Corporation for National and Community Service

2010 Social Innovation Fund

National AIDS Fund

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2010 Social Innovation Fund

National AIDS Fund

Section 1 – Application

NOTE: The following successful application for a SIF grant has been redacted only to the extent that it identifies a potential contractor with whom a contract is not yet in place with the grantee. The posting will be updated and the redaction removed once the parties execute the contract.

PART I - FACE SHEET

APPLICATION FOR FEDERAL ASSISTANCE

Modified Standard Form 424 (Rev.02/07 to confirm to the Corporation's eGrants System)

1. TYPE OF SUBMISSION:
Application [X] Non-Construction

2a. DATE SUBMITTED TO CORPORATION FOR NATIONAL AND COMMUNITY SERVICE (CNCS):	3. DATE RECEIVED BY STATE:	STATE APPLICATION IDENTIFIER:
04/08/10		
2b. APPLICATION ID:	4. DATE RECEIVED BY FEDERAL AGENCY:	FEDERAL IDENTIFIER:
10SI114882	04/08/10	10SIHDC001

5. APPLICATION INFORMATION

LEGAL NAME: National AIDS Fund

DUNS NUMBER: 787936418

ADDRESS (give street address, city, state, zip code and county):
729 15th Street, NW - 9th Floor
Washington DC 20005 - 2132
County: District of Columbia

NAME AND CONTACT INFORMATION FOR PROJECT DIRECTOR OR OTHER PERSON TO BE CONTACTED ON MATTERS INVOLVING THIS APPLICATION (give area codes):

NAME: Maura Riordan

TELEPHONE NUMBER: (202) 408-4848

FAX NUMBER: (202) 408-1818

INTERNET E-MAIL ADDRESS: mriordan@aidsfund.org

6. EMPLOYER IDENTIFICATION NUMBER (EIN):
521706646

7. TYPE OF APPLICANT:
7a. Non-Profit
7b. National Non-Profit (Multi-State)

8. TYPE OF APPLICATION (Check appropriate box).

[X] NEW [ ] NEW/PREVIOUS GRANTEE

[ ] CONTINUATION [ ] AMENDMENT

If Amendment, enter appropriate letter(s) in box(es): [ ] [ ]

A. AUGMENTATION B. BUDGET REVISION

C. NO COST EXTENSION D. OTHER *(specify below):*

9. NAME OF FEDERAL AGENCY:
Corporation for National and Community Service

10a. CATALOG OF FEDERAL DOMESTIC ASSISTANCE NUMBER:94.019

10b. TITLE: Social Innovation Fund

11.a. DESCRIPTIVE TITLE OF APPLICANT'S PROJECT:
Expanding Access to HIV/AIDS Care

11.b. CNCS PROGRAM INITIATIVE (IF ANY):
SIF - Issue Area Healthy Futures

12. AREAS AFFECTED BY PROJECT (List Cities, Counties, States, etc):
Low income populations across the United States with a particular focus on the southern United States and high HIV incidence regions and populations.

13. PROPOSED PROJECT: START DATE: 09/01/10 END DATE: 08/31/11

14. CONGRESSIONAL DISTRICT OF: a.Applicant [DC 001] b.Program

15. ESTIMATED FUNDING: Year #: [1]

a. FEDERAL	$ 3,597,127.00
b. APPLICANT	$ 3,738,969.00
c. STATE	$ 0.00
d. LOCAL	$ 0.00
e. OTHER	$ 0.00
f. PROGRAM INCOME	$ 0.00
g. TOTAL	$ 7,336,096.00

16. IS APPLICATION SUBJECT TO REVIEW BY STATE EXECUTIVE ORDER 12372 PROCESS?

[ ] YES. THIS PREAPPLICATION/APPLICATION WAS MADE AVAILABLE TO THE STATE EXECUTIVE ORDER 12372 PROCESS FOR REVIEW ON:

DATE:

[X] NO. PROGRAM IS NOT COVERED BY E.O. 12372

17. IS THE APPLICANT DELINQUENT ON ANY FEDERAL DEBT?

[ ] YES if "Yes," attach an explanation. [X] NO

18. TO THE BEST OF MY KNOWLEDGE AND BELIEF, ALL DATA IN THIS APPLICATION/PREAPPLICATION ARE TRUE AND CORRECT, THE DOCUMENT HAS BEEN DULY AUTHORIZED BY THE GOVERNING BODY OF THE APPLICANT AND THE APPLICANT WILL COMPLY WITH THE ATTACHED ASSURANCES IF THE ASSISTANCE IS AWARDED.

a. TYPED NAME OF AUTHORIZED REPRESENTATIVE:	b. TITLE:	c. TELEPHONE NUMBER:
Bryan R. Wilt	Chief Fiscal Officer	202-408-4848 x 270

d. SIGNATURE OF AUTHORIZED REPRESENTATIVE:	e. DATE SIGNED:
	07/09/10

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Executive Summary

EXECUTIVE SUMMARY

Title: National AIDS Fund

Name of intermediary: National AIDS Fund (NAF)

Issue-based Social Innovation Fund (Healthy Futures)

Grant amount and period: $3,600,043; 9/1/2010-8/31/2011

Pre-selected subgrantees: No

PROGRAM DESIGN

Focus and goal(s): The Access to Care Initiative (A2C) aims to increase the engagement of people who know they are HIV positive but who are not effectively engaged in care by identifying evidence-based interventions that help clients and systems reduce barriers to care. GOAL: To support 7-9 innovative, public-private partnerships to improve individual health outcomes and strengthen local services systems, connecting at least 3,500 low-income and marginalized individuals with HIV to high quality health care and the supportive services they need.

Overview of qualifications and track record: NAF's mission is to leverage resources, develop leadership and advocacy, and foster community innovation to prevent new HIV infections and care for people living with HIV/AIDS. Through its network of 35 Community Partnerships NAF provides grants and support to over 400 community-based organizations annually and has leveraged and invested over $160M in HIV services over the past 21 years. NAF has deep content expertise in HIV/AIDS and a proven track record helping communities leverage funding dollars.

Overview of subgrant selection process: Qualified lead entities from each targeted area will compete for SIF A2C funding. Applicants must propose evidence-based programs. Satisfactory completion of a 3-

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month formative phase will be followed by a 3 to 5 year implementation phase (based on performance). Selected grantees will have a well-defined plan for achieving A2C measurable outcomes, evaluation of program effectiveness, performance improvement, and replication or expansion. A national external review process including pre-award site visits will determine final grantees and awards.

Overview of evaluation and support of subgrantees: [redacted] will serve as external evaluator and will work closely with NAF to provide ongoing TA to grantees on local evaluation design, tools, and data, and designing or adapting an intervention. TA providers will suggest solutions to challenges and help grantees continue to improve their interventions. A learning community will be fostered through national convenings, regular conference calls, an on-line work-space, as-needed TA visits and quarterly programmatic calls.

ORGANIZATIONAL CAPACITY:

Net assets: $9.554M

Annual grants budget: $7.595M

Number of staff: 21

Overview of organization capacity: NAF's Board of Trustees approves strategic direction and provides portfolio and fiscal oversight. Kandy Ferree, MCP, President and CEO, is responsible for overall strategic direction and fiscal management of the organization; Vignetta Charles, PhD, Vice President for Evaluation and Programs, oversees program evaluation implementation at the national and community levels and management of external evaluation consultants. Maura Riordan, MSW Senior Program Officer, A2C, is responsible for the NAF A2C portfolio. Victor Barnes, MA, Vice President, External Affairs is responsible for meeting the intermediary match requirement.

Bryan Wilt, Chief Fiscal Officer is responsible for all management of fiscal procedures and reporting. A centralized financial management structure insures accountability, integrity and accurate and timely

financial reporting.

Mr. Wilt and the NAF management team will ensure compliance with Federal requirements.

COST-EFFECTIVENESS AND BUDGET ADEQUACY:

Amount of requested federal funds to be subgranted: $3M

Percentage of requested federal funds: 83%

Match ratio: 1:1

Major sources of matching funds: Bristol-Myers Squibb and Walmart Foundation

How budget is aligned with program design: The proposed budget reflects all aspects of the program design from grant making to the provision of technical assistance, to ongoing program evaluation. The budget includes staffing to provide program monitoring and support, evaluation guidance, and fiscal and administrative operations related to SIF, as well as contracting with the [redacted] evaluation team. Resources for national grantee meetings, document development and dissemination, and other costs needed for a successful grantee selection process, program design and implementation and ongoing technical assistance as planned are also included.

Program Design

I. PROGRAM DESIGN

The National AIDS Fund (NAF) proposes to establish the Access to Care (A2C) Initiative, an issue-based Social Innovation Fund proposal addressing the priority area Healthy Futures: promoting healthy lifestyles and reducing risk factors that lead to illness. The goal of this initiative is to support 7-9 innovative, public-private partnerships to improve individual health outcomes and strengthen local services systems, connecting at least 3,500 low-income and marginalized individuals with HIV to high quality health care and the supportive services they need.

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After extensive research on the HIV/AIDS epidemic across the US, NAF has identified 15 communities where the SIF A2C Initiative can have the most impact. Areas were selected based on a range of criteria including: HIV and AIDS case rates, percentage of US total of new AIDS cases, number of annual diagnosed HIV infections, STD case rates, total estimated number of people living with HIV/AIDS (PLWH/A), and a significant population that is low income and underserved. NAF will challenge these areas: the cities of Atlanta, Chicago, Houston, Los Angeles, Miami, Newark NJ, New York City, San Francisco/Oakland, Washington DC, San Diego and Boston, and the southern states of Alabama, Louisiana, North Carolina and South Carolina--to examine the underlying barriers that prevent people with HIV/AIDS from accessing care and support services and to create sustainable systems-level change in their communities.

STATEMENT OF NEED

At the end of 2006, the Centers for Disease Control and Prevention (CDC) reported an estimated 1,106,400 persons in the United States were living with HIV infection, with 21% or approximately 260,000 undiagnosed (CDC 2006, MMWR 2008--full citations are available at http://www.aidsfund.org/sif). CDC estimates that approximately 56,300 people were newly infected with HIV in 2006 (Hall et al 2008). African Americans were estimated to have an incidence rate that was 7 times as high as among Whites. The national case rate for AIDS in 2007 was 12.5 per 100,000; seven of the selected geographic areas targeted for SIF investments have an AIDS case rate over 20; the District of Columbia has a shocking case rate of 148.1.

Despite the tremendous advances in HIV treatment, approximately 644,000 individuals living with HIV/AIDS in the United States are NOT receiving life-sustaining care and treatment. A2C will primarily address communities of color, especially African Americans, who are both disproportionately affected by HIV, and suffer worse health outcomes as a result of barriers to care. For example, of PLWHA in North

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Carolina not in care, 67% were African American; in the SF/Oakland area, African Americans with HIV are more likely to have unmet needs and are less likely to be receiving life-saving antiretroviral treatments. In Chicago, 84% of those who receive Ryan White services are people of color, including 70% African American; 70% of PLWA in the Atlanta area were African American.

Rural and urban regions in Southern U.S. have unfortunately joined the traditional urban epicenters in the severe impact of the epidemic in their communities. North Carolina (NC) illustrates the need to find effective strategies for reaching PLWHA in rural areas. Reif et al found that those in rural NC are less likely to receive needed HIV services than those in urban settings, and that stigma is a factor in whether one seeks or receives care (Reif et al 2005, 2006 and 2008). An estimated 38% of PLWHA in NC are not receiving primary care. Georgia's HIV/AIDS cases increased by about 27 percent from 2004 to 2007 and 52% PLWHA in the Atlanta area were not receiving primary care. In Louisiana, 41% PLWHA are not receiving primary care; of these, 28% reported that they were "not ready to deal with their HIV status," 19% indicated that they did not want others to know their status, and 18% reported using drugs or alcohol (2008 Louisiana Statewide Needs Assessment).

Meanwhile the epidemic continues to hit urban populations hard, and reaching disenfranchised populations with services is a challenge. In Chicago, 48% of PLWHA are not receiving primary care. New York City's HIV/AIDS Services Administration serves more than 31,000 people living with HIV/AIDS annually, yet as many as 60% of clients receiving their services have no regular HIV provider.

It is a time of tremendous transformation in the field of health care. Over the last decade, a spotlight has been shone on inequities in health outcomes based on race, socio-economic status and mental illness (IOM, 2003; NASMHPD, 2006, NCHHSTP 2007). Policy makers have prioritized reducing disparities,

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most recently in the national health insurance reform that has just been signed into law. In the field of HIV, the White House Office of National AIDS Policy is about to issue the first National HIV/AIDS Strategy in the history of the United States, with these key goals: 1) Decreasing incidence of HIV; 2) Increasing access to care and optimizing health outcomes and 3) Reducing Health Disparities.

New, evidence-based strategies that transform the way services are delivered and reduce barriers to care must be implemented, in order ultimately to reduce health disparities. Yet NIH and CDC have acknowledged that historical research and funding mechanisms have not adequately led to translation of science into community-based practice. NAF is a recognized leader in bridging this gap, as evidenced by our presentation at the 3rd Annual NIH Conference on the Science of Dissemination and Implementation in March 2010, "HIV Prevention: Bridging the Community-Science Gap." We bring this expertise to our SIF program design.

RATIONALE

For people living with HIV/AIDS, as for people with other chronic diseases, engagement in care equals life. Without care, people with chronic diseases suffer unnecessary illness and pain and die sooner. One recent study showed that patients who did not take antiretroviral treatments until their immune system showed signs of damage had a nearly twofold greater risk of dying--from any cause--than those who started treatment when their T-cell counts were above 500 (Kitahata 2009). Moreover, treatment is rapidly becoming recognized as a form of prevention. Data just presented at the Conference on Retroviruses and Opportunistic Infections indicate that antiretroviral treatment can help prevent HIV acquisition (Donnell 2010).

The A2C Initiative aims to increase the engagement of people who know they are HIV positive but who are not effectively engaged in care by identifying evidence-based interventions that help clients and

systems reduce barriers to care. Engagement in care for our purposes includes primary and HIV specialty medical care, as well as a range of services that support the client in accessing healthcare, such as peer support, case management, housing, and treatment for mental illness and substance use.

Unfortunately, access to care is not a simple matter of having enough doctors and nurses available--the long-term effects of social marginalization and poverty make improving engagement in care a critical social challenge. The reasons that people who are aware of their HIV positive status are not in care are complex, and may include stigma, denial, depression, lack of information about available services, suspicion of unfamiliar institutions, prior bad experiences with the health care system, poverty, lack of transportation, transience, mental illness, and addiction. Poor organization of systems of care--lack of coordination, rigidity, and "siloed" funding streams and service delivery systems--also plays a role.

The A2C Initiative will use the power of collaboration to help our portfolio of non-profit community organizations develop and implement innovative evidence-based approaches at both the client and the systems level. And because underserved people with HIV generally represent the most marginalized, disadvantaged sectors of the population, facing the most complex social, health and economic challenges, we are confident that strategies that work to engage PLWHA in regular care will be replicable with other disadvantaged populations and systems facing complex health challenges.

A. GOAL AND OBJECTIVES

Goal: To support 7-9 innovative, public-private partnerships to improve individual health outcomes and strengthen local services systems, connecting at least 3,500 low-income and marginalized individuals with HIV to high quality health care and the supportive services they need.

Objective 1: Within six months of award, to conduct a competitive selection process to identify 7-9

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community-based collaborations that:

* Are serving low socio-economic-status areas that are highly affected by HIV

* Have a track record of using evidence-based practices

* Have innovative ideas with at least preliminary evidence of effectiveness, and

* Have the capacity to effectively manage a SIF project including evaluation and expansion / replication of successful programs.

Community collaboratives will propose promising innovative, sustainable approaches designed to address the personal, societal and structural barriers to medical care faced by people living with HIV in their communities. Examples of such programs might be system-level improvements such as breaking down illogical silos that waste resources, for example between the STD and HIV systems of care; structural innovations such as the "patient-centered healthcare home;" or using health information technology for population-based care. Other evidence-based innovations may focus on how services are delivered, for instance the short-term, early intervention case management that has been shown to be effective in engaging newly diagnosed people in care (Gardnera 2005) or integrating peer supports in community-based settings and medical care teams (references at www.aidsfund.org/sif).

Objective 2: To build grantees' capacity to design and deliver programs to achieve moderate or strong evidence of effectiveness.

Recognizing that effective innovation and adaptation takes time and resources, A2C is designed as a multi-year, multi-phase grantmaking initiative, based on a successful model NAF has used in other initiatives. Grantees will use a 3-month formative phase to prepare for implementation by working with the target population to finalize service design, formalize organizational relationships, establish protocols, identify information technology and data collection needs, hire staff, etc. Grantees will then

continue with an implementation period of 3 years (conditional on progress).Based on the results of the initial 3-year implementation period, grantees may be eligible for a 2-year continuation grant for a total implementation period of up to 5 years. Throughout the period grantees will benefit from technical assistance (TA) provided by NAF and a qualified TA consultant team.

Objective 3: To create and foster a nation-wide "learning community" of grantees, evaluators, and local community collaborators, supporting continuous program improvement and expanding the number of programs that have moderate or strong evidence of effectiveness.

Building on its successful Community-Science Partnership (CSP) model, NAF will use telephonic or web-based sessions, regional in-person meetings, and an annual face to face convening to support grantees in sharing knowledge and enable them to exchange peer support, and also use these opportunities to provide training and build skills.

Objective 4: To plan and conduct a rigorous evaluation of grantee impact.

A highly qualified team of evaluation professionals from [redacted] has agreed to join A2C as the evaluator. They will work collaboratively with NAF's TA team, grantees, and in consultation with CNCS, to design the evaluation, capture baseline information, agree on outcome measures, and establish reporting procedures.

Objective 5: To disseminate A2C findings and best practices to the HIV community and to colleagues working to reduce health disparities in similar populations with other chronic diseases.

NAF will ensure that other service providers, funders and policy-makers have the opportunity to learn

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from our efforts. We will work with [redacted] and grantees to develop a dissemination plan and produce for submission to peer-reviewed journals, at least one paper per year focused on lessons learned from the A2C Initiative.

Objective 6: To support grantees to meet or exceed their required dollar-for-dollar cash match.

NAF will offer training, help identify and facilitate contacts with potential funders, and broker relationships with national funding organizations to expand community-based organizations' (CBOs) resource development capacity.

Objective 7: To meet or exceed the required intermediary dollar-for-dollar cash match.

NAF has already secured $4M in matching funds for the SIF program. We will work with businesses, government and foundation leaders as well as individual donors to raise at least one dollar for every dollar awarded to A2C by SIF.

Objective 8: To assure effective project management of SIF Access to Care Initiative.

NAF will maintain effective, efficient and accountable internal processes required to manage a project of this size, including strict fiscal procedures, high-quality information systems, strong administrative standards including conflict of interest, equal opportunity, personnel, and contract monitoring procedures. NAF has a history of managing large private and public grants, and our policies and procedures have been used as "best practices" by auditors and funders.

MEASURABLE OUTCOMES

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The A2C Initiative seeks to have impact at the client, organizational and system levels, and thus proposes outcomes at each of these levels.

Client level

a. Level of clients' access to HIV care and prevention services, for example:

- # of patients who remain in treatment after 12 months
- # of newly diagnosed PLWHA who access medical care within six months of diagnosis
- # who meet case management success criteria
- # who engage with peer support

b. Estimated behavioral change / averted infections from evidence-based interventions

c. Clients' perceived self-efficacy, quality of life, or similar qualitative subjective measures

d. % of clients with AIDS who are prescribed anti-retroviral treatment

e. % of clients with HIV infection who had 2 or more medical visits in an HIV care setting in the measurement year

Organizational level

f. # of programs that achieve moderate or strong evidence of program effectiveness

g. level of organizational capacity of grantees in areas such as leadership development, effective collaboration, data-guided planning, evaluation and implementation of evidenced-based interventions

System level

h. "cost-effectiveness" to clinical providers or to society at large

i. effectiveness of collaboration (i.e., did working collaboratively improve effectiveness?)

Project implementation information will be gathered from semi-annual data reports from grantees using

the NAF online PhilanTrack program management system. Building grantee's capacity to collect evaluation data and document results will be part of the TA provided to grantees.

For more complex measures we will use appropriate validated tools and measurement approaches selected or developed by the [redacted] evaluators in conjunction with CNCS and NAF. For instance, NAF is currently developing a capacity index to measure the effectiveness of Community Partnerships. To measure effectiveness of collaboration we might look at grantee's organizational "social network" pre and post project: at baseline, were there gaps in their network that limited their ability to help connect clients to care? Did collaboration help fill these gaps? Interviews with stakeholders and flow charts presenting how organizations assist clients to access care pre & post project are some examples of how changes in organizational effectiveness might be captured.

QUALIFICATIONS

The Social Innovation Fund program presents a well-timed and targeted opportunity for the National AIDS Fund, matching NAF's mission, capacity and current Board-approved strategic plan (www.aidsfund.org/sif) almost perfectly. NAF's current three-year plan has three pillars: 1) fostering community innovation, 2) leveraging resources and 3) supporting innovative and evidence-based approaches to HIV prevention and care.

NAF will be a strong partner to SIF in achieving our mutual goals. With more than 20 years of experience in the HIV/AIDS field, NAF has deep content expertise. Through 35 state and local funding collaboratives--our Community Partnerships--NAF provides grants and other support to over 400 community-based organizations annually and has established deep, long-standing and trusting relationships with communities across the country, proven our ability to help communities leverage funding dollars, and developed a Learning Community approach (described in section I.D.)

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Furthermore, NAF's Community-Science Partnership model (CSP) provides a structured method for bringing together scientists and CBOs in support of the development and spread of evidence-based approaches and attests to NAF's strong and evolving dedication to rigorous use of data and evaluation. The CSP model puts CBOs at the center of a TA / evaluation collaborative in which the funder provides flexible & formative funding and a structure to create group identity, promote peer exchange and support and motivate participants; and local evaluators and national experts help CBOs build knowledge & develop skills which ultimately enhance their sustainability by increasing critical organizational and programmatic capacity.

B. USE OF EVIDENCE

EVALUATION PLAN

NAF has formed a partnership with [redacted] to plan and execute a rigorous evaluation, provide TA, and identify programs that have moderate or strong evidence of program effectiveness. They will work closely with NAF's TA team led by Vice President for Evaluation and Programs Vignetta Charles, PhD, an expert in the design, implementation and evaluation of health interventions and grantmaking initiatives.

The A2C / [redacted] evaluation team is highly interdisciplinary, with substantial experience in HIV community-based work, clinic-based work, program evaluation, HIV treatment, behavioral and social science, analytic methodologies, multi-site interventions and a commitment to making a difference in the epidemic. [redacted]

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[redacted]

[redacted] will facilitate national exchange and learning among the evaluators via regularly scheduled conference calls (potentially weekly during formative phase, quarterly during implementation phase) and periodic site visits.

[redacted] will:

1. Provide ongoing program evaluation TA to help grantees with their local evaluation design, tools, and data interpretation and to troubleshoot evaluation questions as needed.

2. Work with key stakeholders (including the grantees, NAF, CNCS and others) to articulate a small number of critical, overarching evaluative questions.

3. Develop (in consultation) a set of national evaluation metrics for which data would be collected by each grantee and provide ongoing TA on data collection at each site.

4. Synthesize subgrantee reports to describe national progress made by the initiative. This would include, but not be limited to, answering cross-grantee questions such as:

* What barriers do clients encounter in accessing care, how can these barriers be accurately measured by grantees, and how have grantees overcome these barriers?

* What is the impact of programs on the lives of the clients? And are programs achieving a higher level of evidence and impact over time, as defined by CNCS?

* Has the investment in services resulted in sufficient health gains for the services to be considered "cost-saving" or "cost-effective" either to clinical providers or to society at large?

NAF has a strong track of using rigorous evidence in decision-making, including selection and

monitoring of grantees and strategic investments.

EXAMPLE STUDY #1--GENERATIONS: Strengthening Women and Families Affected by HIV/AIDS, is a national capacity-building grantmaking initiative to prevent HIV transmission among at-risk women and girls. It emphasizes the use of prevention science to support the expansion of the evidence base for effective HIV prevention intervention models for women, and dissemination and replication of effective programs to other communities using the Community-Science Partnership model.

The evaluation and TA team led by Dr. Cynthia Gómez of the Health Equity Institute at San Francisco State University helped the 8 grantees of the second round of GENERATIONS to create or adapt an evidence-based HIV prevention intervention for an at-risk population of women, moving from preliminary to moderate or strong evidence of impact.

To ensure dissemination to programs that may learn from the program, a CBO-friendly report was published August 2009, with press releases to announce the success of the programs and dissemination at the CDC Prevention Conference in 2009 as well as distribution of the publication throughout the NAF network (report at www.aidsfund.org/sif).

SELECTED GENERATIONS OUTCOMES

Girl Smart

Target Population: High-risk girls of color ages 15-21 in metro-Detroit

OUTCOMES: After attending Girl Smart, participants reported a statistically significant increase in knowledge about how to correctly use a condom (from 86.7% at pre-test to 96.5% at post-test); 100% stated that they are confident in their ability to talk with potential partners about using condoms before having sex; 96.5% stated that they can recognize the feelings that might lead them to engage in risky

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behaviors at the end of the program, compared with 89.6% at baseline.

Chieh Mei Ching Yi (The Sisterhood Project)

Target Population: Monolingual Chinese-speaking women massage parlor sex-workers

OUTCOMES: Only 20% of participants at pre-test knew that HIV was not transmitted by mosquitoes but 100% knew this at post-test (pre-post difference significant at $p<0.001$). This knowledge was retained by 89% of participants at the one-month follow-up. Before the intervention only 47% were very sure that they could ask a sexual partner about his sexual history compared to 84% at completion (before-completed significant at $p<0.05$); 75% continued to be "very sure" at follow-up. Less than two-thirds of participants knew how to correctly use a condom before the intervention but 100% of participants retained this skill after the intervention and at follow-up (before-completed significant at $p<0.001$).

Entre Amigas

Target Population: Recently-arrived Latina immigrants in Washington, DC, suburban Maryland, and suburban Virginia

OUTCOMES: After completion of the small group workshops: At post-test there was a statistically significant increase in the number of women who correctly identified that sex with an HIV-positive individual is risky (43.4% to 73.6%) and that kissing and hugging does not transmit HIV (86.8% to 98.1%); the percentage of women who identified using condoms with casual sex partners as a way to prevent HIV increased from 35.8% at pre-test to 75.5% at post-test, and the percentage of women who thought that oral contraceptives prevented HIV transmission decreased from 81.1% at pre-test to 15.1% at post-test; at post-test women reported a statistically significant increase in the number of people they could talk to about their problems ($p <0.001$).

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EXAMPLE STUDY #2--Southern REACH

Southern REACH is a NAF special initiative aimed at broadening and strengthening community capacity and policy advocacy in 9 southern states, through investments in the operations and programming of strategically positioned CBOs. NAF has engaged Emory University Center for AIDS Research to conduct a long-term, cohort-based study to assess overall processes and outcomes from the REACH program. Paula Frew, PhD, MPH, serves as principal investigator of the REACH evaluation project. Launched in March 2009, the study is still underway.

The evaluation plan was developed in collaboration with the National AIDS Fund in accordance with the Centers for Disease Control and Prevention's (CDC) "best practices" evaluation model, principles drawn from Utilization-Focused Evaluation (CDC 1999, Patton 2002) and using American Evaluation Association criteria.

Selected goals of the evaluation:

* Assess overall REACH grantee activities and outputs and how the underlying processes may or may not support desired outcomes and impacts

* Assess and document the extent to which REACH services and programs are contributing to overall individual and network level outcomes

* Utilize evaluation findings to strengthen ongoing HIV/AIDS organizational and programmatic capacity, service delivery, advocacy networks, and public policy influence

The evaluation design is a non-experimental, cohort study with non-randomized approach utilizing prospective quantitative and qualitative data from the cohort of organizations, their staff and board members, and clients. Our approach incorporates multilevel assessment of individuals, organizations, and communities to observe and understand the processes that contribute to outcomes and the impact

of the initiative.

The qualitative assessments include interim and final end-of-cycle interviews with leaders/representatives of the organizations, focus groups with grantee representatives to elicit the facilitators and barriers to their efforts in policy and advocacy, additional interviews with TA consultants, board members, and regional and federal policymakers, and focus groups with clients engaged in policy and advocacy efforts.

Ongoing quantitative assessments include a baseline survey administered to grantee representatives in spring 2009 shortly after funding notification, and a follow-up assessment to be administered approximately 12-months from the baseline.

Other research such as records review and content analysis will also be conducted. A client survey will yield quantitative data for analysis (see evaluation plan at www.aidsfund.org/sif).

Statistical analysis methods of baseline study: An exploratory factor analysis with varimax rotation was conducted with each of the three scales assessing baseline programmatic, organizational, and policy and advocacy capacities. The Cronbach alpha reliability method was used to estimate reliability of each scale. Scales were adjusted prior to regression analysis using SPSS. Basic frequencies were calculated to provide an overview of responses. Multiple linear regression models were used to analyze the association between potential impacts of the Southern REACH funding and baseline programmatic, organizational, and policy and advocacy capacities. Significant models were checked for linear regression assumptions and for multi-collinearity. Significant predictors of potential impacts were assessed at $p < .10$ levels given consideration of the small sample size.

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Results from evaluations such as these are disseminated through NAF's Community Partnership network and our Learning Communities. Each round of funding and its evaluation results shape the direction of future efforts.

The A2C Initiative is a result of years of integrating lessons and evaluation outcomes from previous Initiatives. NAF's commitment to raising the bar in HIV prevention precipitated the development of an 8-year collaboration with renowned HIV prevention scientist, Dr. Cynthia Gomez, and resulted in the development of the Community Science Partnership (CSP) described above. The CSP provided the model on which GENERATIONS was developed. Each subsequent request for proposal (RFP), project design and competitive selection of the GENERATIONS grantees has been informed by the lessons of this early work. Now, CSP model and cumulative lessons from GENERATIONS are being combined and applied to the challenge of increasing access to care for vulnerable, marginalized people with a chronic disease (HIV). A2C in turn will be rigorously evaluated and the process lessons and evaluation data will be cycled back to SIF grantees but also into the network of Learning Communities across NAF's portfolio.

C. COMMUNITY RESOURCES--See Section III b.

D. DESCRIPTION OF ACTIVITIES

SUBGRANTING PROCESS

For A2C, NAF will solicit collaborative proposals that are coordinated by a lead entity from each targeted high need area. The "Draft SIF NOFA" indicated that applicants with pre-selected grantees would be viewed favorably. While this criterion changed in the final NOFA, NAF used these early months to begin planning with prospective applicant communities. Therefore, we fully anticipate that applicants will have formed their local Collaboratives and will be prepared to undergo a rigorous

selection process to ensure the SIF requirements are met.

Qualifications for Lead Sub-Grantee Organization:

* Demonstrated leadership and experience in access to HIV care issues

* A strong theory of change underlying innovative proposed programs that show promise of demonstrating strong evidence of strong impact over time

* Strong administrative leadership, financial and management systems, and accountability mechanisms

* A strong, diversified funding base and demonstrated history of securing philanthropic resources for program sustainability

* Strong relationships with community-based primary care, HIV healthcare providers, state and local health departments

* Commitment and capacity to facilitate participation in national and local planning, evaluation and TA activities

* A demonstrated track record of using data and evaluation for performance improvement and achieving measurable outcomes related to A2C

* A commitment to use grant funds for replication or expansion of programs with strong impact

The A2C's funding structure is coordinated with the CSP model to support the use of evidence throughout the process. Applicants must propose programs that are based on at least preliminary evidence. They then must successfully use the 3-month formative phase to conduct research, involve the target population in program design, pilot test interventions and evaluations, and create detailed action plans before commencing full implementation of their program. This formative phase gives them the time and resources to thoughtfully tailor an intervention to their unique target community and allows NAF to assess the viability of the project and grantee before awarding full implementation phase

funding.

Selected grantees will have a well-defined plan for achieving A2C measurable outcomes, evaluation of program effectiveness, performance improvement, and replication or expansion. Each grantee will set annual targets that will contribute to the national goal of engaging at least 3500 individuals per year in care across the funded sites. Applicants will describe the systems and measures already in place that will facilitate evaluation of their proposed grant-funded efforts, using definitions of impact and evidence adopted by CNCS. Pre-award site visits are included as part of the national external review committee process before final grantees are determined and awards made. NAF has an extensive network of academic and community experts to tap for unbiased external reviewers and long-standing relationships with local community leaders and stakeholders to help us to cast a wide net to find high quality CBOs.

NAF's recent grant competitions have been highly competitive and garnered extensive responses; for example the most recent GENERATIONS round received more than 100 applicants for 6 grants; in the Southern Reach Initiative's most recent round, more than 50 applicants competed for 21 awards; and more than 600 applicants per year apply to the NAF AmeriCorps/Caring Counts' 50 slots, one of the most competitive volunteer service programs in the country.

TECHNICAL ASSISTANCE, SUPPORT & ACCOUNTABILITY

NAF has a 21-year history of working as a national grantmaking intermediary with a specific focus on building and sustaining long-term relationships with our network of Community Partnerships and CBOs. At the core of our work is a belief that impact is strongest when interventions are developed in partnership with local service providers and populations, informed by local needs and culture. This will define our approach to SIF.

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The establishment of shared short and long-term goals begins with the very earliest stages of an initiative. NAF uses a "ground up" approach and gathers information from the field--Community Partnerships, grantees, PLWHA, leaders in the field, etc.--to formulate the overarching concept.

The RFP then articulates the long-term goals of the Initiative. Pre-application TA calls provide a public forum to further clarify goals. Applicants in turn articulate local goals, objectives, interim and long-term benchmarks and outcomes via the use of a theory of change or logic model.

Grant agreements clearly articulate the parameters and process for modifications to program plans and/or budgets. All requests for modification are reviewed by the NAF Program Officer (PO); if proposed modifications have implications for the fidelity of the intervention or evaluation design, the TA provider and evaluator are also consulted before any modification is approved.

NAF knows success is predicated on our ability to support and increase the capacity of our grantees to design and implement evidence-based programs and to evaluate them. NAF has spent the past 8 years developing an approach we call "R3--Rigor, Relevance and Replication," which structures our TA and expectations of grantees regarding data collection and evaluation. The R3 model states that evaluation outcomes must be:

* the result of Rigorous and recognized methodologies
* Relevant and feasible in challenging, resource-constrained environments
* and, while not every intervention will be suitable for Replication, the intent to disseminate and replicate must be embedded as an expectation in the beginning.

Too often CBOs and grantmakers alike avoid evaluation for fear of negative results. With R3, evaluation is but one element of the Learning Community, a tool in a cycle of continuous improvement and

accountability.

R3 Cycle: Formative input from target population -> Program Design -> Evaluation Design -> Program Implementation ->Data Collection & Interim Benchmark Analysis -> Feedback Loop for Improvement Modifications -> Adjustments to Program Ensuring Fidelity -> Data Collection & Evaluation of Performance Measures -> Dissemination -> back to Formative Phase...

NAF sees building capacity as part of its core mission and is structured to deliver such support. NAF will ask applicants to identify areas where they want or need to build additional capacity; program officers may also identify TA that the grantee may not be aware of needing. NAF is experienced in providing organizational development TA as well as more technical support in the areas of evaluation, managing subcontracts, etc. NAF may provide TA directly, or match the grantee with local consultants with whom they can build long-term relationships that will last beyond the life of the grant. We will work with the grantee and TA provider to outline a scope of work and NAF will contract with the evaluators directly and manage the financial aspects of the agreement.

Based on our experience with GENERATIONS, fostering learning communities and creating Community-Science Partnerships have become two of NAF's core strategies for special initiatives. We see them as key to peer-learning, creative problem solving and sustainability. The collaborative relationship between grantees and evaluators empowers grantee staff to take ownership over the evaluation and its results.

Access to TA during the Formative Phase will provide grantees with the skills necessary to conduct formative research and design or adapt an intervention. Throughout the Implementation Phase, TA providers and evaluators from [redacted] will have contact with grantees, providing support and guidance as

grantees execute their programs with their target population, suggesting solutions to challenges that threaten to slow or derail an intervention, and helping grantees continue to improve their interventions.

In GENERATIONS, we fostered a learning community through national convenings and regular conference calls. We will use similar strategies for A2C. Conference calls help grantees to keep up to date on each others' programs and progress and provide the opportunity for them to voice challenges and receive feedback and suggestions from the others. Data review and continuous improvement in real-time occurs through these conference calls. Other modalities to support grantees and the development of a learning community will include TA visits to enable grantees to get help with challenges, broaden the relationship of the TA provider with CBO staff and provide targeted training; along with quarterly programmatic calls for the PO and all grantees.

MATCHING REQUIREMENTS AND SUSTAINABILITY

The National AIDS Fund was built on a foundation of using national resources to leverage local "challenge" or matching funds. To this end, we have leveraged and invested, through our Challenge rants Program alone, over $160M in HIV prevention, care and support services over the past 21 years. NAF will support grantees in achieving their matching requirements through the use of four specific strategies:

1. Using grantee convenings to provide hands-on training by NAF's expert staff in strategies for successful engagement of the private sector and to share lessons learned across the grantee cohort
2. Providing a web-based list of funding opportunities that match the focus of the SIF A2C activities but tailored specifically to local vs. national CBOs.
3. Using the contacts of NAF staff and Board of Trustees to identify corporate funders that have a strategic business interest in the topic or in the region of the country where A2C grantees are located,

and facilitating meetings at the highest levels

4. Brokering relationships with our national funding peers through affinity groups like Funders Concerned about AIDS, Blacks in Philanthropy, Hispanics in Philanthropy, Grantmakers in Health, Grantmakers for Effective Organizations, etc. and presenting them with opportunities to support the projects in their local communities or areas of funding interest.

ACCOUNTABILITY FOR SUBGRANTEES AND NAF; EXAMPLE METRICS

All applicants will be required to articulate goals, objectives, intermediate performance benchmarks and long term outcome measures. The proposal and the formal grant agreement (which is a legally binding document) will outline the deliverables, reporting requirements and any other conditions that need to be met for the grantee to remain in "good standing" with the terms of the Grant Agreement. The NAF Program Officer will be responsible for working with each grantee, the national evaluator and TA team to monitor progress toward stated goals and specific metrics. Site compliance procedures are described in the Organizational Capacity section.

Site level metrics will include cross-site measures and site-specific metrics that are relevant to the intervention(s) proposed by each applicant site. Grantees will be held accountable to metrics that are:

* Relevant to the project goals

* Standard measures used in research or "best practices" scenarios as articulated in the academic literature

* Feasible for CBOs to collect given the service settings and/or

* Likely to provide meaningful contributions to the continuous improvement of service delivery.

Potential grantee metrics:

- # of individuals connected to primary or specialty health care

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- # of individuals connected to supportive services that facilitate personal stability and adherence to medical care and treatment;

- Long-term tracking of improvements in individual and site-level health outcomes, e.g., CD4 count, viral load, and emergency room visits;

NAF holds itself accountable by measuring items such as:

- # of responses to RFPs

- # of new organizations responding

- Timeliness of competitive process

- # grantees participating in calls and TA meetings

- Grantee evaluations of NAF as funder and TA provider

Note that metrics discussed here are for purposes of accountability. Outcome and evaluation measures are presented in section I.A.

Organizational Capacity

II. ORGANIZATIONAL CAPACITY

A. ABILITY TO PROVIDE SOUND PROGRAMMATIC OVERSIGHT

ORGANIZATION HISTORY

The National AIDS Fund (NAF) is one of America's largest philanthropic organizations dedicated to eliminating HIV/AIDS as a major health and social problem. Its mission is to leverage resources, develop leadership and advocacy, and foster community innovation to prevent new HIV infections and care for people living with HIV/AIDS.

In 1987, as the HIV/AIDS epidemic began its devastating first decade in the U.S., the Ford Foundation convened experts to help determine an appropriate institutional and philanthropic response. With an

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initial investment of $2M in 1988-1990, the Ford Foundation helped create an organization that enabled communities to have a direct impact on the epidemic; encouraged the involvement of national philanthropies as well as local philanthropic leaders; and shaped public policy at the national, state and local levels.

As a result of Ford's forward-thinking organizing efforts, the National Community AIDS Partnership (today known as the National AIDS Fund) was launched. Consortia of concerned business, philanthropic and community leaders dedicated to fighting the AIDS epidemic in their local communities came together as Community Partnerships (CPs). Through the CPs, NAF used national Challenge Grants to leverage support locally and to create a structure for making community-level decisions about how and where funds should be spent to meet the most pressing local needs.

From the time of its founding, NAF's mission foreshadowed the goals of SIF: to strengthen the capacity of CBOs to effectively provide services, to leverage private and public resources, and in essence to create what we now call a learning community--a national mechanism through which communities and local agencies can share information and resources about effective work against AIDS. NAF and the activities of its Community Partnership network were (and still are) guided by data. To be eligible to join the CP network, local collaboratives had to conduct needs assessments and use the data: set local priorities, make a case from which to raise local matching funds for NAF's Challenge Grants, conduct competitive local grants programs and conduct evaluation as a key component.

Over the years NAF's portfolio of public and privately funded, national scale initiatives has grown exponentially. In 2008 the NAF Board of Trustees adopted a new strategic plan (www.aidsfund.org/sif) with three pillars: 1) leveraging resources; 2) fostering community innovation (by supporting evidence-based approaches to HIV prevention and care); and 3) developing leadership and advocacy capacity

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across the U.S. NAF set the goal of raising a total of at least $30M between 2009 and 2011 to support an array of grantmaking programs and special initiatives that are aligned with these three pillars and are funded by public funders, national private foundations, corporations and individual donors. These include:

* NAF Community Partnership Challenge Grants Program

* AmeriCorps: Training the Next Generation of Public Health and AIDS Leaders

* GENERATIONS: Strengthening Women & Families Affected by HIV/AIDS

* Southern REACH: Increasing Capacity of Organizations to Address Social Justice and Policy Issues in 9 Southern States

* Syringe Access Fund

* Health & Justice Initiative: Supporting Peer-based HIV Prevention and Community Reintegration programs for HIV positive individuals impacted by incarceration

* Access to Care -- inclusive of the proposed SIF project

NAF's strategic plan explicitly stated its intent to focus resources on those regions and populations that are most impacted by HIV/AIDS, including communities of color, men who have sex with men, injection drug users, and the Southern region of the U.S.

The A2C Initiative that is the focus of the current proposal is one of the new special initiatives identified in NAF's strategic plan. In the plan, NAF committed to raising and investing at least $500,000 annually to reduce or eliminate the structural barriers that prevent HIV+ individuals from knowing their status and getting access to treatment. Through the SIF planning process, NAF has already secured $4M in commitments from private funders to fast-track this initiative well ahead of the strategic plan goals. SIF is a game-changing opportunity to expand the scope and scale as well as expedite the time-line for A2C.

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EXPERIENCE IN PRIORITY AREA

A2C builds on GENERATIONS: Strengthening Women and Families Affected by HIV/AIDS, a collaboration between the National AIDS Fund and Johnson & Johnson that focuses on bringing evidence-based HIV prevention interventions to communities of at-risk women and girls in the United States. Recognizing the critical need for prevention strategies to curb the increasing HIV transmission rate among women and girls, the goal of the GENERATIONS program is to provide capacity-building services to empower local organizations either to

* develop and evaluate innovative interventions based on existing behavioral change theories and evidence or

* adapt proven prevention models for specific populations of women and girls at high risk for infection.

A second example of related experience is Southern REACH (Regional Expansion of Access and Capacity to Address HIV/AIDS), an initiative providing grant resources and technical support for broadening and strengthening community capacity to address HIV/AIDS for marginalized, at-risk, and underserved populations in nine targeted Southern states. REACH has supported more than 50 organizations serving populations that are disproportionately impacted by HIV/AIDS. As of April 1, 2009, the National AIDS Fund had invested nearly $4M in direct grants to agencies throughout the Southeast (in two funding cycles) and committed approximately $300,000 for providing TA to agencies. An independent evaluation found that organizational capacity-building efforts of REACH were highly successful.

NAF has a successful track record of managing large federal grants, including 16 consecutive years of managing an AmeriCorps program funded through Corporation for National and Community Service (CNCS) and over 10 years of Cooperative Agreements with the Centers for Disease Control and Prevention. NAF has a strong record of meeting or exceeding all CNCS requirements. The CNCS annual

report stated that NAF has "excellent recruitment and [100%] enrollment with a diverse class of members;" and "greatly exceeded the expected 400 volunteers." See section II.B. for further discussion of fiscal oversight capacity.

EXAMPLES OF EVALUATIONS

In addition to the evaluations described in the Use of Evidence section, NAF has commissioned rigorous evaluations of its Community Partnership program and the AmeriCorps/Caring Counts programs (www.aidsfund.org/sif).

The Community Partnerships Model Evaluation was conducted in 2008-2009 by Harder+ Company Community Research, in order to assess the lasting impacts of the Community Partnership model. Study methods included:

* Document review of NAF reports, publications and program records dating back to 1988.

* Online confidential surveys to collect standardized information from Community Partners and grantees

* Case studies of 7 Community Partnerships' staff, Advisory Board members, and grantees; using the multi-case study method, an approach to qualitative data collection and analysis that uses a rigorous analytic framework.

Partnership representatives and grantees both reported high levels of confidence in Community Partnerships' abilities to effectively address the HIV/AIDS epidemic in funded communities. A full 100% of Community Partnerships and 97% of grantees agreed that their Partnership had effectively addressed the HIV/AIDS epidemic over the past five years.

In 2008 NAF commissioned a multi-level retrospective evaluation study of the impact of the

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AmeriCorps/Caring Counts Program on alumni, host sites, Operating Sites, and the HIV/AIDS workforce. Ameen Consulting & Associates was hired as the independent evaluator. The evaluation combined survey and interview data for a random sample of alumni and provides detailed information from interviews with 25 host agencies and five City Supervisors. Study results demonstrate our program's success in training the next generation of HIV/AIDS and public health leaders and increasing capacity of both participating organizations and the field of HIV/AIDS.

The results of these reports are shared with the Community Partnerships, grantees, Board of Trustees and staff to identify areas for continuous improvement. Additionally, these reports are typically disseminated to peers in the field, funders and posted on NAF's website. Findings are highlighted in funder reports, shared in NAF newsletters and used as the basis for conference abstract submission and formal presentations.

To ensure evaluations meet high standards, NAF conducts a rigorous RFP-based competitive process seeking reputable evaluators that are either university based or members of professional evaluation firms with longstanding reputations for quality products. We look for evaluators with specific expertise in HIV and associated fields including community capacity development, information dissemination and design replication as well as explicit knowledge of diverse populations being served in the NAF portfolio. In some instances NAF will affiliate itself with a university to provided ongoing evaluation expertise as is the case with our GENERATIONS Initiative and with the current proposal.

Typically NAF requires evaluators to perform the following services:

* Design methods and tools for assessing process and outcomes
* Guide, as required, any data collection that staff or other contractors may conduct;
* Directly collect data that may require the additional capacity or the more objective perspective that

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the contracting evaluator can provide;

* Analyze qualitative and quantitative data;

* Provide a minimum of monthly consultations with NAF staff to ensure evaluation findings are regularly informing on-going programmatic development;

* Produce written evaluation updates and reports, inclusive of any available analysis, at a minimum of 6-month intervals.

NAF's philosophy is to create a culture of continuous improvement. In all of our programs, we share evaluation findings and incorporate them into ongoing programs. In addition to the Community Science Partnership and Learning Community approaches described above, NAF shares the results of evaluations for program improvement at Community Partnership Annual Meetings. Thirty or more community partners gather with NAF staff each year to review community best practices, present evaluation results, identify TA requirements and or resources, discuss changes in the national policy environment, and provide feedback to NAF on its performance as a national funder and TA provider.

Most NAF programs are specifically designed for the purpose of strengthening the evidence base and replicating and expanding effective programs. In fact, A2C is itself a replication and adaptation based on the GENERATIONS experience.

The Community Partnership/Challenge Grants model, the signature portfolio at NAF, has been replicated in 35 cities or regions in 27 states and the District of Columbia, since 1988. AmeriCorps/Caring Counts has been replicated for 15 years with an expanding number of operating sites and more than 500 trained volunteers, many of whom enter the field of public health upon completion of AmeriCorps service. GENERATIONS, Southern REACH and the Syringe Access Fund (SAF) are all programs in which evaluations of the initial funding round led to subsequent rounds that

built on lessons learned and expanded to new communities; Southern REACH is in its 3rd round, SAF is in its 6th round, and GENERATIONS is in its 3rd round. Curricula from GENERATIONS has been used by new GENERATIONS grantees and replicated in the community at large.

NAF has nine program staff whose job is to support and monitor agencies in their implementation and evaluation efforts. A "Partner Extranet" on the NAF website provides a web-based workspace for grantees to share resources, news, working documents, etc. A quarterly newsletter spotlights successes and new ideas.

NAF is well-equipped and experienced in managing multiple programs at different locations. Our portfolio as described throughout is national and multi-site. NAF has established mechanisms for connecting program participants through common program elements and cross-site communication and planning. These include a national convening, standardized access to TA and evaluation expertise and regular program oversight including on-site visits. Finally, we use our new website extranet as well as e-mail distribution lists to maintain efficient communications and information exchange across sites that help to build the sense of a national community.

NAF has 2 general types of programmatic relationships with community organizations:

1) Community Partnerships. At the state, regional and local levels, Community Partnerships serve not only as collaborative fundraising and grant making bodies, but also as neutral conveners, TA providers, program compliance monitors, community builders, and policy advocates. In relationship to the CPs, NAF operates as a funder, coordinating body and provider of organizational and fundraising technical support.

2) Direct grantmaking for special initiatives. This is the model proposed for the SIF / A2C Initiative. In

this case, NAF operates as direct funder to programs, monitors compliance and evaluates performance, and also serves as mentor and collaborator; increasingly, TA has also accompanied NAF grant making initiatives.

Ensuring site compliance begins with a strong selection process for our community partnerships and our directly funded grantees. In CP areas, NAF utilizes the Community Partners to select grantees that exhibit sufficient organizational capacity to meet program requirements. An equally rigorous selection process is undertaken, using external experts and community stakeholders, for our directly funded grantees. Once grantees are selected, NAF uses on-site visits, semi-annual reports, regular calls, and audits to ensure program compliance. NAF requires the submission of written documentation for all funds raised as "matching funds" to meet our Challenge Grant requirements. NAF's national funds are not released to local grantees until matching fund documentation is verified; similar program compliance requirements are placed on our direct grantees before resources are released.

The NAF PO will be responsible for monitoring grantee compliance with reports, grantee participation in TA, evaluation and convenings. If a grantee is determined to be lagging behind the time-phased program deliverables stated in their funding proposal and grant agreement, or if deficiencies are noted in other areas (e.g. narrative or budget reporting, participation in grantee convening) NAF will follow a formal protocol with progressive steps that give the grantee the opportunity to correct the problem(s), or, if performance continues to be unacceptable, to rescind the grant in an orderly manner.

B. BOARD OF DIRECTORS, ADMINISTRATORS, AND STAFF

The NAF Board of Trustees includes 15 dedicated individuals with broad public health and corporate backgrounds, with expertise in HIV/AIDS, fundraising, research, direct services, marketing, the media, strategic planning and law. Trustees include representatives from Fortune 500 Companies, major

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national foundations, academic institutions, people living with HIV/AIDS and two Community Partner representatives. The Board approves strategic direction and provides portfolio and fiscal oversight including approval of proposed expenditures and resource generation. Trustees have also been involved in raising funding for the program and facilitating professional development experiences for NAF staff, program participants and grantees.

Kandy Ferree, MCP, President and CEO, is responsible for overall strategic direction and fiscal management of the organization. She has over 15 years of management experience. In her ten years with NAF, she has led an organizational restructuring and visioning process that has resulted in NAF's annual budget growing from $2M to over $12M. She has extensive experience in designing, implementing and evaluating HIV/AIDS prevention and care services, community capacity building, group facilitation and corporate training, as well as philanthropy and grantmaking at the community and national levels. She will provide strategic guidance and play a lead role in the national and local resource development activities associated with the SIF.

Vignetta Charles, PhD, Vice President for Evaluation and Programs, has the primary responsibility for overseeing program evaluation implementation at the national and community levels, management of external evaluation consultants, compilation of findings and effective strategies for information dissemination. She will be responsible for monitoring the implementation of all aspects of the A2C Initiative at the national and regional levels.

Maura Riordan, MSW Senior Program Officer, A2C, will have overall responsibility for the NAF A2C portfolio and will work closely with the newly hired program officer who will have the primary responsibility for day to day program management of the A2C Initiative. Maura has been executive director of front-line community-based HIV/AIDS organizations. Her experience and her leadership on

healthcare access issues are a valuable asset to NAF and the A2C initiative.

Program Officer (TBD) MPH, will be the primary staff person for the support and management of the Social Innovation Fund A2C Initiative. The incumbent will have experience in federal program management, and relevant experience in the field of HIV/AIDS healthcare, health disparities and access to care issues in the U.S.

Victor Barnes, MA, Vice President, External Affairs, works to align communications and resource development efforts with an eye to strategic partnership development. Victor is a senior leader in the field of HIV/AIDS. Key former positions include Director, The Corporate Council on Africa HIV/AIDS Initiative; Deputy Director Division of HIV/AIDS Prevention, CDC, and Deputy Chief, USAID Division of HIV/AIDS. He will have the primary responsibility for meeting the match requirement for the A2C Initiative.

Lauren Fayish, B.S., Program Associate, A2C, joined the Fund in January 2008 after completing a year of service in the National AIDS Fund AmeriCorps/Caring Counts Program. Following her service year, Lauren also worked as a consultant to the National AIDS Fund to research and analyze expanding the NAF AmeriCorps Alumni Network.

Hortense Hunter, Executive Assistant to the President, has worked in the non-profit sector for more than 30 years. Prior to joining NAF, she provided office management and executive support for a non-profit focusing on women's empowerment and health issues.

PLAN FOR SELF-ASSESSMENT

NAF has an operational plan based on our 3 year strategic plan. It is reviewed on a semi-annual basis to

assess progress toward identified outcomes across all departments. Following this, a departmental performance review provides an opportunity to revise or revamp operational approaches or, when necessary, alter operational outcome expectations. The operational plan covers all aspects of the organization including systems and organizational structure, and identifies staffing and capacity requirements linked to operational and programmatic performance. NAF periodically works with external consultants to refine our mission and vision or to assist in strategic planning.

On an individual level, all staff benefit from ongoing performance evaluations with their supervisors, which include the development and monitoring of personal work plans. While a comprehensive performance review tool is completed annually, performance evaluation is considered an ongoing activity.

Finally, NAF gathers feedback from grantees and partners through surveys or focus groups as a regular part of every program we operate.

II. B. ABILITY TO PROVIDE FISCAL OVERSIGHT

NAF has been a grantmaking institution for more than 20 years. It conducts competitive processes for awarding grants to a diverse portfolio of non-profit organizations, negotiates written grant agreements that include specific goals, objectives and measurable outcomes, and monitors performance of grantees.

A partial list of NAF's strategic collaborations includes Johnson & Johnson, Bristol-Myers Squibb, MetLife, Walmart Foundation, the Ford Foundation, the Elton John AIDS Foundation, Levi Strauss Foundation, and the Irene Diamond Fund. These are in addition to our partnerships with local community foundations and local philanthropies across the US.

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NAF recently implemented the PhilanTrack online grants management system, giving it the capacity to easily conduct pre-grant due diligence, and, once grants are awarded, to efficiently track grant dollars, determine how funds are being used and evaluate the impact funds are having on organizational and programmatic goals. PhilanTrack enhances data collection and improves reporting to the Federal government, other donors, trustees and other stakeholders.

NAF has extensive experience and infrastructure in managing grants as illustrated throughout this narrative. AmeriCorps is an example of NAF's fiscal management capacity. AmeriCorps is particularly complex as it requires financial management of member costs (i.e. stipends, health insurance and other direct member expense). In addition, the operating sites and host agencies are required to report on in-kind contributions to the program. The CFO is responsible for tracking and reporting this fiscal information to CNCS ensuring that the program is in compliance with the match requirements outlined in our grant agreement.

Bryan Wilt, NAF's Chief Fiscal Officer (CFO) is thoroughly familiar with the federal payment management system; he prepares quarterly reports of budget-to-actual income and expense comparisons, and generates appropriate quarterly reports and FSRs through the Web-Based Reporting System and eGrants. A centralized financial management structure insures accountability and integrity of process, combined with accurate and timely financial reporting.

Mr. Wilt holds a BS in Accounting and over twenty-seven years of experience in accounting, investment and fiscal management for private business, non-profit agencies, foundations and national non-profit organizations. Since joining the Fund in 2001, Mr. Wilt has strengthened the organization's fiscal systems, policies and controls by implementing integrated, cross-departmental database software. He is responsible for all management of fiscal procedures and reporting on all incoming grants from both

public and private sources.

NAF's Board approved budget for FY2010 is $ 12.6M. A successful SIF application would add $3.6M from CNCS and related matching funds from the private sector. This would take NAF's annual budget to approximately $20M of which the CNCS/SIF award would account for 19%.

Budget/Cost Effectiveness

SECTION III -- COST EFFECTIVENESS AND BUDGET ADEQUACY

A. BUDGET AND PROGRAM DESIGN

NAF will obtain diverse non-Federal resources for A2C by working with businesses, government and foundation leaders as well as individual donors to raise at least one dollar for every dollar awarded to A2C by SIF. As listed in II B, NAF has made strategic partnerships with large corporations and foundations and has extensive relationships with donors that enable us to leverage resources for the benefit of underserved communities.

NAF's has more than 20 years of grantmaking experience at the national, regional and local levels. NAF uses time tested methodologies to determine program costs including the competitive selection of grantees, program evaluation and TA. NAF is confident that the resources allocated for program implementation are sufficient to support anticipated programmatic outcomes. The SIF budget is modeled after other NAF Special Initiative budgets (e.g. GENERATIONS, Southern REACH) that have been tested over time, tracked by account code, and proved to provide sufficient resources to meet the program management, technical assistance and evaluation outcomes of those projects.

The NAF budget includes approximately $10,000 for convening an external review and selection committee. This includes resources for pre-selection site visits to a subset of finalists where a site visit is deemed important. NAF internal resources, namely our 35 Community Partnerships provide additional

on the ground resources enabling NAF to assess grantee experience and expertise without additional costs to the initiative.

Over two decades, NAF has learned that program evaluation requires internal staff attention to ensure effective monitoring at the national and sub-grantee levels; and requires an external, independent evaluation contractor to ensure efficacy. NAF has allocated .4 FTE for the Vice President for Programs and Evaluation to manage and oversee all aspects of program implementation and evaluation. She will also be the liaison to the [redacted] team. The Senior Program Officer for A2C and a newly hired program officer will support day to day project implementation and work with collaborators at each sub-grantee site to ensure compliance with data collection and evaluation activities. These personnel resources represent approximately $140,000 not including additional support from other senior staff at NAF.

In addition to our internal resources, NAF has allocated $300,000 to support the independent, external evaluator. The budget is painstakingly designed to provide specific support to grantees through planning/formative phase and ongoing technical assistance in evaluation, including assistance in the design and implementation of evaluation methodologies, data collection tools, site-level training on data collection and final analysis and reporting.

The SIF budget includes $250,000 to support a team of technical assistance providers and an additional $50,000 for travel, training, travel and materials development. NAF has a successful history building learning communities and peer support and technical assistance networks among grantees. The most effective way to do this is by hosting a grantee convening at least annually. To this end, the budget allocates $75,000 for all costs (travel, lodging, meals, etc.) for the 9 sub-grantees to select and send a group of 5 individuals from their local collaborative to each technical assistance convening. These meetings will be planned and facilitated by NAF staff, the TA team and evaluation team. A unique

component of NAF's proposed model is the inclusion of a three-month Formative Phase. The resources dedicated to this element of the budget total approx $1M.

In support of these resources dedicated to grantee success, our online grantee tracking system, PhilanTrack will assist with information dissemination among the grantees and their external constituents, and monitor grantee progress on an ongoing basis.

B. MATCHING SOURCES

The National AIDS Fund has secured 100% of matching resources for FY 2010 from Bristol-Myers Squibb and Walmart Foundation and has negotiated with BMS and Walmart consideration for additional resources for up to 5 years of program support for A2C. NAF is also seeking private foundation support from Kellogg and Kresge Foundations to assure resources to guarantee program sustainability in the out years and to support community level resource generation for matching funds.

NAF's Community Partnership Challenge Grants mechanism described above is a proven model to assist communities in meeting resource needs at the local level. NAF is also dedicating .2FTE for the Vice President of External Affairs to work with grantees, assisting them in the process of resources identification and acquisition at the local level as well as resource generation at the intermediary level to assure adequate resources across the initiative. The longstanding resource generating record on the NAF and specifically its Challenge Grants program, generating well above two to one matches of resources at the local level on an annual basis, reflects the proven ability of NAF to identify and generate external resources in a timely manner.

Clarification Summary

Programmatic Issues for Clarification

1. The National AIDS Fund is committed to reducing the incidence and impact of HIV/AIDS

domestically, and nowhere is that need greater than in the Southern United States. The South has some of the nation's highest AIDS rates while receiving the smallest allocations of federal and private funds compared to other regions of the country. NAF was the first grant maker to develop Community Partnership funding mechanisms in the Southern U.S. and has had a consistent presence since our founding in 1988. NAF is currently the second largest funder of HIV/AIDS work in the Southern U.S., and has extensive experience with the unique cultural and structural challenges contributing to the growing HIV/AIDS epidemic in this region. Stigma, high rates of incarceration and sexually transmitted infections, along with poverty, rural geography, and a fragmented health care system are all major obstacles to eradicating the spread of HIV/AIDS in the states of the Deep South. These challenges perpetuate the spread of HIV and also act as major barriers to accessing care for people living with HIV/AIDS.

Through our initiatives of Southern REACH and the Gulf Coast Relief Fund, the National AIDS Fund has invested significant resources into addressing these challenges with organizational, programmatic, and policy advocacy capacity-building. This ongoing work has resulted in strong relationships with funders and service providers, as well as the expertise to strategically target barriers to care throughout the region.

Building upon this expertise and these relationships, the National AIDS Fund will encourage collaborative proposals for the Access to Care Initiative from our Community Partnerships and our extensive network of community organizations, including CBOs specifically engaged in the South, in anticipation of responses from a minimum of five Southern states including Alabama, Georgia, Louisiana, North Carolina, and South Carolina.

The multitude of cultural and structural barriers to HIV care in the South presents many opportunities to apply innovative and/or evidence-based strategies to dramatically improve access to health care for

people living with HIV/AIDS (PLWHA). We expect that proposals from the Southern States will have a particular emphasis on the needs of rural communities which face some of the steepest barriers to accessing care. For instance, rural communities in South Carolina bear a disproportionate burden of HIV/AIDS. An intensive case management intervention has been shown to improve engagement with HIV medical care system in urban areas of the state, and with additional funding there is the opportunity to modify this successful intervention for use in rural communities.

In North Carolina, the rural geography and a lack of public transportation infrastructure create primary barriers to accessing HIV-specific health care. The majority of HIV medical specialists practice in urban areas of the state, which are inaccessible to rural populations. To improve access to critical medical services, public health programs are contracting with doctors in urban locations to provide services in rural communities through a mobile medical clinic.

Innovations are emerging in areas of the South to address the needs of rural populations; however, funding is severely limited for HIV-specific health care and auxiliary services that can reduce barriers to care. As state budgets are cut, there is simply not enough funding to maintain, yet alone improve public health infrastructure for PLWHA. With support from the Social Innovation Fund, the National AIDS Fund would be able to fund critical support services for PLWHA that would otherwise not exist.

2. It is true that critical, HIV/AIDS-specific, federal funding is available through the Ryan White Care Act (Care Act). However the unfortunate reality is that these dedicated resources fall woefully short of the growing needs of PLWHA. Currently CDC estimates there are 1.1 million individuals living with HIV/AIDS in the United States. Of those, half do not have reliable access to care, including 21% who are unaware of their HIV status. HIV/AIDS is increasingly impacting communities of color, low income individuals and the most marginalized populations facing a myriad of social and economic challenges

that prevent access to the limited services that are available. Understanding how PLWHA access health care offers insight into why they rely so heavily on publicly-funded programs -- most are economically disadvantaged with 54% of PLWHA on Medicaid and/or Medicare as opposed to 28% of the general population and only 17% with access to individual or group private health insurance.

Together, Medicaid and Medicare, the two federal health care programs that account for approximately 80% of all federal funding for HIV care. Yet Medicaid and Medicare do NOT provide care in keeping with the U.S Government's own treatment guidelines, as care is largely restricted to those who are fully disabled and leaves out the majority of people living with HIV. The Ryan White Care Act is the only HIV-specific publicly-funded health care program (approximately 80% federal - 20% state) and largely the only program that provides health care to non-disabled people living with HIV. While important, the CARE Act is not keeping pace with growth in the HIV/AIDS epidemic. Between 2002-2007, the number of people living with AIDS increased by 30%, yet Ryan White program funding (when adjusted for inflation) decreased by 5% during the same time period. Additionally, without increases in the AIDS Drug Assistance Program (ADAP), the disparity between care needs and funding is even more glaring.

In the U.S., nearly 50% of PLWHA who already know their HIV status are not in regular medical care. Early and reliable access to HIV care and treatment helps patients with HIV live healthy and productive lives and is more cost effective. Increased need for public HIV/AIDS programs coupled with chronic state and federal underfunding of HIV has created a burgeoning crisis. States, cities, and counties are currently experiencing record deficits and are consequently cutting funding for state and local health departments' HIV, STD, TB, and viral hepatitis programs. To compound this problem, these cuts come after several years of state and local cuts driven by budget deficits. According to a December 2009 survey of states' HIV/AIDS programs conducted by National Association of State and Territorial AIDS Directors (NASTAD), state HIV/AIDS funding reductions totaling more than $170 million occurred in

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29 states during FY 2009. The state budget outlook for FY2011 and beyond once again is dire, and health departments and community-based organizations (CBOs) continue to reduce staff and services. Over one third (33%) of all programs reported in the NASTAD survey anticipate a decrease in state funding in FY 2011. HIV/AIDS clinics around the country continue to close and/or cut hours and services.

So, while federal resources for HIV/AIDS exist -- they are woefully inadequate. There is no question that Social Innovation Fund resources can and should play a strategic role in the fight against HIV/AIDS. Most important, is the fact that the aforementioned funding sources pay for direct services -- medical visits, medications and to a much lesser degree, case management services. However, none of these resources are eligible to be spent on outreach to the most marginalized populations and frankly, are not spurring innovation.

Limited federal funds have been available for Access to Care demonstration projects via the HRSA Special Projects of National Significance (SPNS) funding mechanisms. NAF has already been in touch with Carol Tobias, SPNS evaluator, to ensure our plans are informed by the outcomes and lessons learned from past projects. And, NAF anticipates that SIF applicants may choose to replicate or propose models that have been tested in these projects (i.e. peer-based models). However, the two fundamental differences between HRSA and NAF are:

* NAF has a 20+ year old network of Community Partnerships through which to disseminate SIF lessons and outcomes in real time, reaching hundreds, if not thousands of practitioners;
* NAF has 20+ years of spurring innovation by developing and leveraging public-private partnerships, whereby private resources often pave the way for innovation that is later supported by public resources.

The fact is, more than 600,000 individuals living with HIV/AIDS are simply not in care -- some because

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they don't know their HIV status and many others because they face barriers in accessing existing services. The National AIDS Fund proposes to use the Social Innovation Fund (SIF) funds, to go much farther "up stream" - not to provide direct services, per se, but to catalyze changes in the service systems that address the underlying reasons individuals with HIV/AIDS are not getting into care, to remove those barriers and to facilitate engagement and retention in care.

SIF funding will play a strategic role, offered by no other federal funding sources, to support the creation of model programs that remove the barriers to accessing care for the populations most impacted by health disparities. Further, SIF funds will assist the HIV/AIDS community in leveraging private sector resources at a critical and historical time -- simultaneously as the White House Office of National AIDS Policy (ONAP) releases the first National HIV/AIDS Strategy (NHAS) for the United States. The NHAS will only a "well informed plan" without the strategic investment of new resources and the development of public-private partnerships to help ensure the implementation of the plan. The timing and purpose of SIF funds could not be better suited to address this unique opportunity in U.S. history.

3. The focus of the Access to Care grantees will reflect the socio-economic reality of most HIV positive individuals not in care and facing barriers associated with poverty and other structural impediments to health care. Nearly one in four blacks and one in five Hispanics in the U.S. live in poverty [US Census Bureau]. Socioeconomic problems associated with poverty, including limited access to high-quality health care; the exchange of sex for drugs, money, or to meet other needs; and higher levels of substance use can directly or indirectly increase HIV risk factors. HIV has affected women since the beginning of the pandemic, increasingly disproportionately, and HIV risk continues to be driven by conditions of racial, gender, and economic inequality. Their lives and the situations which put them at risk for HIV infection are largely shaped by these structural forces. A study of HIV transmission among black women in North Carolina found that women with an HIV diagnosis were significantly more likely than women

who were not infected to be unemployed; to have had more sex partners; to exchange sex for money, shelter, or drugs; or to receive public assistance [CDC]. Relatively poor socio-economic conditions across the South have likely contributed to overall poor health outcomes and profound racial/ethnic health disparities, not just for HIV/AIDS but for many preventable diseases. The percentage of individuals with lower levels of education, employment, income and health insurance are all higher in the Deep South compared to the U.S. overall.

Beyond the South, poverty continues to fuel the HIV/AIDS epidemic throughout the U.S. NAF-supported community-based organizations (CBOs) on the ground report that it is the exception, rather than the rule, when a client is not living in poverty -- so the vast majority of people that our grantees serve are people living in poverty. These statistics are borne out in federal data when looking at people living with HIV/AIDS and their heavy reliance on publicly-funded programs for access to care: 54% of people living with HIV/AIDS are on Medicaid and/or Medicare compared to 28% of the general population; while only 17% have individual or group private health insurance compared to 54% of the general population.

4. A number of innovative strategies are being developed to improve the health outcomes of people living with HIV/AIDS by increasing their access to appropriate medical care and supportive services. The four strategies outlined below are being developed by our Community Partnerships and - or in conjunction with the work of - our directly-funded grantees, and have the potential to both influence the interventions of Access to Care as well as be replicated in communities around the country, and to become a part of multi-faceted interventions that identify, connect, and retain individuals in health care. To better understand the various factors that facilitate or impede engagement and retention in care, the AIDS Foundation of Chicago, a NAF Community Partner, is developing an innovative case management assessment tool to strengthen the Chicago HIV/AIDS care system by identifying individuals who may

need more HIV care support, and by examining common system-level barriers that affect treatment retention. The articulation of individualized care is intended to dramatically affect access and adherence to care and enhance the systemic response to the epidemic.

The use of electronic health information exchange systems matching in real time, patients that are entering state hospital systems with the public health data on persons out of care for HIV, syphilis and tuberculosis is an example of innovation that is being developed to assists health care providers in the identification of persons who are out of care and facilitates re-engagement with the health care system, regardless of the point of contact. This direct link between public health and providers has created a more seamless system of health care delivery and assisted in getting out-of-care PLWHA back into care.

New York City is developing a provider learning collaborative for its network of HIV/AIDS care providers to improve the efficiency and effectiveness of the HIV/AIDS medical care system. The intention of the learning collaborative is to increase patient-centered care, reduce wait times for services, and monitor individuals at risk of falling out of care and move beyond client-level barriers, to address the broader system of service delivery.

Much has recently been written about the work of community viral load mapping, a new population-based measure of viral burden, or overall level of HIV infectiousness averaged over a geographic area. High viral loads indicate that individuals are not accessing or adhering to HIV medical care. Using this innovative strategy, outreach workers can target communities with disproportionately high viral loads to more effectively identify people living with HIV/AIDS who are not in care. With additional Access to Care resources there will be opportunities to use community viral load information to create interventions that make a difference in "hot spots" in the epidemic and apply the principles of viral load mapping to develop strategies to not only focus on particular neighborhoods that are heavily impacted

by HIV but increase interventions to bring more HIV-positive community members into care.

Additional models include:

NAF's correctional re-entry projects (including HRSA's HIV jails SPNS project: http://hab.hrsa.gov/special/JAIL_index.htm that improve health and reduce recidivism;

Chicago Housing for Health Partnership: http://www.aidschicago.org/pdf/2009/Housing_Policy_Factsheet.pdf;

Coordinated routine rapid testing in all Illinois birthing hospitals (http://www.aidschicago.org/pdf/2010/SHARP_fullreport.pdf;

ACTS (Assess, Counsel, Test, Support), a paradigm-shifting approach to HIV Counseling and Testing (C&T) that is proven to help make C&T a more routine part of health care services in various health care settings: http://www.adolescentaids.org/healthcare/acts.php

5. The Access to Care Initiative aims to increase the engagement of people who know they are HIV positive but who are not effectively engaged in care by identifying evidence-based interventions that help clients and systems reduce barriers to care and increase the number of individuals connected to primary or specialty care, as well as the number of individuals connected to supportive services, ultimately leading to long-term tracking of improvements in individual and site-level health outcomes.

Ultimately, a decrease in the percentage of people living with HIV/AIDS who are out of care will demonstrate a strong impact; however we anticipate that additional meaningful outcomes will include: substantial reduction at the local and regional levels of systemic barriers within the medical and social

service systems leading to the identification and implementation of cost-effective public health interventions that reduce barriers to HIV care.

Grantees that are able to achieve both client and systems- level change will undoubtedly have a significant impact on the individual health outcomes of PLWHA in their communities and a significant impact on the community viral load and subsequent HIV infection rates within the community [Moupali Das and Julio Montaner]. Reduction of HIV infection as well as increases in HIV medical care access and adherence will also result in substantial personal and public savings associated with the benefits of early treatment and improved long-term health status of people living with HIV.

As a cohort, the outcomes from our national evaluation have the potential to provide knowledge that can transform the delivery of HIV/AIDS care throughout the United States with broader applications to the general public health and medical communities.

6. Multiple data collection tools and strategies will be employed to capture a complete picture of the client-level outcomes of the Access to Care interventions. These tools will be built around standard measurement definitions that will be used across program sites to aid in the national evaluation process. A combination of client surveys, medical visit reports, CD4 counts and viral load measurements will be used to track client-level progress throughout a program. Specifically barriers to care will be identified through a survey of socioeconomic, psychological, and structural barriers to accessing care and treatment services; client needs will be identified through a survey of client needs based on local services and resources; successful linkage to care will be measured through verification of a medical visit with a provider within 30 days of enrollment in the Access to Care intervention and retention in care will be determined through evidence of two medical visits at least three months apart per measurement year. Finally, improvement in health outcomes will be determined by CD4 cell counts collected at point of entry and each follow up medical visit; percentage of clients with health that is excellent, very good, or good and percentage of clients with CD4 < 500 prescribed HAART.

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7. The HIV/AIDS epidemic in some ways is the "perfect storm" of the convergence of multiple and complex health challenges. Many people living with HIV/AIDS are multiply-diagnosed with diabetes, cardiovascular disease, substance abuse, behavioral health issues and more. Although HIV is not the only chronic illness that finds itself at the intersection of many competing health issues, the complexity of this reality is significant. For these reasons, former President Bill Clinton has noted, "If we can beat HIV, we can beat anything." We believe there are specific lessons to be learned from access to care successes that will benefit the growing movements to integrate multiple health services, use electronic health technology to better serve patients and providers, and create more patient-centered medical care in the field of HIV/AIDS and beyond. Integrating health delivery systems: the intersection of competing health and substance abuse and or mental health priorities in the field of HIV/AIDS has made providers on the ground begin to confront the challenges of competing health issues by creatively integrating services and streamlining medical delivery systems to improve their client's health outcomes. E-health technology: the application of innovative uses of medical and pharmacy health records for patient tracking and adherence monitoring has vast implications for other disease management systems in the field of infectious and chronic health. Patient-centered medical care has the capacity to reduce wait times, improve patient navigation through various health systems, and enhance medical care and health outcomes; this strategy has multiple applications particularly in the field of chronic health care delivery and gerontology.

The National AIDS Fund realizes the potential for cross-cutting outcomes to be produced from HIV-specific access to care work and has made an a huge commitment to evaluation because we believe there will be findings that will be applicable to other diseases.

8. The NAF strategic plan has three foci -- leveraging resources, developing leadership and advocacy,

and fostering innovation. These three strategies, developed in 2008 before the call for the National HIV/AIDS Strategy (NHAS), are uniquely positioned and aligned with the Obama Administration's goals for the national strategy and SIF.

NAF's SIF application will be perfectly synergistic with the NHAS in three ways:

1) Increasing Access to Care is one of the three pillars of the NHAS and requires innovation if we expect to change ineffectual systems and remove barriers to accessing care.

2) Developing Public-Private Partnerships (PPP) is an overarching goal of the Obama Administration as an explicit strategy, outlined by the Office of National AIDS Policy (ONAP), critical to reaching the targets that will be outlined in the NHAS. The Access to Care project is an ideal example of how public-private partnerships can come together to achieve a critical goal of the NHAS. Furthermore, NAF has already been in conversations with ONAP about how NAF's 20+ year history engaging the private sector can serve as a catalyst toward increasing support for all pillars of the NHAS, but particularly for the Access to Care pillar.

3) NAF's ongoing development of SIF measures have been guided by the preliminary information available via public ONAP briefings and are expected to be consistent with the principles of "clear benchmarks, increased accountability, measurable outcomes" that are expected to be outlined in the NHAS.

The National AIDS Fund is encouraged that SIF may provide the Obama Administration and NAF a formal opportunity to work together on the development of a public-private partnership that will spur innovation and directly contribute to the success of the National HIV/AIDS Strategy.

9. Emphasis on hard-to-reach populations is integral in NAF's Access to Care work. This initiative is predicated on the understanding of why particular individuals and communities have not engaged in

care and dedicated to creating systems and interventions to alleviate barriers and implement innovative approaches to ensuring access to and engagement in care. The premise of our approach is reaching the most difficult populations with intensive outreach strategies and appropriate resources that otherwise would not be available. The Access to Care proposal recognizes and acknowledges that some strategies in the field have not been fully successful and greater innovation is necessary to find individuals not in care, engage them in a way that optimizes success and breaks down systemic and or personal barriers to accessing care. The use of peers will be integral to identifying and engaging out-of-care PLWHA, and getting them into and retaining them in care. A PLWHA who has gone through diagnosis and who ultimately sought care can offer a unique perspective in reaching out-of-care individuals that is not possible with a social worker or clinician. The ability to illustrate that it is possible to move forward with a diagnosis of HIV and live a healthy life can help engage hard-to-reach individuals. This is also a strategy that looks at cultural competency -- having people on the ground that "look like me" and have similar life experiences. The project will also be soliciting information from participants to assess barriers to care including: socioeconomic (poverty, homelessness, immigration, incarceration); psychological (drug use, fear, stigma, denial, distrust of medical system, lack of per lack of perceived need, competing priorities); structural (transportation, location of care, structure of testing, use of ancillary services); so that we can identify the critical barriers and develop interventions specific to their mitigation.

10. The National AIDS Fund has a 20+ year track record of publicizing and conducting competitive grantee selection processes. NAF has a database of thousands of CBOs across the US which includes AIDS-specific organizations and non-traditional organizations that have access to the priority populations, but may not be HIV/AIDS specialists. NAF believes strongly that any successful access to care efforts will include a broad range of organizations necessary to fundamentally change service delivery systems and to systematically reduce barriers to HIV/AIDS care.

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In order to uncover latent innovation and reach the most marginalized populations, engagement of non-traditional, grassroots organizations will be required. However, the data collection, reporting, fiscal management, matching resource requirements and evaluation capacity needed to successfully manage a SIF grant, will require a significant amount of sophistication and resource generating capacity. In order to span both ends of this continuum, we will encourage collaborative applications from highly impacted communities across the United States. NAF has a two-pronged grant-making philosophy that is fundamental to the value we place on our funder/grantee relationships. NAF explicitly believes that we should:

1) have open and transparent competition for public and private funds; and

2) never encourage CBOs or communities that lack capacity or readiness, or that cannot demonstrate competitive "need" to spend precious time preparing a funding application that has a high likelihood of not being funded.

In anticipation of the RFP process, NAF has conducted a tremendous amount of due diligence to identify the states and metropolitan areas that are highly impacted by HIV/AIDS, have high unmet care needs, and that likely possess the capacity to successfully prepare an application on behalf of their community. Promoting the RFP through our extensive network of community based organizations, our Community Partnerships, the NAF website, and other national philanthropic organizations and grant-making entities, NAF will encourage a broad spectrum of communities to apply for SIF resources through an application process that is open and transparent, with sufficiently detailed programmatic and operational requirements to both encourage collaborative responses and minimize efforts by communities that would likely not be able to address the complexity, level of required collaboration and accountability, and aggressive time-line necessary for a successful response to the RFP.

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NAF will conduct a competitive sub-grant selection process that will include in our review committee qualified, expert reviewers who have no prior connection to the National AIDS Fund or NAF's Community Partnerships; and as is our usual process, NAF will plan to provide technical assistance opportunities to all interested applicants, including expanded technical assistance opportunities targeted to those applicants not currently affiliated with a NAF Community Partnership, or applicants who have not previously applied for NAF funding. It has been our custom to conduct telephone-based technical assistance conference calls once we release an RFP and to provide access to technical assistance questions and answers on our website. We would anticipate following this same process for the SIF sub-grant-making.

11. NAF anticipates that the RFP process will be open to any qualified applicant regardless of their funding status with NAF; applicants who are currently funded through Positive Charge or any other NAF-funded program would be evaluated against the same criteria as other applicants, using the same expert review panel and technical assistance process; however, currently funded applicants would have the additional requirement of articulating how SIF resources would expand the scope and impact of the current project and contribute to innovative and replicable interventions that are beyond existing project activities.

Required Documents

Document Name	Status
Match Verification	Sent

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Section 2 – Clarification Questions

Round 1 Clarification questions:

1. Please clarify your approach and commitment to working in Alabama, Louisiana, North Carolina and South Carolina. For example: How will you target your RFP in these states? Will you likely work in rural areas? What unique challenges might you face in these states and how does your program design address these challenges? How many of the 7 – 9 partnerships do you estimate will be located in these states?
2. There is significant Federal funding dedicated to expanding access to care for people with HIV/AIDS. Why is SIF funding necessary? How would SIF funding be unique? Please provide a detailed response.
3. How will you ensure a focus on low-income communities among your subgrantees?
4. Please provide examples of existing program models that demonstrate the capacity of innovation to impact health outcomes for people living with HIV/AIDS.
5. Utilizing the client outcomes listed on page 12, please provide one or more examples of "strong" impact for an A2C-funded subgrantee. What would you consider a meaningful and potentially transformative outcome?
6. Utilizing the client outcomes listed on page 12, please provide a description of a sample of the tools and methodologies (example, surveys) that would be used to collect this information.
7. You note that "we are confident that strategies that work to engage PLWHA in regular care will be replicable with other disadvantaged populations and systems facing complex health challenges." Please expand on this statement in greater detail. Please be specific about the potential applicability (or inapplicability) of A2C-funded innovations.
8. Explain how the upcoming release of the White House National HIV/AIDS Strategy impacts your initiative.
9. How will you ensure that subgrantees reach beyond individuals pre-disposed to participating in interventions, and secure participation from individuals who may be more difficult to involve?
10. How will you publicize your request for proposals to potential subgrantees in order to ensure a competitive subgrant selection process?

Budget Clarification:

Costs included in Federal grant budgets must meet the standards of reasonable and necessary as described in the Office of Management and Budget Cost Principles (OMB Circular A-122 for non-profit organizations). In order to meet the reasonable and necessary standard, you must provide additional justification for the items described below.

1. Under C. Travel, please review the number of trips proposed to ensure all are necessary. Also review the average cost for lodging for reasonableness in this section.
2. Under F. Consultants, please provide more detail on the need for the $250,000 in TA consultant services to support subgrantees. Also, provide more detail on the $300,000 for evaluation consultant services to subgrantees.
3. Under H. Other, please provide a breakdown of costs associated with the $20,000 in Program Information Dissemination and the $20,000 in Program Evaluation Publication/Dissemination.

4. Please provide a copy of the negotiated federal indirect cost rate agreement with another federal agency; please send it to the Corporation.

Round 2 clarification question:

1. Your response to clarification question #10 describes an insufficiently open and competitive subgrant selection process, based on the requirements of the SIF Notice of Federal Funds Availability (NOFA). In specific, limiting proposals to "single collaborative applications" from each target region is in direct contrast to the requirements in the NOFA and the spirit of the Social Innovation Fund. There are multiple ways to re-structure your selection process to allow for more open competition without over-taxing communities or CBOs that truly lack capacity. Please revise your answer to question #10 to comply with the SIF NOFA.
2. Please modify your answer to clarification question #1 to similarly reflect a more open and competitive subgrant selection process. In specific, remove any reference to an "invitation-only" RFP.

Round 3 clarifications:

As noted in the SIF NOFA, "By statute, SIF intermediaries must select subgrantees on a competitive basis." Our technical assistance period prior to the application deadline clarified that closed-network selection processes are not competitive. Please understand that under the terms of the cooperative grant agreement, each intermediary will need to submit a detailed plan for their competitive subgrant selection process for approval by the Corporation. The Corporation will also monitor the processes for compliance and appropriate outcomes.

Please answer the following clarification questions through the eGrants system. Include your response to question 1. in your revision to clarification question #10. Include your response to question 2. as a new clarification question #11. Your application will shortly be returned to you to facilitate this editing process. Please respond by 5:00 p.m. ET on Friday, July 9, 2010.

1. With respect to your competitive subgrant selection process, can you commit to:
   - Include in your review committee qualified, expert reviewers who have no prior connection to the National AIDS Fund (NAF) or NAF's Community Partnerships; and
   - Provide expanded technical assistance opportunities to interested applicants that are not affiliated with Community Partnership or who have otherwise not received NAF funding in the past.
2. Your web site includes an announcement of recent "Positive Charge" grantees. One of the listed grantees is the "North Carolina Access to Care" initiative. Please explain how this initiative would be considered under a SIF competitive subgrant selection process. Would this initiative be eligible for SIF funding? If they were eligible to apply, would their application be evaluated on a different set of criteria from new applicants to NAF?

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Section 3 – Budget

Expanding Access to HIV/AIDS Care

National AIDS Fund

Application ID: 10SI114882

Budget Dates: 08/01/2010 - 07/31/2015

		Total Amt	CNCS Share	Grantee Share
Section I. Program Costs				
A. Project Personnel Expenses		194,460	97,230	97,230
B. Personnel Fringe Benefits		1,313	657	656
FICA		14,876	7,438	7,438
Health Insurance		8,352	4,176	4,176
Retirement		11,668	5,834	5,834
Life Insurance		1,711	855	856
	Total	$37,920	$18,960	$18,960
C. Travel		147,855	61,300	86,555
D. Equipment				
E. Supplies		18,746	9,873	8,873
F. Contractual and Consultant Services		574,000	209,500	364,500
H. Other Costs		41,020	20,510	20,510
Subgrants		5,625,000	3,000,000	2,625,000
	Total	$5,666,020	$3,020,510	$2,645,510
Section I. Subtotal		**$6,639,001**	**$3,417,373**	**$3,221,628**
Section II. Indirect Costs				
J. Federally Approved Indirect Cost Rate				
Indirect Costs		697,095	179,754	517,341
	Total	$697,095	$179,754	$517,341
Section II. Subtotal		**$697,095**	**$179,754**	**$517,341**
Budget Totals		**$7,336,096**	**$3,597,127**	**$3,738,969**
Funding Percentages			**49%**	**51%**
Required Match			**n/a**	
# of years Receiving CNCS Funds			**n/a**	

2010 Social Innovation Fund

National AIDS Fund

Section 4 – Budget Narrative

Budget Narrative: Expanding Access to HIV/AIDS Care for National AIDS Fund

Section I. Program Costs

A. Project Personnel Expenses

Position/Title -Qty -Annual Salary -% Time	CNCS Share	Grantee Share	Total Amount
President & CEO: - 1 person(s) at 187460 each x 8 % usage	7,498	7,499	14,997
Executive Assistant to President & CEO: - 1 person(s) at 57288 each x 4 % usage	1,146	1,146	2,292
VP, Program and Evaluation: - 1 person(s) at 140000 each x 40 % usage	28,000	28,000	56,000
VP, External Affairs: - 1 person(s) at 164800 each x 20 % usage	16,480	16,480	32,960
Senior Program Officer: - 1 person(s) at 79844 each x 20 % usage	7,985	7,984	15,969
Program Officer: - 1 person(s) at 65000 each x 100 % usage	32,500	32,500	65,000
Program Assistant: - 1 person(s) at 36210 each x 20 % usage	3,621	3,621	7,242
CATEGORY Totals	97,230	97,230	194,460

B. Personnel Fringe Benefits

Purpose -Calculation	CNCS Share	Grantee Share	Total Amount
FICA: FICA rate 7.65% x $194,460 Personnel Costs = $14,876	7,438	7,438	14,876
Health Insurance: Aggregate Health Ins @ 4.3% x $194,460 total personnel = $8,352	4,176	4,176	8,352
Retirement: 403(b)(7) retirement employer matching contribution @ 6% x $194,460 total personnel = $11,668	5,834	5,834	11,668
LIfe Insurance: Aggregate life insurance .88/100 x $194,460 total personnel = $1,711	855	856	1,711
DC - UC tax: Aggregate DC UC Tax @ 1.8% x $54,534 taxable personnel cost = $982	491	491	982
Workers Compensation Insurance: Aggregate WC Insurance @ .17/100 x $194,460 = $331	166	165	331
CATEGORY Totals	18,960	18,960	37,920

C. Travel

Purpose -Calculation	CNCS Share	Grantee Share	Total Amount
Site Visits and TA Travel to Sub grantees: 9 sites x 2 trips ea x 2 persons @ $530 avg airfare per trip = $19,080	8,480	10,600	19,080
Site Visits and TA Travel to Sub grantees: 9 sites x 2 trips ea x 2 persons x 2 nights @ $286 avg lodging per night = $20,592	9,152	11,440	20,592

Site Visits and TA Travel to Sub grantees: 9 sites x 2 trips ea x 2 persons x 2 days @ $65 avg per diem per day = $4680	2,080	2,600	4,680
Subgrantee TA Convening Meeting Travel: 9 sites x 5 persons (4 site staff + 1 evaluator) = 45 persons; 4 NAF staff; 4 speakers; 4 guests. Total 57 persons @ $530 avg airfare per trip = $30,210	10,600	19,610	30,210
Subgrantee TA Convening Meeting Travel: 9 sites x 5 persons (4 site staff + 1 evaluator) = 45 persons; 4 NAF staff; 4 speakers; 4 guests. Total 57 persons x 2 nights @ $286 per night avg = $32,604	11,440	21,164	32,604
Subgrantee TA Convening Meeting Travel: 9 sites x 5 persons (4 site staff + 1 evaluator) = 45 persons; 4 NAF staff; 4 speakers; 4 guests. Total 57 persons x 3 days @ $65 a day per diem avg = $11,115	3,900	7,215	11,115
Preaward Review Site Visits Travel to Subgrantees: 4 subgrantee sites x 1 trip ea x 2 persons (1 NRC and 1 NAF staff) @ $530 avg airfare per trip = $4,240	2,120	2,120	4,240
Preaward Review Site Visits Travel to Subgrantees: 4 subgrantee sites x 2 persons (1 NRC and 1 NAF staff) x 2 nights @ $286 avg lodging per night = $4,576	2,288	2,288	4,576
Preaward Review Site Visits Travel to Subgrantees: 4 subgrantee sites x 2 persons (1 NRC and 1 NAF staff) x 2 days @ $65 avg/day per diem = $1,040	520	520	1,040
Subgrantee TA Convening Meeting Space/AV: Meeting space and AV rental x 2 days @ $1,500 per day avg = $3,000	1,500	1,500	3,000
Program Visibility/Networking Conference Registration/Travel: 5 Conferences (Intl Conf HIV/AIDS; US Conf AIDS;Assoc Public Health Advisors; GIH; other. Includes aggregate Registration, hotel & travel. 5 events x 2 persons x $2,500 aggregate cost = $25,000	12,500	12,500	25,000
CATEGORY Totals	64,580	91,557	156,137

D. Equipment

Item/Purpose -Qty -Unit Cost	CNCS Share	Grantee Share	Total Amount
CATEGORY Totals	0	0	0

E. Supplies

Item -Calculation	CNCS Share	Grantee Share	Total Amount
Program Supplies: General program supplies tracked by account code. Aggregate 12 mos @ $283 per month = $3,446	1,723	1,723	3,446
Fax, Phone (regular non-conference calls): Project general fax/phone calls tracked by account code. Aggregate 12 months @ $167 per month = $2,000	1,000	1,000	2,000
Phone - Subgrantee TA conference calls: Subgrantee TA conference calls for monitoring purposes. 9 sites x 2 calls/yr x $50 per call = $900	450	450	900
Project support technology - program staff: 3 laptops ($1,500 each); 3 printers & ink ($500 each); 3 PC's and monitors ($1,000 each)	5,000	4,000	9,000
Program Printing/Copying: Project general printing/copying tracked by account code. Aggregate 12 months @ $283 per month = $3,400	1,700	1,700	3,400
CATEGORY Totals	9,873	8,873	18,746

F. Contractual and Consultant Services

Purpose -Calculation	CNCS Share	Grantee Share	Total Amount
Website Design - Program Outcomes Dissemination: Website designer contracted to create a web based program information dissemination capacity. $150 per hour x 100 hrs = $15,000	5,000	10,000	15,000
Database multi-user annual license - Program management: Grants management database (FIMS) - user licenses for Program dedicated staff. 2 annual user licenses @ $1,500 each = $3,000	1,500	1,500	3,000
Web based Philantrack subgrant application TA access & support: Acquisition of Philantrack grants application tool components @ $2,500; TA and training for 2 staff @$150/hour x 10 hours = $1,500; $2,000 annual program license	3,000	3,000	6,000
TA consultant services to support subgrantees: 5 TA consultants x 125 days x $400 per day = $250,000	100,000	150,000	250,000
Evaluation consultant services to subgrantees: Evaluation of program and subgrantee outcomes. 2 evaluators x 250 days @ $600 per day = $300,000	100,000	200,000	300,000
CATEGORY Totals	209,500	364,500	574,000

H. Other Costs

Purpose -Calculation	CNCS Share	Grantee Share	Total Amount
Subgrants:	3,000,000	2,625,000	5,625,000
Program Information Dissemination (HGX)- evidence based best practices report design and print costs:	10,000	10,000	20,000
Program Evaluation Publication/Dissemination - (HGX) Design, development, publication and disseminatin of evaluation findings (posters; scientific journals; print findings):	10,000	10,000	20,000
CATEGORY Totals	3,020,000	2,645,000	5,665,000
SECTION Totals	3,420,143	3,226,120	6,646,263
PERCENTAGE	51%	49%	

Section II. Indirect Costs

J. Federally Approved Indirect Cost Rate

Calculation -Cost Type -Rate -Rate Claimed -Cost Basis	CNCS Share	Grantee Share	Total Amount
: Total Direct Costs: NAF federally approved 2008 ICR Final and 2009-10 Provisional Rate = 10.5% of Total Direct Costs. CNCS Federal Share maximum = 5% of total federal budget or 5.26% of total federal budget direct costswith a rate of 10.5 and a rate claimed of 10.5	179,900	517,958	697,858
CATEGORY Totals	179,900	517,958	697,858
SECTION Totals	179,900	517,958	697,858

PERCENTAGE	26%	74%	

BUDGET Totals	3,600,043	3,744,078	7,344,121
PERCENTAGE	49%	51%	

Source of Funds

Section	Match Description	Amount	Type	Source
Source of Funds	$3,700,000 match from Bristol-Myers Squibb Company; $364,000 match from Walmart Foundation	4,064,000	Cash	Private
Total Source of Funds		4,064,000		