

Grant Specific Term(s)

1. This revised Notice of Award is issued to change the Program Director in accordance with your Prior Approval request.

All prior terms and conditions remain in effect unless specifically removed.

Contacts

NoA Email Address(es):

Name	Role	Email
Tina Lester	Authorizing Official	tina.lester@nashville.gov
Fonda Harris	Program Director	fonda.harris@nashville.gov
D'yuanna Allen-Robb	Business Official	dyuanna.allen-robb@nashville.gov

Note: NoA emailed to these address(es)

All submissions in response to conditions and reporting requirements (with the exception of the FFR) must be submitted via EHBs. Submissions for Federal Financial Reports (FFR) must be completed in the Payment Management System (https://pms.psc.gov/).

Director's Update to the Board of Health

October, 2021

Protecting Health – Preventing the Spread of Infectious Disease

COVID

	Sept. 7	Oct. 7	Change
Weekly Attack Rate	14.4%	10.1%	-30.0%
New Cases per 100,000	85.4	35.4	-58.5%
Started Vaccination	59.0%	61.4%	4.0%
Fully Vaccinated	52.8%	56.3%	6.6%

Expect booster doses for Moderna and J&J to be approved mid-October.
Data on Pfizer 5–11-year-olds study to be reviewed by FDA late October.

Flu (and some COVID)

The statewide Fight Flu TN day will be Nov. 9. Flu shots will be distributed at no cost at all three preventive health sites (East, Lentz, and Woodbine), Plaza Mariachi, Southeast Community Center, and The Next Door. From Nov. 9 through the rest of the 2021 flu season, flu vaccine will be available at no cost for any individual six months and older who has not yet gotten it.

Until then we have flu vaccine in our clinics, and have had since Sept. 20. We are using appointments to ensure appropriate social distancing in each clinic. TennCare and Medicare Part B insurance are accepted and fully cover the fee. The fee for a flu vaccine for adults without private insurance is $35, and some people qualify for a free vaccine.

Our annual Metro employee flu shot effort began Sept. 24, and this year includes COVID shots as well. Metro employees can receive flu and COVID vaccines at drive-throughs set up around the city on the following dates: October 5th and 6th at Metro Southeast, October 6 and 7 at Fulton Campus, and October 13 and 14 at Lentz.

Back-to-School Immunizations

The three preventive health immunization sites had 3,032 encounter visits during the "Back to School" period (July 1 through Oct. 10). The most frequently provided vaccines among the total of 7,383 given were pediatric hepatitis A (965), TDaP (888), and Gardasil-9 HPV (753).

	2019	2020	2021	TOTAL
Total Vaccine Encounters (patient visits)	3,687	1,991	3,032	8,710
Total Number of Vaccines provided	13,962	5,650	7,383	26,995

Improving Health – Access & Care Coordination

Strong Babies

The MPHD Nashville Strong Babies (NSB) initiative was awarded $125,000 in supplemental funds to train and hire community-based doulas. Doulas are trained professionals who provide support to women before, during, and after labor and delivery. The inclusion of doula services in NSB builds on the initiative's equity and socio-ecological framework: Doula services are associated with improved perinatal outcomes such as reduced incidence of low birth weight, fewer birth-related complications, greater breastfeeding

initiation, etc., particularly for women of color. Nashville Strong Babies participants will have priority to complete doula training and to be hired as a doula as an initiative economic growth opportunity. Awarded Sept. 7, the funds will support the training of at least 15 community-based doulas who will support a minimum of 72 NSB families through March 2024.

Collaboration with Vanderbilt OB-GYN

The Preventive Health-Vanderbilt OB-GYN collaboration clinic was held in August and again earlier this month. In this collaboration, Vanderbilt residents, along with their supervising physician, conduct visits at Woodbine for patients needing additional women's health services such as colposcopy, ultrasound for difficult IUD insertion or removal, hormone level assessment, etc. This allows patients to have continuity of care within the MPHD system (rather than being referred out), provides in-person enrollment in the breast and cervical screening program to help offset costs for diagnostic colposcopy, and teaches MPHD nurse practitioners the skills needed to perform colposcopies so MPHD can continue to offer these expanded women's health services once the training is completed**.**

Enrollment

Numbers for our ACA enrollment efforts as compared to 2019:

Consumer Email	Family Size (Mom, Dad, Kids... You	How many # enrolled in a QHP? (ACA Health Insurance Plan)?	How many # enrolled in TennCare/CoverKids?	Assisted/ subtotals
Jul 1-31-2021	58	4	15	19
Aug 1-31-2021	67	9	14	23
Sep 1-30 2021	45	2	2	4
Oct 1-31 2021	1	0	0	0
1/1/21 thru current mo	***669***	***97***	***105***	***202***
11/1/19-Dec 31, 2019	***485***	***132***	***158***	***290***

School Health

This week is fall break for MNPS. COVID is slowing down in many areas but remains heavy in Antioch schools. We have a hiatus on hiring nurses due to annual leave and fall break, will resume next week. The COVID after hours team is staffed and functional. Our new supervisor Stacie Davis will start Nov. 1.

WIC

WIC's fiscal year began Oct. 1. The new Nutrition Plan has been submitted to the state. Benefits for fruits and vegetables have been enhanced through December. The mobile team has become active in the community and has begun providing grocery store tours to clients.

Dental

A Dental Educational slide show has been developed is now available to those waiting in the dental clinic in English and Spanish. School-based dental sealant programs are being conducted at Ida B. Wells Elementary, Amqui Elementary and Haywood Elementary.

Organizational Updates

Charter changes

We have met with Dewey Branstetter, chairman of the Charter Revision Commission, to go over the Metro Charter changes requested by the Board in November of 2019. As you know the process was put on hold during the worst of the pandemic. Mr. Branstetter was supportive of the changes and talked through the process with us. Next step is to convey the proposals to Council Member Angie Henderson, who has of Oct. 1 is the chairman of the Metro Council's Charter Revision Committee.

Health Equity

Anthony Johnson, formerly in Population Health (Youth Violence Prevention) has accepted an offer to join the Health Equity Bureau as the Equity Strategies Manager. Timothy McDaniel, a current temp with the COVID-19 team at MPHD, also accepted an offer as an Office Supports Specialist 2. Currently interviews are under way for a Project Director (HM3) of the CDC COVID-19 disparities grant, and the Epidemiologist 1, Partnerships Coordinator (PHA 1), and Research Analyst 2 have posted externally.

The Bureau of Health Equity is participating on the Health in All Policies Team. They presented on Oct. 6 to Judge Sheila Calloway's Rally Team (consisting of representatives from the Mayor's Office, General Services, Finance, Juvenile Court, and Planning) regarding next steps for the Health Lens Pilot Program on the Nashville's Youth Campus for Empowerment (NYCE) building project. The team has been invited to participate in planning meetings for the building expansion starting last week.

The Bureau of Health Equity also is working closely with Track Buck, Celia Larson, and KaShawna Lollis on re-tooling the department's strategic plan to achieve Chair Franklin's directive of SMARTIE goals and ELT buy-in.

The Bureau is beginning its planning process for establishing the city-wide Health Equity coalition as part of the CDC accelerator grant. The Bureau is also working closely with the Epidemiological division on a "collaboration agreement" towards centering health equity in epidemiological practices within MPHD and building partnership between the HE Bureau and the Epi division on current and future endeavors.

Breast Cancer Awareness Month

We are partnering with Nashville General Hospital during extended hours offering mammograms on Tuesdays and Thursdays all month. We have display tables set up in the preventive health clinics all month as well.

- **Saturday, October 9** – Partnering with the Nashville Soccer Club/Nashville Soccer Supporters Trust – setting up breast health awareness display table
- **Thursday, October 21** – MPHD Dress Down Day – 25 team captains to collect donations that will be divided between ACS & Susan G Komen
- **Friday October 22** - Pink & Purple Day- "Wear a Little Purple with Your Pink Campaign"
    - Several staff purchased Stronger Together t-shirts for October with the pink and purple ribbons
- **Friday, November 5** – Pink & Pearl Day "Lung and Breast Cancer Awareness Day"

MACC

Lauren Bluestone submitted her resignation as Director of Metro Animal Care and Control to accept a position with Broward County Animal and Adoption in Fort Lauderdale, Fla. Laura's last day with MPHD was October 1. We wish Lauren the best and are grateful for the progress she made at MACC during her time as director. Under Lauren's leadership, MACC reduced the euthanasia rate to less than 10% (save rate >90%), established strong relationships with agencies that support animal placement, and entered

into a partnership with Friends of MACC, a nonprofit dedicated to supporting MACC activities and operations. MPHD will post the director vacancy and begin a nationwide search for a replacement.

Inspectors
In Food & Public Facilities, Victor Oguntimehin has been promoted into a lead Environmental Health Specialist position. Victor began his career at MPHD at MACC before becoming a field Environmental Health Specialist. In his new role, Victor will provide training and guidance to field staff and work closely with establishment operators to assist them with getting into and remaining in compliance with all regulatory requirements.

Hispanic Heritage Month
The Bureau of Health Equity is launching a department-wide newsletter featuring ELT interviews, program spotlights, health equity resources, and local cultural events. The newsletter will also dedicate a section celebrating Hispanic Heritage Month, honor its significance and history, and list events happening in Nashville celebrating it.

Follow Us!
Please join us, if you haven't already, in following these sites and sharing our message with your networks.

Facebook: Facebook.com/MPHDNashville

Twitter: @NashvilleHealth

Instagram: @NashvillePublicHealth

Update: Drug Overdose Epidemic in Davidson County, TN
October 2021

Overdose Response Program (ORP)
Division of Behavioral Health and Wellness

****Public Health Emergency - Drug/Opioid Overdose Crisis in the U.S.****

On October 26, 2017, the drug overdose crisis was officially declared to be a public health emergency by President Trump. This determination was renewed by the Secretary of Health and Human Services, effective July 7, 2021.
https://www.phe.gov/emergency/news/healthactions/phe/Pages/opioids-7July2021-aspx.aspx

GRANTS

- U.S. DOJ Comprehensive Opioid, Stimulant, and Substance Abuse Program (COSSAP) Grant
- TDH-CDC High Impact Area (HIA) Grant

INTERVENTIONS AND ACTIVITIES

Overdose Fatality Review (OFR) Panel
- Seeks to examine and understand the circumstances surrounding fatal drug overdoses occurring in Davidson County.

ED Post-Overdose Discharge Protocol
- Initiative seeks to improve care through the use of peer recovery navigators, naloxone distribution, harm reduction strategies, and medically-assisted treatment (MAT).

Nashville Fire Department EMS Post-Overdose Follow-Up
- Implementation began in early January 2021.

Substance Use Linkage by ORP Social Worker
- Implementation began in November 2020. Activities include linking MPHD clinic patients with substance use disorder to available resources.

Data-to-Action with Local Prevention Partners
- Collaborating with prevention partners for targeted response to high-activity areas.

Data-to-Action with Local Homeless/Housing Partners
- Currently collaborating and implementing data-to-action activities with local homeless/housing partners surrounding the overdose crisis.

HIA Multidisciplinary Stakeholder Group
- Inaugural quarterly meeting held in July involving stakeholders from multiple sectors aimed at mitigating the local drug overdose crisis. Next meeting slated for October.

SPIKE ALERTS

- Multiple daily spike alerts were detected between 30-Sep and 02-Oct from the NFD-EMS and syndromic surveillance data systems.
- Since implementation in June 2021, the SPIKE Auto Text Program has been utilized 5 times (June 9, July 16, August 13, September 2, and October 4).

MEDIA

WKRN "One Pill Can Kill: DEA issues public safety alert, spike in overdoses linked to fentanyl" - September 27, 2021
https://www.wkrn.com/news/one-pill-can-kill-dea-issues-public-safety-alert-spike-in-overdoses-linked-to-fentanyl/

****Link to Public Health and Safety Advisory issued by ORP and community partners in February 2021 re: fake/counterfeit pills containing fentanyl:**
https://www.nashville.gov/sites/default/files/2021-06/Public_Advisory_Fake_Xanax_Feb2021.pdf?ct=1622820209

****Other Public Health and Safety Advisories issued by ORP:**
https://www.nashville.gov/departments/health/drug-overdose-information

WKRN "Clarksville doctor found guilty of running 'pill mill' where 2 patients overdoses" - September 27, 2021
https://www.wkrn.com/news/clarksville-doctor-convicted-of-running-pill-mill-where-2-patients-overdosed/

WKRN "Man who allegedly sold narcotics to homeless population now charged with murder" - September 24, 2021
https://www.wkrn.com/news/crime-tracker/man-who-allegedly-sold-narcotics-to-homeless-population-now-charged-with-murder/

WKRN "Police investigating suspected drug dealer's link to multiple overdose deaths in Nashville" - September 22, 2021
https://www.wkrn.com/news/crime-tracker/police-investigating-suspected-drug-dealers-link-to-multiple-overdose-deaths-in-nashville/

WKRN "Fentanyl found in Star Wars toy in Rutherford County" - September 2, 2021
https://www.wkrn.com/news/crime-tracker/fentanyl-found-in-star-wars-toy-in-rutherford-county/?ipid=promo-link

Social Media Panel - TBD
- Panel will include subject matter experts to interface with the community and discuss the drug overdose crisis. Event is currently being rescheduled with the aim for this month.

Update: Drug Overdose Epidemic in Davidson County, TN
October 2021

Metro Public Health Dept
Nashville/Davidson County
Protecting, Improving, and Sustaining Health

Data and Surveillance

Suspected Fatal Drug Overdoses

- Through October 2, there have been 543 drug overdose deaths (confirmed and suspected) in 2021, representing a 12% increase compared to the same time period last year.
- Fentanyl has been detected in 76% of overdose-related toxicology reports in 2021 (78% in 2020).
- Monthly Average
  - 2020: 51.8 suspected overdose deaths
  - **2021: 59.9 suspected overdose deaths**

Suspected Nonfatal Drug Overdose-related Emergency Department (ED) Visits

- Through October 2, there have been 1,965 overdose-related ED visits at local hospitals in 2021, representing a 2% decrease compared to the same time period last year.
- Monthly Average
  - 2020: 213.8 overdose-related ED visits
  - 2021: 215.8 overdose-related ED visits

Suspected Drug Overdoses Requiring NFD-EMS Response

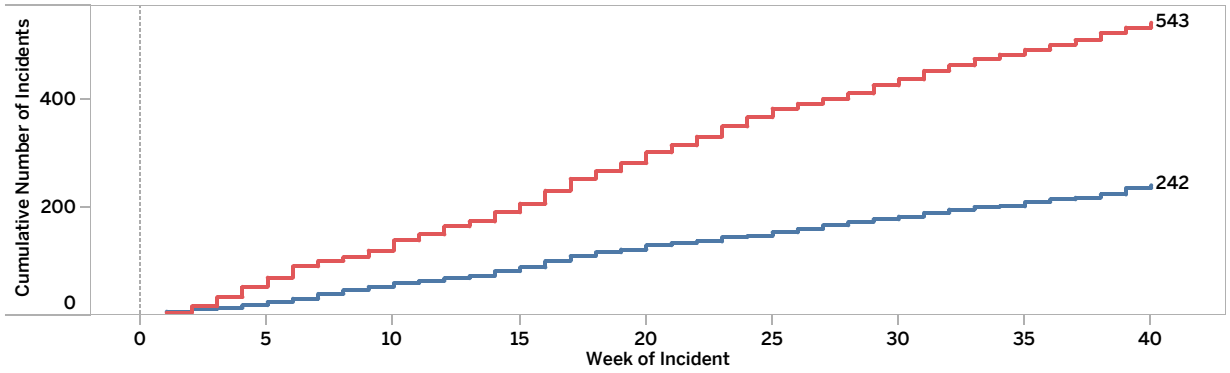
- Through October 2, there have been 4,413 suspected overdoses requiring NFD-EMS response in 2021, representing a 5% decrease compared to the same time period last year.
- Monthly Average
  - 2020: 484.9 suspected overdoses
  - 2021: 484.3 suspected overdoses

Syringe Containers Collected in the Community

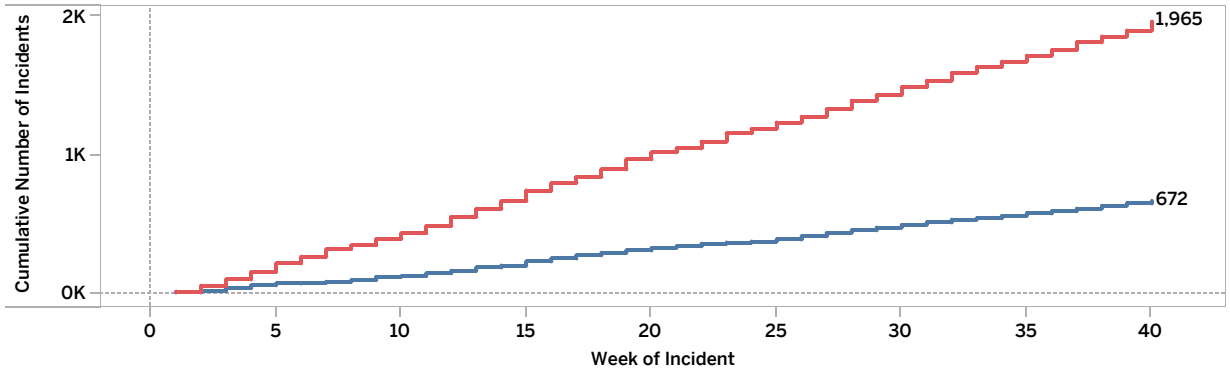
- Through August, there have been 1,248 syringe containers collected by the Metro Public Health Department in 2021, representing an 83% increase compared to the same time last year (each syringe container in estimated to collect between 400 and 430 1cc syringes).
- Monthly Average
  - 2020: 88.7 containers
  - 2021: 156.0 containers

Cumulative, Year-to-Date Drug Overdose Activity Compared to Baseline Year [2017=BLUE, 2021=RED]

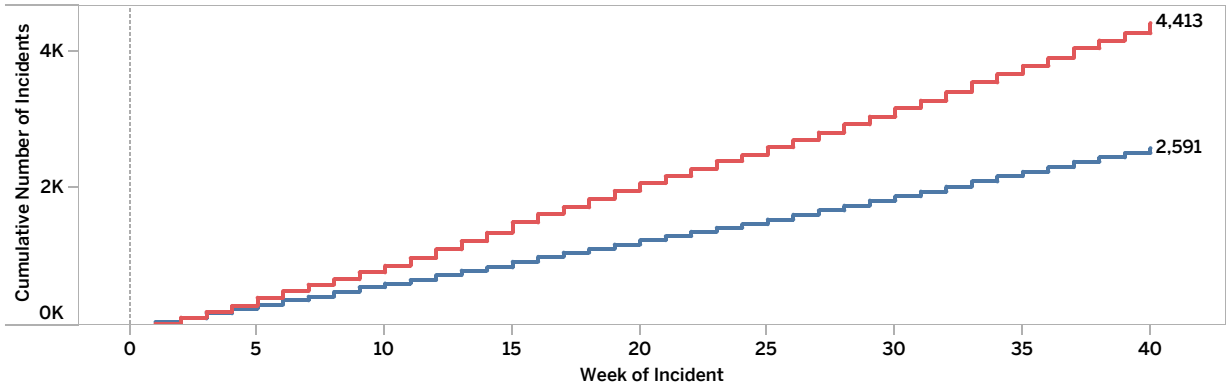
Suspected Fatal Drug Overdoses



Suspected Nonfatal Drug Overdose-related ED Visits



Suspected Drug Overdoses Requiring NFD-EMS Response



Prevention Categories for Activities/Interventions Conducted by ORP

The Overdose Response Program is involved in both actively implementing and supporting a multitude of community activities and interventions aimed at addressing all levels of prevention (primary, secondary, and tertiary). This ensures our program is applying a comprehensive approach which involves mitigating the currently burgeoning local drug overdose crisis while aiming to prevent substance use/addiction before it ever occurs.

Activity/Intervention

Overdose Fatality Review (OFR) Panel - primary, secondary, tertiary

ED Post-Overdose Discharge Protocol - primary, secondary, tertiary

HIA Multidisciplinary Stakeholder Group - primary, secondary, tertiary

Nashville Fire Department Post-Overdose Follow-Up - primary, secondary, tertiary

Substance Use Linkage by ORP Social Worker - primary, secondary, tertiary

Data-to-Action with Local Prevention Partners - primary

Data-to-Action with Local Homeless/Housing Partners - primary

Fentanyl Test Strip Distribution - primary, secondary

SPIKE Auto Text Program - primary, secondary

Drug Overdose Monitoring and Surveillance - primary, secondary, tertiary

Syringe Services Program (SSP) - primary, secondary

Definitions

Primary Prevention: "upstream" measures that prevent the onset of illness before the disease process begins. Immunization against infectious disease is a good example.

Secondary Prevention: measures that lead to early diagnosis and prompt treatment of a disease. Breast self-examination is a good example of secondary prevention.

Tertiary Prevention: involves the rehabilitation of people who have already been affected by a disease, or activities to prevent an established disease from becoming worse.

Metro Public Health Dept
Nashville/Davidson County
Protecting, Improving, and Sustaining Health

Overdose Response Program

Trevor Henderson | Director
Email: trevor.henderson@nashville.gov

Bridget Del Boccio | Coordinator
Email: bridget.delboccio@nashville.gov

Madelynne Myers, MPH | Coordinator
Email: madelynne.myers@nashville.gov

Brigid Vingan, LMSW | Social Worker
Email: brigid.vingan@nashville.gov

Josh Love, MPH | Epidemiologist
Email: josh.love@nashville.gov

Haley Hershey, MPH | Epidemiologist
Email: haley.hershey@nashville.gov

Metro Public Health Department Website

Drug Overdose Information
https://www.nashville.gov/departments/health/drug-overdose-information

Data Sources

Suspected Fatal Drug Overdoses
Death Investigation and Decedent Information (DIDI) Database (maintained by the Davidson County Medical Examiner (DCME))

Suspected Nonfatal Drug Overdose-related ED Visits
ESSENCE-TN

Suspected Drug Overdoses Requiring NFD-EMS Response
Nashville Fire Department Emergency Medical Services (NFD-EMS)

Notes

Data presented in this report were extracted on October 4, 2021 and are provisional. There may be additional fatal/nonfatal drug overdoses reported over this time period in subsequent reports as incidents that occurred from July 2021-September 2021 are not yet finalized. Suspected drug overdose deaths captured in the DIDI database represent deaths under DCME jurisdiction and do not necessarily indicate Davidson County residency status of the decedent.

If you have information on unusual overdose activity, please contact the Overdose Response Program

Opioid.Response@nashville.gov | 615-340-0498

Metro Public Health Dept
Nashville / Davidson County
Protecting, Improving, and **Sustaining** Health

Board of Health Request Tracking Form

Meeting Date: September 9, 2021

Request(s):

1. Dr. Wright will provide clarification on his decision to decline to issue a mask mandate
2.
3.
4.
5.

Assignments & Due Dates per each request:

1.
2.
3.
4.
5.

Outcomes:

1. Dr. Wright/martha emailed clarification on September 16, 2021
2.
3.
4.
5.

Response Filed in Board packet of October 14 2021 ***(date)***

PERSONNEL CHANGES
September 2021

NEW HIRES

Danielle Barbosa, AC&C Control Officer 1, 09/04/2021, $38,300.38 (MACC)
Lori Beck, Public Health Nurse 1 (71%), 09/04/2021, $41,626.66 (School Health)
Nettie Fisher, Public Health Nurse 1 (71%), 09/04/2021, $40,480.97 (School Health)
Ariel De La Torre, Public Health Nurse 1 (71%), 09/04/2021, $42,875.48 (School Health)
Karis Bates, Public Health Nurse 1 (71%), 09/04/2021, $41,626.66 (School Health)
Martin Joseph, Office Support Rep. 3, 09/04/2021, $35,121.46 (Medical/Vital Records)
Raquel de la Huerga, Program Specialist 3, 09/18/2021, $50,310.64 (Health Equity)
Landon Amonett, AC & Control Officer 1, 09/27/2021, $38,300.38 (MACC)

RE-HIRE

Anthony Martinez, AC&C Control Officer 1, 09/13/2021, $38,300.38 (MACC)
Cherlinda Bassham, Office Support Rep. Senior, 09/18/2021, $35,121.46 (Medical/Vital Records)

TERMINATIONS (VOLUNTARY)

Dana Stovall, AC&C Kennel Assist. 1, 09/07/2021, dept. transfer to Metro Action Commission (MACC)
Anthony Pardue, AC&C Kennel Assistant 1, 09/15/2021, resigned (MACC)
Erin Arnold, Public Health Nurse 1, 09/17/2021, resigned (School Health)
Breana Lesch, AC&C Kennel Assistant 1, 09/27/2021, resigned (MACC)
Erene Bell, Program Specialist 2, 09/29/2021, resigned (Nashville Strong Babies)
Jaira McKinney, Program Specialist 2, 09/30/2021, resigned (CHANT)

STATUS CHANGES

Sharna Lee, Dental Hygienist 1 (71%) – Lentz Dental, status change to Dental Hygienist 1 (100%) effective 09/04/2021
Kristen Gardner, Seasonal/Part-time/Temporary – MACC, status change to AC & Control Kennel Assistant 1 effective 09/04/2021

BUSINESS UNIT TRANSFERS

Christopher Alexander, Environmental Health Specialist 1 – FPFP, transferred to Engineering effective 09/04/2021
Katie Scholtman, Epidemiologist – PHEP, transferred to Health Equity effective 09/04/2021
Nicole Rondeau, Epidemiologist – Environmental Health Specialist 1, transferred to Air Pollution effective 09/04/2021

RECLASSIFICATIONS

Tina Lester, Bureau Director – Population Health, reclassified to Deputy Director of Health effective 9/01/2021
Joanna Shaw Kai-Kai, Medical Doctor – TB, reclassified to Medical Service Director effective 9/04/2021
Abigail Holloway, Human Resource Analyst 2 – Human Resources, reclassified to Human Resource Analyst 3 effective 9/18/2021